MENTAL HEALTH SERVICES ACT

ALAMEDA COUNTY

FY 2014-15, 2015-16, 2016-17
PLAN UPDATE

CONTENTS

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 (CFT)**	• Ten year spending plan • Can choose to add up to 20% of previous 5-year average CSS to Capital Facilities

SUMMARY OF CHANGES FROM PREVIOUS PLAN (FY13-14)

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.

I. Involvement of Community Stakeholders

The participation of community members in the planning process is formalized in the MHSA Stakeholder Group, comprised of and representing consumers, family members and providers. 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.

The participating members of the Stakeholder Group are listed in the table below include consumers, family members and providers with key executive leadership:

MHSA STAKEHOLDER GROUP

Name		Seat	Affiliation / Role
Radawn	Alcorn	BHCS	Interim TAY System of Care Director
Penny	Bernhisel	Provider	Telecare Corp.
Aaron	Chapman	BHCS	Medical Director
Gigi	Crowder	BHCS	Ethnic Services Manager
Margot	Dashiell	Family member	Alameda County Family Coalition
Leda	Frediani	BHCS	BHCS Finance Director
Alane	Friedrich	Mental Health Board	Alameda County Mental Health Board
Karen	Grimsich	Provider	City of Fremont
Elsa	Gutierrez	Consumer	Pool of Consumer Champions
Brian	Hill	Consumer	Brian's Online Success Services
Manuel	Jimenez	BHCS	Behavioral Health Director
Janet	King	Provider	Native American Health Center
Sherri	Millick	Family Member	Family Education & Resource Center

Tracy	Murray	Provider	Area Agency on Aging
Raman	Kular	Provider	Hume Center
Jeff	Rackmil	BHCS	BHCS Children's System of Care Dir
Liz	Rebensdorf	Family Member	NAMI East Bay
Yvonne	Rutherford	Family Member	African American Family Support Group
Lillian	Schaechner	BHCS	BHCS Older Adult System of Care Dir
James	Scott	Consumer	Reaching Across
Gwen	Wilson	Provider	G.O.A.L.S. For Women
Cecelia	Wynn	Consumer	Pool of Consumer Champions

Under the MHSA, Alameda County must prepare and submit an Annual Update to its MHSA Plan. The initial draft of the Plan Update was developed by BHCS Executive Leadership, planning staff and fiscal staff in consultation with the Stakeholder Group over a series of meetings from January to July 2014.

II. Recommended Changes

The following programs areas are new or revised for FY 14-15. See full descriptions below the chart:

1. Strategies to improve health outcomes for African American Consumers and Families	• Design and initiate FSP 10 "African American Men Full Service Partnership" • Design and initiate PEI 20 "Culturally-Responsive Programs for the African American Community"
2. Increase capacity for Voluntary Crisis Services	• Planning for community-based, voluntary crisis services (residential and outpatient)
3. Regional expansion of Behavioral Health-Primary Care Integration	• Expand Promoting Access to Healthcare (PATH) to Central County • Support development of Axis FQHC facilities and operations in East County
4. Behavioral Health - Developmental Disability Services	• Initiate Behavioral Health and Developmental Disability Integration Program
5. Increase Early Childhood services	• Initiate partnership with Public Health • Expand 0-8 outreach
6. Unaccompanied Youth Mental Health Services	• Expansion of School-Based mental Health (Bilingual)

1. STRATEGIES TO IMPROVE HEALTH OUTCOMES FOR AFRICAN AMERICAN CONSUMERS AND FAMILIES

		FY 14/15	FY 15/16	FY 16/17
FSP 10	**African American Men Full Service Partnership**	$500,000	$1,020,000	$1,040,400

Program Description: Multi-disciplinary team that engages African American Transition-Age Youth and Adult male consumers to provide a culturally-responsive array of services as an alternative to services currently provided to this population in more restrictive settings. Services will include, but are not limited to, housing, primary care, education and job training, wellness and recovery and co-occurring conditions treatment. Leadership and staffing of this program will reflect the cultural background and lived experience of this population.
FY 14/15 Plan: Design and develop a full-service partnership utilizing promising practices emerging from the African American Quality Improvement process and the history and experiences of our current full service partnership implementation. Procure and implement services before the end of the FY. **FY 15/16 – FY 16/17 Plans:** Full implementation of this program.

		FY 14/15	FY 15/16	FY 16/17
PEI 20	**Culturally-Responsive Programs for the African American Community**	$500,000	$1,020,000	$1,040,400

Program Description: A broad range of culturally- responsive programs addressing all age groups: Children and Youth, Transition Age Youth, Adult and Older Adults. Services will include, but are not limited to, system-wide training for management, providers and staff within county and contracted service providers; technical assistance and leadership consultation on system change efforts and implementation strategies to support the needs of this population; and service delivery, prevention and early intervention programs.
FY 13/14 Plan: Design and develop an array of training, staffing, technical assistance and direct service programs utilizing promising practices emerging from the African American Utilization Report Quality Improvement process and the history and experiences of serving this population in our current systems of care. Procure and implement prioritized initiative and services before the end of the FY. **FY 15/16 – FY 16/17 Plans:** Full implementation of all initiatives and services within this program.

2. INCREASE CAPACITY FOR VOLUNTARY CRISIS SERVICES

		FY 14/15	FY 15/16	FY 16/17
OESD 23	**Community-Based, Voluntary Crisis Services**	$250,000	$2,036,729	$2,077,465

Program Description: Expand the type and capacity of community-based, crisis services to decrease 5150 rates, increase community-based care and strengthen client transitions and connections to outpatient services. These services may include additional voluntary crisis residential programs, "walk-in" crisis clinics and peer respite. BHCS has reviewed and analyzed 5150 data across the county and mapped the Adult System of Care services. This process has identified crisis gaps in our system, which the planning process will address

FY 14/15 Plan: Through a system-wide crisis services planning process, design and develop an array of services which expand the continuum of care between existing crisis response services and prevention and early intervention programs.

FY 15/16 – FY 16/17 Plans: Full implementation of this program.

3. REGIONAL EXPANSION OF BEHAVIORAL HEALTH-PRIMARY CARE INTEGRATION

		FY 14/15	FY 15/16	FY 16/17
PEI 18	**Behavioral Health Medical Home**	$6,164,103	$1,419,722	$1,288,472

Program Description: Provide BHCS consumers with serious mental illness with access to integrated primary health care services in multiple Alameda County Mental Health Community Support Centers.

FY 14/15 Plan:

- Implement the Promoting Access to Healthcare (PATH) Project at Eden Adult Community Support Center by February, 2015, and operate two half day primary care clinics at the site by June 30, 2015, with at 95 enrolled program participants.
- Using the PATH Project's integration model, implement a half time primary care service in collaboration with Tiburcio Vasquez Health Center at the BHCS Gail Steel Wellness and Recovery Center in Hayward, California by May 25, 2015.
- Working in collaboration with the BHCS Substance Abuse Administration staff, identify at least two ways that SMI consumers served by BHCS community support centers and full service partnerships can have improved access to substance abuse treatment and recovery services available in Alameda County.
- Work with the Alameda Health Consortium to develop ways to get access to the physical health information on SMI consumers served by their network of community health centers so that the PATH Project can better monitor the impact of integrated care on emergency room utilization, hospitalizations (psychiatric and medical), and criminal justice contacts.

FY 15/16 – FY 16/17 Plans:

- Work collaboratively with the BHCS Information System Office to make sure that the new Electronic Health Record System can be utilized by the behavioral and primary care staff that is a part of the PATH Project to share health information on program participants.
- Monitor PATH Project staff to ensure that they are billing Medi-Cal for the client services at the BHCS, adult community support centers.

		FY 14/15	FY 15/16	FY 16/17
PEI 9	**Axis Healthcare**	$1.2M	0.	0.

Program Description: Eastern Alameda County is the fastest growing area in the county and with this rapid growth is a surge in residents who have incomes below 200% of FPL. Axis Community Health is the sole provider of primary care services for the indigent and uninsured population of eastern Alameda County/Tri-Valley. Axis received designation as a Federally Qualified Health Center (FQHC) in 2009. Axis has moved quickly to expand services, capacity and efficiency, with achievements including the receipt of Level 2 PCMH (Patient-Centered Medical Home) designation, full implementation of electronic health records at all sites and in both medical and behavioral health services, and the implementation of integrated behavioral health services. Axis has also received recognition from HRSA (US Health Resources and Services Administration) for exemplary access to care in its prenatal services.

Based on demographic and public health data and population growth trends, ACA implementation would add 9,000 – 10,000 Medi-Cal-eligible patients to the pool of potential Axis patients. The service capacity needed to provide these patients with access to medical homes would be in excess of 75,000 visits annually—more than double the 36,000 visits Axis provided in FY 12/13.

FY 14/15 Plan: Axis purchased a 24,000 square foot property in the Hacienda Business Park in Pleasanton. All site plans and have submitted these plans to the City of Pleasanton for approval. Upon completion, the site will include 27 exam rooms, 8 behavioral health rooms, a laboratory draw station, a pharmacy, a patient classroom and administrative space. Clinic design incorporates the patient centered medical home model and fully integrates behavioral health services with medical services.

FY 15/16 – FY 16/17 Plans: Full implementation of this program.

4. BEHAVIORAL HEALTH - DEVELOPMENTAL DISABILITY SERVICES

		FY 14/15	FY 15/16	FY 16/17
OESD 24	**Behavioral Health and Developmental Disability Integration Program**	$345,714	$345,714	$345,714

Program Description: The Schreiber Center offers mental health services for Alameda County residents aged eighteen and over who are diagnosed with developmental disabilities and experience severe mental health symptoms though a collaboration with the Regional Center of the East Bay (RCEB). Program goals include:

- Promoting integrated health care (Regional Center of the East Bay, Primary Care, Behavioral Health Care Services
- Preventing hospitalization, incarceration and institutionalization
- Providing timely and clinically appropriate interventions in a respectful and culturally sensitive environment
- Helping people with developmental disabilities who also have co-occurring severe mental health needs build knowledge and skills that support wellness.

FY 14/15 Plan: Design and develop an array of services which expand the continuum of care between existing crisis response services and prevention and early intervention programs.

FY 15/16 – FY 16/17 Plans: Full implementation of this program.

5. INCREASE EARLY CHILDHOOD SERVICES

		FY 14/15	FY 15/16	FY 16/17
PEI 1.A	**Early Childhood (0-8) Mental Health Consultation**	$2,511,032	$1,019,994	$1,035,136

Program description: The funds for this program are being used to address two strategies for the 0-8 population that include:

- The provision of matching funds for a SAMHSA grant to develop a system of care for the 0-5 community. This program is called **Early Connections,** an Initiative to strengthen services and supports for children 0-5 and their families; and

- Funding for 2 full time mental health consultants to work with and provide training, consultation and referrals for Alameda County's Public Health Nursing/Home Visiting program that will target families of young children who are beginning to show signs or symptoms of reduced wellness and mental health distress.

- Expansion of outreach and engagement by United Advocates for Children & Families (UACF) which increases the access of families with young children to services that support both the child and the family members in identifying and intervening with troubling behaviors prior to being in the Special Education System and identified as SED (Severely Emotionally Disturbed). This enhances our system's role in preventing children from reaching an acuity level that requires Axis 1 diagnosis and opening cases in our systems of care.

For Upcoming FYs:

Early Connections is currently developing sustainability plans for FY 15-16 and 16-17. So the below numbers are estimates based on current data and initial fiscal planning.

Family Partner Integration Strategy
FY 14-15: 130 young children/families
FY 15-16: 100-150 young children/families
FY 16-17: 100-150 young children/families

Parent Café Peer to Peer Support Group Strategy
FY 14-15: 75 young children/families
FY 15-16: 150-200 young children/families
FY 16/17: 150-200 young children/families

The Public Health Nursing Partnership is expected to grow over the next several years due to the significant need for mental health consultation and referral services for families with young children who are beginning to express signs of mental health distress. So the below estimates are preliminary and may change next fiscal year based on utilization in FY 14/15.

Public Health Nursing/Home Visiting Partnership
FY 14-15: 75-100 young children/families
FY 15-16: 100-125 young children/families
FY 16-17: 125-150 young children/families

6. UNACCOMPANIED YOUTH MENTAL HEALTH SERVICES

		FY 14/15	FY 15/16	FY 16/17
PEI 1.B/C	**Addition to School-Based Mental Health Consultation in Elementary-High Schools**	$500,000	$1,000,000	$1,000,000

There are significant health-related issues faced by unaccompanied youth in Alameda County. Healthcare Services Agency has assessed that a large number of unaccompanied youth are enrolled in the Oakland Unified School District and other school districts with large Latino student populations. While this issue requires an urgent and immediate response, ongoing services may be required to address the long-term needs of this population. Healthcare Services Agency has a significant investment with 26 school health centers in 14 school districts and school-based behavioral health services in 160 schools throughout the county. This new program will leverage these investments and expand capacity of the various "portals to healthcare" to effectively address trauma, other health concerns and caregiver support needs of unaccompanied youth.

Program Strategies:

- Establish "No Wrong Door" resources for school and community-based providers to enable billing for providing trauma-informed behavioral health care services.
- Mobilize the School Health Centers (including Fuentes Wellness Center, REACH Youth Center in Ashland) to serve unaccompanied youth, working with lead health providers to address some of the barriers to financing their care.
- Partner with school districts throughout the County to implement strategies for early identification and triage to address urgent health and mental health issues.
- Mobilize a team of one Clinical Case Manager and two Parent Partners (with Spanish and Mama language capacity) to interface with various partners to ensure that unaccompanied youth and their families/caregivers have appropriate access to health services and supports.
- Deploy youth peer-to-peer outreach and care coordination leveraging our youth development provider community.

III. Public Review Process

The Draft Plan Update was presented to the Mental Health Board at their August 11, 2014 meeting and released for public comment. It was made available on the website www.acprop63.org and www.acmhsa.org with notice sent to the Alameda County MHSA email distribution list. Public comments were received until Monday September 8, 2014, when the Mental Health Board hosted the official public hearing to close the public comment period. Additionally, the Stakeholder Group hosted the following meetings below to receive comments from their constituencies:

August 6, 2014 2:00-4:00pm Hume Center 39465 Paso Padre Parkway, Suite 2100 Fremont, CA	**September 3, 2014** 6:30- 8:30p.m. Family Education & Resource Center 1453-1st Street Pleasanton, CA
August 11, 2014 12:45-1:15pm *Summary Presentation to the Mental Health Board* 1100 San Leandro Blvd Redwood Conference Room San Leandro, CA	**September 8, 2014** 2:00-3:00pm *Public Hearing hosted by the Mental Health Board* 1100 San Leandro Blvd Redwood Conference Room San Leandro, CA
August 15, 2014 1:00-2:00pm Alameda County Vocational Program 333 Heggenberger, 6th Floor - Monterey Room Oakland, CA	**September 11, 2014** 6:30-8:30pm Eden United Church of Christ 21455 Birch St. - Jensen Room Hayward, CA
August 26, 2014 5:30-7:30pm Ed Roberts Campus 3075 Adeline Street Ocher A-B-C Conf. Rooms Berkeley, CA	

"Substantive comments" -- defined as comments or requests for changes that would significantly alter the target population, design or budget of one or more programs -- were received during the thirty-day public comment period and are summarized in **ATTACHMENT A.**

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: Alameda

	MHSA Funding			
	A	B	C	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Prudent Reserve
A. Estimated FY 2014/15 Funding				
1. Estimated Unspent Funds from Prior Fiscal Years	40,299,392	7,390,318	6,544,165	
2. Estimated New FY2014/15 Funding	28,089,880	25,929,120	2,842,000	
3. Transfer in FY2014/15[a/]				
4. Access Local Prudent Reserve in FY2014/15				0
5. Estimated Available Funding for FY2014/15	68,389,272	33,319,438	9,386,165	
B. Estimated FY2014/15 MHSA Expenditures	35,594,166	28,080,693	3,639,623	
C. Estimated FY2015/16 Funding				
1. Estimated Unspent Funds from Prior Fiscal Years	32,795,106	5,238,744	5,746,542	
2. Estimated New FY2015/16 Funding	24,244,220	22,379,280	2,453,500	
3. Transfer in FY2015/16[a/]	0			
4. Access Local Prudent Reserve in FY2015/16				0
5. Estimated Available Funding for FY2015/16	57,039,326	27,618,024	8,200,042	
D. Estimated FY2015/16 Expenditures	37,762,171	27,437,452	4,790,273	
E. Estimated FY2016/17 Funding				
1. Estimated Unspent Funds from Prior Fiscal Years	19,277,155	180,572	3,409,769	
2. Estimated New FY2016/17 Funding	25,736,130	21,923,370	2,509,500	
3. Transfer in FY2016/17[a/]	0			
4. Access Local Prudent Reserve in FY2016/17				0
5. Estimated Available Funding for FY2016/17	45,013,285	22,103,942	5,919,269	
F. Estimated FY2016/17 Expenditures	38,081,279	21,862,233	4,663,153	
G. Estimated FY2016/17 Unspent Fund Balance	6,932,006	241,709	1,256,116	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2014	17,945,553
2. Contributions to the Local Prudent Reserve in FY 2014/15	0
3. Distributions from the Local Prudent Reserve in FY 2014/15	0
4. Estimated Local Prudent Reserve Balance on June 30, 2015	17,945,553
5. Contributions to the Local Prudent Reserve in FY 2015/16	0
6. Distributions from the Local Prudent Reserve in FY 2015/16	0
7. Estimated Local Prudent Reserve Balance on June 30, 2016	17,945,553
8. Contributions to the Local Prudent Reserve in FY 2016/17	0
9. Distributions from the Local Prudent Reserve in FY 2016/17	0
10. Estimated Local Prudent Reserve Balance on June 30, 2017	17,945,553

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 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Alameda

	Fiscal Year 2014/15					
	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	2,454,517	1,744,854	671,289			38,374
2. North County Senior Homeless Program	1,153,606	899,768	185,917			67,921
3. Support Housing for TAY	1,464,308	1,129,550	331,794			2,964
4. Greater Hope Project	1,055,091	925,407	126,533			3,151
5. Small Scale Comprehensive Forensic ACT Team	1,897,248	1,270,304	500,421			126,523
6. Transition to Independence	540,079	429,744	109,934			401
7. CHOICES for Community Living	3,631,780	3,537,057	80,987			13,736
8. Transitional Behavioral Health Court ACT Team	1,692,340	1,496,983	195,357			
9. African American Men Full Service Partnership	500,000	500,000				
10. Individual Placement Services	3,074,311	2,522,245	552,066			
11. Housing Services for FSP	3,032,023	2,694,068	337,955			
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Mobile Integrated Assess Team for Seniors	485,601	328,787	102,468			54,346
2. Crisis Response Program - Capacity for Valley and Tri-City	529,670	317,803	211,867			0
3. MH Court Specialist Program	383,669	284,438	99,231			
4. Juvenile Justice Transformation of Guidance Clinic	352,329	236,221	82,934			33,174
5. Multisystemic Therapy	621,575	468,815	152,760			0
6. Crisis Stabilization Service	3,766,676	1,181,140			2,585,536	
7. Co-Occurring Disorders Program	719,871	670,223	49,648			
8. Residential Treatment for Co-occurring Disorders	4,339,684	3,755,827	310,757			273,100
9. Low Income Health Plan Pilot	7,171,981	2,151,594				5,020,387
10. Wellness Center	3,827,749	2,848,549	979,200			
11. Community-Based, Voluntary Crisis Services	250,000	250,000				
12. BH and DD Integration Program	345,714	345,714				
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	7,458,860	5,605,075	1,853,785			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	50,748,682	35,594,166	6,934,903	0	2,585,536	5,634,077
FSP Programs as Percent of Total	57.6%	29,989,091				

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Alameda

	Fiscal Year 2015/16					
	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	2,454,517	1,744,854	671,289			38,374
2. North County Senior Homeless Program	1,153,606	899,768	185,917			67,921
3. Support Housing for TAY	1,464,308	1,129,550	331,794			2,964
4. Greater Hope Project	1,137,591	1,007,907	126,533			3,151
5. Small Scale Comprehensive Forensic ACT Team	1,859,850	1,270,304	500,421			89,125
6. Transition to Independence	540,079	429,744	109,934			401
7. CHOICES for Community Living	3,631,780	3,537,057	80,987			13,736
8. Transitional Behavioral Health Court ACT Team	1,692,340	1,496,983	195,357			
9. African American Men Full Service Partnership	1,000,000	1,000,000				
10. Individual Placement Services	3,074,311	2,522,245	552,066			
11. Housing Services for FSP	2,982,023	2,653,068	328,955			
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Mobile Integrated Assess Team for Seniors	485,601	328,787	102,468			54,346
2. Crisis Response Program - Capacity for Valley and Tri-City	529,670	317,803	211,867			0
3. MH Court Specialist Program	383,669	284,438	99,231			
4. Juvenile Justice Transformation of Guidance Clinic	352,329	236,221	82,934			33,174
5. Multisystemic Therapy	640,222	482,879	157,343			0
6. Crisis Stabilization Service	3,766,676	1,181,140			2,585,536	
7. Co-Occurring Disorders Program	720,876	671,066	49,810			
8. Residential Treatment for Co-occurring Disorders	4,361,411	3,775,956	310,757			274,698
9. Low Income Health Plan Pilot	6,681,882	2,004,565				4,677,317
10. Wellness Center	4,315,571	2,856,371	1,459,200			
11. Community-Based, Voluntary Crisis Services	1,996,794	1,996,794				
12. BH and DD Integration Program	345,714	345,714				
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	7,442,743	5,588,958	1,853,785			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	53,013,562	37,762,171	7,410,648	0	2,585,536	5,255,207
FSP Programs as Percent of Total	55.6%					

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Alameda

	Fiscal Year 2016/17					
	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	2,500,171	1,790,508	671,289			38,374
2. North County Senior Homeless Program	1,198,950	945,112	185,917			67,921
3. Support Housing for TAY	1,517,742	1,182,984	331,794			2,964
4. Greater Hope Project	1,158,167	1,028,483	126,533			3,151
5. Small Scale Comprehensive Forensic ACT Team	1,894,472	1,304,926	500,421			89,125
6. Transition to Independence	550,836	440,501	109,934			401
7. CHOICES for Community Living	3,665,987	3,571,264	80,987			13,736
8. Transitional Behavioral Health Court ACT Team	1,705,437	1,508,116	197,321			
9. African American Men Full Service Partnership	1,020,000	1,020,000				
10. Individual Placement Services	3,074,311	2,522,245	552,066			
11. Housing Services for FSP	3,005,362	2,676,407	328,955			
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Mobile Integrated Assess Team for Seniors	495,313	338,499	102,468			54,346
2. Crisis Response Program - Capacity for Valley and Tri-City	529,670	317,803	211,867			0
3. MH Court Specialist Program	383,669	284,438	99,231			
4. Juvenile Justice Transformation of Guidance Clinic	352,329	236,221	82,934			33,174
5. Multisystemic Therapy	645,297	492,537	152,760			0
6. Crisis Stabilization Service	3,842,010	1,204,763			2,637,247	
7. Co-Occurring Disorders Program	723,273	673,463	49,810			
8. Residential Treatment for Co-occurring Disorders	4,448,640	3,863,185	310,757			274,698
9. Low Income Health Plan Pilot	6,622,520	1,986,756				4,635,764
10. Wellness Center	4,401,882	2,913,498	1,488,384			
11. Community-Based, Voluntary Crisis Services	2,036,729	2,036,729				
12. BH and DD Integration Program	345,714	345,714				
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	7,250,913	5,397,128	1,853,785			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	53,369,393	38,081,279	7,437,213	0	2,637,247	5,213,654
FSP Programs as Percent of Total	55.9%					

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Alameda

	Fiscal Year 2014/15					
	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	2,511,999	2,511,999				
2. School-Based Mental Health Consultation in Elementary & Middle Schools	1,584,302	1,584,302				
3. Stigma & Discrimination Reduction Campaign	1,132,226	1,132,226				
4. Outreach, Education & Consultation for the Latino Community	1,097,152	1,097,152				
5. Outreach, Education & Consultation for the Asian Pacific Islander Community	1,107,285	1,107,285				
6. Outreach, Education & Consultation for the Native American Community	282,875	282,875				
7. Outreach, Education & Consultation for the So. Asian-Afghan	659,674	659,674				
8. Behavioral Health - Primary Care Integration Project	1,200,000	1,200,000	0			
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Early Intervention for the Onset of First Psychosis & SMI Among TAY	1,419,808	1,190,518	176,378			52,912
12. Mental Health-Primary Care Integration for Latino Older Adults	274,467	274,467				
13. Mental Health-Primary Care Integration for Older Adults at Ers	735,563	636,828	98,735			
14. Suicide Prevention and Trama-Informed Cared	1,335,493	964,011	371,482			
15. Wellness, Recovery and Resiliency Services	2,156,419	2,068,847	87,572			
16. Family Education Center	1,321,586	1,321,586				
17. Staffing to Asian Population (ACCESS)	754,939	682,331	72,608			
18. Staffing to Latino Population (ACCESS)	793,443	513,417	97,198		182,828	
19. TAY Resouce Centers	401,487	401,487				
20. Behavioral Health Medical Home	6,383,171	6,164,103	219,068			0
21. Adult and Older Adult Peer Support	492,437	442,972	29,465			20,000
22. Culturally-Responsive Programs for the African-American Community	500,000	500,000				
23.	0					
24.	0					
PEI Administration	3,958,365	3,344,613	613,752			
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	30,102,691	28,080,693	1,766,258	0	182,828	72,912

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Alameda

	Fiscal Year 2015/16					
	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	1,045,332	1,045,332				
2. School-Based Mental Health Consultation in Elementary & Middle Schools	2,042,819	2,042,819				
3. Stigma & Discrimination Reduction Campaign	1,132,226	1,132,226				
4. Outreach, Education & Consultation for the Latino Community	1,097,152	1,097,152				
5. Outreach, Education & Consultation for the Asian Pacific Islander Community	1,107,285	1,107,285				
6. Outreach, Education & Consultation for the Native American Community	282,875	282,875				
7. Outreach, Education & Consultation for the So. Asian-Afghan	659,674	659,674				
8. Behavioral Health - Primary Care Integration Project	402,178	337,742	64,436			
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Early Intervention for the Onset of First Psychosis & SMI Among TAY	1,344,629	1,115,339	176,378			52,912
12. Mental Health-Primary Care Integration for Latino Older Adults	0	0				
13. Mental Health-Primary Care Integration for Older Adults at Ers	735,563	636,828	98,735			
14. Suicide Prevention and Trama-Informed Cared	1,435,493	1,036,195	399,298			
15. Wellness, Recovery and Resiliency Services	2,336,959	2,249,387	87,572			
16. Family Education Center	1,476,212	1,476,212				
17. Staffing to Asian Population (ACCESS)	772,783	700,175	72,608			
18. Staffing to Latino Population (ACCESS)	622,765	525,567	97,198		0	
19. TAY Resouce Centers	851,487	851,487				
20. Behavioral Health Medical Home	6,588,742	6,353,572	235,170			0
21. Adult and Older Adult Peer Support	492,437	442,972	29,465			20,000
22. Culturally-Responsive Programs for the African-American Community	1,000,000	1,000,000				
23.	0					
24.	0					
PEI Administration	3,958,365	3,344,613	613,752			
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	29,384,976	27,437,452	1,874,612	0	0	72,912

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Alameda

	Fiscal Year 2016/17					
	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	1,026,961	1,026,961				
2. School-Based Mental Health Consultation in Elementary & Middle Schools	2,063,675	2,063,675				
3. Stigma & Discrimination Reduction Campaign	1,151,969	1,151,969				
4. Outreach, Education & Consultation for the Latino Community	1,119,095	1,119,095				
5. Outreach, Education & Consultation for the Asian Pacific Islander Community	1,129,431	1,129,431				
6. Outreach, Education & Consultation for the Native American Community	288,533	288,533				
7. Outreach, Education & Consultation for the So. Asian-Afghan	672,867	672,867				
8. Behavioral Health - Primary Care Integration Project	402,178	337,742	64,436			
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Early Intervention for the Onset of First Psychosis & SMI Among TAY	1,371,522	1,132,969	183,503			55,050
12. Mental Health-Primary Care Integration for Latino Older Adults	0	0				
13. Mental Health-Primary Care Integration for Older Adults at Ers	735,563	636,828	98,735			
14. Suicide Prevention and Trama-Informed Cared	1,464,203	1,056,919	407,284			
15. Wellness, Recovery and Resiliency Services	2,368,848	2,281,276	87,572			
16. Family Education Center	1,505,736	1,505,736				
17. Staffing to Asian Population (ACCESS)	788,239	714,179	74,060			
18. Staffing to Latino Population (ACCESS)	622,765	337,138	99,142		186,485	
19. TAY Resouce Centers	409,517	409,517				
20. Behavioral Health Medical Home	1,814,824	1,587,976	226,848			0
21. Adult and Older Adult Peer Support	492,437	442,972	29,465			20,000
22. Culturally-Responsive Programs for the African-American Community	1,020,000	1,020,000				
23.	0					
24.	0					
PEI Administration	3,560,202	2,946,450	613,752			
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	24,008,566	21,862,233	1,884,797	0	186,485	75,050

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Alameda

	Fiscal Year 2014/15					
	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.	3,639,623	3,639,623				
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					
INN Administration	0					
Total INN Program Estimated Expenditures	3,639,623	3,639,623	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Alameda

	Fiscal Year 2015/16					
	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 Program	4,790,273	4,790,273				
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					
INN Administration	0					
Total INN Program Estimated Expenditures	4,790,273	4,790,273	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Alameda

	Fiscal Year 2016/17					
	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 Program	4,663,153	4,663,153				
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					
INN Administration	0					
Total INN Program Estimated Expenditures	4,663,153	4,663,153	0	0	0	0

Full Service Partnership (FSP) Programs: The following measures are being adopted by all full service partnership programs and included in future contract language:

Outcome Measures:

1. At least 85 percent of clients (50% for TAY) shall have a primary care within 12 months of enrollment, after being enrolled for at least 12 months.

2. 80 percent of clients shall be in long-term, stable housing within 24 months of enrollment.
    A. Among 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 (General Living Arrangement or Supervised Placement).
    B. Among 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. Client use of psychiatric hospitalizations and emergency services shall decrease 50 percent post-enrollment, compared to data for 12 months prior to enrollment.

4. The number of partners incarcerated shall decrease 55 percent within 12 months of enrollment, compared to 12 months prior to enrollment.

5. Employment & Education (being developed further)

Process Measure:

6. 90 percent of the clients who enter the program shall have Medi-Cal application or reinstated benefits 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.

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.
FY 12/13 Outcomes, Impact & Challenges: See **ATTACHMENT B** "HOST Adult Full-Service Partnership Program Outcomes …through December 2013".
FY 13/14 Progress Report: Implementation proceeding as planned including graduation procedures and transfer (step-up/step down) procedures to lower levels of care including successful transfers to and from other Level I teams.
FY 15/16 Plans: No significant changes planned. Continued implementation of graduation procedures leading to increased flow of HOST partners to lower levels of care.

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.

For previous FY 12-13 Outcomes, Impact & Challenges :

Number of clients served: 44
Number of new enrollments: 14
Number of discharges to lower level of care: 14

Number of clients who avoided psychiatric hospitalizations during the following initial enrollment periods:

- 3 months: 93%, 13 of 14 clients
- 6 months: 93%, 13 of 14 clients
- 12 months: 93%, 13 of 14 clients

Number of clients who avoided medical hospitalizations during the following initial enrollment periods:

- 3 months: 100%, 14 of 14 clients
- 6 months: 93%, 13 of 14 clients
- 12 months: 100%, 14 of 14 clients

Number of clients who retained housing of their choice during the following initial enrollment periods:

- 3 months: 84%, 12 of 14 clients
- 6 months: 84%, 12 of 14 clients
- 12 months: 93%, 13 of 14 clients

Number of clients who received primary care serves within the following initial enrollment periods:

- 3 months: 100%, 14 of 14 clients
- 6 months: 100%, 14 of 14 clients
- 12 months: 100% 14 of 14 clients

Participants receiving support from NCSHP have had success connecting to primary care services. Supporting participants to receive primary care is critical for the older adult population, many of whom have been disengaged from both physical and mental health services for many years resulting in complex needs that require intensive care coordination. The team meets the challenges that arise for participants when mental health related symptoms, such as paranoid ideation, manifest as behavior that are often received as a barrier to health care services by providers in the community. NCSHP team members use a flexible and person-centered approach to support participants to accept care. For example, participants may be open to receiving psycho-education on topics such as diabetes in their home prior to accepting medical care for such conditions.

For current FY 13-14 Progress Report:

Number of clients served: 37
Number of new enrollments: 8
Number of discharges to lower level of care: 6

Number of clients who avoided psychiatric hospitalizations during the following initial enrollment periods:

- 3 months: 87%, 7 of 8 clients
- 6 months: 100%, 8 of 8 clients
- 12 months: 87%, 7 of 8 clients

Number of clients who avoided medical hospitalizations during the following initial enrollment periods:

- 3 months: 100%, 8 of 8 clients
- 6 months: 87%, 7 of 8 clients
- 12 months: 100%, 8 of 8 clients

Number of clients who retained housing of their choice during the following initial enrollment periods:

- 3 months: 87%, 7 of 8 clients
- 6 months: 87%, 7 of 8 clients
- 12 months: 100%, 8 of 8 clients

Number of clients who received primary care serves within the following initial enrollment periods:

- 3 months: 100%, 8 of 8 clients
- 6 months: 100%, 8 of 8 clients
- 12 months: 100% 8 of 8 clients

For the current year 36 of 37 NCSHP participants have spent 0 nights as homeless. The team has had success working with participants to utilize resources in their communities and natural supports to find shelter and housing.

Early in the year the team promoted a peer support counselor who had been with the program since the inception of the program. While the promotion was well deserved and the staff person is still with the organization, the absence of this team member left a personnel and service gap. The team strategized for appropriate terminations between the staff person and participants. The team is actively pursuing qualified candidates with lived experience to fill the position by June 2014.

For upcoming FY 14-15, FY 15-16, FY16-17 Plans:
The NCSHP team will serve a total of 40 partners at any given time in the coming fiscal year. BACS will explore cost effectiveness and client care benefits of providing psychiatry in house and primary care services as part of the organization's continuum of care. BACS considers the increased access health care as a primary benefit to NCSHP participants.

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.

For previous FY 12-13 Outcomes, Impact & Challenges :

On average, STAY served 48 participants who were homeless or imminently homeless at the time they entered the program, thus reducing homelessness in the community. Based on MORS scores and hospitalization and incarceration data provided at the time of enrollment, STAY continued to reduce the number of hospitalizations and incarcerations by stabilizing participants in the community via intensive community based case management services. Of these 73% were safely housed in either permanent or transitional housing. STAY implemented SAMHSA evidence-based practice of Individualized Placement Support/Supported Education to assist these young adults to gain competitive employment, and our first participant in that program obtained competitive employment in May. STAY also successfully implemented three new groups: one peer support group for young women, one DBT group and one peer support group for young men. We also successfully implemented a new housing subsidy plan that encourages participants to engage in productive activities (e.g. employment) to increase their income.

- 55% of participants who were discharged were transitioned with permanent housing in place and to a lower level of care.
- The number of participants exiting STAY on a planned basis to the same or lower level of care was 90% compared to 75% during the 2011/12 fiscal year.
- Over the year we increased the percentage of participants who were linked to primary care from 33% to 50%.
- For the first half of the fiscal year an average of 44% of participants were seeking employment (e.g. engaged in supportive employment programs or actively working with STAY team to explore employment options). For the second half of the fiscal year the number of participants seeking employment increased to an average of 53%.

For current FY 13-14 Progress Report:

STAY served 56 participants during the fiscal year who were homeless or at risk of homelessness and living with a significant mental health disability. As evidence of working towards our objective of assisting participants with maintaining housing stability, of the 56 served: 36 (64%) were placed in and maintained either permanent or transitional housing. During this period STAY discharged 14, 11 of which were planned discharges. Of the 11 planned discharges:

- 7 (64%) exited the program with permanent housing.
- 6 (55%) exited the program and went to a lower of care.
- 5 (45%) exited the program to the same level of care.

During this period progress was made with regard to competitive employment. Through the SAMHSA evidenced-based practice of Individual Placement Support/Supported Employment (IPS) program which helps participants obtain competitive wage employment, STAY was able to provide

employment services to 28 participants (50% of the total number of participants served). As evidence of working towards our objective of increasing the number of participants who are competitively employed, of the 28 served by IPS participants:

- 12 (42%) were engaged in competitive employment at some point during the FY'13-14.
- Of the 12 employed, 5 (41%) have maintained their jobs for at least 3 to 6 months.

With regard to employment, STAY also became a Department of Rehab vendor which will allow us to provide participants with extra support as they work towards their vocational or educational goals.

In support of our objective to increase the number of groups offered through STAY: During this period we developed and implemented two Dialectical Behavioral Therapy (DBT) groups to assist participants with managing mental health symptoms as well as an ongoing Drop In Group for TAY that focuses on Independent Living Skills, peer connection and support, and improvement of activities of daily living.

In summary: Based on Milestones of Recovery Scale (MORS), for FY'13-14 the average number of participants that were in the 6 – 8 range on the scale (i.e. rehabilitated or in full recovery) increased slightly to approximately 40% suggesting that the trend from FY'12-13 of decreasing hospitalizations, incarcerations and community stabilization continued; and the number of participants that experienced planned discharges to the same or a lower level of care increased from 90% to 100%. During the upcoming 3 year period STAY will continue to work towards starting a monthly family group as well as building upon our efforts to increase the rate at which we link participants to primary health care (and effort to be significantly supported when FFYC opens a Wellness Center in Fall '14).

For upcoming FY 14-15, FY 15-16, FY16-17 Plans:

In support of the overall outcome goal of improving the participant's condition and/or life through the services we provide, STAY will focus on increasing the number of participants that retain housing as well as supporting participants with achieving their employment goals.

FSP 4. Greater Hope Project

Program Description: Engages homeless people through street outreach, through the HOPE Project Mobile Health Clinic and community referrals. Once engaged, the program offers housing, intensive mental health wrap-around service coordination, medication management, counseling, educational/vocational support, recreational opportunities, and peer mentoring.

For previous FY 12-13 Outcomes, Impact & Challenges:

32 clients avoided hospitalization – in emergency room or psychiatric facility for 3 months after enrollment in the Greater HOPE program; 35 after 6 months of enrollment; and, 36 after 12 months of enrollment.

34 clients retained housing of their choice for 3 months after enrollment in the Greater HOPE program; 36 for 6 months after enrollment and 38 for 12 months after enrollment in the Greater HOPE program.

30 clients received primary care services within 3 months after enrollment in the Greater HOPE program; 35 after 6 months in the program and 41 after 12 months in the program.

Many of these individuals were highly visible in the Southern, Eastern, and Central part of Alameda County as well as high end users of emergency services until they were subsequently housed and began receiving Greater HOPE services.

There continues to be a far greater need in the community than there are resources.

Affordable housing in Southern and Eastern Alameda continues to be a challenge. Additionally, vacancy rates are so low in these areas, land lord are choosing to work with subsidized housing program less often and this can make finding housing challenging.

With regards to moving people on to other housing in the community, there are few affordable or subsidized options in Southern and Eastern Alameda county. Moving on for people in the Greater HOPE program, often means uprooting everything and moving to Oakland to a brand new and unfamiliar community.

For current FY 13-14 Progress Report:
Greater HOPE is in the process of determining those 5-7 participants that could move on to a lower level of care and receive a housing subsidy through an alternative source. Some of these participants may continue to receive Greater HOPE services during a transitional period. Conversely, other participants may be at a place in their recovery that they are able to find employment and become increasingly impendent of outside resources. Simultaneously, Greater HOPE continues to get referrals and engage in outreach to some of the most highly visible homeless members of our community.

For upcoming FY 14-15, FY 15-16, FY16-17 Plans:
Greater HOPE will continue to target housing, case management, mental health, psychiatric, vocational rehabilitation and primary care services to 43 severely mentally ill adult participants

The program will be moving to Hayward within the next 6 months. As we move people out of Southern and Eastern Alameda county into more affordable housing in Central and Northern Alameda County, the program will be more centrally located and thus be accessible to program participants.

Greater HOPE also will continue to consider strategies to address the need to broaden our efforts within the scope of available resource.

FSP 5. Forensic Assertive Community Treatment (FACT)

Program Description: Forensic Assertive Community Treatment (FACT), a program of the East Bay Community Recovery Project, is funded by MHSA Prop 63 through its contract with Alameda County Behavioral Health Care. FACT specifically serves persons who have a history of excess utilization of the criminal justice system—jail and court services—and psychiatric and medical emergency services. These individuals have long histories of living with severe mental health and co-occurring substance misuse and other medical issues. FACT follows the ACT model, which utilizes a multi-disciplinary treatment team to provide assertive outreach and engagement to this population. Once engaged, FACT provides subsidized housing, intensive case management, psychosocial habilitation or rehabilitation for daily living, psychiatric evaluation and treatment, medical triage, substance misuse counseling and assistance to detox/treatment, individual and group peer support, employment and educational assistance, and crisis intervention services. FACT provides the vast majority of its services in the community, meeting our partners "where they are."

For previous FY 12-13 Outcomes, Impact & Challenges:

- The program implemented the use of the Milestones of Recovery Scale as a tool to support the teams clinical decisions in determining partner's readiness for transition to a lower level of care. Several FACT partners have successfully graduated and transitioned to Wellness centers for continued support. The FACT program continued to reduce and in most cases eliminate its participant's involvement in the criminal justice system and or their need for psychiatric emergency services. Partners continued to be supported in their efforts for beginning and or returning to school and competitive employment. All graduates are living in affordable housing that is subsidized independent of the program. The graduates participated in our monthly leadership group which plays an integral role in the mentoring of new partners and the planning for and participation in our on-going community meetings.
- Streamlining of measures compendium administered to partners to effectively and efficiently measure change over time
- Increased support and technical assistance from an external evaluator to help prepare Annual Program Report

For current FY 13-14 Progress Report:

FACT is continuing to graduate individuals from the program and transition them to a lower level of care for continuing less intensive services. As of July 2014 FACT has graduated and transitioned a total of 14 participants all of whom have stabilized and have not accessed psychiatric or medical emergency services or been incarcerated in at least 6 months or longer. These graduates are now receiving treatment services through wellness centers, service teams, or through private providers in the community.

For upcoming FY 14-15, FY 15-16, FY16-17 Plans:

Continue implementation and graduation plan for partners.

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.

For previous FY 12-13 Outcomes, Impact & Challenges:

TIP served a total of 37 clients. On average, participants' hospital admissions in the first 12 months after enrollment was decreased by 41%; number of participants enrolled in schools (GED, community colleges, UC system) increased by 27%; 95% participants are housed (14 participants

obtained independent housing through MHSA and Section 8; 13 participants retained housing of their choice (living with parents or family members); number of participants who are employed increased by 8% (competitive and supported employment).

One of the biggest challenges was the lack of permanent housing and competitive employment for TAYs. In order to encourage independent living for our TAYs, participants are encouraged to apply for affordable housing opportunities in different cities and counties. In terms of employment, participants are encouraged to apply for supported employment, volunteer opportunities, and vocational trainings to build up their resumes.

Based on a Total of 37 participants

Psychiatric Hospitalizations

- Number of psychiatric hospital admissions:
  - 12 months prior to enrollment 86
  - First 12 months of enrollment 35
  - Decrease in number of hospital admission 41%

Education

- Number of participants in school or taking classes
  - 12 months prior to enrollment 6
  - First 12 months of enrollment 10
  - Increase in number of participants in school or taking classes 60%

Housing

- Number of participants who obtained independent housing of their choice: 14
- Number of participants who retained housing of their choice (living with parents or family members): 13
- Number of participants who are homeless: 2

Employment

- Number of participants who are employed:
  - 12 months prior to enrollment 0
  - First 12 months of enrollment 0
  - Most recent 12 months of post enrollment 3
  - Increase in number of participants who are employed 8%

For current FY 13-14 Progress Report:
TIP serves participants who live throughout Alameda County. For the current year, TIP collaborated with FERC/Transitional Age Youth-Family Member to increase support to our participants, family members, and care takers as well as increasing their skills in learning and implementing WRAP.

For upcoming FY 14-15, FY 15-16, FY16-17 Plans:
Continue to support the transition of TAYs to independent living by obtaining or retaining housing of their choice, by completing educational goals, and by obtaining competitive employment. Expand services to 40 TAYs per year.

FSP 7. CHOICES for Community Living

Program Description: This FSP is a transformational program for Service Teams that integrates supportive housing, supportive employment, peer counseling and strength-based and person-centered case management to enable clients to graduate into a fuller life in the community without the need for the Service Team.

FY 12/13 Outcomes, Impact & Challenges:

- Throughout the year, one hundred and eighty two (182) unique Partners were served from three different cohorts in the CHOICES Program.
- CHOICES celebrated its first graduation event on October 31st, 2013 with fifty-eight (58) Partners from the first cohort successfully completing the program. Partners and their families were extremely proud of their accomplishments. Many Partners shared about their journey publicly at the event. Each Partner received a framed letter from President Obama congratulating them on their accomplishment.
- Thirty-four (34) Partners were actually discharged from their Service Team. Partners that did not achieve fully graduation will continue to work on their recovery path while still needing the additional supports provided by the Service Team staff.
- While all stakeholders in the CHOICES Program were planning the first graduation event, five (5) additional teams were being oriented toward starting a third cohort in November/December of 2013. The orientation process involves engaging the managers of each program to insure that the organization and new CHOICES case manager from that team are aligned with the vision and values of the MHSA/CHOICES Program. In addition, there are technology and documentation requirements that each team must become oriented to as well.
- The second cohort continued their journey with fifty (50) active Partners out of the original (57) Partners who enrolled in the CHOICES Program.

Housing Services Outcomes:

- Eighty-nine percent (89%) of the CHOICES Partners from the first two cohorts who sought housing services reported that they were in their preferred or most preferred housing.
- Seventy-two percent (72%) of CHOICES Partners from cohort #1 had been able to maintain independent living or improved their independent living environments prior to graduation.
- Sixty-five percent (65%) of CHOICES Partners from cohort #2 were able to maintain their independent living or improved their independent living environments by February 2014.

Employment Services Outcomes:

- Seventy-seven (77) CHOICES Partners from the first two cohorts who sought supported employment (IPS) services achieved their preferred or most preferred employment outcomes. This represents a Seventy-three percent (73%) success rate.
- Fifty-eight (58) Partners received job placements in competitive employment jobs.
- Forty-two (42) Partners worked for more than 90 days in these placements.
- Some Partners started the CHOICES Program with pre-existing competitive employment jobs.

Wellness, Recovery and Resiliency Outcomes:

- Survey instruments were conducted by Consumer Research Assistants designed to measure changes in functioning, well-being, recovery and quality of life. The annual surveys consisted of an hour long interview and a compilation of (212) items from several integrated survey instruments. These surveys were measured upon admission in the program and yearly thereafter.
- Almost every recovery marker showed a statistically significant improvement in overall

functioning.
- In cohort #1 there was a 24% improvement in living situation; a 15% improvement in talk/get together with family and a 12% improvement in being comfortable about money resources.
- In cohort #2 there was a 21% improvement in living situation; a 17% improvement regarding their Stage of Recovery and a 15% improvement regarding their perceived progress.

Challenges:
- During the CHOICES Program, seventeen (17) Partners required acute hospitalization. CHOICES Recovery Coaches and Personal Service Coordinators continued to provide support to these Partners resulting in eight (8) of those Partners continuing with the CHOICES Program after discharge from the acute facility.
- Additionally, eleven (11) Partners became incarcerated while participating in the CHOICES Program. The CHOICES staff continued to provide support to these Partners and seven (7) of these Partners were able to continue in the CHOICES Program after being released from jail.
- Partners reported no significant change in some of the following areas:
    - The way things are in general with my family
    - Feeling safe from victimization
    - Indicators for substance abuse
    - Taking medications just as they are prescribed
    - Losing control of behavior

Team Facilitation and Accountability:
- Facilitation of Team Meetings that integrates services from three different domains and organizations from nine different team cultures continues to be a challenge.
- The domains of housing, employment and recovery coaching each have their own language, best practices, values and perspectives. It should be noted that the Personal Service Coordinator and their supervisor do not directly supervise the other domains that are at the table.
- Coordinating the various services/service providers and strength-based person-centered treatment planning in collaboration with the Partner both continue to be challenging for the teams to accomplish; even though there is a great benefit to the diverse perspectives that are shared with everyone in the team.

Staff/Systems Change Outcomes Reported but not Quantitatively Measured:
- Change in how Housing, Employment and Recovery Coaching Programs organize, supervise and deliver services because of the CHOICES Program.
- Change in CHOICES staff approaches to working with clients on their recovery.
- Change in broader BHCS system approach to working with clients on their recovery.
- Improvements in CHOICES team integration of working among the four domains (i.e. a model for disseminating this out to the larger BHCS system.)
- Change in non-CHOICES service team staff in their approach to working with clients on their recovery.

FY 13/14 Progress Report:

- The third cohort has become increasingly engaged with housing, employment and wellness classes at the CHOICES Learning Center. The program continues to adjust the approach based on the continuous quality improvement process that staff and Partners are actively engaged with.
- The second cohort is actively preparing for graduation. It became very clear with the first cohort graduation that primary care and community psychiatry are resources that need to be engaged early in order to get Partners well connected before graduation.
- The CHOICES all-staff meeting continues to provide educational opportunities to integrate best practices into the services being provided. So far, there have been presentations on how to provide supported educational opportunities for Partners that may want to pursue a career path that requires a certificate or degree. There have been presentations on benefits, housing first, and managing transitions as individuals and as a program experiencing a significant degree of change.

FY 14/15 Plans:

- CHOICES Policy Committee, CHOICES Operations Group, Service Team Directors and Partners are reviewing what we have learned in CHOICES that has worked very effectively to help facilitate the process of recovery and eventual graduation from Service Teams to a fuller life in the community.
- It is clear from these focused conversations that the dedicated resources of recovery coaches, employment specialists, housing specialists and a recovery learning center with a program coordinator are necessary to continue the MHSA transformation of sixteen service teams in twelve programs,
- .The CHOICES Program is reviewing the most effective approach to utilizing these existing resources to support the 3,500 consumers on these service teams; as well as the staff at all levels to continue to support recovery journey progress and graduation from service teams to a fuller life in the community.

FY 15/16 Plans:

- The CHOICES staff in the domains of employment, housing and recovery coaching/wellness classes can be effectively resourced to serve at least two hundred (200) consumers from 12 Service Team sites each year.
- The transition from a three year CHOICES program to a set of resources that will be more fully integrated into twelve (12) Service Team sites will take this year to work out all of the challenges with this change in the program.
- This change will allow consumers at each of these 12 Service Team sites to access IPS employment supports, educational supports, housing supports and wellness/recovery supports when they are ready to become active in any of these targeted services.
- The Program Director will be responsible to insure effective integration of the best practices from these three domains into the (12) Service Team sites as well as a continuation of integrating strength-based person-centered and accountable team practices in each of these programs.

FY 16/17 Plans:

- The resources from the CHOICES Program will be fully integrated into all Twelve (12) Service Team sites serving over 200 consumers every year. The Service Teams will be successfully graduating one hundred (100) or more Partners every year.
- Consumers from each site will be able to access classes focusing on recovery in each of the domains of wellness as soon as they express an interest, such as WRAP, wellness, community

resources, and graduation readiness.
- Consumers from each site will be able to get an employment specialist to work with them on obtaining competitive part time or full time employment as soon as they express an interest.
- Consumers from each site will be able to learn about creating a home for themselves and what options and resources are available to obtain affordable housing.
- Consumers will have a place to go to find peer support, learn and grow and discover their hopes and dreams to create a better life for themselves in the community.

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

Program Description: TrACT (Transitional Assertive Community Treatment) a program of the East Bay Community Recovery Project is contracted through Alameda County Behavioral Health Care using MHSA Prop 63 funding. TrACT, a full service partnership program, is the dedicated service provider for the Alameda County Behavioral Health Court and is to maintain an active caseload of 20 participants. TrACT has been providing intensive wraparound mental health, co-occurring substance misuse 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. These individuals 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 offence. BHC/TrACT is voluntary in nature and individuals choose to participate in the court program instead of having their cases proceed in the regular court process. Their charge or qualifying charges, as related to this particular offence, is expunged from their record with their successful completion of the BHC program.

For previous FY 12-13 Outcomes, Impact & Challenges:
- TrAct had an average monthly census of 18 partners and six newly enrolled partners.
- TrAct discharged partners with a completion of at least 6 months in the program, all of which had income, insurance benefits, housing, and primary medical care.
- TrAct graduated partners who were transferred to service teams and wellness centers.
- Streamlining of measures compendium administered to partners to effectively and efficiently measure change over time
- Increased support and technical assistance from an external evaluator to help prepare Annual Program Report

For current FY 13-14 Progress Report:
Seven participants successfully completed the Behavioral Health Court July 8, 2014, and have been referred to a lower level of care for services. This is the largest number of graduates since the court's inception and is a significant accomplishment given that maintaining mental health stability and sobriety over the course of the 12 month TrACT and 24 month BHC program has proven difficult for participants over the first several years of the program. Relapse is often a part of a participants' experience with the TrACT and court program. The key to an individual's ability to commence from the court is their desire to do whatever it takes, with support services from the TrACT team and encouragement from the Court, to achieve sobriety and mental health stability. Permanent housing and housing, employment, and education support services are key to individuals' wellness and recovery efforts as they address common issues of loneliness and boredom and help to meet the hopes and dreams of the participants.

For upcoming FY 14-15, FY 15-16, FY16-17 Plans:
Continue implementation and graduation plan for partners.

OESD 4A. Mobile Integrated Assessment Team for Older Adults

Program Description: Increases access for homebound seniors through the use of mobile geriatric mental health teams.

FY 13/14 Outcomes, Impact & Challenges:

- Exceeded contracted units of service. Provided 847 home visits to 85 older adults to reduce isolation; decrease 911 calls and ER visits. Through counseling and medication management supported clients with severe mental illness to remain successfully living at home.
- Client's need case management support to coordinate complex health needs, including chronic disease management and acute medical needs. Many clients have not accessed mental health services in the past and have a lot of unmet needs.

FY 14/15 Plans:

- Increased support for clients through intern partnerships with several Schools of Social Work/Counseling. Currently have 6 interns embedded in program. Close collaboration with Afghan Elderly Association to support older Afghan adults with PTSD/Anxiety symptoms. Holding support groups at Senior Housing that has dedicated ACBHCS residents to increase access to services.
- The clients who discharged from the program last year had an average length of stay of 5.5 months. It is challenging for clients, especially those who are isolated, to discharge from the program. We hope to develop more step-down options for clients in the future.

OESD 5A – 5B. Crisis Response Program – Trivalley & Tricities

Program Description: Augment ACCESS services with clinical and peer staff dedicated to East and South County.

FY 13/14 Outcomes, Impact & Challenges:

- CRP sites continue to assign to Level 1 and Level 2 Programs.
- There has been an ongoing need for additional services, particularly Level 2, in East County.
- Many consumers who had Health PAC transitioned to MediCal. This was not a smooth process and impacted CRP's ability to refer consumers to appropriate resources.
- Our Livermore office is co-located with FERC (Family Education Resource Center). Initially, this co-location was going to include additional programs, but that did not happen so there are very few employees at this site. The site is located away from many of the other services that our consumers use and there is very little "walk in" traffic.
- East County Crisis Response Programs served 134 consumers in 2013.
- Fremont CRP served 292 consumers in 2013.

FY 14/15 Progress Report:

- Portia Bell Hume is now offering Level II services in East County.
- Fremont CRP continues to serve a culturally diverse group of consumers.
- CRP hired a new psychiatrist in our Fremont site. She has worked with CRP for four years in East County and previously worked at Tri City Community support Center for 14 years so she is very familiar with the population and services available in the area.
- Though MediCal can still take some time to get approved, the process is running a bit more smoothly and consumers are able to get services more timely.
- CRP has met with Livermore PD and Pleasanton PD and can consult and collaborate with local law enforcement as needed. The East County CRP clinician continues to provide community outreach and partner with agencies as needed.
- There is not adequate staffing available at the Livermore site to provide necessary support so Livermore residents will be served at the Pleasanton site for the time being. Once another location is identified, services may resume in Livermore.
- East County provided services to 147 consumers and to 233 consumers in Fremont in 2014.

FY 15/16, 16/17 Plans: No significant changes planned.

OESD 7. Mental Health Court Specialist (Court Advocacy Program)

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 12/13 Outcomes, Impact & Challenges:

On a daily basis CAP staff connect criminal justice-involved individuals with mental illnesses to appropriate community service programs based on individual needs. Community programs include mental health treatment providers, case management teams, dual diagnosis services, housing, referrals to sub acute facilities etc.

CAP staff provides direct and indirect services such as consultation, assisting other agencies, facilitating connections / services for clients, advocating with attorneys and judges, etc. Currently, the data / statistics on indirect services is not tracked. The only data that is available is for clients who are officially opened to BHCS direct services.

Community Impact: On a daily basis, CAP staff work across multiple agency lines to

1. successfully connect clients with appropriate community services,
2. prevent clients from leaving jail without a follow-up care plan and housing,
3. reduce / mitigate the length and impact of incarceration.

Without CAP assistance, many clients would have longer jail stays, and, when released, would leave jail without any assistance. We have not had the capacity to track this data.

CAP staff work with court personnel to reduce criminal charges and length of time in jail for clients with mental illnesses by securing placements / community care plans.
We have not had the capacity to track this data .

Challenges:

1. Availability and access to community programs. Community programs may be full or not willing to accept referred clients.
2. A system is needed to gather and track the full range of CAP staff activities.
3. Streamline the jail release process for CAP clients to simplify and make more efficient.
4. Difficulty engaging clients who are resistive to, or refuse services and continue to cycle in and out of jail.
5. Cooperation of some court personnel (such as defense attorneys) who may seek different outcomes for their clients.
6. Mental health education for court staff including judges and attorneys.
7. Relationship-building with court staffs can be challenging due to frequent rotation of judges and attorneys.

FY 13/14 Progress Report:

- There have been some staffing changes over the past year which has impacted coverage in some courtrooms.
- CAP staff continues to work in selected courtrooms primarily in Oakland and Hayward. CAP staff provides some assistance to clients referred from Fremont and Pleasanton courtrooms.
- CAP staff assist the new TAY program, REFOCUS, with referrals.

FY 14/15 Plans:
Adults, over 18, are served by the CAP program including TAY and Older Adults. The numbers vary according to how many in each age group are brought to the attention of CAP staff. CAP staff are located in select Alameda County Superior Courts. For the upcoming three years, (2014-2017) the CAP staff will continue to assist in diverting eligible individuals from the criminal justice system into community services with the goal of connecting persons to appropriate services and limiting their criminal justice involvement.

CAP staff will provide assessments and consultation, and will coordinate placement referrals.

The challenges mentioned in the preceding years, will become goals for future Improvements. Some are system- wide challenges and are beyond the control of CAP such as the availability of community resources. Limited resources impact the degree to which CAP is able to be successful in its jail diversion efforts.

OESD 8. Juvenile Justice Transformation of the Guidance Clinic

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.

FY 12/13 Outcomes, Impact & Challenges:
One of the strategies for this program is for services to assist with re-integration into the community. This strategy had been implemented by the hiring of a Mental Health Specialist to work with youth and their families upon discharge from Juvenile Hall. This clinician helped with referrals to services and met with families in the community to assist them in making connections to the services. Recently this position became vacant as the staff member took another job and to date the position has not been filled.

FY 13/14 Progress Report:
In December 2013, BHCS hired a mental health clinician to work in the Transition Center. The role of the clinician will be to assess the mental health, substance abuse, and psychosocial needs of youth and their care givers and link them to service providers in the community. The clinician will also maintain an electronic database to follow-up with families via phone contacts at intervals of 30/60/90 days.

Since January 2014 the Transition Center mental health clinician has met with 151 families.

- Approximately 15% of those families refused services.
- 35% of the minors were already connected to services in the community.
- 10% of the minors were connected to services by the Transition Center mental health clinician.
- 25% were lost to follow-up (runaway, never returned calls, etc.)
- 10% went to placement and 5% had private insurance.

FY 13/14 Plans:
Over the next three years, the goal is to meet with 700 families per year for the next 3 years. The Transition Center mental health clinician will meet with 1 to 3 community providers per month to increase the network of service providers that youth will be connected to upon release. Over the next three years the goal is to boost the number of families who are connected to services from 10% to 30%.

OESD 9. Multi-systemic Therapy (MST)

Program Description: Provides in-depth community-based assessment and treatment for youth in the juvenile justice system. MST partners with the primary caregiver and other key systems (Education, Probation) to understand the multi-systemic drivers of delinquent behavior and then empowers the primary caregiver and other systems to intervene to promote pro-social activity, family connections, and other positive outcomes.

FY 13/14 Outcomes, Impact & Challenges: MST served a total of 81 youth who are under the supervision of the Alameda County Juvenile Probation Department, including 15 youth who were carried over from the previous fiscal year, 66 youth who were accepted for services, and 47 youth who were discharged from services during this time period. Of the 47 youth discharged, 68% met the criteria for completion of MST services, 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.

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 13/14, 11% of youth who discharged from MST closed due to being placed in a restrictive setting, an improvement of 16% from the previous fiscal year. Some contributing factors to this improvement include utilizing MST quarterly trainings to enhance staff's ability to develop and implement interventions that successfully address substance abuse, CBT interventions with caregivers, and developing interventions to address negative peer systems.

FY 14/15 Progress Report: MST aims serve 90-105 youth who are under the supervision of the Alameda County Juvenile Probation Department during FY 14/15. In this current fiscal year, MST has served a total of 84 youth who are under the supervision of the Alameda County Juvenile Probation Department. This includes 33 youth who were carried over from the previous fiscal year, 49 youth who were accepted for services, and 59 youth who were discharged from services during this current fiscal year. Of the 59 youth discharged, 56% met the criteria for completion of MST services, 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.

A continued target area of growth for MST is 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. In this current FY, 15% of youth who discharged from MST closed due to being placed in a restrictive setting, which was an increase of 4% from the previous fiscal year. MST continues to focus on reducing rates in which youth are placed in a restrictive setting for 3 weeks or longer by continuing to utilize quarterly

trainings to enhance staff's ability to develop and implement interventions that successfully address youth's referral behaviors. During this fiscal year, MST quarterly trainings have included addressing runaway behavior through intervention development and collaboration with families and probation, and interventions aimed at reducing involvement with negative peer systems.

FY 15/16, 16/17 Plans: MST aims to serve 90-105 youth who are under the supervision of the Alameda County Juvenile Probation Department during FY 15/16 and during FY 16/17. 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.

OESD 11. Crisis Stabilization Services – Willow Rock

Program Description: This strategy will provide crisis stabilization and acute care to youth ages 12-17 and their families, moving them towards a reduced level of care.

FY 13/14 Outcomes, Impact & Challenges: 1,533 youth were served in the Willow Rock Crisis Stabilization Unit (CSU) with a total of approximately 1,287 unique episodes of crisis assessment and stabilization services provided.
Of these youth, 88% were brought to the CSU on an involuntary hold, while 12% were walk-up clients. Based on the multidisciplinary, comprehensive assessment of the youth's needs, 49% of youth assessed at the CSU were diverted from hospitalization.
Surveys of youth served in the CSU show that 92% strongly agreed that they felt welcome and safe during their time in the program. One youth stated "I loved how throughout this entire process I never felt ashamed, the staff really listened and made me feel loved, I also appreciated how it seemed like they wanted the best for me".
Willow Rock continues to provide an integrated module of the crisis stabilization training for Alameda County police officers, covering the topic of youth mental health issues and providing tours of the facility. In addition, Willow Rock and its staff support community awareness by providing tours for school district personnel, hospital staff, and other community agencies, and engaging in collaborative efforts such as the Chief Mental Health Advisory Board for the Oakland Police Department.

FY 14/15 Progress Report: While we cannot predict the clients to be served in the future due to the nature of the crisis work at the CSU, it is predicted that we will continue to see slight growth each year in the number of youth served by the program. We 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.

OESD 13. Co-Occurring Disorders Program

Program Description: 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.

FY 13/14 Outcomes, Impact & Challenges: Trained 356 clinicians from a broad spectrum of Mental Health and SUD programs through 16 multi-agency skill-building trainings, 26 on-site trainings and TA sessions. This included conducting 1 CME training for physicians, training peer facilitators in the PEERS Tobacco Program, and training and TA to implement the 2011 BHCS Tobacco Policies and Consumer Treatment Protocols in both multi-agency training settings and at specific provider sites. Impact includes increased clinical capacity to intervene with consumers who smoke in settings where clinicians are practicing their clinical skills and where tobacco policies have been, or are being implemented. Project activity also includes providing intensive TA to 5 BHCS tobacco intervention mini-grants designed to improve recipient agencies' competency in intervening with their clients who smoke. Mini-grantees collectively provided interventions to 286 clients in their programs, and continued to strengthen their tobacco policies. Collaborative work with PEERS resulted in PEERS providing 21 tobacco education presentations to over 215 consumers in 15 provider programs. Additionally, 172 consumers who were considering quitting smoking attended Tobacco Recovery Groups at 4 provider sites. ATOD Project provides evaluation analysis to the PEERS Tobacco Program.

Provider implementation of 2011 BHCS Tobacco Policies and Consumer Treatment Protocols has been uneven, with significant successes on one end of spectrum, and little or no movement on the other. Most programs are somewhere in the middle in terms of implementation and tobacco treatment. Continued outreach to those under-performing agencies produced some improvement, but disparities still exist.

FY 14/15 Progress Report: Conducted 5 skill-building and 14 on-site trainings for a total of 128 participants. This includes training consumer facilitators working in PEERS Tobacco Program. Trainings are scheduled through the end of FY. Broad range impact is similar to FY13-14. Continuing to provide support to BHCS tobacco intervention mini-grantees. As of 1/31/15, ninety-five (95) clients received tobacco interventions in these programs. IMPACT: Clients of staff we have trained are reporting decreased stigma ("Now I can be around my children and family"); increased MH/SUD recovery (Clients speak about how quitting smoking has strengthened their recovery from substances and mental health); improved finances (clients have been able to save for housing, furniture, flat screen TVs and more) and more housing opportunities (Section 8 waiting list includes "no smoking" for majority of available housing.)

Disparity in implementation of Tobacco policies as mentioned in FY13-14 still exist. Recently met with the BHCS Director to request additional support and assistance from BHCS to overcome these barriers. Mitigation strategies are now in process.

OESD 17. Residential Treatment for Co-Occurring Disorders

Program Description: 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.

FY 13-14 Outcomes, Impact & Challenges:

- Cronin House is a 34 bed licensed co-occurring capable residential treatment facility serving both men and women. 100% of our clients are required to have co-occurring mental health and substance abuse issues. We serve 230+ clients every year of which 75%-80% are homeless. Cronin House provides education, skills training, intervention, medication support, AA and NA meetings on site, family education/support and a Client Council. We help our clients develop social, recovery, and independent living skills. In the past year we have developed a new gender specific group: *Seeking Safety*, addressing trauma, coping techniques for PTSD, and substance

abuse. We have also increased our focus on smoking cessation and offer resources including consultation and patches. We have decreased the time that clients are allowed to smoke. Cronin House has also focused on providing access to healthcare for clients without primary care physicians. We have instituted a Client Council to provide leadership opportunities for clients. Cronin House continues to offer service for clients on methadone maintenance and in partnership with East Bay Community Recovery Project (EBCRP) provides HIV and Hepatitis C education and testing on site twice a week. EBCRP also provides education and confidentiality training to Cronin House staff.

- Chrysalis is a 16 bed licensed co-occurring capable residential treatment facility serving women 18 years and older. The maximum stay is six months. 100% of our clients are required to have co-occurring mental health and substance abuse issues. 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 prevent hospitalization, promote habilitation and rehabilitation and successful independent living in the community for individuals who have a diagnosed significant mental illness and whose use of drugs or alcohol exacerbate or complicate the illness and increase the risk of unhealthy behaviors and lack of community success. On average approximately seven intakes a month are conducted at Chrysalis and approximately 86 clients every year are being served of which approximately 83% are homeless. Chrysalis operates on the principal of social rehabilitation utilizing co-occurring substance abuse and mental health treatment best practices. Treatment is client centered and strengths based thus placing major emphasis on the involvement of the clients 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 clients 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 client 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 a active Resident Council is developed in order to be the voice of the community. Chrysalis in partnership with East Bay Community Recovery Project (EBCRP) provides HIV and Hepatitis C education and testing on site twice a week. EBCRP also provides education and confidentiality training to Chrysalis staff.
- Harrison House single adults program offers ten shelter beds at any point in time for participants referred through the ACBHCS Housing Services Office for up to six months. HH Single Adults program offers emergency shelter, housing navigation, referral and linkages to community support services and basic needs services to homeless adults who are enrolled in county mental health services. Harrison House singles served 35 individuals during FY 13/14.
- Casa Maria provides interim emergency housing to single adults who are experiencing homeless and are enrolled in an ACBHCS Specialty Mental Health program and are referred through the Housing Services Office. Casa Maria serves up to 24 participants at any point in time. Casa Maria provides up to six months of housing for participants requiring stabilization and housing supports in a supervised program setting including safety planning and monitoring, referral and linkages to community supports, coordination of care with behavioral health care teams. In FY 13/14 casa Maria served 71 individuals. Casa Maria received a Continuum of Care Award in 2014 for Most Improved Program.
- South County Homeless Project- Emergency Housing provides emergency shelter to up to 25 single adults who are experiencing homeless at any point in time for up to six months and are referred through ACBHCS Housing Services Office. SCHP offers shelter, housing navigation, referral and linkages to necessary community support services for individuals who are

experiencing homelessness and mental health, health and substance use and abuse issues. In FY 13/14 SCHP served 87 individuals. SCHP is a safety net service for difficult to serve and treatment adverse homeless adults who often utilize crisis services and emergency services only. SCHP participants often present with multiple barriers to permanent housing including lack of income, lack of documented disability, lack of established primary care and mistrust of the institutions that must be accessed in order to secure such benefits and care. This has resulted in a longer length of stay.

- Housing Service Team provides community based specialty mental health services to individuals with serious mental illness and co-occurring substance use and abuse issues and complex conditions at-risk of homelessness at BOSS housing sites.
- Level 1 Service Team provides comprehensive specialty mental health services to adults who have a serious and persistent mental illness and meet eligibility criteria. BOSS Service Team prioritizes participants with SPMI, homelessness, limited English language proficiency, co-occurring disorders and individuals at risk of institutionalization. This team series a total of 85 UDC annually. Level 1 Service Team and HST served combined 99 clients. The BOSS Service Team experienced a shift in philosophy and practice of care from 13/14.

FY 14-15 Progress Report:

- Cronin House expects to serve 230+ men and women with co-occurring mental health and substance abuse issues each year and a large percentage of these clients will be homeless. All discharge plans include referral to supportive housing. Cronin House is presently in the process of identifying staff training and changes necessary to develop specific program services for LBGTQQI2S clients when they are participating in our program.
- Chrysalis expects to serve 86 women with co-occurring mental health and substance abuse issues each year with a large percentage of these clients being homeless. All discharge plans include referral to supportive housing. Chrysalis is presently in the process of identifying staff training and changes necessary to develop specific program services for LBGTQQI2S clients when they are participating in our program.
- From 7/1/14-3/1/15 HH Singles has served 28 Individuals. Housing Navigation staff has taken a more assertive role in coordination of care with service providers, increasing Wellness Planning and case conferencing and increasing effective harm reduction and motivational interviewing strategies to effectively retain participants with behavioral challenges who may be more readily exited from shelters. Increased training and consultation available to Housing Navigation staff is improving outcomes.
- Casa Maria has served 62 individuals since 7/1/14-2/28/15, an increase in impact. Casa Maria has new program management and removed previous barriers to access such as medications requirements, substance use approaches and has established roles for peer community liaisons, community meetings, increased coordination with service providers and increased safety and wellness interventions, promoting access to the program and retention in the program.
- Since 7/1/14, SCHP has served 54 individuals. New leadership has encouraged Housing Navigation staff to increase effective welcoming, engagement, assessment, planning and linkages services to increase access to necessary supports, enroll in specialty mental health services, as needed and secure housing.
- HST is undergoing integration with Level 1 Service Team in terms of Quality Assurance Measures, team integration and clinical supervision. HST has served approximately 15-20 participants.
- The Service Team reached all goals for capacity before the end of 2014. The Service Team currently serves 90 clients and has introduced evidence based practices such as Motivational Interviewing, CBT, DBT, increased wellness and recovery strategies through training, in-service

learning collaborative and a shift in clinical supervision. The Service Team has increased assertive housing first interventions, employment linkages and reduced hospitalizations. Service Team has also increased in compliance and productivity outcomes.

FY 15/16 Plans:

- Plans to expand current Housing Navigation program to include 10 BHC beds and introduce MAA. Training plan to expand use of best practices such as SOAR, Harm Reduction, Motivational Interviewing and Trauma Informed Care.
- Plans to expand current Housing Navigation program to Casa Maria residents, provide increased clinical interventions such as WRAP and MAA. Training plan to expand use of best practices.
- Plans to expand current Housing Navigation program to SCHP residents and provide increased clinical intervention such as WRAP, SOAR and MAA.
- Housing Service Team will provide specialty mental health services to BOSS permanent supportive housing sites, shelter plus care participants and transitional housing participants who meet eligibility criteria. This is part of the Housing Navigation expansion plan. HST will participate in training plan to expand the use of best practices and culturally responsive treatment approach and interventions.
- The Service Team will integrate Peer Specialists through collaboration with ACBHCS Best Now program and will accept clinical interns through a new training program. The Service Team will increase utilization of evidence based practices and culturally responsive interventions.

OESD 20. Individual Placement Support / Supported Employment (Alameda County IPS)

Program Description: Alameda County Behavioral Health Care Services, in conjunction with the California Department of Rehabilitation, has embarked on a long-term plan to implement Individual Placement and Supported Employment (IPS). This evidence-based practice assists adult and transition-age youth consumers with finding and maintaining competitive jobs in the community available to people with and without disabilities. Engagement, job development, placement, and job follow-along supports are the core program elements of this approach.

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

1. No consumer is excluded from program access or participation due to diagnosis, presence of symptoms, substance abuse, housing status, personal presentation, etc. 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 services, consumers receive direct assistance with making employer contact quickly, usually within 30 days. There are no requirements for vocational testing, work samples, employment groups or other pre-vocational activities.
3. Employment specialists make frequent, in-person employer contact and build employer relationships based on the consumer's preferences in order to make a good job match.
4. Vocational services are individualized to fit the needs and preferences of each consumer. Individualized job search and job follow-along plans reflect each person's unique interests, goals and needs.
5. Competitive jobs are the goal, and transitional and/or sheltered employment is not utilized in

order to avoid delaying progress to achieve competitive employment.
6. Once a consumer obtains a job, the follow-along services are provided continuously until the job is stable or people no longer request services. Employment specialists provide a wide-range of job coaching and job supports to support a person's success.
7. Vocational services are integrated closely with mental health services in order to ensure IPS program success. Employment specialists meet weekly with mental health teams (case managers, personal service coordinators, peer specialists, and/or psychiatrists) to share information, collaborate, and plan services.
8. Ongoing quality improvement efforts focus on building on program and staff strengths to ensure that over time program outcomes for jobs is enhanced. The Supported Employment Fidelity Scale is utilized for quality improvement guidance.

These services are available to people with serious mental illness that are part of ACBHCS adult service teams, Full-Service Partnerships, Level 1 specialty providers, and Level 1 Transitional Age Youth (TAY) Programs.

FY 12/13 Outcomes, Impact & Challenges:

Outcomes:
Competitive employment rate percentage, which is the number of clients in the IPS program who worked a competitive job in the community, divided by the total number of people in the IPS program. Benchmarks set by the Dartmouth IPS Collaborative include 30% minimal standard, 40% good standard, and 50% exemplary standard. Data source: Quarterly data forms submitted by Alameda County IPS to the Dartmouth IPS Learning Collaborative; Vocational Services database

Notable Community Impact:
During this year, Alameda County IPS served 285 consumers, 104 of whom worked competitive jobs, which equals a competitive employment rate of 36%. We secured 88 competitive job placements for people, including positions in the administrative, retail, food service, warehouse, transportation, and education sectors.

MHSA funds have been leveraged to build capacity and infrastructure for IPS services in adult and transition age youth systems of care. We provided ongoing, intensive consultation and technical assistance to Fred Finch Youth Center STAY program and Bay Area Community Services Case Management team to begin providing IPS services this year.

FY 13/14 Progress Report:

Outcomes:
We served 255 consumers, 100 of whom worked competitive jobs, which equals a competitive employment rate of 39%.

Comments on current implementation:
- One additional employment specialist position was created and filled.
- Five county clinics have increased their vocational and mental health services integration, which has increased referrals and outcomes from those programs.
- MHSA funds have been leveraged to build capacity and infrastructure for IPS services in adult and transition age youth systems of care. We provided ongoing, intensive consultation and technical assistance to one additional agency to begin providing IPS services this year. The IPS

programs at Fred Finch and BACS had an average competitive employment rate of 35% this year.
- Individualized benefits counseling has been more widely available for consumers considering work or who have job changes.

July 2014-June 2015 Plans:
Alameda County IPS plans to directly assist 260 adult and TAY consumers with obtaining and maintaining competitive jobs that fit their preferences.

Planned changes:
- We plan to increase the integration of vocational staff onto County-run case management teams through shared office space, attendance at weekly team meetings, and increased communication between staff. This area of IPS fidelity has been shown to increase outcomes and improve services.
- We plan to meet with all contracted mental health programs in Alameda County to assess their readiness to implement IPS and create a project plan.
- We will start a new IPS pilot at BOSS (Building Opportunities for Self-Sufficiency).
- We want to streamline and integrate our vocational data collection and reporting.
- Continue consensus building and marketing activities related to IPS. In October 2014, we plan to host a one-day IPS symposium to highlight success so far and encourage interested agencies to consider implementation.

July 2015-June 2016 Plan:
Alameda County IPS plans to directly assist 280 adult and TAY consumers with obtaining and maintaining competitive jobs that fit their preferences.

Planned changes:
- Continue to provide technical assistance and leadership for vocational services in Alameda County.
- Continue to assess program needs and make needed changes.

July 2016-June 2017 Plan:
Alameda County IPS plans to directly assist 300 adult and TAY consumers with obtaining and maintaining competitive jobs that fit their preferences.

Planned changes:
- Continue to look for opportunities to integrate IPS services into mental health treatment.
- Assessing system-wide implementation of IPS and determining if additional training resources are necessary.

OESD 21. Housing Services Office

Program Description: MHSA funds were used to create the Housing Services Office with the following goals in mind for the entire mental health services network and the people it serves:

1. Increase the availability of a range of affordable housing options with appropriate supportive services so that individuals 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.

For current FY 13-14 Progress Report:

Activities have included:

- Education and training for providers and consumers
- Supporting the development of new affordable housing units with designated housing opportunities for individuals with serious mental health issues and unstable housing
- Management of a financial housing assistance fund to help BHCS consumers obtain and/or maintain housing
- Management of a network of emergency housing resources for BHCS consumers
- Management/oversight of the Alameda County Housing CHOICES website and housing news for the system: www.achousingchoices.org
- Management/oversight of partnership arrangements with the Housing Authority of the County of Alameda (HACA) and Alameda County Housing and Community Development (HCD) to expand affordable housing resources for BHCS consumers
- Education, support, and advocate related to community living facilities – shared living facilities for BHCS consumers, e.g., room and boards, board and cares, etc.

For upcoming FY 14-15, FY 15-16, FY16-17 Plans:

More coordinated management of resources to support community living facilities including licensed board and care homes.

Alameda County has implemented a variety 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."[1]

It's the intention of all PEI programs to emphasize strategies for the goal of reducing 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.

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.[2]

Alameda County's PEI programs create partnerships with schools, justice systems, primary care and a wide range of social services and 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. The MHSA specifies that all funded PEI Programs must include:

- **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)).

1 Proposition 63: Mental Health Services Act 2004
2 MHSOAC PEI Fact Sheet, December 2012

MENTAL HEALTH CONSULTATION PROGRAMS

PEI 1.A School-based Mental Health Consultation in Preschool

Currently the funds for this program are being used as part of the match funding for a SAMHSA grant to develop a system of care for the 0-5 community. This program is called **Early Connections**, an Initiative to strengthen services and supports for children 0-5 and their families.

For previous FY 12-13	For current FY 13-14	For upcoming FY 14-15, FY 15-16, FY16-17
Family Partner Integration Strategy **Outcome Statements:** • Increased family engagement through the utilization of Family Partners • Increased family knowledge regarding community resources • Improved child social/emotional functioning • Increased family leadership skills **Impact:** 110 young children and their families were served by Family Partners in FY 12/13 Family Partners provided services in English, Spanish, Chinese and Vietnamese. In FY 12-13 Early Connections developed and implemented training and infrastructure for Family Partners in the early childhood mental health agencies. Training was provided to both Family Partners and the mental health staff at each of the agencies. Family Partners are parents with lived experience, having used services and supports for	**Parent Café Peer to Peer Support Group Strategy** **Outcome Statements**: • Increased confidence in parenting skills • Increased access to community resources • Increased family leadership skills **Impact:** In FY 13-14 (2) **Parent Café** 6 week sessions were held. Each session was conducted in three languages - English, Spanish and Chinese. Parent Café served 50 parents in Parent Café sessions. Parent Café is informed by the Strengthening Families framework that integrates five strength-based protective factors that are essential for prevention and early intervention. The factors are: • Parental Resilience, • Social Connections, • Knowledge of Parenting and Child Development • Concrete Support in Times of Need • Social and Emotional	Early Connections is currently developing sustainability plans for FY 15-16 and 16-17. So the below numbers are estimates based on current data and initial fiscal planning. **Family Partner Integration Strategy** **FY 14-15**: 130 young children/families **FY 15-16:** 100-150 young children/families **FY 16-17:** 100-150 young children/families **Parent Café Peer to Peer Support Group Strategy** **FY 14-15**: 75 young children/families **FY 15-16:** 150-200 young children/families **FY 16/17:** 150-200 young children/families **Early Connections Co-Learning Project** **FY 14-15**: 30 families **FY 15-16:** 30 families **FY 16/17:** 30 families

their own children. **Challenges:** • Hiring challenges at each of the early childhood mental health agencies. Each agency needed to develop job specifications and dedicate time to outreach and engage qualified individuals. • Understanding of role of Family Partner. • Isolation for Family Partners as sole practitioner on team of mental health staff. <u>Strategies to mitigate:</u> Hiring: • Technical assistance to and increased partnership with early childhood agency directors. Role and Isolation: • Increased training and technical assistance for mental health staff. • Ongoing monthly Family Partner/early childhood mental health agencies Learning Community.	Competence of Children (www.strengtheningfamilies.net) **Family Partner Integration Strategy** In FY 2013- 2014 Early Connections increased the number of Family Partners employed in early childhood mental health agencies from 7 to 12 Family Partners. **Impact:** It is projected that 100-110 young children and their families will be served by Family Partners in FY 13-14. Early Connections will continue to develop and sustain Family Partner services in early childhood mental health programs over the next three years. Early Connections is developing a **Family Partner Integration Tool Kit** that will provide the community with written protocol and training to develop and sustain Family Partners. Early Connections will continue to develop and sustain Co-Learning projects and training. Similar to Family Partner Integration Tool Kit, Early Connections is developing a **Co-Learning Readiness and Fidelity Protocol** for community use and implementation of Co-Learning.	

PEI 1. B/C School-based Mental Health Consultation Programs

Program Description: School-Based Mental Health (SBMH) consultation currently serves 16 out of the 18 Alameda County school districts, and provides a variety of consultation services including: Child Specific Consultation; General Consultation; Trainings/Workshops; Transition Planning; Service Coordination, and Supports.

SBMH Consultation Services must: involve building the capacity of schools to address the social, emotional, and behavioral learning needs of students; promote a school climate that identifies and addresses student mental health needs and is supportive of students at risk for serious mental health issues; develop collaborative partnerships with teachers, staff, parents, and other providers to create school environments that promote healthy, social emotional development; help make social-emotional learning supports available to all students; and facilitate effective problem-solving among adults and students.

For previous FY 12-13	For current FY 13-14	For upcoming FY 14-15, FY 15-16, FY16-17
Our overall vision is that all youth are socially and emotionally healthy and graduate college and career ready. **Outcome Statements:** • Youth and families have an increased access and utilization of mental health consultation services. • Youth report improved social emotional functioning as a result of mental health consultation services **Impact** **Clients Served FY 12/13:** This program produced: 7,607 consultation services for a total of 26,648 contacts, which is a *9% increase* from FY 11/12. These numbers above are indicative that the education community, including families, are interested in and see the need for these consultation services-which increases access for those who utilize the services.	For FY 13/14 the County, in partnership with the Alameda County School Districts, has developed an evaluation framework and has started a data collection process to determine a number of identified results including: 1) children are physically, socially and emotionally healthy; 2) children succeed academically; 3) environments are safe supportive and stable; 4) families are supported and supportive and 5) Systems are integrated and care is coordinated and equitable. As data is gathered analyzed more information will be shared.	No planned changes Projected people served: **FY 14/15:** 8,000 children, youth and families **FY 15/16:** 8,500 children, youth and families **FY 16/17:** 9,000 children youth and families

Another example of impact was the implementation of a 6 week parenting education class for Spanish speaking parents whose children attend school in San Lorenzo Unified. Parent participation was incredibly high and parents reported learning a great deal about community resources and parenting skills that they otherwise wouldn't have learned or understood. **Challenges:** There were minor challenges for this year including: more need and requests for services than staff could address, uneven support from the school district around mental health consultation, and the turnover in staff which led to the need to re-educate on the concept and benefits of mental health consultation services.		

PEI 2. Early Intervention for the Onset of First Psychosis & SMI among TAY

Program Description: The PREP (Prevention and Recovery in Early Psychosis) Program was originally funded by a BHCS contract in early 2010 to identify and intervene with transition age youth (16-24 years) experiencing an initial episode of psychosis associated with schizophrenia and their families. The PREP Program provides the best in 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.

For previous FY 12-13	For current FY 13-14	For upcoming FY 14-15, FY 15-16, FY16-17

Outcome Statements:

- The PREP Program will reduce consumer *hospitalizations*
- The PREP Program will reduce the number of *prescribed antipsychotics*

Impact:

Hospitalization: During FY12-13, PREP collected hospital admission data from INSYST and compared the number of admissions for each active client prior to enrolling in PREP and the number of admissions each client had during their time in PREP. The total number of hospital admissions decreased by 76%; from 133 hospital admissions in the year prior to admission to just 32 during the course of enrollment.

Antipsychotics: During FY12-13, Examining the prescription records kept by the medical team we identified that they were able to significantly reduce the number of antipsychotic medications taken by consumers. The number of consumers not taking any antipsychotic medication increased by 6% and the average number of antipsychotic medications taken by consumers decreased by almost 66%.

Challenges: During FY12-13 the length of stay at hospitals was not measured, so though we saw fewer hospital admissions, several of these resulted in long hospital stays

For FY 13-14 the PREP program is collecting hospital admission and length of stay for all consumers to better report how PREP reduces the burden on the psychiatric crisis system of care in Alameda County.

A WRAP group for consumers and families will provide additional wellness and recovery tools to promote wellness and help identify as well as address potential crisis situations before hospitalization is necessary while leading to shorter stabilization time when hospitalization is unavoidable.

PREP has made changes to the data collection practices to gather more detailed information for both hospitalization and medication management. In addition, they are also collecting IPS data for education and employment.

Through these improved data collection efforts PREP hopes to better report on these very important areas and provide a more detailed picture of the outcomes for PREP graduates.

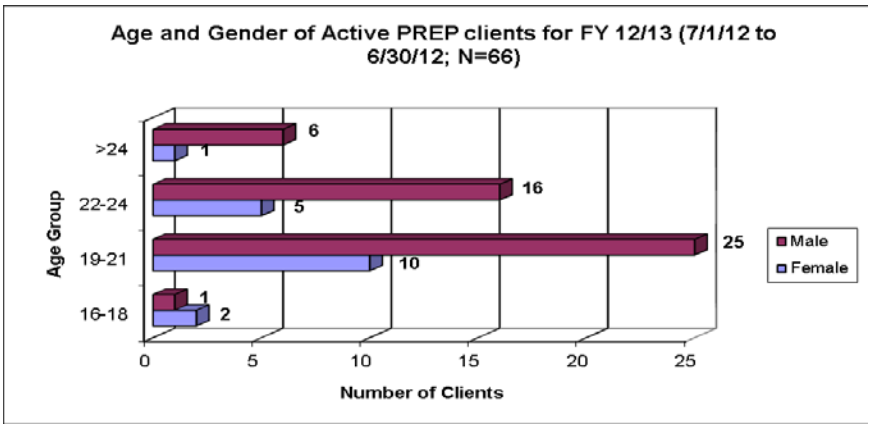
Although there have been some periods of staff turnover, PREP has been fully staffed for much of this fiscal year and plan to serve 60 active TAY consumers during FY 13/14.

PREP will continue to provide services to transition age youth living in Alameda County focused on intervening early with evidence-based practices, culturally competent assessment and thorough assessed diagnosis.

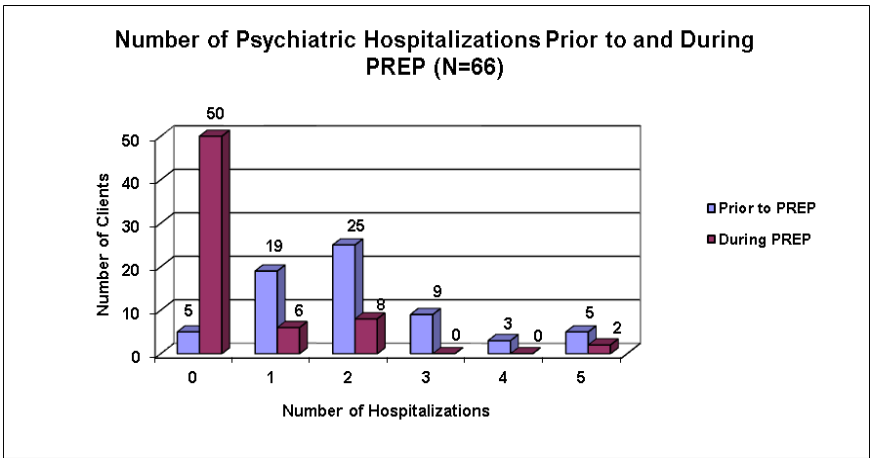
Projected people served:

- **FY 14/15:** 75 TAY,
- **FY 15/16:** 80 TAY
- **FY 16/17:** 85 TAY

Similarly with medication, in FY 12-13 medication dosage was not analyzed. The new medication management system for FY13-14 captures dosage, lab work and several health indicators which will provide a clearer picture of the balance between the effective dose and any side-effects		



The PREP Program is currently serving 58 consumers and PREP has served 66 consumers over the current fiscal year. The program capacity is 60 and it is contracted to provide service to 55-60 consumers at any given time.



PEI 3.A Mental Health-Primary Care Integration for Latino Older Adults

Program Description: Tiburcio Vasquez Health Center (TVHC) as a Federally Qualified Health Center has been implementing the IMPACT model since fiscal year 2011/2012. In fiscal year 12/13 TVHC screened 166 clients (using the PHQ-9[3]), 63 clients were screened positive and 38 clients agreed to be referred to or given a ""warn handoff" by the Primary Care Provider to the Behavioral Health Specialist. For the first two quarters of fiscal year 13/14 TVHC was able to screen 102 clients and give a "warm handoff' of 52 to the Behavioral Health Specialist.

According to THVC's client case reviews they were able to implement behavioral strategies within Problem-Solving Treatment – Primary Care (PST-PC) without psychiatric medication, to examine its effectiveness. Significant treatment gains were noted with the client able to show better functioning and less symptoms of depression.

For previous FY 12-13	For current FY 13-14	For upcoming FY 14-15, FY 15-16, FY 16-17
Outcome Statements: Demonstrated reduction in targeted assessment score for a particular client that meets one of the following thresholds: • >=5 point reduction on the Patient Health Questionnaire-9 (PHQ-9); • >=5 point reduction on the Generalized Anxiety Disorder Seven-Item (GAD-7); • >=10 point reduction on the Post-Traumatic Stress Disorder (PTSD) Checklist-Civilian Version (PCL-C); • >=3 point reduction on the UNCOPE Plus, recommended for assessing substance use disorders; or • >=6 point reduction on the Insomnia Severity Index (ISI), recommended for assessing insomnia. **Impact:**	THVC was able to implement behavioral strategies within Problem-Solving Treatment – Primary Care (PST-PC) without psychiatric medication, to examine its effectiveness. Significant treatment gains were noted with the client able to show better functioning and less symptoms of depression. Overall Client Outcomes include: 1. Reduce or eliminate the symptoms of depression; 2. Lower the risk for suicide; 3. Improve physical health; 4. Reduce functional disability.	No planed changes. Projected people served: **FY 14/15: 70 to 100** **FY 15/16: 75 to 105** **FY 16/17: 80 to 110**

[3] A nine item depression scale of the Patient Health Questionnaire to assist clinicians with diagnosing depression and monitoring treatment response.

Clients Served FY 12/13: 166 Significant efforts have occurred to increase cultural and linguistic responsiveness by BH staff. **Challenges:** Primary care staff turnover, Medical Director inconsistency and recruiting for qualified bi-lingual/bi-cultural staff. Space concerns. PEI program now fully staffed and engaged in screening and assessment activities.		

PEI 3.B Mental Health-Primary Care Integration for API Older Adults
Program Description: Asian Health Services (AHS) as a Federally Qualified Health Center has been implementing the IMPACT model since fiscal year 2011/2012. In fiscal year 2012/2013 AHS screened (using the PHQ-9[4]) 453 clients, 102 clients were screened positive and 15 clients agreed to be referred to or given a ""warn handoff" by the Primary Care Provider to the Behavioral Health Specialist.

Due Healthcare Reform and the new approved set of preventative screening protocols (including screening for depression) AHS's contracted services using MHSA funding are scheduled to end June 2014.

For previous FY 12-13	For current FY 13-14	For upcoming FY 14-15, FY 15-16, FY 16-17
Outcome Statements: Demonstrated reduction in targeted assessment score for a particular client that meets one of the following thresholds: • >=5 point reduction on the Patient Health Questionnaire-9 (PHQ-9); • >=5 point reduction on the Generalized Anxiety Disorder Seven-Item (GAD-	AHS was able to implement behavioral strategies within Problem-Solving Treatment – Primary Care (PST-PC) without psychiatric medication at first and then upon request of some clients medications were added. Significant treatment gains were noted with the client able to show better functioning and less symptoms of depression.	**AHS contracted services to end June 2014.**

[4] A nine item depression scale of the Patient Health Questionnaire to assist clinicians with diagnosing depression and monitoring treatment response.

7); • >=10 point reduction on the Post-Traumatic Stress Disorder (PTSD) Checklist-Civilian Version (PCL-C); • >=3 point reduction on the UNCOPE Plus, recommended for assessing substance use disorders; or • >=6 point reduction on the Insomnia Severity Index (ISI), recommended for assessing insomnia. **Impact** **Clients Served FY 12/13: 453** **Challenges:** Lost productivity during staff transition months; short staffed in PC; lag time in stepped care.	Overall Client Outcomes include: 1.Reduce or eliminate the symptoms of depression; 2.Lower the risk for suicide; 3.Improve physical health; and 4. Reduce functional disability.	

PEI 3.C Mental Health-Primary Care Integration for Older Adults at ERs (Geriatric Assessment and Response Team (GART) Program

For previous FY 12-13	For current FY 13-14	For upcoming FY 14-15, FY 15-16, FY 16-17
Outcome Statement: • FY 13/14 GART will increase enrollment by 50%; • GART clients will meet over 50% of treatment goals upon discharge; • Over 50% of clients will be linked to support services upon discharge from GART. **Impact** **Clients Served FY 12/13:** Over 164 contacts with older adults; 21 met criteria were enrolled in the GART Program.	**FY 13/14 Activities** By the end of FY 13/14: • GART will hire a 1.0 FTE RN-II position and, 1.0 FTE MHS-III position to increase consistency of service delivery; • Increase client enrollment by 50%; maintain FY 12/13 client's meeting treatment goals; maintain FY 12/13 client's being linked to support services upon discharge.	Planed changes: In FY 14/15 GART will be fully staffed & trained in OA services. Projected people served: **FY 14/15:** 44 Older Adults (59+) **FY 15-16:** 55 Older Adults (59+) **FY 16-17:** 69 Older Adults (59+)

Of the clients served in FY 12/13: • Over 70% met treatment goals upon discharge. • Over 70% were linked to support services upon discharge. GART expanded its geographic boundaries beyond "Central County" to address community needs county-wide. GART had over 40 outreach activities throughout the County including attending "Health Fairs" and other community events. **Challenges:** Loss of staff has created some challenges for staff to provide services throughout the County All GART services are provided in the field. GART clinicians are required to "reserve" a County Car when transporting staff. This takes away from client contact; recommending "purchasing" GART car to promote improved efficiency.	• Over 80% of clients' will be satisfied with GART services. (GART client evaluations) Current Evaluation Responses include: "Amazing Resource" "I like the Program because my therapist met with me at my home" "Staff were very helpful and to be commended for their hard work"	

PEI 4. Stigma and Discrimination Reduction Campaign
Program Description: The Alameda County Social Inclusion Campaign's goal is to create welcoming communities by promoting inclusion and eliminating mental health stigma and discrimination. The campaign is run by the consumer led organization Peers Envisioning and Engaging in Recovery Services (PEERS).

For previous FY 12-13	For current FY 13-14	For upcoming FY 14-15, FY 15-16, FY16-17
Outcome Statements: • Reduce stigma and discrimination through the direct contact method. **Community Impact** Research suggests that having contact with people who openly talk about their mental health condition and recovery is the best way to end stigma. To help empower more consumers of mental health to talk about their experiences and provide this contact, PEERS trained a **30 member speaker's bureau, which provided trainings and speeches to 3,089** people in the general public of Alameda County. In addition to the general public special efforts were made to reach members of targeted groups. Unique messages and speakers were utilized to help reduce stigma in these targeted groups: 675 family members, 393 people who hold the power to change housing policies and practices, and 1,491 individuals from the African American community. PEERS also produced and aired 4 Mental Health Matters educational videos for the goal of reducing stigma and increasing awareness of mental health issues.	In FY 13/14 the program focused on building capacity within the special populations they have been working with so that they can continue to address stigma and discrimination within their own community independently. The expansion of Wellness Recovery Action Planning (WRAP) is one example of this capacity expansion. WRAP is a tool that helps consumers of mental health services overcome internal stigma and creates non-stigmatizing supportive environments within a community. To help create sustainable stigma reduction and community and individual empowerment, PEERS trained 12 African American community leaders and 12 people in the Housing Industry as certified WRAP facilitators. These individuals will then be equipped to continuously offer WRAP as a resource and continue the fight against stigma and discrimination within their communities, independent of PEERS.	No Planned Changes Projected people served: **FY 14/15:** 15,150 people countywide through various efforts. **FY 15/16:** 15,250 people countywide through various efforts **FY 15/16:** 15,350 people countywide through various efforts

UNDERSERVED ETHNIC LANGUAGE POPULATION (UELP) PROGRAMS

The UELP programs were designed to provide services to historically 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) Early Intervention 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 12/13 the data show that these UELP providers in total produced:

- 4,943 prevention events, which is a 14% increase;
- 33,101 people were served at these prevention events; (duplicated count) and
- 751 unique clients were served through early intervention services, which is 28% more than the previous year of 585 clients.

Alameda County Behavioral Health Care Services is currently working with all of the UELP programs to finalize a simple outcome-based survey that will be fully implemented in FY 14/15 in 11 languages: English, Spanish, Vietnamese, Chinese, Dari, Hindi, Khmer, Nepali, Korean, Thai, and Burmese. Domains that the survey will cover include:

- 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 identifying progress and success through the above survey domains the county has also started to analyze early intervention data to determine if access has increased for these historically underserved populations. A preliminary round of data analysis does seem to indicate that access to mental health services has increased. BHCS looked at “access” in two ways: 1) Of the people receiving early intervention services, what percent had received services in our system with in the past three years and 2) Of the people receiving early intervention services what percent went on to need mental health treatment services.

For our first question BHCS took a cohort of 598 early intervention clients from FY 12/13 and looked back three years to see if this cohort had ever been served in our system before. The data found that only 15% of these 598 clients had ever been seen before in our system. Reasons for not accessing services in the past are still being investigated; however the data does show an increase in access for a significant number of clients in this cohort.

For the second question BHCS took a cohort of 619 early intervention clients from FY 11/12 and looked forward to see what percent went on to need mental health treatment services. The data found that 31% of the 619 clients went on to receive mental health treatment services (mainly outpatient services) in FY 12/13. This data indicates that the majority of early intervention 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 from 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. More information will be shared on this indicator of access as data is available and analyzed.

PEI 5. Outreach, Education and Consultation for the Latino Communities

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". It's designed to serve Latinos throughout Alameda County by providing services through a four agency collaborative with each agency leveraging its knowledge and trust in their region to provide services to Latinos in their region of Alameda County. La Clínica de La Raza serves the northern region, La Familia Counseling Service serves the central region, Tiburcio Vasquez Health Center serves the southern county region and East Bay Youth and Family Initiatives serves the east county region. More information on this program can be found at http://culturaybienestar.com

For previous FY 12-13	For current FY 13-14	For upcoming FY 14-15, FY 15-16, FY16-17
Outcome Statements • Youth and families have an increased access and utilization of culturally specific prevention and early intervention services • Participants will report increases in social emotional wellness and cultural connections. • Participants will report an increased understanding on where to seek support/help in crisis situations. **Impact** **Clients Served FY 12/13:** This program produced: 2, 137 prevention events (*200% increase*); 14,623 people were served at these prevention events; (duplicated count) and 399 unique clients were served through early intervention services, which is a *35%*	Community PEI Educators continue to help reduce stigma by interchanging the terminology of mental health with emotional well-being, allowing for a more receptive message to be communicated. The emphasis is on promoting a state of well-being, recognizing disequilibrium, and providing tools and resources for establishing emotional well-being, physical health, and supportive, healthy relationships in one's life. This program has also helped to normalize mental health issues by pointing out its prevalence and the availability and efficacy of treatment. Individuals are having a better understanding of what constitutes mental health and how to recognize the signs associated with mental health conditions.	No planned changes Projected people served: **FY 14/15: 2,250** 1,463 children and TAY, 787 adults & older adults **FY 15/16: 2,275** 1,489 children and TAY 786 adults & older adults **FY 16/17: 2,300** 1495 children & TAY 805 adults & older adults

increase from FY 11/12.

These numbers are indicative of the Latino community recognizing the value of this program as consultants for prevention services, CBO trainings, traditional healing, and community development.

Another example of impact is through utilization of media in the form of a monthly radio show on Radio 1010 to discuss mental health topics allowing a question and answer segment that allows callers to receive an immediate consultation and referral for mental health services if needed. This type of format allowed for the discussion of cultural norms and traditions that lay at the foundation for the expression of grief, depression, anxiety, loss, immigration, unemployment, and trauma in the Latino community.

Challenges:

One challenge the program has faced involves access for children and youth during the school year. This challenge was mitigated by providing services during recesses or after school times. In Hayward, the program worked closely with the Hayward Unified School District which provided program staff with access to students during normal school hours. Access to youth is also facilitated by their close relationships with the Union City, Newark, Oakland, and Fremont School Districts.

The program has also

encountered challenges reaching LGBTQQI youth. To remedy this, they conducted outreach at local LGBTQQI events and successfully established ongoing relationships with members of these groups.		

PEI 6. Outreach, Education and Consultation for the Asian/Pacific Islander (API) Communities

Program Description: The UELP program that serves the Asian/Pacific Islander (API) Communities is led by two agencies, Asian Community Mental Health (ACMHS) 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. More information on API Connections can be found at http://www.chaaweb.org/programs/apiconnections and http://acmhs.org

For previous FY 12-13	For current FY 13-14	For upcoming FY 14-15, FY 15-16, FY16-17
Outcome Statements • Youth and families have an increased access and utilization of culturally specific prevention and early intervention services • Participants will report increases in social emotional wellness and cultural connections. • Participants will report an increased understanding on where to seek support/help in crisis situations. **Impact** **Clients Served FY 12/13:** This program produced: 1,936 prevention events (*25%*	Community PEI Wellness Educators continue to help reduce stigma by interchanging the terminology of mental health with personal joy and well-being, allowing for a more receptive message to be communicated. Currently API Connections is engaged in a number of activities including: Networking with Alameda County's Pool of Consumer Champions Asian subcommittee to encourage more community members with lived experience of recovery to become trained as mentors and speakers Started a new support group	• No planned changes • Projected people served: **FY 14/15: 2,250** 1,463 children and TAY, 787 adults & older adults **FY 15/16: 2,275** 1,489 children and TAY 786 adults & older adults **FY 16/17: 2,300** 1,495 children & TAY 805 adults & older adults

increase); 9,410 people were served at these prevention events; (duplicated count) and 183 unique clients were served through early intervention services, which is a *32% increase* from FY11/12. Within the many API communities there is an incredibly high degree of stigma regarding mental health. These numbers above are indicative of services that are culturally responsive and as such people have been interested and open to attending events and utilizing these PEI services. Among the many API communities a number of approaches have assisted in opening dialog about mental health and reducing stigma. Some of these approaches include: taking an ethnic group's world view approach and embedding it into conversations; speaking in their native language; organizing support groups that include non-threatening activities and engaging people in their daily routines, out in the community (not at clinic sites) to make discussions about mental health and resources less threatening. Community friendly Bi-lingual resource brochures were also developed in English, Vietnamese, Chinese, and Khmer. **Challenges:** Several external challenges	for Korean-speaking mothers who have children or youth with mental illness Launched a Cambodian elementary school students' after school wellness program in Oakland to address and prevent the prevalence of youth gang violence among Cambodian neighborhoods In the process of developing social groups for the Mongolian community focused on physical activity, single women, and parenting. Creation of a support group for Pacific Islander families of prisoners, formerly incarcerated individuals and their allies to better support this population in the community.	

were faced in the past year including new leadership at the executive level, implementation of electronic health records, staff unionizing and family deaths. Staff were able to overcome these challenges through re-focusing on clients and hosting a half day retreat. Other programmatic challenges included tracking and timely submission of Medi-cal Administrative Activities. Additional time and training has been dedicated to this so that in FY 13/14 this will not be as challenging.		

PEI 7. Outreach, Education and Consultation for the South Asian/Afghan Communities

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 http://www.humecenter.org and http://www.afghancoalition.org

For previous FY 12-13	For current FY 13-14	For upcoming FY 14-15, FY 15-16, FY16-17
Outcome Statements • Youth and families have an increased access and utilization of culturally specific prevention and early intervention services • Participants will report increases in social emotional wellness and cultural connections. • Participants will report an increased understanding on	The community mental health specialists continue to outreach and engage the various South Asian communities in order to reduce stigma and discrimination. One agency has presented at three different conferences addressing mental wellness among the South Asian community. Conferences include: Healing and Resiliency, Spirituality and	No planned changes Projected people served: **FY 14/15: 850** 442 children and TAY, 408 adults & older adults **FY 15/16: 875** 455 children and TAY 420 adults & older adults **FY 16/17: 900** 468 children & TAY

where to seek support/help in crisis situations. **Impact** **Clients Served FY 12/13:** This program produced: 810 prevention events (*40% increase*); 8,565 people were served at these prevention events; (duplicated count) and 128 unique clients were served through early intervention services, which is a *100% increase* from FY 11/12. Within the many South Asian communities there is an incredibly high degree of stigma regarding mental health. These numbers above are indicative of services that are culturally responsive and as such, people have been interested and open to attending events and utilizing these PEI services. Among the many South Asian communities a number of approaches have helped facilitate dialog and conversations about mental health and reducing stigma. Some of these approaches include: developing "non-psychological jargon" for outreach and engagement, conducting activities in native languages such as Hindi, Punjabi, Dari, Farsi, Urdu, Pashto and Tamil, and providing opportunities for engagement and services out in the community, e.g. at resource fairs, local temples, a youth soccer club, schools, community centers, etc. An additional example of a successful outreach and	Wellness Conference with a focus on Asian Sikh, Hindu, Buddhist, and Islamic Communities, and Women and Trauma Training. Additionally, this same team participated in a radio talk show through a South Asian Radio Show to address mental health illness and early detection. Another goal for FY 13/14 is to increase print media outreach to the Afghan community by having a monthly article on mental health in the Afghan Examiner. There are also goals to partner with existing agencies and schools in the southern part of Alameda County to continue to develop relationships and leverage resources for these communities.	432 adults & older adults

engagement strategy was the use of a “wheel of questions” at various community events. The purpose of the wheel is to engage participants to interact with a mental health specialist in a fun and nonthreatening way to address or highlight healthy coping mechanisms when dealing with stress or a challenging life event. **Challenges:** As with many of the UELP programs the challenge of overcoming mental health stigma and engaging communities is always present. These programs have been able to mitigate this challenge through not using labels or jargon and introducing services as a way to cope with everyday challenges and normalizing clients’ experiences. There has also been staff turnover in one of the programs, which created delayed timelines in implementing a media outreach campaign and lack of continuity at one school site. However these positions have been filled and the program appears to be back on track to meet their annual deliverables.		

PEI 8. Outreach, Education and Consultation for the Native American Communities

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 Spirit, Art & Culture, Guidance and Encouragement (SAGE) 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.

For previous FY 12-13	For current FY 13-14	For upcoming FY 14-15, FY 15-16, FY16-17
Outcome Statements • Youth and families have an increased access and utilization of culturally specific prevention and early intervention services • Participants will report increases in social emotional wellness and cultural connections. • Participants will report an increased understanding on where to seek support/help in crisis situations. **Impact** **Clients Served FY 12/13:** This program produced: 60 prevention events; 503 people were served at these prevention events; (duplicated count) and 41 unique clients were served through early intervention services. The SAGE Center has had a number of impactful projects during this time period including: 1) The introduction of Living By the "Ceremonial Calendar". Native American ceremonies are fundamental to human growth, development and connection to the community. The SAGE Center has conducted three initiation ceremonies during FY 12/13: Manhood Ceremony, Sun Dance Ceremony, and the Womanhood Ceremony. 2) In May 2013 the SAGE Center held their annual Sage Gathering and Wrapping for their community. This provides access for the Native	The PEI Natural Helpers continue to help reduce stigma by interchanging the terminology of mental health with the idea of "being out of balance". This culturally relevant/responsive interpretation of the concept of mental health/illness allows for a more receptive message to be communicated. Staff at the SAGE Center are also involved at the State level though the California Reducing Disparities Initiative, e.g. staff and Native family members were featured in the film "A Different State of Mind", which was aired on PBS in July 2013. The film showed the use of "ceremony", as a collective approach to recovery from imbalance opposed to the individual approach common in western practices.	No planned changes Projected people served: **FY 14/15: 850** 442 children and TAY, 408 adults & older adults **FY 15/16: 875** 455 children and TAY 420 adults & older adults **FY 16/17: 900** 468 children & TAY 432 adults & older adults

community to touch, wrap and handle the medicine in its natural form. They prepare this medicine for use in their community for the entire of year. It provides the Native community with a way to heal from Historical Trauma and at the same time strengthen others by giving back with the preparation and use of traditional medicine. Over 1000 sage bundles were created at this event. **Challenges:** As with many of the UELP programs the challenge of overcoming mental health stigma and engaging communities is always present. This program has been able to mitigate this challenge through using the term historical trauma (HT, which both empowers the community and reduces stigma as it's a term that takes into consideration the context of Native experiences in response to federal policies. Historical trauma responses (HTR) is a constellation of features including substance abuse, suicidal thoughts, low self-esteem, bursts of anger, difficulty with relationships, unresolved grief, mood regulation. All new hires to Native American Health Center learn about HT and HTR as part of their new employee orientation. The SAGE Center conducts on average 2-3 of these trainings a month for staff and the community.		

PEI 9. Mental Health - Primary Care Integration

Program Description: Build behavioral health capacity in primary care clinics with Federally Qualified Health Centers (FQHC) delivering primary care in the County. The project uses the AIMS model, provides training to FQHCs and incentives to encourage those clinics to develop behavioral health positions.
FY 13/14 Outcomes, Impact & Challenges: Despite staffing changes during FY 13/14, BHCS has been able to increase the level of participation by all of the Community Health Centers in the Integrated Behavioral Health Program. BHCS staff working on the integration projects with the Community Clinics are now attend the monthly Alameda Health Consortiums' Behavioral Health Clinicians meeting as well as trainings. This is a new level of collaboration between Safety Net health care providers and behavioral health staff which will benefit all Alameda County residents.
FY 14/15 Progress Report: All of the Alameda Health Consortium's Community Health Centers (including Alameda Health System) are actively participating in the Integrated Behavioral Health Program that focuses on the recruitment and retention of licensed Behavioral Health Clinicians and participation in the Pay for Performance's five measures of patient treatment progress. The Consortium Health Centers are now have two more quarters left on their BHCS Integration contracts, and are working with staff to identify new performance measures that will improve patient behavioral health treatment outcomes and strengthen their ability to serve Alameda County residents with behavioral health concerns.
FY 15/16 Plans: BHCS implemented the county-operated Psychiatric Consultation Service in all 8 of Alameda County CBO Community Health Centers. All of the Community Health Centers have expressed that this new service has been of tremendous value to their primary care providers in their treatment of clients with behavioral health concerns as well as improved their ability to prescribe psychotropic medications. BHCS is currently meeting with the Alameda Health Consortium Leadership to discuss renewal of this service as well identify ways new ways to work as a team in the primary care clinic setting that improve quality of care and patient services.

PEI 12. Trauma Informed Care/Suicide Prevention

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. 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 (or "fixing" something "broken"). It recognizes that people are more than their labels and diagnoses and those relationships are a common context for traumatic events, and that healing most often occurs in the context of relationships. 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.

For previous FY 12-13	For current FY 13-14	For upcoming FY 14-15, FY 15-16, FY16-17
Outcome Statement: Youth Suicide Prevention • 75% of youth who receive suicide prevention training will report an increased understanding of depression and suicidal warning signs. • 75% of youth who receive suicide prevention training will report an increased willingness to seek help for a friend in crisis. **Outcome Statement: Youth Crisis Text Line** • Increase youth access to the crisis text line through linkage with the school-based youth suicide prevention program. **Outcome Statement: Trauma Informed Care** • All group and individual counseling (including grief counseling) will incorporate the seven principles of trauma informed care. **Outcome Statement: Community Education & Consultation Trainings** • 75% of participants who complete community suicide prevention training will feel confident in their ability to directly ask about suicide. **Impact** **Clients Served FY 12/13:** The <u>Teens for Life (TFL) Youth Suicide Prevention program</u>	In FY 13/14 all of the suicide prevention programs and trauma informed care strategies are going strong. See the comments below from several of the programs to better understand the impact these programs are having: **Student Comment from the Teens for Life Youth Suicide Prevention Program:** *"I used to think that learning about suicide wouldn't be very helpful, that common sense would kick in. I now know that isn't the case and I feel prepared to help anyone who may feel depressed or suicidal".* 14 year-old **Youth Comment from the Crisis Text Line:** One texter chose to save the tri-fold text line card given out during a TFL presentation for a future time: "*you guys came and visited my health class in like the beginning of the year...handed out little pamphlets and I kept one in my sock drawer next to my blade. The other day, after being clean for 4 months, I went to go and cut, but saw the number, and yeah, texted and my wrists are still healed :)"* Based on the data from the crisis phone line and text line	• No planned changes Projected people served: • **FY 14/15: 13,700** 12,800 children and TAY, 900 adults & older adults • **FY 15/16: 13,800** 12,850 children and TAY 950 adults & older adults • **FY 16/17: 13,900** 12,900 children & TAY 1,000 adults & older adults

served 12,146 youth through 404 presentations at 34 schools county-wide.
Post TFL training:

- 80% strongly agreed or agreed with the statement "*I can recognize if someone close to me is feeling suicidal."*
- *78%* strongly agreed or agreed with the statement "*If I had a friend who was feeling depressed or suicidal, I would be willing to call a crisis line.*

The Youth Crisis Text Line conducted 386 crisis texting sessions in FY 12/13, which is a 200% increase from FY 11/12.

The group and individual counseling program served 72 adults for a total of 735 sessions and 262 students for a total of 2,803 sessions-all through the lens of being trauma informed and for many individuals addressing the traumatic issue within the counseling sessions.

Community Education & Consultation Trainings served 822 adults through 36 trainings.

Post training 88% strongly agreed or agreed with this statement "I feel confident in my ability to ask directly about suicide."

Challenges:

these are the areas where youth are struggling the most:

Suicidal desire (feeling hopeless)
Anxiety
Self harm
Relationship issues
Bullying
LGBTQ coming out struggles

CSS has also developed a number of new collaborations in FY 13/14 including a partnership with the Oakland Police Department (OPD). OPD provides Crisis Intervention Training (CIT) for law enforcement and CSS was asked to participate as a trainer on Suicide Assessment & Intervention.

Access to teachers and parents in school systems are still a challenge. This has been mitigated somewhat through collaboration with the PEI funded school district mental health liaisons, but remains an ongoing challenge to be addressed each school year.		

PEI 12. Family Education Resource Center

Program Description: The Family Education and Resource Center (FERC) is a program of the Mental Health Association of Alameda County. It's a family/caregiver centered program that provides education, advocacy, support and hope to families and caregivers of a *loved one* with a mental health challenge.

For previous FY 12-13	For current FY 13-14	For upcoming FY 14-15,FY 15-16, FY16-17
Outcome Statements: • **Family Leadership:** Increase leadership and advocacy skills for family members through the Family Leadership Program (FLP). • **Public Education:** Future mental health providers will increase their knowledge of consumer and family member perspectives around mental health and mental health challenges through in-class Public Education Training (PET) Program. **Impact** **Clients Served FY 12/13:** 2,168 individuals were served through the FERC during this fiscal year.	In FY 13/14 the FLP has continued its efforts and has all 5 members sitting on committees or workgroups to represent the family voice and share the family perspective. It's the goal of this program to grow the number of family leaders from 5 to 10 in the upcoming fiscal year. The FERC would also like to support these family leaders in being able to tell their story on various public speaking panels so as to raise awareness of the family voice/perspective. The Public Education Training Campaign has been incredibly successful with 83% of participants strongly agreeing that they expected to use some of the information that they learned during the training.	• No planned changes Projected people served: • **FY 14/15: 2,274** Children: 44 TAY: 440 Adults: 1724 Older Adults: 66 • **FY 15/16: 2,374** Children: 47 TAY: 475 Adults: 1781 Older Adults: 71 • **FY 16/17: 2,474** Children: 49 TAY: 495 Adults: 1856 Older Adults: 74

Five FLP members were trained and conducted numerous outreach activities and collaborated with the family advocates. Listed below are two quotes from the FLP: *"I've been able to create tools for helping others out of my painful experiences. This has helped me to make sense of all that has happened. Also, I don't feel alone in the journey anymore."* *"I feel empowered and ready to share with the community of how being part of FLP has changed my life. The support system has been just great. I don't feel smothered within my situation and exercise my new found empowerment to assist me and others as needed."* Nine Public Education Trainings (to future mental health providers) have been conducted to 230 students at multiple college and community sites including: Wright Institute, John F. Kennedy University, California State University East Bay, University of California Berkeley, Holy Names University, and Fremont Youth and Family Services Counseling Dept. Listed below are 2 quotes from the training participants: *"I was very proud & felt grateful that the speakers were able to talk about the everyday challenges such as stigma that are not deeply discussed in school or in general."* *"I really liked the personal testimonies – helps put things*	Additionally, 87% strongly agreed that the information provided would improve their future collaboration and interaction with consumers and family members.	

into perspective. Transparency, empathy, making connections and being open is very important as a provider." **Challenges:** For the FLP finding family members who are <u>available</u> and <u>ready</u> to share their experiences with having a loved one with a mental health challenge and their experience with accessing care/navigating the Behavioral Health Care System. No challenges for the Public education trainings. Various graduate programs often contacted the FERC requesting this training as they had heard about it from others who have participated.		

PEI 13. Wellness, Recovery and Resiliency 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 is staffed by people trained in organizational development and meeting facilitation, who also had "lived experience" with the public mental health system as clients and family members. The WRRI offers workshops and technical assistance in the form of recovery education workshops, action planning workshops; recovery event planning; meeting facilitation training and leadership training for boards of directors and management teams. 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. The WRRI also supports consumer and family stipends, training and conference costs.

FY 13/14 Outcomes, Impact & Challenges

- **Reach Out** provides services to mental health clients within locked facilities and licensed board and care providers. The role is to eliminate isolation, facilitate the process of consumers planning for the transition of discharge and addition community supports, and some housing advocacy through peer support
- **Berkeley Drop In Center** provides vital services for mental health clients who are also experiencing chronic homelessness and AOD issues. The center offers ongoing housing services, payee representation for consumers, daily food, peer support groups, and other referral services
- **MHSA Leadership Development** provides conference coordination and ongoing community education for POCC members within Alameda County in partnership with ACBHCS Consumer Empowerment Department
- **Reaching Across** provides community activities for mental health consumers who have experience isolation, peer counseling and advocacy. The center also offers physical wellness tools, music and art therapy.
- **BestNow!** Provides an 8-week training program and a 6-month paid internship for consumers with a desire to work within the mental health system as Peer Specialist. BestNOW also facilitates a variety of employment readiness workshops and Medical documentation trainings.
- **Tenant Support Program** provides direct housing supports such as move in costs, housing applications, housing advocacy and education, wellness groups and peer support for mental health consumers

FY 14/15 Progress Report

- **Reach Out** Adults and some older adults. There are no projected changes in services.
- **Berkeley Drop In Center** serves adults with h children, some older adults and adults with In the TAY classification (over 18)
- **Reaching Across** services adults and older adults. There are no projected changes in services
- **BestNOW!** serves adults and older adults. The program is in the process of moving to a new location.
- **Tenant Support Program** services adults with children and older adults. The program will implement 5 WRAP trainings within SRO, Board and Care facilities and onsite at the agency

PEI 15. Asian Pacific Islander staffing to ACCESS

Program Description: Improve availability of ACCESS information and referral; and brief treatment services by increasing bicultural staff in one Asian Pacific Islander crisis clinic. Services include phone referrals, assessment, outreach and brief crisis stabilization treatment.

FY 13/14 Progress Report:

Total numbers of contacts: N=3028. (Phone/walk-in)

- Phone 61.69% (n=1,888)
- Office 37.95% (n=1,149)
- Home 0.17% (n=5)
- Field 0.20% (n=6)

Age Group (Phone/Walk-In) (N=2,220)

- Early Child (0-5) 5.32% (n=118)
- Child (6-17) 19.28% (n=438)
- Transitional Age Youth (18-24) 7.75% (n=172)
- Adult (25-59) 53.74% (n=1,193)
- Older Adult (60 and over) 13.92% (n=309).

For Short Term Crisis Stabilization program, there was an increase of 65 years and older clients being served. They accounted for 11% of open cases during the year of 2013. Largest age group was 45-65 years old and they accounted for about 50% of clients served. Clients who were younger than 34 years old accounted for 23%.

Examples of notable impacts in the community: We reached out to general population, LGBT communities and faith communities. We provided psycho-education presentation and organized Wellness/Safety & Health events. We also collaborated with Chinese speaking NAMI group. In order to expand geographic areas for outreach, two of the outreaches were held in Fremont. We also provided psycho-education to professionals and providers to increase awareness and sensitivities to address mental health treatment needs for API population (Sausal Creek and County ACCESS staff)
There are countless examples of individual cases that without Asian ACCESS, they would never be served. One of the examples is a mute, Mien speaking gentleman. Since he arrived to this country two decades ago, he had been virtually living in the backyard storage unit for most of his adult life while manifesting psychotic symptoms. With outreach and psycho-education to the family, client is now receiving mental health treatment, and be linked to other social services. We often find that once we establish a connection with a client, we start to see more family members who need mental health and social services. As we are able to provide various supportive services within the same agency, it makes coordinated care much more streamlined.

Challenges and barriers: General stigma about and lack of knowledge of mental health treatment among Asians continue to be a challenge. We have been addressing this by engaging public in various settings to provide psycho-education. We note that once the clients find our assistance helpful, the stigma about receiving mental health services was reduced. They or their family and friends are more likely to approach us for services. For example we receive calls from former youth

client who now request services for themselves as adults. We also received calls from former clients referring their family or friends.

Systemic issues: health care system changes make it very difficult for monolingual clients to access services. We will continue to address issues at county level to advocate for the APIC community. We will also help link clients to services if they have language barriers.
We continue to provide integrated health care to our ACCESS clients through the SAMHSA grant.
We felt more impacts of Health Care change. Many clients called in or walked in to ask about changes from HealthPAC to MediCal. They could not get through Alameda Alliance and called 1-800-491-9099 listed on their card, which was Alameda County ACCESS number, as such routed to our Asian ACCESS referral line when they pressed "3" for Asian languages.
When moderate-severe requirements/ screening tool for specialty mental health services was introduced, we felt our clients were unfairly impacted. We were advised to screen caller over the phone, and do not proceed to face to face screening unless they meet moderate-severe criteria over the phone. However, most callers are not able to articulate their symptoms or treatment needs due to stigma, nor will they volunteer personal and family issues right away to some strangers on the phone. In addition, callers tend to undermine problems and are not familiar with mental illness. With screening question on whether callers have any past psychiatric treatment history, the "no" answer may not reflect correctly their service needs. Callers may not have received any treatment in the past due to the non-existence or non-utilization of psychiatric services in their home country. Therefore, the screening tool may present false negative outcomes, preventing them from being accurately assessed for their symptoms, thus treatment recommendations. For this reason, we believe that face to face assessment is crucial for proper assessment and determination of level of care for most immigrant Asian populations.

Mild-Moderate Condition Clients. Related to previous point, the clients who were screened and determined to be functioning at mild-moderate range were referred out to PCP or their health plan mental health providers. However, monolingual Asian clients face tremendous difficulties in obtaining mental health services. First, they have difficulty navigating the automated phone system to talk to a live person and request someone to communicate in their native language. Then they were given phone numbers of providers who do not speak their language, and/or not accepting new clients, requiring them to go through step 1 again. Third, even if they are assigned to providers, most likely they are English speaking providers working with them through translators. Many clients expressed dissatisfaction to continue services under such arrangements. Some of the clients who are lost in the system called us for help, but we need to turn them down because they do not meet the severity level for specialty mental health services. Such system creates unfair barrier to our API monolingual clients as they will most likely give up seeking further help during the process, contributing further the low penetration rate for API group.

Impact of Covered California Plan. Many clients obtained Covered California health insurance plan and as such can no longer receive county's specialty mental health services. When they try to use mental health services under their insurance, however, many face similar problems as stated above.
During FY 13/14, psychotic disorders-related intake calls were at 19.83% as compared to 5.12 % of County ACCESS statistics. This confirms that Asian Americans tend to under-utilize services, and when they do seek services, symptoms tend to be very severe.
Continue to outreach clients in the community by doing home visits assessments and providing consultation to families.

PEI 16. Latino staffing to ACCESS

Program Description: Improve availability of ACCESS and brief treatment clinic/field based services by increasing bicultural staff in one Latino crisis clinic. Includes assessment, brief treatment and referral services.

FY 13/14 Outcomes, Impact & Challenges:

- Performed screening, assessment and referrals for Spanish speaking Latinos 5 days per week. Hoped to transition program for primarily appointment based to open access to allow for greater access to services but this did not occur. Continue to offer appointment based assessments with accommodations for those in crisis that need to be seen immediately.
- Provided brief treatment/crisis stabilization services to 163 clients.
- Performed 402 Assessments to provide level of care determination
- Providing 4 Spanish groups per week including WRAP, Peer Activity, Depression and Trauma facilitated weekly by Peer staff or Peer & Clinical staff together for outreach/engagement and symptom monitoring.

FY 14/15 Progress Report:

- Perform screening, assessment and referrals for Spanish speaking Latinos 4 half days per week. Researched and learned that a drop in assessment model (open access) is best supported by use of collaborative documentation. FY 14-15 setting up rooms for collaborative documentation initiative and all Access/Assessment staff have been trained and are starting to use collaborative documentation with client input. Once collaborative documentation is achieved, our program plans to transition assessment program for primarily to program where clients can select between scheduled appointment and walk-in assessments to allow for greater access to services for FY 15-16. In FY 14-15 Continue to offer appointment based assessments with accommodations for those in crisis that need to be seen immediately.
- Provide brief treatment/crisis stabilization services to 150 clients.
- Perform 350 Assessments to provide level of care determination
- Providing 4 Spanish groups per week including WRAP, Peer Activity, Depression and Trauma facilitated weekly by Peer staff or Peer & Clinical staff together for outreach/engagement and symptom monitoring.
- Depression Group beginning to use Text Messaging to support the group participants and reinforce psycho-educational material and behavioral activation. Selected to be part of a research study regarding the use of Text Messaging to support depression group participants. First group with support of text messaging begins 3/2015. Participants without cell phones/text messaging will be given Metro Phones free of charge by research grant for use in the study. Effectiveness shown in outpatient hospital program with Latinos now being tested at La Clinica in a community based setting with Latinos.

FY 15/16, 16/17 Plans:

- Perform screening, assessment and referrals for Spanish speaking Latinos 5 half days per week. Launch clinic wide open access assessment model supported through the use of collaborative documentation. Offer clients either scheduled appointment and walk-in assessments to allow for greater access to services for FY 15-16. Study client selection and relationship to "no show" rates. Conduct focus group with clients to get feedback about their experience with collaborative documentation to plan for future years.
- Provide brief treatment/crisis stabilization services to 150 clients.
- Perform 350 Assessments to provide level of care determination • Providing 4 Spanish groups per week including WRAP, Peer Activity, Depression and Trauma facilitated weekly by Peer staff or Peer & Clinical staff together for outreach/engagement and symptom monitoring.
- Continue to implement and assess effectiveness of text messaging support for participants in Spanish depression group.

PEI 17. Transition Age Youth (TAY) Youth Centers

Program Description: The TAY Wellness program at Youth Uprising (YU) consists of a team of 2 full time mental health clinicians, a mental health intake intern and Health and Wellness Director. Under the MHSA Wellness contract, these clinicians provide individual, family and group counseling services to TAY ages 13-24, prioritizing uninsured TAY between the ages of 16-24. In addition to counseling services the Wellness Team supports TAY around basic needs including housing, food and shelter in order to minimize barriers to therapy engagement associated with these needs. The YU Wellness Program employs innovative approaches to build relationships and offer mental health services packaged as mentoring, arts, recreation, education and simply meeting basic needs. This approach to service delivery has resulted in a broad definition of "client" and "engaged" which allows Wellness services to be delivered to TAY who may not be ready to engage in traditional weekly therapy services.

For previous FY 12-13	For current FY 13-14	For upcoming F Y 14-15, FY 15-16, FY16-17
Outcome Statements: • Increase the diversity of TAY clients receiving clinical services with a particular focus on LGBTQ youth and youth of color. • Reduce stigma associated with mental illness. • Improve the integration of physical and mental well-	Current programmatic Strengths and Activities: Triple C: "Cool Calm Collective" Group is YU's alternative to "Anger Management". A clinician engages TAY in group activities around mood management, positive coping and mindfulness. Triple C is offered year round with high demand. Wellness Recovery Action Plan	• No planned changes Projected people served: • **FY 14/15: 245 youth** 200 prevention/ wellness classes 45 counseling services • **FY 15/16: 265 youth** 225 prevention/ wellness classes 45 counseling services • **FY 16/17: 295 youth**

being of TAY. **Impact** **Clients served in FY 12-13:** 246 unduplicated TAY served via individual counseling caseload, group services, and crisis support and outreach and engagement activities. Of which, 123 clients (50%) identified as female, 122 as male and 1 as transgender. 73% identified ad African American, 20% Latino and 7% other. In terms of age 5% were between the ages 13-15, 20% between 16-17, 43% between 18-21 and 24% between ages 22-24. TAY Wellness staff worked to increase YU as a welcoming place for the LGBTQ youth consumers through: hosting a Coming Out Party; starting a Queers and Allies (Q&A) standing committee, and adopting a bathroom policy in support of Trans identified members, clients and visitors. TAY Wellness staff have also worked to reduce mental health stigma through the provision of internal trainings for YU staff to reduce discrimination and biases that may be implicitly operating around mental health challenges. Additionally the YU Wellness Team has worked to improve the integration of physical and mental well-being of TAY through the assistance of enrollment in healthcare/health insurance. Assistance included scheduling appointments, attending enrollment	(WRAP) group: In collaboration with the agency PEERS, YU began hosting and offering a WRAP group in January 2014. Six TAY have engaged in this service and are working on their individual plans to reduce personal crisis and maintain/ improve their level of functioning. Mental Health Intake Clinician-Intern. This is a relatively new position on the Wellness Team. This position was added to increase efficiency with referral triage and reducing wait times between referral for service and service contact. The current intern is a YU alumni, who's currently in a psychology doctorate program. She's bilingual and has increased YU's capacity to engage monolingual Spanish speaking parents. **Current Challenges** *Staff vacancy:* TAY Wellness program is currently understaffed due to a clinician departure in December 2013. The vacancy has been posted. Interviews were conducted and an offer was made to a qualified candidate in February, After some delay, that candidate declined the offer of employment. They're still searching for a qualified clinician, with priority of adding Spanish language capacity to the Wellness Team. *Group referrals:* Youth counseling groups rarely reach full capacity. YU is in discussion with multiple	250 prevention/ wellness classes 45 counseling services

appointments with youth, and providing stress reduction for youth during this enrollment process. **Challenges:** One priority in FY12-13 was to support TAY with health care enrollment to facilitate engagement in physical health care services. Despite increased on-site support from the Medi-Cal office and ability to submit HealthPAC applications, there remained challenges in completing health care applications. TAY between ages of 18-24 posed unique challenges of address instability, difficulty proving income and household size, and challenges producing necessary documents to complete the application.	potential partners to increase the number of referrals sources external to YU programming in order to implement more group programming.	

PEI 18. Behavioral Health Medical Home

Program Description: Provide BHCS consumers with serious mental illness with access to integrated primary health care services in two Alameda County Mental Health Community Support Centers.

FY 12/13 Outcomes, Impact & Challenges

In Fiscal Year 12/13, the PATH Project exceeded its enrollment goal of 250 program participants at the Oakland and Tri-City Fremont Adult Community Support Centers. The Fremont Tri-City PATH Clinic opened on August 8, 2012, and by March, 2013, the PATH Project had enrolled 261 program participants at the Oakland and Tri-City Community Support Centers.

The PATH Project amended the primary care partners BHCS contracts to include onetime funds for dental care services not covered by Medi-Cal. Each PATH site received $15,000 to $20,000 in SAMHSA Grant "Carryover" funding to cover dental procedures beyond basic examinations and cleanings authorized by the State of California Dental-Cal Program.

Wellness activities at both sites also were able to start classes on nutritional cooking, medical education, and stress reduction, and walking groups. Peer run support groups also met at the Oakland PATH site to explore how to implement the "Community Connections Program". At the end of the fiscal year, program participants were setting "Healthy Living" goals and close to 50% of the enrolled PATH clients participated in at least one well class or activity.

The Oakland PATH Project completed the first year of the State of California, External Quality Review Organization's Performance Improvement Project (EQRO). The EQRO Team visited the Oakland PATH site on November 8, 2012, and was very impressed with the progress made by the PATH Project staff on the collection of health data and with the high level of satisfaction among the program's participants. An analysis of clients enrolled for a year or more showed significant health improvements were made in lowering metabolic indicators for those with high blood pressure, obesity, diabetes, and high cholesterol (See PIP PATH Data Presentation and PATH Metabolic Indicators Attachments).

On February 7 and 8, 2013, the BHCS PATH Project sponsored the Winter SAMHSA PBHCI Western Regional Conference at the Oakland Airport Hilton Hotel. The conference had over 93 attendees from PBHCI Grantee Programs from the States of Washington, Oregon, Alaska, Utah, Arizona, and California. On Friday, February 8, 2013, Ms. Kathy Reynolds, Vice President Health Integration and Wellness Promotion Services spoke to BHCS Executive Leadership, managers, and directors of primary care, behavioral health, and substance abuse organizations on "How to implement and sustain Integrated Health Services within the Behavioral and Primary Care Health Settings". Over 30 behavioral health program leaders and managers were able to be in attendance for the presentation.

On August, 2013, the PATH Project was able to fill its Registered Nurse and Mental Health Specialist positions at the Oakland Community Support Center as well as start its fourth half day clinic on Friday morning on December 6, 2013.

FY 13/14 Program Outcomes to Date and Plans:

During FY2013/2014, the PATH Project entered its fourth year, and has been able to increase its participant enrollment to over 280 consumers enrolled at the Oakland and Tri-City Adult Community Support Centers with a participant retention rate over 80%.

In February, 2014, the BHCS Decision Support Services and the PATH Project Program Evaluator looked at LifeLong Medical Care's health data for Level I Clients in the PATH Project and Level I Clients not enrolled in a behavioral health integrated primary care service. The results showed that PATH participants not only had more successful access to primary care services, but also over a 12 month period had higher improvement rates for their blood pressure, Body Mass Index (BMI) and blood sugar level.

The PATH Project's Sustainability Workgroup completed a written PATH Project Sustainability Plan in March, 2014, which was approved by Alameda County's SAMHSA, Primary Behavioral Health Care Integration Project Officer. The Sustainability Plan described the activities used by BHCS to create collaborative partnerships with the PATH Primary Care provider organizations, the necessary financial model to cover the costs of the services, and the collection of data that shows the positive impact of the services.

On May 12, 2014, the PATH Project received approval from BHCS Executive Leadership to start exploring the possibility to implement a PATH Project model at the Eden Adult Community Support Center in San Leandro, California. Eden Community Support Center has approximately 325 enrolled Level I program participants.

On May 22, 2014, the Oakland PATH Project sponsored its second Annual "Visioning Retreat" to discuss the project's progress, set new goals, and discuss how the integrated care program has had an impact on Level I consumers participating in the primary care services and health and wellness classes and activities. The retreat was attended by 35 case managers, primary care providers, psychiatrists, peer support counselors, nurses, and program evaluation staff.

Starting in the last quarter of FY 13/14, the PATH Project has been collaborating with three of the BHCS Adult Community Support Center Directors to have discussion meetings with the BHCS, Substance Abuse Administrator and his program staff on how to improve access to substance abuse treatment services for SMI consumers enrolled in the community support centers and full service partnerships.

FY 14/15 Program Plans:

Implement the PATH Project at Eden Adult Community Support Center by February, 2015, and operate two half day primary care clinics at the site by June 30, 2015, with at 95 enrolled program participants.

Using the PATH Project's integration model, implement a half time primary care service in collaboration with Tiburcio Vasquez Health Center at the BHCS Gail Steel Wellness and Recovery Center in Hayward, California by May 25, 2015.

Working in collaboration with the BHCS Substance Abuse Administration staff, identify at least two ways that SMI consumers served by BHCS community support centers and full service partnerships can have improved access to substance abuse treatment and recovery services available in Alameda County.

Work with the Alameda Health Consortium to develop ways to get access to the physical health information on SMI consumers served by their network of community health centers so that the PATH Project can better monitor the impact of integrated care on emergency room utilization, hospitalizations (psychiatric and medical), and criminal justice contacts.

FY 15/16 Program Plans:

Work collaboratively with the BHCS Information System Office to make sure that the new Electronic Health Record System can be utilized by the behavioral and primary care staff that is a part of the PATH Project to share health information on program participants.

Monitor PATH Project staff to ensure that they are billing Medi-Cal for the client services at the BHCS, adult community support centers.

Program Description: Innovative Programs

FY 12/13 Outcomes, Impact & Challenges:

July 2012 - Round One Innovative Grant Program Completion
Twenty-two grantees completed implementation of pilot projects which addressed community mental health needs.

Project Name / Grantee	Outcomes	Impact
1. *Interplay Mental Health Project* / Body Wisdom, Inc.	Conducted two series of 8 session workshops to teach and build somatic self-healing skills.	98 homeless older adult women with mental health issues learned somatic self-healing skills.
2. *MAP: Human Services Mentoring (Maximum Achievement Project - MAP)/*Merritt College	17 community-college students (predominantly African American and many of whom had previously experienced homelessness, or the foster care system) participated in an academic and mentoring program to learn and work in the mental health field.	7 students transfer to 4-year universities with intent to study mental health.
3. Mentors On Discharge (John George Psychiatric Pavilion)	62 consumers being discharged from John George Psychiatric Pavilion was matched with a peer mentor to assist in transition into community.	72% reduction in re-hospitalization as compared to the 12 months prior to the study.
4. MPACT: Parent Child Engagement Through Dance (Luna Dance Institute)	Conducted dance based program that engages families separated due to domestic violence, substance abuse, homeless or immigration Research and evaluation on the effectiveness of the classes.	532 individuals participated in classes and learned strategies to improve engagement and mental health. Taught 119 parent-child dance classes to teach parent-child dance offered to mental health providers, special needs teachers, parents, community/social workers, and other educators.
5. Play on TAY (TAY Advisory Board)	Through a community-based process to engage their peers, Transitional Age Youth (TAY) designed a hand-	Conducted 9 Play on TAY presentations at community and regional conferences with total of 180+ TAY workshop

	painted board game about mental health issues specific to their own community. This game provided education on TAY mental health issues and fostered inter-generational conversations about mental health.	participants and 2,200 conference attendees. Conferences include the California Association of Social Rehabilitation Agencies (CASRA) Conference in San Mateo, the Journey to Change Conference in Oakland, and the Alternatives National Conference of behavioral health consumers.
6. Qi Gong for Oakland Chinatown Seniors (Oakland Asian Cultural Center)	Conducted 3 series of workshops engaging Oakland Chinatown Seniors and pairing Qi Gong (a traditional Chinese martial art) with wellness classes to build culturally appropriate resiliency skills for mental health.	60 participants reported increased well-being, increased ability to identify the signs/symptoms of mental illness, increased social/peer support and connectedness, and a decrease in feeling isolation.
7. SSI Pre-Release Project (Homeless Action Center)	Provided legal advocacy and support to inmates with mental health challenges at Santa Rita Jail in gaining access to SSI benefits prior to their release as a bridge back into the community	14 cases were approved; Of the 5 who were approved in 2011, only 1 is back in the California prison system (despite CCR's reported 80% recidivism rate for prisoners with serious mental illness).
8. Women Overcoming Trauma (Women's Daytime Drop-In Center)	• Conducted 53 peer-supported Women Overcoming Trauma support groups serving 37 consumers; • Provided weekly educational and skill-building support groups for 15 months	• Of the 22 women who attended 20+ meetings: 1 Found permanent housing; 4 Moved into long-term transitional housing; 4 got SSI/Disability; 3 found part time work; 7 Had full psychiatric evaluation; 7 Got health insurance (either Medi-Cal/Health Pac); 8 Had more than 10 individual therapy sessions; 3 had 2-9 Individual therapy sessions; 4 Got family/child therapy; 6 Got needed medical/dental treatment; 2 Got training/education; 3 Engaged in volunteer work; 5 Completed SSI applications;

		and 5 Attended important legal issues.
9. African American Mother Daughter Workshops (Carla Keener & June Allen)	Teach, build, and strengthen resiliency skills to mothers and daughters as a protective factor against mental health issues	Conducted 6 workshops to for 3 mother-daughter dyads.
10. Battlefield Poets (Wee Poets)	Interviews with veterans provided public education about mental health, and promoted mental wellness for veterans.	Filmed & aired 10 episodes of conversations with veterans and service providers about mental illness.
11. Be Present Family Camp (Be Present, Inc.)	Conducted a 4 day "Be Present Empowerment Model" family camp to foster-care and adoptive families and providers to build resiliency skills and address mental health issues related to adoption, foster care, race, and gender. Monthly support groups trainings increased improvements in communication skills and self knowledge.	• 60% reported increased capacity to address issues related to race, gender, power, class, adoption and foster care; • 70% reported increased ability to listen to others without judgment; • 71% reported increased capacity to resolve conflict in a positive way.
12. Earfull Records Project (Darren Linzie)	Assisted low-income mental health consumers to access the music industry, to become self-sufficient, and compose, record, and produce a CD about mental health issues.	12 track CD of songs created by consumers predominantly about mental health issues.
13. Gender Acceptance Project (Gender Spectrum)	• Trained parents, school staff/teachers, and students to increase awareness of issues facing gender diverse students • Provided organizational trainings increasing awareness of gender diversity in children/youth and organizational capacity to serve these children/youth • Provided support groups for family of gender diverse students.	27 school-based trainings 18 months of monthly support groups for parents/caregivers of gender diverse students 2 Professionals' Workshops engaging almost 350 professionals to explore interdisciplinary support for gender diverse youth 2 Family Conferences bringing together gender diverse children and youth, their families/caregivers and the professionals who support

		them.
14. Increasing Access to Wellness for Mayans (AC-Public Health Dept., MADRE)	• Culturally responsive outreach and assistance to monolingual Mayan/Mam speaking families who experienced fetal infant loss • Access case management • Connect with essential health, financial and social resources to promote mental wellness	13 Mam-speaking women and families participated in program 5 healthy babies born
15. Grlpreneur TAY Entrepreneur Boot Camp (Grlpreneur Sustainable Business Incubator)	Provided on-site, program specific and customizable entrepreneurship training to TAY women who are consumers of mental health services in business development to build business and self resiliency skills.	Entrepreneurship training to create a positive set of outcomes for TAY women; Participants self reported and exhibited increased confidence in their understanding of the process of starting a small business, basic marketplace economics and of their economic outlooks as a result of the training.
16. Robertson High School (City of Fremont, Youth & Family Services)	Provided a 12 week Transformative Life Skills yoga course at Robertson Continuation High School.	60+ student participated in weekly transformative life skills yoga course; Self reported immediate benefits include feelings of calmness, reduced tension in the body; Similar positive shifts were seen in staff at Robertson High School and at Youth & Family Services who were exposed to TLS yoga
17. Who Are These Girls? (West Coast Children's Clinic)	Inform and work with motel owners, local Police Departments and the Sheriff's Department in Alameda County re. child sexual trafficking of children.	110 site visits conducted to hotels and motels in Alameda County to provide psycho-education about how to identify and prevent the sexual exploitation of youth in their establishments. Education on red flags and preventative resources to combat this epidemic were provided.
18. Building a Community of Safety & Respect (Albany	• Conducted 8 Community Meetings with LGBTQ	• Self reported rates of bullying were decreased among

Unified School District)	families, school administrators and leaders to reduce LGBT-related bullying. • KidPower conducted workshops • Classroom resources used by teachers to promote understanding and respect regarding LGBT issues, • Teach students how to be allies to their classmates from LGBTQ families.	children of LGBTQ families; • Creating a muti-stakeholder partnership between school districts and LGBTQ families; • Mental wellness increased through community and social support.
19. Exposing Clinicians to Traditional Healing Practices (La Clinica de la Raza)	Provided 12 traditional healer-facilitated experiential workshops to clinical and peer mental health staff.	Research, tested, and evaluated the impact that this exposure had on the clinical services that were provided in an outpatient Latino focused treatment program.
20. Three-Day Weekend Grief Ritual Retreat for Kin Who Lost Family to Street Violence (Wisdom Spring, Inc.)	A 3-day grief ritual and a 1-day follow up event provided to low-income individuals who were victims of street, domestic, sexual, or family violence, and providers.	100% of those who attended the ritual reported that it helped them release or heal some grief or sadness they were experiencing.
21. Legacy Letters (Trena Cleland)	Interviews and oral history were captured to create Legacy Letters: 30-page booklets for HIV-positive women to increase mental wellness.	Participants reported the process empowering, therapeutic, and confidence-boosting.
22. Reformation: Moving Beyond Stigma (Adella)	Conducted two transformative mask-making workshops. Participants created an inner mask and an outer mask and explored the rich emotional experiences of each, culminating in cutting the outer mask to reveal the inner.	Dual Mask workshop helped to address outward social stigma and inner self perception for participants.

In October 2012, these 22 pilot projects were highlighted at the INN 1 Learning Conference. The Conference included grantee workshops, a plenary speaker on innovations in mental health services, and multi- media presentations of the projects. 250 providers, County staff, school representatives, consumers, family members, and other community members participated in the conference.

Challenge: The first round of INN grant funding was awarded based on a learning question posed by the grantee, coupled with their innovative approach designed to answer that question. Though the grants were all quite worthy, Behavioral Health Care Services (BHCS) and the MHSA Ongoing

Planning Council (OPC) learned from this initial process that our funding criteria were too broad. These overly-broad criteria resulted in an overwhelming number of proposals, many of which did not help us address issues facing our system of care. This was a valuable learning experience for BHCS.

Round Two Innovation Grant Projects (INN 2)
Innovative pilot projects were in implementation from April 2012 to December 2013.

For the second round of INN funding, BHCS, with input from the MHSA
Ongoing Planning Council formulated the learning questions and the desired outcomes to address issues rose in the African American Utilization Report. BHCS' intention was to improve the quality of care and more positive mental health outcomes for the African American clients and consumers. Alameda County has historically served African Americans for behavioral health issues at a disproportionately higher rate than other members of our community, yet the outcomes are inconsistent. In late 2009, BHCS leadership commissioned a study to address and explore the various issues affecting behavioral health care services in Alameda County within the African American community. The process was led by a local facilitation team, working with the BHCS Ethnic Services Manager/Cultural Competency Coordinator and a 29-member committee. Input was solicited from a full spectrum of community stakeholders and subject matter experts regarding ways to resolve these disparities and deliver more effective, culturally appropriate care. The African American Utilization Report contains the Committee's findings and recommendations and serves as the foundation for the Innovations Grants, Round Two Learning Questions. BHCS' overarching goal is to decrease African American utilization of more restrictive and often involuntary levels of care by providing and engaging African Americans in more culturally responsive services that result in improved client/consumer outcomes and reduced disparities. BHCS identified as priorities those recommendations that would have the greatest impact on our system and spanned all four systems of care. BHCS created the learning questions to address four critical
needs:

1. Developing culturally responsive practices;
2. Strengthening BHCS partnership with the faith-based community;
3. Supporting trauma informed care that recognizes the trauma related to social issues within the African American community;
4. Engaging African American males in their primary and behavioral health care.

In April 2012, fifteen grantees were selected to implement the second round of Innovative (INN 2) Projects to address these needs. At the completion of the 18 month implementation period, INN 2 grantees would submit one of the following project outcomes:

1. An age-based, culturally-informed provider training curriculum designed to improve effectiveness of behavioral health care services to African American clients/consumers and their families;
2. A program design that includes a set of specific strategies for the development of an effective partnership between the African American faith-based and spiritual communities. These communities will serve as cultural institutions and a natural support for BHCS clients/consumers and their families;
3. An age-based provider training curriculum designed to increase BHCS capacity and expertise on trauma informed care for BHCS African American clients/consumers and families;
4. A set of specific strategies, supports and recommendations that will improve the engagement of African American adult males in behavioral health and primary care services.

FY 13/14 Progress Report:

Innovation Round Two Grant Projects
The implementation of INN 2 projects (below) were completed by December 2013.

***Project Name* / Grantee**	**Outcomes**	**Impact**
1. ***Co-Occurring Healing*** / St. Mary's Center	An age based provider training curriculum that incorporates cultural characteristics into the behavioral health care services provided to African American older adults.	African American older adults with mental health issues and co-occurring disorders reconnected with positive cultural characteristics that foster greater resilience and mental wellbeing.
2. ***His Health*** / AC Public Health Dept. & Brothers on the Rise	An age based provider training manual to build cultural competence for providers to serve African American middle school males inside and outside of the academic setting.	• African American male youth in middle school; • Mental health providers, training professionals for therapy, counseling and wellness, mental health non-profits.
3. ***The Sakhu Project*** / The Institute for the Advanced Study of Black Family Life and Culture, Inc.	A provider training curriculum designed to: • Improve the "culturally grounded services" of existing non-African American community service providers; • Increase availability and involvement of "culturally congruent services" with African American service providers.	African American consumers, clients, and family members.
4. ***Understanding the Impact of Trauma on the Wellbeing of Young African American Children and Their Families***/ Children's Hospital Oakland Center for the Vulnerable Child/Early Intervention Services	A primary care provider training curriculum to: • Improve understanding of the impact of trauma on African American children and their families; • Provide more culturally responsive treatment and more accurate and unbiased mental health diagnoses, • Strengthen the cultural relevancy of services	• African American families and their children (ages 0-5); • Culturally responsive training for mental health and primary care providers.
5. ***Healthy Teens*** / Fremont Unified School District	Culturally responsive practices for schools to address the mental health needs and	• African-American transitional age youth (TAY)

	adolescent health and well-being.	• Teachers, school staff, and mental health providers.
6. ***African American Faith Mental Health Anti-Stigma Campaign***/ Healthy Communities, Inc.	• Partnership with African American faith based institutions to decrease stigma, provide education and incorporate welcome strategies the members of faith based communities. • Mental health guide for ten churches and a mental health resource website.	• African American churches and congregations; • Mental health consumers re-entering from the criminal justice system who are part of a faith community.
7. **Girls Far Above Rubies**/ EC Reems Community Services	• Intervention strategy that evaluates their attachment relationships, the impact mental illness has on relationships and the avenues of intervention to reduce risk factors; • Partnerships with faith-based organizations in Oakland to support target population.	Support African American women and their families recovering from trauma and focus on mothers who display signs of mental illness and their daughters (ages 8-18).
8. **Mental Health Friendly Congregations** / Tri Cities Community Development Center	Program design with strategies for a partnership with African American faith-based community to reduce disparities and improve outcomes for the African American consumers.	Enables consumers, family members, the African American faith community and BHCS agencies and providers to work together to reduce stigma and to improve outcomes.
9. **Community Healing Circles: For African American Men and Adolescents on Probation**/ Bay Area Black United Fund	An age-based provider training to provide African American culturally responsive mental health services focusing on cognitive and experiential learning and practices that foster growth in self-awareness and healing past traumatic experiences.	Transitional age youth, (ages 18 – 25), with focus on African American men on probation and participants' families and the consumers' community.
10. "Conscious Voices" / Conscious Voices	An age based providers' training curriculum that offers multiple strategies: • Connect with Alameda County "10x10 Campaign" in the African American community to increase life expectancy, improve the quality of life;	• African American older adults, TAY, adults and families who have experienced trauma; • Medical and mental health care providers and professionals.

	• Address current trauma and historical trauma; • Psycho-education, social emotional learning, meditation/mindfulness; • Well Being support groups; • Harm reduction intervention to community violence.	
11.***Developing Trauma Informed Practices for Young People Caught in the Crossfire***/ Youth ALIVE!	An age-based culturally-informed provider training curriculum on Trauma Informed Care for BHCS direct service providers of African American TAY focusing on understanding how consumers are treated when accessing services, and seek ways to improve interactions	Violently injured transitional age youth (ages 16 – 29),with a focus on young African American men: • Trauma informed care that increases the wellbeing of young people accessing services; • Positive encounters with service providers that can increase trust and improve relationships in communities.
12. ***Healing Trauma through Support and Care: Trauma Awareness Group*** / East Bay Agency for Children	An age-based provider training curriculum to deliver a school-based culturally relevant, complex trauma treatment group for African American youth and to increase the schools' administration, staff and teachers' capacity to understand the impact of trauma.	• African American youth ages 14-18 with a history of complex trauma, their families, and schools. • Providers of mental health services to African American youth.
13. ***Safe Transitions***/ Centerforce	Program design with: • A model of transitional case management to support African American men releasing from prison and returning to Alameda County, • Adapted culturally responsive protocols and tools for recruitment, identification, and engagement.	African American men releasing from prison and returning to Alameda County, who have experienced trauma.
14. ***Healing Trauma and Overcoming***	An age based provider training curriculum utilizing	African Americans older adults, and any community

Stress: Creating Health and Well-Being Through the Use of Cultural Genograms, Storytelling, and Mindful Based Practices / CJM Associates (CJMA), with Center for Family Counseling (CFC)	family/cultural genograms, stories of trauma and resilience, organize fragmented family narratives, to develop effective stress reduction strategies.	affected by trauma as a result of institutionalized racism and marginalization.

At the Innovation Learning Conference on February 28, 2014, fourteen grantees presented their project findings and final outcomes to the community at large. Over 300 individuals, including consumers, family members, providers, county staff, funders, and other county staff, participated and learned about cultural responsive strategies to serve African American clients and consumers.

BHCS has begun the INN 2 project outcome evaluation process. This process involves community subject matter expert members and BHCS System of Care staff review and scoring of the final INN 2 project outcomes, the curricula and program design.

Innovative Grant Program - Round Three Grant Cycle

Round Three of Innovative Grant Projects address two target populations with specific needs:

- Isolated Adults and Older Adults with Serious Mental Illness;
- Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Two Spirit (LGBTQI2S) Clients/Consumers

In anticipation of the potential Innovation Grants Round Three funding cycle, BHCS commissioned two consulting projects to conduct a demographic analysis and provide a summary of the significant behavioral health care needs for these target populations. The reports 1) informed the development of learning questions for potential inquiry funded by Innovation grants; 2) recommended outreach and engagement strategies; and 3) provided other pertinent information regarding the target population.

Prior to the grant application period, BHCS conducted outreach and information meetings throughout Alameda County. Grant applications were submitted by the end of April 2013. Applications were evaluated by the Innovation Review Panel, which consisted of community content experts and members of the MHSA Stakeholder Group. BHCS selected INN 3 grantees based on the evaluations and recommendations of the INN 3 Review Panel. In April 2014, grantees began Implementation of the pilot projects.

FY 14/15, 15/16, 16/17 Plans:

FY 14/ 15

Round Two Innovative Grant Cycle

The evaluation process of Round Two final project outcomes will be completed by end of 2014. Based on the evaluations and recommendations of the INN Panel of Subject Matter Experts and the BHCS System of Care staff, BHCS leadership will make decisions regarding implementation of the African American culturally responsive curricula and program design. BHCS will recruit and convene community subject matter experts for the African American Steering Committee to give input into the implementation of the final curricula and program designs.

Round Three Innovative Grant Cycle

Implementation of grant projects should be complete by November 2015.
The Round Three Innovative Grants Learning Conference will highlight grant projects and outcomes to the community. Evaluation of project outcomes will be conducted in FY 2016.

The grant projects (below) will develop program designs addressing the needs of Isolated Adult and Older Adult Consumers**.**

Project Name	**Grantee**	(Anticipated) **Project Outcome**
1. City of Fremont Peer Mental Health Coach Program: A Community Mental Health Model	City of Fremont / Human Services Department	Train Peer Mental Health older adults with SMI matched with isolated adults with SMI (age 50+) as MH Coaches.
2. Special Message Project	PEERS	Community Relations Managers and Peer Outreach specialists will be trained to outreach to fifty isolated adult consumers.
3. Reaching In: Reducing Isolation Due to Mental Illness by Partnering With Family Members/Loved Ones	CJM Associates / Center for Family Counseling/ Bay Area Community Services (BACS)	Family Healing: engage the family and isolated consumer through a 12-week workshop series using narrative based story telling and family/cultural genograms, and addressing stress.
4. An SRO Culture of Inclusion to Decrease Isolation Among Residents with Serious Mental Illness	Public Health Institute	Increase engagement with isolated consumers SRO through physical, social, and spiritual activities, including computer-based cognitive training.
5. Project Asian Reach (PAR): Home and Place-based Outreach to Chinese and Korean Isolated Older Adults	Asian Community Mental Health Services	Train culturally appropriate peers and family members paired with bilingual mental health clinicians to launch home-based and place-based

		outreach to reduce isolation of and increase use of mental health services by monolingual Chinese and Korean adults/older adults with SMI.
6. PEP: Peer Elder Program	St. Mary's Center	Elder leaders outreach to isolated older adults with mental illness where they live and develop appropriate assessment and engagement.
7. THRIVE: Teaming Housing Residents with Interest-Based Volunteer Exercises	Berkeley Food and Housing Project	Outreach with a network of non-profit and volunteer placement sites for isolated adults living in Board and Care facility.
8. Asian Elder Wellness Project	Community Health For Asian Americans, with community partners Center for Empowering Refugees and Immigrants (CERI), Filipino Advocates for Justice (FAJ) and Korean Community Center of the East Bay (KCCEB)	Core leadership groups (CLGs) will identify culturally responsive strategies for SMI adult and older adult Cambodian refugees, home care providers from the Filipino community, and Koreans living in housing facilities.
9. Stepping Out and Reaching In (SOAR)	Senior Support Program of the Tri-Valley	Peer mentoring program addressing nutrition, medication management, healthy choices, stress management, and connecting with community.
10. Refugee Well-Being Project	International Rescue Committee	Provides culturally/linguistically appropriate services to isolated refugee adults and older adults including intake and assessment of mental health needs, referral and case management, peer group health education, etc.

The grant projects (below) will develop either a program design, welcoming toolkit or a provider training curriculum to address the needs of LGBTQI2S Clients and Consumers.

Project Name	Grantee	Project Description
1. LGBTQI2S Welcoming Strategies Toolkit for Providers	The Pacific Center for Human Growth	Develop a LGBTQI2S Welcoming Toolkit using site visits, materials review, trainings, and an audit of forms and phone procedures.
2. Rainbow to Wellness	Asian Community Mental Health Services	Develop a Welcoming Toolkit for LGBTQI2S clients/consumers, with special considerations to the Asian and Pacific Islander clients and consumers.
3. Unconditional Pride: A Clinical Framework for Partnering with LGBTQI2S Youth and Allies	Seneca Center	Create two curricula (for Children and TAY) with the expertise of local LGBTQI2S youth and their families and providers, and integrated with Seneca's "Unconditional Care" treatment model.
4. Critical Conversations: Talking About LGBTQI2S Transition Age Youth & Mental Health	Our Space, a program of Bay Area Youth Center	Design a training curriculum that is rooted in the experiences of LGBTQI2S TAY impacted by mental health, via digital storytelling and technology.
5. Community Inclusion Project for Age-Based LGBTQI2S Provider Training Curriculum	The Pacific Center for Human Growth	Develop a LGBTQI2S Provider training curriculum for each age group that will assess the current use of culturally sensitive language and identify cultural competency issues among BHCS providers, and facilitate "learning meetings" in small groups with providers and consumers.
6. Addressing LGBTQI2S Elder Healthcare Disparities: Developing Tools for Online Training	Lavender Seniors, a project of Life Elder Care	Develop an online learning tool to increase provider access to a training to outreach to LGBTQ older adults.

7. Lambda Youth Project - Children	Horizon Services, Inc/ Project Eden	Develop an LGBTQQI2-S Training Curriculum that supports age-based, culturally responsive provider capabilities regarding emotional, developmental, physical, social, and mental health needs and issues for LGBTQQI2-S children.
8. Lambda Youth Project - TAY	Horizon Services, Inc / Project Eden	Develop a LGBTQQ2-S Training Curriculum that supports age-based, culturally responsive provider capabilities regarding emotional, developmental, physical, social, and mental health needs and issues for LGBTQQI2-S TAY.
9. Alameda County Peer Support and Congregations Collaborative – Education and Peer Support Project	California Institute of Mental Health (CiMH)	Develop a best practices program design to work effectively with family members for unserved/underserved, low income, LGBTQI2S African Americans and others of color, their families/allies.
10. Improving LGBTQI2S competency for providers through small group trainings and follow up supports	The Pacific Center for Human Growth	Develop a training template to improve competence in how to reduce barriers for LGBTQI2S people accessing mental health services, based on a small group conversational training model.
11. Adapting Supports for LGBTQI2S people and their families based on the intersections of age and cultural considerations	The Pacific Center for Human Growth	Utilize collaboration, materials creation, small age-based group field test trainings, and LGBTQI2S community meetings to engage the public in addressing the isolation of LGBTQI2S people of all ages.
12. Oyate Tupu'anga Project: Healing Indigenous Two Spirit and Takataapui Communities	Community Health for Asian Americans – with community partners Bay Area American Indian Two Spirits (BAAITS),	Utilize Native American and Pacific Islander traditional cultural practices to bring Native American Two Spirit

	and Community Health for Asian Americans' Pacific Islander Community Advocacy	and Pacific Islander Takataapui people of all ages together to decrease social isolation and to assist with emotional disturbance and serious mental illness.	
13. Alameda County Peer Support and Congregations Collaborative – Welcome Toolkit Feedback	California Institute for Mental Health	Predominantly African American member churches will develop a Welcome Toolkit for LBTQI2S consumers by conducting focus groups and 1-1 interviews.	

Alameda County Behavioral Health Care Services (BHCS), Workforce Education & Training (WET) uses 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

1. 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 12/13 Outcomes, Impact & Challenges:

- The WET manager and staff attended and actively participated in the Bay Area WET Collaborative meetings; twice monthly WET coordinator conference calls.
- WET staff actively participated in the Regional Partnership Workforce Education and Training (WET) Steering Committee meetings.
- WET manager provided oversight of the Bay Area Regional Partnership contract, as BHCS serves as the fiscal sponsor and employer for the state funded Regional Partnership Program.
- The WET team administered and implemented previously approved WET strategies such as the Graduate Intern Stipend Program and the State Mental Health Loan Assumption Program (MHLAP).
- WET manager continued to develop a strong relationship with Berkeley City College and their Public and Human Services Certificate program as well as developed a curriculum for them to use that includes wellness and recovery foundations and information on the consumer and family movements.
- Hired Internship Coordinator.

Workforce Staffing Support continued…

FY 13/14 Progress Report:

- Organized and hosted, in collaboration with the Office of Statewide Health Planning and development (OSHPD), a Community Forum on the State Workforce, Education, and Training five year plan for 2014-2019. 65 participants attended the forum.
- Organized and held an annual WET strategic planning meeting with WET team, facilitated by CiMH WET staff.
- WET Staff has expanded responsibilities for providing administrative functions for Children's System of Care (CSOC) internships.
- Hired a consultant to develop and conduct a workforce needs assessment survey.
- Held a focus group and received important information regarding workforce needs in preparation of the upcoming workforce needs assessment survey.
- Interviewed candidates to fill the Internship Coordinator position as the previous Internship Coordinator transferred to another county department.
- Processed funding agreement between BHCS, as the fiscal sponsor, and OSHPD to fund and implement the Bay Area Regional Partnership program for FY 2014 through 2017.
- BHCS will continue to serve as the fiscal sponsor for this funding as outlined in the OSHPD Agreement Number 14-5004, which will include passing through the funds to CiMH. WET manager will continue to provide contract oversight.

FY 14/15, 15/16, 16/17 Plans:

- WET team will continue to administer and implement WET strategies.
- Develop a needs assessment survey to be administered to all BHCS county-operated and county contracted, community-based behavioral health organizations to identify current BHCS workforce needs.
- Evaluate WET program impact and needs; based on program outcomes and data, continue to enhance and implement activities to achieve WET goals.
- Convene an African American workforce development advisory group.

2. 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.

FY 12/13 Outcomes, Impact & Challenges:

BHCS has developed and implemented the following activities:

- 140 consumers and 79 family providers employed in behavioral health in Alameda County and community based organizations (CBO).
- Provided employment opportunities list serve for consumers and family members.
- Convened ongoing Consumer & Family Employment Work Group meetings to learn, discuss and problem solve consumer and family employment content & issues.
- Provided Family Leadership and Family Advocate Training Programs through the Family Education Resource Center (FERC).
- Implemented annual BEST Now! Consumer Employment Training Program with 6 month internships: 18 graduates.
- Provided two Supervisorial Trainings: "Welcoming and Partnering with Consumer Family Employees" 26 managers in Fall & 24 managers in Summer. This training was designed to build managerial skills, knowledge, and abilities, providing strategies to effectively hire, integrate, supervise and support their consumer and family employees.
- Initiated development of "learning collaborative" for managers who were working with consumer and family employees. The Learning Collaborative will provide ongoing training, technical assistance, and support. Once established, managers can apply the information they learned from the supervisorial trainings to continue to build their skills.
- Hosted third Consumer & Family Job Fair in partnership with consumer and family operated organizations. There were 165 fair participants, 20 provider organizations, 3 academic institutions, and 59 employment opportunities marketed.
- Provided job readiness event: "Dress for Success" Clothing Boutique Exchange. 75 consumers were given free work clothing so that they had appropriate attire when applying and interviewing for employment.
- Established partnership with Berkeley City College (BCC) Public and Human Services program to increase access for our consumers and family members entering community college.
    - Organized outreach event in collaboration with BCC to 32 consumer participants – 2 participants enrolled.
- Developed and submitted Peer Navigator Program pilot plan later approved by Administration.

FY 13/14 Progress Report:

- 142 consumer and 86 family providers currently employed in behavioral health in Alameda County and community based organizations (CBO).
- Continued development of "learning collaborative" for managers who are working with consumer and family employees to provide technical assistance and support
- Developed and facilitated planning workshop for "learning collaborative" with 23 supervisors.
- Provided Family Leadership and Family Advocate Training Programs through the Family Education Resource Center (FERC).
- Implemented annual BEST Now! Consumer Employment Training Program with 6 month internships: 21 graduates.
- Organized two outreach meetings to promote BCC Public and Human Services Programs with BCC & BEST Now & Pool of Consumer Champions (POCC) members for 20 individuals.
- Partnered with BHCS Consumer Empowerment Team & Mental Health Association of San Francisco (MHASF) in their application for Peer Personnel Preparation RFP released by OSHPD. The purpose of this grant was to increase the number of peer specialists in public mental health and to develop career pathways and educational training(s) for peer specialists. MHASF was awarded the grant and developed a new organization: Bay Area Peer Professional Network (BAPPN) of which we are a partner.
- Provided consultation and assistance to Office of Statewide Planning and Development (OSHPD) in planning for FY 2013/2014 statewide WET five-year plan.
- Participated in the interviewing process for the new Project Manager for the Regional Partnership WET program.
- Assisted with planning the Bay Area County Behavioral Health and Human Resources Forum, a collaborative event organized by the Regional Partnership WET program.
- Implemented Academic and Employment Resource Expo, in collaboration with POCC, to provide resources regarding their services and trainings. There were 65 participants, and 10 organizations.

FY 14/15, 15/16, 16/17 Plans:

- For FY 14/15 estimated 144 consumer and 90 family providers to be employed in behavioral health in Alameda County and community based organizations (CBOs); for FY 15/16 estimated 148 consumer and 94 family providers; and for FY 16/17 estimated 152 consumer and 98 family providers.
- Continue developing "learning collaborative" for managers who are working with consumer and family employees to provide technical assistance and support to managers, culminating in establishing and implementing an ongoing series for all three consecutive fiscal years, beginning in FY 2014/2015
- Provide Supervisorial Training: "Welcoming and Partnering with Consumer Family Employees" for managers in FY 14/15; then re-evaluate for next two consecutive years
- Work with BHCS Consumer Empowerment Team, BEST Now & MHASF for their grant with Bay Area Peer Professional Network (BAPPN). Assist in providing necessary information and other needs.
- Develop and implement an educational & supportive skill building series for consumers currently employed in the mental health field to support employment retention and growth.
- Implementation of Peer Navigator Pilot Program by FY 16/17.

3. 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 12/13 Outcomes, Impact & Challenges:

BHCS has developed and implemented the following activities:

- Provided over 50 targeted training events, and 150 CEUs for LCSWs, MFTs, CAADAC, RNs, and registering more than 1,500 participants
- Continued to provide all required Continuing Education (CE) credits and Continuing Medical Education (CME) credit classes annually for licensed providers and physicians employed in County and CBO sites
- Reauthorized for four years to provide CME credit for physicians
- Continued to provide community trainings on Mental Health First Aid
- Offered initial training for 115 staff of primary care clinics and other settings on five Evidence-Based Practices (EBP) including Seeking Safety, Problem Solving Treatment, Cognitive Behavioral Therapy for Insomnia, Motivational Interviewing and Screening, Brief Intervention & Referral to Treatment (SBIRT)
- Continued to develop and implement county wide training on cultural and linguistic competencies to enhance culturally responsive services
- Provided technical assistance on helping to identify training needs and implement training activities for four systems of care (Children's, Transition Age Youth, Adult and Older Adult)
- Provided a regional training on Health Reform and Behavioral Health and Primary Care Service Integration in collaboration with the UCLA Integrated Substance Abuse Programs

Training & Technical Assistance continued…

FY 13/14 Progress Report:

- Provided over 75 targeted training events and more than 200 Continuing Education (CE) credits for diverse disciplines including LCSWs, MFTs, CAADAC, RNs, psychologists, MDs and registering more than 2,000 participants
- Continued to provide required CE credits and Continuing Medical Education (CME) credits annually for licensed providers and physicians employed in County and CBO sites including legal/ethical updates, clinical supervision (general) and clinical supervision for interns
- Continued to provide community trainings on Mental Health First Aid
- Continuing to develop and implement county wide training on cultural and linguistic competencies to enhance culturally responsive services
- Continuing technical assistance on helping to identify training needs and implement training activities for four systems of care (Children's, Transition Age Youth, Adult and Older Adult) and started to offer specialized training specifically to our Alcohol/Other Drug system of care
- Implemented an online registration system in collaboration with the Alameda County Training and Education Center that enables participants to register independently online, have record of their training activities on an official transcript and enables their supervisors to track past, present and future training activities for their staff and for Training Unit staff to automatically prepare participant rosters, certificates of attendance and continuing education credits and other reports.
- Provided a required legal course for staff of ACBHCS Alcohol/Other Drug providers.
- Provided a pilot training for supervisors and direct line staff on Motivational Interviewing
- Offered follow up activities for staff of primary care clinics on five EBPs (listed in FY2012/2013) including mentoring sessions and reviews of secure digital recordings of clinicians utilizing EBP in their work with clients

FY 14/15, 15/16, 16/17 Plans:
Continue to:

- Provide targeted training and providing CE credits for registered BHCS participants (both County and CBO staff)
- Provide required CE credits and CME classes annually for licensed providers and physicians employed in County and CBO sites
- Provide trainings on Mental Health First Aid (general version) and begin to offer a youth version during the fiscal year
- Focus on providing more specialized courses for staff of ACBHCS Alcohol/Other Drug providers
- Provide more training for BHCS supervisors and direct line staff on Motivational Interviewing (MI) and other evidence-based practices (EBP) including Seeking Safety
- Offer more training for staff of primary care clinics on EBPs and other topics related to the integration of care for primary care and behavioral health settings including MI and Seeking Safety.

And in addition to above in FY 14/15:

- Expand our CME dinner programs to more physicians and medical/clinical care staff on a variety of medical/clinical topics related to behavioral health care specifically and the integration of primary care and behavioral health care services
- Provide consultation with our consumer organizations, the Pool of Consumer Champions (POCC) and Peers Envisioning and Engaging in Recovery Services (PEERS), on an annual regional conference focused on wellness, recovery and resiliency.
- Collaborate with the Greater Bay Area Mental Health and Education Workforce Collaborative and county educational organizations and schools to provide a one day conference for high school students to have an introduction to behavioral health careers.
- Develop a pilot mental health paraprofessional training program for unserved and underserved new and emerging immigrant and refugee communities. This program will be an extension of the existing MHSA PEI-funded API Connections program which serves unserved Asian and Pacific Islanders.

And in addition to above in FY15/16:

- Expand our training activities to focus specifically on our Alcohol and Other Drug System of Care with subjects including EBP, documentation and charting skills and more.

And in addition to above in FY16/17:

- Begin to offer more trainings focused on EBPs throughout our behavioral health system including motivational interviewing and change; Seeking Safety; and Cognitive Behavioral Therapy (CBT).

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 clinical supervisors and student interns.

FY 13/14 Progress Report:

- Conducted outreach to county-operated programs and contracted, community-based organizations to update and increase number of trainees/intern opportunities available within BHCS system.
- 200 graduate students interned in both county-operated programs and community -based organizations.
- Launched second round of Graduate Intern Stipend Program in August 2013 with a focus on interns across system, including behavioral health interns in primary care settings.
- Developed and offered orientation to graduate student interns on BHCS System of Care; Mission, Vision and Values.
- Offered trainings to graduate student interns on Behavioral Health Care Services 101, Co-Occurring Conditions, “Seeking Safety”: A PTSD Model, and Welcoming LGBT Consumers and their Families; 130 participants completed the trainings.
- Offered Clinical Supervision Training to increase the number of qualified Intern Supervisors.
- Developed and implemented a new Psychiatric Nurse Practitioner (PMHNP) internship program in collaboration with the University of California San Francisco (UCSF), School of Nursing.
- Identified, developed and prepared PMHNP placement sites and preceptors to provide supervision to PMHNP students.
- Developed memorandum of understanding with UCSF, School of Nursing.

FY 14/15, 15/16, 16/17 Plans:

- Launch Graduate Intern Stipend Program.
- Explore the feasibility of developing an on-line Job Board for graduate student interns.
- Research and explore an undergraduate internship program.
- Continue collaborating with UCSF on developing the PMHNP Student Internship program.
- Continue providing administrative functions and support to CSOC.
- Explore feasibility of developing a psychiatric residency program.

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 12/13 Outcomes, Impact & Challenges:

BHCS has developed and implemented the following activities:

- Developed a 12 module curriculum with Wellness, Recovery, Resiliency (WRR) principles for Berkeley City College (BCC), Health and Human Services Community Health Worker Program.
- BCC integrated WRR curriculum into their existing health education classes. Curriculum was implemented and well received.
- BCC submitted the WRR curriculum to the State Chancellor's office and received approval.
- BCC scheduled a new three-unit required WRR class effective September 2014, titled "Introduction to Behavioral Health Care Services".
- Developed and released an RFP for Mental Health High School Career Pathways Project. Through a competitive bidding process, La Clinica de La Raza, Inc., has been awarded a three year contract. La Clinica is implementing the Pathways Project in collaboration with Life Academy High School and FACES for the Future Coalition at Public Health Institute. This project will provide an opportunity to high school students from various ethnic, cultural and linguistic backgrounds to get exposure on behavioral/mental health careers.
- The WET Manager served on California State University East Bay's School of Social Work Advisory Committee and Berkeley City College's Health and Human Services Advisory Committee.

FY 13/14 Progress Report:

- Developing a three unit curriculum on Co-Occurring Conditions for BCC, Health and Human Services Community Health Worker Program.
- Planning and developing a conference to expose and encourage economically and educationally disadvantaged and or underrepresented high school students to pursue careers in behavioral health. This conference is being developed and organized in partnership with the Bay Area Regional Workforce Education and Training Collaborative, Alameda County Health Pipeline Partnership and the Oakland Unified School District Linked Learning program.
- Continued peer mentoring and supported education for Transitional Age Youth (TAY) at Peralta Colleges.
- The WET Manager continued to serve on California State University East Bay's School of Social Work Advisory Committee, Berkeley City College's Health and Human Services Advisory Committee, and the State Licensed Mental Health Service Provider Education Program.

FY 14/15, 15/16, 16/17 Plans:

- Continue implementing Mental Health High School Career Pathways Project including organizing additional conferences on introducing high school students to behavioral health careers.
- 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.
- Offer co-occurring conditions classes at BCC, Public and Human Services program.

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 11/12 Outcomes, Impact & Challenges:

BHCS has developed and implemented the following activities:

- BHCS has partnered with OSHPD to implement the State Mental Health Loan Assumption Program (a vital retention strategy).
- BHCS has established eligibility criteria, with an emphasis on increasing workforce diversity and language capacity as well as addressing hard to fill positions and skill sets.
- In 2012/13, 37 clinicians in County and contract Community Based Organization (CBO) settings received up to $10,000 towards their outstanding student loans.
- Provided financial support for Federally Qualified Health Centers (FQHCs) to hire behavioral health clinicians.
- Hired County-funded psychiatrists to offer behavioral health consultation.

FY 12/13 Progress Report:

- BHCS has partnered with OSHPD to implement the State Mental Health Loan Assumption Program (a vital retention strategy). OSHPD received a total of 113 applications from Alameda County for the October 2013 Cycle of which 67 applications met Alameda County's hard to fill/retain eligibility criteria.
- BHCS Graduate Intern Stipend Program (recruitment strategy)
    - Launched second round of graduate intern stipend program in August 2013, with a focus on interns across system, including behavioral health interns in primary care settings.
    - Awarded 37stipends in the amount of $6,000 for 720 internship hours. Of the 37 awardees, 53% represent the diverse communities of Alameda County.

FY 14/15, 15/16, 16/17 Plans:

- BHCS will continue to partner with OSHPD to implement the State Mental Health Loan Assumption Program (a vital retention strategy).
- Implement BHCS Loan Assumption Program.
- Launch third round of the BHCS Graduate Intern Stipend Program in August 2014.

ATTACHMENT A: PUBLIC COMMENT & RESPONSES

NOTE: Only "substantive comments" -- defined as comments or requests for changes that would significantly alter the target population, design or budget of one or more programs – are shown and responded to. Other comments are available upon request.

FSP 10 - African American Full Service Partnership

Public Comment	Response
Does "Multi-disciplinary team" mean that there will only be one provider for all Alameda County African American TAY and Adult Male consumers? One provider at $500,000? *If the intent is to fund only one provider, Alameda County has done this in the past (e.g. funded only one or two programs and they have not been as effective). The services mentioned above could be achieved through case managers and peer counselors and a half time or less program assistant for handle data reporting. A team lead/program manager at 25% FTE would also be sufficient. When the funds are smaller and more equitably distributed among providers there is more of an incentive to collaborate to leverage resources and also keep the overall African American Full Service Partnership goals in the mission driven vision of BHCS.* *Recommend funding four (4) FSP at $125,000 each and see how they do in leveraging those funds to meet the needs of the consumers they would be contracted to fund. You would at least increase the likelihood of more streamlined, client-centered strategies and an incentive to the providers to carefully plan their services for strategic impact during ramp up. The African American community is very heterogeneous. You could get more bang for the people's buck by funding four providers all the same and each one bring a component of the array of services you are seeking.*	The number of providers will be based on the responses to the Request For Proposals (RFP). The majority of our current Full Service Partnerships are implemented by one provider or two providers in partnership. $500,000 is for the start-up year while $1M will be the ongoing annual budget. The current design of Full Service Partnerships requires a wide array of services and resources that is normally available only to a larger scale program with more staff employed to serve a higher number of clients. However, BHCS will examine different approaches in the design and development phase of this program.
My primary question centers on what input did the African American community fulfill in influencing this process?	The concept of this program was based on service statistics that show African American males as the largest group receiving services in our most restrictive settings which include locked psychiatric facilities and criminal justice settings. As this plan only represents the budgeting of funding for this program, BHCS will engage the African American Steering Committee to provide input on the final design of the program.
Since most FSPs serve a large percentage of African American consumers, it would benefit our System of Care to have some of the funds be dedicated to the training and resources needed for current FSPs to include culturally responsive practices that are not already included in the current FSPs. This strategy addresses cultural responsiveness of a single new FSP but does not address the further development of culturally responsive practices in the existing FSPs.	Funds for the training of current FSP staff will be budgeted separate from this program.

ATTACHMENT A: PUBLIC COMMENT & RESPONSES

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Female consumers are also in great need. Please provide at least 20% of the designated resources to African American Transition Age Youth and Adult female consumers, who are often mothers, care-givers, silently struggling with depression and other mental health struggles.	African American women, children and families will be served in 1.B – PEI 20.

OESD 23 - Community-Based, Voluntary Crisis Services

Public Comment	Response
People would rather go to service providers in their neighborhoods. As a consumer I strongly support this initiative. I want service providers for this initiative to be African American for the African American communities. I want the care providers of this initiative to be Black agencies with Black staff who knowledgeable about Black psychology as a science and who are grounded in the science of Black psychology. I want the coordination and efforts of the initiative designers to be with the Association of Black Psychologists.	Cultural competence in serving all clients of crisis services, including African Americans, will be an important consideration in the design and development of these programs. At the appropriate phase, providers and associations with this expertise may be consulted to ensure such competencies are reflected in the final program requirements and scope of services.
Expand Sausal Creek – or locate other services in south county. *There is limited crisis response and it is in Oakland. There is a need for an active car in South County: increase for cars for Crisis Response programs both north and south county; I suggest incorporating a car for each: GART, Tri-valley, Tri-cities and unincorporated areas.* *When someone needs help – if they do need to end up going to John George involuntarily– that person has to be transported – is there room on the John George campus - another building? – that could serve as a diversion from needing to wait until some-one needs to be 5150'd – a voluntary facility on the John George campus for crisis service expansion.* *We need more room for people who need the involuntary facilities – do not diminish the facility for involuntary while expanding the voluntary.*	Each of these suggestions will be reviewed in the crisis planning process.

ATTACHMENT A: PUBLIC COMMENT & RESPONSES

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PEI 12 - Suicide Prevention & Trauma Informed Care

Public Comment	Response
It is not clear how additional MET funding is a focus on suicide prevention. The vast majority of MET calls are not for suicidal ideation/plan/intent, but for co-occurring MH and SUD conditions related to homelessness and behaviors that warrant police attention. Might these funds be better served through continued training of law enforcement regarding psychiatric conditions and how to intervene in strength based and empathetic manner?	MET funding is listed under PEI 12 because the MET Team responds to individuals in psychiatric crisis, including suicidal ideation, in order to provide the appropriate assessment and level of care through a clinician and officer team. In addition to the MET funding, BHCS is in its fourth year of providing funding for Crisis Intervention Training (CIT) for all Alameda County law enforcement departments and dispatch units. CIT is comprised of 18 modules including a consumer and family member panel and a cultural diversity module, both of which are strengths based and aim to increase officers knowledge and empathy.
So this is a direct contract with CSS, not out for bid?	Yes, this is an expansion of an existing contract.

PEI 15 - ACCESS for API Population; PEI 16 - ACCESS for Latino Population

Public Comment	Response
I applaud many of the programs in terms of trying to get some of the gaps, there hadn't really been a prevention program that gears more to a cultural approach to the African-American population, there hadn't been a lot of geographic diversity so I'm glad to see some of those. I know there's been a lot of work by a lot people to come with these programs, I don't see any that don't have tremendous value in to address the gap that's not taking away this issue about what are the outcomes. The reason I'm here today to ask in preparation of the next plan. When we started this program with MHSA, the Latinos were served at ½ the rate of the general population Asian/API of 1/3 of rate we put a lot of MHSA money in programs out there and that disparity still there today, I don't see a single program that is really addressing getting at that disparity and it probably take a planning process as there was one for the African-American prevention program, my request for today is not a criticism of many of these programs I truly don't know the	Over the next three year period, the accumulated unspent MHSA funds are projected to be exhausted; all existing programs are being reassessed and evaluated for their relevance and effectiveness. Under this review, some programs may be expanded if the program effectiveness matches the community need.

depths of any of these they sound like they do address some of the gaps but in terms of these gaps serving Latino population and the Asian/API they've been underserved for a long time, there's been a lot of change in the programs but it doesn't really change the disparity my request for today is we will have another plan update my hope for BHCS is that we can start to talk together as a community about what can we do we know that specifically design program really can infuse in population that are necessarily so trusting these big partnership that supposed to serve everybody we know that there are population continue to be underserved that are not specifically design from a more cultural or linguistic place. I think we are addressing some of the gaps and in particular geography I really pleased to see that East county is getting more services and also I know there's a group working on African-American Prevention Strategy. I think we put a lot of programs out there but still disparity for Latinos and API community is not changing. We need some very specific program to address this.	

PEI 18 - Behavioral Health Medical Home

Public Comment	Response
Half of the Adult Service Teams are county operated and half are CBO operated. This funding should be used to build primary care clinics at CBO Service Team sites since prior MHSA funding was already used to build primary care clinics at BHCS operated site of Oakland CCS. There is already a disparity in the system of care and this strategy seems to further divide the system. There are many CBO Service Team sites that would be able to build primary care availability on site in partnership with an FQHC with this level of funding. It is suggested that these funds be targeted to Service Teams that focus on serving BHCS's most underserved target populations (Latinos, Asians) which no other strategy addresses like geography which is addressed in the next strategy	Our long term goal is to integrate primary care with as many of our service teams as possible future funding permitting.

ATTACHMENT A: PUBLIC COMMENT & RESPONSES

NOTE: Only "substantive comments" -- defined as comments or requests for changes that would significantly alter the target population, design or budget of one or more programs – are shown and responded to. Other comments are available upon request.

PEI 20 - Culturally-Responsive Programs for African American Community

Public Comment	Response
The funding level for such a large percentage of community members is not sufficient. At least $500,000 to $750,000 more is far more equitable considering how similar programs have been funded for other cultural communities over the last five years or so. With an investment of an additional $750,000 taken from some of the other higher funded projects, you could essentially fund 10 projects at $125,000 and truly start to build stronger collaboration among African American cultural providers. The problem of competition for scarce resources would be eliminated as equity would require all programs to fit their models to a $125,000 budget. And, again, over time they can strategically strengthen their programs and services rather than trying to do too much with more money than is needed to meet the people where they are at. Alameda County has had a long tradition of competitive contracting vs. collaborative and that funding allocation formula may work for traditional mental health programs but it is culturally incongruent to African American cultural values, beliefs and traditions as a communal people. It would be greatly appreciated if BHCS would encourage embedding those cultural values throughout its system of care. Collaboration is empowering, competition has fueled the fragmented systems that have plagued African Americans in Alameda County for a very long time. *Incentives for collaboration among the funded providers would also be a powerful system transformation consideration. Incentives in the form of ability to attend the annual cultural competence trainings support to develop evaluation or data collection tools and databases unless you would require use of Insyst. Discounts with your printers and desk top publishing companies for creating health promotion materials and special project funds to encourage community members to get involved in the efforts and you could set the parameters of the special projects (e.g. potted cherry tomato plants for disadvantaged African American families who live in public housing but could as a part of self care/homework or whatever strategy designed the families would receive their fresh vegetable pots to grow on the balconies. Children and family support could include assigning chores and parenting the potted garden growing child (or children and assigning chores of using the watering can to water the plants, etc. This helps to develop a focus on growing their own food and bringing the family together.*	Over the next three year period, the accumulated unspent MHSA funds are projected to be exhausted; all existing programs are being reassessed and evaluated for their relevance and effectiveness. Under this review, some programs may be expanded if the program effectiveness matches the community need. The current design of Full Service Partnerships requires a wide array of services and resources that is normally available only to a larger scale program with more staff employed to serve a higher number of clients. However, BHCS will examine different approaches in the design and development phase of this program. These programmatic ideas can be considered by the African American Steering Committee in their recommendations for program design.

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My first question centers on what input did the African American community fulfill in influencing this process? Secondly, what factors were used to set the allocation limits and range?	The goals of Prevention & Early Intervention programs are sufficiently broad to address many of the recommendation from the African American Utilization Report (2011). As this plan only represents the budgeting of funding for this program, BHCS will engage the African American Steering Committee to provide input on the final design of the programs. The allocation for this was established to match the budgeted amount for 1.A. – FSP 10.

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June 2007 through December 2013
Based on a Total of 133 Partners

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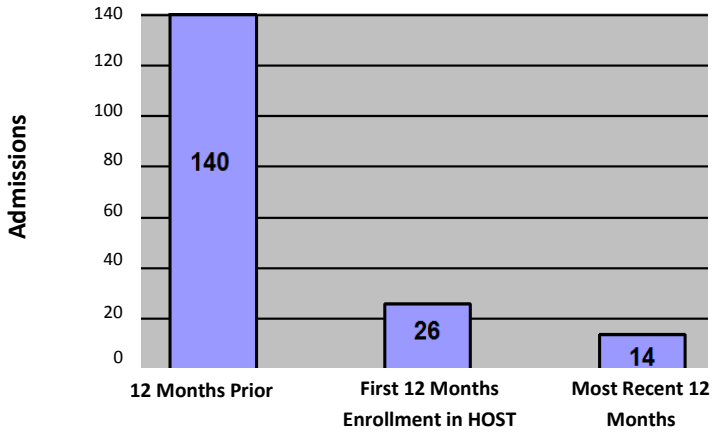
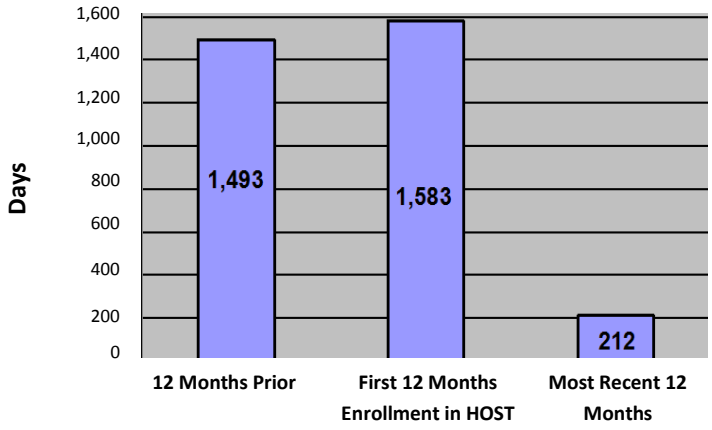
Number of New Psychiatric Hospital Admissions for Partners



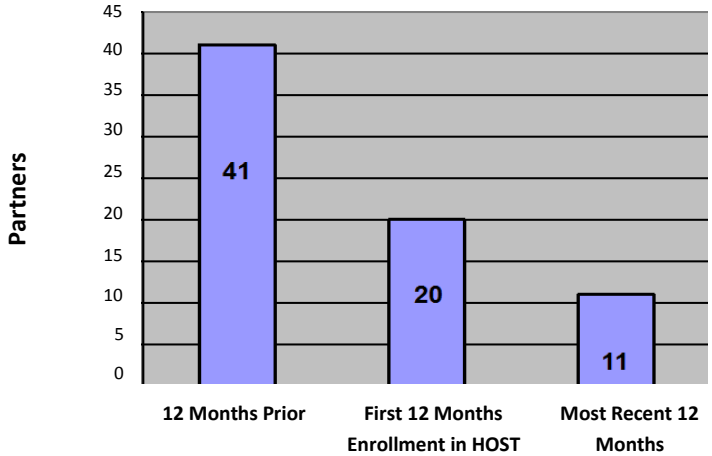
90.0% Decrease in the Number of Psychiatric Hospital Admissions from the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2013

Number of Psychiatric Hospital Days for Partners



85.8% Decrease in the Number of Psychiatric Hospital Days from the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2013

Number of Partners with Psychiatric Hospitalizations



73.2% Decrease in the Number of Partners with Psychiatric Hospitalizations from the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2013

ATTACHMENT B

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June 2007 through December 2013
Based on a Total of 133 Partners

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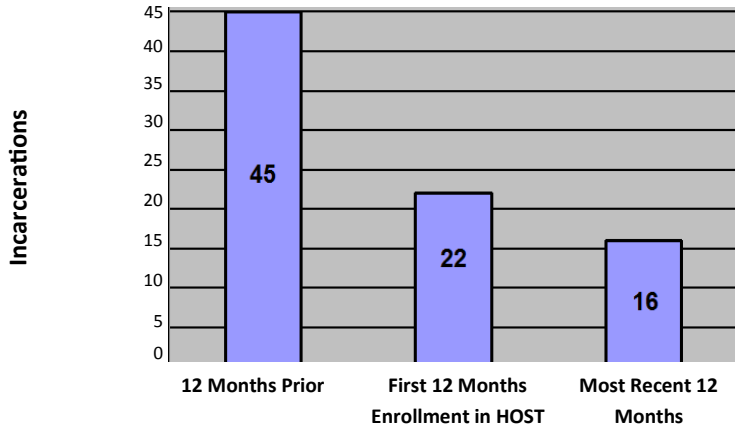
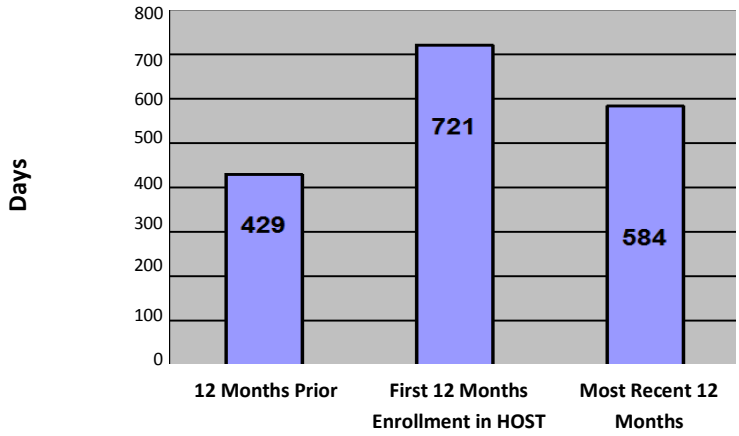
Number of New Incarcerations for Partners



64.4% Decrease in the Number of New Incarcerations from 12 Months Prior to Enrollment in HOST Compared to Most Recent 12 Months of Enrollment as of 12/31/2013

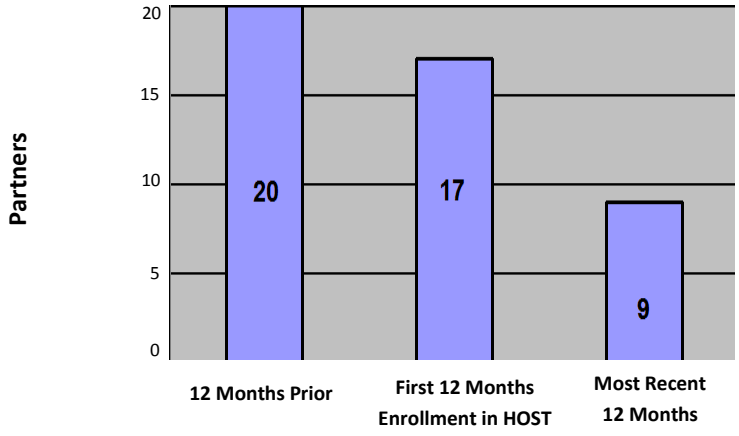
Number of Incarceration Days Among Partners



36.1% Increase in the Number of Incarceration Days for Partners from the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2013

NOTE: In the most recent 12 months of enrollment a small number of partners have been incarcerated for long periods of time. HOST has been unsuccessful in negotiating with the courts for reduced sentences in exchange for assertive treatment in the community.

Number of Partners Incarcerated



55.0% Decrease in the Number of Partners Incarcerated from 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2013

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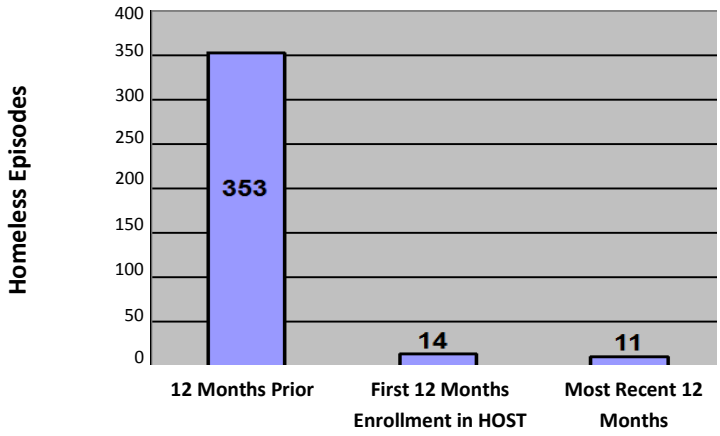
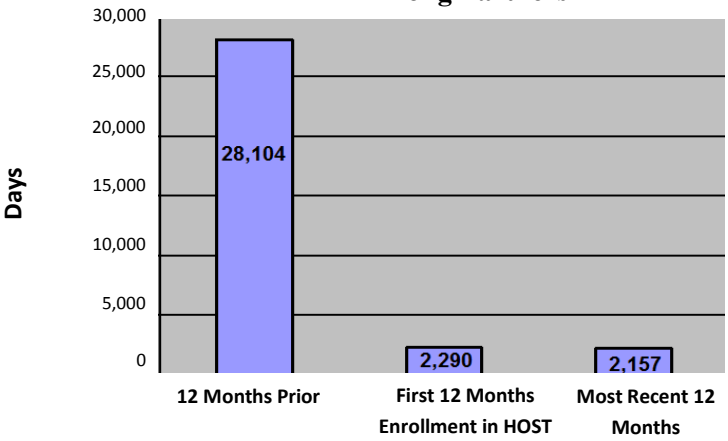
Number of New Homeless Episodes Among Partners



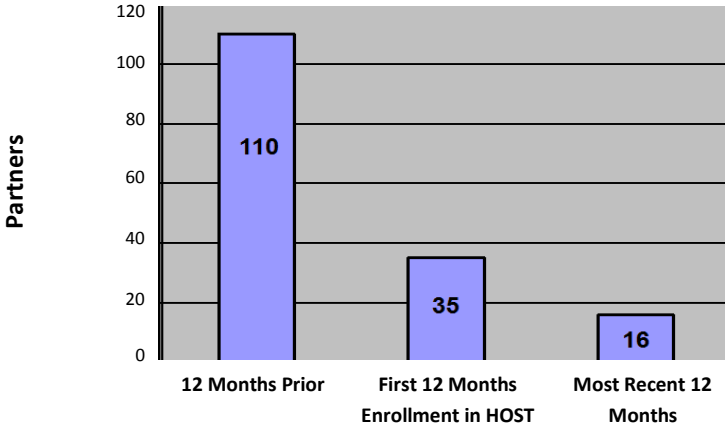
96.9% Decrease in the Number of Homeless Episodes Among Partners from the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2013

Number of Days of Homelessness Among Partners



92.3% Decrease in the Number of Days of Homelessness Among Partners from the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2013

Number of Partners Experiencing Homelessness



85.5% Decrease in the Number of Partners who Experienced Homelessness in the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2013

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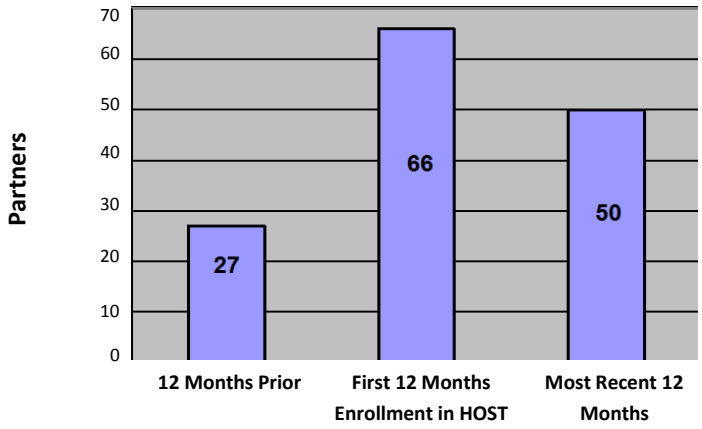
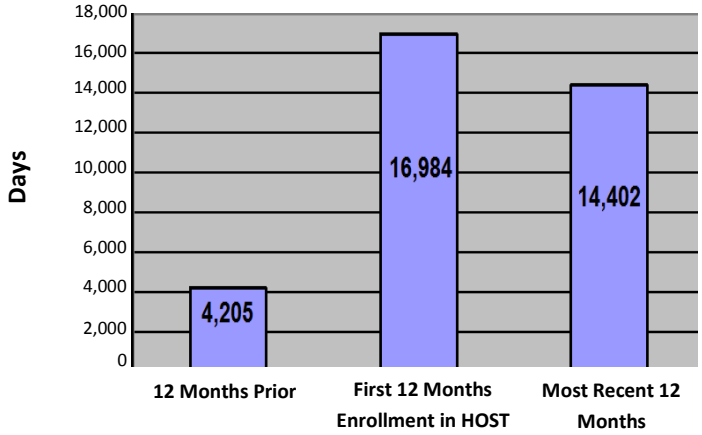
Number of Partners Employed



85.2% Increase in the Number of Partners Employed from the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2013

Number of Days of Employment Among Partners



242.6% Increase in the Number of Days of Employment Among Partners from the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2013

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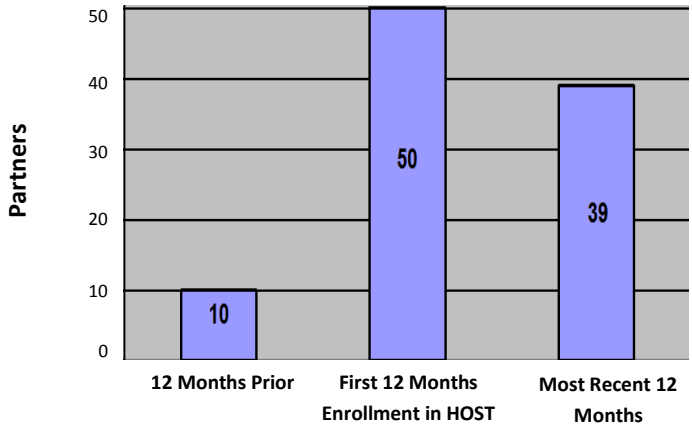
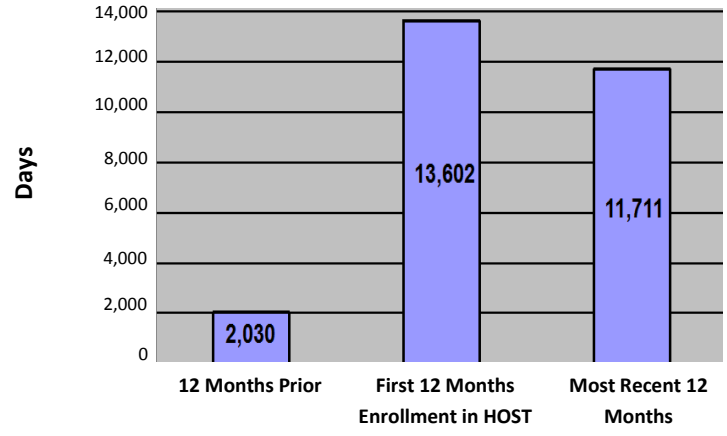
Number of Partners in School or Taking Classes



290.0% Increase in the Number of Partners in School or Taking Classes from the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2013

Number of Days Partners in School or Taking Classes



476.9% Increase in the Number of Days Partners in School or Taking Classes from the 12 Months Prior to Enrollment in HOST Compared to the Most Recent 12 Months of Enrollment as of 12/31/2013

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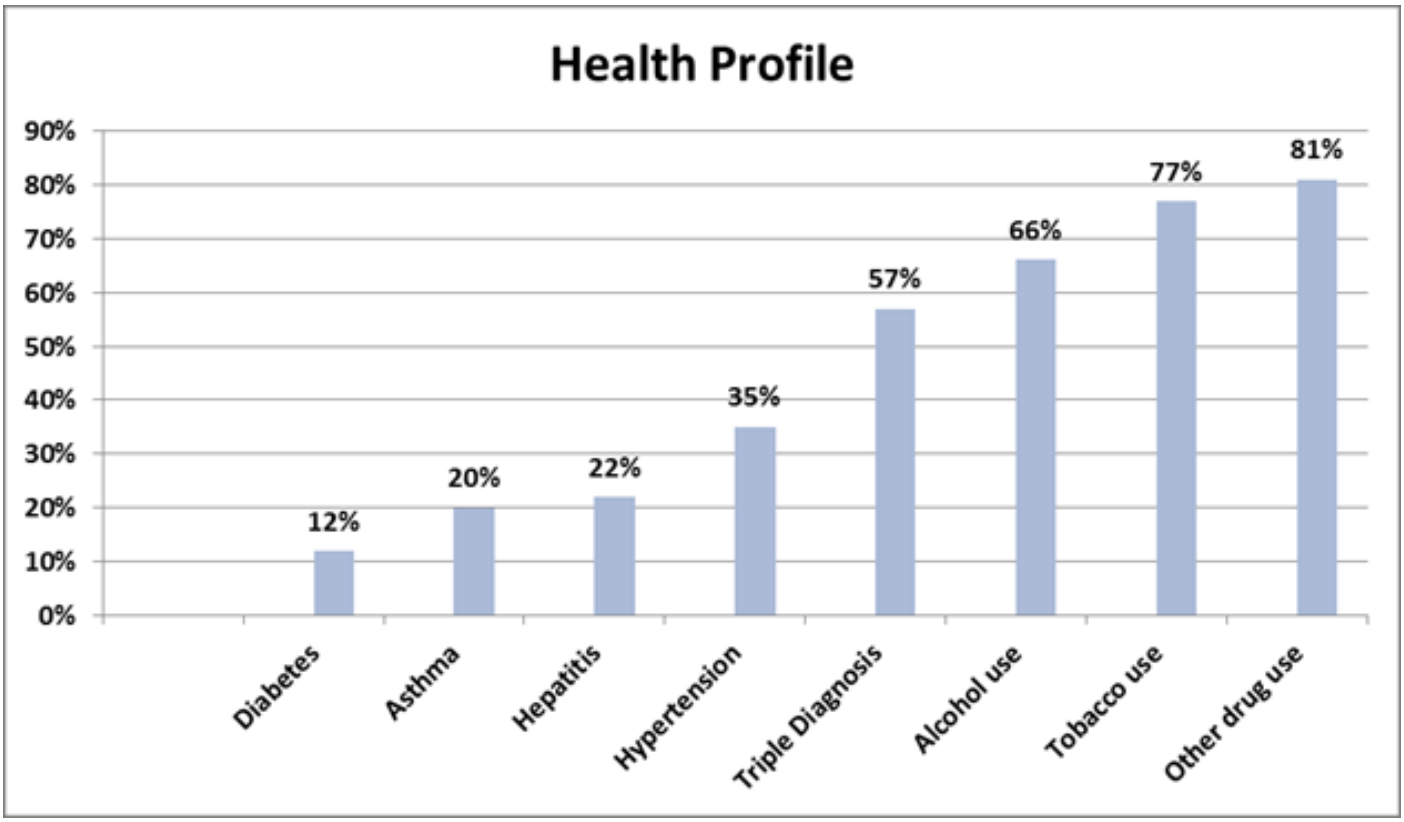
Adult Full-Service Partnership Program Outcomes

Partner Medical Records and Disease Registry

Data Collected for Partners Enrolled in HOST

January 1, 2013 through December 31, 2013



57% of partners are 'triple diagnosed,' which is defined as concurrent chronic physical, mental, and substance use diagnoses.

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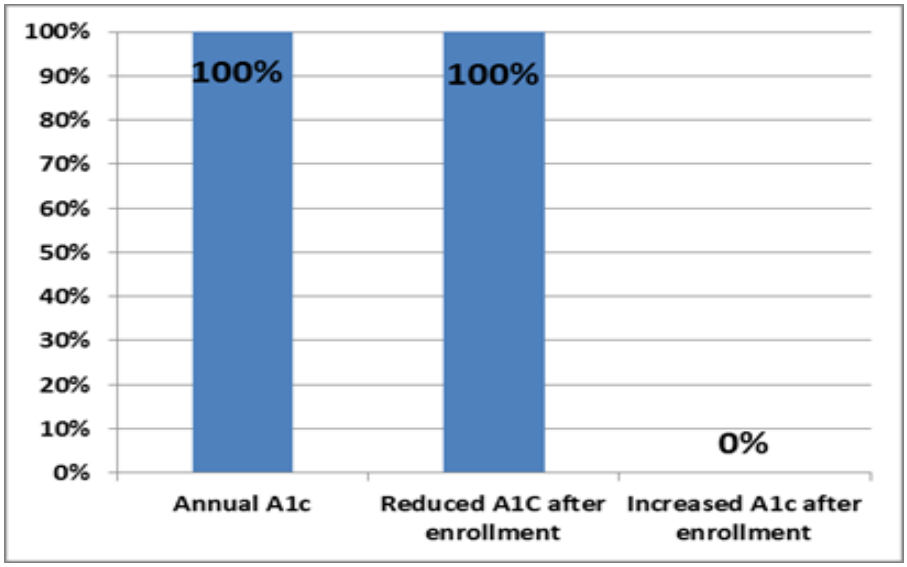
Adult Full-Service Partnership Program Outcomes
Partners Medical Records and Disease Registry
Data Collected for Partners Enrolled in HOST
January 1, 2013 through December 31, 2013

Diabetes Management

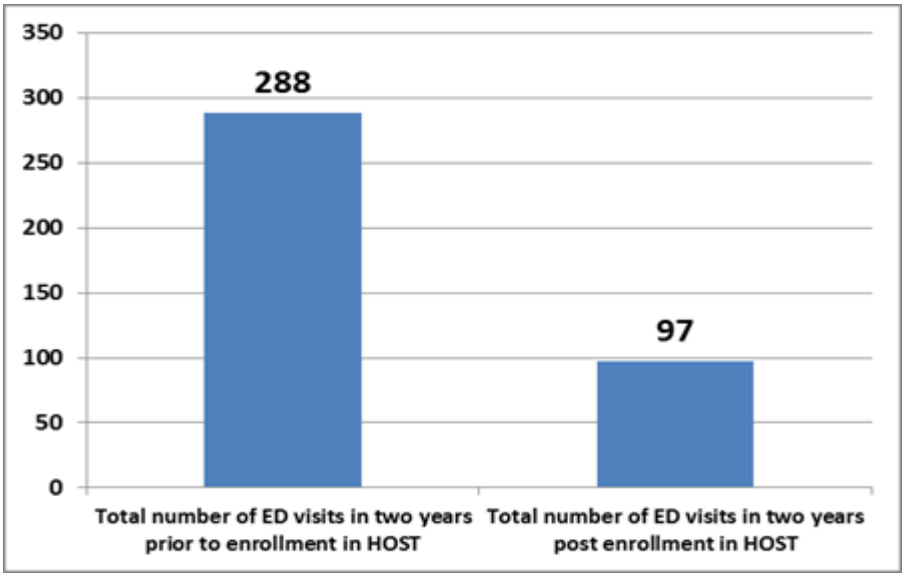


***100% Improvement** in Blood Glucose Levels in 2013 for Diabetic Partners Provided Care by HOST Primary Care Provider (PCP).*

These results significantly exceed national community clinic outcomes.

****The A1c Test** gives a picture of average blood glucose control over the past three months, providing feedback on how well a diabetes treatment plan is working.*

Emergency Department Utilization



***66%** decrease in the number of emergency room visits from the two years prior to enrollment in HOST compared to the two years post enrollment in HOST.*

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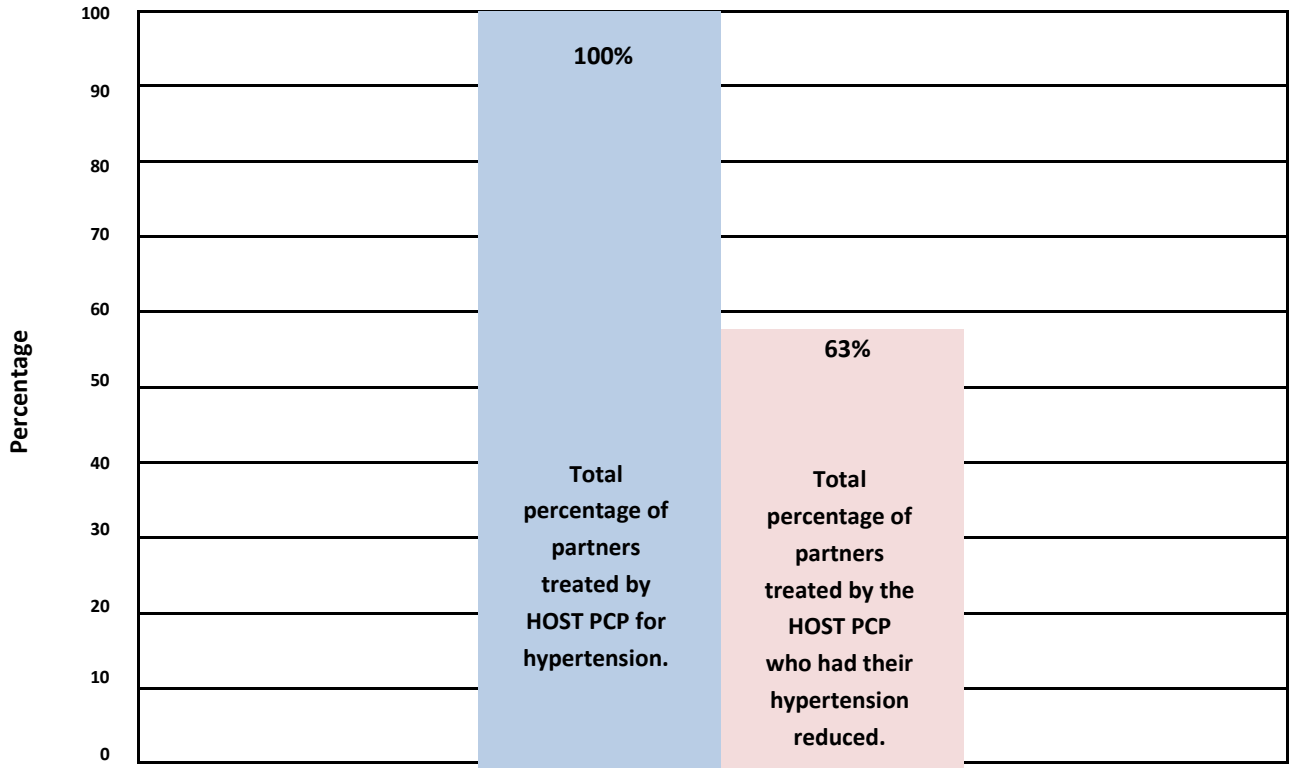
Adult Full-Service Partnership Program Outcomes

Partner Medical Records and Disease Registry

Data Collected for Partners Enrolled in HOST

January 1, 2013 through December 31, 2013

Hypertension Management



63% of partners treated by the HOST PCP for hypertension had their hypertension under control with systolic BP < 140.

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Psychiatric Hospitalizations

- Number of new psychiatric hospital admissions:
  - 12 Months Prior to Enrollment 140
  - First 12 Months of Enrollment 26
  - Most Recent 12 Months Post Enrollment 14
  - **Decrease** in number of new psychiatric hospital admissions: 90.0%

- Number of psychiatric hospital days:
  - 12 Months Prior to Enrollment 1,493
  - First 12 Months of Enrollment 1,583
  - Most Recent 12 Months Post Enrollment 212
  - **Decrease** in number of psychiatric hospital days: 85.8%

- Number of partners with psychiatric hospitalizations:
  - 12 Months Prior to Enrollment 41
  - First 12 Months of Enrollment 20
  - Most Recent 12 Months Post Enrollment 11
  - **Decrease** in number of partners with psychiatric hospitalizations: 73.2%

Incarcerations

- Number of new incarcerations:
  - 12 Months Prior to Enrollment 45
  - First 12 Months of Enrollment 22
  - Most Recent 12 Months Post Enrollment 16
  - **Decrease** in number of new incarcerations: 64.4%

- Number of incarceration days:
  - 12 Months Prior to Enrollment 429
  - First 12 Months of Enrollment 721
  - Most Recent 12 Months Post Enrollment 584*
  - **Increase** in number of incarceration days: 36.1%

**Note: In the most recent 12 months of enrollment a small number of partners have been incarcerated for long periods of time. HOST has been unsuccessful in negotiating reduced sentences with the courts in exchange for assertive treatment in the community.*

- Number of partners incarcerated:
  - 12 Months Prior to Enrollment 20
  - First 12 Months of Enrollment 17
  - Most Recent 12 Months Post Enrollment 9
  - **Decrease** in number of partners with incarcerations: 55.0%

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Homelessness*

- Number of new episodes of homelessness:
  - 12 Months Prior to Enrollment 353
  - First 12 Months of Enrollment 14
  - Most Recent 12 Months Post Enrollment 11
  - **Decrease** in number of new episodes of homelessness: 96.9%

- Number of days of homelessness:
  - 12 Months Prior to Enrollment 28,104
  - First 12 Months of Enrollment 2,290
  - Most Recent 12 Months Post Enrollment 2,157
  - **Decrease** in number of days of homelessness: 92.3%

- Number of partners homeless:
  - 12 Months Prior to Enrollment 110
  - First 12 Months of Enrollment 35
  - Most Recent 12 Months Post Enrollment 16
  - **Decrease** in number of partners homeless: 85.5%
  -

***Homelessness** after enrollment in HOST reflects:*

(1) A small number of partners who are still in their first year of the program and are not comfortable yet with living in housing; and (2) A very few partners who have repeatedly lost housing (due to not paying rent, causing continued disruptions in their building, etc.) and choose to not go to emergency housing.

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Employment (Competitive or Supported)*

- Number of partners employed:
  - 12 Months Prior to Enrollment 27
  - First 12 Months of Enrollment 66
  - Most Recent 12 Months Post Enrollment 50
  - **Increase** in number of partners employed: 85.2%

- Number of days partners employed:
  - 12 Months Prior to Enrollment 4,205
  - First 12 Months of Enrollment 16,984
  - Most Recent 12 Months Post Enrollment 14,402
  - **Increase** in number of days partners employed: 242.6%

***Competitive employment** is defined as any employment placement that is taxable and reported to the IRS. Competitive employment opportunities are jobs that offer above minimum wage and/or medical coverage.*

***Supported employment** is a Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based practice. Job search process begins immediately after a consumer expresses an interest to return to work and is determined by consumer preference and abilities.*

Education

- Number of partners in school or taking classes:
  - 12 Months Prior to Enrollment 10
  - First 12 Months of Enrollment 50
  - Most Recent 12 Months Post Enrollment 39
  - **Increase** in number of partners in school or taking classes: 290.0%

- Number of days partners in school or taking classes:
  - 12 Months Prior to Enrollment 2,030
  - First 12 Months of Enrollment 13,602
  - Most Recent 12 Months Post Enrollment 11,711
  - **Increase** in number of days partners in school or taking classes: 476.9%