MENTAL HEALTH SERVICES ACT

ALAMEDA COUNTY

FY 2017 - 2020

THREE YEAR PLAN

RELEASED FOR PUBLIC COMMENT: JANUARY 16 – FEBRUARY 16, 2018

MENTAL HEALTH SERVICES ACT
FY17-20 THREE YEAR PLAN

TABLE OF CONTENTS

MHSA PLAN COMPONENTS

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

Message from the Deputy Director

Thank you for your interest in the Alameda County Department of Behavioral Health Care Services' (BHCS) Mental Health Services Act (MHSA) Three Year Integrated Plan (17/18-19/20). In 2006, Alameda County received approval for the first MHSA Plan for the Community Services and Supports (CSS) component, followed by Prevention and Early Intervention in 2008, Workforce Development and Training and Capital Facilities and Technology in 2009 and Innovation in 2010. Our portfolio of programs and services supports a comprehensive continuum of care that embraces the MHSA Core Values of community collaboration, cultural responsiveness, being consumer and family driven, the ideals of wellness recovery and resiliency and integrated services.

As the Deputy Director of Alameda County Behavioral Health Care Services I am excited about this new Three Year Plan and the opportunity to engage more with our consumer and family member community, local nonprofit stakeholders, and our public systems on multiple new Innovation projects that have the potential to truly transform our behavioral health system. Alameda is looking to embark on a variety of new Innovation programs around housing, crisis services and alternative transportation, and the connection between marijuana and young adults with mental health challenges.

I hope you will find this Three Year Plan both informative and a reflection of our BHCS vision where we strive to empower all individuals and their families to successfully realize their potential and pursue their dreams and where stigma and discrimination against those with mental health and/or substance use issues are remnants of the past.

Thank you to everyone who came out this summer to our community input meetings, focus groups and key informant interviews, your input has been invaluable and is incorporated into this Plan. Please see the community input section for details.

We look forward to advancing the ideas, activities and programs listed in this Three Year Plan.

Sincerely,

James Wagner, LMFT/LPCC
Deputy Director of Alameda County Behavioral Health Care Services

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.*

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Alameda Date: 12/8/17

MHSA Funding Summary

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: Alameda Date: 12/8/17

	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 2017/18 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	44,182,571	6,682,355	10,027,359	1,782,291	9,301,772	
2. Estimated New FY2017/18 Funding	38,876,959	25,917,973	3,410,632			
3. Transfer in FY2017/18[a/]						
4. Access Local Prudent Reserve in FY2017/18						0
5. Estimated Available Funding for FY2017/18	83,059,530	32,600,328	13,437,991	1,782,291	9,301,772	
B. Estimated FY2017/18 MHSA Expenditures	55,040,915	26,388,585	2,429,304	1,580,848	5,439,877	
C. Estimated FY2018/19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	28,018,615	6,211,743	11,008,687	201,443	3,861,895	
2. Estimated New FY2018/19 Funding	37,533,227	25,022,151	3,293,878			
3. Transfer in FY2018/19[a/]	(1,311,262)			1,311,262		
4. Access Local Prudent Reserve in FY2018/19						0
5. Estimated Available Funding for FY2018/19	64,240,580	31,233,894	14,302,565	1,512,705	3,861,895	
D. Estimated FY2018/19 Expenditures	53,538,756	26,860,579	7,766,118	1,512,705	0	
E. Estimated FY2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	10,701,824	4,373,315	6,536,447	(0)	3,861,895	
2. Estimated New FY2019/20 Funding	42,694,045	22,989,101	3,293,878			
3. Transfer in FY2019/20[a/]	0					
4. Access Local Prudent Reserve in FY2019/20						0
5. Estimated Available Funding for FY2019/20	53,395,870	27,362,417	9,830,325	(0)	3,861,895	
F. Estimated FY2019/20 Expenditures	53,100,712	27,337,274	7,603,080	0	0	
G. Estimated FY2019/20 Unspent Fund Balance	295,158	25,143	2,227,245	(0)	3,861,895	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2017	36,066,228
2. Contributions to the Local Prudent Reserve in FY 2017/18	0
3. Distributions from the Local Prudent Reserve in FY 2017/18	0
4. Estimated Local Prudent Reserve Balance on June 30, 2018	36,066,228
5. Contributions to the Local Prudent Reserve in FY 2018/19	0
6. Distributions from the Local Prudent Reserve in FY 2018/19	0
7. Estimated Local Prudent Reserve Balance on June 30, 2019	36,066,228
8. Contributions to the Local Prudent Reserve in FY 2019/20	0
9. Distributions from the Local Prudent Reserve in FY 2019/20	0
10. Estimated Local Prudent Reserve Balance on June 30, 2020	36,066,228

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 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Alameda Date: 12/8/17

	Fiscal Year 2017/18					
	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						
1. Homeless Outreach & Stabilization Team	2,550,853	2,112,395	438,458			
2. North County Senior Homeless Program	1,123,127	772,616	350,511			
3. Support Housing for TAY	1,533,374	1,090,473	442,901			
4. Greater Hope Project	1,848,588	1,429,912	418,676			
5. Small Scale Comprehensive Forensic ACT Team	2,327,558	1,877,445	450,113			
6. Transition to Independence	607,245	463,011	144,234			
7. CHOICES for Community Living	3,060,855	2,888,149	172,706			
8. Transitional Behavioral Health Court ACT Team	1,788,438	1,258,782	529,656			
9. Housing Services for FSP	8,696,553	7,964,674	731,879			
10. Community Conservatorship	750,000	750,000				
11. Assisted Outpatient Treatment (AOT)	768,981	768,981				
12. CHANGES	993,190	595,914	397,276			
13. STRIDES	1,365,743	790,789	574,954			
14. STAGES	493,198	281,692	211,506			
15.	0					
Non-FSP Programs						
1. Mobile Integrated Assess Team for Seniors	575,052	449,342	125,710			
2. Crisis Response Program - Capacity for Valley and Tri-City	576,225	345,735	230,490			
3. MH Court Specialist Program	407,525	308,294	99,231			
4. Juvenile Justice Transformation of Guidance Clinic	376,287	263,401	112,886			
5. Multisystemic Therapy	720,114	506,992	213,122			
6. Crisis Stabilization Service	4,834,269	1,328,531	288,988			3,216,750
7. Co-Occurring Disorders Program	505,539	454,585	50,954			
8. Residential Treatment for Co-occurring Disorders	3,178,930	2,666,495	512,435			
9. Low Income Health Plan Pilot	2,715,700	1,727,457	988,243			
10. Individual Placement Services	3,485,287	2,456,459	1,028,828			
11. Community-Based, Voluntary Crisis Services	3,142,414	3,142,414				
12. Behavioral Health and Developmental Disability Integration Program	374,474	262,132	112,342			
13. Behavioral Medical Home	7,444,336	6,440,567	1,003,769			
14. Culturally-Responsive Treatment Programs for the African-American Community	1,000,000	1,000,000				
15. In-Home Outreach Team	2,139,054	2,139,054				
16. SAGE Case and Care Management	2,224,837	2,224,837				
17. Older Adult Service Team	579,513	245,192	334,321			
CSS Administration	8,879,577	6,034,597	2,844,980			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	71,066,834	55,040,915	12,809,170	0	0	3,216,750
FSP Programs as Percent of Total	50.7%	49,006,318				

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Alameda Date: 12/8/17

	Fiscal Year 2018/19					
	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						
1. Homeless Outreach & Stabilization Team	2,625,501	2,174,215	451,286			
2. North County Senior Homeless Program	1,155,880	795,003	360,877			
3. Support Housing for TAY	1,578,545	1,122,508	456,037			
4. Greater Hope Project	1,903,020	1,471,945	431,075			
5. Small Scale Comprehensive Forensic ACT Team	2,395,756	1,932,350	463,406			
6. Transition to Independence	625,394	476,853	148,541			
7. CHOICES for Community Living	2,575,752	2,403,011	172,741			
8. Transitional Behavioral Health Court ACT Team	1,810,535	1,274,401	536,133			
9. Housing Services for FSP	7,932,994	7,193,349	739,645			
10. Community Conservatorship	750,000	750,000				
11. Assisted Outpatient Treatment (AOT)	792,050	792,050				
12. CHANGES	1,022,986	601,516	421,470			
13. STRIDES	1,406,715	814,512	592,203			
14. STAGES	507,994	290,142	217,852			
15.	0					
Non-FSP Programs						
1. Mobile Integrated Assess Team for Seniors	592,304	462,823	129,481			
2. Crisis Response Program - Capacity for Valley and Tri-City	576,225	345,735	230,490			
3. MH Court Specialist Program	407,525	308,294	99,231			
4. Juvenile Justice Transformation of Guidance Clinic	376,287	263,401	112,886			
5. Multisystemic Therapy	741,717	522,201	219,516			
6. Crisis Stabilization Service	4,979,298	1,374,387	297,658			3,307,253
7. Co-Occurring Disorders Program	505,539	454,585	50,954			
8. Residential Treatment for Co-occurring Disorders	3,274,298	2,746,489	527,809			
9. Low Income Health Plan Pilot	2,762,000	1,754,661	1,007,339			
10. Individual Placement Services	3,486,963	2,458,135	1,028,828			
11. Community-Based, Voluntary Crisis Services	3,881,187	3,881,187				
12. Behavioral Health and Developmental Disability Integration Program	374,474	262,132	112,342			
13. Behavioral Medical Home	6,450,631	5,446,862	1,003,769			
14. Culturally-Responsive Treatment Programs for the African-American Community	1,000,000	1,000,000				
15. In-Home Outreach Team	1,790,964	1,790,964				
16. SAGE Case and Care Management	2,440,918	2,440,918				
17. Older Adult Service Team	760,347	321,703	438,644			
18.	0					
19.	0					
CSS Administration	8,457,403	5,612,423	2,844,980			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	69,941,202	53,538,756	13,095,193	0	0	3,307,253
FSP Programs as Percent of Total	50.6%					

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Alameda Date: 12/8/17

	Fiscal Year 2019/20					
	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						
1. Homeless Outreach & Stabilization Team	2,702,389	2,237,890	464,499			
2. North County Senior Homeless Program	1,189,615	818,061	371,554			
3. Support Housing for TAY	1,625,070	1,155,504	469,566			
4. Greater Hope Project	1,959,086	1,515,240	443,846			
5. Small Scale Comprehensive Forensic ACT Team	2,466,001	1,988,904	477,097			
6. Transition to Independence	644,088	491,112	152,976			
7. CHOICES for Community Living	2,091,089	1,918,311	172,778			
8. Transitional Behavioral Health Court ACT Team	1,833,294	1,290,489	542,805			
9. Housing Services for FSP	8,066,561	7,315,527	751,034			
10. Community Conservatorship	750,000	750,000				
11. Assisted Outpatient Treatment (AOT)	815,812	815,812				
12. CHANGES	1,053,675	606,537	447,138			
13. STRIDES	1,448,917	838,948	609,969			
14. STAGES	523,234	298,847	224,387			
15.	0					
Non-FSP Programs						
1. Mobile Integrated Assess Team for Seniors	610,073	476,707	133,366			
2. Crisis Response Program - Capacity for Valley and Tri-City	576,225	345,735	230,490			
3. MH Court Specialist Program	407,525	308,294	99,231			
4. Juvenile Justice Transformation of Guidance Clinic	376,287	263,401	112,886			
5. Multisystemic Therapy	763,969	537,868	226,101			
6. Crisis Stabilization Service	5,128,676	1,421,619	306,587			3,400,470
7. Co-Occurring Disorders Program	505,539	454,585	50,954			
8. Residential Treatment for Co-occurring Disorders	3,372,527	2,828,884	543,643			
9. Low Income Health Plan Pilot	2,809,689	1,782,681	1,027,008			
10. Individual Placement Services	3,488,689	2,459,861	1,028,828			
11. Community-Based, Voluntary Crisis Services	3,176,686	3,176,686				
12. Behavioral Health and Developmental Disability Integration Program	374,474	262,132	112,342			
13. Behavioral Medical Home	6,457,118	5,453,349	1,003,769			
14. Culturally-Responsive Treatment Programs for the African-American Community	1,000,000	1,000,000				
15. In-Home Outreach Team	1,844,692	1,844,692				
16. SAGE Case and Care Management	2,499,259	2,499,259				
17. Older Adult Service Team	783,157	331,354	451,803			
18.	0					
19.	0					
CSS Administration	8,457,403	5,612,423	2,844,980			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	69,800,818	53,100,712	13,299,637	0	0	3,400,470
FSP Programs as Percent of Total	51.2%					

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Alameda Date: 12/8/17

	Fiscal Year 2017/18					
	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						
1. Early Childhood (0-8) Mental Health Consultation	1,446,595	1,255,324	191,271			
2. School-Based Mental Health Consultation in Elementary & Middle Schools	2,226,689	2,226,689				
3. Stigma & Discrimination Reduction Campaign	1,331,473	1,303,994	27,479			
4. Outreach, Education & Consultation for the Latino Community	1,234,062	1,112,091	121,971			
5. Outreach, Education & Consultation for the Asian Pacific Islander Community	1,481,176	1,255,528	225,648			
6. Outreach, Education & Consultation for the So. Asian-Afghan	780,576	725,337	55,239			
7. Outreach, Education & Consultation for the Native American Community	318,175	289,278	28,897			
8. Suicide Prevention and Trauma-Informed Cared	1,594,518	1,594,518	0			
9. Wellness, Recovery and Resiliency Services	2,096,231	1,943,574	152,657			
10. Family Education Center	1,660,423	1,628,655	31,768			
11. Staffing to Asian Population (ACCESS)	825,458	752,850	72,608			
12. Staffing to Latino Population (ACCESS)	722,821	625,623	97,198			
13. TAY Resource Centers	847,109	694,709	152,400			
14. Adult and Older Adult Peer Support	270,265	270,265				
15. Culturally-Responsive Programs for the African-American Community	1,000,000	1,000,000				
16. Wellness Center	4,473,493	3,943,993	529,500			
17. LGBT Support Services	324,204	324,204				
18. Post Crisis Peer Mentorship	319,349	319,349				
PEI Programs - Early Intervention						
19. Early Intervention for the Onset of First Psychosis & SMI Among TAY	1,334,091	933,436	400,655			
20. Mental Health-Primary Care Integration for Older Adults at Ers	784,143	554,150	229,993			
21.	0					
22.	0					
23.	0					
24.	0					
25.	0					
26.	0					
27.	0					
28.	0					
29.	0					
30.	0					
31.	0					
32.	0					
PEI Administration	4,736,797	3,635,018	1,101,779			
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	29,807,648	26,388,585	3,419,063	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Alameda Date: 12/8/17

	Fiscal Year 2018/19					
	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						
1. Early Childhood (0-8) Mental Health Consultation	1,472,537	1,280,765	191,772			
2. School-Based Mental Health Consultation in Elementary & Middle Schools	2,282,936	2,282,936				
3. Stigma & Discrimination Reduction Campaign	1,366,837	1,339,358	27,479			
4. Outreach, Education & Consultation for the Latino Community	1,271,084	1,145,454	125,630			
5. Outreach, Education & Consultation for the Asian Pacific Islander Community	1,515,958	1,283,541	232,417			
6. Outreach, Education & Consultation for the So. Asian-Afghan	803,994	747,098	56,896			
7. Outreach, Education & Consultation for the Native American Community	327,720	297,956	29,764			
8. Suicide Prevention and Trauma-Informed Cared	1,642,353	1,642,353				
9. Wellness, Recovery and Resiliency Services	2,123,225	1,970,568	152,657			
10. Family Education Center	1,710,236	1,677,515	32,721			
11. Staffing to Asian Population (ACCESS)	850,222	777,614	72,608			
12. Staffing to Latino Population (ACCESS)	744,506	647,308	97,198			
13. TAY Resource Centers	857,282	704,882	152,400			
14. Adult and Older Adult Peer Support	278,373	278,373				
15. Culturally-Responsive Programs for the African-American Community	1,000,000	1,000,000				
16. Wellness Center	4,607,698	4,062,313	545,385			
17. LGBT Support Services	333,930	333,930				
18. Post Crisis Peer Mentorship	328,929	328,929				
PEI Programs - Early Intervention						
19. Early Intervention for the Onset of First Psychosis & SMI Among TAY	1,374,113	961,438	412,675			
20. Mental Health-Primary Care Integration for Older Adults at Ers	784,143	554,150	229,993			
21.	0					
22.	0					
23.	0					
24.	0					
25.	0					
PEI Administration	4,645,877	3,544,098	1,101,779			
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	30,321,953	26,860,579	3,461,374	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Alameda Date: 12/8/17

	Fiscal Year 2019/20					
	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						
1. Early Childhood (0-8) Mental Health Consultation	1,499,257	1,277,875	221,382			
2. School-Based Mental Health Consultation in Elementary & Middle Schools	2,339,528	2,339,528				
3. Stigma & Discrimination Reduction Campaign	1,403,263	1,375,784	27,479			
4. Outreach, Education & Consultation for the Latino Community	1,309,216	1,179,817	129,399			
5. Outreach, Education & Consultation for the Asian Pacific Islander Community	1,551,784	1,312,394	239,390			
6. Outreach, Education & Consultation for the So. Asian-Afghan	828,114	769,511	58,603			
7. Outreach, Education & Consultation for the Native American Community	337,552	306,895	30,657			
8. Suicide Prevention and Trauma-Informed Cared	1,691,624	1,691,624				
9. Wellness, Recovery and Resiliency Services	2,116,690	1,964,033	152,657			
10. Family Education Center	1,761,543	1,727,840	33,703			
11. Staffing to Asian Population (ACCESS)	875,728	803,120	72,608			
12. Staffing to Latino Population (ACCESS)	766,841	669,643	97,198			
13. TAY Resource Centers	867,761	715,361	152,400			
14. Adult and Older Adult Peer Support	286,724	286,724				
15. Culturally-Responsive Programs for the African-American Community	1,000,000	1,000,000				
16. Wellness Center	4,745,929	4,184,182	561,747			
17. LGBT Support Services	343,948	343,948				
18. Post Crisis Peer Mentorship	338,797	338,797				
PEI Programs - Early Intervention						
19. Early Intervention for the Onset of First Psychosis & SMI Among TAY	1,415,337	990,282	425,055			
20. Mental Health-Primary Care Integration for Older Adults at Ers	784,143	515,818	268,325			
21.	0					
22.	0					
23.	0					
24.	0					
25.	0					
PEI Administration	4,645,877	3,544,098	1,101,779			
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	30,909,656	27,337,274	3,572,382	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Alameda Date: 12/8/17

	Fiscal Year 2017/18					
	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						
1. Innovation grant	1,216,586	1,216,586				
2. Prop 47 Case Management Services for Re-Entry	300,000	300,000				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	1,000,514	912,718	87,796			
Total INN Program Estimated Expenditures	2,517,100	2,429,304	87,796	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Alameda Date: 12/8/17

	Fiscal Year 2018/19					
	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						
1. Innovation grant	3,177,927	3,177,927				
2. Prop 47 Case Management Services for Re-Entry	300,000	300,000				
3. Housing	1,000,000	1,000,000				
4. Children & Youth	1,000,000	1,000,000				
5. Alternative Transport	500,000	500,000				
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	1,875,987	1,788,191	87,796			
Total INN Program Estimated Expenditures	7,853,914	7,766,118	87,796	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Alameda Date: 12/8/17

	Fiscal Year 2019/20					
	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						
1. Innovation grant	2,331,555	2,331,555				
2. Housing	2,000,000	2,000,000				
3. Children & Youth	2,000,000	2,000,000				
4. Alternative Transport	1,000,000	1,000,000				
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	359,321	271,525	87,796			
Total INN Program Estimated Expenditures	7,690,876	7,603,080	87,796	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Alameda Date: 12/8/17

	Fiscal Year 2017/18					
	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						
1. Workforce Staffing Support	682,458	499,403	183,055			
2. The ACBHCS Training Institute	135,844	135,844				
3. Peer Employment Toolkit	480,929	480,929				
4. Educational Campaign to Increase the Diversity and Language Capacity of the	99,172	99,172				
5. Development of a Coordinated Internship Program	1,000	1,000				
6. Development of a Financial Incentives Program	154,500	154,500				
7. Graduate Level Stipend Program to Increase Workforce Diversity	210,000	210,000				
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	1,763,903	1,580,848	183,055	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Alameda Date: 12/8/17

	Fiscal Year 2018/19					
	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						
1. WET Programs	1,512,705	1,512,705				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	1,512,705	1,512,705	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Alameda Date: 12/8/17

	Fiscal Year 2019/20					
	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						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	0	0	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Compoent Worksheet

County: Alameda Date: 12/8/17

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. A Street Shelter	550,000	550,000				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Behavioral Health Management Systems	4,905,331	4,666,661	238,670			
12. YellowFin	97,000	97,000				
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	180,308	126,216	54,092			
Total CFTN Program Estimated Expenditures	5,732,639	5,439,877	292,762	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Compoent Worksheet

County: Alameda Date: 12/8/17

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

F 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Alameda Date: 12/8/17

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

SUMMARY OF CHANGES FROM PREVIOUS PLAN (FY16-17)

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

I. COMMUNITY SERVICES AND SUPPORTS

a. FULL SERVICE PARTNERSHIP PROGRAMS IN PROCUREMENT

Full-Service Partnerships

The Full-service Partnerships (FSP) were the first set of MHSA-funded programs to be implemented upon approval of our Community Services & Supports plan in 2006. This upcoming procurement effort will ensure that the most qualified and experienced providers continue to utilize the most effective treatment practices for the populations with the highest-need in Alameda County.

An RFI was completed in FY 16/17 and data from the RFI responses were incorporated into the Request-For-Proposal (RFP) that will be released in early FY17-18 with a start date of early FY18/19.

[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.

The RFI articulates BHCS' plan to enter into a contract for FSP services for one program per Contractor with the following allocation:

Population	No. of Teams per Program	No. of Programs	Total Allocation
Child/Youth	2	1	$2,235,000.00
TAY	3	1	$3,489,110.00
FEP	1	1	$1,163,037.00
Adult	2	2	$4,652,146.00
Forensic	2	2	$4,652,146.00
Older Adult	2	1	$2,326,073.00
Chronically Homeless	2	2	$4,652,146.00
TOTAL		**10**	**$23,169,658.00**

Note: Most programs will run two FSP teams with no more than 50 clients served per team at any given time except for the Child/Youth, TAY and FEP FSP.

b. Outreach, Education and System Development (OESD) Programs in Development for the African American Community

On November 30, 2017 BHCS released a Request for Interest (RFI) #17-11 to identify qualified Bidders to provide mental health programs specifically designed for Alameda County African American communities and to solicit community feedback on proposed programs.

Alameda County Behavioral Health Care Services will be offering technical assistance to respondents to the RFI that have not previously contracted with BHCS and indicate an interest in receiving training and technical assistance on the procurement and contracting process

BHCS will follow this process with the release of a Request for Proposal (RFP) in 2018. That RFP will be informed by feedback provided at the informational sessions conducted as part of this RFI process. BHCS intends to procure up to $1,000,000 in Mental Health Services Act (MHSA) Community Services and Supports (CSS) and up to $456,000 in MHSA Prevention and Early Intervention (PEI) services, which will fulfill the two million ongoing budget allocation designated for this target community.

The table below provides an overview of potential CSS programs to be included in the RFP.

Program	Funding Source	Service Overview
Re-entry Mental Health Services	MHSA CSS	• Provision of mental health services and supports to re-entry populations. The priority population for this program includes individuals released from State or Federal prisons or discharged from State parole, Federal parole, or Federal Supervised Release.

Program	Funding Source	Service Overview
Support Services at MHSA Funded Housing Sites	MHSA CSS	Provide site-based supportive services to residents to accomplish the following goals: • Support tenants in securing permanent, sustainable housing including coordination with property management and support with following lease expectations; • Expand consumers' network of social support outside of the health care system; • Foster increased client involvement in personally meaningful activities; • Improve client health status through linkages to health care coverage, health care providers, and services as appropriate; and Support tenants increase annual incomes and access through effective linkages to clinical, social services, employment, education or public benefits.
Training and Technical Assistance on accurate diagnosis and treatment and healing practices	MHSA CSS	• Development of trainings for mental health providers on accurate diagnosis, treatment, and healing practices for African American communities. • Provision of technical assistance and support to mental health providers in better serving African American communities.

II. PREVENTION AND EARLY INTERVENTION (PEI)

a. PEI Programs focused on the African American Community

On November 30, 2017 BHCS released a Request for Interest (RFI) #17-11 to identify qualified Bidders to provide mental health programs specifically designed for Alameda County African American communities and to solicit community feedback on proposed programs.

The table below provides an overview of potential PEI programs to be included in the RFP. Please note due to funding limitations the top ranked program ideas based on the RFI process will move forward with the RFP process.

Program	Funding Source	Service Overview
Faith-based Mental Health Trainings	MHSA PEI	• Development of a training curriculum for faith-based groups to support their communities in addressing the mental health needs of consumers and their family members. Faith-based groups may include churches, congregations, and/or religious or spiritual organizations. • Provision of workshops or trainings to faith based groups and their congregations and members as well as ongoing support and consultation.
Mental Health Support Groups	MHSA PEI	• Development and implementation of a culturally responsive mental health support group curriculum to support participants in using their voices and experiences to address their mental health needs. • Provision of support group sessions. • Development of a Train the Trainer curriculum that community groups or agencies can implement in various community settings. • Provision of ongoing mentoring and support to trainees.
Transgender Mental Health Services	MHSA PEI	• Provision of prevention and early intervention services to transgender communities to create and support safe and trans-affirming environments. This may include workshops and/or training development and implementation.
Culturally Transformative Groups	MHSA PEI	• Provision of technical assistance, training, and consultation to build capacity at schools and community sites to provide culturally responsive services. Cultural transformation should incorporate strategies to promote system level changes.
LGBTQ Youth Development Workshops	MHSA PEI	• Development of a culturally appropriate Youth Development workshop curriculum for Lesbian Gay Bisexual Transgender Queer or Questioning (LBGTQ) middle and high school age youth that empowers participants and promotes leadership. • Facilitation of Youth Development Workshops using a

b. Underserved Ethnic and Linguistic Populations (UELP) RFP

In October 2017 BHCS released a Request for Proposal (RFP) #17-09 to seek proposals for the provision of Prevention and Early Intervention (PEI) services to families and individuals of all ages who identify as part of Unserved or Underserved Ethnic and Language Populations (UELP) in Alameda County. BHCS will use this RFP to establish up to twelve contracts to provide services to the following priority populations:

- Afghan
- African
- Asian

- Middle Eastern and Arabic
- Native American
- Native Hawaiian, other Pacific Islanders and Filipino
- South Asian
- Southeast Asian

These contracts are scheduled to begin in July 2018 (FY 18/19).

III. INNOVATION

a. INN Programs under Procurement

As a follow-up from BHCS' previous MHSA Plan Update several Request-For-Proposals have been implemented for small, time-limited, innovative approaches to address the following areas:

Innovative Technology Applications

In October 2017 BHCS released a Request for Proposal (RFP) #HCSA-900817 to seek 18 month mini grant proposals from teams of qualified behavioral health providers and software developers to design, develop, pilot and test mobile and desktop software applications and tools for improved communication, engagement, support, care coordination and referrals for specific target populations and their service providers.

The purpose of this project is to serve residents of Alameda County who are children/youth, Transition Age Youth (TAY), adults, and older adults who are consumers of mental health services and their family members, consumers of substance use disorder programs, and/or individuals of any age who are currently under-served by mental health services due to language and cultural barriers.

These contracts are scheduled to begin in early 2018 (FY 17/18).

- Educational Mental Health Training Opportunities for Underrepresented and Disadvantaged High School and Undergraduate Students

In May 2017 BHCS released a Request for Proposal (RFP) #17-07 to seek 18 month mini grant proposals to design materials and/or implement programs to support public behavioral/mental health career pathway development at the high school and/or undergraduate level. This project is intended to support the County's ability to attract, recruit, train and retain a qualified and diverse workforce serving the County. A diverse workforce reflects the County culturally, linguistically and economically.

Eight projects were selected and began implementation in early FY 17/18. The projects will cover the following learning question areas:

- Working with Underrepresented Student Populations
- Destigmatizing Public Behavioral/Mental Health Careers
- Innovative Partnerships

Additional Innovative Projects

Additional mini-grant, time-limited, innovative approaches are being developed to address the following areas:

Suicide Prevention: This project strives to reduce suicidality in Alameda County and improve the care and outcomes for individuals at risk of suicide using tools and strategies based on the Zero Suicide Initiative developed by Substance Abuse and Mental Health Services (SAMHSA).

Understanding Children's Mental Health Outcomes: Recommendations for measurement and accountability in a multi-system context to fill a critical knowledge gap and provide new information about the interplay between children's mental health and other factors including other public systems.

Culturally-responsive services and organizational capacity-building to address the needs of diverse, underserved API consumers and family members. In addition, API Mental Health Empowerment statewide conference will be conducted to outreach to API communities and encourage statewide collaboration.

Trauma Informed Systems (TIS) in School project will address community violence and trauma by conducting an innovative project to test the Trauma Informed Systems (TIS) model in a school systems that serves children of color, who have been historically and systematically marginalized.

Juvenile Justice Center - Team Based Group Model project will conduct an innovative group based approach to provide holistic primary care, behavioral health, and other follow up services for youth transitioning from the Juvenile Justice Center (JJC) into the community.

b. New INN Programs under Development for Future Procurement

Alameda County Behavioral Health Care Services (BHCS) is currently developing multiple new proposals for the Innovation component of the Mental Health Services Act. These will be presented to the Mental Health Services Oversight and Accountability Commission (MHSOAC) staff for technical assistance. Those proposals with a strong Innovation aspect will be written up in detail for submission to the Alameda County Board of Supervisors in early Spring and then the MHSOAC for final approval. A summary of the proposed concepts to date are provided in the Innovation section (pg 227). Additional project ideas are also being developed based on this summer's community input and may be included when all INN projects are posted for the 30 day review period however these are the first three areas BHCS is developing:

- Supportive Housing Land Trust
- Community Assessment and Transport Team (CATT)
- Cannabis Education Program for Transition Age Youth (TAY) with Mental Health Challenges

IV. WORKFORCE DEVELOPMENT AND TRAINING (WET) AND CAPITAL FACILITIES AND TECHNOLOGY NEEDS (CFTN)

WET and CFTN will be completing its ten-year block grant from the Mental Health Services Act at the end of FY 2017/18.

BHCS is committed to continue WET activities and currently in the process of shifting WET programs and services to other funding sources. As part of this effort, in November 2017, the WET team conducted an assessment of workforce and training needs with BHCS county and contracted community based organizations (CBOs) through an online survey and a focus group to gather feedback from stakeholders.

The last workforce and training needs assessment was conducted in 2014 as part of MHSA planning, against the backdrop of Affordable Care Act implementation and the shift to an integrated behavioral health care environment. This time, BHCS WET modified the tools from the 2014 assessment to reflect ongoing prioritization of various workforce related activities that the WET team is currently engaged and supporting. Currently the results from the survey and the focus group is being analyzed and a final report will be developed and completed by the beginning of 2018.

The results and data from the 2017 workforce needs assessment will inform our system on further developing BHCS' workforce and training programs in FY 18/19 and FY 19/20. The WET team will also evaluate WET program impact and needs; based on past program outcomes and data, to enhance and implement activities to achieve WET goals in FY18/19.
BHCS WET will include future WET activities in the FY 19/20 MHSA Plan Update.

V. NEW PLANNING EFFORTS

In FY 17/18 BHCS, in collaboration with the African American Health and Wellness Steering Committee, other public systems and the African American community, will begin planning efforts to effectively design a culturally congruent, holistic African American Mental Health and Wellness Center to improve and expand current service delivery systems serving African Americans.

Once a programmatic design is complete, BHCS will work with Alameda County's General Services Administration (GSA) to identify for purchase and retrofit a facility to house and implement the future African American Mental Health and Wellness Center. The capital facility exploration and purchase will take place during this Three year MHSA Plan (FY18/19-19/20).

Involvement of Community Stakeholders

The MHSA FY 17-20 Three Year planning process engaged community stakeholders in county-wide community input meetings, community based focus groups, and online community input surveys. In addition, the MHSA Stakeholder Group, comprised of and representing consumers, family members and providers, formally convenes on a monthly basis. The Stakeholder Group reviews the effectiveness of MHSA strategies, recommends current and future funding priorities, consults with BHCS and the community on promising approaches that have potential for transforming the mental health systems of care and communicates with BHCS and relevant mental health constituencies.

Alameda County Demographics

Alameda County is the seventh most diverse and populous county in California[2], with the highest population (1.64 mil) among the other counties of the Bay Area (Contra Costa, Napa, San Francisco, San Mateo, Santa Clara, Sonoma counties). [3] Alameda County encompasses 14 incorporated cities and several unincorporated communities. In 2016, Alameda County population increased by 9.1% while the state increased by 5.4%. Alameda County ranks one of the most diverse counties and its ethnic makeup continues to change drastically. For example, number of Asian (33.4%) and Latino (24.1%) residents increased drastically, while White (-12.8%) and African American (-12.9%) residents have declined[4]. Diversity is reflected in immigration status. 30.8% of Alameda County residents are immigrants, 50% of whom are naturalized and 43% whose primary language is not English. [5] The threshold languages for Alameda County are English, Spanish, Cantonese, Chinese, Vietnamese, Farsi, and Tagalog.

Table 1. Demographics of Alameda County vs. California (2016)

FACT	CALIFORNIA	ALAMEDA COUNTY, CA
Population estimates, July 1, 2016, (V2016)	39,250,017	1,647,704
Population, percent change - April 1, 2010 (estimates base) to July 1, 2016, (V2016)	5.40%	9.10%
Persons under 5 years, percent, July 1, 2016, (V2016)	6.30%	5.90%
Persons under 18 years, percent, July 1, 2016, (V2016)	23.20%	21.00%
Persons 65 years and over, percent, July 1, 2016, (V2016)	13.60%	13.10%
Female persons, percent, July 1, 2016, (V2016)	50.30%	50.90%
White alone, percent, July 1, 2016, (V2016)	72.70%	50.90%
Black or African American alone, percent, July 1, 2016, (V2016)	6.50%	11.60%
American Indian and Alaska Native alone, percent, July 1, 2016, (V2016)	1.70%	1.10%
Asian alone, percent, July 1, 2016, (V2016)	14.80%	30.20%
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2016, (V2016)	0.50%	1.00%
Two or More Races, percent, July 1, 2016, (V2016)	3.80%	5.30%
Hispanic or Latino, percent, July 1, 2016, (V2016)	38.90%	22.50%
White alone, not Hispanic or Latino, percent, July 1, 2016, (V2016)	37.70%	32.10%
Veterans, 2011-2015	1,777,410	58,797
Foreign born persons, percent, 2011-2015	27.00%	31.40%
Housing units, July 1, 2016, (V2016)	14,060,525	599,732
Owner-occupied housing unit rate, 2011-2015	54.30%	52.70%
Median value of owner-occupied housing units, 2011-2015	$385,500	$543,100

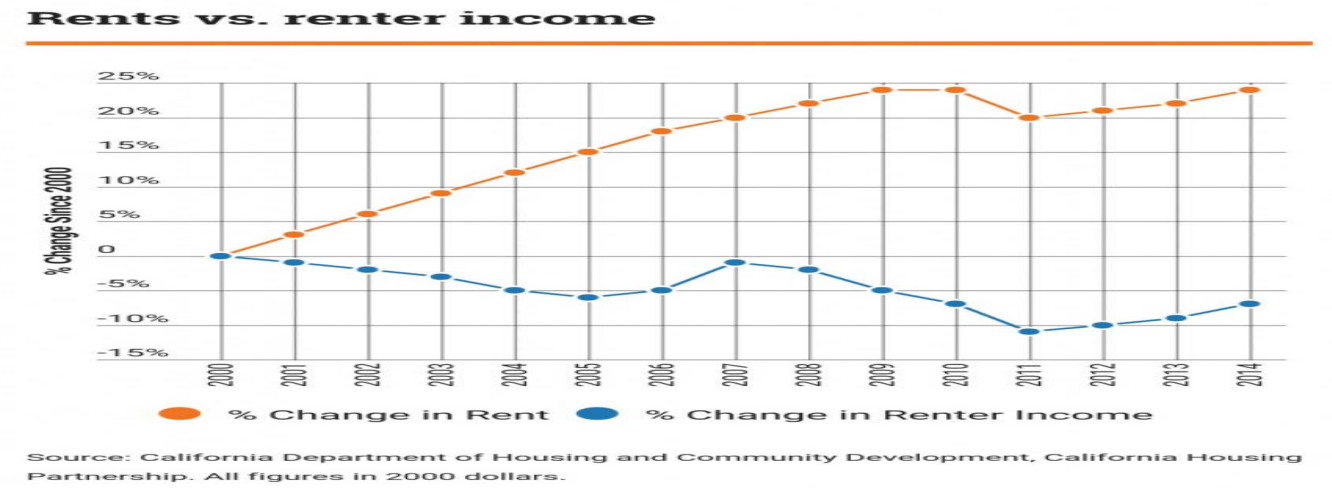
[2] Superior Court of California, County of Alameda 2010
[3] US Census Bureau, American Community Survey 2014
[4] Alameda County Health Data Profile, 2014
[5] Alameda County Health Data Profile, 2014

FACT	CALIFORNIA	ALAMEDA COUNTY, CA
Households, 2011-2015	12,717,801	558,907
Persons per household, 2011-2015	2.96	2.78
Total health care and social assistance receipts/revenue, 2012 ($1,000)	248,953,592	12,949,087
Median household income (in 2015 dollars), 2011-2015	$61,818	$75,619
Persons in poverty, percent	14.30%	11.50%
Population per square mile, 2010	239.1	2,043.60

County Challenges

Alameda County has severe shortage of affordable housing. Since 2000, the gap between renters income and rents have increased by approximately 30%.

Table 2. Rents vs. Renter Income in Alameda County



Source: California Department of Housing and Community Development, California Housing Partnership. All figures in 2000 dollars.

Consequently, homelessness has increased dramatically. The 2017 Alameda County Point-in-Time Count, community-wide effort street count, indicated increase of 4,341 unsheltered individuals in 2009 to 5,329 in 2017. [6]

Table 3. Sheltered/ Unsheltered Individuals by Household

Household Breakdown	Sheltered	Unsheltered
Unaccompanied Children (72 Individuals)	14%	86%
Unaccompanied Transitional Age Youth (919 Individuals)	26%	74%
Families (270 Families/ 711 members)	96%	4%
Veterans (531 Individuals)	29%	71%
Single Adults (4,533 Households/4,846 members)	22%	78%

ACBHCS Consumers Demographics

According to Alameda County Behavioral Health Care Services (ACBHCS) utilization data (FY15-16) , 32,061 individuals were served.

[6] Alameda County Everyone Counts: 2017 Point in Time Count and Survey

Table 4. ACBHCS Consumers by Age (FY15/16)[7]

Age Group	Ages	Number of Consumers/ Clients	% Total County Population
Children/ Youth (C/Y)	0-15	9,513	29.7%
Transitional Age Youth (TAY)	16-24	6,337	19.8%
Adults	25-59	14,168	44.2%
Older Adults	60+	2,043	6.4%
TOTAL POPULATION		32,061	100%

Table 5. Medi-Cal Penetration By Race in Alameda County (2015-2016)[8]

Ethnic Group	Beneficiaries	Served w/ Medi-Cal	Penetration Rate	Outpatient	Outpatient Penetration Rate	Served w/o Medi-Cal	Total Served
Native/ American Indian	1,569	127	8.09%	87	5.54%	52	179
Asian	**127,267**	2,450	1.93%	1,664	**1.31%**	594	3,044
African American	98,185	8,251	8.40%	5,295	5.39%	1,855	10,106
Hispanic	111,595	5,647	5.06%	4,739	4.25%	282	5,929
Other	83,290	4,184	5.02%	2,713	3.26%	1,890	6,074
Pacific Islander	902	56	6.21%	41	4.55%	47	103
White	68,152	4,587	6.73%	2,734	4.01%	2,036	6,623
Total	490,960	25,302		17,273		6,756	32,058

[7] ACBHCS Utilization Data FY2015-2016
[8] ACBHCS Utilization Data FY2015-2016

MHSA Introduction

The Mental Health Services Act (Prop. 63), a California state voters' initiative passed in 2004, funds mental health services. MHSA imposes 1% tax on annual personal income over $1 million. The intention of MHSA is to transform the public mental health system through the MHSA components:

- Community Services and Supports (CSS)
- Prevention and Early Intervention (PEI)
- Innovation (INN)
- Workforce, Eduction and Training (WET)
- Capital Facilities and Technology (CFT)

State legislation defined MHSA Core Values are:

- Community Collaboration
- Cultural Responsiveness
- Consumer and Family Driven
- Wellness, Recovery, Resiliency
- Integrated Service experience

Alameda County has integrated the MHSA values with MHSA goals through program implementation :

- Transformation of mental health system
- Improved quality of life for consumers
- Effective treatment, prevention and early intervention services
- Outreach support services and family involvement
- Increase access and reduce inequities for unserved, underserved and inappropriately served populations

Alameda County's MHSA Component Plans were approved, beginning in 2006 with CSS Plan. All component plans were approved by 2010. Table 6 shows the year each MHSA Component was approved by the MHSA Oversite and Accountability Committee (MHSOAC) and the average funded amount for each MHSA component.

Table 6. Alameda County Approved MHSA Plan Components

Community Services & Supports (2006)	Prevention & Early Intervention (2008)	Workforce, Education & Training (2009)	Capital Facilities & Technology (2009)	Innovative Programs (2010)
30+ ongoing programs	**18 ongoing programs**	**9 programs and strategies**	**1 site / EHR project**	**Multiple short-term projects**
$52.0M annually	**$26.2M annually**	**$7.6M over 10 years**	**$16.2M over 10 years**	**$4.1M (18-month projects)**

Alameda County MHSA Community Program Planning

Initial Planning Process

WIC Sec 5848 and Sec 3300 state all counties shall partner with stakeholders, including clients and their families, throughout the planning process that includes meaningful involvement with stakeholders.

The original planning processes for each MHSA individual component engaged stakeholders in various outreach and education meetings and forums, workgroups and planning panels for the MHSA Plan. Over one thousand residents of Alameda County were involved in the development of all five component plans since 2005 at various large stakeholder meetings, focus groups and planning panels. Outreach and community input was gathered throughout Alameda County. Over 40 individuals served on the OPC and represent a diverse array of consumers, family members and service providers. Members are nominated by community organizations to be effective representatives of the various interests, viewpoints and populations in the County. Consumer and family members are provided training and orientation on all DMH policies, procedures and planning guidelines and are provided stipends for their participation. Meetings of the OPC are open to the public and allow for significant public comment and discussion.

MHSA Community Planning And Stakeholder Engagement

MHSA Stakeholder Committee

The Ongoing Planning Council (OPC) was the stakeholder body that met since the first planning process to help develop the individual plans and review the initial program implementation. In 2010, the OPC transitioned to the MHSA Stakeholder Group which engages in monitoring, evaluation and quality improvement of existing MHSA programs, as well as reviews mental health policy. The MHSA Stakeholder Group convenes on a monthly basis guided by the leadership of the MHSA Stakeholder Steering Committee.

Table 7. MHSA Stakeholder Group Full Membership

Name		Seat	Affiliation / Role
Penny	Bernhisel	Provider	Telecare
Viveca	Bradley	Consumer	Pool of Consumer Champions
Carol	Burton	BHCS	Interim Director, BHCS
Aaron	Chapman	BHCS	Medical Director
Margot	Dashiell	Family Member	Alameda County Family Coalition
Linda	Flores	BHCS	MHSA Senior Planner
Leda	Frediani	BHCS	BHCS Finance Director
Alane	Friedrich	Mental Health Advisory Board	Mental Health Board
Karen	Grimsich	Provider	City of Fremont

Tracy	Hazelton	BHCS	MHSA Division Director
Alex	Jackson	BHCS	BHCS Interim TAY Director
Terri	Kennedy	BHCS	MHSA Administrative Assistant
Janet	King	Provider	Native American Health Center
Tracy	Murray	Provider	Alameda County, Area Agency on Aging
Jeff	Rackmil	BHCS	Children/ Youth/ TAY System of Care Director
Liz	Rebensdorf	Family Member	NAMI East Bay
Yvonne	Rutherford	Family Member	African American Family Support Group
Elaine	Peng	Consumer/ Family Member	Family Education Resource Center / NAMI
Lillian	Schaechner	BHCS	Older Adult System of Care Director
James	Scott	Provider	Reaching Across
James	Wagner	BHCS	Deputy Director, BHCS
Leah	Weinzimer	Provider	Partnerships for Trauma Recovery
Sanjida	Mazid	BHCS	Workforce, Education & Training
Carl	Pascual	BHCS	MHSA Innovations Coordinator
Javarre	Wilson	BHCS	Ethnic Services Manager

During the FY17-20 MHSA planning process, the MHSA Stakeholder Group members reviewed and conducted site visits on a number of current CSS and PEI programs. They provided input on program implementation and made recommendations for quality improvement.

CSS programs – Stakeholder Input

CSS Programs	Effective	Needs Improvement
• FSP 15 STAGES • FSP 5 Forensic ACT Team (FACT) • FSP 9 Transitional Behavioral Health ACT Team (TRACT) • OESD 5 Multi-Systemic Therapy (MST) • OESD 27 In Home Outreach Teams (IHOT)	• Caring staff • Good vocational / employment services • Effective therapy for consumers • Flexible, culturally sensivitivity • Multi-discipline staff team work with consumers	• High need for homeless consumers need to access appropriate care • High need for affordable housing • Would like to talk with current and past program participants • Need for transportation for consumers

PEI programs – Stakeholder Input

PEI Programs	Effective	Needs Improvement
• PEI 19 Older Adult Peer Support Program • PEI 8 Outreach, Education & Consultation for the Native American Community • PEI 7 Outreach, Education & Consultation for the South Asian/Afghan Community • PEI 21 Wellness Centers	• Provides cultural wellness and community for healing; • Helps decrease consumer experience of isolation; • Provided food to program participants	• Stigma experienced in the community are barriers for consumers; • Stakeholders want more authentic discussion with program participants • Need a balance of consumer choice and recommended activities; • Transportation is barrier to accessing services

Community Input Process

During the FY17-20 MHSA community input process, ACBHCS staff provided update and information on current MHSA programs. Community members provided input on mental health needs and services. Five community forums and eighteen focus groups were conducted throughout Alameda County. MHSA Input Surveys were submitted by 550 unique individuals.

The MHSA community outreach and input process was conducted from June – October 2017. ACBHCS conducted outreach to providers, consumers, family members and residents of Alameda County. For outreach, ACBHCS collaborated with a community based provider, Health & Human Resource Education Center (HHREC), and with Alameda County's consumer empowerment group, Pool of Consumer Champions (POCC). More than 1,000 MHSA Community Input Meeting invitations were distributed in person and/ or by email to stakeholders, providers, consumers, family members, and other community members.

Table 8. FY 17/20 MHSA Community Input Outreach List
Outreach Period: July – October 2017

Community Organization/ Location	Location	Outreach Method
Board of Supervisors	county-wide	email
MHSA Stakeholder Group	county-wide	email
Mental Health Board	county-wide	email
Mental Health Assoc. of Alameda County (MHAAC)	county-wide	In person Invitation
MHAAC Family Caregiver and Advocacy	John George Psychiatric Pavilion	In person Invitation
NAMI East Bay Family Support Group	Fremont	In person Invitation
NAMI East Bay Support Group for Families of Children and Teens	Fremont	In person Invitation
NAMI East Bay, President of the board	Albany	In person Invitation
Berkeley Families Support Group	Berkeley	email
Albany Public Library	Albany	In person Invitation
Berkeley Public Library, all branches (Central, West, South, North, and Claremont)	Berkeley	In person Invitation
NAMI Alameda County	Fremont	email
Native American Health Center	Oakland	email
NAMI East Bay and African American Family/Caregiver Support Group	Oakland	email

Community Organization/ Location	Location	Outreach Method
Family Education and Resource Center (FERC)	Oakland	email
Bonita House	Oakland	Email
NAMI Alameda County South	Southern Alameda County	Email
Youth in Mind	Oakland	Email
Trauma Transformed	Oakland	Email
Goals for Women	Berkeley	Email
Pacific Center	Berkeley	Email
Helping Hands	Oakland	Email
CHAA	Oakland	Email
Eden Medical Center, and Board of Mental Health Assoc. Of Alameda County	Castro Valley	Email
East Oakland Health Center	East Oakland	In person Invitation
Aids Hospice	East Oakland	In person Invitation
MLK Library	East Oakland	In person Invitation
Berkeley Bowl	Berkeley	In person Invitation
12th Street Bart	Oakland	In person Invitation
San Leandro Bart	San Leandro	In person Invitation

Community Organization/ Location	Location	Outreach Method
San Leandro Sr. Center	San Leandro	In person Invitation
San Leandro Main Library	San Leandro	In person Invitation
McDonalds	San Leandro	In person Invitation
Fremont Bart	Fremont Line	In person Invitation
Harrison Motel	Oakland	In person Invitation
Davis Court Apt	San Leandro	In person Invitation
Allen Temple Church	Oakland	E-mail
Innovations Grantees and Conference Participants	Previous INN Grantees	E-mail Total 750
BHCS Providers	Providers of Mental Health and Substance Use Disorder services	E-mail

From July – October 2017, community members were able to provide input in three different ways: 1) Community meetings, 2) Focus groups, and Individual surveys. Five MHSA community input meetings were conducted throughout Alameda County in each Board of Supervisorial districts. Community meetings were located in cities of Berkeley, Oakland, San Leandro, Livermore, and Hayward. During the meetings, MHSA Division Director and Senior Planner presented information regarding MHSA components and current MHSA programs. Then, community members provided input on mental health needs, prioritized underserved populations and effective MHSA programs. Approximately two hundred fifty individuals participated in the MHSA Community Input Meetings. Translators in Spanish, Cantonese, and Mandarin were available in three community input meetings.

MHSA Community Meeting Invitation Card

Alameda County Behavioral Health Care Services:

Invites you to attend public meetings to:
Listen to your ideas about how to improve the County's mental health services
Share information about the Mental Health Services Act.

ALL COMMUNITY INPUT MEETINGS ARE FROM 5:30 - 7:30 PM. A LIGHT MEAL IS SERVED.

Tues. July 25, 2017**	**Berkeley** Ed Roberts Campus, Osher Room 3075 Adeline St. in Berkeley (adjacent to Ashby BART station)
Thurs. Aug. 24, 2017	**San Leandro** San Leandro Senior Community Center, Main Room 13909 E. 14th St. in San Leandro
Tues. Aug. 29, 2017**	**Oakland** Allen Temple Baptist Church, Mary Morrissey Room 8501 International Blvd. in Oakland
Tues. Sept. 12, 2017	**Livermore** Livermore Community Center Palo Verde Room 4444 East Ave. in Livermore
Tues. Sept. 19, 2017*	**Hayward** Weekes Community Center, Main Hall 27182 Patrick Ave. in Hayward

Spanish translation will be available. ** Spanish and Mandarin translations will be available. If translation in other languages is needed, please indicate in your RSVP.

RSVPs encouraged, but not required. Click to **RSVP** or call 510-834-5990.

Eighteen focus groups were co-hosted by ACBHCS and community based organizations in which stakeholders provided input on mental health needs, priority underserved populations and mental health services.

Table 9. MHSA Community Input Focus Groups

MHSA Focus Group	Location	Participants	# Participants
National Alliance on Mental Illness (NAMI) – Chinese Family Support Group	Family Education Resource Center (FERC) -- Fremont	Chinese speaking family members	10
Mental Health Association of Alameda County (MHAAC) - African American Family Project	Oakland	African American family members	7
East Bay Refugee Forum	Catholic Charities of East Bay - Berkeley	Providers for refugees	32
Pride Committee	ACBHCS - Oakland	Providers for LGBTQ Community	12
Health & Human Resource Education Center (HHREC) -	HHREC – Oakland	Transitional Age Youth (TAY)	3
Afghan Men's Support Group	Fremont	Afghan immigrants	20
BHCS / WET HS Interns	ACBHCS – Oakland	High school/ undergrads (12)	12
City of Fremont – Older Adults	Fremont	Older adults	8
Community Health for Asian Americans (CHAA)	CHAA- Alameda	API and refugees - providers & advocates	12
Regional Center of East Bay	San Leandro	Providers who serve consumers with developmental disabilities and mental illness	8
POCC	BHCS	34 POCC members	34
18 Focus Group meetings			**138**

Individual community members were able to access online MHSA Surveys and translated in Alameda County's threshold languages: Mandarin, Cantonese, Spanish, Farsi, and Vietnamese, as well as Korean. Members of the Pool of Consumer Champions (POCC) outreached to and engaged with community members, including individuals who were homeless, to provide input through the MHSA surveys. Community members were also accessible online.

FY 17/20 MHSA Community Input Survey Results

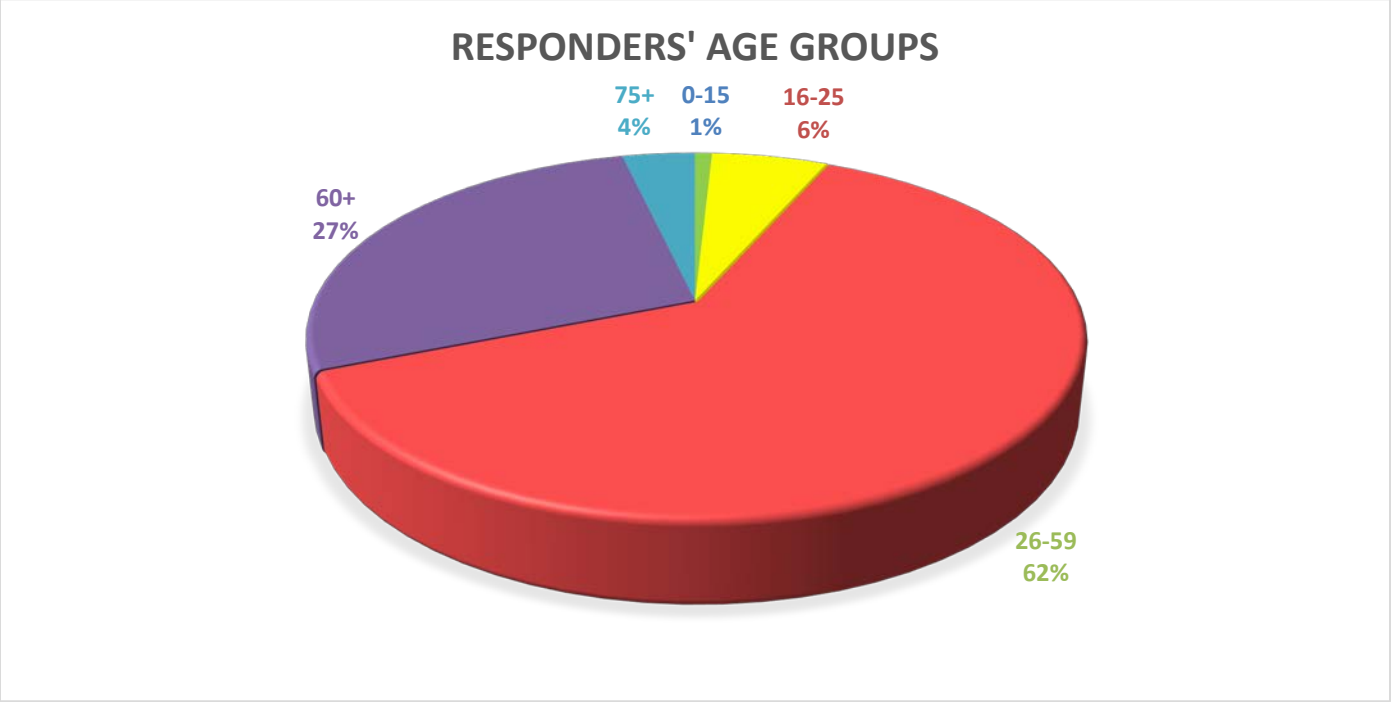
Individual community members were able to access online MHSA Surveys and available in Alameda County's four threshold languages: Chinese, Spanish, Farsi, and Korean. Members of the Pool of Consumer Champions (POCC) outreached to and engaged with community members, including individuals who were homeless, to provide input through the MHSA surveys. Community members were also accessible online.

550 MHSA community input surveys were completed by unduplicated individual community members.

Demographics of Responders

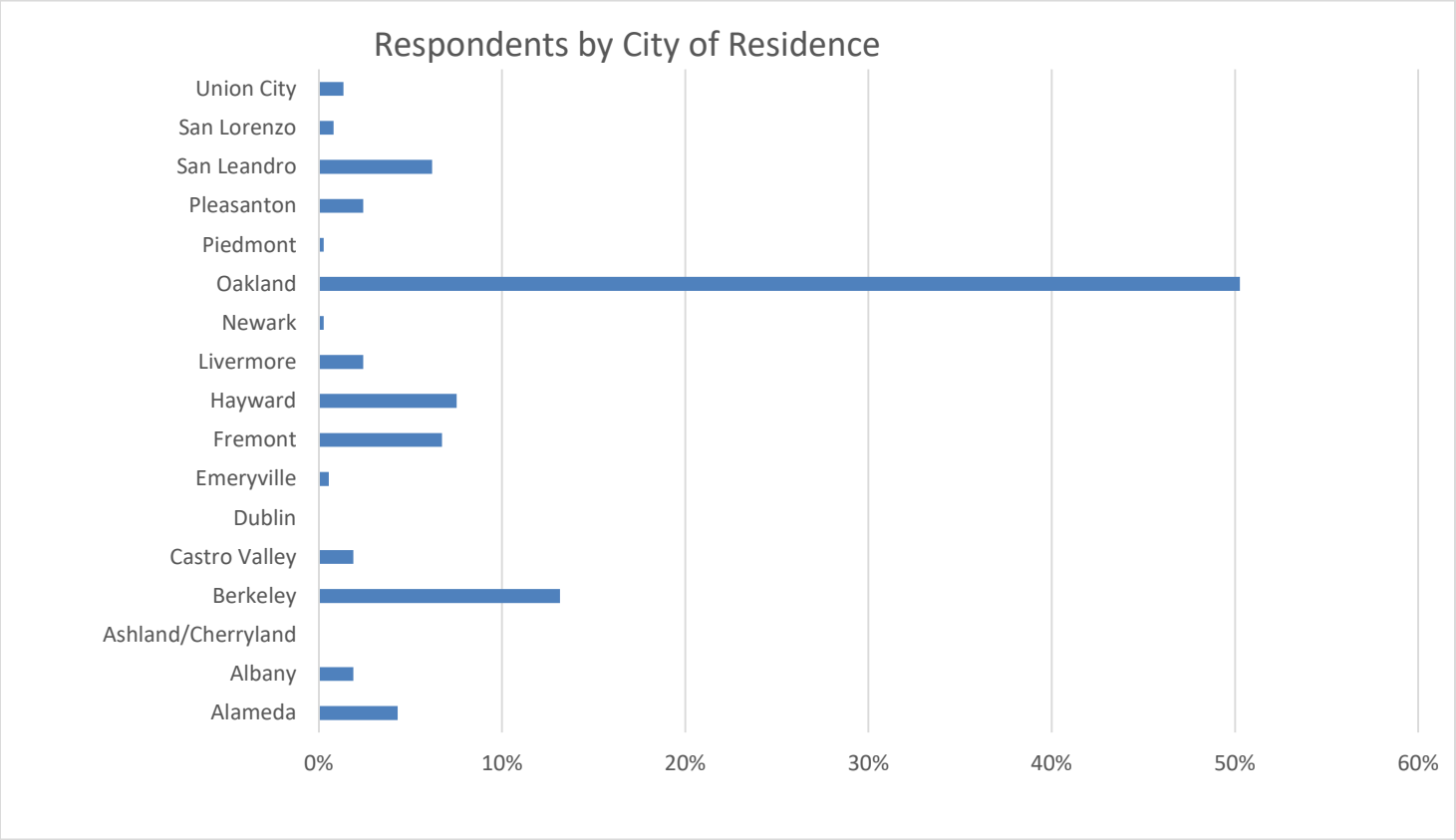
62% of responders were adults (age 26-59 yrs), followed by 27% older adults (ages 60+ yrs.).

Chart A. MHSA Responders' Age Groups



Although the MHSA Community Input meetings were conducted throughout Alameda County in five different Supervisorial Districts over 50% of respondents resided in Oakland, while the other top five respondent cities were Berkeley (13%), Hayward (7%), San Leandro (6%), Fremont (6%), and Alameda (4%). Table B (below) shows details of respondents' by city of residence.

Table B. MHSA Respondents by City of Residence



For Ethnic/ Race representation of respondents consisted of 29% White/Caucasian, 22% African American, 21% Asian, 15% Hispanic/Latino, 3% Native American/Alaskan Native, and 1% Pacific Islander.

Chart C. MHSA Respondents' Race / Ethnicity

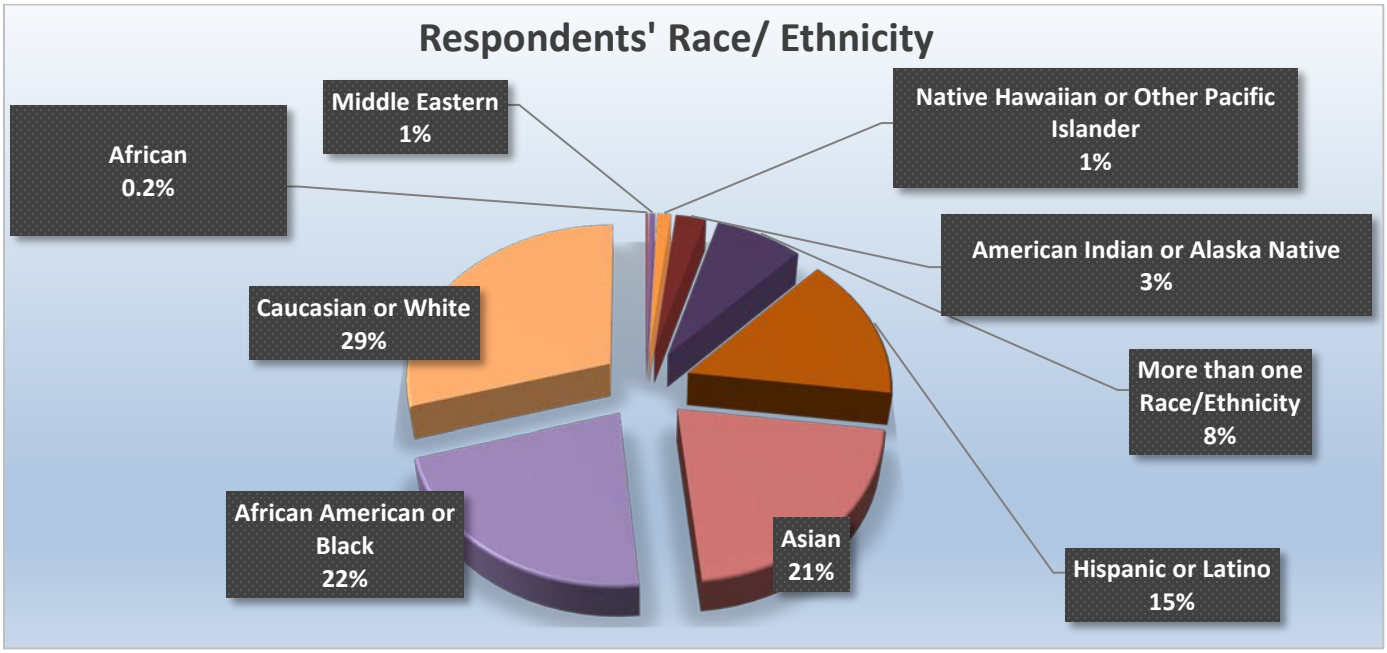
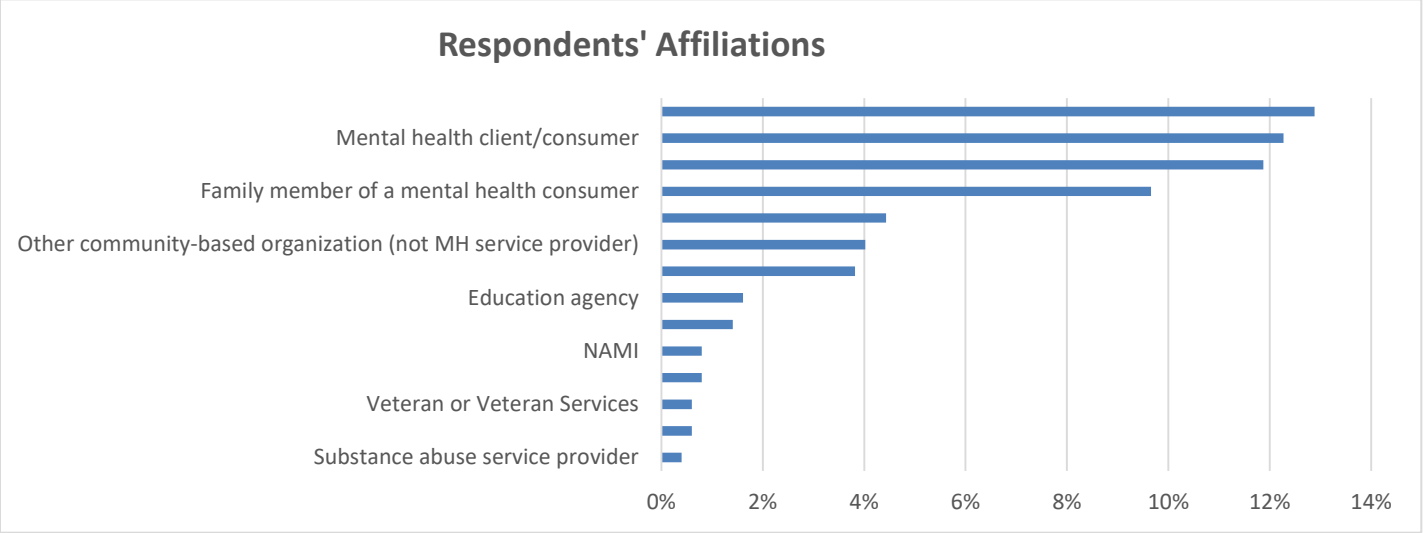


Table D. MHSA Respondents' Affiliations



MHSA Survey Results

The following are the results of the MHSA Survey provided by 550 unduplicated individuals living and/or working in Alameda County.

In response to the community input, BHCS has provided information on current and/or pending programs that address each of the top identified needs. Below each of the MHSA survey questions, there's a description of ACBHCS services that are currently in implementation (available), in planning (pending), and/or in consideration for future (future).

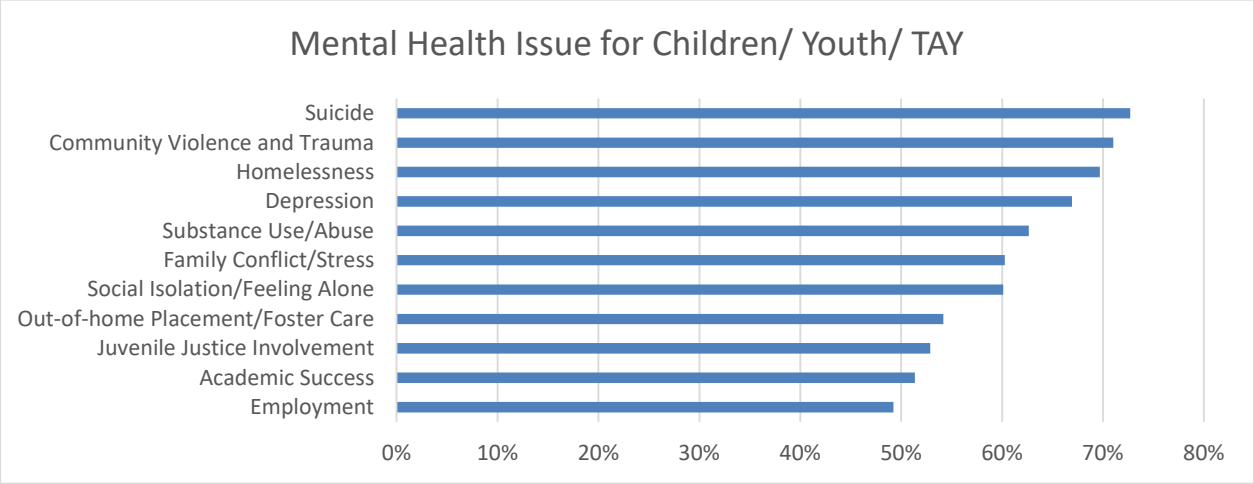
87% of respondents stated it was their first time providing input for the MHSA planning process.

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

Q2. Please rank the importance of each Child/Youth/Transition Age Youth's mental health issue listed below by importance. (529 Responses)

Respondents identified the top three mental health needs for children, youth and TAY as: 1) suicide (73%), community violence and trauma (71%), and homelessness (70%). See Table E. for other identified mental needs for children, youth and TAY.

Table E. Mental Health Needs for Children, Youth, TA



MHSA Programs for Children/ Youth/ Transitional Age Youth

Prioritized Needs for Children/ Youth/ Transitional Age Youth	**Available** (Programs in implementation)	**Pending** (in planning)	**Future Opportunity** (for future consideration)
1. Suicide Prevention (73%)	X		
2. Community Violence & Trauma (71%)	X		X
3. Homelessness (70%)	X	X	X

Analysis

Suicide Prevention

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

Community Violence & Trauma

For Children and Youth: Trauma Trainings are available for faculty and staff on school sites so that they can be better equipped to receive children and youth experiencing Community Violence and Trauma. Additionally, many of the children/ youth providers offer groups focusing on the effects of trauma and offer those support for children and youth in schools. For TAY, current programs address community violence and trauma include the TAY FSP program, Transition to Independence Process (TIP), and PEI funded programs such as Youth UpRising, Beats Rhymes & Life (BRL), and Health and Human Resources Education Center- Downtown TAY.

Two Innovation projects are in the planning phase that address community violence and trauma: 1) Roses in Concrete – school based program to pilot a trauma and mental health program for children and youth; and 2) Juvenile Justice Center – Group Support Model (details in Section C. Innovation). There are additional future Innovation proposals in development by the ACBHCS Children/Youth/ TAY System of Care as Innovation proposals to be submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) for approval in 2018.

Homelessness

Homelessness continues to be an overwhelming challenge in Alameda County, and impacts children, youth, and TAY. To combat homelessness BHCS funds TAY Full Service Partnerships such as Support Housing for TAY (STAY) and Transition to Independence Process (TIP). PEI funded programs also offer assistance in helping TAY and families find housing opportunities:

- Berkeley Place - Casa De La Vida
- Casa Maria
- Dream Catchers
- Bay Area Youth Centers (Sunny Hills)
- BACS Woodroe Place
- BACS - Hope Intervention Program supports TAY in short-term case management
- BOSS Meekland

Pending: TAY Residential Services is in planning phase.

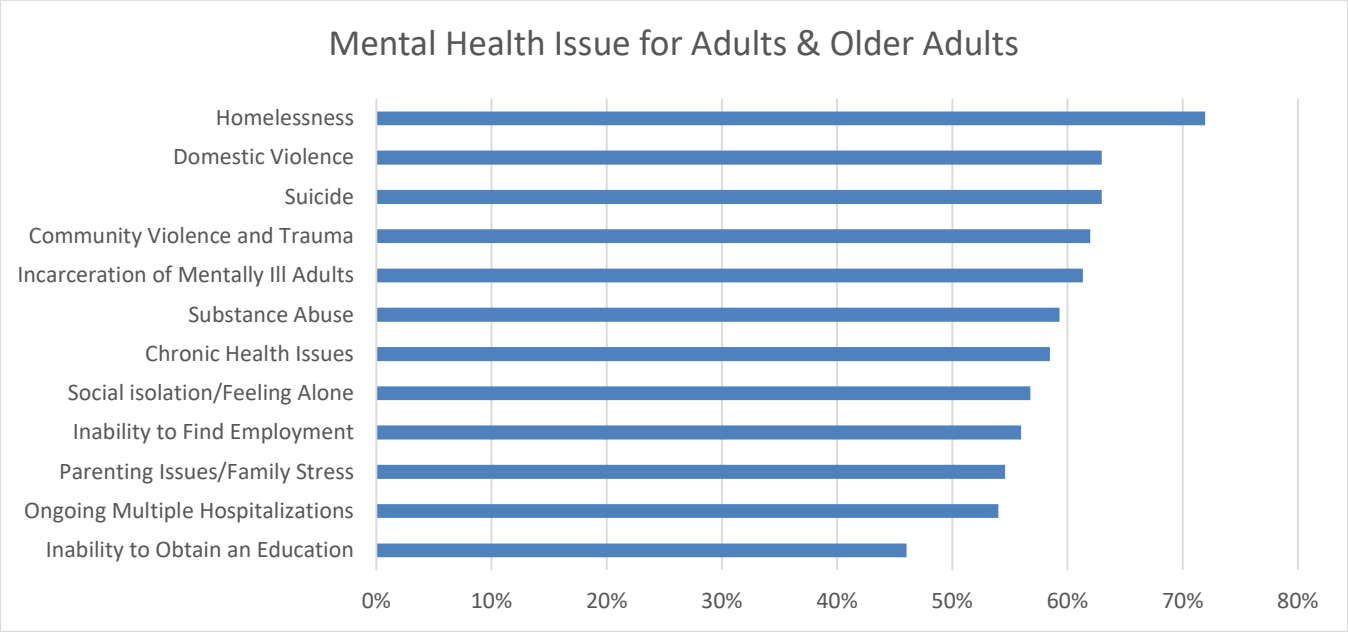
Future Opportunities: ACBHCS is considering future programs and strategies for TAY in job development, coaching and support services.

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

*Q3. Please rank the importance of each Adult/Older Adult mental health issue listed below by importance (*538 Responses).

Respondents identified the top three mental health needs for adults and older adults as : 1) homelessness (72%), domestic violence (63%), and suicide (63%). See Table F. for other identified mental needs for adults and older adults.

Table F. Mental Health Issues for Adults and Older Adults



MHSA Programs for Adults and Older Adults

Prioritized Mental Health Needs for Adults and Older Adults	Available Services	Pending Services	Future Opportunity
1. Homelessness (72%)	x		x
2. Domestic Violence (63%)			x
3. Suicide (63%)	x		
4. Community Violence & Trauma (61%)	x	x	x

Analysis

Homelessness

MHSA Permanent Supportive Housing: To date, 23 housing projects with 1,225 total units that include 164 MHSA-designated permanent supportive housing units have been developed within Alameda County. In the next five years, BHCS' Housing Services Office (HSO) hopes to double the number of permanent supportive housing units by applying for No Place Like Home housing development funding - http://www.hcd.ca.gov/grants-funding/active-funding/nplh.shtml

In FY 17-18, this process should result in an increase of at least 50 new formerly homeless individuals with serious mental illness receiving a permanent housing subsidy slot and will allow FSP enrollees to step down to lower levels of care and retain their housing subsidy. Referrals into these slots can be made via Alameda County's developing Housing Crisis Response System and its Home Stretch permanent supportive housing matching effort - http://everyonehome.org/our-work/home-stretch/.

Temporary housing beds are filled via referrals from mental health service providers in the BHCS network. Beds are reserved for homeless individuals with serious mental illness referred from outpatient programs, crisis residential, and psychiatric emergency departments. BHCS contracts for 79 beds with 10 beds in Berkeley, 35 beds in Oakland, and 24 beds in Hayward. Beds have been historically filled on a first-come, first-served basis. Beginning in January 2018, BHCS will prioritize access to the limited beds based on agreed upon countywide prioritization criteria.

Domestic Violence

A number of MHSA funded programs support individuals and families struggling with domestic violence, including Crisis Stabilization Services, Court Advocacy Program, and other community based providers such as Oakland Community Support (OCS). Community input indicates that future opportunities should improve programs with culturally responsive strategies to reduce stigma in seeking help.

Suicide

Crisis Stabilization Services serves adults in suicide prevention. The CSS Mobile Integrated Assessment Team for Seniors and the Older Adult Peer Support Program provides assessment, referral and treatment for older adults.

Crisis Support Services of Alameda County runs our county's 24 hour Suicide Hotline 1-800-309-2131 and provides multiple suicide prevention services including: grief counseling services for those effected by suicide and homicide, various support groups, older adult counseling services and community gatekeeper trainings to various communities and Alameda County agencies on an annual basis.

Pending: The Community-Based, Voluntary Crisis Services is planning for the Mobile Crisis Teams (MCT) & Mobile Evaluation Teams (MET) (CSS/ OESD 23) to implement teams in north county, mid county and south county.

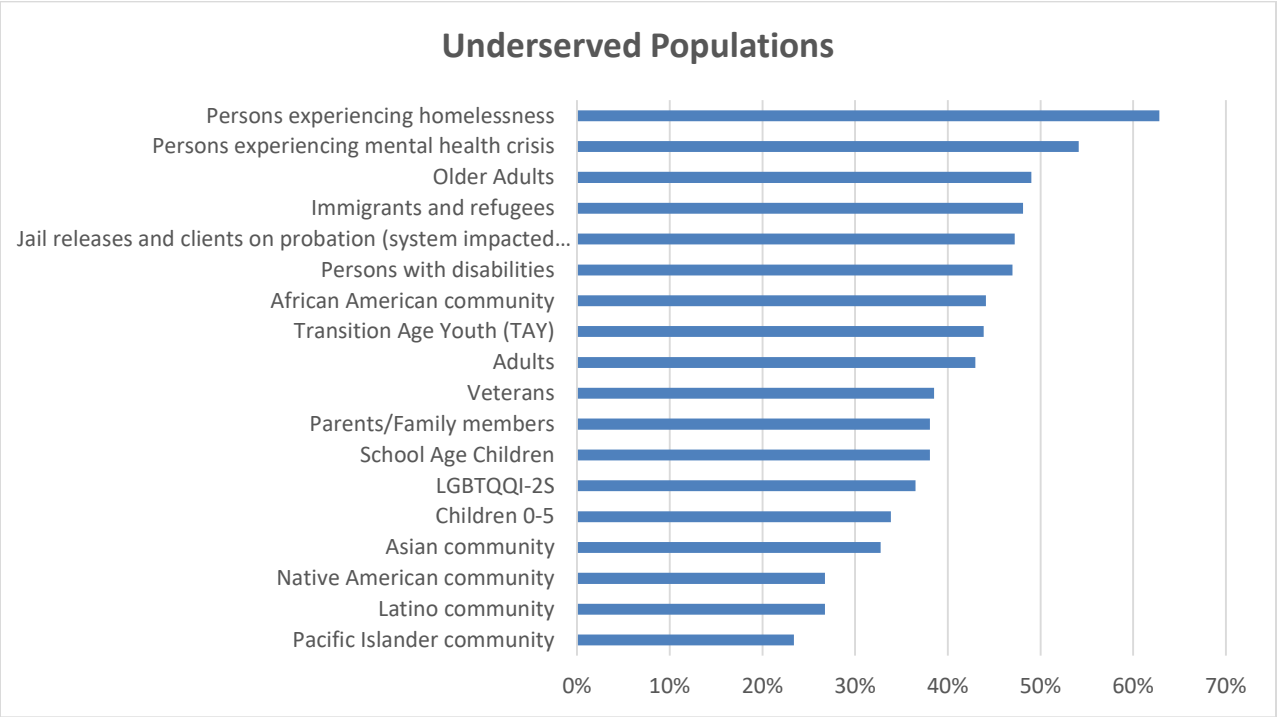
Opportunity: Through an Innovation 18 month mini grant BHCS is developing a Zero Suicide Initiative, for FY 17/18-FY18/19.

Survey Question #4: Underserved Populations

Q4. Are there any populations or groups of people whom you believe are not being adequately served by the current MHSA programs in Alameda County? (449 Responses)

Respondents identified the top four underserved populations as 1) Persons experiencing homelessness (63%), 2) Persons experiencing mental health crisis (54%), 3) Older Adults (49%), and 4) Immigrants and Refugees (48%). See Table G. for details on other identified underserved populations.

Table G. Underserved Populations



MHSA Programs for Underserved Populations

Prioritized Underserved Populations	Available Services	Pending Services	Future Opportunity
1. Persons experiencing homelessness (63%)	x	x	
2. Persons experiencing mental health crisis (54%)	x	x	
3. Older Adults (49%)	x	x	
4. Immigrants/ Refugees (48%)	x	x	

Analysis

For MHSA Housing programs serving Persons experiencing homelessness, see FSP 10 Housing. See above for FSP programs which serve adults and older adults experiencing homelessness.

Crisis Stabilization Service (OESD 11), In Home Outreach Team / IHOT (OESD 27), and the Assisted Outpatient Treatment/ AOT (FSP 12) provide services for persons with mental health crisis.

ACBHCS Adult and Older Adult system of care coordinate behavioral health services for older adults. Current MHSA programs include:

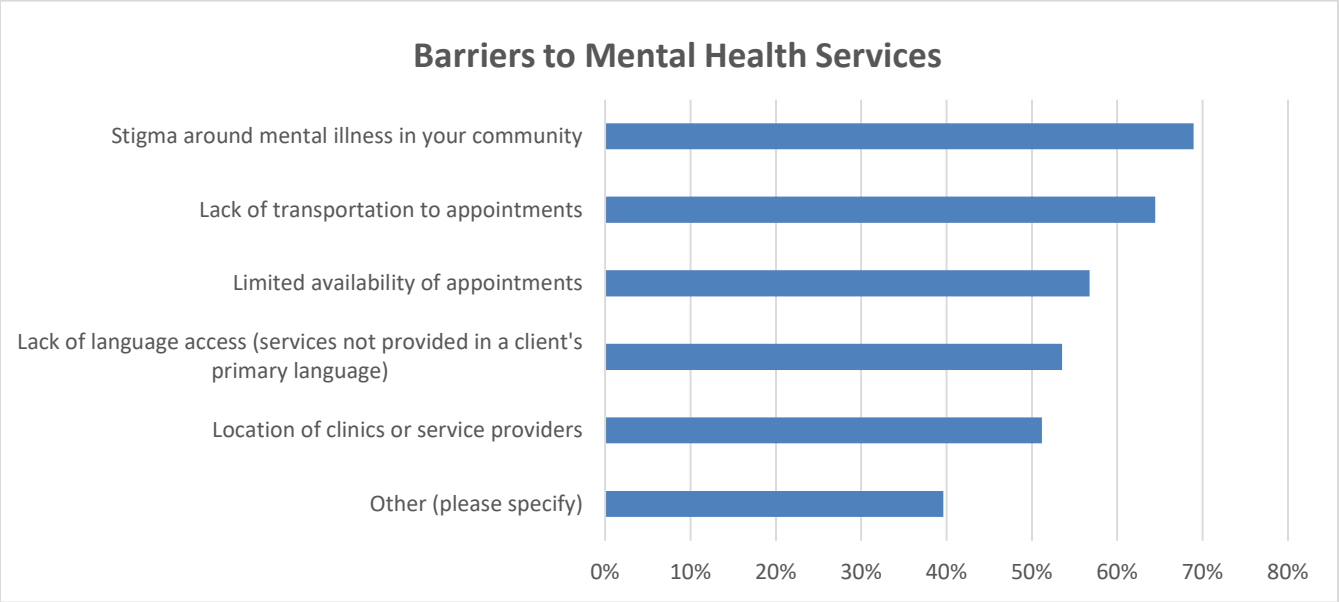
- Older Adult Peer Support Program (OESD 4A)
- GART – Mobile mental health services (PEI)
- STAGES – Older Adult FSP (FSP 15)

Survey Question #6: Barriers To Accessing Mental Health Services

What issues make it more challenging for consumers and their families to receive mental health services? Please check all that apply. (467 Responses)

Respondents prioritized the top three barriers to accessing mental health services as 1) Stigma around mental illness in the community (69%), 2) Lack of transportation to appointments (64%), 3) Limited availability of appointments (57%), and 4) Lack of appropriate language access (54%).

Table H. Barriers to Mental Health Services



MHSA Services to Address Barriers to Mental Health Services

Barriers to accessing services	Available	Pending	Future Opportunity
1. Stigma in community (69%)	x		
2. Lack of transportation to appointments (64%)			x
3. Limited availability of appointments (57%)			
4. Lack of language access (54%)	x	x	

Analysis

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

Transportation to appointments and providers is a challenge for many consumers. Currently FSP programs and other MHSA programs are only able provide limited transportation to appointments.

Pending: ACBHCS will submit an Innovation proposal, Community Assessment & Transport Team, which will provide access (including transportation) to crisis services in the community.

Many monolingual communities experience barriers in mental health services due to lack of appropriate language access. The PEI Underserved Ethnic Languages Populations (UELP) program conducts outreach, education, and early intervention services to underserved populations. ACBHCS Language Access Line provides telephone interpretation for providers, consumers and family members. However, many monolingual communities continue to underutilize mental health services.

Pending: Innovation Round Five grants will focus on implementation of pilot projects to improve access to mental health services for API and Refugees. RFP will be released in FY18-19.

Survey Question #9. Effectiveness of MHSA Services

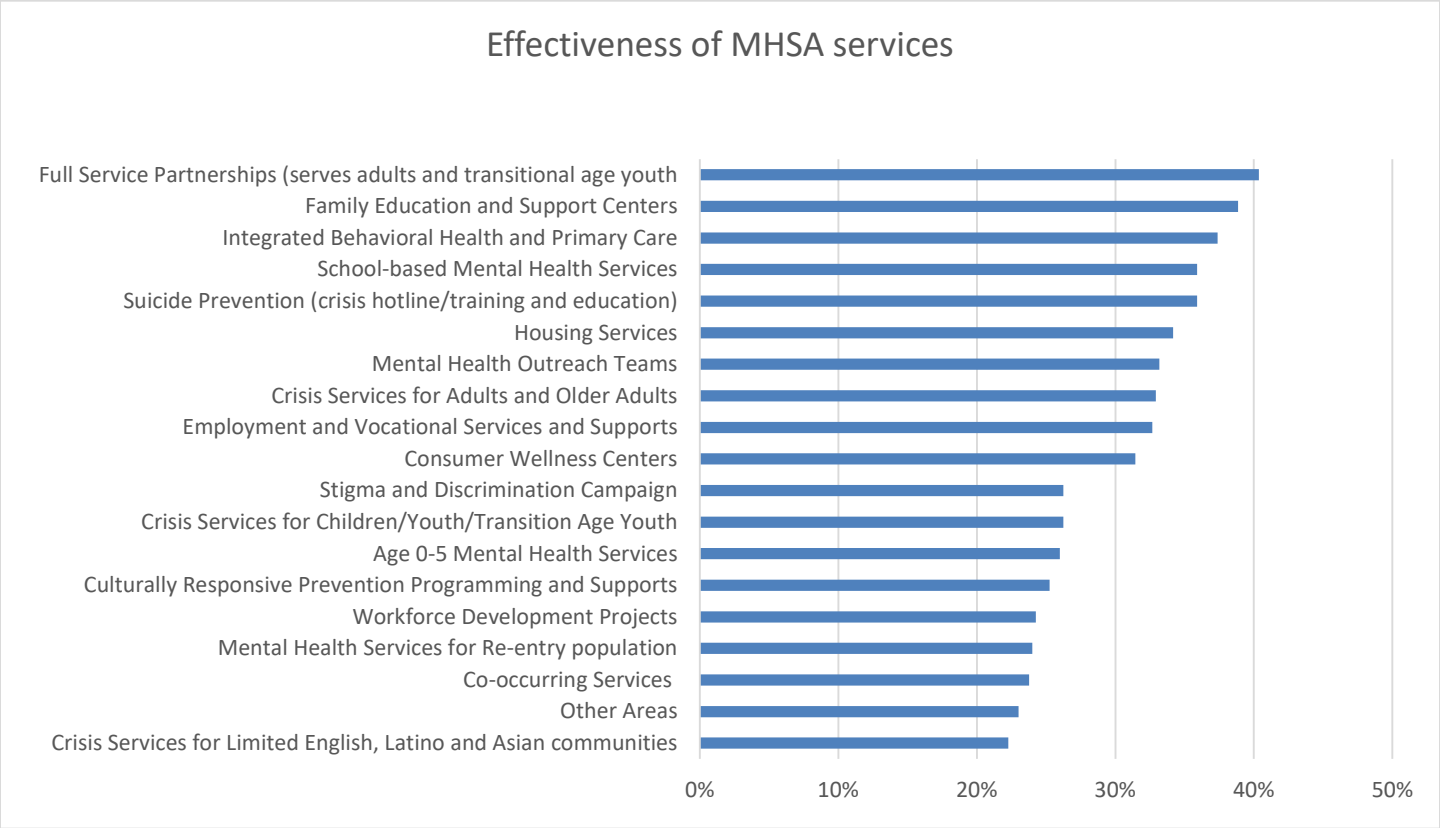
Which of the following MHSA Service Areas do you feel have been effective in addressing our local mental health concerns and negative outcomes that may result from untreated mental illness? (404 Responses)

Respondents ranked top five effective programs:

1. Full Service Partnerships (FSP) (40%)
2. Family Education and Support Centers (39%)
3. Integrated Behavioral Health and Primary Care (37%)
4. Suicide Prevention (36%)
5. School-based Mental Health Services (36%)

See below for more details: Table I. Effectiveness of MHSA Services.

Table I. Effectiveness of MHSA Services



A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

Community Services & Support (CSS)

Mental Health Services Act (MHSA) encompasses five components. The Community Services & Support (CSS) is the largest component, which is focused on community collaboration, cultural competence, client and family driven services and systems, wellness focus. CSS programs implementation focus on recovery and resilience, integrated service experiences for clients and families, and serving the unserved and underserved. Housing is also a large part of the CSS component.

CSS component funds thirteen Full Service Partnerships (FSP) programs and sixteen Outreach Engagement/ System Development (OESD) programs. CSS services include outpatient treatment, crisis response, behavioral health court, co-occurring substance use disorders, integrated behavioral health and primary care, integrated behavioral health and developmental disability services, and in- home outreach. CSS programs are implemented through ACBHCS age based systems of care which serves four age groups:

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

CHANGES IN CSS PROGRAMS

I. Full Service Partnerships

The Full-service Partnerships (FSP) were the first set of MHSA-funded programs to be implemented upon approval of our Community Services & Supports plan in 2006. This upcoming procurement effort will ensure that the most qualified and experienced providers continue to utilize the most effective treatment practices for the populations with the highest-need in Alameda County.

An RFI was completed in FY 16/17 and data from the RFI responses were incorporated into the Request-For-Proposal (RFP) that will be released in early FY17-18 with a start date of early FY18/19. The RFI articulates BHCS' plan to enter into a contract for FSP services for one program per Contractor with the following allocation:

Population	No. of Teams per Program	No. of Programs	Total Allocation
Child/Youth	2	1	$2,235,000.00
TAY	3	1	$3,489,110.00
FEP	1	1	$1,163,037.00
Adult	2	2	$4,652,146.00
Forensic	2	2	$4,652,146.00
Older Adult	2	1	$2,326,073.00
Chronically Homeless	2	2	$4,652,146.00
TOTAL		**10**	**$23,169,658.00**

Note: Most programs will run two FSP teams with no more than 50 clients served per team at any given time except for the Child/Youth, TAY and FEP FSP.

II. OESD 26 Culturally Responsive Treatment Programs for African Americans RFP has been released. A total of nine contracts are expected to be awarded through an RFP process in early 2018. All contracts are planned to be awarded in June 2018 for a July 1, 2018, start date.

III. OESD 31 Older Adult Service Team

BHCS conducted the RFP process beginning early 2017 and selected Family Services Agency of San Francisco (FSA) as provider for the Older Adult Service Team. The Older Adult Service Team will serve an average of 60 clients per month delivering an average of five hours of outpatient service to each client per month. Program implementation will begin in FY18/19.

Full Service Partnership (FSP) Programs

The following measures are being adopted by all Full Service Partnership programs and will be included in future contract language starting in

FY 17/18 FSP Goals:

1. Primary Care, after being enrolled for at least 12 months.

2. Housing: At least 85 percent of clients (50% for TAY) shall have a primary care within 12 months of enrollment recent of clients shall be in long-term, stable housing within 24 months of enrollment.

    A. FSP partners enrolled for at least six months, more than 80% of them at any point in time will be in a known and non-institutional living arrangement.

    B. FSP partners enrolled for at least six months, at least 60% of partners will have a current living arrangement that is more independent and less restrictive than their living arrangement at the time of admission into the FSP program (Measure based on the FSP housing hierarchy established by the BHCS Housing Services Office and attached).

3. Psychiatric/ Emergency Services shall decrease 50 percent post-enrollment, compared to data for 12 months prior to enrollment.

4. Incarceration recidivism shall decrease 55 percent within 12 months of enrollment, compared to 12 months prior to enrollment.

5. Benefits

    - 90 percent of the clients who enter the program shall have Medi-Cal or a completed Medi-Cal application within three months of program enrollment.

    - 80 percent (60% for TAY) of the clients who enter the program shall have Supplemental Security Income (SSI), or an open application for SSI, within six months of program enrollment.

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

FSP 1. Homeless Outreach & Stabilization Team (HOST)

Program Description: Multi-disciplinary team engages homeless adults and links them to a range of services with a focus on community services, peer support and the means to obtain and maintain housing.

FY16/17 Program Outcomes

Unduplicated Number of Partners Served: 89

GOALS	Clients who met Goals
Reduction in Hospital Days	56%
Reduction in Hospital Admits	18%
Reduction in Psychiatric Emergency Services (PES)	48%
Primary Care linkage within 12 months of program enrollment	100%
Partners whose income through public benefits or wages increased within 12 months of enrollment.	80%

FY 17-18 Impact/ FY18/19, FY19/20 Challenge

83 (92%) partners were at or above the SSI rate. Seven (8%) of the partners were not at or above the SSI rate. Six of these partners are currently in an active appeal process. 1 partner is not engaged with pursuing SSI. One client officially began receiving SSI during these quarters. Another client has gotten SSI during the most recent quarter. Four partners gained new competitive employment during this time period.

FSP 2. North County Senior Homeless Program

Program Description: Multidisciplinary team engages homeless seniors and provides housing with community supports. Provides linkage for family members and offers peer support.

FY16/17 Outcomes

Unduplicated Number of Partners Served: 49

GOALS	Clients who met Goals
Reduction in Hospital Days	77%
Reduction of Hospital Admits	26%
Reduction in Psychiatric Emergency Services (PES)	51%
Primary Care linkage within 12 months of program enrollment	100%

FY 17-18 Impact/ FY18/19, FY19/20 Challenge

Employment/ Education
47 unduplicated partners were served; increase of 6 over the previous reporting period.
34 (72%) partners are engaged in a regular activity that is meaningful to them, increasing their sense of self-efficacy and quality of life.

Housing
Of our 47 partners served during this reporting period, 19 were living in permanent housing affordable to them without Housing Financial Assistance (HFA) funding, continuing to allow us to use this funding for our most vulnerable partners who are unable to obtain or maintain independent housing due to mental health challenges.

FSP 3. Supportive Housing for Transition Age Youth (STAY)

Program Description: Provides permanent supportive housing for youth who are homeless, are aged out of foster care, leaving the justice system or residential treatment.

FY16/17 Outcomes

Unduplicated Number of Partners Served: 56

Goals	Client who met Goal
Reduction in Hospital Days	59%
Reduction in Hospital Admits	41%
Reduction in Psychiatric Emergency Services (PES)	67%
Primary Care linkage within 12 months of program enrollment	67%
Partners whose income through public benefits or wages increased within 12 months of enrollment.	22%

FY 17-18 Impact, FY18/19, FY19/20 Changes and Challenge

During the period the program had difficulty meeting the benchmark of 80% of participants in stable, long-term housing within the first six months of program participation. The program's outcome for the period for this deliverable was 64.52%. One of the factors impacting this outcome is the severity of the mental health impairments experienced by several of our participants. Four participants have needed long-term institutional care which has precluded their accessing long-term housing, Additionally, substance abuse and exacerbated mental health symptoms for three of our participants has led to ongoing housing instability and inconsistent engagement with our staff team. Lastly, the high cost and unavailability of housing in the area has made it difficult for participants without subsidies to find permanent housing they can afford.

The program continued to serve a lower census than the target 50-53 individuals, averaging 37.5 for the period. The program is dependent on TAT approval for all referrals, and thus, is not in control of the inflow of potential participants. STAY staff continue to persistently outreach to all authorized TAT referrals.

FSP 4. Greater HOPE

Greater HOPE will provides housing, case management, mental health, psychiatric, vocational rehabilitation and primary care services to 60 severely mentally ill adult participants (ages 18-59). Greater HOPE supports clients in reducing criminal justice involvement and recidivism, reducing hospitalization and utilization of emergency health care services for mental health and physical health issues, and ensures clients obtain and maintain health insurance and enrollment in eligible public benefits programs.

FY16/17 Outcomes

Unduplicated Number of Partners Served: 60

Goals	Clients who met Goal
Reduction in Hospital Days	79%
Reduction in Hospital Admits	27%
Reduction in Psychiatric Emergency Services (PES)	36%

FSP 5. Small Scale Comprehensive Forensic Assertive Community Treatment (FACT)

Program Description: FACT is a full service partnership (FSP) program offered by the East Bay Community Recovery Project to provide services to adult participants (age 18-59). FACT provides housing and intensive wraparound supportive services to individuals identified by the county as persons who continue to cycle in and out of psychiatric emergency and inpatient services and Santa Rita jail. The program provides an ACT level of services to the individuals, partners, enrolled in the program to encourage and support their wellness and recovery efforts with the goal of improving their ability to function independently in the community and significantly reducing or eliminating the need for psychiatric emergency or inpatient services and the number of incarcerations in the county jail.

FY16/17 Outcomes

Unduplicated Number of Partners Served: 85

Goals	Clients who met Goal
Reduction in Hospital Days	50%
Reduction in Hospital Admits	30%
Reduction in Psychiatric Emergency Services (PES)	58%
Primary Care linkage within 12 months of program enrollment	100%
Partners whose income through public benefits or wages increased within 12 months of enrollment.	71%

FSP 6. Transition to Independence (TIP)

Program Description: Provides intensive mental health services to transition-age youth who are experiencing severe mental illness, aged out of foster care, leaving the justice system, or residential treatment.

FY16/17 Outcomes

Number of unduplicated clients: 29

Goals	Clients who met Goal
Reduction in Hospital Days	0%
Reduction in Hospital Admits	0%
Reduction in Psychiatric Emergency Services (PES)	67%
Primary Care linkage within 12 months of program enrollment	100%
Partners whose income through public benefits or wages increased within 12 months of enrollment.	0%

FY 17-18 Impact; FY18/19, FY19/20 Changes / Challenge

TIP staff is currently at full capacity and this staffing should support excellent client care. TIP remains focused on maintaining full enrollment while transitioning clients to lower levels of care when this is appropriate. TIP is in the process of transitions 3 clients to lower levels of care. Simultaneously, we continue to provide supportive and assertive outreach to new referrals.

For upcoming FY 17-18+ Plans: TIP will continue to support the transition of TAYs to independent living by reducing frequency of psychiatric hospitalizations, including completion of education and employment goals.

FSP 9. Transitional Behavioral Health Court (BHC)/ Assertive Community Treatment (TrACT) Team

Program Description: TrACT is a full service partnership (FSP) program of the East Bay Community Recovery Project and is the dedicated service provider for the Alameda County Behavioral Health Court. TrACT is a program sub-contracted with Behavioral Healthcare Services to provide services to and maintain an active caseload of 29 adult (age 18-59) participants. TrACT has been providing intensive wraparound mental health, co-occurring substance use and other health related services to participants of the court program since August 2009. This court-supervised program is for adult individuals arrested in Alameda County and are awaiting their court appearance either in custody or in the community and have chosen to participate in the court program instead of having their cases proceed in the regular court process. Eligibility for the program requires that the individual or potential BHC participant have a mental health condition that is severe in degree and persistent in duration. This condition has to have been a determining factor for the commission of their crime. A partners charge or qualifying charges, as related to their alleged crime, are either reduced from a felony to a misdemeanor or dismissed from their record with their successful completion of TrACT.

FY 16/17 Outcomes

Number of unduplicated clients: 46

Goals	Clients who met Goal
Reduction in Hospital Days	82%
Reduction in Hospital Admits	40%
Reduction in Psychiatric Emergency Services (PES)	70%
Primary Care linkage within 12 months of program enrollment	100%
Partners whose income through public benefits or wages increased within 12 months of enrollment.	100%

Current FY 16/17 Impact, FY17/18, FY 19/20 Changes and Challenges

TrACT increased capacity both in the quality and quantity of services provided and the number of partners (29) who will be eligible for program services. This has enabled the program to increase the number of licensed or licensed eligible direct service provider's, to increase the diversity of services provided (including the increase in the program's capacity for the provision of 1 on 1 counseling). The programs increased capacity in the number of participants to be served has helped the program to take more referrals and enroll more partners in the program. This has helped to positively impact our relationships with our community provider's/referral sources that have been wanting to refer potential participants to the program. Program's increased funding has allowed increase in provision of employment and education services.

FSP 10. Housing Services

Program Description: The Alameda County Behavioral Health Care Services Housing Services Office (HSO) coordinates a range of housing programs and services for individuals struggling with serious mental illness. 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 serious mental illness can "choose", "get", and "keep" their preferred type of housing arrangement;
2. Minimize the time individuals 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 BHCS target populations;
4. Provide centralized information and resources related to housing for BHCS 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 through active participation in the EveryOne Home plan implementation.

Specific program categories that operate under the Housing Services Office include:

1) Long-term housing subsidy programs that make it possible for individuals with serious mental illness to live in permanent supportive housing and licensed board and cares;
2) Short-term housing financial assistance to help individuals with serious mental illness to obtain and maintain housing with one-time and short-term payments of security deposits and rent;
3) Supportive services linked with permanent subsidized housing to create "permanent supportive housing" options for individuals to live in community-based rental housing settings;
4) Temporary housing programs for individuals with serious mental illness experiencing homelessness to be sheltered and supported while they work to return to permanent housing;
5) Street outreach and housing navigation services focused on helping homeless individuals with serious mental illness living in public places and emergency shelters to return to permanent, safe, and supportive housing as quickly as possible;
6) Supporting an affordable housing search website and news alerts related to current housing opportunities relevant to people with serious mental illness and extremely low incomes;
7) Referrals, coordination, clinical consultation, training ,and oversight of a network of more than 450 licensed board and care and permanent support housing slots countywide;
8) Staff involvement and financial support toward countywide efforts focused on addressing homelessness;
9) MHSA affordable housing project application preparation in partnership with nonprofit affordable housing developers.

Target population

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

Program Services

The categories of services and programs offered by the Housing Services Office (HSO) are outlined above with details about outreach, engagement and referrals described below:

1) Long-term housing subsidies for permanent supportive housing have historically been accessed by clients enrolled in Full Service Partnerships (FSPs). In FY 16-17, the HSO secured additional funding through Alameda County's Whole Person Care effort known as Alameda County Care Connect to expand the reach of and to centralize the management of previously decentralized MHSA and HUD housing subsidies. In FY 17-18, this process should result in an increase of at least 50 new formerly homeless individuals with serious mental illness receiving a permanent housing subsidy slot and will allow FSP enrollees to step down to lower levels of care and retain their housing subsidy. Referrals into these slots can be made via Alameda County's developing Housing Crisis Response System and its Home Stretch permanent supportive housing matching effort - http://everyonehome.org/our-work/home-stretch/. Participants receiving long-term licensed board and care subsidies are referred from subacute care facilities and state hospital beds under contract with Alameda County.
2) Short-term housing related financial assistance is available to any client receiving mental health services funded by Alameda County Behavioral Health Care Services (BHCS). The program requires that referring service providers complete the application process with clients and commit to supporting clients to keep their housing for at least a 12 month period. BHCS clients in need of support on their application that do not have a provider willing to support them can receive support from a BHCS-funded wellness center or client-run drop-in center. Information about this resource can be found at the following website link: http://www.acbhcs.org/bhcs-everyone-home-fund/
3) Permanent supportive housing services are linked with specific buildings that were developed with MHSA housing development and/or operating subsidy funds. To get into these buildings, applicants now apply through the process described for long-term housing subsidies or through enrollment in specific supportive service programs linked with a particular building.
4) Temporary housing beds are filled via referrals from mental health service providers in the BHCS network. Beds are reserved for homeless individuals with serious mental illness referred from outpatient programs, crisis residential, and psychiatric emergency departments. BHCS contracts for 79 beds with 10 beds in Berkeley, 35 beds in Oakland, and 24 beds in Hayward. Beds have been historically filled on a first-come, first-served basis. Beginning in January 2018, BHCS will prioritize access to the limited beds based on agreed upon countywide prioritization criteria.
5) Street outreach services conduct ongoing outreach in specific regions of the County to identify and link homeless individuals with serious mental illness to mental health and health programs and to temporary and permanent housing resources. Referrals to outreach programs come via referrals from the general public, law enforcement, other health and social service providers, and word-of-mouth. Housing navigation slots have historically been filled via direct outreach to homeless individuals with serious mental illness on the street identified by general outreach efforts or other sources. Going forward, these service slots will be filled via countywide prioritization criteria as part of Alameda County's Housing Crisis Response System.
6) Eden Information & Referral (I&R) manages an affordable housing search and information website at www.achousingchoices.org that is accessible to the general public. HSO staff manage a housing news email service that the general public can subscribe to at http://www.acbhcs.org/housing-news/
7) HSO staff provide a range of supports and follow-up with MHSA-funded permanent housing sites and subsidized licensed board and cares. These staff work with existing clients and program operators and do not accept external referrals. Request for assistance from this team comes from enrolled clients, service providers, property managers, board and care operators, and other parties linked with particular housing sites.

8) HSO staff actively participate in the EveryOne Home – www.everyonehome.org – collective impact effort to end homelessness, provide matching services dollars for HUD housing programs, and work to braid funding and services with other county and city entities to ensure all Alameda County residents have a safe and supportive place to call home. HSO staff help oversee Alameda County Care Connect housing services and housing efforts in partnership with newly hired Care Connect housing staff.
9) HSO staff along with other key stakeholders spent multiple years strategically investing nearly $20M of one-time MHSA funding in affordable housing projects with supportive housing set aside units for homeless individuals with serious mental illness. To date, 23 housing projects with 1,225 total units that include 164 MHSA-designated permanent supportive housing units have been developed within Alameda County. In the next five years, HSO hopes to double the number of permanent supportive housing units by applying for No Place Like Home housing development funding - http://www.hcd.ca.gov/grants-funding/active-funding/nplh.shtml

Program Staff Structure

The Housing Services Office (HSO) includes ten full-time equivalent staff including a Director, Clinical Director, three full-time housing clinical consultation team staff, a Home Stretch team that includes three full-time staff, and two administrative support staff members. The HSO, with help from other parts of BHCS, currently manages 25 different program contracts and oversees 23 MHSA housing sites that together include more than 100 FTE of staff. The HSO also coordinates partnership work with through formal and informal arrangements with multiple other county agencies and city departments.

Outcomes for FY16/17

1. Number of consumers served: combined MHSA-funded housing service programs reach more than 1,000 people with serious mental illness each fiscal year.

2. Number of activities or services utilized: more than 400 households received long-term housing financial assistance and supportive services to keep their housing, 100 households received short-term housing financial assistance, over 100 stayed in MHSA-funded temporary housing, and more than 400 received housing-related services including outreach, navigation, or permanent supportive housing services.

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

FY16/17, FY17/18 Impact

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

The most significant improvement over the past 12 months has been the partnership between the HSO and the Alameda County Care Connect team. This partnership is bringing in an additional $9M/year of housing-related services to the County along with increased resources for developing new housing. These funds in partnership with funding from Alameda County Housing and Community Development are being used to create a countywide Housing Crisis Response System that utilizes standard assessment, prioritization, and matching approaches for housing resources. These efforts will also enhance communication, data sharing, and coordination across housing and health care service provider silos.

An infrastructure to track population and program performance is under development as part of this effort and will result in more regular tracking and reporting on the impact of our housing and housing service efforts.

FY16/17 – FY19/20 Changes/ Challenges/ Barriers

Since 2011, housing costs in Alameda County have skyrocketed, the number of room and board and licensed board and care facilities has been in decline, and the number of homeless people in the county has increased nearly 40%. Declines in affordable housing funding and long-standing barriers to housing and affordable housing development at the local level have presented significant challenges to BHCS clients trying to obtain and maintain safe and supportive homes. Staff members that work in the BHCS provider network have also been impacted by the housing affordability crisis in the region with many staff needing to live outside of the county and with higher rates of provider staff turnover than in prior years.

FSP 11. Community Conservatorship (CC)

Program Goal: To work closely with existing community resources to assist individuals with transitioning back into their community.

Program Description: CCP specifies that a hospitalized individual is referred to Community Conservatorship (CC) by a hospital psychiatrist and, following referral, is vetted by the conservator's office, the public defender, and County Counsel. If deemed appropriate for CC, they are referred to the court for a conservatorship hearing. CCP services are delivered by an FSP team from Telecare that provides extensive individualized behavioral health and social services in the least restrictive environment suitable, available, and necessary. Individuals under CC live in the community, either in a Board and Care facility or in a supported or independent living environment. Individuals under CC in Alameda County are intended to be stepped down more quickly and have additional rights that are associated with living in the community as opposed to a locked facility. CCP referrals come from John George Psychiatric Pavilion and are screened by the Public Guardian's Office before partners are invited to voluntarily participate.

Admission Criteria:

- Adults ages 18 and older.
- Resident of Alameda County.
- Clinical determination that the person is unlikely to survive safely in the community without supervision.
- Person's condition is substantially deteriorating.

Person has been offered chance to participate in development of their treatment plan for services and continues to fail to become involved. Have a history of lack of participation in a mental health program that have resulted in 2+ hospitalizations or incarcerations within the last 36 months, or have attempted to cause harm in the last 48 months.

Changes/ Challenges/ Barriers

The CC program is no longer a pilot program. CC has adjusted its referral process to allow Villa Fairmount to refer consumers to CC, which provides additional time for the County and service providers to complete the referral.

FSP 12. Assisted Outpatient Treatment (AOT)

Program Goal: To work closely with existing community resources to assist individuals with transitioning back into their community.

Program Description
Based on a recovery-centered model, AOT/CC of Alameda County is an intensive community support service and an Assertive Community Treatment (ACT) for individuals with severe mental illness (SMI), many of whom would otherwise require extended care in institutional settings. AOT/CC serves individuals who are high utilizers of mental health services and who are considered to be at great risk for psychiatric hospitalization. Services at Alameda AOT/CC include, but are not limited to:

- Recovery-focused, strength-based services
- Intensive case management/wraparound services
- Co-occurring disorder treatment
- 24/7 on-call staff response if needed
- Field-based services
- Peer-run activities
- Providing education and vocational services and training

Population Served: Adults (age 18+) diagnosed with a severe mental illness.

Program Staff Structure
AOT multidisciplinary team includes a psychiatrist, a nurse, masters-level clinical staff, and personal service coordinators who are all here to help individuals in our program on their path. AOT/CC staff will walk with 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.

AOT can be requested by immediate family members; adults residing with the individual; the Director of treating agency, organization, facility, or hospital; Treating licensed mental health professional
Peace officer, parole or probation officer supervising the individual.

Number of Unduplicated Clients to serve: 17

Changes/ Challenges/ Barriers
Population estimates for AOT eligibility indicate that the current number of AOT spots in Alameda County may not adequately meet the potential eligibility levels of the County's population[9]. Given that over 90 consumers received outreach and engagement services from an IHOT provider during the first week of implementation, it is likely that more IHOT consumers may need AOT enrollment. Without AOT spots available, the only option for IHOT clients is voluntary engagement to engage in specialty mental health services that will support their quality of life and reduce their hospitalization, criminal justice involvement, and/or homelessness. AOT placements to accommodate the needs of those consumers currently served by IHOT providers who may need additional support.

[9] According to the US Census Bureau July 2015 estimate, Alameda County has a population base of 1,638,215, which may indicate a need for additional AOT capacity.

FSP 13. CHANGES

Program Description: The CHANGES co-occurring recovery program serves individuals who are diagnosed with mental health and substance use issues and who are also frequent users of emergency psychiatric care utilizing an integrated approach to support individuals needing wraparound support services that fall under the Assertive Community Treatment (ACT) model, as well as individuals who qualify for intensive case management services. The goal is to help decrease the frequency and inappropriate use of psychiatric emergency services by members who have co-occurring diagnoses, to decrease overall system cost – including jail cost to Alameda County – and to empower members to regain control of their lives.

Number of Unduplicated Clients: 64

GOALS	% CLIENTS WHO MET GOAL
Reduction in Hospital Days	48%
Reduction in Hospital Admits	59%
Reduction in Psychiatric Emergency Services (PES)	75%
Primary care linkage within 12 months	100%
Partners whose income through public benefits or wages increased within 12 months of enrollment.	100%

FY17/18 Changes/ Challenges/ Barriers

CHANGES hired our Vocational Specialist and implemented several Evidence Based Practices during this period, including Seeking Safety groups, Brief Negotiated Interview from SBIRT, and CBT for psychosis. Member participation increased with our Co-Occurring Education Groups and our Family Support groups.

FSP 14. STRIDES

Program Description: Based on the Assertive Community Treatment (ACT) model, STRIDES of Alameda County is an intensive community support service for individuals with severe mental illness (SMI), many of whom would otherwise require extended care in institutional settings. STRIDES serves individuals who are high utilizers of mental health services and who are considered to be at great risk for psychiatric hospitalization.

This program was moved to the FSP category midyear FY 16/17 and the evidence-based program Individual Placement Services (IPS) was added as a programmatic requirement. An additional 20 client FSP slots were also created to increase this program's capacity as an FSP. More information and evaluation data will be available in the following Three Year MHSA Plan (FY 17/18-19/20).

FY16/17 Outcomes
Number of unduplicated clients: 131

Goals	Clients who met Goal
Reduction in Hospital Days	65%
Reduction in Hospital Admits	42%
Reduction in Psychiatric Emergency Svcs. (PES)	44%
Primary Care linkage within 12 months of program enrollment	100%
Partners whose income through public benefits or wages increased within 12 months of enrollment.	0%

FSP 15. STAGES

Program Description: Alameda STAGES is an Assertive Community Treatment (ACT) program for older adults (ages 60 and above) who have a diagnosis of severe mental illness (SMI) living in community-based settings in Alameda County. STAGES specialize in the unique challenges of older adults who receive behavioral health services.

FY16/17 Outcomes

Number of unduplicated clients: 51

Goals	Clients who met Goal
Reduction in Hospital Days	75%
Reduction in Hospital Admits	46%
Reduction in Psychiatric Emergency Services (PES)	48%
Primary Care linkage within 12 months of program enrollment	100%
Partners whose income through public benefits or wages increased within 12 months of enrollment	100%

FY 17/18 Changes/ Challenges/ Barriers

STAGES employed one peer staff during this period. Retention was addressed by providing ongoing trainings and participation in POCC and PEER activities individually and with partners. Peer staff won a leadership award at the annual POCC conference in 2016. A Co-occurring Education Group was initiated to provide education to partners who are in the pre-contemplation and contemplation stages of change. Hiring for nursing and case management positions has been challenging. There has been severe housing shortages for partners. Partners with co-existing skilled nursing and behavioral health care needs have experienced difficulty in accessing appropriate level of care.

FSP 16 Early Intervention for the Onset of First Psychosis & SMI Among TAY

Program Name: Prevention and Recovery in Early Psychosis (PREP)

Program Description:

PREP provides evidence-based treatment and support for youth and families through an intensive outpatient model of care that includes the provision of: algorithm-based medication management, cognitive behavioral therapy for psychosis (CBTp), individual placement and support (IPS), assertive outreach, multi-family groups, cognitive remediation, and strength-based care management services.

FY16-17 Impact

Number of Clients Served: 67

Number of these partners who graduated during this period: 13 (19%)

Number of these partners who entered the program during this period: 7

10 unique PREP participants attended a WRAP group at least once. This is a significant improvement in attendance from our last WRAP cycle in April-June of 2016, which saw an average of 0-1 participant and only 4 unique clients attending at least one group. During the first half of FY 16/17 peer support has engaged with 39 participants and provided 75 distinct sessions of peer support to 12 unique individuals. The Coordinator of Peer and Family Support Services provided individual support to 6-7 families on an ongoing weekly basis, and ongoing support to a total of 22 families in this quarter.

Changes/ Challenges/ Barriers

From its inception, PREP has been a collaborative comprised of East Bay Community Recovery Project (EBCRP), Felton Institute (formerly Family Service Agency of San Francisco), Mental Health Association of Alameda County, UCSF and ACBHCS, although UCSF has since withdrawn. EBCRP is the lead agency.

This program was moved to the FSP category midyear FY 16/17 in order to create a more robust clinical program for TAY experiencing a first break episode. In January 2017, PREP was moved from PEI to a FSP. In October 2017, it was determined that PREP should not be an FSP and return to PEI. Consequently, PREP will not be part of mega RFP in January. PREP EBCRP and Felton will continue PREP through June 30th 2018.

Note: FY17-18 PREP transitioned to PEI #2.

OESD 4A. Mobile Integrated Assessment Team for Older Adults
Provider Name: City of Fremont Human Services Department

Program Description: Provide services for homebound and/or isolated older adults who are experiencing difficulty accessing mental health services due to barriers associated with aging and mental health stigma. Work with First Responders and other community agencies to identify isolated older adults in need of mental health support. Transition clients who are stable from intensive therapy programs to supportive group programs. The goal of the program is to reduce the impact that mental health issues have on clients to improve community functioning and support clients to live well in the community.

Target population: Older adults (60+) residents of Fremont, Union City, Newark and Hayward, who are homebound and/or isolated and experience difficulty accessing mental health services due to barriers and need assistance to manage their mental illness and who. Clients must meet specialty mental health criteria with impairments in the moderate to severe range.

Program Services:
Mobile Mental Health program provides a thorough assessment and evaluation in the client's home. The assessment identifies the client's need for mental health services and how to support family caregivers. A plan is developed that includes interventions to treat symptoms of mental illness including medication support and individual therapy. The MMH team uses Cognitive Behavioral and Problem solving therapy along with Motivational Interviewing techniques. Clients are supported in accessing other community services such as medical care, home-delivered meals and transportation services. The peer coach will work with the clinician to support the client's social engagement and activities. The peer coaches are stable MMH clients who receive extensive training and on-going support. The goal is to reduce a client's need for crisis intervention but crisis services will be provided if needed to help a client stabilize in an emergency situation. Clients receive two or more visits within the first 30 days of treatment and four or more visits within the first 60 days of treatment.

Clients are primarily referred to the program through the City of Fremont's Human Services Senior HelpLine. Community members, other service providers, Adult Protective Services and First Responders (primarily Fire Department staff) refer directly to the HelpLine intake staff. The Community Ambassador Program for Seniors (CAPS) has trained 200 volunteers who speak 50+ languages and are connected to many ethnic and cultural agencies in the area. The CAPS ambassadors receive extensive training and are knowledgeable about community programs, such as the Mobile Mental Health program and refer to the Senior HelpLine on a regular basis. Once stable, client may transition to the Recovery & Resiliency (R&R) program, with goals to support the client in maintaining daily functioning, management of their self-care, increasing their engagement in social activities and increase their awareness of crises planning. The R&R program participants meet weekly for structured group classes and may receive additional individual and medication support if required. Clients who are not able to meet with the group, receive R&R support in their home.

Program Staff Structure: The Mobile Mental Health Team is comprised of a psychiatrist, nurse practitioner, Clinical Supervisor, LCSW clinician and peer coaches. Administrative support for the program includes billing and health records. The Recovery & Resiliency program is supported by a designated Human Services Specialist, a MSW who is working towards her LCSW. Interns also support the R&R program. The Peer Coaches, all of whom have lived experience with mental health issues and are over the age of 60, are support by an LCSW.

Number of clients served: 75

FY16/17 Outcomes

Number of consumers served: 81 clients were served during the fiscal year: 68 in Mobile Mental Health and 13 in Recovery & Resiliency in the first year of the R&R program. Twenty clients were referred from First Responders and/or Adult Protective Services. The majority of clients experienced severe depression (87%) and/or anxiety (90%) along with complex medical problems (60% had diabetes or hypertension and 50% had arthritis). Sixty percent of clients have PTSD.

Number of activities or services utilized: 1,404 units of service were provided. This included mental health treatment (individual and group therapy), case management and medication support.

% Consumer satisfaction: On an annual basis we send out a satisfaction survey to the Mobile Mental Health Clients. We sent out 55 last year and had 26 responses (47% return rate). The clients rated the program high and said they would refer a friend if appropriate.

% Retention Rates: We were able to transition 13 clients to the step down program Recovery & Resiliency. Moving clients from the intensive therapy program to R&R that promotes self-care through group structure. One R&R client had to be reenrolled in Mobile Mental Health when his psychiatric challenges increased.

FY16/17 and FY17/18 Impact

The Recovery & Resiliency program has a pre- and post- test for group sessions. The session include understanding grief and loss; understanding crisis and post-crisis planning; early warning signs of relapse; the negative perceptions of aging and healthy aging; human response to stress; problem solving and communication styles. On average the class pre-test score was 20/40 and the post-test was 35/40. Clients showed an increase in knowledge.

This year the addition of the Recovery & Resilience 'step-down' program has been a positive improvement for clients. While some clients needed support to transition to the new program, after they did they responded well to the new format.

FY17/18 Changes/ Challenges/ Barriers

The Mobile Mental Health Program has not been able to hire a Nurse Practitioner. The client's complex medical needs and changing health conditions complicate their mental health status. The program continues to recruit for a Nurse Practitioner to help with medication support. Due the complex medical and emotional concerns each older adult client has, the program has integrated self-care training to support mental health and physical health conditions. Self-care class includes information on physical, psychological and emotional and spiritual self-care. Clients have shown an increase in knowledge in all areas.

OESD 5 Crisis Response Program -Valley & Tri-City
Program Name: Crisis Response Program (CRP)

Program Description:
Out-patient brief mental health services for adults who are new to mental health services, uninsured, in crisis, and or being discharged from an acute psychiatric setting. Services include case management, targeted crisis therapy, and psychiatry. Participants on average, 30-90 days. Once stabilized, participants are transferred to a level of care most appropriate to meet the participant's needs. Our target population are those living with a serious and persistent mental illness. We also evaluate those who may not need specialty mental health services but need to be connected to a lower level of care such as primary care, substance use treatment, and other community services.

FY16/17 Outcomes

Number of consumers served: 75

Number of activities or services utilized: case management, brief therapy, psychiatry

FY16/17, FY17/18 Impact
Participants are stabilized and assessed for the appropriate level of care for ongoing mental health services. The services are essential to developing rapport with BHCS's greater system, providing psychological education, introduction to psychiatry for some with medication adjustments for all, and brokerage with other social supports. For many, contact at CRP is their first introduction to out-patient services in Alameda County.

Changes/ Challenges/ Barriers
Due to low numbers and facility issues we closed our Livermore site. We recognize that for many of our difficult to engage participants, more community engagement is needed. Therefore we are in the process of increasing our mobile teams to cover all of Alameda County. Participants can now choose from the other four sites for services in Oakland, Hayward, Fremont, Pleasanton. Fremont and Pleasanton sites are funded by MHSA.

OESD 7. Mental Health Court Specialist (Court Advocacy Program)
Program Name: Court Advocacy Program (CAP)

Program Description: Increase access to community mental health services and reduce recidivism through advocacy and release planning for the chronic and severe mentally Ill population in the criminal justice system.

FY 16-17 Outcomes, Impact & Challenges:

Number served: 630

The Court Advocacy Program (CAP) has continued to provide services to individuals involved in the Criminal Justice System in Alameda County. This has included working as a liaison with the Courts/Attorneys/Community and Family members as well as community providers in helping them navigate both the court and the mental health system. They often take on some of the most difficult and challenging cases and assist in connecting them to services in the community. Over the last year they have been involved with finding appropriate placements for individuals who are being released from the State Hospitals who have been found unlikely to regain competency. They often have to coordinate placement in a matter of days, including housing, connect with a treatment team or facilitate treatment at a sub-acute facility. The CAP staff has been successful in diverting many clients from jail to community treatment, often allowing Courts the confidence to allow for community placement as opposed to jail time.

- The new Dublin Courthouse was opened in September, 2017. CAP received an office space for one full time CAP employee in the Probation Office. All criminal cases from the Hayward courthouse have been re-assigned to Dublin.
- The program did not have full staff due to an employee's medical leave which affected its capacity to provide the level of service initially envisioned for this FY.
- CAP has continued to be integral in helping very difficult to place clients divert from jail to the community.
- In 2017, CAP staff have leveraged the services of the BACS-FREE re-entry program to help connect clients to mental health services in the community.
- CAP staff has referred clients to the new SSI advocacy programs to help ensure clients resume benefits when returning to the community. A study showed that obtaining benefits showed a marked reduction in incarceration and hospitalizations.
- The CAP program has not been successful in developing a data system to track some of the services that staff provide to the court staff. This continues to be a goal.
- Many of the services provided by CAP staff may not be captured as it may be general information or not related to clients who we would open cases for.

FY 17-18 Impact

- A Mental Health Specialist was added to the CAP staff.
- CAP continues to review its data forms to make them more "user friendly" such as referral forms.
- CAP staff plans to provide education/trainings for Court Staff about mental health services and how to access them. (Judges/Public Defenders/District Attorneys).
- In tandem with the sub-acute facilities, CAP has co-created a process for the flow of 1370.01 cases (incompetent to stand trial).

FY 18-19, FY 19-20 Plans Changes, Challenges, Barriers

- The CAP program continues to work towards having a dedicated supervisor/manager. Plan to re-classify an existing position as a Behavioral Health Clinical Supervisor in order for CAP to have a full time, dedicated supervisor.

- Create a CAP database (similar to the one that Crisis Response Program uses) in order to track referrals in a more concise manner.

OESD 8. Juvenile Justice Transformation of the Guidance Clinic
CSS Program Name: Juvenile Justice Transformation of the Guidance Clinic
Provider Name: Guidance Clinic
Number served: 900+

Program Description: Provides in-depth assessment and treatment for youth in the juvenile justice system. Creates linkages to community based services and expands on-site treatment in juvenile hall.

Target population: Justice involved youth and their families.

Services
Pre-Release
Meet with youth in-custody to assess for behavioral health needs, family needs, and strengths for youth who have been referred to the Behavioral Health Clinician in the Transition Center. Provide information about therapeutic support in the community and support with case planning to address behavioral health needs upon release.

Community Reentry
Youth and family are provided with information on behavioral health care options in the community and receive short-term follow up as needed to address ongoing behavioral health needs.
Behavioral health clinician facilitates referrals as needed and maintains relationships with community providers to support youth and families in establishing initial connections.
Youth and families are provided with support in accessing psychiatric assessments and medications as needed.

Program Staff Structure
The Behavioral Health Clinician in the Transition Center works in collaboration with providers from the Alameda County Probation Department, Oakland Unified School District, The Center for Healthy Schools and Communities, Alameda County Public Health Department, Health Care Services Agency, Alameda County Office of Education, City of Oakland.

FY16/17 Outcomes
July 2016 to June 2017: 947 youth and families were seen by the Behavioral Health Clinician in the Transition Center.

Number of activities and services utilized:
Of the 947 youth seen by the Behavioral Health Clinician in the Transition Center:

- 63% (597 youth) were already connected to mental health services in the community and planned to return to their previous providers
- 10% (93 youth) were released with medication and of those, 14% required a referral for community psychiatry
- 22% (209 youth and families) requested information about community mental health services and of those, 91% received information and referrals for community mental health programs

The behavioral health clinician provides services to all youth coming through the transition center and does not hold a caseload. Because of this, customer satisfaction and retention rates have not been calculated. Success in the program is measured by the number of families requesting information or referrals receiving appropriate information and referrals. The goal for the 2016-2017 fiscal year was for 85% of these families receiving services. The behavioral health clinician was able to surpass this objective with 91% of the families receiving requested information and referrals. Youth and families are encouraged to return to the transition center to receive any follow up services as needed.

FY16/17, FY17/18 Impact

The role of the behavioral health clinician helps youth and families to navigate the complex systems involved with probation and mental health care. The role of the behavioral health clinician supports families in advocating for appropriate mental health treatment while minimizing the trauma and stress of identifying providers. Families are able to establish a trusting relationship with the behavioral health clinician and as such are more likely to engage with unfamiliar community providers. Similarly, the behavioral health clinician is able to provide relevant clinical information to community based providers so that providers have a framework with which to engage youth and families. The reciprocal relationship between community providers and behavioral health clinician in the transition center also helps to connect youth/ families that have been historically challenging to engage.

Behavioral health clinician had developed working relationships with several community providers and probation officer to support the linkages and probation officer buy-in to encourage youth's access to community mental health. Similarly, community probation officers have developed better understanding of the behavioral health clinician's role in the transition center and will access support for youth in the community who have outstanding mental health need. The behavioral health clinician has been better able to incorporate recommendations made in the psych-diagnostic court ordered evaluations into the referral and assessment process, which results in referrals that are better suited for each family's situation.

FY16/17 – FY19/20 Changes/ Challenges/ Barriers

During the 2016-2017 fiscal year, probation experienced significant changes in the administrative and director level. This shift has impacted behavioral health's role in the collaborative as probation continues to readjust their approach to the youth at intake, at release, and post-release.

Several factors including changes in policing, gentrification, and lenient judgement has resulted in fewer youth detained in juvenile hall as well as youth being release more quickly. This has had moderate impact to the work of the behavioral health clinician in the transition center. The youth detained are presenting with higher acuity and are being released at a shorter rate, which requires increased vigilance in making sure youth in need of mental health supports are able to access the services needed.

As probation shifts their approach to include a comprehensive case plan beginning at entry into juvenile hall, this will support continuity of care that is informed by youth/ family's initially identified needs. This sift in leadership has also increased probation's involvement in pre-release work and will ideally help to initiate discussion about mental health needs and referrals at the onset of detention. Behavioral health clinician will continue to work with probation in minimizing trauma experienced by youth and families navigating the court system and will continue to advocate for the mental health needs of the population of consumers served.

OESD 9. Multi-systemic Therapy (MST)
CSS Program Name: Multi-systemic Therapy (MST)
Provider Name: Seneca Family of Agencies
Number of consumers served: 81

Program Description: Multi-Systemic Therapy (MST) is a unique, short-term, intensive, goal-oriented, comprehensive treatment program designed to serve youth and their families in their community. MST is one of only a few family-focused and community-based treatment programs that has been the focus of several major research studies, and demonstrated clinical and cost-effectiveness in serving youth with complex emotional, social and academic needs. MST has been shown to be effective with youth who are on probation and who may be experiencing significant mental health needs.

MST services are provided in the home, school, neighborhood and community by therapists fully trained in MST. 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, probation officers, school teachers and principals, etc. In order to develop strengths-based, family-focused, individualized services, the MST therapist provides a complete functional assessment of the youth in the context of their families. Treatment then focuses on helping parents build supportive social networks and empowers parents to address the needs of the youth more effectively. Therapists work in teams and provide coverage for each other's caseloads so that services can be provided flexibly at the times and in the locations most convenient to the family. MST Therapists are available 24 hours a day, seven days a week. Treatment averages 3-5 months and services are provided multiple times a week, daily if needed.

Target population: MST serves Alameda County probation-involved youth and their families. MST-eligible youth are under the supervision of Alameda County probation, between the ages of 12-17, and living at home with a caregiver who is willing to participate in MST services and interventions.

Services provided: Probation youth under the supervision of Alameda County Juvenile Probation's Family Preservation, Placement, Intensive Supervision, and Community Probation units are eligible to receive services from Seneca's Alameda MST program. Referrals from these units are made by the probation officer and sent to the MST Program Supervisor for screening and case assignment. Probation-involved youth being supervised by other probation units may be eligible to receive MST upon review and approval through the SOS committee, which is facilitated by probation. Each youth receiving MST is assigned an MST clinician who works with the youth and family to provide therapeutic intervention, skill building, case management, therapeutic intervention, and crisis response. Services focus on collaborating with and empowering parents to address youth problem behaviors by establishing and maintaining structure in the home. To this end, MST works with parents and caregivers to build upon identified strengths and develop natural support systems (e.g. extended family, neighborhoods, and friends) so that youth can successfully remain in their communities and with their families. Therapists work with their family members daily or weekly to achieve behavioral changes that can be observed and measured. The effectiveness of these therapeutic efforts is evaluated continuously from multiple perspectives (e.g. caregivers, identified youth, school teachers, supervisors, MST consultant).

Program Staff Structure:
MST staff includes a Master's level clinician who provides therapeutic intervention, skill building, case management, therapeutic intervention, and crisis response to caseload of 4-6 clients, to support flexibility to work with each client and family intensively throughout the course of treatment. MST Clinicians also participate in an on-call rotation of the MST Crisis Phone, which MST clients and families may access 24/7. MST staff are supervised by an MST Supervisor in order to ensure high quality services and promote on-going professional development. MST Therapists also receive clinical supervision weekly as they are responsible for the mental health assessment and treatment plan that is completed for each client.

FY16 -17 Impact

During FY 16/17, MST served a total of 81 youth under the supervision of the Alameda County Juvenile Probation Department, including 65 youth who were discharged from services during this time period.

Of the 65 youth discharged, 86% met the criteria for completion of MST services (an improvement of 10% from the previous fiscal year), signifying clear evidence of the following: primary caregiver has improved parenting skills necessary for handling subsequent problems, improved family relationships specific to the instrumental and affective domains in that family's subsystems that were drivers of the youth referral, family has improved network of informal social supports in the community and has demonstrated skill at successfully accessing a range of supports (formal and informal) as needed, youth is showing evidence of success in an educational or vocational setting, youth is involved with prosocial peers and activities and is minimally involved with problem peers, and changes in behavior of youth and in the systems contributing to the referral problems have been sustained 3-4 weeks. It is the goal of the MST program to continue to improve outcomes for youth and families in FY 17/18.

A targeted area of growth for MST has been to address the rates in which youth were placed in a restrictive setting for 3 weeks or longer – a duration of time that precluded further MST involvement. This included youth who were detained at juvenile hall or residential placement. During FY 16/17, 6% of youth who discharged from MST closed due to being placed in a restrictive setting, compared to 14% the previous fiscal year. MST continues to assess factors contributing to the slight increase in the number of youth who discharged due to being placed in a restrictive setting and has implemented interventions such as further training for staff to address this issue.

FY16-17, 17-18 Changes/ Challenges/ Barriers

A challenge impacting the program and consumers during FY 16/17 is the continued housing crisis and rising cost of living the Bay Area. As a result, 2 MST clinicians (1 Bilingual Spanish-speaking, 1 English speaking) left the program to relocate outside of the Bay Area. This also impacted our capacity to serve Spanish-speaking families. Another challenge the program faced this year was a decline in referrals, as the overall probation population in Alameda County has declined in recent years.

Seneca MST is addressing these challenges by continuing active recruitment efforts to fill clinician vacancies and are hopeful they will be filled soon. We are also exploring with Alameda County Behavioral Health the potential of expanding MST services to include youth involved in mental health system of care who may not be under supervision of probation.

Addressing Changes and Challenges

FY 17-18 MST aims to serve 90 youth who are under the supervision of the Alameda County Juvenile Probation Department. MST will continue to focus on improving treatment outcomes for youth served, with particular emphasis on increasing treatment completion rates and decreasing rates in which youth were placed in a restrictive setting for 3 weeks or longer. MST will also continue to strengthen collaboration with Probation. This information will ensure that community members, the Alameda County Board of Supervisors, and the State have an accurate picture of the positive impact of the program. There are no planned changes to the program at this time.

OESD 11. Crisis Stabilization Services
Program Name: Willow Rock Crisis Stabilization Unit
Provider Name: Seneca Family of Agency

Program Description:
The Willow Rock Crisis Stabilization Unit (Title 9, Div.1, § 1810.210) provides specialty mental health services lasting less than 24 hours, to or on behalf of medically stable youth for a crisis condition that requires a more timely response than a regularly scheduled visit. A centralized WIC 5151/5585 Receiving Center and Crisis Stabilization Unit ensures that youth with mental disorders in Alameda are not unnecessarily hospitalized and that they receive services in the least restrictive level of care to prevent long-term disability.

Target population
The Willow Rock Crisis Stabilization Unit serves medically stable youth ages 12 to 17 years and may serve up to a maximum of ten clients at a time. Clients can arrive on a WIC 5585 civil commitment hold for danger to self, danger to others, or grave disability (i.e. by ambulance, by police) or not on a hold (i.e. walk up).

Services Provided
Services last less than 24 hours to or on behalf of a child for conditions that requires more timely response than a regularly scheduled visit. Service activities include: Crisis Intervention, Medication Support Services, Assessment, Evaluation, and Safety Planning.

Medical Clearance: Under the direction of a CSU psychiatrist, all youth receive a physical assessment prior to admission to the Crisis Stabilization Unit (CSU). Clients who medically unstable are be transferred to an acute or general hospital for medical screening and/or treatment. A mental health assessment is conducted at the CSU once the client has been medically cleared at the emergency department or hospital prior to admission to the CSU.

Risk Oriented Diagnostic Triage Assessment: A psychosocial mental health assessment is conducted on each client prior to the determination of the validity of the WIC 5585 Hold initiated in the community. The diagnostic (DSM-TR) process includes the collection of collateral information from caregivers and others knowledgeable about the client's baseline functioning, history and the current crisis. The overall assessment process consists of an interdisciplinary analysis of the client's medical, psychosocial, developmental, and legal conditions as they appear to constitute the problem.

Level of Care Assessment: If the youth is imminently a danger to self, danger to others, or gravely disabled, the WIC 55585 is accepted and the client is transferred to an inpatient psychiatric facility. Once a WIC 5585 has been accepted at the CSU, only a psychiatrist is authorized to Drop a WIC 5585 hold on a client. If the client does not meet WIC 5585 criteria and can be stabilized in less than 24 hours, referred to their health care provider network, and safely discharged to the community; the WIC 5585 Application is Not Accepted. All CSU clients receive individualized mental health interventions including the development of client-driven Safety Plan and Aftercare and Discharge Plan. In addition, clients discharged to the community are assessed by a psychiatrist before they participate in the Aftercare and Discharge meeting with a caregiver. Prior to discharge, clients and their caregiver are referred to the Willow Rock Outpatient Program or their behavioral health care provider network for follow-up services.

Program Staff Structure

The Willow Rock CSU staffing structure consists of several distinct positions. A CSU Nurse meets with EMTs and the youth to conduct a medical screening to determine initial medical stability, as well as conducts a physical assessment once a youth is admitted to the CSU. A master's level Clinician conducts the risk-oriented Triage Assessment prior to the determination of the validity of the WIC 5585 hold initiated in the community. The clinician may also provide facilitation,

case management, therapeutic intervention, and crisis response. Clinicians receive supervision in order to ensure high quality services and promote on-going professional development. Bachelor's level counselors work with clients providing crisis interventions, crisis stabilization and safety planning. A CSU Psychiatrist conducts a face-to-face assessment of clients before they are discharged back to the community.

FY16/17 Outcomes, Impact & Challenges

The Willow Rock Crisis Stabilization Unit provided 1291 assessments to adolescents (aged 12-17) in crisis. Of these youth, 86% were brought to the CSU on an involuntary civil commitment hold (WIC 5585), while 14% were voluntary walk-up clients. Based on the multidisciplinary, comprehensive assessment of the youth's needs, 46% of youth assessed at the CSU were diverted from hospitalization.

Impact

46% of youth assessed at the CSU were successfully stabilized and diverted from hospitalization. The CSU continues to work to ensure that youth aren't unnecessarily hospitalized.

Willow Rock continues to participate in Crisis Intervention Training for Alameda County police officers, where officers tour the facility and learn about best practices in working with adolescents with mental health needs. When asked how welcome staff at the CSU made youth feel, satisfaction surveys of youth served in the CSU show a score of 3.8 out of 4. When asked about how professional and friendly CSU staff were, satisfaction surveys of caregivers served show a score of 3.9 out of 4. One caregiver stated, "They went above and beyond our expectations" and another caregiver stated "Thank you! You are very understanding and compassionate with parents when we really need the support to help our children. You really helped me feel at ease." Willow Rock continues to participate in the Crisis Intervention Training for Alameda County police offers

FY 17-18 Plans: Program will continue to monitor and evaluate the program as well as the acuity and needs of the youth served in order to adjust to an ever changing population as indicated.

Changes/ Challenges/ Barriers

The total number of youth served at Willow Rock has slightly decreased, however the diversion rate (46% diverted from hospitalization) has decreased which is likely due to serving more acute youth. This will likely continue as Willow Rock serves many youth who would benefit from partial hospitalization and crisis residential program which are not a part of the Alameda County continuum of crisis services. The length of stay has also slightly increased, an average of 14.52 hours.

OESD 13. Co-Occurring Disorders Program
Program Name: ATOD Provider Network Tobacco Dependence Treatment Training
Provider Name: Thunder Road

Program Description:

ATOD is a training and technical assistance project to improve clinical skills on how to provide evidence-based tobacco dependence treatment. This program's staff provides consultation to BHCS staff regarding tobacco-free policies and helped to develop the new 2016 BHCS Tobacco Policies and Consumer Treatment Protocols. Program outreach and training is county wide, and targets/encompasses staff who work anywhere to provide any BHCS services to any age group. Services are provided to BHCS programs and agencies contracted with BHCS and include Alameda County consumer run agencies. Only half of the ATOD Network is paid for by BHCS funds. The other half is funded by the Alameda County Public Health Tobacco Control Program.

The program worked with BHCS housing staff and the board and care staff to make more tobacco-free housing available and to support Board and Care providers in implementing support for clients to become tobacco free. We recognize the extreme importance of peer support and continue to support Peers in their tobacco harm reduction program by training the peers to be able to co-lead the tobacco harm reduction informational group.

Program Staff Structure

For the behavioral health component and the community clinic component of the program is a 1.0 FTE Project Manager, .40 FTE time Project Director, .50 FTE project assistant.

FY16/17, 17/18 Outcomes

- Provided consultation to 320 Grantees
- Number of staff attending trainings: 236
- 24 trainings and 91.5 hours of TA provided
- 86%-100% staff report the training met expectations well or extremely well.

FY16/17 -17/18 Impact

The project trained 236 clinicians from a broad spectrum of mental health and SUD programs to perform culturally appropriate tobacco interventions and implement tobacco policies through 9 multi-agency skill-building trainings and 15 on-site trainings. The project also provided 91.5 hours of TA sessions. In addition we sent an important update to 20 members of BHCS Psychiatric Practices Committee on Chantix. Collaborative work with Peers consumer agency that we work very closely with resulted in 8 presentations which reached 79 consumers. 80% of the tobacco users reached reported an increased interest in quitting and 56% said they would use tobacco treatment services if available. This data exemplifies the need to make tobacco treatment services readily available by all BHCS providers consistent with the revised ACBHCS Tobacco policy. ATOD provided intensive technical assistance to 4-5 BHCS tobacco intervention Innovations in recovery mini-grantees designed to improve recipient agencies' competency in intervening with their clients who smoke.
To date the project has trained 108 staff from a broad spectrum of positions in mental health and SUD programs to perform culturally appropriate tobacco interventions and implement tobacco policies through 3 multiagency trainings including our very successful Tobacco Recovery Learning Conference which focused on implementing the December 2016 revised tobacco policies and consumer treatment protocols.
PEERS facilitators are just beginning their tobacco harm reduction presentations for FY 17-18 to provide Tobacco Harm Reduction Presentations at BHCS agency sites.

The direct effects of this program are to help agencies and staff to recognize that it is crucial to systematically identify and treat tobacco use disorder that has been ignored far too long in this population and to work to implement comprehensive tobacco-free policies in their agencies.
It was a major improvement to embark on planning 2 Tobacco Recovery learning conferences and brought in additional agencies to the planning process. It was also helpful to have some salary savings due to staff turnover that allowed us to contract with the Helpline to distribute Nicotine patches. This also allowed us to purchase other materials for conference attendees like relevant multiethnic posters and bilingual signage. We anticipate that the opportunity to provide free training to existing BHCS staff to become Tobacco Treatment Specialists will also move tobacco policies and treatment forward at agencies, which is our goal.

FY17 –20 Changes/ Challenges/ Barriers

Staff transition has presented some challenges. The Project Director of 19 years is retiring and it is challenging finding a replacement for this niche position. We still face some barriers among providers in acceptance of tobacco-free policies, recommended by the US Public Health Service and the Substance Abuse and Mental Health Services Administration. The new employees are doing pretty well in their positions. The recruitment is very slow but ongoing. We have weathered the transition to a new agency (BACS) and have lined up a highly likely next home. We will continue to work with our Program Specialist to conduct outreach on the trainings through conference calls, posters, signs, etc.

ATOD Provider Network Tobacco Dependence Treatment Trainings - Staff Evaluations

Training Title FY 16-17	**Met expectations well or extremely well**
Tobacco Intervention Program- 2 day training on tobacco treatment group	100%
Brief Tobacco Interventions	100%
Roundtable Homeless	94%
Brief Tobacco Interventions	100%
Addressing tobacco in HIV/Hep C	90%
Round Table Practical Tools for Treating Tobacco	86%
Thunder Road Staff- Tobacco RX	90%
Learning about Healthy living	100%
Tobacco Recovery Learning Conference • keynote • provider panel • lived experience panel • small group discussion • binder of materials	19 respondents 94% somewhat to most helpful 95% somewhat to most helpful 95% somewhat to most helpful 89% somewhat to most helpful 100% somewhat to most helpful
Brief Tobacco Intervention	25/26 96%
Tobacco Policy Training	15/17 88%

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

OESD 13 Co-Occurring Disorders Program
Program Name: Integrated Substance Abuse Treatment (SAT) for clients with Serious Mental Illness
Provider: Options' Recovery Services

Number Served: 116

Program Description
Target population: Adults with SMI being served by an Adult Community Support Center in Alameda County

Services Provided:
Weekly group meetings (educational and therapeutic), case conferencing with providers, and one on one counseling sessions, transportation and phone calls to assist with access to the SAT program. Referrals are primarily from BHCS case management staff and by self-referral; outreach is done with phone calls to potential participants, putting up posters.

Program Staff Structure:
1 full time addiction counselor, and part time clinical director and part time executive director, and support counselors.

Outcomes for FY16/17
Retention Rates over a 12 month period: 50%

FY16/17, FY17/18 Impact
There has been improved abstinence and reduction in use of alcohol and other drugs, improved quality of life reported. See descriptions in the annual report

FY17 – FY20 Changes/ Challenges/ Barriers
Options is waiting for contracts to provide services at Eden and other centers. The biggest challenge for clients to get treatment is transportation. Options is looking into purchasing or renting a van to be able to pick up more clients. Currently counselors use their own vehicles and the program is growing. SAT provides clients with healthy, safe, and comfortable environments to work on their health and mental health, and on their recovery.

OESD 17. Residential Treatment for Co-Occurring Disorders
Program Name: Horizon Services Cronin House - Residential Treatment for Co-occurring Disorders

Program Description

Horizons Residential Co-Occurring Treatment Program provides housing, medication assessment, evaluation, education, support and monitoring to individuals with co-occurring mental health and substance abuse disorders in alcohol and drug treatment settings throughout the county.

Target population: Adult clients with co-occurring substance use and mental health diagnoses who are physically capable of completing basic hygiene and functioning (no medical issues beyond our capacity to serve).

Program staff structure:

Program Director, Office Manager, and Lead Clinical Counselor, six non-clinical direct care staff members, and six direct clinical counselors to provide therapeutic services, food services coordinator to support all aspects of our food services practices.

Outcomes for FY16/17

Number of consumers served: 156 total

Number of activities or services utilized: We provide a minimum of three clinical groups per day, one recreation group per day, and one substance-use treatment focused group per day. We are also in the process of expanding our group activities to promote increased use of coping strategies and management of symptoms.

FY16/17, FY17/18 Impact

Cronin House served 67 clients from July 2017-November 2017 and by the end of the fiscal year we are on track to serve approximately 160 clients. Approximately 60% of our clients are homeless. Clients are being connected to additional services upon discharge more frequently and are engaging with counselors more consistently to seek support. Clients are verbally reporting that they feel they are gaining more information from our clinical groups and learning more life skills that will be useful once they transition from Cronin House to their next step in treatment. Compared to previous 12 months, we have been able to start increasing our census and providing services to a greater number of clients. We are currently simplifying our intake process to support an effective intake for incoming clients. We have also begun the process of clarifying/simplifying our program expectations for clients, which will support client engagement in the program activities. The length of stay for our clients has increased based on this clarification.

FY16/17 – FY19/20 Changes/ Challenges/ Barriers

We do not have medical professionals in the Cronin House staff structure, which impacts our ability to provide medical services and update medications for clients. Transportation continues to be a challenge for Cronin House in supporting clients arriving at appointments on time, and our limited staff resources impact our ability to provide trainings to our staff members. We do not have managerial oversight of our non-clinical staff members (other than the Program Director), which limits our ability to train staff and limits our ability to retain staff since there is not a clear structure that promotes internal professional development. Case management has also been a challenge for the clinical counselors, as housing is difficult to find in Alameda County, as well as the entire Bay Area. Clinical counselors have expressed feeling challenged in time management based on needing to provide clinical group therapy, individual therapy, continuous documentation of all services being provided, and case management throughout treatment and in preparation for discharge during the short duration of the program.

Addressing challenges and barriers

Cronin House is currently in the process of updating our policies and procedures to accommodate LGBTQ needs, and we are also looking at our physical layout to identify additional space clients can use to feel safe and supported. We are re-examining our organizational chart for the program and our budget in order to find ways to better utilize our staffing to allow for more training and support for clients. With additional staff we can also support transportation needs and client appointments more effectively. We are in the process of creating new data collection criteria and data collection tools to help us evaluate the work we are doing and provide a better quality of service for the wide range of clients we serve at Cronin House.

For FY 2017-2018 and Future FY 2018-2019 and FY 2019-2020

The majority of the clients served by Cronin House have a mental health diagnosis of Depression, Bipolar Disorder, Psychosis, Schizophrenia, or Post-Traumatic Stress Disorder; furthermore, many clients have secondary diagnoses including anxiety and various mood disorders. The clients have also been diagnosed with a wide range of substance use diagnoses, including the use of alcohol, methamphetamine, heroin, cocaine, and various opioids.

Cronin House has provided crisis intervention and stabilization, education, process and skills training groups in addition to supportive case management and linkage services to clients in early recovery from mental health and substance abuse issues. In addition, we have provided on-site Dual Recovery groups, a Family Education Group and structured family visitation time to work with our clients on developing stronger/healthier family connections. In addition, we provide art-therapy groups, conflict-management groups, and CBT (Cognitive-Behavioral Therapy) groups to support clients in managing symptoms, increasing coping skills, and addressing behavioral changes. We offer process groups to address clients' feelings and emotional responses, and we continuously explore the possibilities of gender-specific group meetings to address specific concerns our clients may have. We provide various groups to address identification of triggers, increasing coping skills, and environmental awareness to support our clients in making lifestyle changes once they leave Cronin House treatment. Clients also have an opportunity to develop leadership and peer support skills on Client Council and be a Big Brother or Sister to a new client in the program.

When clients come to Cronin, there is an assumption they have experienced intense trauma that they may or may not be able to acknowledge while at Cronin. Operating from this lens, we offer opportunities to identify and practice coping skills to help clients manage trauma, substance abuse and other triggers that have led to maladaptive behaviors in the past. Cronin House has continued its focus on providing access to healthcare for the increasing number of clients without a psychiatrist, primary care physician and/or dentist. Cronin House offered service for clients on methadone maintenance and has continuously consulted with various psychiatrists to ensure we are providing updated and educated services regarding medication monitoring.

There are various challenges we face in providing the highest quality of services to our clients. Without a Cronin House medical professional on site, we face many delays in providing medical care and updating medication needs of our clients. It can be logistically challenging to schedule appointments, provide transportation, and still continue to provide the best care possible for the rest of our clients. Our limited staff resources limit our ability to provide transportation for our clients. Additionally, having a limited number of staff prevents us from providing the individualized services that many of our clients require to maintain engagement in treatment. With the shift from substance-use treatment to co-occurring treatment, our clients require additional support and our staff members require additional training to provide that effective support. With additional staff members we could provide increased training and enhance the ability to provide high-quality services. We are also constantly reassessing our ability to provide the best possible services to the LGBTQ community. Currently we are examining the physical layout of our building and our use of space to provide an additional space that may support clients in feeling increased safety and support within the program. We are also working on tailoring our groups to accommodate clients from a wide variety of cultural backgrounds. As we move forward we are planning to make changes to our program structure and activities being offered so we can more adequately support the wide variety of clients we serve culturally and diagnostically. Finally, we are working on improving our data collection system so we can more accurately track our successful interventions and the areas we hope to improve in.

We plan to provide a more effective staff-to-client ratio in our staff schedule throughout the day to provide higher quality services. We will be updating our policies and procedures to match best-practices in the treatment of co-occurring disorders. We will be re-purposing several rooms to accommodate needs of clients from various backgrounds and to allow us to support clients more effectively. We will be creating data collection tools that can be used for years to come so we can constantly re-evaluate the efficiency of our services in a meaningful way. I am happy to provide a more detailed “breakdown” of when we plan to accomplish these goals upon request.

OESD 17. Residential Treatment for Co-Occurring Disorders
Program Name: Chrysalis
Provider: Horizon Services, Inc.

Program Description: Provides housing, medication assessment, evaluation, support and monitoring to individuals with co-occurring mental health and substance abuse disorders in alcohol and drug treatment settings throughout the county.

FY 16-17 Outcomes, Impact & Challenges:
Chrysalis is a licensed and certified co-occurring residential treatment facility serving women 18 years and older. The maximum stay is six months. 100% of our consumers are required to have co-occurring mental health and substance abuse diagnosis. FY 16-17 Chrysalis admitted 89 people and 81% were homeless.

Chrysalis is a tobacco free program offering smoking cessation education groups, nicotine patches and gum to assist with withdrawals as well as referrals to 1-800-NO-BUTTS. The purpose of this community based program is to reduce the risk of hospitalization, promote habilitation, rehabilitation and successful independent living.

Chrysalis operates on the principal of social rehabilitation utilizing co-occurring substance abuse and mental health treatment best practices. Treatment is consumer centered and strengths based thus placing major emphasis on the involvement of the consumers in the determination of their own treatment and rehabilitation plans. Cognitive Behavioral, Motivational Interviewing, Seeking Safety and other programs form the foundation of our behavioral interventions. Staff support and witness consumers self-administer their medications, learn how to monitor, dispense and be aware when they need refills or a Doctor's consult. The goal is to assist the consumer to be as medically-literate as possible, gain or enhance her capability to be responsible for her own medications, and engage in constructive dialogue about medications with her own physician, pharmacist or other medical personnel.

Onsite AA and NA meetings are offered. Family education/support groups are conducted and an active Resident Council is developed in order to be the voice of the community. Chrysalis is currently working towards a partnership with Woman Organizing to Respond to Life-threating Diseases (WORLD) to provide HIV and Hepatitis C, testing, counseling, and education.

The level of mental health disability and medical complications has increased in our consumers over recent years. The majority of our consumers have complex mental health issues including multiple traumas and PTSD symptoms. Because our consumers are in early recovery and are often homeless, they have many unmet emotional and physical needs. We are challenged to find new avenues to help our consumers with their psychiatric, medical and dental needs. We struggle to provide the needed transportation to psychiatric, medical, and dental appointments. To serve our more severely disabled population, we need highly skilled, well trained staff that understands mental illness, trauma and addiction. Chrysalis provides intensive training in order to support our staff as they serve our consumers in a uniquely challenging environment. Services provided by Chrysalis include crisis intervention and stabilization, education, process and skills training groups in addition to supportive case management and linkage services to consumers in early recovery from mental health and substance abuse diagnosis. We also provide medication management on site Dual Recovery groups, a Family Education Group and therapy to family members and couples. We focused on developing consumer's strengths, peer connections and understanding of the connection between their mental health and substance abuse. Chrysalis has implemented a more holistic approach in treating our consumers. We have incorporated medication, mindfulness practices, yoga, exercise, and a more nutrition conscious approach to eating.

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

FY 17/18 Plans:

- In an effort to effectively serve consumers within the community an agency Culturally and Linguistically Appropriate Services (CLAS) committee has been established to ensure Chrysalis will implement and abide by the National CLAS standards.
- This year, we will be researching and implementing evidence based and best practice interventions appropriate for the population we serve and educating staff on cultural awareness and its implications in treatment as a means to increase engagement and retention of consumers.
- This year, we will focus on revising current evaluation tool in order to be able to accurately measure overall consumer satisfaction.

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

OESD 19. Low Income Health Plan Pilot (HPAC)
CSS Program Name: Pathways to Wellness Medication Clinics
Provider Name: Hiawatha Harris, M.D., Inc.

Program Description:

Pathways to Wellness provides the following clinic-based services based on the acuity client of needs to promote successful transition of patients to primary care:

Medication Support, which shall include:
- Initial Assessment and Follow-up Assessment thereafter
- Issuing medication prescription(s) for the right drug therapy for client
- Administration of injectable medication, when applicable
- Face-to-face evaluation and monitoring for possible drug interactions, contraindications, adverse effects, therapeutic alternatives, allergies, over/under dosing, polypharmacy, side effects, adverse effects, dietary conflicts or any other medication related issues. Evaluation and monitoring shall also include consultations with physicians, clients and family members as authorized by the client

Mental Health Services, which shall include:
- Assessment
- Collateral
- Plan Development
- Individual Rehabilitation
- Brief Individual and/or Group Therapy

Case Management/Brokerage
Crisis Intervention

Target population
Pathways to Wellness provides services to children (5 – 9 years old), adolescents (10 – 17 years old), and adults (18 years and older) who have moderate to severe mental illness impairments resulting in at least one significant impairment in an important area of life functioning. All clients must meet specialty mental health criteria with impairments in the moderate to severe range. All clients are referred by Alameda County Acute Crisis Care and Evaluation for System-Wide Services (ACCESS).

Services
- Medication management - Child and adult outpatient psychiatric medication support services
- Therapy - Provide brief psychotherapy
- Case Management (***Brokerage and linkage)*** **-** Provide diagnosis letters to clients to aid in accessing community resources, link clients to housing and transportation services, link clients to PCP's for collaborative care. Partner with community resources on helping client's access social security benefits or other sources of income or support. Monthly eligibility checks and assist clients with re-enrolling for Medi-cal.

Program staff structure:
- Program Managers
- Medical Staff to include: Psychiatrists, Psychiatric Nurse Practitioners, Program Nurses and Clinical Pharmacists
- Care Coordinators (Mental Health Rehabilitation Specialists)
- Engagement Coordinator
- Children's Family Navigator

- Program admin support staff

Pathways has a total of 3 facilities (Oakland, Union City and Pleasanton) and the medical staff to client ratios are on average 1: 400+ clients, per prescriber. Pathways Medical Team would like to get the caseloads to be within the average standard of care in the industry which is approximately 1: 250 clients, per prescriber.

Outcomes for FY16/17

Number of consumers served:

- 2,733 return clients each month
- 120 new clients admitted into program each month / Approximately 1440 new clients annually

Number of activities or services utilized (Oakland, Union City and Pleasanton)

ADULT SERVICES	
Medication Support:	24,169 units
Case Management:	3723 units
Mental Health Services:	3043 units
Adults Total:	30,935 units
CHILDREN SERVCES	
Medication Support:	1647 units
Case Management:	167 units
Mental Health Services:	259 units
Children's Total:	2073 units
Total Agency Units:	33, 008 units

% Consumer satisfaction: (see detailed graphs attached)

Retention Rates:

- 65% average *show rate* for return clients
- 54% average *show rate* for new clients (who've never been seen at our clinic)

FY16/17, FY17/18 Impact

- Reducing and/or preventing psychiatric hospitalizations
- Reducing and/or preventing incarceration
- Helping to divert and/or eliminate crisis or need for higher levels of care
- Improving clients with daily living skills

Types of Improvements

- Added on a pilot Engagement Coordinator to ensure that clients make it is to their first appointment. This staff educates clients on services, their rights, what to expect and to determine what each new clients wants to achieve out of services. Engagement Coordinator provides a warm hand off to the assigned Pathways provider.

- Added psychiatric trained clinical pharmacists to the medical staff team to respond to the significant shortage in psychiatry. Clinical pharmacist are able to provide medication support service and increase education around medications to all clients enrolled in the programs. Clients really like this added position.

- Added Family Navigator for children's services to help improve Children's engagement and coordination of services for Foster Care Youth. This person is accountable for reaching out to Child Welfare Workers, Schools and obtain information from pediatricians to ensure that the Pathways provider has all required information in order to provide quality medication support services to identified children who are being admitted into Pathways.

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

FY16/17 – FY19/20 Changes/ Challenges/ Barriers

Changes

- Pathways level 2 program was eliminated from our contract in July 2016 causing a complete gap in services for clients who are in need of more than Pathways level 3 services but do not need level 1 services. Level 2 services went away but the clients and their needs for intensive case management services did not go away. Overall, this is costing the county more money since clients are going to JGPP when they need additional help since Pathways is no longer able to provide them with level 2 services.
- Significant increase in new patient needs for medication support services however not enough resources (manpower) allocated inside of Pathways to Wellness budget to effectively serve this acute population.

Challenges

- Large number of new clients who are given appointments but high % that do not show up for their first appointments. This leaves new clients at risk for decompensation or use of higher levels of care. In addition, this negatively impacts Pathways fiscally because we have secured physician time on the books for new client admission but client does not show for appointment.
- The clients we serve have moderate to severe mental health impairments with very limited support services. However, services such as intensive case management is often needed in order to secure housing, transportation and benefits are very much needed to ensure success.
- Pathways does not have consistent designated providers who are able to accommodate the volume of discharged clients that we actually need to refer out to for medication support services *on a regular monthly basis* in order to make room in our clinics for new client referrals needs from ACCESS. Clients are not being moved to the PCP fast enough to balance the demand of new clients in need of at Pathway to Wellness services. Therefore Pathways is faced with keeping up with *ACCESS* new client referrals, providing maintenance services for those clients open to our agency who are actually in need of *continued treatment with Pathways* plus we are challenged with needing to continue to provide medication support services to clients who do not have a place to go, in our efforts to avoid decompensation or use of higher levels of care within the system. Pathways needs an organized plan and place to send clients to for lower level of care and we need an amended contract that allows for funding to secure additional staff resources to support this overflow until the county has come up with an organized plan and provider to accept Pathways volume.
- Recruitment and retention of psychiatrists is becoming more challenging due to the decline of doctors pursuing this specialty and competitive salaries being offered with lower productivity standards than that of Pathways.

Addressing Changes, Challenges and Barriers

- Slightly increases physician salaries to become more competitive with recruitment of qualified Child Psychiatrists.
- Added a full-time Engagement Coordinator to educate new adult clients on services that will be provided and prepare client for what to expect on the first appointment. This person spends lots of time with clients coming right out of JGPP and additional time on the front end to ensure success. Overall, this has helped with increasing engagement and retention of new clients.
- Added clinical pharmacists as prescribers and to increase client education around medications being prescribed. We continue to utilize nurse practitioners and program nurses to handle demand for services and created weekend schedules for new assessments.
- Added a Family Navigator for children's services. This person serves an engagement coordinator and ongoing clinician for all "at risk" children being referred into the clinics.

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

OESD 19. Low Income Health Plan Pilot (HPAC)
Program Name: STEPS
Provider Name: Telecare
Number Served: 80

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. Our 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 (age 18+) 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 rooms 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.

Services

Individuals who are high users of Alameda County Mental Health Services are referred to STEPS from Villa Fairmont or Gladman IMD, or by Alameda County BHCS when applicable. The referral is reviewed by the Clinical Director for completion and eligibility. The individual is assigned a case manager on the team and the outreach begins usually while the individual is still living in the IMD and preparing for discharge to the community. STEPS provides case management services in the community, including psycho-educations (individual and family), symptom management, medication tracking and coordination with pharmacies/providers, coordination of health care services, increasing social supports, accessing/locating community resources, housing search/education, and independent living skills training.

Program Staff Structure

STEPS program is led by an administrator and a clinical director, as well as 4 Personal Services Coordinator II providers.

Outcomes for FY16/17

Number of consumers served: 73 clients

Number of activities or services utilized : 2,549 individual charted services with clients, estimated 350 outreach contacts with referrals in preparation for them returning to the community.

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

% Consumer Satisfaction = data from the May 16/17 survey		
I liked the services I received here	100%	Agree/strongly agree
Given other choices, I would still choose to get services from this agency	100%	Agree/strongly agree
Services were available at times that were good for me	90%	Agree/strongly agree
I was able to get all the services I thought I needed	87%	Agree/strongly agree
I would recommend this program to a friend or family member	94%	Agree/strongly agree

% Retention Rates: contractual expectation is a length of stay of 90 -120 days.

Average length of stay FY16/17 = 182 days.

FY16/17, FY17/18 Impact

STEPS provides support to individuals around re-entry to the community from long-term hospitalizations. We assist clients with connecting to PCP/psychiatry services, coach and instruct clients around developing and practicing coping strategies from Evidenced Based Practices, explore and locate safer housing options, connect with community groups and activities including employment services, provide psycho-education around understanding diagnosis and symptom management, understanding and accessing resources and services, and increasing self-advocacy skills.

Describe types of improvement compared to previous 12 months.

STEPS demonstrates a decrease in hospitalizations, decrease in incarceration/recidivism rates, increase in acquisition of state and federal benefits, improved housing stability by number of days housed, increase in medication maintenance, and 100% connection with PCP and psychiatry services.

FY16/17 – FY19/20 Changes/ Challenges/ Barriers

The current challenge is predominantly around locating and securing safe and affordable housing, but we also find it challenging at times to coordinate with multiple specialty medical services due to time delays and the complexity of organizing multiple providers.

We work closely with county leadership to develop housing resources and increase coordination with service teams and specialty providers. We develop relationships with county service team and HSP programs to provide extra support for clients with complex needs.

A. COMMUNITY SERVICES & SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 20. Individual Placement Services (IPS)
Program Name: Individual Placement and Support (Alameda County IPS)
Provider Name: BHCS Vocational Program and Center for Independent Living (CIL)

Program Description:

Alameda County Behavioral Health Care Services has embarked on a long-term plan to implement Individual Placement and Support (IPS) Supported Employment throughout our specialty mental health services. This evidence-based practice assists people with finding and maintaining competitive jobs in the community. Engagement, job development, placement support, and job follow-along supports are the core program elements of this approach.

The following key features illustrate some of the essential aspects of IPS:

1. Nobody is excluded from vocational services due to diagnosis, symptoms, substance use, or any other personal challenges. Desire to get a competitive job is the criterion for services, because motivation to work is a strong predictor of success.
2. Upon entry into IPS, people receive help to start looking for a regular job in the community right away. There are no requirements for vocational testing, work samples, employment groups or other pre-vocational activities.
3. Each IPS participant receives individualized benefits counseling to understand how working will impact their public benefits, including Social Security, Medi-Cal and other health insurance, food stamps, etc. Benefits counseling is provided by the Center for Independent Living.
4. Employment specialists make frequent, in-person employer contact to build employer relationships and effectively link people to jobs of their choice.
5. Vocational services are individualized to fit the needs and preferences of each person. Individualized job search and job follow-along plans reflect each person's unique interests, goals and needs.
6. Once a person obtains a job, job retention services are provided continuously until the job is stable or people no longer request services.
7. Vocational services are integrated closely with mental health services in order to ensure the best employment outcomes. Employment specialists meet weekly with mental health teams to share information, collaborate, and plan services.
8. Ongoing quality improvement efforts include biannual or annual program reviews using the Supported Employment Fidelity Scale. Programs create action plans to increase fidelity to the model and employment outcomes.

Target Population
These services are available to people with serious mental illness that are part of BHCS case management teams, Full Service Partnerships, Level 1 specialty providers, and Level 1 Transition Age Youth (TAY) programs.

Services
Vocational staff is assigned to various mental health teams and work closely with those team members through meetings and interactions to identify referrals for vocational services based on people's motivation to work. Consumers can self-refer or be referred from mental health team members. Rehabilitation counselors complete a program intake for each referred person and employment specialists provide vocational assessment, job search, job placement, and job retention supports, which are individualized to each person. Staff also provide engagement services when people need it and will connect with mental health team members, make home or community visits, and connect with family (with permission) to try to make contact and engage people about their interest in vocational supports. If people are interested in attending school for career development purposes, our staff will help them with enrolling, staying in school, and completing the school program.

In addition, two program specialists/ IPS trainers provide ongoing, intensive consultation and technical assistance to the Vocational Program and nine other BHCS-funded IPS programs. This includes fidelity reviewing, didactic and field-based training, and outcome monitoring.

Benefits counselors provide group presentations and individual counseling on how working impacts public benefits like Social Security, Medi-Cal and other health insurance, Food Stamps, General Assistance, and other benefits. They have office hours at various clinic locations and meet with people by appointment. They help people understand their financial situation and teach people how to report earned income to Social Security to avoid overpayments.

Program Staff Structure

The Vocational Program includes one director, two managers, two program specialists/ IPS trainers, nine employment specialists, five rehabilitation counselors, and three mental health specialists. In addition, the business unit has one administrative supervisor, administrative assistant, and two specialist clerks.

CIL benefits counseling includes two part-time benefits counselors.

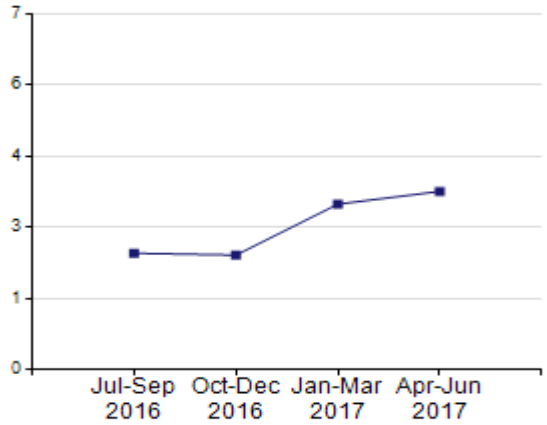
FY16/17 Outcomes and Impact

Number of consumers served: The Vocational Program served 257 people, 106 of whom worked competitive jobs in the community (41%). 20 Vocational Program consumers received assistance to go back to school. BHCS-funded IPS programs that received technical assistance and monitoring from IPS trainers helped a combined 348 people, 169 of whom worked competitive jobs in the community (49%). CIL provided benefits counseling to 139 people.

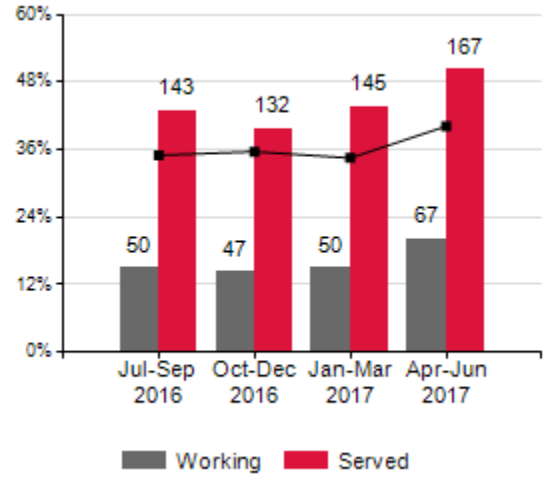
Number of activities or services utilized: The Vocational Program provided 11,363 hours of service. CIL had 310 contacts with people.

The Vocational Program achieved good fidelity to the IPS model, with a score of 102 out of 125. 41% of IPS consumers worked at least one competitive job in the community during the year and 9% attended an education program for career development. 106 people worked jobs in a wide range of sectors, including warehouse, retail, food service, education, social service, and transportation. 93% of IPS consumers expressed moderate to very high satisfaction with services.

Job starts per full time Vocational Program employment specialist



Percent of Vocational Program Clients Working per Quarter (duplicated across quarters)



FY16/17, FY17/18 Impact

People earned an average of $12.58 per hour at job start, with a range of $9.00 - $22.00.

Types of improvement compared to previous 12 months.

FY16/17 – FY19/20 Changes/ Challenges/ Barriers

Staffing: The Vocational Program has 35% of their staff positions vacant due to turnover and slow recruitment processes, including one director, one manager, one rehabilitation counselor, one administrative supervisor, two specialist clerks, and three employment specialists. This has limited the number of people served.

CalWORKS: Alameda County CalWORKS mental health services reorganized under Alameda County IPS in 16-17.

Quality improvement and service expansion: Conversations and planning to implement IPS in BHCS substance use disorder programs, TAY programs, CalWORKS, Whole Person Care, and criminal justice programs.

Addressing changes, challenges, and barriers

Staffing: Vocational Program management is working closely with HR to fill open positions through county recruitment processes.

CalWORKS: Alameda County BHCS will issue an RFP in 2018 to re-bid CalWORKS contracts to include IPS services.

Quality improvement and service expansion: Continue to look for opportunities to increase fidelity to the IPS model. Continue to provide technical assistance to agencies providing IPS. Continue to promote IPS expansion throughout BHCS programs.

A. COMMUNITY SERVICES & SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 23 Community Based, Voluntary Crisis Services
Program Name: Transition to Mobile Crisis Teams (MCT) & Mobile Evaluation Teams (MET)

Program Description

Mobile Crisis Teams (MCT) & Mobile Evaluation Teams (MET): The Mobile Crisis Teams will respond to 5150 calls, engage with consumers who are in crisis, and assessment consumer needs and conduct follow up post crisis situation. MCT & MET will transition BHCS CRP from providing outpatient clinic services to only Mobile Crisis Services, with all CRP clinical staff to work primarily out in the field. An expansion of these services will increase the community-based crisis prevention and early intervention services, thereby ensuring clients are referred to the appropriate type of mental health services.

Program implementation is projected to begin FY18/19.
Clinicians will be out in the field performing the following activities:

- Engaging with consumers, conducting follow-up calls
- Conduct outreach activities and
- Engage in prevention visits to shelters, Board and Care Homes, homeless encampments, schools, substance recovery programs and County clinics
- Collaborate with physicians for consultation as needed.
- Interact with police jurisdictions and ACCESS.

Program Staff will comprise of 24 full-time clinical staff and 3 full-time clerical staff. There will be 2 North County Teams, 2 Mid-County Teams and 2 South County Teams.

Training: All clinical staff will go through the following training when transitioning from outpatient clinic services to the mobile crisis team structure:

1) Crisis Prevention Institute's "Non-Violent Crisis Intervention" Training
2) Oakland Police Department's Crisis Intervention Training (CIT)
3) Screening, Brief Intervention, Referral to Treatment (SBIRT)
4) Stages of Change
5) Conducting Crisis Intervention throughout the Lifespan
6) Providing Culturally Responsive Crisis Intervention
7) Documentation
8) Differential Diagnosis
9) Co-occurring Disorders
10) Performing Crisis Intervention through a Trauma-Informed Lens
11) Environmental Awareness - Safety in the Community
12) Video Interpretation and Video Physician Consultation on iPad Devices
13) Performing Differential Diagnosis

A. COMMUNITY SERVICES & SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 24. Behavioral Health and Developmental Disability Program
CSS 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 Care Services, 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. Our team of professionals specializes in supporting clients with complex behavioral, emotional, or psychiatric needs. The Center was named in honor of Dr. Mary Lu Schreiber and Dr. Robert Schreiber, two beloved psychiatrists who provided psychiatric services for thousands of individuals with intellectual and developmental disabilities in Alameda County.

Target population
Serves the mental health care needs of adults with intellectual and developmental disabilities. The Schreiber Center currently serves residents of Alameda County ages 18 and up who are clients of the Regional Center of the East Bay. Additionally, clients must meet the Specialty Mental Health Criteria and have a covered behavioral health care plan to be considered eligible for services.

Services
The core services offered by the Schreiber Center are:
1) Assessment for Specialty Mental Health Services, 2) Case Consultation, 3) Psychotherapy, and 4) Medication Support.

Program Staff Structure
- Behavioral Health Clinician II (full time)
- Psychiatrist (half-time)
- Behavioral Health Clinical Supervisor

FY16/17 Outcomes

Number of consumers served 47
Number of Services Utilized:

Services	Contacts
Psychotherapy	42
Medication Support	42
Crisis Intervention	2

FY/16-17, FY17/18 Impact

Of the 47 individuals served by Schreiber Center over the past year, there have been 13 discharges. The majority of the discharges (8) were individuals who were seen for psychiatric assessment and did not meet specialty mental health criteria. These people were referred to alternate mental health providers for the best-matched care to address their needs. Three individuals were referred for a higher level of care and Schreiber Center clinicians assisted with a warm hand-off to alternate providers. One person discharged because they met all their treatment goals. Six of the 47 individuals served by Schreiber Center this year made significant improvements in their functioning and were

transitioned from regular psychotherapy services to a "meds-only" status.
Schreiber Center has excellent retention. Over the past year, we have only had one individual who decided to discontinue services because they no longer desired therapy. The majority of Schreiber Center clients are very satisfied with services. For example, one active client regularly expresses her gratitude because clinicians identified a more accurate diagnosis for her and adjusted treatment to better address her needs. Another client no longer drools excessively after his doctor simplified his medications. Finally, the one individual who discharged having met all treatment goals, told us that he could sleep and live more easily now that the anxiety which interfered with his daily functioning had subsided.

With ongoing, direct client contact Schreiber Center clinicians continue to increase competencies around assessment and differential diagnosis for individuals with developmental & intellectual disabilities (DD/ID). This has resulted in better matched care to address mental health needs for RCEB clients referred as well as improved therapeutic and psychiatric treatment for these individuals.

The Schreiber Center team continues to participate in multiple education & outreach activities. Efforts in this area have continued to increase awareness of the unique needs of individuals dually diagnosed with intellectual disabilities and mental illness – as well as to increase our own clinical skills. On May 3rd, Dr. Chris Esguerra provided a well-attended CME presentation to approximately 40 Alameda County medical and psychiatric providers. Dr. Esguerra is a well-respected psychiatrist who pioneered the Puente Clinic in San Mateo County – a model which inspired Schreiber Center!

These outreach efforts have also improved access to mental health services for individuals with DD/ID by increasing awareness of co-occurring mental illness for individuals with DD/ID and improving the accessibility of mental health services for all.

Multi-disciplinary consultation team continued from July, 2016 through May, 2017. These monthly meetings enabled the Schreiber Center team to discuss the mental health needs of RCEB clients in depth with licensed clinicians from either ACBHCS or RCEB – all of whom are experts in either mental health assessment and treatment or service provision and treatment of individuals with DD/ID or autism. The collaborative efforts of this team contributed to skilled adaptation of treatment tools for the DD/ID population, increased competency in differential diagnosis and improved mental health outcomes for Schreiber Center clients.

Because of the clinical competencies referenced above, the Schreiber Center team has become a valuable resource for both ACBHCS and RCEB as well as Alameda County in general. Schreiber Center clinicians have regularly provided information and clinical consultation to family members, service providers within primary care as well as colleagues at ACCESS, Napa State Hospital, CHANGES, Herrick Hospital & John George Psychiatric Hospital.

FY17/18 – FY19/20 Changes/ Challenges/ Barriers

Small staff size and finite resources continues to limit the number of clients who can be served clinically. We are collaborating with RCEB on funding options with the hope of increasing capacity and have begun the process of supervising a student intern for Fall 2018. Our hope is that inviting an intern to join the team will increase capacity and also work toward increasing and developing a workforce who will be competent to serve individuals with intellectual and developmental disabilities. Because of the complicated bio-psycho-social-developmental history and clinical presentation that accompanies most every referral to Schreiber Center, psychiatric assessments take time.

A. COMMUNITY SERVICES & SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 25 Behavioral Health – Primary Care Integration Project
CSS Program Name: Trust Clinic
Provider Name: LifeLong Medical Care

Number Served: 1,000

Program Description

LifeLong provides primary care including medical and behavioral health services, in collaboration with ACBHCS and Health Care for the Homeless. (acupuncture, podiatry, MAT) Assuming the contract is renewed, we anticipate reaching and maintaining services to 1,500 patients.

For people on GA applying for SSI, providers provide documentation of disability to support application.

Target population
Adults who are homeless or at risk of homelessness in Alameda County, people with GA working with disability advocates, and others who are frequent users of multiples systems of care and/or high risk with multiple chronic physical and behavioral health conditions

Services
Primary care services includes integrated medical and behavioral health services (mental health and substance use). These services are provided by a multidisciplinary team including health coaches and with a focus on addressing social determinants of health including housing, income and food access. Special programs implemented at Trust include:

- Buprenorphine Clinic for patients with opioid use disorder
- Health home projects to provide intensive case management to high cost/high risk patients who are members of Alameda Alliance for Health.
- Psychiatric Crisis Management Pilot in collaboration with county Psychiatric Emergency Services
- Housing Navigation in collaboration with Home Stretch

Program Staff Structure

AMD overseeing medical care, in charge of MD, RN and MAs
LCSW Lead in charge of BH team psychiatrist, psychologist, LCSW, MSW
4 FTE Health & Wellness Coaches,
1 FTE Housing Navigator
2 FTE Health Homes Case Manager
County staff embedded in Trust: .5 FTE Psychiatrist, 1 FTE Psychologist, Psychiatry Resident

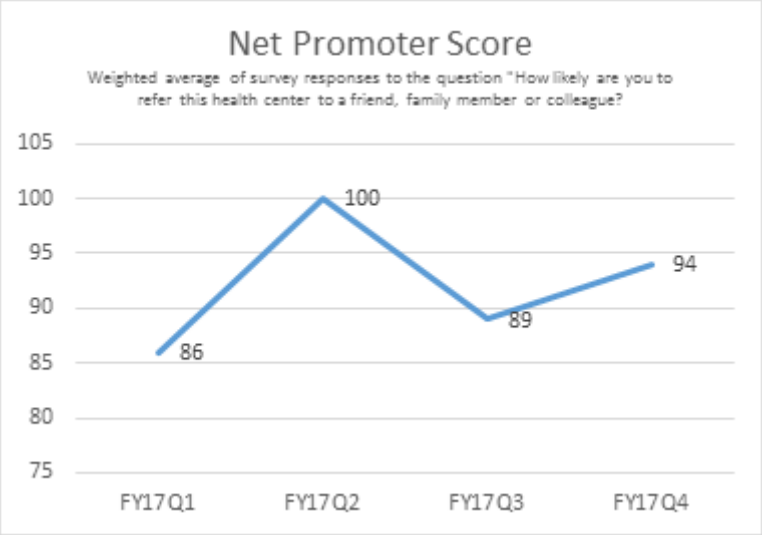
Outcomes for FY16/17 (Please include data graphs and/ or charts, if available)

A. Number of consumers served: 600

B. Number of activities or services utilized: 7,134 visits (billable and non-billable) provided

C. % Consumer satisfaction: see graph below for Net Promoter Score; an index measuring the willingness of consumers to recommend a company to others and is used as a proxy for gauging overall satisfaction.
NPS = Net Promoter Score – How likely are you to refer LifeLong to your friends and family? (industry standard for consumer satisfaction)

A. COMMUNITY SERVICES & SUPPORTS (CSS) PROGRAM SUMMARIES



Retention Rates

As a new health center, most Trust patients are new (avg. 50 new patients per month). LifeLong is working with HCH and HCSA to develop RBA metrics of retention, such as number of patients who have 3 visits in the first 6 months, which is validated through VA studies.

FY16/17, FY17/18 Impact

The goal is to establish a health home for the target population that offers an integrated model to address both physical and behavioral health needs. We aim to improve income and housing stability and empower patients to engage in self-care.

New QI initiatives are as follows:

a. Use panel management to better track and coordinate behavioral health services provided at Trust.
b. Focus on increasing use medication assisted treatment for opioid use disorders.
c. Increase number of applications submitted to Home Stretch for access to permanent housing.
d. Implementation of screening tools for depression and trauma
e. Improved patient engagement by incorporating the patient voice into program with a patient advisory board that meets monthly.

FY16/17 – FY19/20 Changes/ Challenges/ Barriers

Challenges:

- Achieving high patient volume given the initial referral process and sole focus on GA recipients;
- Provider recruitment challenges made it difficult to fill medical provider positions;
- Initially to determine the best entry-point for Trust services, whether medical or behavioral health;
- Limited space to accommodate the volume of staff, providers and the range of services.
- Create access by balancing drop-in vs. scheduled appointments.

Addressing Changes, Challenges and Barriers

Eligibility for Trust has broadened to include homeless and marginally housed who may already have SSI. This is significantly increases patient volume, which ultimately supports sustainability of the program. Targeted outreach to engage with behavioral health consumers with SMI who are in need of a health home. Behavioral health services are now consistently the entry-point for Trust services, which means they can get to the clinic sooner (there are more BH

providers than medical) and build relationships that help retain them in care. Flexible use of office space and staggering staff and providers are strategies to address space limitations. Increased use of drop-in appointments.

A. COMMUNITY SERVICES & SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 25 Behavioral Health – Primary Care Integration Project
CSS Program Name: Eastmont PATH, Oakland and San Leandro
Provider Name: LifeLong Medical Care

Program Description:
LifeLong provides co-located primary care services, care coordination and referral for specialty services in collaboration with Alameda County Behavioral Health Care Services and embedded in the Oakland Community Support Center.

Target population
Alameda County residents and members of the Oakland Community Support system with serious mental illness (SMI) and co-occurring chronic health conditions.

Services
LifeLong provides primary care, drop-in care, podiatry services, onsite blood draws, routine adult immunizations, and Health Education groups. In collaboration with the Oakland Community Support team and other Behavioral Health Centers, care coordination with case managers, psychiatrist, Board & Care staff, family members and care givers is provided.

Program Staff Structure
Eastmont PATH staff include a Center Supervisor, MA, MA, a county RN and Peer Health Educator, 3 internal medicine providers, podiatrist and a Center Manager.

Number Served: 380

FY16/17 Outcomes
Number of consumers served: 302
Number of activities or services utilized: 1,627 encounters

FY16/17, FY17/18 Impact
Patients are engaged in a number of Healthy Living groups, one of which is mindfulness. Participants abide by the guidelines of the program. In the past 12 months we've seen more engagement by participants in wellness activities, i.e. Healthy Living groups. We've also noticed more effective Peer Health Education. In addition, we were able to add a second exam room to improve clinic flow.

FY17/18 – FY19/20 Changes/ Challenges/ Barriers
It is often challenging to coordinate with case managers, since they work for a different organization and have heavy caseloads. Patients come to the site from Board and Care facilities s that are infested with bed bugs, scabies, etc. and it is a challenging to resolve these ongoing problems that impact health and wellness. Transportation to the health center and other locations continues to be a problem for this population.

Addressing Challenges/ Barriers
We have reached out to OCSC to ask for the Board and Care facilities to show proof of extermination of infested properties. We continue to work with case managers to coordinate transportations for appointments both at the clinic and outside specialists when needed. Consistent staffing is important in engagement with this population.

A. COMMUNITY SERVICES & SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 26 Culturally Responsive Treatment programs for African Americans

Program Description: A Steering Committee has formed and convened to discuss funding priorities and identified several keys values that shape recommendations for funding.

FY18-19 – FY19/20 Changes Challenges

BHCS continues to collaborate with the African American Steering Committee and other community partners to explore ways the available funding can be utilized to specifically target current needs in the African American community. In addition, a collective and culturally congruent process is underway to explore the establishment of a Wellness Hub to link external programs into one service location for members of the African American community.

BHCS will procure culturally appropriate mental health services for the African American community for fiscal year 18/19. See "Changes Summary" section in the beginning of this document for details.

A. COMMUNITY SERVICES & SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 27 In-Home Outreach Teams (IHOT)

Program Description

IHOT is designed to serve individuals who have struggled for many years with serious mental illness, repeated hospitalizations, and interactions with law enforcement and are not connected with services. The majority of IHOT consumers served in the initial pilot (60%, n=104) had a primary diagnosis of Schizophrenia or another psychotic disorder, while about a quarter (24%, n=42) of consumers had a mood disorder (RDA 12-Month Evaluation, October 2017). Less than 10% of consumers (n=16) had a documented co-occurring substance use disorder. It is likely that the number of consumers with an actual co-occurring disorder is closer to 60-80% based on other data sources. Additionally, the majority of IHOT consumers were male (67%, n=116), between the ages of 26-59 (71%, n=124), and either Black/African American (37%, n=64) or White (36%, n=63).

Services

Consumers are referred to IHOT through the County Access phone line or are identified by the County as high utilizers of psychiatric emergency services. In its first year of IHOT implementation, Alameda County received referrals for 195 unique consumers. 149 referrals came through the County Access line, and 40 were from the High Utilizers List. The remainder, 6 referrals, were from undetermined sources. Family members and mental health providers made the most referrals through the Access Line. On average, it took eight days from the time a consumer was referred to IHOT and when the IHOT team made its first contact attempt. Referrals with no information on consumers' families were more challenging, because it was more challenging to find consumers without any leads. Once IHOT providers receive a referral, the teams begins an intensive outreach and engagement process with the consumer, the consumer's family, and others in the consumer's network. The teams engage individuals "where they're at," by meeting consumers and other individuals in a variety of locations, including the community, hospitals, shelters, and local clinics, as well as by phone call, text messages, and email.

Program Staff Structure

IHOT providers conduct outreach attempts using interdisciplinary teams. BHCS currently maintains four IHOT Teams (3 Adult Teams and 1 Transition Age Youth/TAY Team). Each of the Adult Teams is comprised of one Licensed Practitioner of the Healing Arts (LPHA), 1 Peer Staff, and 1 Family Support. The TAY Team includes 1 Peer Staff and 1 Family Staff. BHCS is expanding the Adult Teams to include one additional Peer Staff on each team. For individuals not voluntarily engaging in services, IHOT was designed to provide:

1. Intensive outreach and engagement
2. Mental health screening
3. In-home intervention
4. Family education
5. Support and linkage to treatment

Outcomes for FY16/17

IHOT providers made 4,015 attempts at engagement with the 175 consumers and their support systems (i.e. family members, friends, neighbors, roommates, and other service providers), which suggests that persistent outreach is a key component of IHOT implementation. On average, IHOT providers spent the most time (73 minutes per contact) with engaged consumers; however, they also spent a similar amount of time (70 minutes per contact) with consumers who refuse services. This may indicate that providers spent time searching for consumers, as well as trying to get them to engage in services, and that they are persistent in their outreach efforts even when consumers are unwilling to engage.

On average, consumers were enrolled in IHOT for 124 days, with participation ranging from four to 371 days. The majority of consumers (67%, n=118) were enrolled in IHOT for over 90 days.

A. COMMUNITY SERVICES & SUPPORTS (CSS) PROGRAM SUMMARIES

1. Number of consumers served

The County received IHOT referrals for 195 unique consumers, 175 of whom were connected to an IHOT provider. Sixty-eight consumers were still receiving IHOT services at the conclusion of the evaluation period, while 107 were discharged from IHOT during the program's first year of operation. Fifty consumers who completed IHOT were connected to mental health services, of whom 44 accepted services on a voluntary basis and six were connected through an Assisted Outpatient Treatment (AOT) petition and agreement with the court (i.e., voluntary settlement agreement or AOT court order). Twelve of the 52 consumers discharged without service connection withdrew, were unavailable, or were discharged without meeting their treatment goals (e.g., IHOT was unable to engage them in services).

Provider	Total Number of Consumers Served
Abode	54
Bonita House	63
La Familia	51
Stars	24

Summary of Consumers' Service Connections after IHOT Enrollment (N = 107)

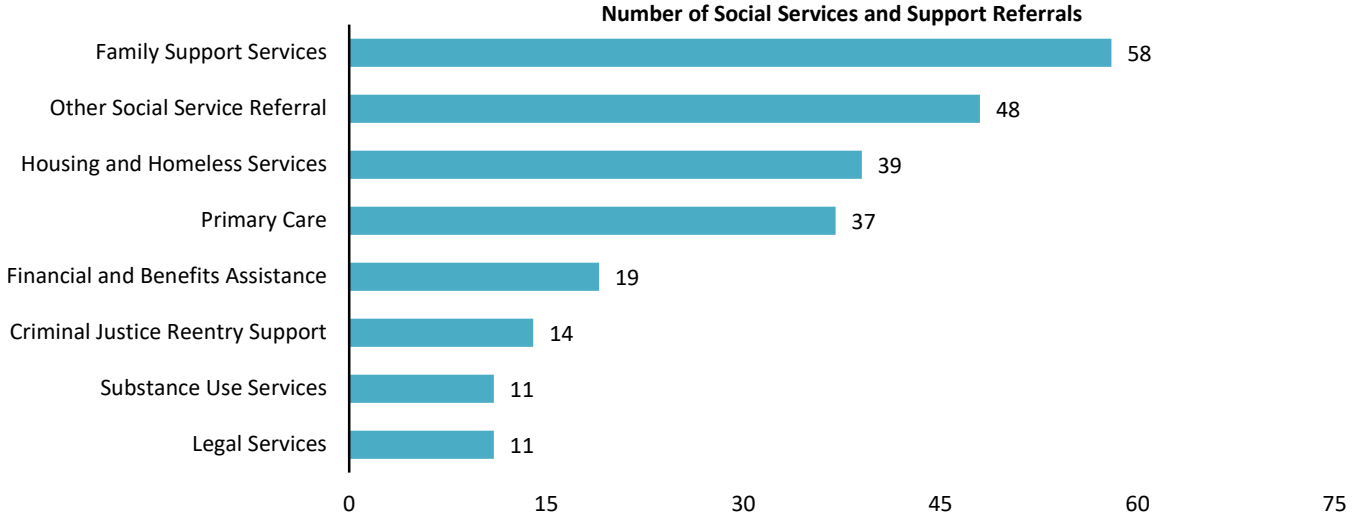
Level of Engagement	Consumers	Summary of Engagement
Discharged with Meaningful Service Connection	36% (n = 38)	• At least three days of outpatient or day treatment • At least three consecutive residential treatment days • At least three services from FSP or service teams
Discharged with Some Service Connection	10% (n = 11)	• One to two days of outpatient, day, or residential treatment • One to two services from FSP or service teams
Discharged with No Service Connection	49% (n = 52)	• No connections to outpatient, day, residential, FSP, or service teams
Cannot be determined	5% (n = 5)	• Service data was unavailable

Number of activities or services utilized:

As part of their outreach and engagement efforts, IHOT providers make a variety of referrals to connect consumers and their families to social services and supports. Overall, providers are connecting both consumers and consumers' families to a variety of supportive services, in addition to mental health services. IHOT providers made about one-fourth of their referrals to various family support services (e.g. NAMI) for consumers' family members. About 20% of referrals were to a variety of other social support services for consumers, including education, employment, DMV, procuring phones or food, and support making utility payments. Several referrals were also made for housing and homelessness services (16%, n=39) and primary care providers (16%, n=37).

A. COMMUNITY SERVICES & SUPPORTS (CSS) PROGRAM SUMMARIES

IHOT Social Services and Support Referrals



% Consumer Satisfaction

Focus groups with consumers and family members suggest that IHOT providers' persistence and consistency in outreach builds trust and promotes service engagement. Some family members compared IHOT to their previous experiences trying to get help for their loved one and noted that the IHOT program allows providers to expend more effort and time with consumers compared with other mental health services. Overall, focus groups with family members and consumers indicate that the program is successful for consumers who are willing to engage; however, there is a subset of consumers for whom IHOT may be insufficient and who may need additional incentives to engage in specialty mental health services.

% Retention Rates

Outreach and engagement data indicate that just over half (59%) of consumer outreach attempts resulted in either service engagement (e.g. with IHOT or another service provider) or a willingness to participate in ongoing outreach services, which suggests that the teams' persistence in making contact with consumers can result in consumers' ongoing engagement. Survey responses and focus groups (RDA 12-Month Evaluation, October 2017) indicate that the IHOT teams' ability to meet consumers outside the traditional mental health service office setting is a key component to IHOT's success. Family members noted the value of family and peer advocates for the support they provide to both the family member and their loved one.

FY16/17, FY17/18 Impact

IHOT is likely decreasing the number of avoidable hospitalizations and crisis stays, as evidenced by the decrease in consumers experiencing these outcomes, while maintaining an appropriate use of hospitalization and crisis services for consumers who continue to need it.

- The number of consumers with at least one crisis stabilization episode decreased by over 50% during IHOT.
- Just over half 56%, of IHOT consumers were hospitalized at least once in the three years before engaging with an IHOT provider.
- The number of consumers with at least one psychiatric hospitalization decreased by just under 50% during IHOT.

IHOT Consumers' Crisis Episodes Before and During IHOT (N* = 159)

*N = data available for pre and post IHOT.

Crisis Stabilization		
	Pre-IHOT Enrollment	During IHOT Enrollment
Number of Consumers	n = 108	n = 63
Number of Episodes	3.5 episodes per 180 days	5.4 episodes per 180 days
Average Length of Stay	1.3 days	1.1 days

Table 1. IHOT Consumers' Psychiatric Hospitalizations Before and During IHOT (N = 159)

Psychiatric Hospitalization		
	Pre IHOT Enrollment	During IHOT Enrollment
Number of Consumers	n = 89	n = 44
Number of Episodes	1.1 episodes per 180 days	2.3 episodes per 180 days
Average Length of Stay	8.4 days	12.3 days

Each consumer was also asked about their experiences of homelessness in the 12 months before beginning the IHOT program and during program participation. Despite data limitations, providers were able to assess housing status at enrollment for 77 consumers:

- 35% (n = 27) were stably housed
- 31% (n = 24) were homeless
- 21% (n = 16) did not report their housing status
- 13% (n = 10) were in the hospital or jail

Improvement compared to previous 12 months

Many consumers and their family members reported positive progress towards recovery while in IHOT. Consumer and family member feedback suggests that IHOT providers are approaching their work from a recovery orientation, with focus on not only consumers' health but also their sense of purpose and community. In focus groups, IHOT consumers discussed their appreciation for IHOT providers' support to get their basic needs met (e.g., food, clothing, transportation, physical health needs). Further, they noted improvements in their overall wellness:

"I'm able to better manage. I feel better off now. I used to be in bed all day and stuff. I feel more grounded. I feel like I am doing good."

Family members echoed this perspective, noting that their loved ones are doing better since working with IHOT. One discussed their loved one's reduced involvement in law enforcement, noting that "we see a lot of changes since he has been going to second chance [drug and alcohol treatment program]."

Most IHOT consumers feel like they have a say in their treatment plan.

In focus groups, IHOT consumers described feeling autonomous and expressed appreciation for how IHOT teams listened and considered their perspective. For example, one consumer noted, "they'd respect it if we said no" while another echoed that "there's no pressure." Family members mentioned similar experiences and discussed how IHOT providers listen to their loved ones and consider their needs when identifying potential service linkages.

FY16/17 – FY19/20 Changes/ Challenges/ Barriers

Given that IHOT is intended to provide a 90-day period of outreach and engagement, implementation data suggest that the majority of consumers are participating for longer than expected. While it is not possible to know definitively the factors influencing a longer period of engagement for each consumer enrolled for more than 90 days, conversations with IHOT providers and evidence from the literature suggest that extended enrollment periods may be attributed to some or all of the following:

1. IHOT consumers may be more difficult to engage and require a longer period of engagement.
2. IHOT providers are given minimal information about consumers upon referral to the program and may take an extended period of time to find consumers before beginning outreach and engagement efforts.
3. A portion of IHOT consumers may be willing to engage with IHOT programs but may not be ready or willing to voluntarily accept ongoing mental health services. Without a court-involved capacity to compel participation in mental health services, such as AOT, IHOT providers may be serving people for longer than anticipated.
4. Providers may not be consistently entering administrative discharge paperwork in a timely manner, thereby artificially increasing the length of IHOT enrollment.

Addressing Changes, challenges, and barriers

- BHCS Added Staff to the IHOT Teams (1 Peer FTE to each of the Adult Teams)
- IHOT Teams expanded services to consumers beyond 90 days.
- BHCS hosts a monthly Learning Collaborative designed to provide a space for IHOT Teams to learn from one another and improve quality of services.
- RDA conducted a 12-month Evaluation of IHOT with the goal of describing program implementation and evaluating outcomes to support quality improvement activities.

A. COMMUNITY SERVICES & SUPPORTS (CSS) PROGRAM SUMMARIES

Program Name: Adult and Older Adult Hope Intervention Program (HIP)

Program Description:
This program will link adults and older adults who are exiting John George Psychiatric Hospital, Crisis Residential Programs or Cherry Hill Detoxification Unit and not yet involved with outpatient behavioral health services, with short-term case management. It will serve between 20-40 adults and older adults with community outreach, engagement, short-term therapy, and intensive case management services, including crisis intervention, for up to 90 days with a "warm hand-off" to other community services. Staffing will include two Personal Services Coordinators and one Peer Counselor.

Program implementation will begin FY18/19.

OESD 30 SAGE Case & Care Management Services – SSI Advocacy

Provider: Bay Area Community Services (BACS)

Program Description

The Supplemental Security Income (SSI) Case & Care Management Program will provide case management to serve SMI clients who are currently receiving SSI Advocacy services. This program will serve approximately 320 unduplicated clients.

Additional details will be provided in MHSA Plan Update FY18/19.

A. COMMUNITY SERVICES & SUPPORTS (CSS) PROGRAM SUMMARIES

OESD 31 Older Adult Service Team
Provider: Family Service Agency of San Francisco (FSA)

The Older Adult Service Team will support client recovery through a holistic and strength-based approach that considers the overall bio-psycho-social needs of older adult clients. Over twelve percent of the consumers are sixty or older. With a significant number of older adults needing this level of service, creating a team to focus on the unique needs of the older adult population is 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 to their recovery. The overarching goal is for clients to attain a level of autonomy within the community of their choosing.

The Older Adult Service Team will serve an average of 60 clients per month delivering an average of five hours of outpatient service to each client per month. In addition, provider will provide the following deliverables:

- 85% clients will receive two or more visits within 30 days of beginning services;
- 85% of clients will receive four or more visits within 60 days of beginning services;
- 85% of clients will remain engaged in the program after six months of services.

FY17/18 Outcomes

BHCS conducted the RFP process beginning early 2017 and selected FSA as provider for the Older Adult Service Team.

Program implementation will begin FY18/19.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Alameda County has implemented a variety and continuum of Prevention and Early Intervention (PEI) programs for the purpose of "preventing mental illness from becoming severe and disabling and improving timely access for underserved populations."[10]

It's the intention of all PEI programs to implement services that promote wellness, foster health and emphasize strategies to reduce these seven negative outcomes that may result from untreated mental illness:

- Suicide,
- Incarcerations,
- School failure or dropout,
- Unemployment,
- Prolonged suffering,
- Homelessness, and
- Removal of children from their homes.

As Alameda County works to fully incorporate the new Mental Health Services Oversight and Accountability (MHSOAC) approved Prevention and Early Intervention Component Regulations into its services we will be focusing our future evaluation efforts on the above seven negative outcomes.

California's historic commitment to prevention and early intervention through Prop 63 moves the mental health system towards a "help-first" instead of a "fail first" strategy. PEI identifies individuals at risk of or indicating early signs of mental illness or emotional disturbance and links them to treatment and other resources.[11]

Alameda County's 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 services and local community groups. In addition to these partnerships, the county has also placed these preventative and early intervention services in convenient places where people go for other routine activities.

On October 6, 2015, updated Prevention and Early Intervention (PEI) Component Regulations became effective. The updated regulations were designed by the Mental Health Services Oversight and Accountability Commission (MHSOAC) and changed the framework and structure of the PEI component as compared to the guidance received via DMH-IN 07-19.
The majority of changes relate to restructuring guiding Institute of Medicine (IOM) Framework principles and concepts. The principles are now parceled out as individual programs. A program is defined in the new regulations as "a stand-alone organized and planned work, action, or approach that evidence indicates is likely to bring about positive mental health outcomes either for individuals and families with or at-risk of serious mental illness or for the mental health system (WIC §3701 (b))."

[10] Proposition 63: Mental Health Services Act 2004
[11] MHSOAC PEI Fact Sheet, December 2012

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Currently, there are six (6) State-Defined Prevention and Early Intervention Programs:

The MHSA also specifies that all funded PEI Programs must include the following strategies:

- **Outreach** to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illness;
- **Access and linkage** to medically necessary care…as early in the onset of these conditions as practicable;
- **Reduction in stigma and discrimination** associated with either being diagnosed with a mental illness or seeking mental health services and reduction in discrimination against people with mental illness (MHSA, Section 4, Welfare and Institutions Code (WIC) § 5840(b)).

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

STATE DEFINED PREVENTION AND EARLY INTERVENTION PROGRAMS

PREVENTION

- Activities that reduce risk factors for developing a potentially serious mental illness and to build protective factors.
- Activities that improve mental health for individuals/groups whose risk of developing a potentially serious mental illness is greater than average.
- Prevention services may include relapse prevention for individuals in recovery from a serious mental illness and population health prevention services.

EARLY INTERVENTION

- Provide mental health treatment, including relapse prevention, intended to promote recovery and related functional outcomes for a mental illness early in its emergence.
- Length of services not to exceed 18 months. If the individual is identified living with Severe Mental Illness (SMI) with psychotic features, up to four years of service can be allowed. This program can be combined with the Prevention Program.

OUTREACH

- Processes that engage and/or train potential responders about ways to recognize and respond to early signs of potentially severe and disabling mental illness.
- Supports for individuals who can identify early signs of severe and disabling mental illness to provide support, and/or refer individuals to treatment or other mental health services.
- Outreach may include reaching out to individuals with signs and symptoms of a mental illness, so they can respond to their own symptoms

STIGMA & DISCRIMINATION REDUCTION

- Activities that reduce negative feelings, attitudes, beliefs, perceptions and/or discrimination related to being diagnosed with a mental illness or to seeking mental health services.
- Activities that increase acceptance, dignity, inclusion, and equity for individuals with mental illness and members of their families.
- Programs include approaches that are culturally congruent with the values of the populations for whom changes are intended.

ACCESS & LINKAGE TO TX

- Set of related activities to connect children, adults, and seniors with severe mental illness to medically necessary care and treatment as early in the onset as practicable.
- These types of programs can include, but are not limited to, screening, assessment, referral, telephone help lines, and mobile response.
- Includes targeted access and linkage activities for cultural populations.

SUICIDE PREVENTION

- Organized activities that the County undertakes to prevent suicide as a consequence of mental illness without focus on or intended outcomes for at-risk individuals.
- These types of focused activities may be part of a prevention program or an early intervention program.
- This program is optional and includes, but is not limited to, strategies such as information campaigns, survivor-informed models, screenings, training, and education.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Prevention Program

PEI Data Report FY16/17

As required for each Prevention Program:

MHSA program Number: **PEI 1A**

Program Name: **Early Childhood (birth-8) Mental Health Prevention: Blue Skies Mental Wellness Team (MWT)**

Program Description:

Blue Skies MWT serves families participating in home visitation and family support through the Alameda County Public Health Department Maternal and Paternal Child and Adolescent Health Program (MPCAH) with clinical case management, brief therapy and case consultation-case review services. These services help to provide stabilization, referrals and resources to families where mental health issues, complex psychosocial needs and barriers to receiving mental health services are identified.

Number of unduplicated individuals served in the preceding fiscal year (FY 16/17): **62** parents/caregivers

Number of individual family members (this number will be included in your total above): **91** (parent child dyad)

Demographics

Report disaggregates numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Age (Years)	Primary Parent	Child
Children/Youth (0---15)	1	32
Transition Age Youth (16---25)	17	0
Adult (26---59)	37	0
Older Adult (60+)	0	0
Decline to Answer	0	0

Race (Unduplicated)

American Indian or Alaska Native	0
Asian	0
Black or African American (non Hispanic)	42
Native Hawaiian or other Pacific Islander	0
White (non Hispanic)	4
Other	6
More than one race	8
Decline to Answer	2

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	0
Central American	3
Mexican/Mexican---American/Chicano	6
Puerto Rican	0
South American	0
Other	2
Decline to Answer	5
Non-Hispanic or Non-Latino as follows:	
Asian Indian/South Asian	0
Chinese	0
European	0
Filipino	0
Other	0
More than one ethnicity	0
Decline to Answer	1

Primary Languages

English	46
Spanish	16

Sexual Orientation

Gay or Lesbian	2
Heterosexual or Straight	41
Bisexual	0
Questioning or unsure of sexual orientation	0
Queer	0
Another sexual orientation	0
Decline to Answer	0
Unknown/Missing Data	21

Disability

Yes	
No	
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Other	
Decline to Answer	62

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Veteran Status

Yes	0
No	28
Decline to Answer/ Unknown	27

Gender

Assigned sex at birth:	
Male	
Female	
Decline to Answer	
Current Gender Identity:	
Male	17
Female	45
Transgender	0
Genderqueer	0
Questioning or Unsure of Gender Identity	0
Another Gender Identity	0
Decline to Answer	0

Access and Linkage to Treatment Strategy (Required):

Number of individuals with SMI or SED referred to BHCS treatment system (includes county and CBO providers): **62**

List type(s) of treatment referred to:

Agencies Referred To:	**Cases**
24 hours Crisis Line Alameda County	3
AC Parental Stress Hotline	3
ACCESS 24hrs hot line	12
Blue Skies Mental Wellness	21
Crisis Support Services	6
Family Paths 24 hours Hotline	9
La Casa Del Sol-La Clinica	2
Parental Stress Hotline	1
Psychiatric Hotline 24 hours Crisis line	1
Sausal Creek outpatient services	2
Seneca Center	1
West coast Children's Center	1
Total	**62**

Number of individuals who followed through on referral & engaged in treatment: **21** (34%)
Average duration of untreated mental illness: data unavailable Standard Deviation: data unavailable
Average time between referral and participation in treatment: **10.5 days** Standard Deviation: **21**

Improving Timely Access to Services for Underserved Populations Strategy (Required):

Target population: **Families with young children needing mental health services and supports**

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Number of referrals to a Prevention program: _____**100**_____
Number of referrals to an Early Intervention program: _____**63**_____
Number of individuals followed through on referral & engaged in early intervention treatment services: ____**57**_____
Average time between referral and participation in treatment: _____**9 days**_____
Standard Deviation: ____**15**_____

And/Or

Number of referrals to BHCS treatment system (beyond early onset): _____**55**_____
Number of individuals followed through on referral & engaged in treatment: _____**21**_____
Average time between referral and participation in treatment: _____**10.5 days**_____
Standard Deviation: ____**21**____

As required for each Prevention Program:

Implementation Challenges:

- Staffing (both clinical and support staff) remains a challenge based on the increasing needs of the families this program serves and the heavy paperwork burden) Multiple solutions are being looked at for both of these staffing areas.

- The referrals for the team continue to remain consistent however client/families, due to the crisis and trauma elements in their lives are often inconsistent in keeping scheduled appointments and in responses to engagement efforts. The program is working through various efforts to address the overall concerns regarding inconsistent client follow-thru in hopes of supporting more consistent client appointments.

Success:

The MWT is now providing consultation case review support to (6) ACPHD-MPCAH home visiting programs including:

- Black Infant Health, Fatherhood Program, Nurse Family Partnership, Women's Health Promotion, Family Health Promotion and The Health Families America Program providing monthly case consultation meetings to discuss and refer mental health related cases , provide trauma informed check in's and provide resource and referral information for programs regarding mental health linkages.

- The MWT has continued its commitment to provide quarterly Transformational Healing Circles for the MPCAH-Home Visiting staff including support activities to support moral, offer vicarious trauma resiliency and to allow a space for relaxation and reflection modeling.

- The MWT is also working with BHCS staff to explore funding to offer family therapy, fatherhood clinical support and Trauma Informed Consultation to MPCAH Home Visiting Programs serving the African American community.

Lessons Learned:

- Importance of consistent team meetings, annual off site retreats, training opportunities and providing wellness strategies for team members who work within the fast paced system of ACPHD-MPCAH (focusing on wellness awareness)

- Balancing incoming triage and referral to MWT members-Slowing down pace of dissemination of cases when needed to protect staffs optimal level of functioning

- Maintaining consistent rapport with community partner; Project LAUNCH, Early Childhood Mental Health-BHC

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Relevant Examples of Success/Impact:

- The Blue Skies MWT has assisted the ACPHD-MPCAH home visiting programs with establishing a place and protocols for referring clients in need of mental health services to receive services by licensed clinicians focusing on Perinatal Mood Disorders.

- The MWT has supported (6) home visiting programs with consultation/team case review meetings on a monthly consultation process providing case review where discussion is held on challenging cases of concerns, referral, linkages are established and case referrals are made for home visiting clients. Programs receiving these services include: Black Infant Health, Nurse Family Partnership, Fatherhood Program, Healthy Families American, Women's Health and Family Health Promotion.

- The MWT has continued offering MPCAH-Home visiting programs quarterly trauma informed Transformational Healing circles where staff members can connect, relax, engage and participate in healing activities.

Additional Information:

In this section please include the number of clients and/or contacts you estimate to serve in:

FY 17/18: **72**
FY 18/19: **82**
FY 19/20: **92**

Any changes you intend to make to your program over the next three fiscal years:

- The program would like to hire a full-time clerical administrative assistant to assist with special projects, program development and general clerical task needed to support the team.

- As numbers of clients and referrals increase, the program would like to hire (1) additional full-time clinician that could accept in coming referrals and new cases to keep the caseloads balanced and prevent worker burn out.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES
UNDERSERVED ETHNIC LANGUAGE POPULATION (UELP) PROGRAMS

The UELP programs were designed to provide services to historically unserved and underserved populations, which the State defined as: Afghan/South Asian, Asian/Pacific Islander (API), Native American, and Latino.

Each UELP program is built on a foundation of three core strategies: 1) Education and Outreach, 2) Mental Health Consultation and 3) Preventative Counseling services. These strategies are implemented through a variety of services such as one-to-one outreach events, psycho-educational workshops/classes, consultation sessions, 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 challenge or mental illness.

In FY 16/17 the data show that these UELP providers in total produced:

- 7,244 prevention events, which is a 16% increase over last year;
- 39,188 people were served at these prevention events; (duplicated count) and
- 659 unique clients were served through early intervention services, which is a 24% increase in the number of clients served in FY 15/16.

Alameda County Behavioral Health Care Services currently uses a community defined Health and Wellness survey, which includes quality of life and outcome indicators. The survey is administered to the UELP community in 11 different languages: English, Spanish, Vietnamese, Chinese, Dari, Hindi, Khmer, Nepali, Korean, Thai, and Burmese and covered the following domains:

- Connecting individuals and families with their culture;
- Forming and strengthening identity;
- Changing knowledge and perception of mental health;
- Building community and wellness, and
- Improving access to services and resources.

In addition to the survey, focus groups (FGs) and Key Informant Interviews (KII) with 103 clients were conducted by our Public Health Department's evaluation unit in order to get a more comprehensive understanding of the impact of these PEI services.

A summary of key findings, based on each of the domains above, from the administration of the FY 16/17 survey (of 332 participants) and the FGs/KIIs shows that *in connection with receiving UELP services*:

Forming and Strengthening Identity

After participating in these services, UELP participants are better equipped to handle problematic situations and crises. Survey data shows that UELP participants have strengthened their identity and improved their self-efficacy.

Changing Individual Knowledge and Perception of Mental Health Services

The data shows a change in perception of mental health for both types of services, suggesting a ***reduction in personal stigma***. Ninety-one percent of *Prevention* respondents and 92% of Preventative Counseling (PC) respondents reported having a stronger belief that most people with mental health experiences have the ability to grow, change and recover.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Building Community and Its Wellness

Clients have established relationships with people inside their UELP communities, and feel ***less isolated***. The majority (90%) of respondents reported knowing there are people who will listen and support them when they need someone to talk to.

Connecting Individual and Family with their Culture

Connection to culture was a large theme found in the FG/KII. Ninety-one percent of survey respondents receiving *Prevention* services and 74% of *PC* respondents reported feeling more connected to their culture and community.

Improving Access to Services and Resources

The majority of participants are more successful at navigating the system to obtain the services and ***resources*** they need. Eighty-eight percent of clients receiving *Prevention* services and 84% of *PC* survey respondents reported they have become more effective in getting the resources they need for themselves or for their family.

Transforming Mental Health Services

Nearly every person interviewed or that participated in the focus groups said it was necessary to receive services from someone that speaks their ***language*** and/or knows their culture. All (100%) of *PC* and 96% of *Prevention* services survey respondents said that staff treated them with dignity and respect. When discussing participant's ***relationship with their service provider***, some of them spoke so highly of the staff that they considered them as family members.

Remaining Challenges

Although these UELP services significantly and positively impact the clients being served there are still multiple client challenges. Several of the challenges that surfaced during the FG/KII that are extremely worthy of highlighting.

Across most of the ethnic groups involved in this process, there is still a large problem with ***community/family stigma*** in their cultures. ***Housing*** is another big issue that surfaced during the sessions. Lastly, FG/KII participants made it clear that *without these services many of them would have committed* ***suicide***.

Access

In addition to identifying progress and success through the above survey domains the county continues to analyze Preventative Counseling (early intervention) data to determine if access has increased for these historically underserved populations.

Five years of data analysis does seem to indicate that access to mental health services has increased for these historically underserved populations.

BHCS looked at "access" in two ways: 1) of the people receiving early intervention services, what percent had received services in our system within the past
three years and 2) of the people receiving Preventative Counseling services what percent went on to need mental health treatment services.

For our first question BHCS took a cohort of 502 Preventative Counseling clients from FY 16/17 and looked back five years to see if this cohort had ever been served in our system before. The data found that only 19% of these 502 clients had ever been seen before in our system. This percentage is also similar for FYs 15/16 and 14/15 clients. Reasons for not accessing services are varied but include the areas of no language capacity, cultural issues, fear, stigma, not knowing where to access services, family members trying to support their loved ones themselves and not meeting Specialty

Mental Health criteria.

For the second question BHCS took a cohort of 537 early intervention clients from FY 15/16 and looked forward to see what percent went on to need mental health treatment services. The data found that 10% of the 537 clients went on to receive mental health treatment services (mainly outpatient services) in either FY 15/16 or 16/17. This percentage is similar for the past three fiscal years with approximately 10% of clients needing a higher level of acre.

This data indicates that the majority of Preventative Counseling clients who are experiencing early signs and symptoms of a mental health challenge or mental illness are being able to receive the appropriate level of care through a cultural lens that they are familiar with; and that for those needing a higher level of care, they're being referred for this care.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Prevention Program

PEI Data Report FY 16/17

As required for each Prevention Program:

MHSA program Number: **PEI 5**

Program Name: **Outreach, Education & Consultation for the Latino Community**

Program Description:

The UELP program that serves the Latino community is led by the agency La Clinica de La Raza and is called "Cultura y Bienestar" (CyB). It's designed to serve Latinos throughout Alameda County by providing services through a three agency collaborative. La Clinica de La Raza serves the northern region, La Familia Counseling Service serves the central and east region, and Tiburcio Vasquez Health Center serves the southern county region. More information on this program can be found at http://culturaybienestar.com

Number of unduplicated individuals served in the preceding fiscal year (FY 16/17): **380**

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	27%
Transition Age Youth (16---25)	8%
Adult (26---59)	57%
Older Adult (60+)	8%
Decline to Answer	

Race (Unduplicated)

American Indian or Alaska Native	
Asian	1%
Black or African American	
Native Hawaiian or other Pacific Islander	
White	1%
Other	58%
More than one race	
Decline to Answer	

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Latino	58%
Central American	
Mexican/Mexican---American/Chicano	
Puerto Rican	
South American	
Other	
Decline to Answer	
Non---Hispanic or Non---Latino as follows:	
Asian Indian/South Asian	
Chinese	
European	
Filipino	
Other	
More than one ethnicity	
Decline to Answer	

Gender

Assigned sex at birth:	
Male	25%
Female	75%
Decline to Answer	
Current Gender Identity:	
Male	25%
Female	75%
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

Primary Languages

English	11%
Spanish	88%
Other Non-English	1%

*Additional Demographic data will be available in FY 18/19

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

This section is optional. Please complete if your program conducts outreach activities in relation to your program.

Total number of potential responders (outreach audience): **14,478 contacts** and **1,700 events**

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, community center)	Type(s) of Potential Responders (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
Location	**# of Events by Location**
Agency Organization	43
Faith Setting	66
Health Center	27
Home	54
Office	514
Other Community	169
Phone	86
School	741
TOTAL	1,700
Audience	**# of Audience contacts from all Events**
GEN. COMMUNITY	7,915
FAITH LEADERS	88
COMM. LEADERS	715
SCHOOL STAFF	66
LOCAL CBO	-
LAW ENFORCE.	1
FAMILY MEMBERS	256
CONSUMERS	830
YOUTH	3,339
UNKNOWN	1,268
TOTAL	14,478
	*See additional data in the Attachment

As required for each Prevention Program:

Implementation Challenges:

- There have been two main challenges for this program in FY 16/17. First and foremost is the fear that this year's election has brought to the Latino population. Latinos are living in fear that they or family members will be deported. As a result of this fear there has been a large no show rate for appointments. Children are afraid to go to school which has impacted services; the threat of ICE raids were of major concern to our client population. CyB staff have reached out to clients to let them know La Clinica provides services at home visits, schools or other places they feel safe.

- The second challenge has been multiple staff vacancies throughout the three agency partnership. While these vacancies were difficult on the existing staff, leadership at these three agencies stepped up to fill the vacancies as quickly as possible allowing the program to stay on track with contractual deliverables and community focused mental health needs.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Success:

- In FY 16-17, CyB was selected to present at the 2017 CiBHS Cultural Competence Summit XX: Supporting Community Defined Practices. The presentation was attended by more than 75 people and focused on how CyB incorporates Latino cultural wellness practices of traditional healing into mental health services.

- Requests for leadership trainings, workshops, and mental health consultations from community based organizations, schools, and faith- based institutions continue to grow. Children's Hospital, Fatherhood Initiatives, First5, Wisdom Keepers, Restorative Justice Programs, and the Juvenile Justice Center, are a few that CyB continues to provide professional training on Latino mental health needs. Traditional medicine workshops have also received excellent responses from the community which is confirmed through their evaluations.

- CyB continues to provide Mental Health First Aid Training and 100 individuals from various CBO's and schools were trained in FY 16/17. Lastly, La Clínica was awarded a five year grant from the California Department of Public Health to evaluate the impact of CyB services and increase services by ensuring that all positions are full time which should decrease staff turnover.

Lessons Learned:

- CyB continues to recognize the power of hiring multiple types of staff to run this program instead of a program completely comprised of clinicians. Having this combination of staff helps to shift cultural norms and issues of stigma around mental health with staff being able to cross refer clients based on their needs and who they're most comfortable seeing. CyB includes three types of staff: l) Mental Health Specialists who are licensed/license eligible staff; 2) Promotores (community health educators) who are hired from the community and trained as mental health educators; and 3) a faculty of traditional healers who provide community workshops.

Relevant Examples of Success/Impact:

- CyB continues to bridge sacred traditional healing modalities, and mental health prevention and early intervention by emphasizing the integration of wellness and emotional balance with the use of herbs, meditation, visualization, massage (sobado) techniques, and general curanderismo. Cultura y Bienestar has been able to weave the topics of mental health/emotional well-being into traditional healing modalities such as traditional medicinal arts and music activities. Mental health topics are weaved into all activities, including outreach, CBO trainings, and individual, couples, family consultations, as well as the traditional medicine workshops.

- This topic of traditional healing and mental health prevention is a culturally responsive and very relevant topic for many communities. CyB had the opportunity to share their knowledge on this topic at the 2017 CiBHS Cultural Competence Summit XX: Supporting Community Defined Practices. Their presentation was attended by more than 75 people and focused on how CyB incorporates Latino cultural wellness practices of traditional healing into mental health services.

Additional Information:

In this section please include the number of clients and/or contacts you estimate to serve in:

FY 17/18: **350 clients, 14,000 outreach cont**acts
FY 18/19: **350 clients, 14,000 outreach contacts**
FY 19/20: **350 clients, 14,000 outreach contacts**

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Any changes you intend to make to your program over the next three fiscal years:

- CyB will continue striving to expand services into Castro Valley, San Leandro, and San Lorenzo and continue cultivating relationships and alliances in these communities. They'll also focus on reaching out more to the LGBTQQI community to inform them about services and engage in dialog to start building a trusting relationship in order to work more closely with this community.

- Services for men continue to grow therefore CyB will continue to build upon the male "Promotor" model. CyB will continue working on expanding the men's group to Castro Valley, San Leandro, and San Lorenzo. Male Promotors are well trained and are very interested in starting these men's groups.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Prevention Program

PEI Data Report FY 16/17

As required for each Prevention Program:

MHSA program Number: **PEI 6**

Program Name: **Outreach, Education & Consultation for the Asian Pacific Islander Community**

Program Description:

The UELP program that serves the Asian/Pacific Islander (API) Communities is led by three agencies, Asian Health Services (AHS), Center for Emerging Refugees and Immigrants (CERI) and Community Health for Asian Americans (CHAA) and is called "API Connections". It's designed to serve a diverse range of unserved and underserved API communities through the provision of culturally responsive mental health promotion/prevention and early intervention services.

Number of unduplicated individuals served in the preceding fiscal year (FY 16/17): **89**

Number of individual family members (this number will be included in your total above): data unavailable

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	26%
Transition Age Youth (16---25)	6%
Adult (26---59)	41%
Older Adult (60+)	28%
Declined to Answer	

Race (Unduplicated)

Asian	83%
Other	17%
Declined to Answer	

Primary Languages

English	24%
Vietnamese	26%
Other Non-¬-English	8%
Cantonese	33%
Mandarin	2%

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Gender

Assigned sex at birth:	
Male	26%
Female	69%
Decline to Answer	5%
Current Gender Identity:	
Male	26%
Female	69%
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	5%

*Additional Demographic data will be available in FY 18/19

This section is optional. Please complete if your program conducts outreach activities in relation to your program.
Total number of potential responders (outreach audience): **8,418**

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school, community center)	Type(s) of Potential Responders (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
Location	**# of Events by Location**
Agency Organization	503
Faith Setting	34
Health Center	21
Home	240
Office	245
Other Community	169
Phone	195
School	43
TOTAL	1,450
Audience	**# of Audience contacts from all Events**
GEN. COMMUNITY	4,122
FAITH LEADERS	108
COMM. LEADERS	696
SCHOOL STAFF	16
LOCAL CBO	440
LAW ENFORCE.	2
FAMILY MEMBERS	510
CONSUMERS	566
YOUTH	1,614
UNKNOWN	344
TOTAL	8,418

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

As required for each Prevention Program:

Implementation Challenges:

- This past year brought a number of challenges to the three agencies that comprise this program. Some of the challenges included, staff moving from one agency to another, changes in staff roles and split time between prevention and treatment funded programs, learning new skills in a new work environment, staff vacancies, the shortage of housing, especially for low income refugees and immigrants and the implementation of the new PEI regulations.

- Yet despite of these challenges, staff continued to be committed to serve the API community in a culturally and linguistically responsive manner.

Success:

- CERI was able to bring on a dozen new volunteers and interns this year. These volunteers contribute to group activities, assist with fundraising and marketing, contribute to the wellbeing of their clients and much more. They have also been able to provide multigenerational services for the first time in FY 16/17, which has been an immense success.

- CHAA's successes include:
  1. Developing increased capacity to provide services in API Community native languages.
  2. Expanding connections between API Connections Advocates and the communities they served
  3. Enhancing Partnerships and building access to behavioral and mental health resources for API Communities
  4. Enhanced data collection and assessment to inform decision making

- For AHS, they expanded their wellness program to pilot new API wellness support groups to serve the Burmese and Karen communities. Through their collaborative partnership with Oakland International High School and Burma Refugee Family Network, they were able to host three prevention and wellness support groups: 1) Karen Boys Group, 2) Karen Girls Group, 3) Burmese and Karen family groups. These wellness supports enable Karen youth and family to build social networks/support, engage in intergenerational learning, support each other to acculturate in the US, learn mental and wellness skills to cope with academic, family, and social stressors, and reduce cultural mental health stigma in order to access mental health services in a timely manner.

Lessons Learned:

- Being more pro-active in bringing in housing resources to their communities, especially for their TAY and elderly population, as it's anticipated that housing will be an on-going challenge.

- Given the difficulties that many of the young adults face, programs would like to intervene more intensely and at a younger age with at risk Cambodian youth.

- We have also been able to become more effective in educating clients and communities about the importance of seeking help for mental health concerns, as evidenced by our growing number of EI-related clients. It's slow but powerful work.

- The demand for Prevention and Wellness program services continues to exceed staff capacity and resources to provide support. The need for the increase in resources is evident by the increase in the number of clients and communities served this fiscal year. As the API Community is so complex and diverse in their culture, languages, and unique community struggles, more funding and resources are required to address each ethnic community's needs to reduce health, mental health, and wellness disparities.

Relevant Examples of Success/Impact:

- CERI puts a huge effort into having their site be welcoming to anyone in need of help. During their hours of operation they always have a Khmer speaking staff or volunteer available to provide services in Khmer and English. Their waiting room is decorated to invite people to come in, meet others, have coffee or tea, and get the help they need.

- At AHS, the Prevention & Wellness program collaborated with multiple community partners to host the Alameda County BHCS sponsored 10x10 Wellness Campaign, "We Move for Health" event. In the 10x10 wellness events, they provided an array of wellness activities such as healthy eating and food demonstrations, walking, Zumba, tai chi, and mindful meditation/deep breathing activities to promote mental health and wellness.

- Mostly importantly, they were able to weave in stories about consumers who struggled with mental health problems and their journeys to healing and recovery. Through this story sharing, mental health consumers told about their mental health experiences, shared ways they manage and reduce their mental health symptoms, and identified community resources they utilized to help them in their recovery and healing. Through their story sharing, these individuals found the courage to challenge mental health stigma and normalize mental health issues to the wider community and help engage individuals to seek mental health services through their powerful stories of mental health healing and recovery.

Additional Information

In this section please include the number of clients and/or contacts you estimate to serve in:

FY 17/18: **120 clients, 8,400 outreach contacts**
FY 18/19: **120 clients, 8,400 outreach contacts**
FY 19/20: **120 clients, 8,400 outreach contacts**

Any changes you intend to make to your program over the next three fiscal years:

- Continue to collaborate and build partnerships with school based, community based, and faith based organizations to expand services to Central County.

- Further expand their programs and deepen the connections between the younger and older generations. We hope to increase our multigenerational services, having our elders teach Khmer, cooking, and gardening to the younger generation.

- Despite the progress that CHAA has made in reaching out to underserved API communities, stigma, shame, lack of awareness of services, mistrust of service providers, and lack of insurance continue to be pervasive. Hence, their focus will be to engage underserved API populations to empower them through a series education and training opportunities. These training and educational programs will have mental health support and referral capacities seamlessly woven in so that more individuals and families have increased access to behavioral and mental health services, as well as acquire new skills for self-sufficiency and empowerment.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Prevention Program

PEI Data Report FY 16/17

As required for each Prevention Program:

MHSA program Number: **PEI 7**

Program Name: **Outreach, Education & Consultation for the South Asian/Afghan Community**

Program Description:

The UELP programs that serve the South Asian and Afghan Communities are run by two prominent community-based agencies, the Portia Bell Hume Center and the Afghan Coalition. Both of these agencies work collaboratively in providing services to these underserved populations. Examples of their activities include (but are not limited to): home visits, gender specific support groups, psycho-educational workshops and presentations, mental health consultations, healing practices that address issues of trauma, low-intensity early intervention visits and other cultural celebrations. More information on this program can be found at www.humecenter.org and www.afghancoalition.org

Number of unduplicated individuals served in the preceding fiscal year (FY 16/17): **111**

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	23%
Transition Age Youth (16---25)	8%
Adult (26---59)	52%
Older Adult (60+)	17%
Decline to Answer	

Race (Unduplicated)

American Indian or Alaska Native	
Asian	37%
Black or African American	2%
Native Hawaiian or other Pacific Islander	
White	25%
Other	19%
More than one race	
Decline to Answer	17%

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Latino	2%
Central American	
Mexican/Mexican---American/Chicano	
Puerto Rican	
South American	
Other	
Decline to Answer	
Non---Hispanic or Non---Latino as follows:	
Asian Indian/South Asian	
Chinese	
European	
Filipino	
Other	
More than one ethnicity	
Decline to Answer	

Primary Languages

English	48%
Other Non--English	25%
Farsi	25%
Other Sign Language (non ASL)	2%

Gender

Assigned sex at birth:	
Male	39%
Female	61%
Decline to Answer	
Current Gender Identity:	
Male	39%
Female	61%
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

*Additional Demographic data will be available in FY 18/19

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Total number of potential responders (outreach audience): **8,240**

Type of Setting(s) (ex: school, community center)	Type(s) of Potential Responders (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
Location	**# of Events by Location**
Agency Organization	226
Faith Setting	9
Health Center	1
Home	1
Office	545
Other Community	106
Phone	225
School	189
TOTAL	1,301
Audience	**# of Audience contacts from all Events**
GEN. COMMUNITY	4,606
FAITH LEADERS	39
COMM. LEADERS	486
SCHOOL STAFF	413
LOCAL CBO	449
LAW ENFORCE.	12
FAMILY MEMBERS	650
CONSUMERS	392
YOUTH	900
UNKNOWN	293
TOTAL	8,240

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Implementation Challenges:

- The use of part-time staff (due to funding). It can be difficult for part time staff to complete all needed tasks due to limited hours. The staff mitigated this challenge by incorporating a set schedule. The set schedule allows part-time staff to plan their day accordingly and schedule clients and activities based on availability and need.

- Continued high levels of mental health stigma and lack of trust regarding MH services. This was mitigated by creating a familiar environment where the staff speak the language of the client seeking services. Additional details have also been incorporated into the space, e.g. a prayer rug, or The Qu'ran above the door, into the space where services are being provided. Also assuring clients of complete confidentiality and offering a safe and private location has also been a great help in building trust with clients.

- Commitment to long term support groups continued to be a challenge due to the stigma for mental health that is prevalent in the community. This was mitigated by offering a mindfulness stress reduction group that would not focus on individual problems but would function more as a psychoeducation and skills learning group. This was a great success and will continue to be a model to follow so there can be more groups.

- Some religious/cultural groups were more difficult to engage in services. The Hume Center was persistent though which resulted in establishing contact with a women led mosque in Berkeley and the Baha'i Iranian community.

- People in the community continue to view mental health services as taboo and deny family members from receiving services. Through this program the Hume Center has been able to introduce their services in a unique way, i.e. rather than labeling people they introduce their services as coping with everyday challenges. The language they use helps to normalize their experience rather than labeling people.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Success:

- Staff worked with high school students who conducted research on socially relevant topics like decreasing stigma of mental health in the South Asian community and as a result one of the students was able to reach out to faith leaders and consumers in the community to spread awareness about mental health stigma and increasing awareness of services.
- Building an alliance with the first Muslim led women's mosque in Berkeley who has shown a greater openness to mental health services.
- Developed innovative promotional materials and techniques to connect with children at outreach events (e.g., bookmarks that provided tips to manage feelings of fear, anger and sadness).
- Developed innovative ways to increase visibility at outreach events like having their logo printed on health fair promotional materials "passport" and ensuring people visit their outreach table by requiring they have their "passports" stamped to be eligible for the raffle.
- The use of Facebook continues to be successful to raise awareness of mental health and services available to the Afghan community. The page continues to grow with over 2,600 like (www.facebook.com/afghanwellnessc/).
- Implemented a monthly resource training with local agencies that provide complimentary services. These training have been invaluable to the Afghan staff. It has allowed them to build a network of partners to help clients attain services outside the capacity of the program.

Lessons Learned:

- Programs must continue to use creative and innovative ways to reach out to these communities.
- When a community is resisting or avoiding services, it's important to be flexible and change the way the service is delivered for maximum impact. Similarly another agency stated: There's no one solution. Everyone is different and every situation is unique. There are community members who are hesitant to reach out and seek services, but there are also community members who are very receptive and willing to reach out to address their mental health needs. Each client has their own story, and own challenges, and although we have procedures to follow, each client needs to be approached in their own unique way.
- Agencies learned that they need to be even more visible in their community and use more social media and technological tools.
- Consistency produces results. Consistency is a common theme in all our successes, especially in providing education to the community and reducing the stigma attached to mental health.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Relevant Examples of Success/Impact:

- The Hume Center screened a documentary called Unbroken Glass which portrayed a child's struggle with his mother's mental illness and suicide. The screening was attended by consumers and providers in the area (South County). They were able to spread awareness about their program and services by orienting and educating people about what the Hume center does. It was also an opportunity to dialogue about issues such as mental illness in the family and the experiences of the family members during a Q&A portion between the director of the documentary and consumers and providers.

- The Hume Center also established a connection with the LGBT group for South Asians and has enlisted them as a resource for mental health services on their website.

- The Afghan Wellness Center continues to work closely with the Family Education and Resource Center (FERC) to help provide support for Afghan families experiencing mental health issues. As an example one Afghan mother dealing with an unbearable amount of stress due to her son and husband going through mental health challenges. In collaboration with FERC, they were able to build a network of support for her and her family which helped lessen her stress as well as gain access to resources for her son and husband.

Additional Information

In this section please include the number of clients and/or contacts you estimate to serve in:

FY 17/18: **115, 8,200 outreach contacts**
FY 18/19: **115, 8,200outreach contacts**
FY 19/20: **115, 8,200 outreach contacts**

Any changes you intend to make to your program over the next three fiscal years:

- The Afghan Wellness Center (AWC) will continue to build on its collaboration with the International Rescue Commission (IRC) and aim to provide prevention and early intervention services to their newly arrived clients. IRC has expressed interest in further collaboration with AWC by providing men and women support groups to their clients. The AWC would like to develop informational presentations on well-being and mental health topics to help new arrivals manage the stress of being in a new environment.

- The Hume Center will expand the scope of outreach activities to reach different sub groups within the community by making connections with places of worships like mosques and temples and community centers that are frequented by members who may not attend mainstream centers of worship and social support. They'll also offer more psychoeducational workshops for skill building in topics like sleep hygiene, stress reduction, self-care, communication skills, and mindfulness as well as enhance their use of social media in outreach and education to reach out to more youth.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Prevention Program

PEI Data Report FY 16/17

As required for each Prevention Program:

MHSA program Number: **PEI 8**

Program Name: **Outreach, Education & Consultation for the Native American Community**

Program Description:

The UELP program that serves the Native American Communities is led by the community organization the Native American Health Center (NAHC). This PEI program run by the NAHC is called the "Native American Prevention Center." A majority of the program activities take place on site at the S.A.G.E (Spirit, Art & Culture, Guidance and Encouragement) Center. To date this program, has been very successful in providing culturally appropriate mental health promotion/prevention and early intervention services to the Native American community.

Number of unduplicated individuals served in the preceding fiscal year (FY 16/17): **79**

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	9%
Transition Age Youth (16---25)	9%
Adult (26---59)	70%
Older Adult (60+)	13%
Decline to Answer	

Race (Unduplicated)

American Indian or Alaska Native	15%
Asian	8%
Black or African American	29%
Native Hawaiian or other Pacific Islander	
White	11%
Other	15%
More than one race	
Decline to Answer	22%

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Latino	22%
Central American	

Mexican/Mexican---American/Chicano	
Puerto Rican	
South American	
Other	
Decline to Answer	
Non---Hispanic or Non---Latino as follows:	
Asian Indian/South Asian	
Chinese	
European	
Filipino	
Other	
More than one ethnicity	
Decline to Answer	

Primary Languages

English	95%
Spanish	3%
Vietnamese	1%
Cambodian	1%
Unknown	1%

Gender

Assigned sex at birth:	
Male	37%
Female	63%
Decline to Answer	
Current Gender Identity:	
Male	
Female	
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

*Additional Demographic data will be available in FY 18/19

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Total number of potential responders (outreach audience): **2,102**

Type of Setting(s) (ex: school, community center)	Type(s) of Potential Responders (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
Location	**# of Events by Location**
Agency Organization	
Faith Setting	
Health Center	
Home	
Office	309
Other Community	1
Phone	
School	
TOTAL	
Audience	**# of Audience contacts from all Events**
GEN. COMMUNITY	2,060
FAITH LEADERS	
COMM. LEADERS	
SCHOOL STAFF	
LOCAL CBO	
LAW ENFORCE.	
FAMILY MEMBERS	2
CONSUMERS	
YOUTH	11
UNKNOWN	29
TOTAL	2,102

As required for each Prevention Program:

Implementation Challenges:

- There were significant challenges this year in this program including staff turnover, competing agency priorities, difficulty understanding PEI expectations and new requirements. The year was really focused on stabilizing the current work as staff resigned and replacements were put into to manage the work. Learning the intricacies of a job and training to build competency is time consuming and challenging.

- Lastly, in 2016-2017 the Native American Health Center became AAAHC accredited. The efforts leading to accreditation diverted considerable agency resources and priorities. This halted movement in other areas and time to discuss initiatives with key staff to later times. During this time patience was a valuable virtue. NAHC is still working on systems to ensure work moves forward without interrupting other work and initiatives.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Success:

- In 2016-2017, the Native American Prevention Center focused on providing meaningful well planned groups and events that were specific to the needs of the Alameda County Native American community. They rely on formal community feedback as well as informal interactions and conversations with community members to stay up to date with what is important to member's Mental Health needs.

- Efforts by their team have produced an increase in prevention visits with their Community Health Worker and Care Coordination team members. Additionally, they saw improvements with their referral systems. Members have reported positively on their satisfaction surveys and attended and contributed to Alameda County focus groups providing important feedback.

- Their groups have been a key component of the Native American Prevention Center work. They allow staff to engage community members through culture and help translate Mental Health concepts. The different ways include: - Exposure to Native Culture and Tradition - Participating and learning ceremony and etiquette - In-depth practice of Native Culture and Tradition - Reporting a stronger sense of cultural connectedness - Reporting a stronger sense of community and belonging - Reporting a stronger sense of social connectedness - Practicing bodily movements and techniques related to mindfulness and reprocessing of traumatic experiences.

Lessons Learned:

- Their interventions to increase their prevention visits were successful. They significantly improved in that area. However, they also learned a consequence of the increase and the population served was more of a challenge than expected. This caused them to struggle with closing of cases. They've been working on systems to improve upon this as goal for next fiscal year.

- They also learned the importance of Continuity of Operations documents and manualizing all work in case of turnover. Work is mapped out and workflows exist but could be improved upon. This is another goal for next fiscal year.

- They learned how to better complete county forms (MAA logs and forms). Their documentation is now streamlined and consistent. However, changing the culture of some staff who did not previously need to submit paperwork has proven challenging. Ongoing reminders, training and disciplinary consequences need to be used to stress the importance of deadlines and paperwork submission.

Relevant Examples of Success/Impact:

- NAHC recently invested in Eye Movement Desensitization and Reprocessing (EMDR) therapy for many of their licensed clinicians. EMDR therapy is particularly useful for individuals who have experienced traumas. Through bilateral movement and reprocessing the trauma, individuals are able to move past the traumatic experience without it causing reoccurring body stimulus.

- This is notable in the prevention program because of the similarities their clinicians brought up with the Prevention Service groups offered through the Prevention Center. Through bilateral movement and focus on drum beats, finger sewing, beading, individuals are able to speak about experiences and reprocess traumas and difficulties in a powerful way. A member recently shared her story about reconnecting with the tradition of beading and how the movement allows her to heal without speaking.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Additional Information

In this section please include the number of clients and/or contacts you estimate to serve in:

FY 17/18: **80, 2,000 outreach contacts**
FY 18/19: **80, 2,000 outreach contacts**
FY 19/20: **80, 2,000 outreach contacts**

Any changes you intend to make to your program over the next three fiscal years:

- Goals for fiscal year 2017-2018 include better manualizing of program workflows, expectations, processes, documentation requirements, and calendaring program activities throughout the course of the year. This will help NAHC staff to see the future clearer and enable them to plan better. 2016-2017 was focused on stabilization and continuity. 2017-2018 will focus on improvement of the program, starting with shoring up their processes and expectations.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Prevention Program

PEI Data Report FY 16/17

As required for each Prevention Program:

MHSA program Number: **PEI 14**

Program Name: **Family Education & Resource Center, Mental Health Association of Alameda County**

Program Description:

The Family Education & Resource Center (FERC) is a program of the Mental Health Association of Alameda County and provides education, resources, support and hope for family caregivers who have a loved one with a mental health challenge. The team of Family Advocates (FA) accompany clients to court, IEP meetings within school settings, and any other session/meeting where the client requests the support from their FA. In addition to working closely with clients, FERC also provides / involved in various community trainings: 5150 trainings for caregivers and consumers, Crisis Intervention Training for law enforcement and dispatch, provider education training, public education campaign for future mental health providers (graduate students), and suicide prevention.

Number of unduplicated individuals served in the preceding fiscal year (FY 16/17): **3,022**

Number of individual family members (this number will be included in your total above**): 2,569**

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0--15)	10%
Transition Age Youth (16--25)	15%
Adult (26--59)	65%
Older Adult (60+)	10%
Decline to Answer	

Race (Unduplicated)

American Indian or Alaska Native	
Asian	3%
Black or African American	35%
Native Hawaiian or other Pacific Islander	
White	35%
Other	10%
More than one race	15%
Decline to Answer	2%

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican--American/Chicano	13%
Puerto Rican	
South American	
Other	1%
Decline to Answer	
Non--Hispanic or Non--Latino as follows:	
African	35%
Asian Indian/South Asian	1%
European	35%
Korean	4 (unduplicated)
Middle Eastern	2%
Other	2%
More than one ethnicity	8%
Decline to Answer	3%

Primary Languages

English	80%
Spanish	20%
Sign ASL	1 client
Korean	4 clients
Cantonese	<1%
Mandarin	<1%
Farsi	<1%

Disability

Yes	
No	
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	<1%
Other (specify)	
Mental Domain	<15%
Physical/Mobility Domain	<5%
Chronic Health Condition	<10%
Decline to Answer	79%

Sexual Orientation

Gay or Lesbian	15%
Heterosexual or Straight	70%
Bisexual	
Questioning or unsure of sexual orientation	5%
Queer	
Another sexual orientation	

Decline to Answer	10%

Veteran Status

Yes	<10%
No	
Decline to Answer	90%

Gender

Assigned sex at birth:	
Male	35%
Female	65%
Decline to Answer	
Current Gender Identity:	
Male	34%
Female	64%
Transgender	1 client
Genderqueer	
Questioning or Unsure of Gender Identity	1 client
Another Gender Identity	
Decline to Answer	<2%

Total number of potential responders (outreach audience): **3,000 contacts**

Type of Setting(s) (ex: school, community center)	Type(s) of Potential Responders (ex: principals, teachers, parents, nurses, peers) Separate each type of responder with a comma.
School	Students, parents, caregivers, teachers, school faculty
Community Cultural Event	Parents, residents, volunteers, consumers, other vendors
Hospital	Social workers, therapists, nurses, clinicians, interns
Street Festival	Consumers, families, friends, neighbors, roommates, significant
Mental Health Walk	Peers, supporters, families, providers, therapists, advocates

Number of individuals with SMI or SED referred to BHCS treatment system (includes county and CBO providers): FERC refers SMI & SED clients to county & CBO providers (warm transfer consumers to appropriate services & supports) directly and/or via their caregiver.

List type(s) of treatment referred to: ACCESS, CRP, JGPH, BACS, STARS, Willow Rock, Casa de la Vida, PREP

Number of individuals who followed through on referral & engaged in treatment: **80%**

Average duration of untreated mental illness: data unavailable Standard Deviation: data unavailable

Average time between referral and participation in treatment: data unavailable Standard Deviation: data unavailable

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Implementation Challenges:

- Housing is one of the most challenging requests from clients; displacement, homelessness
- Level 1 services: clients who are in need of intensive treatment, but do not meet eligibility
- Issues with medication(s)
- Hospitalization → revolving door → early discharge
- Client's distrust in the "system"
- Family burden; family members are overwhelmed with stress, report lack of communication with their loved one's providers/unwillingness to hear family input, feeling blamed, financial burdens, no respite, loss of hope

Success:

- Collaboration (with clients, their loved one, loved one's treatment team)
- 5150s: when individuals report back that it wasn't what they wanted, but realize that it was what they needed. It was done in a respectful manner (positive interaction with law enforcement) therefore, hospitalization was better than what they anticipated
- Improving communication within families with their loved one
- Restoring trust between consumer and caregiver
- Advocacy: guiding clients on how to advocate for themselves and their loved ones

Lessons Learned:

- At FERC, we believe in the whole "family unit." Every voice matters.
- Options. There are always options.
- The power of asking. You won't know until you ASK.
- Tomorrow is a new day.
- Big or small, success is success. Progress should be celebrated and recognized.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Relevant Examples of Success/Impact:

- Crisis Intervention Training with law enforcement: 5150 calls; responding officers refer families and consumers to FERC
- Clients report positive 5150 outcomes
- Increasing the importance / knowledge of AB 1424 forms
- Collaboration with other CBOs / providers → how it led to treatment / buy-in
- Families attending monthly support group meetings, participating in Family-to-Family 12 week session
- Clients referring their families and friends to FERC after their own positive experience
- Improving relationships between family caregivers & consumers

Additional Information

In this section please include the number of clients and/or contacts you estimate to serve in:

FY 17/18: **3,173**
FY 18/19: **3,331**
FY 19/20: **3,498**

Any changes you intend to make to your program over the next three fiscal years:

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Prevention Program

PEI Data Report FY 16/17

As required for each Prevention Program:

MHSA program Number: **PEI 17A**

The Program Name: **REACH Ashland Youth Center Health and Wellness Program**

Number of unduplicated individuals served in the preceding fiscal year: **389**

Number of individual family members: **67**

Demographics

Report disaggregate numbers served, number of potential responders engaged (for optional Outreach Strategy), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0-15)	158
Transition Age Youth (16-25)	231
Adult (26-59)	0
Older Adult (60+)	0
Decline to Answer	

Race (Unduplicated)

American Indian or Alaska Native	1
Asian	4
Black or African American	165
Native Hawaiian or other Pacific Islander	2
White	127
Other	8
More than one race	61
Decline to Answer	21

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	112
Puerto Rican	
South American	
Other	
Decline to Answer	

Non-Hispanic or Non-Latino as follows:	
African	165
Asian Indian/South Asian	5
European	15
Filipino	2
Other	25
More than one ethnicity	61
Decline to Answer	4

Primary Languages

English	361
Spanish	26
Other Non-English	2

Sexual Orientation

Gay or Lesbian	
Heterosexual or Straight	
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	389

Disability

Yes	
No	
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Other	
Decline to Answer	389

Veteran Status

Yes	
No	
Decline to Answer	389

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Gender

Assigned sex at birth:	
Male	186
Female	199
Decline to Answer	4
Current Gender Identity:	
Male	
Female	
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	389

As "optional" for each Outreach for Increasing Recognition of Early Signs of Mental Illness Strategy:

Total number of potential responders: **70**

Type of Setting(s) (ex: school)	Type(s) of Potential Responders (ex: principals, teachers, parents, nurses) Separate each type of responder with a comma.
youth center	workforce development staff, public entities/county providers
youth center cont	community providers, recreation staff, education staff, arts teachers
health center	clinical case managers, medical staff, dental staff, health educators
child care	child care providers
cafe	food providers/work site
law enforcement	police officers

Number of individuals with SMI referred to treatment: **116**

List type(s) of treatment referred to:

- Coordination of care, including intensive case management & wrap around care with a multidisciplinary team
- Individual therapy
- Clinical case management
- Brokerage & advocacy
- Family therapy
- Parental support and education
- Pro-social activity groups

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Number of individuals followed through on referral & engaged in treatment: **49**

Average duration of untreated mental illness: **8-12 months** Standard Deviation: data unavailable

Average time between referral and participation in treatment: **1 week** Standard Deviation: data unavailable

As required for each Improve Timely Access to Services for Underserved Populations Strategy:

The program Name: **REACH Ashland Youth Center Health and Wellness Program**

Identify target population: **Youth ages 11-24 and their families**

Number of referrals to a **Prevention** program: **231**

Number of individuals followed through on referral & engaged in treatment: **2**

Average time between referral and participation in treatment: **1 day**

Number of referrals to an **Early Intervention** program: **42**

Number of individuals followed through on referral & engaged in treatment: **5**

Average time between referral and participation in treatment: **2 weeks**

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Describe ways your program encouraged access to services and follow through on referrals:

- Counselors made available in the milieu and with easily accessible office spaces.
- Counselors and health & wellness staff forwarding relationship with youth and families, encouraging self, peer, and family referrals.
- Non-clinical staff trained to reference the benefits of support and provide warm hand offs to clinical staff.
- Health and Wellness Staff produced presentation materials de-stigmatizing HW services by normalizing everyone's need for a support network, in successful or challenging times.
- Staff Strengthened linkages to school, probation, and community providers.

As required for each Prevention Program:

Implementation Challenges

- A need for additional training and development of non-clinical staff and partners in the areas of youth behavioral management in order to better address normative youth and adolescent challenges – freeing up clinical staff to focus on more challenges cases.
- Lack of clarity in procedures and protocols within the larger REACH operations, leading to a lack of alignment at times across some partnerships and care coordination challenges.
- Prevalence of crises, at times spilling over from schools and community.

Success:

- Youth engaged in programs and services that better prepared them for education and career goals, decreased level of risk, and increased social emotional learning.
- 90+% youth at REACH expressed experiencing a sense of safety at REACH.
- Youth leader/peer educator cadres supported youth to learn and lead their peers in making informed healthy choices, healthy risk mitigation and harm reduction, safe sexual practices and healthy nutrition.

Lessons Learned:

- Building the capacity and alignment of non-clinical staff to address prevention and early intervention needs in order to support clinical staff to focus on providing more intensive (Tier 2 and 3) services.
- Alignment between partners and adults is critical to provide well-structured, consistent services that are trauma informed and can hold youth effectively system wide.
- PEI services are a critical part of a continuum that includes more intensive services. PEI supports the ability to build trust, relationship and choice/self-determination in regards to youth-adult connection

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Relevant Examples:

- In regards to Peer Leadership, (Prevention and Early Intervention groups) REACH Health and Wellness and program staff outreached to youth who had been coming to REACH for some time, had developed varying levels of relationship, but were seen as trouble makers in their community. By engaging these youth who demonstrated clear leadership qualities but were not being encouraged into leadership roles, they were able to support their leadership development while also providing them with support on the life stressors (trauma, family displacement or incarceration, risks of school failure, probation involvement, threats to immigration status, depression and anxiety, social challenges, risk of homelessness, etc.) that would impede their ability to thrive.

Additional Information

In this section please include the number of clients and/or contacts you estimate to serve in:

FY 17/18: **400**
FY 18/19: **450**
FY 19/20: **500**

- During the course of this reporting period, REACH adopted a more effective referral and coordination system (COST).
- Additionally, REACH worked on revamping the Member Application in order to capture more granular demographic data.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Prevention Program

PEI Data Report FY 16/17

As required for each Prevention Program:

MHSA program Number: **PEI 21A**

The Program Name: **Community Wellness Centers: Casa Ubuntu**

Casa Ubuntu (House of Human Kindness), is a Creative Wellness Center, is located at Eastmont Town Center in the East Oakland Community. This center is an entry point to system recovery/supportive services for people with co-occurring conditions (mental, substance abuse or physical health conditions). Casa Ubuntu's services include state of the art onsite employment services; linkages to housing, benefits, and primary care; case management; medication management; and a full array of peer driven support groups, recreational, wellness, and recovery programming. Casa Ubuntu is a barrier free, friendly, drop-in environment accessible to adults, operating 5 days a week (Monday – Friday) and every other Saturday.

Number of **unduplicated** individuals served in the preceding fiscal year: **450**

Demographics

Report disaggregate numbers served, number of potential responders engaged (for optional Outreach Strategy), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0-15)	
Transition Age Youth (16-25)	
Adult (26-59)	405
Older Adult (60+)	45
Decline to Answer	

Race (Unduplicated)

Asian	4
Black or African American	257
White	63
Other	63
More than one race	18
Decline to Answer	

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Hispanic	45
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	

South American	
Other	
Decline to Answer	
Non-Hispanic or Non-Latino as follows:	
Other	
Decline to Answer	

*Additional demographic data will be available in the FY 18/19 MHSA Plan Update

Gender

Assigned sex at birth:	
Male	279
Female	167
Decline to Answer	4
Current Gender Identity:	
Male	279
Female	167
Transgender	4
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

As required for each Prevention Program:

Implementation Challenges:

- Outreach to Latino community- Due to political climate, outreach to Latino community has been limited and difficult due to reports of mistrust, and fears of services. Per the Peer Specialist team, the two biggest barriers have been child care, and lack of group rehabilitation sessions in Spanish that have impacted Latino community.

- Intellectual Disability/Autism Spectrum Disorder- Casa Ubuntu has received referrals and provided support services to consumers with mental health challenges who are also diagnosed with Intellectual Disability or Autism Spectrum Disorder. Barriers have been identified regarding level of services and type of services needed to address any diagnosis outside of mental health, substance use, and/or physical disability.

- Staff Turnover- During the first year, Casa Ubuntu has experienced turnover from all levels, except for Program Director, due to lack of competitive market value pay rate for employees.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Success:

- Casa Ubuntu stands for the whole person and whole community, where consumers participate in services to stabilize their behaviors and symptoms of mental health and substance use and begins the healing process in the community. Casa Ubuntu's workshops have been tailored to be culturally sensitive workshops to address mental health stigma that is prevalent in African American and Latino communities. This approach has enabled Casa Ubuntu to provide individualized, positive behavioral approaches to services.

- Casa Ubuntu is located in East Oakland, which is an area that contains a sense of stigma and oppression. At Eastmont Town Center, a hub of centralized outpatient services, Casa Ubuntu has provided social rehabilitation services that have been highly regarded in the community. This has been demonstrated by our consumers' stabilizing of behaviors and symptoms, secure housing and employment, and gain a sense of safety in their lives.

Additional Information

In this section please include the number of clients and/or contacts you estimate to serve in:

FY 17/18: **450**
FY 18/19: **500**
FY 19/20: **500**

Casa Ubuntu will be making the following changes to improve services and tracking of retention:

- Their clinical team will increase participation in community outreach and events to develop greater network collaboration and resources to build on individual's needs and strengths. They will also be developing a consumer satisfaction feedback questionnaire that will provide consumers an opportunity to provide feedback monthly.

- Staff will also be developing a data management tool to track retention rates between Outpatient Services and Peer Support Services. A follow up process will also be adopted regarding treatment recommendations and engagement, no shows/cancellations policies, and management of possible turnover with consumers.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Prevention Program

PEI Data Report FY 16/17

As required for each Prevention Program:

MHSA program Number: **PEI 21B**

The Program Name: **Community Wellness Centers: Bay Area Community Services (BACS)** (Towne House, Hedco, Valley, and South County Wellness Centers)

BACS provides barrier-free support for anyone who has been diagnosed with a mental health illness or who self-identifies as needing support for mental health issues. Wellness Center services are inclusive to any race/ethnicity, culture, gender or gender identity, military status, and sexual orientation. We aim to support individuals of various self-identification groups via our daily curriculum. BACS currently provides services in English, Spanish, Farsi, Portuguese, and Tagalog. The Wellness Centers offer groups and curriculum specifically addressing issues that TAY and aging adults face in the community and system of care at large. All four BACS Wellness Centers are accessible for individuals with mobility restriction. BACS prides itself as an organization whose staff represent the cultural diversity of the East Bay community.

Number of unduplicated individuals served in the preceding fiscal year: **approximately 256** clients in medication support and case management.

There were **23,272** sign-ins for the Wellness center's services overall for FY 16/17

Demographics

Report disaggregate numbers served, number of potential responders engaged (for optional Outreach Strategy), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated) N=256

Children/Youth (0-15)	
Transition Age Youth (16-25)	10%
Adult (26-59)	72%
Older Adult (60+)	18%
Decline to Answer	

Race N= 3,398 Visits

Asian	7%
Black or African American	17%
White	26%
Other	8%
More than one race	
Decline to Answer	35%

*Additional demographic data will be available in the FY 18/19 MHSA Plan Update

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

As required for each Prevention Program:

Implementation Challenges:

- The Wellness Centers experienced seasonal dip in average daily attendance. Towne House attendance dipped by 40%, and Hedco's attendance dropped by 20%. These numbers are consistent with data from FY15-16 Q4. The Wellness Center teams and peer councils have responded with increased outreach.

- Data from the iPad kiosk sign-in suggests consistent drop in use of "the Spot" TAY space at Towne House, while Older Adult utilization at the Wellness Centers remains consistent as well. The data continues to be challenged as 42% of all sign-ins decline to identify their age range thus rendering age demographic information inaccurate.

- Annually 12% of all individuals that sign in identify as LGBTQI, though nearly 70% decline to respond to identify, this data is consistent through all four quarters.

- Utilization at Valley and South County Wellness Centers for DOORs (Medication Support) remains low by comparison. The teams are prioritizing outreach efforts to local communities to build the case load and meet the needs of the community.

Success:

- Average Monthly attendance at all four BACS Wellness Centers increased from FY15-16 to FY16-17 by an average of 28% between South County, Towne House, and Valley. Also, the overall number of sign-ins for the year increased 10% from 20,883 to 23,272.

- Peer councils of the centers are developing culturally specific events such as LGBTQI Awareness, Women's month, and Immigrant Stories.

- PES, Jay Mahler Recovery Center, Cherry Hill and Woodroe Place case managers at JGPH and with CJMH at Santa Rita are also referring clients with identified mental health needs to the Wellness Centers.

- In Q4 the Towne House Wellness Centers hosted 2 youth interns from FACES for Change project in collaboration with La Clinica de la Raza, the youth created an 8 Dimensions of Wellness community agreement project that is now in use and on display at Towne House Wellness Center. The Wellness Centers also hosted two BESTNOW! Interns who have graduated from the program.

- The Wellness Centers continue to partner with the POCC, NAMI, FERC, NA, Best Now!, La Clinica and Bonita House, as well as host service team and ACT teams for meetings with participants that they serve.

- The Wellness Centers have formalized MH specific programming to better serve the target population. Groups have been added for Smoking Cessation, Seeking Safety, Medication Management Skill building, money management, and WRAP.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Prevention Program

PEI Data Report FY 16/17

As required for each Prevention Program:

MHSA program Number: **PEI 20A**

The Program Name: **African American Ethnic Programming: Beats, Rhymes and Life WISE Academy Program**

Program Description:

The WISE program is comprised of youth who participate in Beats, Rhymes & Life (BRL's) Therapeutic Activity Groups (TAGs), TAY who are interested in learning about social services, and/or youth who graduate from high school and are seeking "real-world" experience prior to enrolling in college. (This program began at the end of FY 15/16)

Number of unduplicated individuals served in the preceding fiscal year: **10**

Number of individuals at risk (if program served Prevention clients): **1**

Demographics

Report disaggregate numbers served, number of potential responders engaged (for optional Outreach Strategy), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	
Transition Age Youth (16---25)	10
Adult (26---59)	
Older Adult (60+)	
Decline to Answer	

Race (Unduplicated)

American Indian or Alaska Native	
Asian	
Black or African American	10
Native Hawaiian or other Pacific Islander	
White	
Other	
More than one race	
Decline to Answer	

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican-¬-American/Chicano	
Puerto Rican	1

South American	
Other	
Decline to Answer	1
Non-¬-Hispanic or Non-¬-Latino as follows:	
African	8
More than one ethnicity	1
Decline to Answer	

Primary Languages

English	10
Spanish	
Other Non-English	

Sexual Orientation

Gay or Lesbian	
Heterosexual or Straight	9
Bisexual	1
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	

Disability

Yes	
No	
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	1
No	9
Decline to Answer	

Veteran Status

Yes	
No	10
Decline to Answer	

Gender

Assigned sex at birth:	
Male	7
Female	3
Decline to Answer	
Current Gender Identity:	

Male	
Female	
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

As required for each Prevention Program:

Implementation Challenges:

- There were staff recruitment challenges. The Academy Dean for the program moved from New York to accept the position and his start date was in late June.
- Due to the timing of hiring staff, the prime period for recruitment was unavailable, as high schools and colleges were closing.
- There were also staffing challenges, with on staff out for five weeks to teach a college course and the case manager and clinician not being able to start until the week of September 4th.

Success:

- The team adjusted their program design and orientation start date to accommodate challenges. Starting on August 15th would give more time for recruitment and allow staff to integrate new/returning staff in a way that would not be felt by participants.
- The Academy Dean was able to create a recruitment plan that focused on CBOs to compensate for the college and high school closings and at the same time build community with organizations with similar populations and missions. Looking for CBOs that also had a leadership focus was helpful because their participants were more understanding about the opportunity that we were offering.
- The staff transitions were eased by the extension of the start date. Because of the scheduling and flexibility of staff we were able to execute a smooth handoff from our Assessment Counselor who did the bulk of intake and downloading of personal stories for the clinician.

Lessons Learned:

- Switching from school-based to CBO-based recruitment may not be ideal but it was crucial in relationship building for other opportunities that we can pipeline youth into. Moving forward, an ideal recruitment model would work with both schools and CBOs and continue to collaborate and communicate throughout the two year period and beyond.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Additional Information

In this section please include the number of clients and/or contacts you estimate to serve in:

FY 17/18: **10**
FY 18/19: **10**
FY 19/20: **15**

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Prevention Program

PEI Data Report FY 16/17

As required for each Prevention Program:

MHSA program Number: **PEI 25**

Program Name: **Post Crisis Peer Mentorship**

Program Description:

This program is run by Alameda Health Systems in partnership with the Southern Alameda County National Alliance on Mental Illness (NAMI) chapter. The goals fo the program are to: Establish a connection to a peer Mentor and maintain this connection post-discharge

1. Connect with local resources essential for their recovery, including those related to WRAP
2. Increase the length of time between psychiatric hospitalization
3. Reduce episodes of psychiatric re-hospitalization and utilization of other acute crisis services
4. Reduce episodes of psychiatric re-hospitalization and utilization of other acute crisis services

Number of **unduplicated** individuals served in the preceding fiscal year (FY 16/17): **47** clients referred and opened

Eligible Population:

1. Individuals age 18 and over who reside in Alameda County
2. Being discharge from JGPH, Gladman, Jay Mahler, Villa, or Woodroe (crisis or acute care settings)
3. Voluntarily agree to engage with a Mentor
4. Have access to a telephone or some manner to communication while out of the facility
5. Are not incarcerated or admitted into a skilled nursing, rehabilitation or half-way facility.

Mentors:

- 8 engaged and trained
- 5 Females and 3 Males
- All mentors are African Americans
- Training: 5 day workshop "The Art of Facilitating Self Determination". Mentors are offered an on-line suicide prevention course on knowing the possible signs and how to have The Conversation

Demographics

Report disaggregate numbers served, number of potential responders engaged (for agencies conducting outreach), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	
Transition Age Youth (16---25)	
Adult (26---59)	47
Older Adult (60+)	
Decline to Answer	

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

All other required demographic information will be collected in FY 17/18

As required for each Prevention Program:

Implementation Challenges:

- All mentors periodically encounter the issue of having a participant without a phone and is also homeless. That situation puts a heavier burden on the Participant to be more proactive and stay in contact with the mentor until the Mentor can assist them to obtain a free cell phone. At that point, the relationships can become more productive.
- Challenge to starting the program a quarter into the fiscal year, however the program was still able to make its 45 person goal.
- Receiving referrals from certain sites was also a challenge.

Success:

- Of the 47 participants (mentees) opened to this program 38 (81%) had no acute psychiatric episode within 30 days after connecting with a mentor.

Lessons Learned:

Personal Mentor Growth Stories:

- "Mentoring has helped me because it gives me a platform to interact with other people and share my experiences with them- also learning from them at the same time."
- "I feel gratified to see someone share with me and I get to help them make decisions for themselves that works for them.
- "Mentoring assists me greatly in my personal growth as I can see that I am assisting an individual overcome great odds and adversity, and I feel a sense of accomplishment and relief within myself."

Relevant Examples of Success/Impact:

Case Studies:

 # 1 Mentor Joe C: "One of my participants who was very difficult to interact with due to the medication he was taking; and his living situation made him not want to meet anyone new. After 4 to 5 ten minute meetings, it all changed. Now he meets with me longer and phones me when he wants someone to talk to."

#2 Mentor Michael K: "One of the challenges I faced was a Participants who was homeless. We overcame this problem when he was sent to Jay Mahler rehab facility from John George Hospital and with help from the social workers and myself Jason was referred to East Oakland Community Project/Crossroads which is transitional housing. He will apply for permanent subsidized housing for the next 9-12 months from that facility."

 # 3 Mentor Tracy S: "One of my greatest challenges was when I mentored this person and she revealed to me that she was in the process of transitioning from female to male. At the time, she was under a great deal of stress, and was also doing some drugs. In addition to being there and validating and supporting her decisions, I learned a lot about having so many different things to deal with which included having a mental illness and a gender issue to resolve. She is now working in the community."

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: PREVENTION

Additional Information

In this section please include the number of clients and/or contacts you estimate to serve in:

FY 17/18: **45 participants**
FY 18/19: **45 participants**
FY 19/20: **45 participants**

Any changes you intend to make to your program over the next three fiscal years:

- Additional data collection and evaluation information will be available in FY 18/19.

Early Intervention Program

PEI Data Report FY 16/17

As required for each Early Intervention Program:

MHSA program Number: **PEI 2**

The Program Name: **Early Intervention for the Onset of First Psychosis & SMI among TAY**

Program Description:

PREP provides evidence-based treatment and support for youth and families through an intensive outpatient model of care that includes the provision of: algorithm-based medication management, cognitive behavioral therapy for psychosis (CBTp), individual placement and support (IPS), assertive outreach, multi-family groups, cognitive remediation, and strength-based care management services.

FY18/19 PREP will change from FSP 16 to PEI 2. See update on FSP16.

Early Intervention Program

PEI Data Report FY 16/17

As required for each Early Intervention Program:

MHSA program Number: **PEI 3C**

The Program Name: **Geriatric Assessment & Response Team (GART)**

Program Description:

GART is a mobile geriatric behavioral health team that provides support services to older adults ages 60 and above with serious behavioral health care needs. GART provides brief voluntary behavioral health care services with the aim of resolving immediate behavioral health needs. The GART Program staffing includes a multi-disciplinary team and support staff.

Number of unduplicated individuals served in the preceding fiscal year: **41**

Demographics

Report disaggregate numbers served, number of potential responders engaged (for optional Outreach Strategy), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	
Transition Age Youth (16---25)	
Adult (26---59)	2
Older Adult (60+)	39
Decline to Answer	0

Race (Unduplicated)

Asian	16
Black or African American	7
White	13
Other	5
More than one race	
Decline to Answer	

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican---American/Chicano	
Puerto Rican	

South American	
Other	3
Decline to Answer	
Non-Hispanic or Non-Latino as follows:	
Chinese	14
Other	24
More than one ethnicity	
Decline to Answer	

Primary Languages

English	18
Spanish	1
Chinese Dialect	14
Farsi	2

Sexual Orientation

Gay or Lesbian	
Heterosexual or Straight	
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	41

Disability

Yes	
No	
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Decline to Answer	41

Veteran Status

Yes	
No	
Decline to Answer	41

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: EARLY INTERVENTION

Gender

Assigned sex at birth:	
Male	14
Female	27
Decline to Answer	
Current Gender Identity:	
Male	14
Female	27
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

As required for each Access and Linkage to Treatment Strategy:

Number of individuals with SMI referred to treatment: **43**

List type(s) of treatment referred to:

Outpatient psychotherapy, outpatient psychiatry, neuropsychology, inpatient geriatric & non-geriatric providers for additional assessment & treatment, day treatment programs and drop-in socialization and day rehabilitation centers, field-based case management programs, peer-based support groups for older adults, friendly visitors, culturally responsive and language-specific mental health providers, recovery oriented substance abuse programs and providers, housing & homeless resources that cater to either older adults or individuals with mental health needs. Referrals to Alzheimer's Association are frequently made for individuals (& their families) who have co-occurring dementia diagnoses.

Number of individuals followed through on referral & engaged in treatment: **30**

Average duration of untreated mental illness: **1 month to 40+ years** Standard Deviation: data unavailable

Average time between referral and participation in treatment: **24-72 hours** Standard Deviation: data unavailable

Describe the ways your program encouraged access to services and follow-through on referrals:

GART clinicians begin their work by establishing trust and developing a therapeutic relationship with each client as well as their loved ones. This valuable connection lends itself to positive client responses to brief therapy techniques including a successful termination process. GART clinicians develop a discharge plan with the client and engage their natural support systems when possible. Together, they identify best-matched, continued care, to fit a client's mental health needs. Clinicians will call providers to arrange appointments and, when appropriate, accompany clients to first meetings. Prior to discharge, clinicians will follow up with clients and providers to confirm that a connection has been made and assist further if needed.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: EARLY INTERVENTION

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

Implementation Challenges:

- GART would like to have more successful outcomes with primary care referrals. Clinicians have found that clients may agree to mental health services while at the primary care provider's office, but they decline when GART follows up afterward. They've attempted to mitigate this issue by developing a strong relationship with primary care providers (PCP). They've also suggested that, when possible & appropriate, PCP coordinate with GART to meet client at the doctor's office to facilitate referrals.

Success:

- Well-trained clinicians have expedited services to clients by completing the assessment process and documentation requirements within the first or second meeting. Once medical necessity is determined, Medi-CAL services can be provided and billed for. This has increased GART's provision of psychotherapy, brokerage and medication support services over the past year.

- GART clinicians have become regular presenters for the Alameda County Social Services Training and Consulting Team. They have provided valuable information about MHSA, the GART program and the mental health needs of older adults as part of an induction class for new public guardianship, public conservator and APS workers.

- Strengthened collaborative relationships with Social Services Agency and Public Health by participating in quarterly multi-disciplinary case consultation meetings. These meetings are used to discuss clients with complex mental health, medical and social needs who are being served by multiple providers – including Adult Protective Services, In Home Supportive Services and Healthcare for the Homeless.

- Successfully re-classed a non-licensed MHSIII/Mental Health Specialist position to licensed BHCII/ Behavioral Health Clinician. GART now has three licensed clinicians providing assessment, brief treatment and brokerage services. GART has interviewed and accepted its first MSW intern from the University of California at Berkeley, School of Social Welfare for Fall 2017.

- Older Adult Division Director negotiated GART use of county car located at office. This has increased clinician's ability to transport clients when needed and appropriate. Accessible car use has decreased time lost to checking out cars from central county lots.

Relevant Examples:

- Daughter called GART program concerned about her 75 y/o mother who won't attend church anymore, stopped visiting friends and began avoiding family gatherings – all of which used to bring her joy.

- GART visited client in her home & conducted a bio, psycho-social & medical assessment. They learned that although client had been widowed for many years, she recently lost a close friend. It was also revealed that client has been having dizzy spells and fell once in the past month. Because of this, she has become fearful to leave the house. She also didn't want to burden her daughter, who has young children & works full-time, with requests for help.

- GART RN reviewed medications & suspects that due to side effects of one of her medications, client may be getting dehydrated which can lead to increased dizziness. She reached out to client's primary care physician to consult. Clinician provided brief therapy to address issues of grief & made referrals for ongoing supports. Referrals to both transportation resources and Senior Injury Prevention Programs were provided in order to prevent falls and promote client's independence.

Relevant Examples:

Relevant Examples cont.:

- Client responded well to therapeutic strategies. She became less isolated and eventually agreed to weekly, in-home meetings from the Friendly Visitors program. She and daughter began to check in regularly and attending church together once again.

As "optional" for each Outreach for Increasing Recognition of Early Signs of Mental Illness Strategy:

Total number of potential responders: **1,600, 25 outreach activities**

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school)	Type(s) of Potential Responders (ex: principals, teachers, parents, nurses) Separate each type of responder with a comma.
Health fairs	Community members
Senior Services events	Older adults, family members, general community
Hospitals	staff

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: EARLY INTERVENTION

Early Intervention Program

PEI Data Report FY 16/17

As required for each Early Intervention Program:

MHSA program Number: **PEI 17B**

The Program Name: **Youth Uprising TAY Resource Center**

Number of **unduplicated** individuals served in the preceding fiscal year: **115**

Number of individuals at risk (if program served Prevention clients): 0

Number of individual with early onset: 0

Number of individual family members: 0

Demographics

Report disaggregate numbers served, number of potential responders engaged (for optional Outreach Strategy), and number of referrals for treatment and other services for the following categories:

Age Group (Unduplicated)

Children/Youth (0---15)	50
Transition Age Youth (16---25)	64
Adult (26---59)	1
Older Adult (60+)	0
Decline to Answer	0

Race (Unduplicated)

American Indian or Alaska Native	
Asian	1
Black or African American	60
Native Hawaiian or other Pacific Islander	
White	3
Other	43
More than one race	
Decline to Answer	8

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican---American/Chicano	19
Puerto Rican	
South American	
Other	

Decline to Answer	20
Non---Hispanic or Non---Latino as follows:	
African	25
More than one ethnicity	20
Decline to Answer	31

Primary Languages

English	103
Spanish	12

Sexual Orientation

Gay or Lesbian	2
Heterosexual or Straight	47
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	66

Disability

Yes	10
No	
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	10
Physical/Mobility Domain	
Chronic Health Condition	
Other	
Decline to Answer	105

Veteran Status

Yes	
No	35
Decline to Answer	80

Gender

Assigned sex at birth:	
Male	54
Female	61

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: EARLY INTERVENTION

Decline to Answer	
Current Gender Identity:	
Male	54
Female	61
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

As required for each Access and Linkage to Treatment Strategy:

Number of individuals with SMI referred to treatment: 0

Number of individuals followed through on referral & engaged in treatment: 0

As required for each Improve Timely Access to Services for Underserved Populations Strategy:

Identify target population: youth ages **13-24**

Number of referrals to a **Prevention** program: **98**

Number of individuals followed through on referral & engaged in treatment: **80**

Average time between referral and participation in treatment: **7 days** Standard Deviation: data unavailable

Describe the ways your program encouraged access to services and follow-through on referrals:

- YU continues to partner with Children's hospital and other community agencies to demystify referral process when support linkage to care. Coordinating services from a trauma informed community based approach allows for clinicians and case managers to provide direct service in a warm, inviting and culturally aligned way with youth from the community. YU utilizes social justice infused wellness practices to empower youth to increased internalized motivation ideally supporting continued mobilization for linkage to other programs.

As required for each Early Intervention Program:

Implementation Challenges:

- Changes in staffing continue to require shifts in program delivery which impact implementation and ways in which programs are offered based on skill set of staff. Events within also impact desire of programs, when traumatic events occur, attendance to set groups will fluctuate as staff responds to support crisis needs. January 2015 was a heavy grief month, YU hosted memorials and healing spaces.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: EARLY INTERVENTION

Success:

- Groups such as Triple C: Cool Calm and collected, Sister circle and visual arts. Back on track program for Castlemont, leadership program which allowed youth to go on a trip to hike and ski. Provided memorials and healing spaces to support grieving of community. Film viewing, consistent engagement with members for individual therapy and drop in services. Offering innovative ways to provide support that is culturally aligned with the members presenting for support.

Lessons Learned:

Relevant Examples:

- A trans identified member committed suicide in January, which motivated YU to revamp and recentralize the needs of LGBTQ youth in the area of their mental health programming. Another two YU members were victims of homicide in December which continues to be a need for support through proactively addressing violence as well as holding ongoing healing spaces for members.

As "optional" for each Outreach for Increasing Recognition of Early Signs of Mental Illness Strategy:

Total number of potential responders: **50**

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school)	Type(s) of Potential Responders (ex: principals, teachers, parents, nurses) Separate each type of responder with a comma.
school	Castlemont High School students, staff and faculty

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: OUTREACH

Outreach for Increasing Recognition of Early Signs of Mental Illness Program

PEI Data Report FY 16/17

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

MHSA program Number: **PEI 1E**

The Program Name: **Early Childhood Mental Health Consultation**

Program Description:

The agency Jewish Family and Community Services of the East Bay was recently awarded the contract to provide Early Childhood Mental Health Consultation to teachers and directors in low income preschool programs utilizing the Mental health Consultation Standards of Practice. Consultation with parents when additional support and linkages are indicated for

Total number of potential responders: **31**

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school)	Type(s) of Potential Responders (ex: principals, teachers, parents, nurses) Separate each type of responder with a comma.
Preschools	Directors, teachers, and site managers

Demographics

Report disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services for the following categories:

Age Group

Children/Youth (0-15)	
Transition Age Youth (16-25)	2
Adult (26-59)	25
Older Adult (60+)	4
Decline to Answer	

Race/ Ethnicity (Cultural Heritage)

American Indian or Alaska Native	
Asian	6
Black or African American	10
Native Hawaiian or other Pacific Islander	
White	3
Other	12
More than one race	
Decline to Answer	
Hispanic or Latino as follows:	

Caribbean	
Central American	3
Mexican/Mexican---American/Chicano	3
Puerto Rican	
South American	2
Other	
Decline to Answer	
Non-Hispanic or Non-Latino as follows:	
African	2
Cambodian	1
Chinese	3
European	3
Vietnamese	2
Other	12
More than one ethnicity	
Decline to Answer	

Primary Languages

English	17
Spanish	8
Chinese Dialect	2
Vietnamese	2
Cambodian	1
Other Non---English	1

Sexual Orientation

Gay or Lesbian	2
Heterosexual or Straight	29
Bisexual	
Questioning or unsure of sexual	
Another sexual orientation	
Decline to Answer	

Disability

Yes	2
No	29
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech	
Other (specify)	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	2
Decline to Answer	

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: OUTREACH

Veteran Status

Yes	
No	
Decline to Answer	31

Gender

Assigned sex at birth:	
Male	1
Female	30
Decline to Answer	
Current Gender Identity:	
Male	1
Female	30
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

Implementation Challenges:

- Challenges included hiring a bi-lingual Spanish consultant with previous experience in a timely manner. We needed to hire someone with no early childhood experience and train them on early childhood mental health consultation as well as early childhood development.
- Another challenge has been to find sites that serve the very low income underserved population have NEVER had previous mental health consultation services. Many teachers have not have received consultation but other teachers in the classroom may have. Other sites were very interested but did not meet the state or federal y subsided requirement.

Success:

- We have established a few sites that are very excited to receive services and are in great need. We have established some very promising relationships.
- We have trained 2 very skilled diverse consultants who are ready to begin service provision.
- We have created some excellent protocols for implementation and established evaluation tools. Our other consultants and supervisors have been engaged to participate in the evaluation as well.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: OUTREACH

Lessons Learned:

- It always takes more time to develop a program than expected.

Additional Information

In this section please include the number of outreach contacts you estimate to provide in:

FY 17/18: **15 more responders and 20 parents, 20 children**
FY 18/19: **20 responders, 20 parents, 20 children**
FY 19/20: **15 more responders and 20 parents, 20 children**

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: OUTREACH

Outreach for Increasing Recognition of Early Signs of Mental Illness Program

PEI Data Report FY 16/17

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

MHSA Program Number: **PEI 19**

The Program Name: **Older Adult Peer Support**

Program Description:

This program is run by the City of Fremont and provides support services to support LGBT older adults in the community. The program will provide outreach and prevention services to complement existing programs with the older adult population. The program aims to reduce social isolation by encouraging positive social support system with process of developing a network of supportive relationship that reduce the risk of prolonged suffering and increase confidence among the target population. The program offers 1:1 time with peer coach, support group and educational resources.

Potential Responders: **10**

Type of Setting(s) (ex: school)	Type(s) of Potential Responders (ex: principals, teachers, parents, nurses) Separate each type of responder with a comma.
Community based setting	The program enrolled one client to the program this quarter. Client has now been
(client's home)	assigned an LGBT coach who will be working with the client develop an action
	support his recovery from mental illness and enhancing his overall wellness.
Tri-City Health Center	Program outreached to Trans-vision medical staff and provide information about
(Trans-Vision Clinic)	LGBT program and discussed potential service collaboration.
Life Elder Care	The program outreached to Life Elder Care through their Meals on Wheels
	worked with volunteers who are delivering meals to our seniors to share program
	information to potential clients.
Pacific Center (Berkeley)	The program outreached to Pacific Center for possible cross referral for clients to
	receive services in the Fremont area and vice versa.
Lavender Senior	The program outreached to Lavender Senior to share program information and
	refer potential clients to the program.

Demographics

Age Group

Children/Youth (0---15)	
Transition Age Youth (16---25)	
Adult (26---59)	
Older Adult (60+)	1 client + 10 potential older adults
Decline to Answer	

Race

American Indian or Alaska Native	

Asian	
Black or African American	
Native Hawaiian or other Pacific Islander	
White	1 client
Other	10
More than one race	
Decline to Answer	

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican---American/Chicano	
Puerto Rican	
South American	
Other	
Decline to Answer	
Non---Hispanic or Non---Latino as follows:	
European	1 client
Other	14 clients
More than one ethnicity	
Decline to Answer	

Primary Languages

English	1 client
Spanish	
Chinese Dialect	
Vietnamese	
Laotian	
Cambodian	

Disability

Yes	
No	
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	Diagnosis: MDD, recurrent moderate
Chronic Health Condition	Diabetes, HTN, high Cholesterol
Other	

Sexual Orientation

Gay or Lesbian	1 client
Heterosexual or Straight	
Bisexual	

Questioning/unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	

Veteran Status

Yes	
No	Not a veteran
Decline to Answer	

Gender

Assigned sex at birth:	
Male	1 client
Female	
Decline to Answer	
Current Gender Identity:	
Male	1 client
Female	
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

As required for each Access and Linkage to Treatment Strategy:

The Program Name: **LGBT Mental Health Peer Coaching Program for Older Adults**

Number of individuals with SMI referred to treatment: **1 client**

List type(s) of treatment referred to:

Client was referred to Recovery and Resiliency Program for continuation of outpatient mental health services.

R&R aims to serve moderate to severe clients being discharged from Senior Mobile Mental Health program. The goal is to provide mental health and supportive services to clients for a smooth transition from current situation to stable community placement and prepare them for independent living. Also, to promote successful community reintegration.

Program Goals: To maintain client's daily functioning, to manage client's Self-care, to increase engagement in social activities and to establish and understand crisis planning.

Number of individuals followed through on referral & engaged in treatment: **1 client at this time**

Average duration of untreated mental illness: **Client has long history of mental illness dating back in 1980, approx. 37 years**

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: OUTREACH

Average time between referral and participation in treatment: **1 week** Standard Deviation: N/A

Describe ways the County encouraged access to services and follow-through on referrals:

- The county offers opportunities to develop specific programs to meet unmet needs of the LGBT population. This program will broaden the services offered by county funded existing programs.
- The primary goal of the program is to provide LGBT mental health peer coaching services to older adults. Program strategy is to increase service collaboration with other community providers in order to identify potential LGBT clients. The program aims to reduce isolation and increase self-esteem via 1:1 time with their peer, support groups, educational and other community resources.
- The program screens referrals for program eligibility. Once determined to be eligible for the program, client will be assigned a LGBT peer coach.

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

The Program Name: **LGBT Mental Health Peer Coaching Program for Older Adults**

Implementation Challenges:

- Prejudice and stigma among the LGBTQ population for seeking mental health treatment.
- Finding mental health provider that provide LGBTQ specific mental health treatment in the community (southern part of Alameda county) was a challenge in identifying potential participants
- Potential participants take longer time to make decision to participate and receive services.

Success:

- Being connected with identified community providers instills hope for the program to recruit more participants.
- At present one client has been identified and been paired with the trained LGBTQ peer coach for mental health services.
- The program has volunteers who are interested in doing an outreach to their specific cultural community.
- The program continues to provide on-going support to the trained peer coach to manage their own mental health issues.
- The program provides training opportunities to the peer coach to enhance his coaching skills and increase knowledge of needed community resources.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: OUTREACH

Lessons Learned:

- Being LGBT and suffering from mental health issues create more challenges to both client and service providers.
- There are few places they feel safe to be connected and belong. They need more support to reach out to other people so they can create a safe place to talk about what they are going through.
- Limited family support.
- Rejecting behaviors from other people in the community who have difficulty accepting our client's sexual orientation and identity.
- We learned that LGBT population needs more support and empowerment as they go through with their unique challenges of growing old.

Additional Information:

In this section please include the number of outreach contacts you estimate to provide in:

FY 17/18: **9 minimum**
FY 18/19: **9 minimum**
FY 19/20: **9 minimum**

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: OUTREACH

Outreach for Increasing Recognition of Early Signs of Mental Illness Program

PEI Data Report FY 16/17

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

MHSA program Number: **PEI 13**

The Program Name: **Wellness & Recovery Resource Initiative**

Program Description:

The Wellness, Recovery and Resiliency Initiative's (WRRI) aim is to support "systems transformation" by helping behavioral health programs integrate wellness practices into culture and operations. The WRRI offers outreach and engagement opportunities, workshops, housing supports, support groups, technical assistance in the form of recovery education workshops, and action planning workshops. These workshops, ongoing classes and events were designed to help clients build wellness-oriented experience, knowledge, skills and practice. The WRRI continues to implement quality improvement activities and lead initiatives including ongoing best practices, promoting consumer and family involvement and peer support.

Total number of potential responders: 455 (Reach Out Program) + 1992 (Berkeley Drop-in Center) + 1524 (Reach Across Program) + 141 (BN)

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) Separate each type of responder with a comma.
Board and cares	Consumers
Psychiatric Locked facilities	Mental health workers, social workers, rehab therapist, consumers, activity leaders
2 Peer Drop In Center's	Peer Counselors, AOD Counselors, Consumers, Family Members
Peer training Center	County staff, clinicians, program managers, supervisors

Demographics

Age Group

Children/Youth (0---15)	
Transition Age Youth (16---25)	639
Adult (26---59) 680 + 129	2744
Older Adult (60+) 79 + 9	934
Declined to Answer 103 + 9	971

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: OUTREACH

Race

American Indian or Alaska Native	182
Asian	
Black or African American	1,850
Native Hawaiian or other Pacific Islander	85
White	1,202
Other	584
More than one race	235
Declined to Answer	615

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	56
Central American	41
Mexican/Mexican---American/Chicano	428
Puerto Rican	24
South American	222
Other	639
Declined to Answer	65
Non---Hispanic or Non---Latino as follows:	
African	1231
Asian Indian/South Asian	128
Cambodian	11
Chinese	136
Eastern European	0
European	679
Filipino	65
Japanese	32
Korean	7
Middle Eastern	13
Vietnamese	5
Other	411
More than one ethnicity	155
Declined to Answer	695

Primary Languages

English	2,880
Spanish	158

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: OUTREACH

Sexual Orientation

Gay or Lesbian	96
Heterosexual or Straight	3,181
Bisexual	169
Questioning or unsure of sexual orientation	10
Queer	72
Another sexual orientation	203
Decline to Answer	988

Disability

Yes	2,847
Communication Domain:	
Difficulty Seeing	452
Difficulty hearing, or having speech understood	340
Other (specify)	30
Mental Domain	2,360
Physical/Mobility Domain	568
Chronic Health Condition	459
Other	471
No	
Decline to Answer	512

Veteran Status

Yes	430
No	
Decline to Answer	

Gender

Assigned sex at birth:	
Male	
Female	
Decline to Answer	
Current Gender Identity:	
Male	2,494
Female	1,348
Transgender	16
Genderqueer	67
Questioning or Unsure of Gender Identity	28
Another Gender Identity	57
Decline to Answer	775

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: OUTREACH

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

Implementation Challenges:

- Tennant Support Housing Program: Difficulty in transitioning clients from Shelter Plus care to the Home Stretch program.
- Lack of affordable housing.

Success:

- Successful housing placements at least 3 in a 3 month period.
- Everyone Home Loans approved at 21 thus far for the year

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: OUTREACH

Outreach for Increasing Recognition of Early Signs of Mental Illness Program

PEI Data Report FY 16/17

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

MHSA program Number: **PEI 22**

The Program Name: **Unaccompanied Immigrant Youth Care Team**

Program Description:

The Unaccompanied Immigrant Youth (UIY) program provides linguistically appropriate and culturally sensitive mental health services and interventions for youth who immigrated to the United States without the accompaniment of a parent. We specialize in trauma-focused and family oriented treatment to Unaccompanied Immigrant Youth families.

Total number of potential responders: **5,950**

Type of Setting(s) (ex: school)	Type(s) of Potential Responders (ex: principals, teachers, parents, nurses) Separate each type of responder with a comma.
Location	# of Events by Location
Agency Organization	87
Faith Setting	5
Health Center	4
Home	44
Office	60
Other Community	27
Phone	746
School	1,510
TOTAL	2,483
Audience	# of Audience contacts from all Events
GEN. COMMUNITY	151
FAITH LEADERS	7
COMM. LEADERS	565
SCHOOL STAFF	2,244
LOCAL CBO	144
LAW ENFORCE.	8
FAMILY MEMBERS	847
CONSUMERS	-
YOUTH	1,970
UNKNOWN	14
TOTAL	5,950

Demographics

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: OUTREACH

Report disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services for the following categories:

Age Group

Children/Youth (0---15)	143
Transition Age Youth (16---25)	418
Adult (26---59)	883
Older Adult (60+)	2
Decline to Answer	0

Race

American Indian or Alaska Native	0
Asian	29
Black or African American	60
Native Hawaiian or other Pacific Islander	0
White	162
Other	0
More than one race	0
Decline to Answer	165

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	5
Central American	386
Mexican/Mexican---American/Chicano	211
Puerto Rican	2
South American	34
Other	0
Decline to Answer	392
Non---Hispanic or Non---Latino as follows:	
Other	
More than one ethnicity	
Decline to Answer	

Primary Languages

English	685
Spanish	754
Other Non---English	7

Sexual Orientation

Gay or Lesbian	1
Heterosexual or Straight	380
Bisexual	0

Questioning or unsure of sexual orientation	0
Queer	0
Another sexual orientation	0
Decline to Answer	1,064

Disability

Yes	9
No	1,457
Communication Domain:	
Difficulty Seeing	3
Difficulty hearing, or having speech understood	
Mental Domain	
Physical/Mobility Domain	5
Chronic Health Condition	
Other	1
Decline to Answer	

Veteran Status

Yes	0
No	1446
Decline to Answer	0

Gender

Assigned sex at birth:	
Male	526
Female	920
Decline to Answer	0
Current Gender Identity:	
Male	526
Female	920
Transgender	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: OUTREACH

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

Implementation Challenges:

- The present contract does not include any funds with which we may support students in this way, and often staff spend a fair amount of time working to clarify and meet these needs.
- Many students also have difficulty accessing legal supports and thus face immigration uncertainty, which is also very stressful.
- Staffing is also difficult as the positions require clinical training, being bilingual, and experiences with immigrant populations.

Success:

- Already in the new school year, staff have been able to reach a large number of students quickly and begin implementing support and psychoeducation groups at most school sites.
- Staff have also improved their skills at navigating the often-confusing nuances of providing services on school sites, including development of relationships with school staff and administrators.

Lessons Learned:

- Where we can, we capitalize on partnerships and resources to help support client's basic needs and have been able to create a cache of hygiene products that we can give to clients when they need it and supply students with shelf-stable snacks at school (e.g., granola bars).

Relevant Examples of Success/Impact:

- Staff have developed skills at describing our programs and services to others - including school staff and external partners - and meeting our students where they are and acknowledging their special needs.

Additional Information

In this section please include the number of outreach contacts you estimate to provide in:

FY 17/18: **3,000**
FY 18/19: **3,000**
FY 19/20: **3,000**

Any changes you intend to make to your program over the next three fiscal years:

• The UIY program is showing itself to be an essential support for the students they serve, individuals who would otherwise either not be served at all or not receive services that account for their particular needs and circumstances. We hope to provide more support for access to basic needs and, ideally, expansion to provide services to more students throughout Alameda County.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: OUTREACH

Outreach for Increasing Recognition of Early Signs of Mental Illness Program

PEI Data Report FY 16/17

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

MHSA program Number: **PEI 23**

The Program Name: **School-based Health Centers (Alameda and Encinal High School and Community Learning Centers**)

Total number of potential responders: **1,479**

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school)	Type(s) of Potential Responders (ex: principals, teachers, parents, nurses) Separate each type of responder with a comma.
Community Outings	parents, students, community members (250)
meetings w/	principals, dean of students (9)
school staff	principals, teachers, school faculty (270)
GSA presentation	lgbtq students (51)
meeting w/ school	superintendent, director of student services (2)
classroom	students, teachers (222)
sbhc focus groups	students (15)
meeting with school	school counselors (12)
monthly	school faculty (270 *not counted b/c duplicate)
SBHC informational	school faculty (270 *not counted b/c duplicate)
youth development	students (14)
freshman	students (300 * not included as potential responder)
all school assembly	students, faculty, principals (1786 * not included as potential
COST meetings	principal, dean of students, counselors, teachers (6 *not counted b/c
Harbor Bay	Community Security guards (12)
Wellness Fair	faculty, students, community members (50)
Alameda Police	City Police Officers (88)
Creating Goodness	Teachers & students (254)
Mental Health	Students & Teachers (230)

Demographics

Age Group

Children/Youth (0-15)	0
Transition Age Youth (16-25)	954
Adult (26-59)	525
Older Adult (60+)	0
Decline to Answer	0

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: OUTREACH

Race

American Indian or Alaska Native	2
Asian	290
Black or African American	96
Native Hawaiian or other Pacific Islander	86
White	240
Other	181
More than one race	59
Decline to Answer	525

Sexual Orientation

Gay or Lesbian	30
Heterosexual or Straight	
Bisexual	8
Questioning or unsure of sexual orientation	2
Queer	
Another sexual orientation	11
Decline to Answer	1,428

Disability

Yes	
No	
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Other	
Decline to Answer	1,479

Veteran Status

Yes	
No	
Decline to Answer	1,479

Gender

Assigned sex at birth:	
Male	
Female	
Decline to Answer	1,479
Current Gender Identity:	

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: OUTREACH

Male	
Female	
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	1,479

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: OUTREACH

Outreach for Increasing Recognition of Early Signs of Mental Illness Program

PEI Data Report FY 16/17

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

MHSA program Number: **PEI 24**

The Program Name: **East Bay Agency for Children - Fremont Healthy Start**

Total number of potential responders: **1,912**

List type of setting(s) in which the potential responders were engaged and the type(s) of potential responders engaged in each setting:

Type of Setting(s) (ex: school)	**Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) Separate each type of responder with a comma.
Family Resource	parents, general community members
Place of Worship	clergy, congregation members
School	school staff, teachers, parents

Demographics

Report disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services for the following categories:

Age Group

Children/Youth (0---15)	15
Transition Age Youth (16---25)	172
Adult (26---59)	1236
Older Adult (60+)	492
Decline to Answer	

Race

American Indian or Alaska Native	2
Asian	1262
Black or African American	30
Native Hawaiian or other Pacific Islander	181
White	379
Other	
More than one race	
Decline to Answer	

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: OUTREACH

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	199
Mexican/Mexican---American/Chicano	180
Puerto Rican	
South American	
Other	
Decline to Answer	
Non-Hispanic or Non-Latino as follows:	
African	0
Asian Indian/South Asian	319
Cambodian	0
Chinese	196
Eastern European	0
European	0
Filipino	178
Japanese	0
Korean	257
Middle Eastern	485
Vietnamese	5
Decline to Answer	

Primary Languages

English	526
Spanish	183
Other Non---English	163
Korean	160
Cantonese	18
Portuguese	1
Arabic	1
Farsi	552
Other Chinese Dialects	31

Sexual Orientation

Gay or Lesbian	
Heterosexual or Straight	847
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: OUTREACH

Disability

Yes	47
No	
Communication Domain:	
Difficulty Seeing	1
Difficulty hearing or having speech understood	
Other (specify)	
Mental Domain	13
Physical/Mobility Domain	26
Chronic Health Condition	5
Other	6
Decline to Answer	56

Veteran Status

Yes	2
No	
Decline to Answer	

Gender

Assigned sex at birth:	
Male	927
Female	1,010
Decline to Answer	
Current Gender Identity:	
Male	
Female	
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: OUTREACH

As required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

The Program Name: **East Bay Agency for Children - Fremont Healthy Start**

Implementation Challenges:

- In terms of implementation challenges, there continues to be a lack of bilingual and bicultural therapists available in local mental health agencies, so there are limited options for staff to refer clients. Another challenge for staff is maintaining good time management with clients once they do open up.
- Sometimes it is hard for staff to end the discussion because it is uncomfortable to interrupt a very personal moment.
- The following are some of the challenges that staff have experienced with family resource center participants. Staff use these opportunities to help reduce stigma and encourage use of mental health services and community supports. For example, if parents are told by school officials that child has ADHD, they think its a terrible disease. Staff help parents in looking for resources, so that they know it is not a disease, but something they can help with. Some cultures believe that if a child or adult in the family has a mental health issue, it is a form of punishment to the parents. Sometimes the children of immigrants know that therapy would greatly help parents and suggest it but parents refuse services. Many clients are fearful of being so open with someone they don't know, so they rely on prayer and family support to get through stressful challenges.

Success:

- Family Resource Specialists have engaged family resource center participants or potential responders by active listening of family concerns and engage and educate family members regarding early signs of mental illness as needed to families with children who live in the City of Fremont. Having an empathetic ear helps clients to feel heard, seen and share without judgement or expectation. Clients have greatly benefited by connecting with someone from their community. Some of the issues they share with staff are: I had a fight with my daughter, my son is on the internet all day long, my child was expelled from summer camp, I work and I feel like a bad parent because I can't watch or protect my child during summer months. Having staff who share the client's culture and language makes the transition into sensitive subjects easier to bring up. Staff are able to engage clients and educate responders about early signs of mental illness and/or encourage use of mental health and community supports.

Lessons Learned:

- Staff have learned to make second appointments for when client can identify through our behavior health screening questionnaire for early identification of mental illness. This way the client has more time to sit and share comfortably their story in the first session. It is easier also for staff to make the appropriate referrals.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: ACCESS & LINKAGE

Access and Linkage to Treatment Program

PEI Data Report FY16/17

As required for each Access and Linkage to Treatment Program:

MHSA Program Number: **PEI 1. B/C**

Program Name: **School-Based Mental Health Consultation Programs**

Program Description:

This program is a school-based mental health consultation and access & linkage program that provides services in16 out of the 18 Alameda County school districts. This program operates as a partnership between Behavioral Health Care Services Agency (BHCS) and the Center for Healthy Schools and Communities (CHSC).

Number of individuals with SMI referred to treatment: _____8,861_____

List type(s) of treatment referred to:

Youth are mainly referred to outpatient school-based mental health treatment programs, but are also referred to community-based outpatient treatment programs.

Number of individuals followed through on referral & engaged in treatment: ____6,098 (69%)_____

Average duration of untreated mental illness: ____data not available__Standard Deviation: data not available

Average time between referral and participation in treatment:
71% were connected within 1 month, 29% connected within in 1-2 months. Standard Deviation: data not available

Demographics

Age Group

Children/Youth (0-15)	5,937
Transition Age Youth (16-25)	2,924
Adult (26-59)	--
Older Adult (60+)	--
Declined to Answer	--

Race N=7392

American Indian or Alaska Native	1%
Asian	10%
Black or African American	28%
Native Hawaiian or other Pacific Islander	2%
White	17%
Other	8%
More than one race	4%
Declined to Answer	

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Hispanic or Latino	36%
Caribbean	
Central American	
Mexican/Mexican-American/Chicano	
Puerto Rican	
South American	
Other	
Declined to Answer	
Non-Hispanic or Non-Latino as follows:	
African	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other	
More than one ethnicity	
Declined to Answer	

Primary Language N=9,656

English	39%
Spanish	22%
Chinese Dialect	2%
Japanese	
Filipino Dialect	5%
Vietnamese	
Laotian	
Cambodian	
Sign ASL	
Other Non-English	
Korean	
Russian	
Polish	
German	
Cantonese	
Mandarin	
Portuguese	
Armenian	
Arabic	1%
Samoan	
Thai	
Farsi	
Other Sign	
Other	4%
Decline to State	50%

Sexual Orientation

Gay or Lesbian	**Not available**
Heterosexual or Straight	
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	

Disability Status

Yes	**Not Available**
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Other	
No	
Decline to Answer	

Veteran Status

Yes	**Not Available**
No	
Decline to Answer	

Gender N=1685

Assigned sex at birth:	
Male	55%
Female	45%
Decline to Answer	
Current Gender Identity:	
Male	55%
Female	45%
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

As required for each Improve Timely Access to Services for Underserved Populations Strategy:

Target population: _____**School age youth**_____

Number of referrals to a **Prevention** program: _____9,715_____

Number of referrals to an **Early Intervention** program: _____Not Available_____

Number of individuals followed through on referral & engaged in early intervention services: Not Available

Average time between referral and participation in EI: Not Available Standard Deviation: Not Available

And/Or

Number of referrals to **treatment beyond early onset:** _____8,861_____

Number of individuals followed through on referral & engaged in treatment: _____6,098_____

Average time between referral and participation in treatment: 71% were connected within 1 month, 29% connected within in 1-2 months Standard Deviation: Not Available

Describe ways your program encouraged access to services and follow-through on referrals:

- COST is an access and linkage model comprised of a multidisciplinary team of school staff and providers who integrate learning supports and resources for students (including mental health), as well as review and participate in the development of the overall landscape of the school climate, trends, and needs.
- Through the SBBHI Partnership, Coordination of Service Teams (COST) has been rolled out in 204 of 281 schools in the County (73% of all schools now have a COST program). This is a 30% increase over FY 15/16.

As required for each Access and Linkage to Treatment Program:

Implementation Challenges:

Challenges to implementing COST have included:

- Continuing the ongoing efforts to shift the emphasis of behavioral health from reactive to proactive
- School District budgets
- Funding regulations and restrictions
- Turnover of District leadership

Success:

- The goal of COST is to identify students who need additional supports or referrals at each school site and connect those students to services.
- School districts have been increasing access to these COST teams through training to school staff on the COST process, increasing the frequency of COST meetings at some sites, improving COST data tracking, and following-up with community agencies to ensure that students get connected to services.

Lessons Learned

- To implement COST successfully and to fidelity there needs to be buy-in at all levels at the school site and district. When this buy-in occurs mental health staff are able to work much more collaboratively and efficiently in regards to supporting students referred for various service needs.
- Family Partners (FPs) contribute significantly to the linkage of youth and their families to mental health services. FPs

- provide peer to peer support to families with children ages birth through high school who receive services through the Behavioral Healthcare System of Alameda County. Fps bring the perspective of a parent/caregiver and have experience raising children with behavioral and/or emotional challenges. So through their own experiences they can help with navigation and linkage to mental health services.

- Tracking of COST data also needs ongoing support and attention. Districts that have provided this focus on data and tracking have been able to regularly report COST data and utilize it to assess what services the student has received and/or suggested.

Relevant Examples of Impact/Success

- The COST model when implemented correctly and resourced adequately is a highly successful tool for creating access and linkage to mental health services. The COST team has the ability to assess the needs of an individual student as well as the needs of an entire family.

- One example of this is that a student in Newark Unified was referred to COST for mental health services. During discussion of the student's needs it was determined that this youth had two other siblings potentially in need of support. A Parent partner contacted mother and connected her with mental health treatment services on the children's school campuses; she also assisted the mother with housing issues. Through this support, the mom was able to get rental assistance to stabilize their housing and received her own mental health treatment referral.

- As a result, the three students were able to stay in school and have the same home that they were at risk of losing.

Any changes you intend to make to your program over the next three fiscal years:

1) Continue to ensure that COST is running efficiently at all sites. 2) Work towards better data tracking and tracking systems. 3) Increase collaboration between COST and the parent partners at each site. 4) Develop evaluation tools to document the impact of COST as related to at least one of the seven negative outcomes that MHSA PEI funds are intended to prevent as a result of untreated mental illness.

Access and Linkage to Treatment Program

PEI Data Report FY 16/17

As required for each Access and Linkage to Treatment Program:

MHSA Program Number: **PEI 15**

Program Name: **Asian Health Services – Asian ACCESS: Access & Linkage to Treatment Programs**

Program Description:

Asian ACCESS Program operates a designated Intake and Referral line, screens and evaluates medical necessity and determine appropriate service levels for community members requesting mental health services. Program also provides short-term crisis stabilization outpatient services for clients in crisis to reduce utilization of higher levels of care.

Number of individuals with SMI referred to treatment: **172**

List type(s) of treatment referred to:

1. Language Acute Crisis Care & Evaluation for System-wide Services (Language ACCESS) Program such as Asian ACCESS Program (RU 01PHA6); La Clinica's ACCESS Program;
2. Adult Level 1 Service Team Program (RU 01PHT1)
3. Adult Outpatient Therapy Program (RU 01PH4)
4. Children Level 1 Program (RU 01PH5); Children Hospital
5. Early Childhood Program (RU 01PH1)
6. Asian Central County Children & Youth Services Program (RU 01PH2)
7. Medication Only Clinic (e.g. Pathway to Wellness)
8. Integrated Behavioral Health in Primary Care Setting
9. Sausal Creek Urgent Medication Clinic
10. Mobile Crisis Team for home-based crisis evaluation
11. Psychiatric Emergency Hospital (e.g. John George Psychiatric Pavilion, Willow Rock)
12. CalWORKs Program

Number of individuals followed through on referral & engaged in treatment: __**142**_____

Average duration of untreated mental illness: _unable to calculate at this time Standard Deviation: _____

Average time between referral and participation in treatment: data unavailable

Demographics

Age Group

Children/Youth (0---15)	70
Transition Age Youth (16---25)	52
Adult (26---59)	134
Older Adult (60+)	62
Decline to Answer	43

Race

American Indian or Alaska Native	0
Asian	338
Black or African American	4
Native Hawaiian or other Pacific Islander	1
White	11
Other	
More than one race	
Decline to Answer	7

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	
Central American	
Mexican/Mexican-¬-American/Chicano	8
Decline to Answer	
Non-Hispanic or Non-Latino as follows:	
African	4
Asian Indian/South Asian	2
Cambodian	19
Chinese	183
European	3
Filipino	5
Japanese	7
Korean	9
Vietnamese	63
Other	51
Decline to Answer	

Language

English	123
Spanish	
Chinese Dialect	2
Japanese	2
Filipino Dialect	3
Vietnamese	45
Laotian	1
Cambodian	12
Sign ASL	
Other Non---English	19
Korean	7
Mien	11
Cantonese	105
Mandarin	28
Thai	3

Sexual Orientation

Gay or Lesbian	
Heterosexual or Straight	
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	361

Disability

Yes	
No	
Communication Domain:	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Decline to Answer	361

Veteran Status

Yes	
No	
Decline to Answer	361

Gender

Assigned sex at birth:	
Male	155
Female	206
Decline to Answer	
Current Gender Identity:	
Male	155
Female	206
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

As required for each Improve Timely Access to Services for Underserved Populations Strategy:

Target population: Alameda County residents who are experiencing or at risk of developing serious mental health issues; at least 75% of clients served are from API groups, from all age groups and geographic regions of Alameda County. Services are provided in API languages including but not limited to Burmese, Cantonese, Khmer, Korean, Japanese, Mandarin, Mien, Tagalog and Vietnamese.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: ACCESS & LINKAGE

Number of referrals to a **Prevention** program: _____**88**_____ (UELP Outreach Program)

Number of individuals followed through on referral & engaged in prevention: data unavailable

Average time between referral and participation in prevention: Standard Deviation: data unavailable

Number of referrals to an **Early Intervention** program: _____**88**_____ (UELP Preventive Counseling)

Number of individuals followed through on referral & engaged in Early Intervention treatment: **70** (80%)

Average time between referral and participation in treatment: data unavailable

Describe ways your program encouraged access to services and follow---through on referrals:

Follow up calls in a month regarding to status of referrals:

1) Referral via County ACCESS for Pathway to Wellness (PTW) Referrals – follow up with County ACCESS to confirm assignment. Check with client to confirm that 1st appointment with PTW has been set up.
2) Referral to Blue Cross or Beacon for Mild-Moderate cases – Fax the Mild-Moderate screening referral form to Beacon/Blue Cross; call Beacon to confirm the receipt of the form faxed; advise client of completion of referral to Beacon/Blue Cross and that client should receive intake calls from the latter.
3) Advise Referring Medical Providers about the referral status and coordination of care if applicable.

As required for each Access and Linkage to Treatment Program:

Implementation Challenges:

In FY16-17, Asian ACCESS Program was transferred from another agency to Asian Health Services. The transition happened in June 2016 and program started in operation on July 1, 2016. It was very difficult to find trained intake clinicians to answer the Intake & Referral Line. In the first 4 months from July 2016 to November 2016, the Intake Line was answered by an experienced MSW consultant, and an MSW intern. Intakes were then forwarded to Licensed Managers for review and case assignment.

Starting from Dec 2016, they were able to hire and deploy two Chinese speaking Registered LPHA staff to screen, and evaluate the referral requests. To increase record accuracy, intake efficiency and follow up, they decided to adopt and record all the intake services in the County Contact Tracking Database system effective 2/1/17.

Even though the County Contact Tracking Database System serves well to record all the intake service entries, the types of stock reports available are limited and there's difficulty in analyzing and tallying service data as required by the MHSA PEI Regulations.

Success:

- Completed more than 430 Asian language speaking/culture mental health screenings (172 referrals to treatment program + 88 referrals to Prevention program + 177 client records shown by Contact Tracking Database's Services by Disposition (unique client = 177)), connected them with appropriate level of services, and obtaining related info.
- Re-engineered the Intake Process Workflow to expedite screening, case assignment, case opening and refer-outs
- Handled emergency suicidal, homicidal assessment, done above and beyond our allocated Intake resources.
- Conducted Pre-treatment home-based and hospital-based engagement services with clients to connect them with treatment programs.

Lessons Learned:

- Struggle with limited resources to provide more comprehensive Mental Health Intake services for Asian language speaking/culture clients.
- Difficulty referring out Mild-Moderate Asian Language/culture clients due to inadequate bilingual and bicultural

Relevant Examples of Impact/Success:

- Immediate crisis Intervention on the phone was provided, including developing safety plan, and divert intake clients from psychiatric hospitalization.
- Educate and support family members on how to support and monitor client's psychiatric conditions. Also provide family members crisis resources.
- Psycho-education on mental health issues to diverse API communities, including 7-series training to Burmese youth and community leaders; plus some Community outreach events, trainings, we had reached over 1,300 community members in FY16-17.

Additional Information

In this section please include the number of clients and/or contacts you estimate to serve in:

FY 17/18: **500 clients/1050 hours of contacts**
FY 18/19: **525 clients/1075 hours of contacts**
FY 19/20: **550 clients/1100 hours of contacts**

Any changes you intend to make to your program over the next three fiscal years:

like to explore having increased staffing resources to support more API language groups' intake needs, and ways to collaborate and support County's Crisis Diversion Efforts, e.g. Mobile Crisis Team, Amber House, JGP PES when it comes to API community members' crisis assessment and diversion from psychiatric hospitalization, and provide early connection and engagement to link clients who are distressed to appropriate level of treatment and/or preventive counseling services.

Access and Linkage to Treatment Program

PEI Data Report FY 16/17

As required for each Access and Linkage to Treatment Program:

MHSA Program Number: **PEI 16A**

Program Name: **La Clinica – Latino ACCESS: Access & Linkage to Treatment Programs**

Program Description:

The ACCESS program offers entry into ACHBCS system of care with a focus on clients in need of Spanish language capacity. Adults and children with linguistic and culturally based need that are members of Spanish-speaking community are able to obtain screening, evaluation of medical necessity and referral to treatment. La Clínica offers crisis stabilization services to adults with high acuity mental health needs and reduce utilization of higher levels of care. La Clínica provides these services the setting and manner that is most comfortable for clients. La Clinica also provides services that increase functioning and coping skills, client's understanding of their mental illness and responsibility for monitoring/managing their treatment and recovery and access to mental health services for underserved Latino communities in Alameda County.

Number of individuals with SMI referred to treatment: **361**

List type(s) of treatment referred to:

1. Language Acute Crisis Care & Evaluation for System-wide Services (Language ACCESS) Program such as Asian ACCESS Program; La Clínica's ACCESS Program; Adult Level 1 Service Team Program
2. Adult Outpatient Therapy Program
3. Children Level 1 Program; Children Hospital
4. Early Childhood Program
5. Medication Only Clinic (e.g. Pathway to Wellness)
6. Integrated Behavioral Health in Primary Care Setting
7. Sausal Creek Urgent Medication Clinic
8. Mobile Crisis Team for home-based crisis evaluation
9. Psychiatric Emergency Hospital (e.g. John George Psychiatric Pavilion, Willow Rock)

Number of individuals followed through on referral & engaged in treatment: **265** (73%)

Average duration of untreated mental illness: data unavailable Standard Deviation: data unavailable

Demographics

Age Group

Children/Youth (0---15)	206
Transition Age Youth (16---25)	126
Adult (26---59)	322
Older Adult (60+)	12
Decline to Answer	1

Race

American Indian or Alaska Native	
Asian	
Black or African American	
Native Hawaiian or other Pacific Islander	
White	669
Other	
More than one race	
Declined to Answer	

Sexual Orientation

Gay or Lesbian	
Heterosexual or Straight	
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	669

Disability

Yes	
Difficulty Seeing	
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	
Physical/Mobility Domain	
Chronic Health Condition	
Other	
No	
Decline to Answer	669

Veteran Status

Yes	
No	
Decline to Answer	669

Gender

Assigned sex at birth:	
Male	232
Female	435
Decline to Answer	
Current Gender Identity:	
Male	232
Female	435
Transgender	

Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

As required for each Improve Timely Access to Services for Underserved Populations Strategy:

Target population: Latinos with limited English proficiency and other underserved populations within all geographic areas of Alameda County.

Number of referrals to a **Prevention program**: 27
Number of individuals followed through on referral & engaged in treatment: data unavailable
Average time between referral and participation in treatment: data unavailable

Number of referrals to an **Early Intervention program**: 11
Number of individuals followed through on referral & engaged in treatment: data unavailable
Average time between referral and participation in treatment: data unavailable

Number of referrals to **treatment beyond early onset**: 361
Number of individuals followed through on referral & engaged in treatment: 265 (73%)
Average time between referral and participation in treatment: data unavailable

Describe ways your program encouraged access to services and follow---through on referrals:

1. When clients are referred out it is our practice to ensure that clients leave with a written copy of referral information.
2. Whenever possible, calls for services are made with the client during the appointment.

As required for each Access and Linkage to Treatment Program:

Implementation Challenges:

At this time La Clínica does not have an electronic health record (EHR) that allows La Clínica capture the abundance of the patient data requested. However, this data is entered into INSYST at the time of registration, but not available at the client level. In addition, successful linkage to lower levels of care is inconsistent as there does not exist a clearinghouse or updated database of these providers. Lastly, Medicare-MediCal recipients also comment on increased challenges with seeking mental health services as they often do not understand that when selecting their health plans they are also selecting mental health providers.

Success:

- In FY 16-17, 668 clients received an assessment. Of these clients, 185 received a referral to a group, 27 received a referral to La Clínica's Prevention and Early Intervention program, Cultura y Bienestar, 387 received a referral to specialty mental health care such as La Clínica's Adult Outpatient Level I Service Team (RU 01911), Children's Outpatient Level I Services, (RUs 01912 and 01F62) or Ryan White services, 16 received a referral to La Clínica's child abuse program, 38 were referred to other programs such as ACCESS, Beacon, Help Me Grow or Si Se Puede.

Lessons Learned:

- There is difficulty referring out mild/moderate Spanish language clients due to inadequate bilingual and bicultural providers in the community.

Relevant Examples of Impact/Success:

- Client AL is a 41 year old Latino male who came to La Clínica's ACCESS program after discharge from incarceration. He was released from incarceration with a long history of untreated mental health needs. La Clínica's ACCESS program provided him with an intake and linkage to other services. Since engaging in care, the client has been linked to sober living residential services, psychiatry and ongoing treatment.

Additional Information

In this section please include the number of clients and/or contacts you estimate to serve in:

FY 17/18**: 3,566 hours of service to 480 unduplicated clients**
FY 18/19: **3,566 hours of service to 480 unduplicated clients**
FY 19/20: **3,566 hours of service to 480 unduplicated clients**

Any changes you intend to make to your program over the next three fiscal years:

La Clínica will be moving to an electronic health record (EHR) in FY 17-18. La Clínica is aware that 98% of clients served in the program are Latino but do not have the specific ethnic breakdown requested in the report. In addition, La Clínica serves a large number of Spanish-speaking clients. While there are many elements that La Clínica was unable to capture in FY 16-17, the move to EHR will enable many more data elements to be collected in FY 17-18.

Access and Linkage to Treatment Program

PEI Data Report FY 16/17

As required for each Access and Linkage to Treatment Program:

MHSA Program Number: **PEI 16B**

Program Name: **La Familia – Latino ACCESS: Access & Linkage to Treatment Programs**
Program Description:

The ACCESS program offers entry into ACHBCS system of care with a focus on clients in need of Spanish language capacity. Adults with linguistic and culturally based need that are members of Spanish-speaking community are able to obtain screening, evaluation of medical necessity and referral to treatment. La Familia offers crisis stabilization services to adults with high acuity mental health needs and reduce utilization of higher levels of care.

Number of individuals with SMI referred to treatment: 137
List type(s) of treatment referred to:

1. Psychiatric Services
2. Brief Psychotherapy
3. Case Management.

Number of individuals followed through on referral & engaged in treatment: 103 (75%)

Average duration of untreated mental illness: data unavailable Standard Deviation: data unavailable

Average time between referral and participation in treatment: **6 days** Standard Deviation: data unavailable

Demographics

Report disaggregate numbers served, number of referrals for treatment and other services for the following categories:

Age Group

Children/Youth (0---15)	
Transition Age Youth (16---25)	21
Adult (26---59)	79
Older Adult (60+)	3
Declined to Answer	

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: ACCESS & LINKAGE

Race

American Indian or Alaska Native	
Asian	
Black or African American	1
Native Hawaiian or other Pacific Islander	
White	
Other/Latino	102
More than one race	
Declined to Answer	

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Caribbean	78
Central American	16
Mexican/Mexican---American/Chicano	
Puerto Rican	2
South American	6
Other	
Declined to Answer	
Non---Hispanic or Non---Latino as follows:	
African	1
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other	
More than one ethnicity	
Declined to Answer	

Language

English	12
Spanish	91

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: ACCESS & LINKAGE

Sexual Orientation

Gay or Lesbian	3
Heterosexual or Straight	100
Bisexual	
Questioning or unsure of sexual orientation	
Queer	
Another sexual orientation	
Decline to Answer	

Disability

Yes	
Communication Domain:	
Difficulty Seeing	1
Difficulty hearing, or having speech understood	
Other (specify)	
Mental Domain	1
Physical/Mobility Domain	2
Chronic Health Condition	
Other	6
No	93
Decline to Answer	

Veteran Status

Yes	
No	103
Decline to Answer	

Gender

Assigned sex at birth:	
Male	29
Female	74
Decline to Answer	
Current Gender Identity:	
Male	29
Female	74
Transgender	
Genderqueer	
Questioning or Unsure of Gender Identity	
Another Gender Identity	
Decline to Answer	

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: ACCESS & LINKAGE

As required for each Improve Timely Access to Services for Underserved Populations Strategy:

Number of referrals to an Early Intervention program: **10**
Number of individuals followed through on referral & engaged in treatment: **10** (100%)

Average time between referral and participation in treatment: N/A Standard Deviation: N/A

Describe ways your program encouraged access to services and follow---through on referrals:

- By providing services in the Spanish language, including administrative materials.
- By continually networking with other providers, especially other Latino organizations such as La Clinica and Tiburcio Vasquez Health Center. They also work closely with John George Pavilion and the Hayward Wellness Center.
- By providing inter agency-referrals to their own Early Intervention and Prevention Program, "Cultura y Bienestar."

As required for each Access and Linkage to Treatment Program:

Implementation Challenges:

- Having only 1.5 FTE ACCESS clinicians.
- Not enough Spanish speaking after care referrals providers in the community that serve the uninsured.
- Not enough resources to track data.

Success:

- Getting Level I Services approvals.
- Preventing psychiatric hospitalizations.
- Preventing mental health relapses.
- Linking clients to long-term services and community resources.

Lessons Learned:

- Need to increase mental health services to the Latino community.
- Importance of using the preferred language of the client.

Relevant Examples of Impact/Success:

- Good engagement to treatment.
- Very low client psychiatric hospitalization rates during the duration of their ACCESS treatment program.

Additional Information

In this section please include the number of clients and/or contacts you estimate to serve in:
FY 17/18: 100 FY 18/19: 150 (if FTE is increased) FY 19/20: 150 (if FTE is increased)
Any changes you intend to make to your program over the next three fiscal years:
The program would like to request an increase in the number of FTE so as to meet the needs of the population.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: STIGMA & DISCRIMINATION REDUCTION

Stigma and Discrimination Reduction

PEI Data Report FY 16/17

As required for each Stigma and Discrimination Reduction Program:

MHSA Program Number: **PEI 4**

The Program Name: **Everyone Counts Campaign (ECC) http://www.everyonecountscampaign.org/**

Available number of individuals reached: **2,556** (unduplicated participants)

List number of individuals reached by each activity (ex: # who accessed website): 822 web subscribers

Type of Activity (ex: accessed website)	Number of Individuals Reached (#)
Chinese American Stigma Reduction Campaign – 2 Cultural Responsiveness Trainings	40
Latino American Stigma Reduction Campaign – Cultural Responsiveness Trainings (3)	43
Latino American Stigma Reduction Campaign – Latino American Action Team (7 Mtgs)	23
"Lift Every Voice and Speak" (LEVS) Speakers Bureau – Adult Speaker Trainings (Bi-Monthly)	29
"Lift Every Voice and Speak" (LEVS) Speakers Bureau – Member Speaking Engagements (10)	94+
Spirituality Gatherings – Monthly Mtgs + Annual Mental Health Day of Prayer	37+
Therapeutic Arts – Reflections and Expressions Workshops (6 events)	40
ECC Outreach / Community Engagement Events (42 events)	1428+
ECC Media / Communications – ECC Website Subscribers	822

Demographics

Report disaggregate numbers served, number of referrals for treatment and other services for the following categories:

Age Group

Children/Youth (0--15)	1%
Transition Age Youth (16--25)	5%
Adult (26--59)	24%
Older Adult (60+)	10%
Declined to Answer	60%

Race

American Indian or Alaska Native	0.5%
Asian	1%
Black or African American	28%
Native Hawaiian or other Pacific Islander	0.5%
White	5%
Other	3%
More than one race	2%
Declined to Answer	60%

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: STIGMA & DISCRIMINATION REDUCTION

Gender

Assigned sex at birth:	
Male	
Female	
Decline to Answer	
Current Gender Identity:	
Male	14%
Female	24%
Transgender	1%
Genderqueer	
Questioning or Unsure of Gender Identity	0.5%
Another Gender Identity	0.5%
Decline to Answer	60%

As required for each Access and Linkage to Treatment Strategy:

The Program Name: Everyone Counts Campaign_(ECC)
Number of individuals with SMI referred to treatment: 10 Participants

List type(s) of treatment referred to:

Life Long Medical Services, Jay Maler Center, Sausal Creek Clinic, Bonita House, Berkeley Drop-in Center, ACBHCS Crisis Support Services, East Bay Community Recovery Project

Number of individuals followed through on referral & engaged in treatment: 5(50%)

As required for each Improve Timely Access to Services for Underserved Populations Strategy:

The program Name: Everyone Counts Campaign (ECC)

Identify target population: Mental Health Consumers, primarily people of color

Number of referrals to a **Prevention** program: 20

Number of individuals followed through on referral & engaged in treatment:10 (50%)

Average time between referral and participation in treatment: data unavailable

Number of referrals to an **Early Intervention** program: 30

Number of individuals followed through on referral & engaged in treatment:15(50%)

Average time between referral and participation in treatment: data unavailable

Number of referrals to **treatment beyond early onset:** 10

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: STIGMA & DISCRIMINATION REDUCTION

Number of individuals followed through on referral & engaged in treatment: **5** (50%)

As required for each Stigma and Discrimination Reduction Program:

Implementation Challenges:

- At times participants struggled with interpersonal issues within the group LEVS and Latino Action Team (LAAT) Group. To resolve this problem, we provided participants tools to overcome these barriers and used parts of the meeting to intentionally build team/community. We will continue to use these practices to support healthy group dynamics.

Successes:

- Participants expressed a decrease of internalized stigma around their own mental health experiences.
- Participants felt empowered to share their message of hope and recovery, educating the community around mental health to eliminate external stigma.
- Participants felt a sense of community and had access to more resources as a result of this program.
- An increase in ECC Website subscribers (from 347 to 822) allows more participants access to resources and Mental Wellness information.

Lessons Learned:

- The Toastmaster's curriculum was used this FY to support LEVS speakers with sharing their story. Since the curriculum requires members to spend some time practicing and reading materials outside of the LEVS meetings, we have found that this is an unrealistic expectation for our group. As a result, we will utilize the "Coming Out Proud" curriculum which supports stigma reduction for speakers with mental health challenges.
- Many people that we engage during our outreach events prefer not to complete demographic data and will many times only provide name and e-mail addresses. This provides a gap in our data since most of our participants are reached through outreach efforts.

Relevant Examples:

- Jean Lee's video, which adds a human face to the mental health stigma experienced in the API community. https://youtu.be/stIhWWByGLY
- Two LAAT members shared their mental health story during the team meeting. https://youtu.be/8MTAnTOHdmE Everyone Counts Campaign media alerts that include topics such as supporting family members with mental health experiences, anxiety, suicide prevention, and spirituality. http://www.everyonecountscampaign.org/media-alerts

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: SUICIDE PREVENTION

Suicide Prevention Program

PEI Data Report FY 16/17

As required for each Suicide Prevention Program:

MHSA Program Number: **PEI 12**

Program Name: **Suicide Prevention and Trauma Informed Care**
Program Description:

Program Description: Crisis Support Services of Alameda County (CSS) is a nonprofit, volunteer-based crisis intervention and suicide prevention agency. They provide a variety of mental health services to a wide range of persons in varying degrees of crisis. Services include crisis hotline, school-based suicide prevention training, community gate keeper trainings and consultation, Mental Health First Aid, teen text line, Trauma Informed Care (TIC) trainings, grief counseling for all ages and crisis event counseling. *Their primary mission is to assist people in emotional distress, to offer supportive counseling to those in crisis and to prevent suicide.*

CSS is leading the way for suicide prevention centers across the nation in providing sensitive and timely services to people impacted by traumatic stress. Trauma-Informed Care (TIC) is a person-centered response that focuses on improving functioning over curing mental illness, i.e. "fixing" something "broken". CSS utilizes a wide range of TIC components and responses when working with all of their clients, but predominantly with those affected by traumatic loss, particularly suicide and homicide bereavement.

Available number of individuals reached: 23,024 individuals reached (not including website traffic)
List number of individuals reached by each activity (ex: # who accessed website):

Type of Activity (ex: accessed website)	Number of Individuals Reached (#)
Suicide Prevention Crisis Line	63,786 calls 12,626 indiv.
Youth Text Line Program (duplicated)	589
Teens for Life Suicide Prevention Program (unduplicated)	8,528
School Gatekeeper Program (teachers, parents, staff, counselors) unduplicated	477
Health Fairs and Informational events (unduplicated)	974
Adults served through consultation and Mental Health First Aid trainings (unduplicated)	376
Community Gatekeeper program (unduplicated)	1,079
Trauma Informed Care Workforce trainings (unduplicated)	601
Grief Counseling Services	375
TOTAL	25,625

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: SUICIDE PREVENTION

Age Group (All services)

Children/Youth (0---15)	9,584
Transition Age Youth (16---25)	3,877
Adult (26---59)	27,161
Older Adult (60+)	5,458
Declined to Answer	Approx. 50%

Race

American Indian or Alaska Native	16
Asian	2,164
Black or African American	2,152
Native Hawaiian or other Pacific Islander	6
White	5,283
Other	32
More than one race	98
Declined to Answer	Approx. 50%

Ethnicity (Cultural Heritage)

Hispanic or Latino as follows:	
Latino	1,163
Caribbean	
Central American	
Mexican/Mexican---American/Chicano	
Puerto Rican	
South American	
Other	
Declined to Answer	
Non---Hispanic or Non---Latino as follows:	
African	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Declined to Answer	

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: SUICIDE PREVENTION

Primary Languages: (data is for the crisis line N=63,786)

English	63,664
Spanish	109
Chinese Dialect	
Japanese	
Filipino Dialect	
Vietnamese	1
Laotian	
Cambodian	
Sign ASL	
Other Non---English	
Korean	1
Russian	
Polish	
German	
Italian	
Mien	
Hmong	
Turkish	
Hebrew	
French	
Cantonese	6
Mandarin	5
Portuguese	
Armenian	
Arabic	
Samoan	
Thai	
Farsi	
Other Sign	
Other Chinese Dialects	
Ilocano	

Sexual Orientation (data from Grief Counseling Program N=375)

Gay or Lesbian	17
Heterosexual or Straight	172
Bisexual	6
Questioning or unsure of sexual orientation	3
Queer	3
Another sexual orientation	2
Decline to Answer	172 (46%)

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: SUICIDE PREVENTION

Gender (Data from crisis calls and Grief Counseling Program N=40,002)

Assigned sex at birth:	
Male	17,956
Female	21,016
Decline to Answer	
Current Gender Identity:	
Male	16,803
Female	21,016
Transgender	1,889
Genderqueer	13
Questioning or Unsure of Gender Identity	163
Another Gender Identity	6
Decline to Answer	

As required for each Suicide Prevention Program

Implementation Challenges:

- Access to teachers and parents in school systems continue to be a challenge. This has been mitigated somewhat through continued collaboration with the PEI funded school district mental health liaisons, but remains an ongoing challenge to be addressed each school year.

- Gathering demographic information can be challenging in the various suicide prevention modalities (over the phone, text and in person. This decision tree is used to weigh the following questions:

  1. Will asking for demographic information further create safety for this texter/caller right now?
  2. Is it related to the topic the texter/caller is presenting?
  3. Will it help or hurt the rapport?

- Getting demographic information must always be done with the texter's/caller's needs in mind so that they may be the most effective support system possible. Sometimes it is a rapport building question. Other times, it must be set aside for other priorities in a session.

B. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: SUICIDE PREVENTION

Success:

- The Teens for Life program for middle and high school aged youth reached 8,491 youth in 12 school districts.

- 589 text sessions were conducted with great success. Examples of some of the positive feedback the volunteer have received include:

Texter: Thank you for your texts. Just even having a reply back from someone who cares helps a lot when I'm feeling this low
Texter: I'm not feeling suicidal anymore tysm for all ur help
Texter: "Thank you so much. This really helped me tonight. It's so good to talk about it instead of bottling it up and taking it out on myself."
Texter: "I feel comfortable stopping here until tomorrow. Thank you Aaron u saved my life tonight."

Successes Continued:

- CSS responded to 63,786 calls on their four Alameda County call lines. (24 hour Crisis Line, Alameda County Behavioral Health ACCESS Afterhours Lines, Substance Use Helpline, National Suicide Prevention Lifeline.) They answered 530 calls with high risk to suicide, a 53.6% increase from last year's number of high risk calls. In 80 calls, a suicide attempt was in progress, up 58% from last year.

- Only 39% of high risk calls resulted in police intervention and hospitalization. Utilizing collaborative problem solving and safety planning, the crisis line counselors deescalated suicidal crisis over the phone, evaluating and connecting the callers with suicidal desire and intent to their coping skills and their support network. Not only is this cost saving to the county Behavioral Health Care system, it also reduces further traumatization that may occur when interacting with law enforcement agencies or mental health institutions.

Lessons Learned:

- Age information was available for 45% of the crisis callers. When Crisis Support Services looked at the distribution of national suicide rates by age they noticed that people age of 65+ have comparable death rates as those aged 55-64, yet on the crisis lines, they've seen low rates (18.03%) of callers age 65 and up. This indicates a need for further outreach to people 65 years of age and up.

Additional Information

In this section please include the number of clients and/or contacts you estimate to serve in:

FY 17/18: **26,000**
FY 18/19: **27,000**
FY 19/20: **28,000**

In FY 18/19 Crisis Support Services is hoping to engage with Alameda County on an Innovative 18 month pilot project aligned with The American Association of Suicidology and the Substance Abuse & Mental Health Services Administration (SAMHSA) called the Zero Suicide Campaign.

The focus of the campaign is to identify gaps in service for at risk folks and to close those gaps with the highest

standards and best practices of suicide prevention. The goal is to recognize and fill all the gaps in service and the outcome will be zero suicide. Two large gaps in services have been identified for Alameda County. One is the lack of suicide assessment especially in primary care settings but also among other helping professionals. Psychoeducation to reduce stigma, teaches suicide assessment and risk assessment could help. The second gap is the wait, sometimes a long wait for services without adequate support and/or advocacy after a crisis and/or during a crisis. Outreach, follow up and perhaps a warm hand off to services could be helpful. These services, among others will be piloted to determine the most effective methods for the goal of zero suicide for Alameda County.

C. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: INNOVATION

Innovative Programs is intended to provide mental health systems with an opportunity to learn from innovative approaches. Innovation Programs are not designed to support existing or ongoing programs or services, but rather to provide the mental health system with innovative demonstration projects that will support system change in order to increase access to services and improve client/ consumer outcomes.

An Innovative Project may introduce a novel, and/ or ingenious approach to a variety of mental health practices. Innovative 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.

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.

Innovation Approval Process: Before Innovation funds can be spent on an Innovation project, the project idea must be vetted through a 30 day public review process, approved by the County Board of Supervisors and then approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC). The first two steps may take place as part of a Three year Plan or Plan Update or may be implemented as a stand alone process.

Summary of Changes

1. INN Programs under Procurement

As a follow-up from BHCS' previous MHSA Plan Update several Request-For-Proposals have been implemented for small, time-limited, innovative approaches to address the following areas:

A. INN 4A: Innovative Technology Applications

These contracts are scheduled to begin in early 2018 (FY 17/18).

B. INN 4B: Educational Mental Health Training Opportunities for Underrepresented and Disadvantaged High School and Undergraduate Students

Eight projects were selected and began implementation in early FY 17/18. The projects will cover the following learning question areas: Working with Underrepresented Student Populations, Innovative Partnerships, Funding

Models and Sustainability Reporting, Industry Preparation and Participation in Behavioral/Mental Health Pathways, De-Stigmatizing Public Behavioral/Mental Health Careers and Mentorship.

C. Additional Innovative Projects (Round 5): Small, time-limited, innovative approaches are being developed to address the following areas:

i. Suicide Prevention: This project strives to reduce suicidality in Alameda County and improve the care and outcomes for individuals at risk of suicide using tools and strategies based on the Zero Suicide Initiative developed by Substance Abuse and Mental Health Services (SAMHSA).

ii. Understanding Children's Mental Health Outcomes: Recommendations for measurement and accountability in a multi-system context to fill a critical knowledge gap and provide new information about the interplay between children's mental health and other factors including other public systems.

iii. Culturally-responsive services and organizational capacity-building to address the needs of diverse, underserved API consumers and family members. In addition, API Mental Health Empowerment statewide conference will be conducted to outreach to API communities and encourage statewide collaboration.

iv. Trauma Informed Systems (TIS) in School project will address community violence and trauma by conducting an innovative project to test the Trauma Informed Systems (TIS) model in a school systems that serves children of color, who have been historically and systematically marginalized.

v. Juvenile Justice Center - Team Based Group Model project will conduct an innovative group based approach to provide holistic primary care, behavioral health, and other follow up services for youth transitioning from the Juvenile Justice Center (JJC) into the community.

2. New INN Programs under Development for Future Procurement

Alameda County Behavioral Health Care Services (BHCS) is currently developing multiple proposals for the Innovation component of the Mental Health Services Act. A summary of the proposed concepts to date are provided here. These will be further developed and discussed with the Mental Health Services Oversight and Accountability Commission (MHSOAC) staff for technical assistance. Those proposals with a strong Innovation aspect will be written up in detail, published for 30 day public comment and then submitted to the Alameda County Board of Supervisors and then the MHSOAC for final approval. Please note additional Innovation projects are being internally developed based on this summer's community input sessions and may be included when all Innovation projects are posted for the 30 day review period.

A. Supportive Housing Land Trust

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.

Community Land Trusts (CLTs) are nonprofit, community-based organizations designed to ensure community

stewardship of land. Community land trusts are often associated with conservation efforts, but there is also a significant effort to ensure affordable long-term housing through this form of ownership. The trust acquires land and maintains ownership of it permanently. The CLT enters into a long-term, renewable lease with residents. When the resident leaves, they earn a portion of the increased property value. The remainder is kept by the trust, preserving the affordability and purpose of the property for future households.

The proposed Innovation Project will promote interagency collaboration to create an **Alameda County Supportive Housing Land Trust to develop and maintain supportive housing units.** BHCS will partner with Alameda County Housing and Community Development Department, housing and real estate legal and financial experts, consumer/client representatives, family member representatives, and existing nonprofit affordable housing developers to develop a land trust focused on supportive housing that incorporates unique aspects in order to address local conditions.

B. Community Assessment and Transport Team (CATT)

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 proposed Innovation Project will improve access to services in Alameda County by bringing together a few efforts to significantly transform the response to behavioral crises in the community:

- Develop a crisis response team that includes Behavioral Health Clinicians and an Emergency Medical Technicians (EMT) in order to provide both medical and behavioral assessments in the field, including in a medical emergency department. This team would initially be available 16 hours a day, 7 days a week, and focus on two communities that are identified as underserved. The team would be able to provide transport to the appropriate services, including psychiatric hospital, emergency department, crisis residential, sobering center or other site, for clients on 5150 holds or not requiring a hold.
- Enhance the bed availability software program (Reddinet) to show availability of psychiatric, crisis stabilization units, and sobering center beds and provide alerts when the psychiatric emergency services is reaching capacity in order to provide real time information about the availability of disposition options.
- Provide access to tele-psychiatry for the crisis response team in the field.
- Provide the crisis response team with access to a Community Health Record through AC Care Connect, which enables them to send an alert about the episode to other providers involved with the client.

By bringing together the right staffing and the right technology, this innovative crisis response team will *reduce unnecessary 5150 holds, transportation to medical facilities for medical clearance, and the many hours of waiting for clients and first responders.* In addition, it will increase access to appropriate services by connecting and transporting clients whether or not they are on a 5150 hold.

C. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: INNOVATION

C. Cannabis Education Program for Transition Age Youth (TAY) with Mental Health Challenges

The changes in the laws regarding cannabis in California provide an opportunity to find proactive ways to address the potential impact on mental health. Alameda County proposes a collaborative approach to reducing potentially harmful effects on TAY mental health consumers. The focus of this proposed Innovation Plan is to collaborate with key stakeholders, including TAY consumers and the cannabis industry. Developing a positive and proactive collaboration with the cannabis industry is a unique approach to supporting the health of TAY consumers.

Two policy development advisory committees will be formed:

1) One will include representation from providers (hospitals, health clinics, Alameda County departments, etc), law enforcement (parole, probation, court, jail, etc.), education (public schools, college, vocation schools, etc.), and the cannabis industry. This will focus on determining best practices and policies among these institutions.
2) One will include TAY mental health consumers, family and community members. This one will focus on better understanding cannabis usage by TAY consumers and best practices for education campaigns, as well as providing input on the work of the policy and practices committee.

The results of this process are expected to lead to:

1) A model for working with the cannabis industry to develop and implement best practices to support the health of mental health consumers
2) A well-informed and collaborative harm reduction approach to cannabis usage for TAY consumers that is responsive to the current legal environment regarding cannabis.

C. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: INNOVATION

Round Four Innovation Grant Projects

Program Name: (INN4A) Mental Health Technology

Project Description: Community based providers will collaborate with web developers to create innovative web-based mental health technology to support the wellness of consumers.

Learning Questions:

1. How does this application improve personal health outcomes for consumers of behavioral health services, their family members and providers?
2. How does this application increase utilization of behavioral health services for individuals belonging to under-served populations, their families and providers?

Project Categories	Application User Groups
I. Mental health wellness promotion, care coordination	A. Children and Youth (0-18) who are currently served by an Alameda County mental health program, their family members and providers.
	B. Transition-Age Youth (16-24) who are currently served by an Alameda County mental health program, their family members and providers.
	C. Adults (18-59) who are currently served by an Alameda County mental health program, their family members and providers.
	D. Older Adults (60+) who are currently served by an Alameda County mental health program, their family members and providers.
II. Recovery support, care coordination	Individuals of any age who are currently served by an Alameda County Substance Use/Co-occurring Disorders program, their family members and providers.
III. Outreach, engagement, education to promote mental health wellness and referrals to existing mental health services	Individuals of any age who are currently under-served by public mental health services due to language and cultural barriers, their family members and providers.
TOTAL	14-22 projects not to exceed $3,000,000 in total

C. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: INNOVATION

FY17-18 Outcomes

Request For Proposal (RFP) process for grantee selection was delayed until September 2017. Review and selection of Round Four Grantees is currently underway. Eighteen month project implementation is anticipated to begin Spring 2018. Project completion and learning conference are anticipated for end of 2019.

Program Name:

INN 4B. Behavioral/Mental Health Career Pathways for High School and Undergraduate Students

Program Description

The MHSA INN Behavioral/ Mental Health Career Health Pathways will address challenges and barriers in building cohesive, effective and efficient academic and career pathway programs to attract, recruit, train and retain culturally, linguistically and economically diverse individuals into the public behavioral/mental health field. This project is intended to focus on students at the high school, community college and/or undergraduate level who have demonstrated interest in exploring behavioral/mental health careers.

Project Categories

A. Working with Underrepresented Student Populations

Premise: There continue to be disparities in representation in public behavioral/mental health professions and Alameda County needs to both grow and diversify its behavioral/mental health workforce starting at the high school, community college and/or undergraduate level.

Learning Question A. What specific culturally responsive and trauma informed program and curriculum design elements can be included when building a behavioral health workforce pathway at the high school or undergraduate level, that best support skills building, interest in pursuing a career in public behavioral/mental health, and understanding of the requirements necessary to accessing employment in their chosen field, for underrepresented student populations (i.e. consumer, family member, African American, Asian Pacific Islander (API), Latino, Native American, South and Southeast Asian, Emerging Immigrant, and Lesbian Gay Bisexual Transgender Queer Questioning Intersex 2-Spirit (LGBTQQI2S) communities) who may otherwise have a difficult time being retained in a behavioral health pathway?

B. Innovative Partnerships

Premise: Health career pathway programs typically are partnerships between educational institutions (i.e. K-12, community college, four-year institutions) but those partnerships often face challenges and obstacles in implementation, while other community based organizations working with underrepresented youth are often overlooked in pathway development.

Learning Question B. Does working with community based organizations instead of academic institutions (i.e. K-12, community college, four year colleges) offer opportunities to provide skill building and work-based learning to underrepresented high school and undergraduate students interested in pursuing careers in public behavioral/mental health who may otherwise not be captured by the traditional school-to-career pipeline program model?"

C. Funding Models and Sustainability Reporting

Premise: As of yet, there does not exist a fully sustainable funding model for pathway programs looking to grow and diversify the public behavioral/mental health workforce in Alameda County, though there may exist sustainability models in other parts of the state and/or country that could be leveraged to support replicability.

Learning Question C. Does a state-wide and national review of pathway programs supporting underrepresented high school, community college and/or undergraduate students pursuing careers in public behavioral/mental health, offer lessons learned and sustainability models that have achieved success and replicability, and promote growth and diversity within the workforce, that could be leveraged and applied to Alameda County?

D. Industry Preparation And Participation In Behavioral/Mental Health Pathways

Premise: Employers need training in order to host interns at the high school, community college and/or undergraduate level and consistency in training would be valuable in developing a public mental and behavioral health care workforce in Alameda County.

Learning Question D. What is the benefit of developing an employer informed tool kit (including curriculum and training materials) to support public behavioral/mental health agencies hosting underrepresented high school and undergraduate students in internships, and that addresses youth development, trauma informed practices and culturally relevant programming?

E. De-Stigmatizing Public Behavioral/Mental Health Careers

Premise: There remains stigma associated with professions in behavioral and mental health that may limit diversity in the workforce without addressing the issues directly.

Learning Question E. Does the development of curriculum and trauma informed tools, coupled with a work-based learning program for underrepresented high school, community college and/or undergraduate students within public behavioral/mental health agencies in Alameda County, work to destigmatize the behavioral/mental health professions and increase interest in pursuing career pathways in these fields?

F. Mentorship

Premise: Navigating academic and career pathways in public behavioral/mental health is complex and particularly difficult for high school, community college and/or undergraduate students coming from underrepresented backgrounds.

C. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: INNOVATION

Learning Question: Does embedding mentorship in pathway programs between underrepresented high school, community college and/or undergraduate students, and public behavioral/mental health professionals, assist in supporting navigation and understanding of the academic pathway and help to increase interest in the field, knowledge of requirements to proceed into employment, better understanding of employment options, and what types of supports do public behavioral/mental health professionals need in order to mentor underrepresented youth?

FY 17/18 Outcomes

INN4b Grantees were selected through an RFP process. Implementation began in October 2018. Seven grantees were selected to implement high school and undergraduate pathways health/ mental health pathways projects and develop internship program design and tools. With a 18 month implementation period, INN projects are projected to be completed by the end of 2019.

INN 4b Grant Project Descriptions:

1. Tri-City Health Center
   Innovation Project: Warm hand-offs; develop support staff skill sets around BH.

   Partnership with Unitek – MA trainees at Tri-City receive BH certification module. 25 of current MAs will receive BH certification free of charge. Spring and Summer cohorts. If slots are not filled, will offer opportunities to MAs at sister clinics.

2. The Youth Employment Partnership (YEP)
   Innovation Project: Build a trauma/mental/behavioral health vocational pathway for young adults participating in the YEP program. Develop a strategy that leads youth to career in BH field.

3. Mentoring in Medicine and Science (MIMS)
   Innovation Project: Integrate BH into MIMS' work with students at Dewey High

   School – thinking about how to expose students to mental/BH careers. Utilizing

   12-module curriculum created by a partner and integrate it into curriculum for students at Dewey High School. Partners with Merritt College and Roots Community Health Center.

4. Safe Passages
   Innovation Project focus on violence prevention, currently provides continuum of services, including economic development / workforce development. Implementation will include one-year immersive experience for 30 Americorps member cohort to expose them to mental/BH workforce options. Partnership with Safe Passages.

5. Lincoln Families
   Innovation Project: CEO Youth, a program that exposes youth to entrepreneurial

mindset, will pilot a 12 month training program for cohort of 15 young people.

Students will receive training including new hire orientation series, youth mental health first aid, restorative justice, guest presenter series by professionals of color. Project culminates in paid summer internships for youth that include job- shadowing of clinicians of color.

6. Diversity in Health Training Institute

Innovation Project: Focus on high school immigrant students at Oakland International High School by providing different pathways for students to engage with BH:

- Internally focused – Pathway for students to work within the OIHS community; developing self-care tools, education for peers at school
- Externally focused – Pathway for students to learning about community outside of the school (developing professional skills, summer bridge program, community needs assessment – more like an internship)
- Pathway focused on working with immigrant population outside of the school (3-week mental/BH focused training)

7. Health Initiatives for Youth (HIFY)

Innovation Project: Oakland Unified School District (OUSD) health career pathways in three high schools:

- Oakland Tech
- Oakland High School
- Castlemont High School

Three main goals:

- Address issues of lack of young men of color entering
- Reduce stigma around seeking help/helping others for young men of color
- Create marketing campaign: youth will work with health professionals to receive peer health educator training and create a marketing campaign to destigmatize "seeking help" especially for boys of color. Peer health educators will support peers with mental/BH needs.
- Increase interest in mental/BH careers, especially in young men of color.

C. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: INNOVATION

Round Five Innovation Grant Projects

Program Name: (INN 5b) Improving Mental Health Services Utilization for Asian/ Pacific Islanders (API) And Refugees

Program Description

The API population in Alameda County remains persistently underserved or mostly unserved. Specifically, API Medi-Cal beneficiaries and API with a Serious Mental Illness and/or Serious Emotional Disorder continue to have the lowest rate of seeking mental health help and substance disorder treatment. ACBHCS seeks to improve this situation and to help produce a strategic plan to move forward in serving and working with the API community.

The API Utilization Report guided the development of INN Round Five Learning Questions for Round Five grant cycle serving API and Refugees (below) as well as the development of the RFP for PEI Underserved Ethnic Languages Populations Program.

FY17/18 Outcomes

ACBHCS commissioned a consultation report to address the disparity of Asian /Pacific Islanders' (API) low utilization rate of mental health services. The report provided:

a. Review of county demographic data, literature research, and community reports
b. Analysis of BHCS mental health services utilization data, and
c. Input from stakeholders (i.e., providers, consumers, family members, content experts) through community reports, focus groups and individual interviews.

API Utilization Report informed the development of INN 5b Learning Questions:

Learning Questions

1. Can the use of interpretation training and community provider team improve access and utilization of mental health services for service population?
2. How can a culturally defined community centered program decrease stigma and increase engagement with the API community?
3. How can integrated behavioral health & primary care services be incorporated into cultural community based settings providing holistic services?

C. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: INNOVATION

Project Name: K-Stories, Our Stories

Grantee: Korean Community Center of the East Bay

Project Description: An INN Grant project was implemented in FY17/18 to develop a cultural responsive drama intervention to reduce stigma among Korean older adult immigrants and develop leadership among TAY and young adults.

FY 18-20 Changes/ Challenges

Using findings from the API Utilization Report, ACBHCS will conduct a Statewide API Mental Health Empowerment Conference that will connect API individuals and address the API community's underutilization of mental health services on micro, mezzo, and macro levels. The goal is to provide a forum wherein mental health professionals/providers, healthcare providers, law enforcement, elected officials, and the API community can build bridges to establish a common platform and strategic plan for impacting this silence. The goal of the conference is to empower the Alameda API community to help de-stigmatize and raise awareness about this very silent illness with individuals, families, and the community at large. The outcomes of the API Mental Health Empowerment Conference will further inform the RFP for INN 5B Grantees to serve API and refugee communities. RFP is anticipated to be released Spring 2018.

C. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: INNOVATION

INN 5B - CHILDREN/ YOUTH / TAY PROJECT

The FY17/18 MHSA Community Input Process, community members prioritized the top five "absolutely essential" mental health need for children/ youth/ TAY:

1. Suicide (73%)
2. Community Violence and Trauma (71%)
3. Homelessness (70%)
4. Depression (67%)
5. Substance Use/Abuse (63%)

FY18 /19 – 19/20

To respond to the community input and address these essential needs, ACBHCS is planning the following INN 5 grant learning projects, each with an 18 month implementation period.

These INN projects will focus on understanding Children's Mental Health Outcomes and will make recommendations for measurement and accountability in a multi-system context to fill a critical knowledge gap and provide new information about the interplay between children's mental health and other factors including other public systems.

INN5C (1) Trauma Informed Systems (TIS) in School

Project Description

This INN project will address community violence and trauma. TIS will develop and test the Trauma Informed Systems (TIS) model in a school systems that serves children of color, who have been historically and systematically marginalized.

Learning Questions

- How do current approaches to trauma informed practice in schools approach teacher's own trauma history and/or secondary trauma and how do these approaches need to be enhanced to address the experiences of teachers of color?
- Can a trauma-informed systems approach that addresses the needs of teachers of color increase teacher satisfaction and retention?
- What innovations in trauma-informed classroom practices will emerge when teachers of color work intentionally with students of color to address race and sociocultural trauma?
- Will improved teacher wellness and classroom practices lead to improved student behavior?

INN5C(2) Juvenile Justice Center - Team Based Group Model

Project Description:

Innovation project will adapt the primary care medical model of multi-disciplinary team-based group visits to address the physical and mental health of trauma in juvenile justice involved youth. This pilot project will provide primary care, behavioral health, and other follow up services for youth transitioning from the Juvenile Justice Center (JJC) in their reentry into the community.

Learning Questions:

- Can the team-based group visit model used in primary care, improve youth engagement and retention in mental health services?
- Will the group-visit model strengthen the cultural relevancy of services by increasing the number of multidisciplinary, culturally appropriate service delivery teams in the field?

- Can a client-centered, team-based, trauma-informed, and culturally responsive approach (i.e., group visits) to working with juvenile justice involved youth help improve life outcomes by reducing symptoms of trauma and recidivism?

INN5C(3) Understanding children's mental health outcomes: Recommendations for measurement and accountability in a multi-system context.

Project Description:

Currently, there is no framework for children's mental health outcomes that accounts for the joint responsibility of other systems, interpersonal and sociocultural trauma, and the community environment. This project will articulate the implications of these above factors for measurement and evaluation. This will be a timely contribution given recent statewide adoption of the Child and Adolescent Needs and Strengths Assessment (CANS) tool as a common measure. As a result of this project, Alameda County Behavioral Health Care Services Children's System of Care leadership will have a framework for developing meaningful performance measures and making better use of CANS data to understand how the overall system is performing.

Learning question:

How should children's mental health outcomes be measured in the context of multi-system involvement, community environment and interpersonal and sociocultural trauma?

INN5D Grant Project: Suicide Prevention

Project Description

This project strives to reduce suicidality in Alameda County and improve the care and outcomes for individuals at risk of suicide using tools and strategies based on the Zero Suicide Initiative developed by Substance Abuse and Mental Health Services (SAMHSA).

Learning question

What methods or combination of methods and tools/strategies are most effective for the goal of zero suicide for Alameda County?

C. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: INNOVATION

Program Name: Innovations In Reentry (IIR)

Program Description

Innovations In Reentry (IIR) is a pilot grant program designed to spur innovative, creative ideas for addressing the needs of the adult reentry population. Funded by MHSA Innovative funds and AB109, the grant projects contribute to reducing adult recidivism in Alameda County. Innovations in Reentry is not designed to support existing programs or services or provide ongoing grants.

For details, see Innovation in Reentry website (www.innovationsinreentry.org).

FY 16-17 Outcomes

Innovations In Reentry Round 1C

In 2016, seven of the Round 1 grantees were awarded almost $450,000 in six-month Continuation Grants to utilize their original project findings to develop final organizational assets and tools. These project deliverables were developed with the intention of system learning, and may be adopted by other service providers.

Innovations In Reentry Round 2

In July 2016, Alameda County Behavioral Health Care Services awarded $1,029,497 in funding for Round 2 of the Innovations In Reentry Grant Program. The Funding Board, which consisted of reentry experts from local government agencies, community-based organizations, and community stakeholders, recommended seven projects implemented by twelve community-based organizations in the following funding categories:

1. Stakeholder Participation (6 month grant period) – Effective and implementable models or practices to ensure the "voice of stakeholders" is included in significant decisions impacting the design and effectiveness of programs serving reentry or formerly incarcerated individuals in the community.
2. Re-entry Workforce Development for Peer Services (18 month grant period) – Effective and adoptable plans for incorporating formerly incarcerated individuals into the workforce of agencies and programs providing services to the reentry population.
3. Medi-Cal Billing Readiness (6 month grant period) – Development and field testing of a standardized and effective assessment of organizations' capacity and readiness to claim and retain funding through Short-Doyle claiming processes.

Categories 1 and 3 completed their projects in December 2016, while category 2 is ongoing and will conclude in December 2017.

Innovations In Reentry Inaugural Conference

On March 3, 2017, the first Innovations In Reentry Conference was held at Allen Temple Baptist Church. Seven of the Round 1/Round 1 Continuation Grantees, three of the Round 2 grantees, and two innovative projects presented their programs at workshops. In addition, the conference featured keynote speakers and plenary panels with local reentry leaders and consumers to discuss the direction of reentry services for Alameda County. Over 300 individuals attended the conference, including consumers, family members, providers, public protection staff, advocates, local policymakers, and other community members attended the event.

C. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: INNOVATION

Innovations In Reentry Round 1C

Project Name	Grantee	Project Outcome
1. Reducing Recidivism Through Cultural Empowerment	Asian Prisoner Support Committee	Program model and toolkit for culturally competent reentry services for Asians and Pacific Islanders
2. Roots of Labor Birth Collective (RLBC) formerly The Community Doula Project	Birth Justice Project / UCSF Office of Sponsored Research	Program model for incorporating reentry peer collective service organizations as non-profit and other alternative organizational structures
3. ACT (Alameda County Transitional) Program	Centerforce	Training curriculum for providers to most effectively provide re-entry services to people leaving incarcerated settings and returning to Alameda County
4. Model Policies for Reentry Hiring in Alameda County Behavioral Health Care Services	Lawyers' Committee for Civil Rights & National Employment Law Project	Model reentry hiring policy for Alameda County, with a particular focus on health-related agencies. The model policy will allow the County to: 1) expand economic opportunity for people with criminal records; and 2) position itself as a leader in reentry hiring in local, regional, and national forums
5. Street Scholars Peer Mentoring Program	The Gamble Institute	Peer-mentoring and training program focused on academic success for formerly incarcerated students enrolled in one of the four Peralta Colleges
6. The Transformative Leadership Institute	The Mentoring Center	Service methodology manual for inter-generational, gender-specific, culturally-responsive leadership development and mentoring program for young men reentering from incarceration
7. TAY Service Delivery Evaluation Video Project	Youth Uprising & East Bay Community Law Center	Video project sharing best practices from a consumer perspective, consisting of interviews and digital story telling around TAY's experience with service referral and engagement, with highlights of effective practices and barriers to service engagement

C. PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES: INNOVATION

Innovations In Reentry Round 2

Project Name	Grantee	Project Description
Stakeholder Engagement (July 1, 2016 to December 31, 2016)		
1. Reentry Engagement Framework Reentry Leader Fellowship "OUR Project"	Roots Community Health Center, Timelist, & Centerforce	Program model to increase stakeholder capacity and interest in directly impacting program and policy decisions at community/board level
2. Stakeholder Advisory Group	The Reset Foundation	Program model to develop stakeholder capacity to impact program and policy decisions at organizational level
Reentry Workforce Development for Peer Services (July 1, 2016 to December 31, 2017)		
3. Reentry Navigators	Asian Prisoner Support Committee & Building Opportunities for Self Sufficiency	Program model to train qualified peer specialists for case management contracts, using cross-racial dialogue and partnership
4. Community Mental Health Worker Training	Conscious Voices	Program model to train formerly incarcerated women to be community health workers
5. Women Far Above Rubies	E C Reems Community Services	Program model to train qualified peer specialists for case management contracts, focusing on women
6. The Fresh Start Initiative	Genesis Worship Center & Tricities Community Development	Program model to train qualified peer specialists for case management contracts, starting pre-release in jail
7. Trauma Informed Specialists	Oakland California Youth Outreach	Program model to train peer specialists to provide case management services with trauma-informed care
Medi-Cal Billing Readiness Assessment Tool (July 1, 2016 to December 31, 2016)		
8. Medi-Cal Billing Readiness	California Institute for Behavioral Health Solutions & Roots Community Health Center	Standardized assessment tool of organizations' capacity and readiness to claim and retain funding through Short-Doyle claiming processes

FY 18 – 20 Changes and Challenges

Round Three Innovations In Reentry Grant Cycles

ACBHCS is currently in the planning phase for the Round Three Innovations In Reentry Grant Projects. The funding categories are currently in discussion with the Community Corrections Partnership Executive Committee and

Workgroups and the Community Advisory Board. The project categories will be finalized in December 2017, and the RFP is anticipated to be released in January or February 2018.

D. WORKFORCE, EDUCATION, TRAINING (WET) PROGRAM SUMMARIES

Alameda County Behavioral Health Care Services (BHCS), Workforce Education & Training (WET) program follows six strategies to build and expand behavioral health workforce capacity:

1. Workforce Staffing Support
2. Consumer and Family Training, Education and Employment
3. Training and Technical Assistance
4. Internships
5. Educational Pathways
6. Financial Incentives

CHANGES in WORKFORCE, EDUCATION & TRAINING

WET will be completing its ten-year block grant from the Mental Health Services Act at the end of FY 2017/18. BHCS is committed to continue WET activities and currently in the process of shifting WET programs and services to other funding sources. As part of this effort, in November 2017, the WET team conducted an assessment of workforce and training needs with BHCS county and contracted community based organizations (CBOs) through an online survey and a focus group to gather feedback from stakeholders.

The last workforce and training needs assessment was conducted in 2014 as part of MHSA planning, against the backdrop of Affordable Care Act implementation and the shift to an integrated behavioral health care environment. This time, BHCS WET modified the tools from the 2014 assessment to reflect ongoing prioritization of various workforce related activities that the WET team is currently engaged and supporting. Currently the results from the survey and the focus group is being analyzed and a final report will be developed and completed by the beginning of 2018.

The results and data from the 2017 workforce needs assessment will inform our system on further developing BHCS' workforce and training programs in FY 18/19 and FY 19/20. The WET team will also evaluate WET program impact and needs; based on past program outcomes and data, to enhance and implement activities to achieve WET goals in FY18/19.

D. WORKFORCE, EDUCATION, TRAINING (WET) PROGRAM SUMMARIES

WET Program Summaries

Workforce Staffing Support

Program Description: Provides infrastructure to manage the development, implementation and evaluation of all Workforce Education and Training (WE&T) programs and initiatives. Spearheads partnerships with community-based organizations, peer-run agencies, educational institutions and local, regional and state agencies.

FY 16/17 Progress Report

- WET in collaboration with Mental Health Services Act (MHSA) Innovation (INN) conducted a focus group in January 2017 to capture ideas from the stakeholders about the needs and challenges of developing a diverse Mental/Behavioral Health workforce.

- WET INN released an RFP (Request for Proposals) in May, 2017 seeking proposals from qualified organizations through a competitive bidding process for the Behavioral/Mental Health Career Pathways for High School and Undergraduate students. This pilot project is funded by MHSA INN to provide educational and training opportunities to underrepresented and disadvantaged high school and undergraduate students to gain experience in the Public Mental/Behavioral Health.

- WET INN provided funding to eight grantees to implement the pilot projects for eighteen months from October 2017 through June 2019. The total allocation for the project is $2,129,203. MHSA INN funding intended to provide the mental health system with an opportunity to learn from innovative approaches.

- WET INN Collaborative Project hired a qualified consultant to provide technical assistance to the WET INN grantees to help develop Internship Pilot Projects for high school and college students.

- WET participated as a program partner in the implementation of the Alameda County Whole Person Care Plan. Alameda County has been approved by the California Department of Health Care Services to implement its Whole person Care Plan.

FY 17/18 Anticipated Changes:

- BHCS WET does not expect any significant program implementation changes during FY 17-18

3. Consumer & Family Training, Education and Employment

Program Description: Offers an integrated, coordinated approach to consumer and family member employment and supports consumer and family employees at all stages of the employment process, from recruitment to retention. The goal is to develop and retain authentic consumer and family member voices in leadership roles as we develop new wellness, recovery and resiliency practices across the system.

D. WORKFORCE, EDUCATION, TRAINING (WET) PROGRAM SUMMARIES

FY 16/17 Progress Report:

- BEST Now, contracted community based organization provided peer specialist training program with 6 month internships and fifteen participants graduated.

- WET Employment Liaison is co-spearheading planning workgroup to develop peer specialist trainings to build knowledge, skills and abilities; in collaboration with the Consumer Empowerment Team Leadership, Family Empowerment Team Leadership, and the WET Manager.

- Provided Advanced Peer Specialist trainings/educational experiences to build knowledge, skills and abilities including the following:

    - DBT 32-hour online training series for 60 individuals. Outreach and orientation in process; training will take place over one-year and is self-paced.

    - Community Inclusion and Peer Support Training by the Copeland Center with 12-14 trainees each day.

    - Two trainings on "Holistic Service Provision in Mental Health" by Dr. Leonard Ferrara, PhD with a total of 20 participants.

    - Planning and outreaching to provide Hearing Voices Simulation Exercise; pre-loaded mp3 players to 20 participants.

FY 17/18 Anticipated Changes:
Employment Liaison's role changed and have a larger scope than building consumer employment in behavioral health.

7. Training & Technical Assistance

Program Description: Provides a coordinated, consistent approach to training and staff development. Develops, researches and provides a broad array of training related to mental health practice; wellness, recovery and resiliency; peer employment and supports and management development.

FY 16/17 Progress Report:

- Offered or collaborated on a total of 50 training activities; topics including legal and ethical issues, clinical documentation, neuro-developmental issues, substance use disorders, eating disorders, trauma-informed care, Mental Health First Aid and evidence-based practices (EBP) including motivational interviewing, working with families with EBP, SBIRT (Screening, Brief Intervention, and Referral to Treatment), ASAM (American Society of Addiction Medicine) Criteria and more. In addition, 6 Continuing Medical Education (CME) training activities were offered our psychiatric and medical/clinical staff including recovery strategies for medical and behavioral health care, the role of religion and spirituality in psychiatry, primary care and mental health integration

- Managed a continuing and regular meeting (8 x per year) of a 17 member Training Committee composed of

representative staff from county units and community-based organization. The Training Committee advises the Training Officer on training activities related to both clinical and administrative staff throughout our system

- As of mid-October 2017, BHCS applied to CAMFT (California Association of Marriage and Family Therapists) to continue being a CE provider in our trainings for MFT, LCSW, and LPCCs. BHCS WET is awaiting licensing approval and this can take up to 60 days.

- In FY16-17, WET provided 66 training, 2234 people trained, and 307.5 Ce credits.

- Reapply for reauthorization to provide Continuing Medical Education (CME) credits for physicians and other medical staff through the Institute of Medical Quality.

D. WORKFORCE, EDUCATION, TRAINING (WET) PROGRAM SUMMARIES

4. Internship Program

Program Description: Coordinates academic internship programs across the ACBHCS workforce. Meets with educational institutions to publicize internship opportunities and provides training to . Internship Programs.

FY 16/17Progress Report:

- Launched the fifth cycle of Graduate Intern Stipend Program. Current cycle included Clinical Psychology student interns pursing a Doctorate degree. Awarded 20 stipends in the amount of $6,000 for 720 internship hours worked.

5. Educational Pathways

Program Description: Develops a mental health career pipeline strategy in community colleges, which serve as an academic entry point for consumers, family members, ethnically and culturally diverse students, and individuals interested in human services education, and can lead to employment in the ACBHCS workforce.

FY 16/17 Progress Report

- WET in collaboration with Alameda County Health Care Services Agency (HCSA) provided Summer Career Exploration program to high school students from diverse backgrounds, both culturally and socially. 2017 Summer Career Exploration program consisted of five (5) week experiential project-based learning opportunity college and career exploration.

- The WET team collaborated with the BHCS Pool of Consumer Champions (POCC) and Merritt College Medical Assistant program to administer and implement a pilot program that provides education and training to a cohort of four mental health consumers who will receive a certification as a Medical Assistant followed up by placement in a primary care facility such as a Federal Qualified Health Center (FQHC) or another facility designated by Merritt College.

- Center for Empowering Refugees and Immigrants (CERI) implemented a pilot mental health paraprofessional leadership training program for unserved and underserved new and emerging immigrant and refugee communities funded by WET. This program is an extension of the existing MHSA PEI-funded API Connections program which serves unserved Asian and Pacific Islanders. To date, of the original 13 interns, 5 graduates found employment in the Mental/Behavioral Health field at La Clinica, Lao Family Agency, CHAA and a Bhutanese Community Program in Oakland.

- Provided advanced training in “primary care psychiatry” to eight primary care providers in collaboration with the UC Davis Train New Trainers (TNT) Primary Care Psychiatric Fellowship Program.

- Provided clinical education and experience to one selected UCSF Psychiatric Fellow at the BHCS Trust Clinic and she is currently working as a staff Psychiatrist at the Trust Clinic.

D. WORKFORCE, EDUCATION, TRAINING (WET) PROGRAM SUMMARIES

- Co-hosting the fifth Bright Young Minds (BYM) conference in March, 2017 to expose and encourage economically and educationally disadvantaged and or underrepresented high school students to pursue careers in behavioral health.

- WET in collaboration with Health Care Services Agency (HCSA), Alameda County Health Pipeline Partnership (ACHPP) and Oakland Unified School District (OUSD) participated in a 5-week summer internship for high school students from OUSD. 23 tenth and eleventh grade students were exposed to a variety of health careers and opportunities.

- Collaborated with Chabot Community College, Mills College, McClymonds High School, Albany High School and Mentoring in Medicine and Science to provide education activities related to introducing students to careers in Behavioral Health Care. Over 150 students from diverse ethnic and under-represented communities participated in exploring behavioral health care career options.

- Continue partnership and coordination with Berkeley City College on their Public and Human Services program to increase access for our consumers and family members entering community college.

D. WORKFORCE, EDUCATION, TRAINING (WET) PROGRAM SUMMARIES

6. Financial Incentives Program

Program Description: Offer financial incentives as workforce recruitment and retention strategies, and to increase workforce diversity. Financial Incentives are offered to individuals employed in ACBHCS and to graduate interns placed in ACBHCS and contracted community-based organizations, and who are linguistically and or culturally able to serve the underserved and unserved populations of the County.

FY 16/17 Progress Report:

- BHCS continued to partner with OSHPD to implement the State Mental Health Loan Assumption Program (a vital retention strategy).
- Continue to provide employment verification support to applicants and serve as the liaison between applicants and MHLAP staff.
- 50 clinicians in County and contract Community Based Organization (CBO) settings received up to $10,000 towards their outstanding student loans.

FY 17/18 Anticipated Changes:

- BHCS WET does not expect any significant program implementation changes during FY 17-18

FY 18/19 and FY 19/20

- WET will be completing its ten-year block grant from the Mental Health Services Act at the end of FY 2017/18. BHCS is committed to continue WET activities and currently in the process of shifting WET programs and services to other funding sources. As part of this effort, in November 2017, the WET team conducted an assessment of workforce and training needs with BHCS county and contracted community based organizations (CBOs) through an online survey and a focus group to gather feedback from stakeholders. The last workforce and training needs assessment was conducted in 2014 as part of MHSA planning, against the backdrop of Affordable Care Act implementation and the shift to an integrated behavioral health care environment. This time, BHCS WET modified the tools from the 2014 assessment to reflect ongoing prioritization of various workforce related activities that the WET team is currently engaged and supporting. Currently the results from the survey and the focus group is being analyzed and a final report will be developed and completed by mid-December, 2017.
- The results and data from the 2017 workforce needs assessment will inform our system on further developing our workforce and training programs in FY 18/19 and FY 19/20. WET team will also evaluate WET program impact and needs; based on past program outcomes and data, to enhance and implement activities to achieve WET goals in FY18/19.
- BHCS WET will include future WET activities in the FY 19/20 MHSA Plan Update.

E. CAPITAL FACILITIES & TECHNOLOGY NEEDS (CFTN) PROGRAM SUMMARIES

Project Name: South County Homeless Project (SCHP)

Project Description

The South County Homeless Project (SCHP) emergency shelter provides 24 shelter beds for men and women with serious mental illness currently experiencing homelessness. The shelter operates out of a county-owned property located at 259 A Street in Hayward and has not received any significant maintenance or upgrade work since it was first used for this purpose in 1989.

FY17-18 Outcomes

At the request of BHCS with BHCS financing, the Alameda County General Services Agency (GSA) completed an assessment of the property and identified some key areas in need of repairs including the Heating, Ventilation, and Air Conditioning (HVAC) systems, electrical, plumbing, fire safety and prevention systems, and other areas identified in their report. The proposed repairs can be completed within a 30-45 day period provided that the site can be entirely vacated for this time period.

Proposed Timeline:

- Construction to take place six months after notification of current shelter residents. Notification will occur following Board of Supervisors approval of the funding and proposed General Services Agency (GSA) plan for this capital project.
- Work is to be completed in the late spring or summer months of 2018.

FY18-20 Changes/ Challenges

SCHP will continue operations as is until the six month notification date. New referrals after that date will be asked to sign an acknowledgment notice prior to entry that they will need to vacate the property on or before the start of construction. SCHP will work diligently to find permanent housing options for all residents prior to the shelter closing. For those residents unable to obtain permanent housing by this date, BHCS EveryOne Home will provide housing assistance funding for temporary hotel or other accommodations for up to 45 days on a case-by-case basis in consultation with BHCS Housing Services Office staff. During the construction period, program staff will be engaged with helping current residents transition into permanent housing or providing support in other temporary accommodations. Overnight and on-call staff will not be needed during the construction phase. Some one-time program contract funds may be needed to cover the costs of protection, storage, and transportation of items at the shelter. The BHCS Housing Services Office and Network Office will work with BOSS to make adjustments to the FY 17-18 BOSS contract to account for these expenses. These expenses will be covered within the existing contract allocation.

E. CAPITAL FACILITIES & TECHNOLOGY NEEDS (CFTN) PROGRAM SUMMARIES

Program Name: MHSA Technology Project
Program Description
Purchase, installation and maintenance of a new Behavioral Health Management Information System, to include: billing, managed care, e-prescribing functions, data interoperability and functions as needed to support clinical and fiscal operations of BHCS. Additional expenditures for the necessary support staff during the implementation process, and other projects that provide access to consumers and family members to their personal health information and other wellness and recovery supports. In addition, BHCS developed and has implemented Yellowfin, BHCS dashboard of utilization data to facilitate client data collection and outcome evaluation.

CFTN funding is limited to ten years and will end in FY17/18.