WELLNESS • RECOVERY • RESILIENCE

MENTAL HEALTH SERVICES ACT

ALAMEDA COUNTY

FY 2016-2017
PLAN UPDATE

RELEASED FOR PUBLIC COMMENT MARCH 10 – APRIL 10, 2017

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

MENTAL HEALTH SERVICES ACT (MHSA)

FY 16-17 PLAN UPDATE

SUMMARY OF CHANGES FROM PREVIOUS PLAN (FY15-16)

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. FULL SERVICE PARTNERSHIP PROGRAMS IN PROCUREMENT

a. Full-Service Partnerships

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

- Individual Placement Services (IPS) was added as a programmatic requirement for Telecare CHANGES, STRIDES and STAGES.
- Increased clinical services and supports have been added to the Early Intervention for the Onset of First Psychosis & SMI among TAY program.

On February 23, 2017 BHCS released of Request for Interest (RFI) #17-03 to identify qualified Bidders interested in participating in the Request for Proposal (RFP) for Full Service Partnership (FSP) services. The RFI articulates BHCS' plan to enter into a contract for FSP services for one program per Contractor with the following allocation:

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

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

It is anticipated that the Request-For-Proposals (RFP) will be released in early FY17-18 with a start date before the end of the fiscal year.

II. WELLNESS CENTERS FUNDED UNDER PREVENTION & EARLY INTERVENTION (PEI)

New PEI data and outcome requirements instituted this year include the identification of clients who are SMI or SED and referral to appropriate services, tracking of timely access to those services and demographic information of clients served. This provides BHCS an opportunity to monitor and access the effectiveness of wellness and recovery programs in both providing clients less intensive supportive care and ready access to higher levels of care when appropriate. In order to institute these additional data requirements, funding for the Wellness Centers is shifted from Community Services & Supports to PEI.

III. INNOVATIVE PROGRAMS FOR WORKFORCE EDUCATION & TRAINING, MENTAL HEALTH & TECHNOLOGY AND SERVICES TO UNDERSERVED ASIAN-PACIFIC ISLANDER POPULATIONS.

Before the end of the fiscal year, Request-For-Proposals will be announced for small, time-limited, innovative approaches to address the following areas:

- Educational and training opportunities for underrepresented and disadvantaged high school and undergraduate students to gain experience in the public Mental/Behavioral Health areas;
- Direct and supportive services utilizing web-based and mobile applications that increase access and improve mental health outcomes for consumers and family members; and
- Culturally-responsive services and organizational capacity-building to address the needs of diverse, underserved API consumers and family members.

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 during the planning period are listed in the table below including 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.
Viveca	Bradley	Family Member	Pool of Consumer Champions
Aaron	Chapman	BHCS	Medical Director
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
Manuel	Jimenez*	BHCS	Behavioral Health Director
Janet	King	Provider	Native American Health Center
Tracy	Murray	Provider	Area Agency on Aging
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
Karyn	Tribble*	BHCS	Deputy Behavioral Health Director
Gwen	Wilson	Provider	G.O.A.L.S. For Women
Cecelia	Wynn*	Consumer	Pool of Consumer Champions

*No longer on this group due to retirement, different role or other transition

The initial draft of the Plan Update was developed by BHCS Executive Leadership, planning staff and fiscal staff in consultation with the Stakeholder Group. BHCS posted the draft Plan on its website for thirty (30) days for public comments beginning on March 10, 2017. The Mental Health Board hosted a public hearing on Monday April 10, 2017. Public comments received and response from BHCS are in the ATTACHMENTS.

FY 2016/17 Mental Health Services Act Annual Update
Funding Summary

County: Alameda

	MHSA Funding			
	A	B	C	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Prudent Reserve
A. Estimated FY 2016/17 Funding				
1. Estimated Unspent Funds from Prior Fiscal Years	37,295,683	15,184,487	12,080,172	
2. Estimated New FY 2016/17 Funding	45,179,605	15,059,868	3,171,441	
3. Transfer in FY 2016/17[a/]	(9,000,000)			9,000,000
4. Access Local Prudent Reserve in FY 2016/17				0
5. Estimated Available Funding for FY 2016/17	73,475,288	30,244,355	15,251,613	
B. Estimated FY 2016/17 MHSA Expenditures	51,923,810	26,298,309	4,111,062	
G. Estimated FY 2016/17 Unspent Fund Balance	21,551,478	3,946,046	11,140,551	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2016	26,945,553
2. Contributions to the Local Prudent Reserve in FY 2016/17	9,000,000
3. Distributions from the Local Prudent Reserve in FY 2016/17	0
4. Estimated Local Prudent Reserve Balance on June 30, 2017	35,945,553

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 2016/17 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

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							
FSP 1	Homeless Outreach & Stabilization Team	2,508,541	1,826,396	682,145			
FSP 2	North County Senior Homeless Program	1,170,339	979,448	190,891			
FSP 3	Support Housing for TAY	1,589,325	1,252,484	336,841			
FSP 4	Greater Hope Project	1,937,226	1,611,385	325,841			
FSP 5	Small Scale Comprehensive Forensic ACT Team	2,250,680	1,743,234	507,446			
FSP 6	Transition to Independence	586,787	476,171	110,616			
FSP 7	CHOICES for Community Living	3,761,528	3,761,528				
FSP 9	Transitional Behavioral Health Court ACT Team	1,753,201	1,553,294	199,907			
FSP 10	Housing Services	6,449,854	5,871,379	578,475			
FSP 11	Community Conservatorship Pilot	750,000	750,000				
FSP 12	Assisted Outpatient Treatment (AOT) Pilot	515,481	515,481				
FSP 13	CHANGES	959,604	575,762	383,842			
FSP 14	STRIDES	1,319,558	744,604	574,954			
FSP 15	STAGES	476,520	265,014	211,506			
FSP 16	Early Intervention for the Onset of First Psychosis & SMI Among TAY	730,638	510,196	220,442			
Non-FSP Programs							
OESD 4A	Mobile Integrated Assess Team for Seniors	555,606	429,896	125,710			
OESD 5AB	Crisis Response Program - Capacity for Valley and Tri-City	558,232	334,940	223,292			
OESD 7	MH Court Specialist Program	407,450	308,219	99,231			
OESD 8	Juvenile Justice Transformation of Guidance Clinic	376,212	260,104	82,934			33,174
OESD 9	Multisystemic Therapy	695,762	538,419	157,343			
OESD 11	Crisis Stabilization Service	4,184,580	1,293,709	51,020			2,839,851
OESD 13	Co-Occurring Disorders Program	734,195	683,910	50,285			
OESD 17	Residential Treatment for Co-occurring Disorders	3,446,950	2,896,328	550,622			
OESD 19	Low Income Health Plan Pilot	3,752,418	2,777,590	974,828			
OESD 20	Individual Placement Services	3,482,962	2,454,265	1,028,697			0
OESD 23	Community-Based, Voluntary Crisis Services	2,000,000	2,000,000				
OESD 24	Behavioral Health and Developmental Disability Integration Program	353,033	353,033				
OESD 25	Behavioral Health - Primary Care Integration Project	5,474,570	4,258,172	1,216,398			
OESD 26	Culturally-Responsive Treatment Programs for African-American Community	1,000,000	1,000,000				
OESD 27	In Home Outreach Team	1,669,053	1,669,053				
CSS Administration		10,945,584	8,229,797	2,715,787			
CSS MHSA Housing Program Assigned Funds		0					
Total CSS Program Estimated Expenditures		66,395,888	51,923,810	11,599,053	0	0	2,873,025
FSP Programs as Percent of Total		51.5%					

FY 2016/17 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: Alameda Date: 2/21/17

		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							
PEI 1A	Early Childhood (Birth-8) Mental Health Prevention	1,294,237	1,294,237				
PEI 1BC	School-Based Mental Health Consulation in Elementary & Middle Schools	2,107,886	2,107,886				
PEI 4	Stigma & Discrimination Reduction Campaign	1,243,301	1,215,822	27,479			
PEI 5	Outreach, Education & Consultation for the Latino Community	1,192,330	1,114,241	78,089			
PEI 6	Outreach, Education & Consultation for the Asian Pacific Islander Community	1,417,974	1,362,805	55,169			
PEI 7	Outreach, Education & Consultation for the South Asian/Afghan Community	754,179	697,423	56,756			
PEI 8	Outreach, Education & Consultation for the Native American Community	307,415	299,987	7,428			
PEI 12	Suicide Prevention and Trama-Informed Care	1,590,597	1,440,597	150,000			
PEI 13	Wellness, Recovery and Resiliency Services	2,008,448	1,917,134	91,314			
PEI 14	Family Education Center	1,604,273	1,604,273				
PEI 15	Staffing to Asian Population (ACCESS)	819,828	747,220	72,608			
PEI 16	Staffing to Latino Population (ACCESS)	698,378	601,180	97,198			
PEI 17	TAY Resource Centers	877,641	877,641				
PEI 19	Adult and Older Adult Peer Support	1,366,091	1,366,091				
PEI 20	Culturally-Responsive Programs for the African-American Community	1,000,000	1,000,000				
PEI 21	Wellness Centers	4,543,098	3,583,094	960,004			
PEI Programs - Early Intervention							
PEI 2	Early Intervention for the Onset of First Psychosis & SMI Among TAY	730,638	510,196	220,442			0
PEI 3C	Mental Health-Primary Care Integration for Older Adults at ERs	779,523	674,742	104,781			
PEI Administration		4,691,625	3,592,857	1,098,768			
PEI Assigned Funds		290,883	290,883				
Total PEI Program Estimated Expenditures		29,318,345	26,298,309	3,020,036	0	0	0

FY 2016/17 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: Alameda Date: 2/21/17

	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 Project	3,678,681	3,678,681				
INN Administration	617,687	432,381	185,306			
Total INN Program Estimated Expenditures	4,296,368	4,111,062	185,306	0	0	0

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

Full Service Partnership (FSP) Programs: The following measures are being adopted by all Full Service Partnership programs and will be included in future contract language starting in Fiscal Year 17/18:

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 (still under development)

Process Measure:

6. 90 percent of the clients who enter the program shall have Medi-Cal or a completed 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.

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

FSP 1. Homeless Outreach & Stabilization Team (HOST)

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

FY 15/16 Progress Report: See ATTACHMENTS: "Bonita House, HOST Adult Full-Service Partnership Program Outcomes, June 2007-December 2015".

The notable challenge the program is experiencing is that our housing budget had not been increased and we no longer have enough housing money to house all 90-95 HOST Partners.

FY 16/17+ Update and Plans: Establishment of a Partner Advisory Committee (PAC). The PAC is a group of HOST partners that meet monthly and advise the program about issues and concerns that they would like addressed. This is an exciting new development that gives the HOST partners a powerful voice in the continuing development and evolution of the HOST program.

For 16/17, HOST currently only has enough housing money to meet the needs of 61 partners. As of October 1, 2016, our Shelter Plus Care contract has increased and we will now have the ability to house 70 partners. However, that falls far short of the 93 partners currently enrolled in the program.

This housing budget problem will be a significant factor for the rest of this year and next fiscal year.

In addition to these concerns, the revenue targets for the HOST program have been unrealistic since the program started. HOST has doubled the Medi-Cal revenue estimated in the original RFP, but unfortunately, MAA revenue does not bring in very much money at all. With our outreach capacity now eliminated because we are accepting referrals exclusively from the Home Stretch list, we do not bill hardly any MAA.

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 15-16 Outcomes, Impact & Challenges:

Number of clients served: 46
Number of new enrollments: 8
Number of discharges to lower level of care: 10

Number of clients who avoided psychiatric hospitalizations during the following initial enrollment periods:
- 3 months: 75%, 6 of 8 clients
- 6 months: 87%, 7 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: 87%, 7 of 8 clients
- 6 months: 75%, 6 of 8 clients
- 12 months: 87%, 7 of 8 clients

Number of clients who retained housing of their choice during the following initial enrollment periods:
- 3 months: 75%, 6 of 8 clients
- 6 months: 75%, 6 of 8 clients
- 12 months: 87%, 7 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

North County Senior Homeless Program (NCSHP) continued to expand collaborations with other community organizations in order to identify and serve older adults. 20% of participants graduated to a lower level of care. Of participants open at year end 26 (65%) have obtained permanent housing with 18 (45%) no longer using Housing Financial Assistance.

Due to ever decreasing affordable housing options in Alameda County, we have seen older adults make greater use of unlicensed board and care units. Our response has been increased outreach to private landlords who are willing to work with the HFA subsidy in order to create additional permanent housing opportunities for participants.

During FY 15-16, NCSHP served 46 older adults.

For current FY 16-17:

Number of clients served: 41
Number of new enrollments: 3
Number of discharges to lower level of care: 1

Number of clients who avoided psychiatric hospitalizations during the following initial enrollment periods:
- 3 months: 100%, 3 of 3 clients
- 6 months: 100%, 3 of 3 clients

Number of clients who avoided medical hospitalizations during the following initial enrollment periods:
- 3 months: 100%, 3 of 3 clients
- 6 months: 100%, 3 of 3 clients

Number of clients who retained housing of their choice during the following initial enrollment periods:
- 3 months: 66%, 2 of 3 clients
- 6 months: 66%, 2 of 3 clients

Number of clients who received primary care services within the following initial enrollment periods:
- 3 months: 100%, 3 of 3 clients
- 6 months: 100%, 3 of 3 clients

The NCSHP team serves a total of 40 participants at any given time. The expansion of medical and psychiatric services has been successful with 26 (65%) of 40 participants currently seeing the in-house psychiatrist regularly. Additionally, NCSHP has begun a medically focused weekly group to address medical trends seen in participants (diabetes, HPB, etc.).

NCSHP continues to use the ACT model to ensure a high level of care to participants and to prevent staff burnout.

For upcoming FY 17-18:

The NCSHP team will serve a total of 40 partners at any given time in the coming fiscal year. No significant changes planned.

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 15-16 Outcomes, Impact & Challenges:

Community Impact: During the 15-16 fiscal year, the STAY Program served a total of 56 unduplicated individuals who were homeless or at risk for homelessness. The program discharged 15 participants during the period, 11 (73%) of which were planned discharges. Of the 15, 5 (33.3%) exited the program with permanent housing, and 9 (60%) exited to a lower level of care.

The STAY Program continued to experience success in engaging participants in employment services using the IPS model for services. During the period, 26 individuals participated in IPS services. Of the 26, 15 (58%) were employed for at least some time, with 3 holding down a job for the entire fiscal year. The program received a positive score on the IPS fidelity review conducted in late 2015.

The program continued to offer skill building groups for participants focused on ADL's and social skills. During the period, STAY collaborated with a county consumer peer support program (PEERS) to offer an onsite 6-week Wellness and Recovery Action Plan (WRAP) group to support participants to be active agents in the recovery and self-care. The PEERS program has agreed to return to offer subsequent WRAP group series onsite every 6 months.

Challenges: The STAY Program experienced increasing difficulty achieving our goals for independently housing participants during the period due to the shortage of affordable housing in the area. In addition, this past spring, a fire at an apartment building housing several STAY participants delayed new placements by diverting time and resources into shelter and locating new units for the displaced residents. A total of 22 of the 56 (participants served were placed and maintained in

permanent or long-term transitional placements in the community. Given the limited availability of affordable permanent housing for STAY participants aging out of services, Alameda County Behavioral Health and Recovery Services is in the process of planning a transfer of existing housing subsidy vouchers tied to the STAY Program into permanent subsidies offered through the Housing Authority. This will enable our currently housed STAY participants to maintain their subsidies when they age out of the program. In the future, participants aging out of services will need to apply for placement on a centralized waitlist for subsided units in the county.

The STAY program has been assisting participants in increasing their chances of securing permanent housing by providing advance notice of subsidized housing application opportunities and assistance completing required documents. The program has held three housing workshops for participants during the period timed to aid participants in meeting the deadlines for multiple housing opportunities.

For current FY 16-17 Progress Report:

Serving 50-55 TAY.

During the first part of FY 16/17, the program has reported improved housing outcomes with 38 (46%) independently housed in permanent or long-term transitional housing, compared with 22-26% from May to August of 2016. This improvement was, in part, due to the opening of a new permanent subsidized housing option which prioritized the program's target population. Currently, 5 STAY participants inhabit permanent shared apartments in this complex.

For upcoming FY 17-18+ Plans:

Plan to serve 50-55 TAY.

FSP 5. Forensic Assertive Community Treatment (FACT)

Program Description: FACT is a full service partnership (FSP) program offered by the East Bay Community Recovery Project. The program is contracted with Behavioral Healthcare Services to provide services to and maintain an active caseload of 79 adult participants (age 18-59). FACT has been providing housing and intensive wraparound supportive services to individuals identified by the county as persons who continue to cycle in and out of psychiatric emergency and inpatient services and Santa Rita jail. The program provides an ACT level of services to the individuals, partners, enrolled in the program to encourage and support their wellness and recovery efforts with the goal of improving their ability to function independently in the community and significantly reducing or eliminating the need for psychiatric emergency or inpatient services and the number of incarcerations in the county jail.

See ATTACHMENTS: "East Bay Community Recovery Project, Forensic Assertive Community Treatment, Bi-Annual Monitoring Report, Jan 1- June 30, 2016"

For previous FY 15-16 Outcomes, Impact & Challenges:

Number of Partner served: 79
Number of new enrollments: 16

Number of transitions: 6

Community Impact:

REDUCTION in RECIDIVISM
Psychiatric Emergency and inpatient units and Jail. The program continues to reduce recidivism for its partners as has been the case every year since the programs start in August of 2007. The largest reduction in recidivism is in the number of days spent in jail and the hospital, both saw a reduction of 60%.

ENROLLMENT, TRANSITION AND GRADUATION
This year we experienced the highest number of enrollments (16) in a single year since bringing the program to capacity in June 2009. This year we had 4 partners who transitioned to a lower level of care. These individuals graduated from the program when they completed the phases of the program, when their applications for the S+C housing subsidy were approved, and when the housing specialists were able to support the partners in securing a housing unit they could afford and a unit that met their needs for independent living.

PROGRAM CAPACITY
The FACT program was awarded an increase of funding in December 2015 to expand capacity for the number of partners to be served (70-79). This is not a large increase in capacity, however, it is a step in the right direction that has allowed us to increase services to our partner population. We added 1 full time personal service coordinator/therapist, and increased hours for nursing, psychiatry, and employment.

PRIMARY CARE
We continue to triage new partners into community based primary care services such as Lifelong Medical Care. We were able to connect 88 % of the newly enrolled partners with primary care within 12 months of enrollment. The remaining partners were discharged in a few months' post enrollment or have yet to complete 12 months in the program. We are still moving forward with plans for offering primary medical care from our 2730 Adeline office and are patiently waiting for the MOU to be drawn up and for the medical provider to hire a medical practitioner along with a medical assistant.

HOUSING
The difficulty in housing partners was challenged further this past year by the continued highly competitive housing market both in locating units and affordability. HCD and the Shelter + Care program worked very closely with the program to review each application on a case by case basis allowing all the subsidy requests to exceed the set fair market rate by price units in the same area to determine rent reasonableness. We were able to bring on a few new landlords and several new properties in the latter part of FY 15/16. We were able to house everyone who had been on our waiting list for an extended period of time. The new units were located in prime areas of alameda county and the tenants were extremely excited and grateful for the spacious apartments and the calm and serene neighborhoods.

EMPLOYMENT
This past fiscal year brought changes to the employment program as we hired 2 new employment specialist and with the assistance of the county vocational program we were able to move completely to the IPS model of supported employment. Educational services were transferred to the responsibilities of the personal service coordinators saw the program. The new employees worked closely with the county IPS program supervisor to increase employer contacts to increase the

eligible employment positions for partners to apply. The employment specialist shared a caseload of over 20 partners who were either working or applying for work

POSITVE IMPACT

The positive impact of the FACT program is demonstrated through the aforementioned sections 1-6. Another important impact is the number of partners—26 or 33%—remaining in the community in permanent subsidized housing with no jail time since enrolling in the criminal justice behavioral health FACT program. This is up from 23 partners or 27%. These partners are mostly graduates who have already transferred to a lower level of care and may be involved in the community through employment, education, volunteerism and ongoing consumer sponsored social and educational trainings and events.

The FACT program of the East Bay Community Recovery Project has positively impacted the west Oakland neighborhood, families, and the community by continuing to instill hope for the individuals we serve and for the families impacted by the behavioral expressions of individuals who are under the influence of alcohol and drug abuse, experiencing mental health symptomatology, and participating in criminal activities. Our provider site in West Oakland has been providing easily accessible in-house or in your house individual-group-family illness education, crisis intervention and treatment services that are diverse, compassionate, non- judgmental and confidential. The goal is to facilitate individual recovery and wellness and to create an opportunity for healing families and communities.

The programs efforts in reducing recidivism in the utilization of psychiatric emergency, inpatient, and jail services has been a cost saving outcome of the program allowing the county the possibility of shifting funds away from the jails and hospitals and into community based services that provide illness education and strategies for prevention that aim to keep individuals from ever having to utilize these systems.

Program Challenges and Strategies:

1a. Challenge - Partner Substance Abuse

The primary challenge to the FACT program meeting its outcomes continues to be the pervasive and chronic substance use/addiction that plagues a majority, 91% (70 of 77), of the overall program partners. Partners' substance use/ addictions compromise their ability to adhere to basic program instruction or guidelines whether it is taking medication as prescribed or following through with orders from the court. Substance use diminishes a partners functioning capacity which in most cases keeps them from being able to utilize and benefit from the many resources and opportunities available to them from this MHSA funded programs.

The programs' success rate of graduating partners would be exponentially higher if there were substantially more co-occurring mental health substance abuse residential programs, step-down community based recovery support and self-help programs that complement the therapeutic and rehabilitative services of FACT. The outcome of such a system of care would provide longer term comprehensive services and or support individuals with their efforts to maintain their personal program for recovery, increase their sober community network and to create a sober history. These challenges, experienced by partners along with the absence of a comprehensive mental health and co-occurring substance use treatment and services continuum of care in this county, significantly decreases the program's capacity for effectively supporting partners in achieving program milestones and successfully achieving their wellness and recovery treatment goals.

1b. Strategy
Fortunately, there have always been a percentage of partners who have been able to achieve and maintain their sobriety, achieve and maintain competitive employment, complete the program and live independently in the community. We looked at the elements of these individual's success and began to look at what we could do to increase partner success.

Over the past 1 ½ years our strategy consisted of a restructuring the program staffing roles and responsibilities and patterns—updating the required skills and experience of incoming employees—and redesigning the program curriculum to increase our ability to address and work with partners co-occurring mental health and substance use conditions and a partner's risk for violence and criminal behaviors. This has led to an increase and diverse presentation of individual and group services. We are now offering cognitive behavioral groups that focus on understanding partner substance use, criminal behaviors and creating plans for "change" with an increase in individual therapy services to support the co-occurring needs of our partners. We have implemented a policy of not providing support services if a partner comes into the office intoxicated or if a partner is intoxicated when we go to pick them up from their homes. Psychiatric, medical triage, and counseling services may be allowed on a case by case basis. We are determined to be consistent with our policy and support partners to the county detox program when intoxicated as a way of providing some extra motivation for sobriety.

2a. Challenge - Partner Substance Abuse and increased incidence of partner behavioral issues
As a forensic behavioral health program, behavioral issues can be expected; however, these partner violent behaviors continue to occur with increased frequency and aggression, as compared to partner behaviors from previous years in the programs. This increases the need for caution in providing services and the skills required for "crisis prevention, intervention and management" services. The team members along with the program leadership have developed new safety protocols and strategies for implementation. This year we have had 2 violent partner outbursts that have traumatized some of the staff and has put the question of our safety front and center.

Substance use disorders play a significant role in the likely increased incidence of partners "acting out" behaviors, specifically, their use of derogatory statements (verbal abuse) and use of intimidation and threats of violence with team members is unfortunate, unacceptable and difficult to predict and prevent. Partner intoxication has played a part in most of the incidents experienced by the team in the past, however, this past year saw an unregulated upset sober partner perpetrate violence in our front lobby. The need for safety on the job (both in the office and the community) has been compromised and requires increased vigilance by team members when working with partners, especially when responding to partner crises. Fortunately, the actual incidence of these partner behavioral issues occurring, although increasing in frequency, are still an exception to the norm.

The program serves as representative payee for many of the partners that are in need of support to budget and manage their money so that the bills get paid and the partner has access to funds throughout the full month. This becomes a problem when partners under the influence come into the office, without prior notice given, demanding access to their money (that they have already spent or are not scheduled to receive). Partners can, on occasion, get verbally and physically (less frequent) escalated and aggressive to the point where their interactions with team members become volatile, unpredictable and on a few occasions unmanageable. The team has been able to prevent or successfully manage partners and their escalating behaviors through effective non-violent communication and teamwork. Requiring that the partner leave the building for the day and assertively escorting them outside. We have found that the threat of calling the police will in most

cases diffuse a situation.

2b. Strategies

The program leadership has integrated risk assessment tool, “Risk and Responsivity” into our mental health screening and assessment to begin addressing partner behavioral issues through the screening and intake process. In addition, this fall will see the introduction and administration of the ANSA Needs Assessment. This will support team members in collecting an in-depth history for newly enrolled individuals as to increase our knowledge of these individuals while also supporting the development of a comprehensive and individualized treatment plan.

This past year we were able to confirm with the adult system of care director that the program has the authority to refuse a referral of an individual with a history of violence that may compromise our ability to minimize risk in our daily work. We are also able to refer program partners, when certain criteria are met, to another organization when we are no longer able to serve an individual due to continued aggressive behaviors that are likely to compromise the safety of staff, partners and visitors to our 2730 Adeline office.

The agency is committed to taking steps to ensure the safety of staff by securing the office building and parking lot. We have hired a security company to monitor the office and the parking lot for the 2 days of the week (Tuesday and Thursday) when the partners are scheduled to come into the office to pick up checks/money from their sub-payee accounts. Having a security officer has helped to instill a sense of safety back into the workplace.

Program Curriculum implementation strategies

It is our belief that the implementation of the above strategies along with the implementation of the following program curriculum suggestions and The TrACT program leadership have been reaching out and soliciting support from other programs in and outside of the county and state with the goal of not having to reinvent the wheel in the form of information and ideas on addressing and overcoming the issues/challenges as stated in the previous section. The following is a brief summary of our strategies for a multi-pronged approach or course of actions to address and hopefully mitigate the challenges experienced by the program.

Comprehensive and measurable needs and strengths assessment

The program will be implementing the use of the ANSA (Adult Needs and Strengths Assessment) to increase the quality and depth of the partner assessment to include a thorough collection of risk information both historical and current and criminal information process treatment history information collected to include risk history and current assessment, criminal history and assessment of current needs.

Treatment Services

The program has have completed a thorough criminal justice mental health community based treatment literature and program review to procure ideas and examples of best practices and programs with the goal of adopting innovative and evidenced based treatment service and We have researched and reviewed many theoretical approaches to working with our particular population and will be implementing new or updated evidence based strategies and practices, that were alluded to in section 2b, which will increase the quantity, quality and effectiveness of clinical and recovery services provided to the partners in the group and individual therapy and rehabilitation modalities. These strategies and practices are rooted in the traditional mental health practice model of cognitive behavioral therapies however, are being presented by the different organizations in a modern form. One such potential new modality for open group services is a format and materials that were

developed in part and offered by David Mee-Lee, MD. And members of the change companies (author of the ASAM instrument). The modality is based on the traditional mental health practice of cognitive behavioral therapies specifically as it has been developed to treat individuals with histories of trauma, violence (perpetrators and victims), substance abuse and incarceration.

Alternative Payee Services
We have been in negotiations with and will be meeting this fall to begin offering a new type of payee service that is available directly to our partners through telephone or email. The company is out of county and has no in person dealings with the partners. They have developed a clear, consistent and realistic money management and budgeting system for serving as a representative payee to consumers and will be able to support our program by serving as the representative payee for our more difficult and challenging partners. Thus, removing the financial responsibility variable from the dynamic of the professional partnership (partners and staff) in our attempt to work with and hold the individuals accountable for their actions and responsible for their treatment goals.

For 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 15-16 Outcomes, Impact & Challenges: For this fiscal year, TIP served a total of 38 clients, according to the Clinician's Gateway reports and key event tracking forms.

Psychiatric Emergency Services (PES) Episodes:
12 Months prior to enrollment: 49
First 12 months of enrollment:21
Decrease in episodes: 28 (57%)

Psychiatric Hospital Days:
12 Months prior to enrollment:92
First 12 months of enrollment: 75
Decrease in hospital days: 17 (18%)

Hospital Episodes:
12 Months prior to enrollment: 16
First 12 months of enrollment: 14
Decrease in hospital episodes: 2 (13%).

Days in Jail:
12 Months prior to enrollment: 304
First 12 months of enrollment: 439 Increase in jail days: 135 (44%) (one of our new TAYs was incarcerated for a total of 304 days prior to enrollment in June of 2016).

Residential Treatment: 8%

Employment: remained the same from last year: 6 clients employed (competitive and supported).

Education: 1 client graduated from 4 year college. 8 clients enrolled in community college.

Primary Physician: 82% had a primary physician compared to 83.3% last year.

Residential Setting: 28 clients (73%) have been successfully maintained with family.
5 homeless (staff are working to assist with housing).
4 living independently in his or her own apartment.
1 incarcerated.

During this reporting period, it is worth noting that 1 of our clients graduated from Mills College and entered into graduate school studying psychology. Another client was able to successfully step down, has permanent housing, is living independently, and successfully manages own finances. Another Client has graduated from high school and has entered into community college and a training program for computer science.

Any challenges or barriers with each of the programs and strategies to mitigate those challenges or barriers:
While the program was able to reduce psychiatric hospital admissions for most of our clients, TIP was challenged with the high needs of 4 clients who continued to require more intensive and structured interventions as in hospital or residential settings. As a result, our data showed an increase in number of psychiatric hospital days during FY 15-16. Additionally, one of the challenges for these clients was the limited access to residential drug treatment program that serves monolingual clients. Due to lack of treatment, clients' behaviors while they were under the influence occurred with increased frequency and aggression and at times compromised their ability to adhere to their mental health treatment goals.

Another challenge to the program and clients was the lack of affordable housing and employment opportunities in the Bay Area. In general, most of our clients were reluctant to pursue or to maintain permanent employment for fear of losing their SSI and Medi-Cal benefits.

One of our strategies to mitigate these problems was by encouraging and supporting clients to complete their educations (with the hope that they can qualify for higher paying jobs). Another strategy was to ensure that all clients apply for Section 8 (when there is an opening throughout the region) and or MHSA funded housing programs. Staff also actively use 211 and Housing Choices website to assist our clients in finding affordable or subsidized housing options.

For current FY 16-17 Progress Report: TIP staff is currently at full capacity and this staffing should support excellent client care. TIP remains focused on maintaining full enrollment while transitioning clients to lower levels of care when this is appropriate. TIP is in the process of transitions 3 clients to lower levels of care. Simultaneously, we continue to provide supportive and assertive outreach to new referrals.

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

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

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

See ATTACHMENTS: “East Bay Community Recovery Project, Transitional Assertive Community Treatment, Annual Monitoring Report, July 1, 2015 - June 30, 2016.”

For previous FY 15/16 Outcomes, Impact & Challenges:

Number of Partner served: 49
Number of new enrollments: 33
Number of transitions: 11

Community Impact:

REDUCTION in RECIDIVISM
Psychiatric Emergency and inpatient units and Jail. The program continues to reduce recidivism for its partners as has been the case every year since the programs start in August of 2009. The largest reduction in recidivism is in the number of days’ partners spent in jail which were 2238 days 12 months prior to enrollment reducing to 376 days 12 months’ post enrollment into TrACT. This showed a positive reduction of 83%. Episodes of incarceration were 2nd with 81 episodes 12 months prior to enrollment and then 27 episodes 12 months post enrollment which is a reduction of 67%.

ENROLLMENT, TRANSITION AND GRADUATION
As in FACT this year TrACT experienced the highest number of enrollments (33) for a single year. This year we had 8 partners who transitioned to a lower level of care. These individuals graduated from the program when they completed their commitment to the court and when their applications for the S+C housing subsidy were approved, when the housing specialists were able to support the

partners in securing a housing unit they could afford and a unit that met their needs for independent living.

PROGRAM CAPACITY

The TrACT program was awarded an increase of funding in December 2015 to expand capacity for the number of partners to be served (20-29). This is not a large increase in capacity, however, it is a step in the right direction that has allowed us to increase services to our partner population. We added 1 full time personal service coordinator/therapist and 1 full-time employment specialist, and increased hours for nursing, and psychiatry.

PRIMARY CARE

We continue to triage new partners into community based primary care services such as Lifelong Medical Care. We were able to connect 82 % of the newly enrolled partners with primary care within 12 months of enrollment. The remaining partners were discharged in a few months' post enrollment or have yet to complete 12 months in the program. We are still moving forward with plans for offering primary medical care from our 2730 Adeline office and are patiently waiting for the MOU to be drawn up and for the medical provider to hire a medical practitioner along with a medical assistant.

HOUSING

The difficulty in housing partners was challenged further this past year by the continued highly competitive housing market both in locating units and affordability. HCD and the Shelter + Care program worked very closely with the program to review each application on a case by case basis allowing all the subsidy requests to exceed the set fair market rate by price units in the same area to determine rent reasonableness. We were able to bring on a few new landlords and several new properties in the latter part of FY 15/16. We were able to house everyone who had been on our waiting list for an extended period of time. The new units were located in prime areas of alameda county and the tenants were extremely excited and grateful for the spacious apartments and the calm and serene neighborhoods.

EMPLOYMENT

This past fiscal year brought changes to the employment program as we hired 2 new employment specialist and with the assistance of the county vocational program we were able to move completely to the IPS model of supported employment. Educational services were transferred to the responsibilities of the personal service coordinators saw the program. The new employees worked closely with the county IPS program supervisor to increase employer contacts to increase the eligible employment positions for partners to apply. The employment specialist shared a caseload of over 20 partners who were either working or applying for work

TRACT PROGRAM IMPACT

The TrACT programs primary positive community impact is the ability to reduce partner recidivism to psychiatric emergency, psychiatric inpatient and incarceration services. The program partners were able to significantly increase their time living in the community mostly free from the often paralyzing symptoms of their mental illness that in the past would require a partner to voluntarily or sometimes be 5150'd to be strongly encouraged to utilize psychiatric emergency services, inpatient hospitalization or in the case of a crime committed arrested and incarcerated to stabilize psychiatrically and behaviorally. Now, the partners are creating new histories for themselves and have become active members participating in and contributing to their communities of choice by living independently and participating in various forms of meaningful activities that contribute to their well-being and the wellbeing of the community at large.

Challenges and Strategies:

1a. Challenge - Partner Substance Abuse
The primary challenge to the TrACT program meeting its outcomes continues to be the pervasive and chronic substance use/addiction that plagues a majority, 77 % (17 of 22), of the overall program partners. Partners' substance use/ addictions compromise their ability to adhere to basic program instruction or guidelines whether it is taking medication as prescribed or following through with orders from the court. Substance use diminishes a partners functioning capacity which in most cases keeps them from being able to utilize and benefit from the many resources and opportunities available to them from this MHSA funded programs.

The programs' success rate of graduating partners would be exponentially higher if there were substantially more co-occurring mental health substance abuse residential programs, step-down community based recovery support and self-help programs that complement the therapeutic and rehabilitative services of TrACT. The outcome of such a system of care would provide longer term comprehensive services and or support individuals with their efforts to maintain their personal program for recovery, increase their sober community network and to create a sober history. These challenges, experienced by partners along with the absence of a comprehensive mental health and co-occurring substance use treatment and services continuum of care in this county, significantly decreases the program's capacity for effectively supporting partners in achieving program milestones and successfully achieving their wellness and recovery treatment goals.

1b. Strategy
Fortunately, there have always been a percentage of partners who have been able to achieve and maintain their sobriety, achieve and maintain competitive employment, complete the program and live independently in the community. We looked at the elements of these individual's success and began to look at what we could do to increase partner success.

Over the past 1 ½ years our strategy consisted of a restructuring the program staffing roles and responsibilities and patterns—updating the required skills and experience of incoming employees—and redesigning the program curriculum to increase our ability to address and work with partners co-occurring mental health and substance use conditions and a partner's risk for violence and criminal behaviors. This has led to an increase and diverse presentation of individual and group services. We are now offering cognitive behavioral groups that focus on understanding partner substance use, criminal behaviors and creating plans for "change" with an increase in individual therapy services to support the co-occurring needs of our partners. We have implemented a policy of not providing support services if a partner comes into the office intoxicated or if a partner is intoxicated when we go to pick them up from their homes. Psychiatric, medical triage, and counseling services may be allowed on a case by case basis. We are determined to be consistent with our policy and support partners to the county detox program when intoxicated as a way of providing some extra motivation for sobriety.

2a. Challenge - Partner Substance Abuse and increased incidence of partner behavioral issues
As a forensic behavioral health program, behavioral issues can be expected occasionally; however, these partner violent behaviors continue to occur with increased frequency and aggression, as compared to partner behaviors from previous years in the programs. This increases the need for caution in providing services and the skills required for "crisis prevention, intervention and management" services. The team members along with the program leadership have developed new safety protocols and strategies for implementation. This year we have had 2 violent partner outbursts that have traumatized some of the staff and has put the question of our safety front and center.

Substance use disorders play a significant role in the likely increased incidence of partners "acting out" behaviors, specifically, their use of derogatory statements (verbal abuse) and use of intimidation and threats of violence with team members is unfortunate, unacceptable and difficult to predict and prevent. Partner intoxication has played a part in most of the incidents experienced by the team in the past, however, this past year saw an unregulated upset sober partner perpetrate violence in our front lobby. The need for safety on the job (both in the office and the community) has been compromised and requires increased vigilance by team members when working with partners, especially when responding to partner crises. Fortunately, the actual incidence of these partner behavioral issues occurring, although increasing in frequency, are still an exception to the norm.

The program serves as representative payee for many of the partners that are in need of support to budget and manage their money so that the bills get paid and the partner has access to funds throughout the full month. This becomes a problem when partners under the influence come into the office, without prior notice given, demanding access to their money (that they have already spent or are not scheduled to receive). Partners can, on occasion, get verbally and physically (less frequent) escalated and aggressive to the point where their interactions with team members become volatile, unpredictable and on a few occasions unmanageable. The team has been able to prevent or successfully manage partners and their escalating behaviors through effective non-violent communication and teamwork. Requiring that the partner leave the building for the day and assertively escorting them outside. We have found that the threat of calling the police will in most cases diffuse a situation.

2b. Strategies

The program leadership has integrated a risk assessment tool, "Risk and Responsivity" into our mental health screening and assessments to begin addressing partner behavioral issues through the screening and intake process. In addition, this fall will see the introduction and administration of the ANSA Needs Assessment.

This will support team members in collecting an in-depth history for newly enrolled individuals as to increase our knowledge of these individuals while also supporting the development of a comprehensive and individualized treatment plan.

This past year we were able to confirm with the adult system of care director that the program has the authority to refuse a referral of an individual with a history of violence that may compromise our ability to minimize risk in our daily work.

We are also able to refer program partners, when certain criteria are met, to another organization when we are no longer able to serve an individual due to continued aggressive behaviors that are likely to compromise the safety of staff, partners and visitors to our 2730 Adeline office.

The agency is committed to taking steps to ensure the safety of staff by securing the office building and parking lot. We have hired a security company to monitor the office and the parking lot for the 2 days of the week (Tuesday and Thursday) when the partners are scheduled to come into the office to pick up checks/money from their sub-payee accounts. Having a security officer has helped to instill a sense of safety back into the workplace.

Program Curriculum implementation strategies

The following is a brief summary of our strategies for a multi-pronged approach or course of actions to address and hopefully mitigate the challenges experienced by the program.

Comprehensive and measurable needs and strengths assessment
The program will be implementing the use of the ANSA (Adult Needs and Strengths Assessment) to increase the quality and depth of the partner assessment to include a thorough collection of risk information both historical and current and criminal information process treatment history information collected to include risk history and current assessment, criminal history and assessment of current needs.

Treatment Services
The program leadership have worked with staff to develop a new curriculum for treatment services. Groups are offered Tues, Thursday and Friday and include skill development, relapse prevention, art group, anger management and the WRAP. These strategies and practices are rooted in the traditional mental health practice model of cognitive behavioral therapies. One such potential new modality for open group services is a format and materials that were developed in part and offered by David Mee-Lee, MD. And members of the change companies (author of the ASAM instrument). The modality is based on the traditional mental health practice of cognitive behavioral therapies specifically as it has been developed to treat individuals with histories of trauma, violence (perpetrators and victims), substance abuse and incarceration.

Alternative Payee Services
We have been in negotiations with and will be meeting this fall to begin offering a new type of payee service that is available directly to our partners through telephone or email. The company is out of county and has no in person dealings with the partners. They have developed a clear, consistent and realistic money management and budgeting system for serving as a representative payee to consumers and will be able to support our program by serving as the representative payee for our more difficult and challenging partners. Thus, removing the financial responsibility variable from the dynamic of the professional partnership (partners and staff) in our attempt to work with and hold the individuals accountable for their actions and responsible for their treatment goals.

Current FY 16/17
Our goal is to serve a total of 55 individuals throughout this reporting period.

The TrACT program received an increase in funding (funding relating to the Alameda County version of Laura's Law) this current FY increasing the programs' capacity both in the quality and quantity of services provided and the number of partners (29) who will be eligible for program services. This has enabled the program to increase the number of licensed or licensed eligible direct service provider's, to increase the diversity of services provided (including the increase in the program's capacity for the provision of 1 on 1 counseling). The programs increased capacity in the number of participants to be served has helped the program to take more referrals and enroll more partners in the program. This has helped to positively impact our relationships with our community provider's/referral sources that have been wanting to refer potential participants to the program. The increase in funding has allowed us to increase the full time equivalency for the provision of employment and education services (1. to ~2. FTEs)—increasing program capacity for adhering to the fidelity scale for the IPS Supported employment model. We also increased our nursing staffing from 1.4 to ~1.6 FTEs and the psychiatry position (.35 to ~.50 FTEs) or 20 hours of services per week.

The program leadership continues to lobby to bring primary care services on site at least 1 day a week through a collaborative effort with a local medical clinic. This will enable the program to increase partner access to primary care and support, especially the more medically fragile partners who have had difficulty in making staff supported scheduled appointments.

TrACT continued its intern program this fiscal year which has also contributed to our ability to increase the services we provide to our partners.

Upcoming FY 17/18 planned program changes:

- No significant changes planned.
- Will continue to be mindful of the need to continue the flow of partners in and out of the program ensuring as many individuals have access to services as possible
- Prepare for the RFP Process scheduled to take place in the beginning of fiscal year 17/18.

FSP 10. Housing Services

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.

Program Name	FY 15-16	FY 16-17	FY 17-18
County	The Housing Services Office includes 7.0 FTE of BHCS county staff – 1.0 FTE Housing Services Administrator, 1.0 FTE Behavioral Health Clinical Supervisor, 2.0 FTE Rehabilitation Counselor, 1.0 FTE Administrative Specialist. Staff are located at Eastmont Mall and 1404 Franklin St. in Oakland. This funding also covers funding provided to Alameda County Housing and Community Development (HCD) and EveryOne Home to support their efforts to increase housing resources for individuals with serious mental illness. Some of this funding supports a housing search website – www.achousingchoices.org The Housing Services Offices is responsible for the activities outlined in this document and has broad goals outlined at: http://www.acbhcs.org/Housing/housing_default.htm	Staff from the Housing Services Office (HSO) will become members of the Alameda County Care Connect (AC3) Whole Person Care implementation team. Additional staff focused on housing as a health care issue will occur under AC3. BHCS staff currently have two vacant positions – Clinical Supervisor and Behavioral Health Clinician II that are responsible for providing oversight of the MHSA housing units and Housing Support Program licensed board and care beds.	Refill vacant positions. Work in partnership with AC3 effort to expand housing-related resources for Alameda County Medi-Cal beneficiaries.

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

BACS – North County Housing Connect	Provides outreach, engagement, housing navigation, and specialty mental health services to chronically homeless individuals with serious mental illness in Northern Alameda County. The program serves up to 40 people per year with a focus on helping individuals obtain permanent housing, increased income, and ongoing supports to enable them to maintain their housing.	Proposed change for this fiscal year is that open program slots will be filled via referrals from Home Stretch – a countywide registry of homeless individuals with disabilities. More info can be found at: http://everyonehome.org/our-work/home-stretch/	Possible expansion of programs similar to this program through the addition of Whole Person Care funding.
BOSS – Casa Maria	25-bed interim housing program for homeless individuals with serious mental illness currently receiving services from BHCS-contracted field-based services program. 100 people entered program during this fiscal year and 76 exited. Thirty-three percent (33%) obtained permanent housing at time of exit from the program.	No changes planned for this fiscal year other than working to improve housing outcomes from prior year.	Referral process into program likely to change as a result of the creation of a coordinated entry system for addressing homelessness scheduled for implementation in FY 17-18.
BOSS – Service Team	Additional funding provided to the BOSS service team as a result of their displacement from a county-owned property in Downtown Oakland. This additional funding allows BOSS to retain a presence in downtown Oakland.	No planned changes.	No planned changes.
BOSS – Housing Services Team	Provides supportive services to residents living in permanent supportive housing sites and programs affiliated with BOSS. Designed to support 25 clients at a given point in time.	Program to shift focus to providing supportive services to residents at three BOSS permanent supportive housing sites – Pacheco Court, Meekland, and Rosa Parks. The team will be split into two teams with one focused on serving transition age youth living at Meekland. All three properties will have converted from transitional housing to permanent supportive housing by December 31, 2016.	Continuation of services planned for FY 16-17. Possible expansion of this type of service using Whole Person Care funding.
BOSS – South County Res.	Provides emergency shelter to homeless individuals with serious mental illness. Referrals are coordinated by BHCS Housing Services Office staff. The program served 71 people during the fiscal year and 69 exited. Forty-nine percent (49%) obtained permanent housing at the time of exit.	Focus on continuing to improve housing outcomes. Plan to seek additional funding to make improvements to the shelter property.	Referral process into program likely to change as a result of the creation of a coordinated entry system for addressing homelessness scheduled for implementation in FY 17-18.

Abode - OPRI	Small amount of funding to serve as matching dollars for a HUD grant focused on helping homeless people with serious mental illness to obtain permanent housing. Funding helps support 25 permanent supportive housing slots for this population.	Proposed change for this fiscal year is that open program slots will be filled via referrals from Home Stretch – a countywide registry of homeless individuals with disabilities. More info can be found at: http://everyonehome.org/our-work/home-stretch/	Planned expansion of this type of program model to securing permanent housing slots in the private market using third-party landlord finding service. Expansion will come from the consolidation of MHSA FSP housing funds and Whole Person Care funding.
Abode – Housing Services	Housing subsidy and landlord finding service associated with the Fred Finch Youth Center STAY program. Helps provide housing slots for 25 youth at any point-in-time and 30 youth over the course of the year.	Plan to transition youth in this program to other centralized housing subsidies over the course of the year. Funding for this service will become part of a centralized pool of housing resources that will support BHCS clients in FY 16-17.	Planned transitional year of funding for this effort to close out this program. The program will be replaced with a centralized housing subsidy and landlord finding service that involves MHSA and Whole Person Care funding.
Life Long - OPRI	Provides intensive, field-based services to help 25 formerly homeless individuals with serious mental illness to obtain and maintain permanent supportive housing subsidized by HUD funding in the private market. Program operates in partnership with Abode Services, Operation Dignity, the City of Oakland, and the Oakland Housing Authority.	Proposed expansion of this program to include 15 additional clients contingent upon receiving an equivalent number of housing subsidy slots. Proposed change for this fiscal year is that open program slots will be filled via referrals from Home Stretch – a countywide registry of homeless individuals with disabilities. More info can be found at: http://everyonehome.org/our-work/home-stretch/	Possible expansion of programs similar to this program through the addition of Whole Person Care funding.
GA Housing Subsidies	Revolving fund to provide additional dollars ($298/month) for disabled General Assistance recipients working toward obtaining Social Security disability payments. The additional funding was designed to reduce the likelihood of homelessness among this population. Only individuals actively working on a Social Security application with a contracted SSI advocate are eligible for this funding. Funding is managed in collaboration with the Alameda County	Continue to track use of this fund and results from this funding. Initial data indicates that additional funding correlates with reductions in crisis and inpatient mental health service utilization among this population. The state of California plans to promote this model among other counties by making revolving	Potential expansion of this program depending on need, outcomes, and availability of other funding.

	Social Services Agency. Program has helped 588 people to date and 530 are currently receiving this additional funding.	fund dollars available. Alameda County may apply when funds become available. An increase in the number of county funded SSI advocacy slots will take place this fiscal year through the Social Services Agency.	
Community Living Support (formerly SRP) – Housing Support Program (HSP)	Provides an additional housing subsidy to licensed board and care operators that accept direct referrals from BHCS. Most referrals come from Villa Fairmont and other subacute facilities. BHCS currently subsidized 250 out of 275 available beds at 17 facilities (6 Residential Care for the Elderly and 11 Adult Residential).	Propose increasing the number of subsidized beds by 20 and providing some financial support to licensed board and care operators to meet increased reporting requirements.	Continue to explore methods for enhance the quality of operations at licensed board and cares through partnerships with existing clinical programs. Monitor the impact of this program on BHCS cost of services and client outcomes.

FSP 11. Community Conservatorship Pilot (CCP)
FSP 12. Assisted Outpatient Treatment (AOT) Pilot

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

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

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

At Telecare's Alameda Assisted Outpatient Treatment (AOT) and Community Conservatorship (CC) program in downtown Oakland, our goal is to work closely with existing community resources to assist individuals with transitioning back into their community. Our multidisciplinary team includes a psychiatrist, a nurse, masters-level clinical staff, and personal service coordinators who are all here to help individuals in our program on their path. AOT/CC staff will walk with individuals on their journey in healing and provide a full range of services, including medical and psychiatric services, case management services, advocacy and linkage, referral to safe and affordable housing, substance use interventions and counseling, assistance with entitlements, support and education with family and significant others, connection with community resources, and self-help groups.
Clients to serve: 17
Population Served: Adults (age 18+) diagnosed with a severe mental illness.

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

CCP referrals come from John George Psychiatric Pavilion and are screened by the Public Guardian's Office before partners are invited to voluntarily participate.

Admission Criteria:

- Adults ages 18 and older.
- Resident of Alameda County.
- Clinical determination that the person is unlikely to survive safely in the community without supervision.
- Person's condition is substantially deteriorating.
- Person has been offered chance to participate in development of their treatment plan for services and continues to fail to become involved. Have a history of lack of participation in a mental health program that have resulted in 2+ hospitalizations or incarcerations within the last 36 months, or have attempted to cause harm in the last 48 months.

FSP 13. CHANGES

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

This program was moved to the FSP category midyear FY 16/17 and the evidence-based program Individual Placement Services (IPS) was added as a programmatic requirement. More information and evaluation data will be available in the following Three Year MHSA Plan (FY 17/18-19/20).

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

FSP 14. STRIDES

Program Description: Based on the Assertive Community Treatment (ACT) model, STRIDES of Alameda County is an intensive community support service for individuals with severe mental illness (SMI), many of whom would otherwise require extended care in institutional settings. STRIDES serves individuals who are high utilizers of mental health services and who are considered to be at great risk for psychiatric hospitalization.
This program was moved to the FSP category midyear FY 16/17 and the evidence-based program Individual Placement Services (IPS) was added as a programmatic requirement. An additional 20 client FSP slots were also created to increase this program's capacity as an FSP. More information and evaluation data will be available in the following Three Year MHSA Plan (FY 17/18-19/20).

FSP 15. STAGES

Program Description: Alameda STAGES is an Assertive Community Treatment (ACT) program for older adults (ages 60 and above) who have a diagnosis of severe mental illness (SMI) living in community-based settings in Alameda County. STAGES specialize in the unique challenges of older adults who receive behavioral health services.
This program was moved to the FSP category midyear FY 16/17 and the evidence-based program Individual Placement Services (IPS) was added as a programmatic requirement. More information and evaluation data will be available in the following Three Year MHSA Plan (FY 17/18-19/20).

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

Program Description: Alameda STAGES is an Assertive Community Treatment (ACT) program for older adults (ages 60 and above) who have a diagnosis of severe mental illness (SMI) living in community-based settings in Alameda County. STAGES specialize in the unique challenges of older adults who receive behavioral health services.
This program was moved to the FSP category midyear FY 16/17 in order to create a more robust clinical program for TAY experiencing a first break episode. For information on FY 15/16 please see the PEI section of the Plan Update. More information and evaluation data will be available in the following Three Year MHSA Plan (FY 17/18-19/20).

A. COMMUNITY SERVICES & SUPPORTS PROGRAM SUMMARIES

OESD 4A. Mobile Integrated Assessment Team for Older Adults

Program Description: Increase the access for homebound and/or isolated older adults who are experiencing difficulty accessing mental health services due to barriers associated with aging and mental health stigma. Work with First Responders and other community agencies to identify isolated older adults.

FY 15/16 Outcomes, Impact & Challenges: During the fiscal year 2015-16, the Mobile Mental Health Team provided 57 older adults, over the age of 60 years, with mental health services. The clients received individual/group therapy and medication support. The most common chief complaint on initial assessment was severe depressive disorder (87%); anxiety disorder (90%); and PTSD (60%). Twenty-four percent of the clients were referred from the Afghan Elderly Association and these are older Afghan refugees who have experienced life trauma. We also receive about the same number of referrals from the City of Fremont's Senior Helpline, a local phone number that screens over 150 calls a month. The Senior Helpline is a direct referral from the City's Emergency Responders, primarily the Fire Department but also the Code Enforcement team. This is often how we serve isolated older adults who don't usually seek services. All clients have complex medical conditions. The most common being Hypertension (55%) and Chronic Pain (22%) and are on an average of 8 medications.

The Mobile Mental Health program added a Peer Coach service that is available to clients who have a goal in their Treatment Plan to address social isolation. At the end of its first year of operation, the Peer Coach program was evaluated by San Jose State. The evaluation utilized the General Self Efficacy Scale and the UCLA Loneliness Scale. The Mental Health Peer Coaching program had a significant impact on reducing loneliness and social isolation in recipients of the program services. There was also a significant positive impact on self-efficacy for both mental health coaches and their assigned peers.

The City of Fremont established a contract with Beacon Services as a means to serve individuals who do not meet Specialty Mental Health criteria.

FY 16/17 Progress: Many of our clients are referred by First Responders (Fire/Code Enforcement) and have not been connected to mental health services in the past. Clients are often referred to our program in crisis. They are overwhelmed with issues of aging and are experiencing serious symptoms of mental illness. After intensive treatment with the Mobile Mental Health Team, the clients are stable but remain uncertain of their ability to manage the increased demands of aging. They are moving towards a time in life of interdependence. This year we will begin the implementation of a 'Step Down' level of services so that we can remain connected to the clients and monitor their well-being.

We continue to work closely with the Afghan Elderly Association to support older Afghans with PTSD/Anxiety symptoms. This year we are increasing the use of interns to develop a health promotion program that will include mental health screening.

Fully implement the Peer Coach program: We have trained 14 Peers, who are clients enrolled in our program, and they now all have a peer to support. This is a new program and this will be our first full year. We are assessing both the Coach and their peer on self-efficacy and isolation scales. This year we will collect and analyze the data.

We are in the process of obtaining a contract with Beacon Health to be in their Network to provide mental health services to individuals with mild to moderate symptoms. We feel this will support our Step Down program. We are also monitoring changes to Medi-Cal reimbursement to see if Peer

support will be reimbursed.

We are upgrading our Electronic Health Record in a move towards being paperless.
The Mobile Mental Health Team is serving older adults with severe mental illness. We provide individual and group counseling along with medication management. We continue to partner with emergency responders and other service providers to support individuals in their ability to continue living in the community.

We started a 'step-down' program for our clients called R&R (Recovery and Resiliency) program. This program will monitor and support MMH clients who are discharged from MMH but without support could experience severe mental health challenges. We now have 10 clients in this new program.

This year we are adding a LGBT+ component to our Peer Coach program. We will identify and train two coaches to support older adults with mental illness who have a lived experience as an LGBT+ individual. The Peer Coaches will then offer support to reduce isolation and improve self-efficacy as part of the treatment team to this underserved population.

We are happy to report we have hired a Nurse Practitioner to assist our Psychiatrist with medication management and monitoring the complex health needs of our clients. This position had been unfilled and it was challenging to fill the position.

FY 17-18 Plans: Continue to provide services to impact the quality of life of Older Adults with Mental Health challenges. The City of Fremont is working on becoming designated as a World Health Organization Age-Friendly City and we will elicit the input from our older adults who participate in our Mobile Mental Health program. We will continue to refine systems across our three programs: Mobile Mental Health, R&R and the Peer Coach program.

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 15-16 Outcomes, Impact & Challenges: The Court Advocacy Program (CAP) has continued to provide services to individuals involved in the Criminal Justice System in Alameda County. This has included working as a liaison with the Courts/Attorneys/Community and Family members as well as community providers in helping them navigate both the court and the mental health system. They often take on some of the most difficult and challenging cases and assist in connecting them to services in the community. Over the last year they have been involved with finding appropriate placements for individuals who are being released from the State Hospitals who have been found unlikely to regain competency. They often have to coordinate placement in a matter of days, including housing, connect with a treatment team or facilitate treatment at a sub-acute facility. The CAP staff has been successful in diverting many clients from jail to community treatment, often allowing Courts the confidence to allow for community placement as opposed to jail time.

- The program did not have full staff which affected its capacity to provide the level of service

initially envisioned for this FY. (2015/16)
- CAP has continued to be integral in helping very difficult to place clients divert from jail to the community.
- In 2016 we have added the additional resource of the BACS-FREE re-entry program, CAP staff have used this as a resource to help clients who are not currently connected to mental health services in the community. CAP have actively referred to BACS-FREE and assisted with the transition to the community including securing discharge medications to help with continuity of care.
- CAP staff has referred clients to the new SSI advocacy programs to help ensure clients resume benefits when returning to the community. A study showed that obtaining benefits showed a marked reduction in incarceration and hospitalizations.
- The CAP program has not been successful in developing a data system to track some of the services that staff provide to the court staff. This continues to be a goal.
- Many of the services provided by CAP staff may not be captured as it may be general information or not related to clients who we would open cases for.

FY 16-17 Progress Report:

- A Mental Health Specialist will be added to the CAP staff
- Over the next FY year CAP will continue to review its data forms to make them more "user friendly" such as referral forms.
- CAP staff plans to provide education/trainings for Court Staff about mental health services and how to access them. (Judges/Public Defenders/District Attorneys).

FY 17-18 Plans:

- With the addition of 1 FTE, a 20 percent increase in services is projected for 17/18. Hopefully when the new BHCS new EMR system is up and running CAP will have a better system for tracking contacts and services provided to the courts.
- The CAP program continues to work towards having a dedicated supervisor/manager.
- Expand the policies and procedures for the CAP program.
- Expand staff to provide services in the new Dublin Courthouse.

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 15/16 Outcomes, Impact & Challenges:
April, 2016 the clinic hired a Behavioral Health Clinician at the Transition Center continuing to help youth transition back to the community. From July 2015 to June 2016 approximately 905 youth and their families have need seen in the Transition Center by the mental health clinician.
- Approximately 54% of those families refused services.
- 22% of the minors were already connected to services in the community and returned to their previous community providers.
- 21% of the minors were referred to therapeutic services by the Transition Center Behavioral

Health Clinician.
- 14% of the youth were committed to out-of-home placement.
- 15% had access to services through their private insurance providers.

FY 16-17 Progress Report: The Behavioral Health Clinician will continue to link youth and families to services in the community.
- We also found that in the previous two years approximately 12% of the youth were discharged from JH with meds.
- 30 days after release, only 11% received medication support through BHCS affiliated clinics in the community.
- 60 days after release only 14% received medication support in the community.
- In the current fiscal year the Behavioral Health Clinician will continue to work with youth and families improve medication support in the community by doing the following:
    - Ensure that every youth on medication will be provided with a valid prescription.
    - Work with the family to schedule an appointment with a psychiatrist in the community.
    - Follow-up with the youth and family at 15 and 45 days and provide additional support to ensure that the youth receives appropriate treatment.

FY 16/17+ Plans:
- Over the next three years, the goal is to meet with 900families per year for the next 3 years.
- The Transition Center's Behavioral Health Clinician will also continue to meet with 1 to 2 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 Guidance Clinic plans to increase the number of community service connections for youth and families. The goal is to ensure that at least 85% of the families requesting information about therapeutic supports are connected with community-based services.
- The Guidance Clinic will continue to closely monitor youth on medication to ensure continuity of care when released from Juvenile Hall.

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 15/16 Outcomes, Impact & Challenges: MST served a total of 87 youth under the supervision of the Alameda County Juvenile Probation Department, including 14 youth who were carried over from the previous fiscal year, 73 youth who were accepted for services, and 66 youth who were discharged from services during this time period. Of the 66 youth discharged, 76% met the criteria for completion of MST services (an improvement of 15% from the previous fiscal year), signifying clear evidence of the following: primary caregiver has improved parenting skills necessary for handling subsequent problems, improved family relationships specific to the instrumental and

affective domains in that family's subsystems that were drivers of the youth referral, family has improved network of informal social supports in the community and has demonstrated skill at successfully accessing a range of supports (formal and informal) as needed, youth is showing evidence of success in an educational or vocational setting, youth is involved with prosocial peers and activities and is minimally involved with problem peers, and changes in behavior of youth and in the systems contributing to the referral problems have been sustained 3-4 weeks.

During FY 15-16, the Seneca MST team received training to implement Contingency Management (CM), a substance use treatment model within MST, as part of MST's service delivery for youth needing additional services aimed to address substance-use. The protocol for CM requires that MST clinicians begin MST treatment and assess if the youth and family meet criteria for CM. Youth and families who meet CM criteria and agree to protocols required for CM are then approved to receive CM by the MST Supervisor and MST Expert Consultant.

Two MST bilingual and bicultural Spanish-speaking clinicians were hired during FY 15-16, increasing MST service availability for Spanish-speaking families.

Challenges/Barriers and Strategies to Address Them: 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 15-16, 14% of youth who discharged from MST closed due to being placed in a restrictive setting, compared to 11% the previous fiscal year. MST continues to assess factors contributing to the slight increase in the number of youth who discharged due to being placed in a restrictive setting and has implemented interventions such as further training for staff to address this issue. There have already been improvements in this area, which are further detailed in the next section.

FY 16/17 Progress Report:

FY 16-17 Number of youth to be served: MST aims to serve 90 youth who are under the supervision of the Alameda County Juvenile Probation Department during FY 15-16.

Current Implementation and Changes from Previous Year: In this current fiscal year, MST has served a total of 45 youth who are under the supervision of the Alameda County Juvenile Probation Department. This includes 24 youth who were carried over from the previous fiscal year, 21 youth who were accepted for services, and 25 youth who were discharged from services during this current fiscal year. Of the 25 youth discharged, 84% 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. MST continues 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, 8% of youth who discharged from MST closed due to being placed in a restrictive setting, which is an improvement of 6% 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: interventions to address negative peer interactions and engagement and skill building with parents. An upcoming quarterly training will focus on working with commercially sexually-exploited youth and their families.

- MST continues to provide Contingency Management (CM) to youth and families meeting criteria for, and agreeing to CM services.
- Our 2 MST bilingual and bicultural Spanish-speaking clinicians continue to serve Spanish-speaking families
- There are no anticipated changes to services for the upcoming year.

FY 17/18 Plans:

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

OESD 11. Crisis Stabilization Services – 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 15-16 Outcomes, Impact & Challenges: The Willow Rock Crisis Stabilization Unit provided 1303 assessments to adolescents (aged 12-17) in crisis. Of these youth, 89% were brought to the CSU on an involuntary civil commitment hold (WIC 5585), while 11% were voluntary walk-up clients. Based on the multidisciplinary, comprehensive assessment of the youth's needs, 47% of youth assessed at the CSU were diverted from hospitalization. When asked how welcome staff at the CSU made youth feel, satisfaction surveys of youth served in the CSU show a score of 3.7 out of 4. One youth stated that while at the CSU, "Everyone was really kind and they explained everything that was going to happen thoroughly and answered all of my questions". Another youth stated "They [staff] made me feel like I could talk about anything".

Willow Rock continues to impact the community by participating in Crisis Intervention 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.

FY 16-17 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 a similar number of

youth, and see an increase in the acuity of youth we serve.

Approximately 56% of youth assessed at the CSU during fiscal year 15/16 were TAY youth (aged 16 and 17) which is a significant increase from last fiscal year. It is estimated that as similar percentage of TAY youth will be served this year.

FY 17-18 Plans: 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: Programs to treat consumers with co-occurring mental health and substance-abuse issues.

ATOD Network: Training and technical assistance project to improve clinical skills on how to provide evidence-based tobacco dependence treatment, and implement 2011 BHCS Tobacco Policies and Consumer Treatment Protocols. Program outreach and training is county-wide, and targets/encompasses all age groups and BHCS programs, including consumer groups. This is a much needed service as those with serious psychological distress are underserved in terms of tobacco treatment.

For previous FY 15-16 Outcomes, Impact & Challenges:

ATOD Network: Trained 180 clinicians from a broad spectrum of Mental Health and SUD programs through 11 multi-agency skill-building trainings, 8 on-site trainings and provided 169 hours of TA (technical assistance) sessions. Training included one CME training for psychiatrists and one all day training for peer facilitators in the PEERS consumer Tobacco Program. And includes providing 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 4-5 BHCS tobacco intervention mini-grants designed to improve recipient agencies' competency in intervening with their clients who smoke. Mini-grantees collectively provided interventions to 240 clients in their programs, and continued to strengthen their tobacco policies. Many clients they served decreased their smoking and some quit. Collaborative work with PEERS resulted in PEERS providing 16 tobacco education presentations to over 140 consumers in 16 provider programs and beginning to do presentations at board and care provider programs. ATOD Project provides evaluation analysis to the PEERS Tobacco Program.

Disparity in implementation of Tobacco policies as mentioned in FY 14-15 still exist however BHCS leadership agreed to update tobacco policies and make them even more formal. We are planning two major conferences in fall 2017 and Spring 2018 to get all staff and all agencies on board. In January 2016 our valued Project Coordinator took another position and worked for us occasionally until she was replaced in September 2016. Her occasional work helped us through this period and we were able to keep up.

Current FY 16-17:

ATOD Network: Conducted 2 skill-building and 6 on-site trainings for a total of 72 participants. This includes training consumer facilitators working in PEERS Tobacco Program. Trainings will be scheduled through the end of FY. Broad range impact is similar to FY15-16. This year we were able to finalize the newly revised 2016 tobacco policies which will be disseminated with a cover from agency director. We plan to support up to 8 BHCS tobacco intervention mini-grantees after the application review process is completed. This year there is special emphasis on agencies which have not had tobacco mini grants in the past.

The Project Manager, who has been with the project for many years, had to resign due to illness in October. We are currently recruiting to replace this woman who was a staunch effective advocate for the work the network does. BHCS leadership has recently signed newly revised Tobacco Policies which have yet to be disseminated. A series of 2 conferences is planned for FY 17-18 to provide additional support for agencies to adopt the policies and for staff to have the skills to help clients to become tobacco-free.

For upcoming FY 17-18:
No impact yet however we anticipate gains in this fiscal year because contracts will include increased emphasis on follow-through and accountability with the newly revised tobacco policy.

More on-site technical support is expected to be provided to increase compliance with these policies and increase the number of clients receiving support to become tobacco-free.

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 15-16 Outcomes, Impact & Challenges:

Cronin House is a licensed and certified 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 diagnoses. We served over 200 clients in FY 2015-2016. 80% of our clients are homeless. Cronin House provided crisis intervention and stabilization, education, process and skills training groups in addition to supportive case management and linkage services to clients in early recovery from mental health and substance abuse issues. In addition, we provided on site Dual Recovery groups, a Family Education Group and therapy to family members and couples. We focused on developing client's strengths, peer connections and understanding of the connection between their mental health and substance abuse. Clients also have an opportunity to develop leadership and peer support skills on Client Council and be a Big Brother or Sister to a new client in the program. When clients come to Cronin, there is an assumption they have experienced intense trauma that they may or may not be able to acknowledge while at Cronin. Operating from this lens,

we offer opportunities to identify and practice coping skills to help clients manage trauma, substance abuse and other triggers that have led to maladaptive behaviors in the past. Cronin House continued its focus on providing access to healthcare for the increasing number of clients without a psychiatrist, primary care physician and/or dentist. Cronin House offered service for clients on methadone maintenance and in partnership with East Bay Community Recovery Project (EBCRP) provided HIV and Hepatitis C education on site twice a month. Peers Envisioning and Engaging in Recovery (PEERS) provided quarterly day long Wellness Recovery Action Plan trainings for the clients. 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.

Cronin House is a licensed and certified 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 diagnoses. 75%-80% of our clients are homeless.

The level of mental health disability and medical complications has increased in our clients over recent years. The majority of our clients have complex mental health issues including multiple traumas and PTSD symptoms. Because our clients are in early recovery and have often been homeless, they have many unmet emotional and physical needs. We are challenged to find new avenues to help our clients with their psychiatric, medical and dental needs. We struggle to provide the needed transportation to psychiatric, medical, and dental appointments. To serve our more severely disabled population, we need highly skilled, well trained staff, who understand mental illness, trauma and addiction. Cronin House provides intensive training in order to support our staff as they serve our clients in a uniquely challenging environment.

Services provided by Cronin House include crisis intervention and stabilization, education, process and skills training groups in addition to supportive case management and linkage services to clients in early recovery from mental health and substance abuse issues. We also provide medication management on site Dual Recovery groups, a Family Education Group and therapy to family members and couples. We focused on developing client's strengths, peer connections and understanding of the connection between their mental health and substance abuse. This year, we will be implementing Cognitive Behavioral Therapy Groups (CBT), an evidenced based practice, with the intention of training the clients to use CBT techniques to help them with their mental health and substance related symptoms. In the past, we have incorporated CBT into our program, specifically in the Co-occurring Disorders Group, Relapse Prevention Group and individual therapy. The new CBT Group will train clients using CBT vocabulary and provide opportunities to practice and develop individual techniques.

Chrysalis is a licensed and certified 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 nearly 90 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 an 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.

Chrysalis is a licensed and certified 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 diagnoses. 75%-80% of our clients are homeless.

The level of mental health disability and medical complications has increased in our clients over recent years. The majority of our clients have complex mental health issues including multiple traumas and PTSD symptoms. Because our clients are in early recovery and have often been homeless, they have many unmet emotional and physical needs. We are challenged to find new avenues to help our clients with their psychiatric, medical and dental needs. We struggle to provide the needed transportation to psychiatric, medical, and dental appointments. To serve our more severely disabled population, we need highly skilled, well trained staff, who understand mental illness, trauma and addiction. Chrysalis provides intensive training in order to support our staff as they serve our clients in a uniquely challenging environment. Services provided by Chrysalis include crisis intervention and stabilization, education, process and skills training groups in addition to supportive case management and linkage services to clients in early recovery from mental health and substance abuse issues. We also provide medication management on site Dual Recovery groups, a Family Education Group and therapy to family members and couples. We focused on developing client's strengths, peer connections and understanding of the connection between their mental health and substance abuse. This year, we will be implementing Cognitive Behavioral Therapy Groups (CBT), an evidenced based practice, with the intention of training the clients to use CBT techniques to help them with their mental health and substance related symptoms. In the past, we have incorporated CBT into our program, specifically in the Co-occurring Disorders Group, Relapse Prevention Group and individual therapy. The new CBT Group will train clients using CBT vocabulary and provide opportunities to practice and develop individual techniques.

FY 16/17 Plans:

- Cronin House is presently in the process of identifying staff training and logistical changes necessary to develop specific program services for LBGTQQI2S clients. We have attended trainings and have updated our intake form to reflect variations in gender identity and sexual orientation.
- Cronin provides a unique program serving men and women with both severe mental health and substance use disorders. We are experiencing increasingly time consuming requirements for staff to case manage the complex medical and psychiatric needs of our clients as described above. Perhaps even more significant is our difficulty in hiring and retaining qualified staff to work in our program. The barrier is inadequate funding to enable us to pay adequately skilled staff to provide the services needed by our clients. We plan to meet with BHCS staff to discuss specific strategies to mitigate these barriers.
- Chrysalis, in our efforts to more effectively serve LGBTQQIS2S clients has consulted with the Transgender Law Center, Gender Spectrum, and the Pacific Center this past year. Chrysalis' Clinical and Milieu Counselors have attended both external and internal training to improve our service to the LGBTQQIS2S community as well. Chrysalis' Intake Forms have been modified to include Gender Identity and Sexual Orientation.
- Chrysalis provides a unique program serving women with both severe mental health and substance use disorders. We are experiencing increasingly time consuming requirements for staff to case manage the complex medical and psychiatric needs of our clients as described above. Perhaps even more significant is our difficulty in hiring and retaining qualified staff to work in our program. The barrier is inadequate funding to enable us to pay adequately skilled staff to provide the services needed by our clients. We plan to meet with BHCS staff to discuss specific strategies to mitigate these barriers.

OESD 19. Low Income Health Plan Pilot (HPAC)

Program Description: Broad array of services to provide increased access of consumers of the system to primary care services.

FY 15/16 Outcomes, Impact & Challenges:

Pathways to Wellness:

- We provide approximately 25,000 plus services in a given year that includes connecting moderately to severely clients to outpatient medication support psychiatric services, housing, transportation, and social security benefits.
- We increased outreach, education and consultation due to the large volumes of clients we serve within Pathways to Wellness. We admitted over 1200 new clients who are in need of outpatient specialty mental health care.
- Collaborated with ACBHCS and JGP whereas clients discharged from JGP are admitted to Pathways to Wellness for initial an assessment within 7 days of discharge.
- We provided psycho-education to guide clients on recognizing their early signs of potentially severe and disabling mental illness.
- We continued to reduced incarcerations, psychiatric hospitalizations, and mental health disparities across Alameda County.
- Launched Primary Care Integration for collaboration with PCP to assist stabilized clients in

properly transitioning care to their medical homes. Successfully transitioned approximately 200 clients.

- Participated in a direct messaging pilot program to support initiatives to improve integration of primary care with mental health care services. Our efforts with primary care/medical homes enabled providers to collaborate and deliver the highest level of care to patients. By having easy access to medical providers, Pathways is able to play a significant role in coordinating care and alleviating client concerns that exacerbate mental illnesses. Overall, the Direct Messaging program increases the level of trust, credibility and long lasting patient-provider relationships. It also creates synergy among a multidisciplinary team and expedites the level of connection and communication among all providers and agencies that have patients in common.
- Clients were provided with resources and additional Pathways staff support due to an increase in homelessness, poverty, substance abuse, health related issues, and psychiatric hospitalizations as a result of gentrification in the Urban Oakland area.
- We continuously hire staff that reflects the community that we serve to include LGBTQ, other ethnic groups and cultures.
- The clients we serve have moderate to severe mental health impairments, therefore their length of stays are lengthier and/or it is difficult to find an alternative lower level of care other than level 3 services who are willing to treat clients with severe mental health impairments. Strategies: Utilize nurse practitioners and program nurses to handle demand for services, create weekend and evening schedules for new assessments and continue to collaborate with PCP's to ensure warm off hand of client and to facilitate discharge.
- Recruitment and retention of psychiatrists is becoming more challenging due to the decline of doctors pursuing this specialty and competitive salaries being offered with lower.
- Strategy: Utilize nurse practitioners and program nurses to provide med support services under the guidance of the Medical Director.
- Long wait times provoke agitation and increases suffering among clients waiting to be assessed and stabilized.
- Strategy: Create patient scheduling models that allow for reasonable workloads that improve provider retention while achieving improved quality patient outcomes.

STEPS:

STEPS served 52 partners, 3 of whom were TAY-age partners and 5 of whom were Older Adult partners. For the FY 15-16, we have had some notable community impacts:

We have greatly reduced hospitalizations for the partners served by STEPS.

a. in the year prior to admission to STEPS, our partners had a total of 9425 hospital days, out of a possible 19032 days. This gives them a hospitalization percentage of 49.5%; in other words, our partners spent approximately half of their time in hospitals prior to STEPS.

b. while in STEPS, our partners had a total of 342 hospital days, out of a possible 10,681 (total member-days provided by STEPS). This hospitalization rate is 3.2%; in other words, our partners had a 93% (100 - 3.2%/49.5%) reduction in hospital days during their stay in STEPS. Many of whom had spent the bulk of their time in the hospitals never returned to the hospital; they stabilized when they had adequate community support.

We assisted 11 partners obtain housing while in STEPS. While the majority of our partners were housed prior to their admission to psychiatric facilities, 11 suffered from chronic homeless. We assisted 11 obtain transitional and/or permanent housing while in STEPS.

We assisted 8 partners in obtaining benefits while in STEPS. While most obtained SSI, we also assisted several in obtaining SSDI, unemployment, and food stamp benefits. This facilitated their

transition to permanent housing and to the community.

We supported 4 partners in searching for and obtaining employment.

In the past year, the housing crisis within Alameda County has had the largest impact. Many MH partners who were self-sustaining prior to the crisis were driven to homeless by rising costs of housing. The housing crisis also resulted in many MH clients who were self-sustaining being driven into the shelters; this caused congestion within the shelter system. As a result, shelter beds were at a premium and less available to discharging MH partners from local hospitals; this extended stays of MH partners in our local hospitals and in the crisis residential programs.

Our strategy to manage this challenge is to link up with AC's new Seeking Shelter program; it is a clearing house for low-income housing and the shelter systems. We also remain strong advocates for our partners within the existing low-income and shelter systems.

FY 16/17 Progress:
Pathways to Wellness:

- We plan on servicing approximately 3300 total clients, 2000 Adults, 480 TAY, 270 Older Adults, and 250 Children.
- Pathways to Wellness is seeing a significant increase in client symptom severity of which more clients are in crisis at admission. Multiple crisis interventions are being completed due to clients who are in need of additional psychiatric care and services. We anticipate needing additional staff in QA/Customer Service to address concerns presented by clients in crisis.
- PCP collaboration is increasing as a direct result of the PCP Pilot Initiative and the addition of the Community Primary Care Coordinator position.
- Integration of pharmacists into the medication staffing model to provide psychiatric stabilization through medication management.
- The addition of Intake Engagement Specialist to improve new client show rate and to ensure that the psychiatrists have all needed information at admission.

STEPS:
STEPS will serve even more partners than last year. We have completed our expansion and we are operating at our capacity of currently enrolled 28 partners. We currently have 12 partners referred to us with whom we are engaging. We anticipate approximately 5 TAY-age partners and 10 Older Adult partners in this fiscal year.

In the next year, the housing crisis within Alameda County will probably have the largest impact. Many MH partners who were self-sustaining prior to the crisis will continue to be driven to homeless by rising costs of housing. The housing crisis will probably continue to cause congestion within the shelter system. As a result, shelter beds will remain at a premium and less available to discharging MH partners from local hospitals; this will extend stays of MH partners in our local hospitals and in the crisis residential programs.

Our strategy to manage this challenge will be to improve our linkages with AC's new Seeking Shelter program. We will also remain strong advocates for our partners within the existing low-income and shelter systems. In addition, STEPS will strive to be more fully integrated into the crisis services; in other words, we will strive to improve linkages with Jay Mahler Recovery Center and Woodroe Place and facilitate rapid placement of at-risk, high utilizers of emergency services.

FY 17/18 Plans:

Pathways to Wellness:

- We plan on servicing approximately 3800 total clients, 2800 Adults, 480 TAY, 270 Older Adults, and 250 Children.
- The startup of the Pathways behavioral health internship program to provide culturally competent care within a psychiatric community mental health model. Emphasis will be on social justice and advocacy. The parameters for the Pathways internship will be in line with MHSA initiatives.

STEPS:

- I expect that the housing crisis will not abate; housing for MH partners will remain at a premium. We will continue to utilize our existing strategies to maximize our impact on the mental health system, providing assistance to at-risk, high utilizers, facilitating their access to psychiatric and medical care, and reducing their cost to the system.

OESD 24. Behavioral Health and Developmental Disability Program

Program Description: Specialty mental health services for adults with developmental disabilities based on a model, the Puente Clinic, in San Mateo County.

For previous FY 15-16 Outcomes, Impact & Challenges:

- Schreiber Center Grand Opening took place on 6/28/16. It was well attended by community members, dignitaries, the Schreiber Center Advisory Committee Members and local providers.
- Overall, increased staff competency around assessment and differential diagnosis for individuals with developmental & intellectual disabilities (DD/ID).
- Ongoing education and outreach activities, including: basic mental health training for Regional Center (RCEB) staff, attendance in the DD Council meeting, co-sponsoring a Trauma Informed Care training event that had over 100 direct service providers, family members and RCEB leadership.
- Ongoing facilitation of a multi-disciplinary consultation team. The collaboration has led to skilled adaptation of treatment tools for the DD/ID population, and outcomes.
- In general, community-wide stakeholder resource for individuals with both mental health and DD/ID conditions.
- Information Flyers in English, Spanish, Chinese, and Vietnamese.
- Partnership with RCEB, Alameda County Public Health and BHCS.
- Had great difficulty hiring staff that had expertise and/or desire to work with adults with a developmental disability and a mental health disorder. Mental health providers are not routinely trained to work with this population.
- Small staff size and finite resources limits number of clients served. Possible collaboration opportunities with RCEB.
- Length of time to complete assessments secondary to complicated bio-psycho-social-developmental history and clinical presentation of population.

Current FY 16-17:

- Since 9/15, Schreiber Center has had over 100 referrals. Of those, approximately 45 cases have been open to the program. Schreiber Center services include: Assessments for “specialty mental health”; Case consultation; Psychotherapy; and Medication support. Currently, Schreiber cases

include: (4) open to "Medication Support only; (15) open to Medication Support and Psychotherapy; (1) Psychotherapy only; (4) Assessment phase.
- Clinicians' caseload increased and stabilized with the addition of psychiatry to the Schreiber Center Program in 10/15. Goal for July-2016 –July 2017 is to maintain the clinician's caseload and increase the psychiatry caseload from current 25 to 30-60.
- Clinicians have adapted well-known, therapeutic tools for use with adults who, because of co-occurring DD/ID, may not respond to "talk therapy" methods of treatment. Current tools being used include: Mixed emotions and "feelings flyer" to teach CBT skills, Temper Tamers cards, Mixed Emotions cards, DBT skills workbook for teens, Zones of Regulation, Should I or Shouldn't I, and Mind over Mood.

For upcoming FY 17-18:
- Projected 25-30 for psychotherapy
- 60-80 for psychiatrist
- In order to increase and improve services to the community as well as to share the tools and knowledge obtained by the team, Schreiber Center is looking into student intern opportunities.
- Schreiber Center is considering developing a therapeutic group for individuals with DD/ID.

OESD 26 Culturally Responsive Treatment programs for African Americans

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

Broad treatment recommendations include:
- Treatment programs funded should be developed and operated for Blacks by Blacks.
- Funds should be utilized to address the need for housing as the increasing cost of living in Alameda County contribute to difficulties in overcoming historic housing discrimination towards this population.
- The use of clarifying assessments and treatment services by providers with demonstrated skills that advance positive outcomes when working with the African American population.
- Ensure that any implementation of AB1421 is consistent with responding in a culturally responsive manner to African Americans.

More information and evaluation data will be available in the next Three Year MHSA Plan (FY 17/18-19/20).

OESD 27 In-Home Outreach Teams (IHOT)

Program Description: This program provides home or community-based support and education to clients/consumers, family members and caregivers. Modeled after San Diego County's successful pilot, IHOT focuses on outreach, engagement and support and links participants to services and community resources.

An RFP was released in spring 2016 and four teams were created. More information and evaluation data will be available in the next Three Year MHSA Plan (FY 17/18-19/20).

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

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

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

MENTAL HEALTH CONSULTATION PROGRAMS

PEI 1.A Mental Health Consultation in Preschool

Program Description: 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 0-8 community. This program is called **Early Connections**, an Initiative to strengthen services and supports for children 0-5 and their families.

For previous FY 15-16

Trauma Informed Child Parent Psychotherapy (CPP) Training for Children Birth-Five and their Families

Alameda County Behavioral Health Care Services (ACBHCS) is in the process of developing services and supports that are trauma informed across the children's system of care, with the goal of establishing a trauma informed infrastructure to support the children and families in Alameda County. The goal is to build capacity to serve children and families who have experienced trauma using a sustainable, evidence-based model. One of those models is Child Parent Psychotherapy (CPP). CPP is an early intervention model for children, birth-5, who have experienced traumatic events and/or are experiencing mental health, attachment, and/or behavioral problems.

Outcomes

- The intent is to incrementally train qualified early childhood mental health providers in Alameda County in CPP and gradually build capacity to serve young children and families.
- There are currently 24 county and community-based mental health providers being trained in the 18 month UCSF Child Trauma Research CPP training program.
- CPP is listed on the SAMHSA National Registry of Effective Programs and Practices. For information about the research on CPP, including five randomized trials conducted on the model, please see the Child-Parent Psychotherapy Research Summary: http://tinyurl.com/CPPResearch2014

Challenges

The future challenge will be developing a strategy on sustaining and developing further capacity in CPP. The current idea is to develop a county-wide CPP Learning Community to ensure continued professional development in this evidence-based practice.

Alameda County Early Childhood Policy Committee (ACECPC)

ACECPC is a cross systems policy committee comprised of family members, Alameda County early care and education providers, Alameda County mental health and health providers, family run organizations, local community-based organizations and F5 Alameda County. The goals of

ACECPC are:

1. Inform and align with county, statewide and national efforts while focusing on the needs of Alameda County's young children and families.
2. Monitor and take positions on federal, state and local issues, legislation and initiatives that significantly impact early childhood including quality, access and affordability issues
3. Advocate for the imperative of maintaining and increasing funding for programs that strengthen the health and learning capacity of our next generation.
4. Prioritize Alameda County's most vulnerable young children and their families including those living in poverty, with social, emotional and developmental needs.

Outcomes

MHSA PEI funds support the work of Parent Voices. Parent Voices provides:

- planning,
- facilitation,
- coordination
- documentation of the work of ACECPC
- Coordination and implementation of a yearly Parent Policy Forum.

Early Childhood Mental Health Consultation in Early Care and Education (Infant/Toddler and Preschool Programs)

Early childhood mental health consultation in early care and education is a promising prevention and early intervention mental health service – see www.ecmhc.org

Early childhood mental health consultation (ECMHC) is a preventative mental health intervention which partners a mental health professional with early childhood professionals to promote the social, emotional, and behavioral health of children B-5 in early care and education programs.

One of the key goals of ECMHC is to increase school readiness skills for young children thus mitigating against school failure.

Outcomes

In order to maximize the efficacy of ECMHC, BHCS has developed ECMHC Standards of Practice. The goal is to serve young children, their families, and the ECE staff while implementing the ECMHC Standards of Practice. The ECMHC Standards of Practice will be formally evaluated over a two year time period.

In FY 15-16 BHCS and F5 Alameda County completed the development of early childhood mental health consultation (ECMHC) Standards of Practice. The goal is to establish consistent ECMHC practices county-wide.

Challenges

Primary challenge was gathering input from 8-10 provider agencies who currently provide ECMHC services in Alameda County. Over time we were able to reach consensus on the components of

the core Standards of Practice.

Blues Skies Mental Wellness Team (MWT)

This is a new and innovative partnership between Alameda County Public Health and Alameda County Behavioral Health Services. The goals of MWT are:

To provide stabilization, support, referrals and resources to families where mental health issues, complex psychosocial needs and barriers to receiving mental health services are identified. Support the overall functioning, safety, well-being and efficacy of pregnant moms, parents of young children; infant-toddlers in maximizing their potential for healthy overall development and stabile mental health.

Outcomes

- Provide clinical case management, consultation and brief therapy for early childhood home visiting programs within the Maternal Paternal, Child, and Adolescent Health Unit of the Alameda County Public Health Department.
- Offer counseling support for perinatal mood disorders and reflective consultation for home visiting staff (outreach workers, public health nurses and health educators) and their collateral partners when needed.
- Support family centered and child focused relationships through existing Early Childhood System of Care in Alameda County.
- Support mental wellness of referred client's by offering referrals, resources and service linkages and acknowledging the need for mental wellness, renewal and positive change efforts with parents and HV teams
- Provide culturally sensitive, best practice interventions
- Offer consultation and case review processes for referring programs
- Provide a trauma informed care perspective for Early Childhood home visiting programs that seek consultation with MWT and quarterly Transformational Healing circles for participants
- Worked with MPCAH Steering Committee to begin Edinburgh Depression Screening Committee to implement EPDS protocols for MPCAH Unit
- Created Documents for utilization for MWT: Intake, referral forms, protocol manual and referral decision tree

Impact

- Mental Wellness Team manager was hired by Alameda County Public Health Department and migrated from role of Mental Health Specialist Consultant working for First 5 Alameda County to full time management staff at ACPHD
- Began work on developing protocols and program implementation plan with MPCAH Home Visiting Coordinator
- Established meeting relationship with BHC and developed job description and hiring protocols/job descriptions and hired (2) F/T Mental Health Specialist for Blue Skies Mental Wellness Team. Established case load ratio
- Received 115 referrals for MWT case management/counseling support in 2015-2016. 115 children and families were served in FY 15/16.

- Established and maintained consultation case review relationships with (4) home visiting programs: Black Infant Health, ACHSI-Women's Health Promotion and Family Health Promotion, Fatherhood Programs.

Challenges

- Seeking relevant training options for adult/parenting consultation model enhancement
- Continuing work demands with Project LAUNCH-reporting requirements
- Lack of updates on MAA reporting-fiscal updates

Strategies to Mitigate Challenges-

- Work with MPCAH Coordinator and LAUNCH Mental Health Consultant to identify other creative and successful mental health adult early childhood models of intervention.
- Continue to request fiscal updates from MAA contacts and engage BHC contract contacts for strategy planning ideas

Evaluation of Coaching

The Coaching for Collaboration Project of the BHCS Office of Family Empowerment engaged the services of Bright Research Group (BRG) to work with Beth Sauerhaft, Coaching and Capacity Building Coordinator to design and implement two inquiry projects in 2015-16.

1) Integration of coaching skills and mindset among the team in the BHCS Early Childhood Consultation and Treatment Program ---The Early Childhood Mental Health Consultation and Treatment (ECCTP) Program has participated in Coaching for Collaboration for the past couple years. (Coaching for Collaboration began through Early Connections) The internal coach (Beth Sauerhaft) is a trained and certified coach who has developed several projects to support family and provider partnership and leads Coaching for Collaboration (CFC). Through CFC, the ECCTP Team participated in coaching training, coaching learning communities, received one on one individual coaching and coaching to support integration of coaching skills to support work with families, supervision, MHC and team communications. This team is comprised of a clinical supervisor, several licensed providers, social work interns, and a family partner. Through the inquiry project, the ECCTP team piloted specific coaching skills over the course of the inquiry project. In monthly meetings with BRG, team members shared how they used the coaching skills and reflections on what shifted for themselves and their clients, supervisor, supervisee. Notes were analyzed for key themes emerging in the team's reflections. This inquiry found that coaching offered a mindset, orientation, shared language and specific techniques for engaging in empowering relationships and collaboration and movement towards action.

2) Supporting the Emerging Role of an Internal Coach: The role of a 'Coach' within ACBHCS is new and emerging. The inquiry focused on learning more about the ways that public sector and non-profit organizations are using an internal coach to integrate coaching and promote a coaching culture. Interviews were conducted with 'internal coaches', coach trainers, and beneficiaries of an internal coach (team members who had received coaching or coach training) Emphasis was on exploring the conditions/ contexts that best support the role.

Current FY 16-17:

Parent Tools to Thrive (PT3)

Developed and began implementation of Parent Tools to Thrive (PT3).

Outcomes

- Parent Tools to Thrive (PT3) is a 10 session parent developed and parent led education and support group for parents of children, birth-five. PT3 is for parents who are wondering if their young child's development is progressing as it should, as well as for parents who have identified a specific concern(s) about their child. Child development and mental health experts were consultants on the content of PT3.

- Parent Tools to Thrive (PT3) provides education and support for parents in an atmosphere that feels safe and non-judgmental. Parents who facilitate PT3 have often experienced similar concerns about their children, which contributes to their ability to implement PT3 with empathy and understanding, and speak "parent to parent."

- Parent Tools to Thrive (PT3) provides education about young children's challenges, and the system that exists to meet the needs of their children's challenges. PT3 guides parents on how to advocate for their children, and as a result parents often develop parent leadership skills.

- BHCS staff and consultants completed a Training of Facilitators and trained a cohort of 11 parents to implement the program.

Challenges

PT3 was developed with parents from the very beginning process of conceptualization. One of the challenges we encountered was the time and resources required to coordinate and facilitate planning meetings with mental health providers, family run organization staff, parents and consultants. Given the variance in experiences and priorities among the planning teams, the process required more time and intentional strategies to reach consensus on decisions regarding the curriculum.

PT3 is being piloted from September 2016-January 2017 by a family-run community-based organization and a Head Start program. PT3 will be finalized in January 2017, and translated into Spanish in Spring 2017. Total number of parents served in the pilots: 20

Alameda County Early Childhood Policy Committee (ACECPC) 16/17

Continued funding to support the work of ACECPC to accomplish the 15/16 goals.

Early Childhood Mental Health Consultation in Early Care and Education (Infant/Toddler and Preschool Programs)

Outcomes:

- Developed and released a Request for Proposal (RFP) to early childhood mental health provider community.

- Awarded Jewish Family & Community Services (JFCS) to implement the ECMHC Standards of Practice. Award is to fund (2) FTE ECMHC mental health consultants who will implement ECMHC Standards of Practice as part of their ECMHC service delivery over a two year time period.

- Contract with JFCS will be finalized in January 2017, and services will begin that month.

- In FY 16-17, JFCS will lay the foundation for implementation of ECMHC Standards of Practice and ECMHC mental health consultation services.

This initial "start-up" period includes:
- Hiring of 2 FTE ECMHC consultants.
- Assess and select ECE programs/classrooms where services will be provided.
- Utilize BHCS training & technical assistance offered through BHCS ECMHC Coordinator.
- Be trained in MHSA PEI data collection tools.
- Service delivery may begin in FY 16-17 if ECMHC consultants are hired within timeframe. Two ECMHC consultants are projected to serve a total of 16 classrooms, 32 teachers and 2 directors.

Challenges:
It is a requirement of this award (for evaluation purposes) that ECE programs not have received prior or existing ECMHC services. JFCS will need to identify ECE programs who have not received prior ECMHC services and this may take longer.

Blue Skies Mental Wellness Team (MWT)

Goals for 16/17

1. Maintain or increase the current number of cases referred to Mental Wellness Team from 115 to125 cases per year.

2. To maintain existing consultation case review monthly contacts with 3 home visiting programs established and increase relationships with 2 additional HV programs for case review consultation support.

3. Establish referral MOU protocols with Alameda County Behavioral Health Care Services Early Childhood Consultation & Treatment Program for cases in need of longer term therapy and early childhood interventions.

Evaluation of ECMHC Standards of Practice:
Developed and released an Informal Request for Proposal for evaluation of the ECMHC Standards of Practice over a two year time period. Evaluation organization was awarded and is in the contracting process.

Outcomes

In FY 16-17, BHCS staff and evaluator will:

- Develop Theory of Change, Evaluation Plan, and Outcomes.
- Identify data collection tools and train consultants on use of tools.
- Begin data collection at early care and education sites.

FY 17-18 Plans:

Parent Tools to Thrive (PT3)

- PT3 will be available for county-wide dissemination under the auspices of BHCS Office of Family Empowerment, via partnerships with Head Start Programs, family run organizations (FRN and Parent Voices), and school district child development centers.
- Projected number of parents to be served: 40-60

Alameda County Early Childhood Policy Committee (ACECPC) 17/18

Continued funding to support the work of ACECPC to accomplish the 15/16 goals.

Early Childhood Mental Health Consultation in Early Care and Education (Infant/Toddler and Preschool Programs)

- Two FTE JFCS ECMHC consultants will serve a total of 16 classrooms, 32 teachers and 2 directors.
- Projected number of children to be served in FY 17-18 is 320. Projected number of teachers is 32 and projected number of ECE directors is 2.

Blue Skies Mental Wellness Team (MWT)
Goals for 17/18

- Maintain or increase the current number of cases referred to Mental Wellness Team from 115 to 130 cases per year.
- To maintain existing consultation case review monthly contacts with all established home visiting programs.
- Identify funding to hire another BHC II to support team with consultation/case work load.

Evaluation of ECMHC Standards of Practice:

- In FY 17-18, evaluation of ECMHC Standards of Practice will be in progress using a standardized ECMHC data collection tool. Results of data will be communicated to JFCS to ensure continuous quality improvement.
- Evaluation outcome measures will be monitored and documented.
- The overarching goal of evaluation is to determine which, if any, of the Standards of Practice need to be revised or modified to maximize ECMHC service delivery efficacy.

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

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

Program Description: The School-Based Mental Health (SBMH) consultation program is comprised of three components including:

- Outreach and Engagement Services located in two student health centers in the city of Alameda and a family resource center in the city of Fremont;
- SBMH Consultation Services in 16 out of the 18 Alameda County school districts, and
- A Comprehensive School-Based Outreach & Engagement, Mental Health Consultation and Preventative Counseling Program for the Unaccompanied Immigrant Youth (UIY) population, which is mainly focused in Oakland and Central County.

SBBHI: In 2009, Alameda County Health Care Services Agency (HCSA) launched a School-Based Behavioral Health Initiative (SBBHI), bringing together two divisions within the Alameda County's local health authority, the *Center for Healthy Schools and Communities (CHSC)* and *Behavioral Health Care Services Agency (BHCS)*, to create a shared model for building and financing school-based behavioral health systems across the county. Through the SBBHI, Alameda County collaborates with its many partners to provide a range of services and supports such as: district capacity building, coordination of resources and services, school climate training and funding and treatment and early intervention services.

UIY: In response to the increased number of UIY crossing the US border, many of whom are locating to Alameda County, Behavioral Health Care Services (BHCS) through the Mental Health Services Act allocated $2.5 million over a three year period specifically for UIY in school-based, school-linked and community settings. As part of this funding BHCS contracted with La Familia Counseling Services to launch the Unaccompanied Immigrant Youth (UIY) Care Team comprised of 4 Clinicians and 2 Case Managers to serve UIY in areas that have been identified as high need service areas. BHCS also partners with The Center for Healthy Schools and Communities (under health Care Services Agency) and hired and assigned a Senior Clinical Case Manager (SCCM) to lead the work of the UIY Care Team, as well as assess, identify, and work with schools and community organizations to address the needs of UIY across the county. For more information please see attached report.

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

For previous FY 15-16	For current FY 16-17	For upcoming FY 17-18
Outreach and Engagement Services: **Fremont Resource Center** Approximately 60 parent/caregivers/children were referred to therapy because of their outreach efforts and another approximately 150 potential responders were provided with education and resources on mental health. **SBBHI:** Through the SBBHI Partnership Coordination of Service Teams (COST) has been rolled out in 157 of 281 schools in the County (56% of all schools now have a COST program) Across the districts 7,228 referrals for behavioral health related needs were given out and 72% of these resulted in a positive connection to services. 2,436 PEI events (trainings, consultation, restorative justice activities, and positive school climate work) took place for a total of 60,116 contacts. (Duplicative count). The most common topics for these events were wellness/self-care, SUD/MH issues, resources/referral, classroom behavior and educational issues. **UIY Program:** The UIY Care Team provides comprehensive and culturally/linguistically competent school-based mental health and case management services to UIY and caregivers where they are needed most. The team is a collaboration between HCSA and La Familia Counseling Services and consists of a Behavioral Health Consultant Lead from the Center for Healthy Schools and Communities and 4 mental health clinicians from La Familia.	**Outreach and Engagement Services:** Approximately 100-230 potential responders will be provided education or referral for mental health resources. Another 800-1,000 will be interacting with Family Resource Specialists who have received Mental Health First Aid training. Additional school staff may be outreached and engaged through the Fremont School District. **SBBHI:** In FY 16/17 it's expected that the SBBHI partnership will continue to grow with a deeper emphasis on access and linkage to services for school-based youth. This program will be expected to provide approximately 7,000 to 7,500 referrals for behavioral health services with an increase in the % of positive linkages from FY 15/16. Staffing on the UIY Care team was restructured for the 2016-17 year to better support the needs of the UIY community. Staffing now consists of 4 Full-Time, bilingual and bicultural clinicians and two case managers, with an	**Outreach and Engagement Services:** It's estimated to outreach to 140-270 potential responders who will receive substantial education There are also plans to expand some of other services to this site. (Grief and Loss, parenting classes, etc.) so there will be opportunity to screen and outreach to more people on site. **SBBHI** • **FY 16/17: 7,500**children & TAY • **FY 17/18: 7,500** children & TAY **UIY** • **FY 16/17: 150** children & TAY • **FY 17/18: 150** children & TAY Starting in FY 16/17 the SBBHI program will have a deeper focus on access and linkage for school-based youth and will be categorized under the new MHSA PEI programs as an Access and linkage program.

The UIY Care Team provided 1,680 prevention-oriented activities and events, such as professional leaders consultation, family consultation, one-to-one outreach, prevention visits (i.e. first contact with a youth), psychoeducation workshops, training professional leaders 72 clients received preventative and early intervention treatment. **Some challenges include:** **Outreach:** Families with children who are recent arrivals are the most influenced by cultural taboos. Many come with issues that they consider their "secrets" and it is very difficult to open up and share. Some have faced trauma and come baring scars, inflicted by crossing borders, rapes, wars, domestic violence, etc. It is very difficult for to convince them of the benefits of therapy or of speaking to someone who may be able to help them. In some cases, there are controlling husbands who forbid wives from even considering therapy. By having staff who share their culture and some of their stories it facilitates having conversations that lead to referrals and positive and desired outcomes within the family. **UIY:** Many school districts in the county still do not have systems in place to track UIY students at registration. Not all UIY have been apprehended and therefore are harder to find. Not all UIY attend school, so it can be difficult to engage them.	expectation to serve up to 150 UIY and their support systems per year.	

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

PEI 2/FSP 16: Early Intervention for the Onset of First Psychosis & SMI among TAY

Program Description: The PREP (Prevention and Recovery in Early Psychosis) Program's overarching goal is to identify and intervene with transition age youth (16-24 years) experiencing an initial episode of psychosis associated with schizophrenia and their families. It provides evidence-based treatment and support for youth and families through an intensive outpatient model of care that includes the provision of: algorithm-based medication management, cognitive behavioral therapy for psychosis (CBTP), individual placement and support (IPS), assertive outreach, multi-family groups, cognitive remediation and strength-based care management services.

For previous FY 15-16

See ATTACHMENTS: "East Bay Community Recovery Project, PREP Alameda County, August 2016."

Community Impact
Of the 48 clients who were enrolled in the PREP program for at least 12 months:

60% were engaged in school or work after 12 months compared to 42% at baseline, which is a 45% increase. Of these 48 clients, 35 chose to participate in PREP Educational/Vocational Services. Of those 35 clients, 77% were in school or working after 12 months in PREP compared to 54% at baseline. Of the clients who did not participate in Ed/Voc services, 15% were in school or working after 12 months compared to 8% at baseline.

There was a 57% reduction in the hospitalization rate of PREP clients during the first year of participation in the program.

Challenges
The targeted number of client hours were not achieved. Several factors contributed to this including: a staff therapist resigning in Jan. and a replacement not hired until May, the office moving from Oakland to Hayward that led to fewer clients attending groups and dropping by the office, and a reduction in referrals from the County Transition Age Treatment (TAT) team with the first 6 months of 2015 having 28 referrals compared to the first 6 months of 2016 receiving 20 referrals.

To address these challenges the following steps are being taken:

Work with County TAT team to increase referrals

Outreach at least 2 times per month to different programs that would be likely referral sources

Work on staff retention issues including conduct a staff satisfaction survey and increase in-service trainings

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

For current FY 16-17	For upcoming FY 17-18
PREP should serve 55-60 TAY at any given time. In addition to this, PREP serves family members of clients in their family support, and Multi-Family Group.	PREP should serve 55-60 TAY at any given time. In addition to this, PREP serves family members of clients in their family support, and Multi-Family Group.
PREP will transition from a PEI program to an FSP program in Jan. 2017. When all of the FSP programs have an RFP later in 2017, PREP will be part of this RFP.	As stated, PREP will be transitioned to an FSP program and be part of the RFP for FSPs.

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

Program Description: GART is a county-wide mobile geriatric behavioral health team that provides support services to older adults ages 60 and above with serious behavioral health care needs. GART provides brief voluntary behavioral health care services with the aim of resolving immediate behavioral health needs. The GART Program staffing includes a multi-disciplinary team and support staff.

FY 15-16
See ATTACHMENTS: "Geriatric Assessment & Response Team (GART), FY 2015-16."
OUTCOMES:
Client enrollment has increased 250% from FY 11/12 to FY 12/13, 48% from FY 12/13 to FY 13/14, 39% from FY 13/14 to FY 14/15, from FY 14/15 to FY 15/16 29% for an overall increase from GART's inception of 42%.
For FY 15/16 of the 42 discharged clients 32 clients (76%) reached or partially reached their treatment goal(s).
Service hours provided for FY 15/16, 22% was Case Management, 35% was Medication Support, 42% was Mental Health and 1% was Crisis Intervention. For a total of 1,199 service hours for FY 15/16; approximately 27.5 client hours in about a 2 month period.
GART provided over 550 indirect contact services; clients who did not meet the GART screening criteria were referred to other support services.
100% of clients who completed the "GART Client Evaluation" expressed satisfaction with the

services they received at GART.

Notable community impact:

GART has had over 58 outreach community activities including Older Adult trainings and health fairs.

GART continues to provide system wide consultation on older adult issues. GART continues to work closely with John George Psychiatric Pavilion's (JGPP) social workers to identify older adults who have been in recent psychiatric crisis and who are not connected to mental health services. GART multidisciplinary approach enables GART team to provide consumers and their families with bio-psycho-social supports.

GART services can be provided in English, Spanish, Mandarin and Tagalog.

GART Provides trainings on gero-psych issues to Adult Protective Services (APS) field workers.

Barriers:

There is a need to increase capacity of the program to meet the growing older adult community of Alameda County. The current staffing pattern limits the ability to reach out to the larger community.

FY 16-17	FY 17-18
Projected people served: **FY 16-17: 45 Older Adults** For the past two years the client enrollment has leveled out due to the current capacity of GART staffing. Since GART's inception in 2011 client enrollment has increased 250% from FY 11/12 to FY 12/13, 48% from FY 12/13 to FY 13/14, 39% from FY 13/14 to FY 14/15, from FY 14/15 to FY 15/16 29% for an overall increase from GART's inception of 42%.	Projected people served: **FY 16-17: 45**

PEI.4 Stigma and Discrimination Reduction Campaign Program Description

Program Description: The Alameda County Everyone Counts 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).

FY 15-16

The Everyone Counts Campaign aims to reduce stigma and discrimination against people with mental health experiences. It also promotes the empowerment of individuals and communities through various activities that support wellness and recovery. Through the programs in the stigma reduction campaign we have made the following impact:

Overcoming Internalized Stigma in the Chinese-American Community:
In the Chinese and other Asian Pacific Islander communities, mental health issues are present, but often a taboo. PEERS hosted Overcoming Internalized Stigma support groups for Chinese American mental health consumers that supported participants with reducing internalized stigma, while gaining a stronger sense of self and integrating back into their community.

Two cultural responsiveness trainings with a total of 85 participants were held where the community was educated on mental health topics and shared findings were presented from the support groups to aid the community on supporting loved ones with mental health experiences. They also held 2 support groups (in collaboration with Dr. Larry Yang, Columbia University) where a pre/post survey was used to measure outcomes with a particular focus on measuring internalized stigma. The outcomes of the survey were:

- Across all participants, an average 33% reduction in negative self-esteem after group participation.
- 4 participants gained full or part time employment, 3 participants began volunteering.
- 4 participants joined together to form a "sub-group" to continue the work that they have started in the support group.

Challenges/barriers and strategies to mitigate barriers:
There was a delay in finding a location for the support groups to meet as the participants expressed not feeling comfortable meeting outside of their own community. They were able to accommodate their participants by finding a location in China Town. In the future, they will consider the needs of the specific community that they're serving.

Lift Every Voice and Speak (LEVS) Speakers Bureau
The Speaker's Bureau offers opportunities for 20 mental health consumers to gain tools that empower members to share their stories of recovery and hope in the community. Through this program:

- Participants expressed a decrease of internalized stigma around their own mental health experiences.
- Participants felt empowered to share their message of hope and recovery, educating the

community around mental health to eliminate external stigma.
- Participants model to other consumers that recovery is possible.
- Participants felt a sense of community and had access to more resource as a result of this program.

Challenges/barriers and strategies to mitigate barriers:
At times participants struggled with interpersonal issues within the group. To resolve this problem, they provided participants tools to overcome these barriers and used parts of the meeting to intentionally build team/community. They will continue to use these practices to support healthy group dynamics.

Spirituality
For many consumers and their families, spirituality is an essential element in an integrated approach to resilience, wellness, and recovery. PEERS hosts monthly peer-led spirituality gatherings that create a nurturing space for 24 participants to discuss the impact that spirituality has on their wellness. They also collaborated with Alameda County Behavioral Health Care Services Department to host a day of prayer for the Mental Health National Day of Prayer where 20 participants from various spiritual walks came together to honor mental health consumers. Additional outcomes:
- Increased knowledge of mental health stigma in the spiritual community.
- Increased awareness of the spiritual practices used to support wellness.

Challenges/barriers and strategies to mitigate barriers:
The spirituality gatherings were very impactful spaces that included a small group of participants. Their goal is to reach more members of the spiritual community as they have found that there's a great need to provide such a space where stigma and discrimination in these communities can be addressed. They're working on a targeted outreach plan that would allow them to reach outside of the communities that they generally target. They also would like to hold these gatherings at local religious institutions and spiritual centers.

Everyone Counts Campaign Outreach Efforts
Outreach efforts through media communications and community outreach enabled the Campaign to expand mental health and stigma reduction efforts to a broader community.
- Everyone Counts Campaign website views – 4,610
- Subscribers to the Everyone Counts Campaign mailing list - 347
- Outreach events - 56
- 5 Reflections and Expressions events (105 participants) where they used creative expression to share the message of wellness and stigma reduction.

Challenges/barriers and strategies to mitigate barriers
The goal is to increase the number of people we reach through our outreach efforts. They specifically would like to increase subscribers to the Everyone Counts Campaign. They'll be working with our communications coordinator to create outreach strategies to expand their reach.

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

FY 16-17	FY 16-17
The number of children, TAY, adults, and/or Older Adult to be served: Maintain or exceed the 3,194 TAY and adults that were served in FY15-16 **Comments on current implementation and changes from the previous year:** Over the course of Spring 2016, in collaboration with ACBHCS, the campaign designed a new evaluation process for the 2016-2017 LEVS program. PEERS engaged in this work using a Results-Based Accountability (RBA) framework as a guide. This pilot program will be implemented FY 16-17.	**The number of children, TAY, adults, and/or Older Adult to be served:** Maintain or exceed the 3,194 TAY and adults that were served in FY15-16 **Comments on current implementation and changes from the previous year:** After evaluating the outcomes of the LEVS evaluation process, PEERS would like to use what they learn to evaluate all of PEERS' programs.

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

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) Preventative Counseling services. These strategies are implemented through a variety of services such as one-to-one outreach events, psycho-educational workshops/classes, consultation sessions, support groups, traditional healing workshops, radio/television/ blogging activities, and short term-low intensity early intervention counseling sessions for individuals and families who are experiencing early signs and symptoms of a mental health challenge or mental illness.

In FY 15/16 the data show that these UELP providers in total produced:

- 6,210 prevention events, which is an 11% increase over last year;
- 40,833 people were served at these prevention events; (duplicated count) and
- 533 unique clients were served through early intervention services, which almost identical to the number of clients served in FY 14/15.

Alameda County Behavioral Health Care Services developed and implemented a health and wellness survey, which included quality of life and outcome indicators, in the fall of 2015. The survey was disseminated to the UELP community in 11 different languages: English, Spanish, Vietnamese, Chinese, Dari, Hindi, Khmer, Nepali, Korean, Thai, and Burmese.

Domains Included:

- 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.

A summary of key findings from the survey (of 318 participants) shows that *in connection with receiving UELP services*:

- 84% of clients reported feeling connected to their culture and community (connection)
- 89% of clients reported feeling confident and good about themselves (identity)
- 83% of clients believe that stress worries and happiness can impact mental and emotional health (knowledge/perception of MH)
- 90% of clients reported knowing people who will listen and support them (community)
- 86% of clients reported knowing where to get help in a crisis (access)
- 87% of clients reported knowing how to get services or resources (access)

In addition to the above domains, four open-ended questions were also asked in order to better understand: 1) if and how respondents felt services were beneficial to them; 2) what kind of needs they might still have; 3) if and how their lives would be different if they were *not* receiving prevention

or early intervention services; and 4) anything else they thought would be helpful for service providers to know.

Below are the results from open ended question #3:

WHAT WOULD HAVE BEEN DIFFERENT WITHOUT THESE SERVICES

Table 7. Different Experiences Without Receiving Services	# of Respondents Reporting That Difference
Learning Opportunities	35
Continued Previous Path	19
Lonely, Depressed, Sad	15
More Problems, Worse Off, Doing Bad	15
Stressed, Worried, Anxious	15
Uniformed About Services, Programs and Resources	15
Other Answers	12
Without Direction, Awareness	12

"I would not know how to help myself or another

*179 survey participants responded to this question.

Learning Opportunities was the largest theme in this section. Respondents reported that without their participation in these programs, they would not have had the opportunity to learn what they did in the program.

"I wouldn't have the opportunity to learn everything I did here."
"I would like to have known how to treat my adolescent daughter. I learned a lot."

Continued Previous Path was the second most recurring theme. Respondents explained that without these services, they would have continued doing what they were doing, prior to the program, such as making mistakes or getting into trouble, fighting with family.
"I would have continued making the same mistakes."

“I would be the same or more hysteric, it help me to be calmer.”

Without Direction/Awareness is a larger theme than it has been in the past. Respondents reported feelings of being unaware of what to do, feelings of being in the dark or ignorant about certain issues had they not been participating in their UELP programs.

“I wouldn’t be living each day with more conscience.”
“I would have been in ignorance.”

Other key themes that generated ten or more responses included: feeling lonely, depressed, sad, worried or anxious; having more problems or being worse off in general, or being uniformed about services, programs and resources available to them.

See ATTACHMENTS: “Alameda County Underserved Ethnic Language Population Programs, PEI Community Survey and Focus Group Results FY 2015-16.”

Access to Services for UELP Communities

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.

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

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

For our first question BHCS took a cohort of 547 early intervention clients from FY 15/16 and looked back five years to see if this cohort had ever been served in our system before. The data found that only 18% of these 547 clients had ever been seen before in our system. This percentage is also similar for FY 14/15 clients. Reasons for not accessing services are varied but include the areas of no language capacity, cultural issues, fear, stigma, not knowing where to access services, family members trying to support their loved ones themselves and not meeting Specialty Mental Health criteria.

For the second question BHCS took a cohort of 512 early intervention clients from FY 14/15 and looked forward to see what percent went on to need mental health treatment services. The data found that 10% of the 512 clients went on to receive mental health treatment services (mainly outpatient services) in either FY 14/15 or FY 15/16. 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 are being referred for this care. More information will be shared on this indicator of access as data is available and analyzed.

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

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” (CyB). It’s designed to serve Latinos throughout Alameda County by providing services through a three 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 and east region, and Tiburcio Vasquez Health Center serves the southern county region. More information on this program can be found at http://culturaybienestar.com

FY 15-16
Impact **Total Prevention Contacts:** **FY 15/16: 19,134 (8% increase over FY 14/15)** 7,463 children and TAY 11,671 adults & older adults **Total Prevention Events:** 2,517 (12% increase over FY 14/15) **Early Intervention (EI) Clients:368** CyB’s outreach efforts and exemplary community work have allowed them to continue gaining the Latino community’s trust and support. Requests for leadership trainings, workshops, and mental health consultations from CBOs, schools, and faith-based institutions continue to grow. This year CyB engaged agencies that traditionally are not involved in prevention services, i.e. Children’s Hospital Oakland, Fatherhood Initiatives, Alameda County First Five, Wisdom Keepers, Restorative Justice Programs, and the Juvenile Justice Center. Traditional medicine workshops have received excellent responses from the community and evaluations confirm its success and value to the community. CyB Promotores have been certified to teach MH First Aid, and have trained 60 Spanish speaking community members from various CBOs and schools. CyB Health Promoters have started a Men’s Group in Union City, based on their very successful men’s group in Oakland. CyB’s work with school-age children and their families continued to increase in FY 15-16 due to an overwhelming number of requests from teachers inviting CyB staff to meet with students and their parents, As a result of these presentations, the CyB Health Educators have presented several six (6) session workshops for parents and their children titled “*Porque Tenemos Hijos*” (Because We Have Children). Additionally, parents call requesting parenting services to address the behavioral issues their children are displaying, and request services for their children in order to improve communication and build healthy family dynamics.

Challenges:
Several challenges continue to be highlighted for FY 15-16 and are expected to continue into FY 16-17.

Community requests for services are beyond the resources that are available through CyB so not all requests for services can be fulfilled. Additionally linking community members who need treatment services can be challenging as most services have waiting lists for Spanish services due to workforce challenges recruiting fully bilingual staff; stigma of treatment services is also an issue.

Maintaining staff who are in part time positions is an ongoing challenge for which CyB is hoping to mitigate through combining several positions to be able to retain our MH Specialists in this project for longer periods of time.

FY 16-17	FY 16-17
For FY 16/17 CyB will strive to expand services into Castro Valley, San Leandro, and San Lorenzo and continue cultivating relationships and alliances in these communities. CyB will also reach out more to the LGBTQQI community to let them know who they are, what they do and ask how they can build greater trust to work more with members of these communities. Additionally, CyB has found a large population of women who feel unappreciated in their lives, don't have a voice, feel under-valued, isolated, and alone. CyB will work on a plan to begin a women's group, which will focus on building self-esteem, providing education about depression, self-care, and include "temezcals" for women. A **temazcal** is a type of sweat lodge which originated with pre-Hispanic Indigenous peoples in Mesoamerica. CyB's mental health education efforts continue to produce well informed/trained community members as *Promotores* (Health Promoters) who are identified as "change agents." CyB trains these community members to identify mental health issues and how to seek help for mental health issues for themselves, family members or other community members. The community *Promotores* are critical to the	All of the UELP programs, of which CyB is one of, will be put out for public bidding in FY 17/18. Therefore there are no proposed changes for this year. Projected people served: **FY 16/17: 20,664** 8,266 children & TAY 12,398 adults & older adults **FY 17/18:** TBD based on results from RFP

program as they help to raise public awareness by educating, normalizing, and de-stigmatizing mental health issues in their immediate communities. Overall CyB continues to bridge sacred traditional healing modalities and mental health education and early intervention. This is accomplished by emphasizing the integration of wellness and emotional balance with the use of herbs, meditation, visualization, massage (*sobado*) techniques, and general curanderismo.	

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 three agencies, Asian Community Mental Health (ACMHS), Center for Emerging Refugees and Immigrants (CERI) and Community Health for Asian Americans (CHAA) and is called "API Connections". It's designed to serve a diverse range of unserved and underserved API communities through the provision of culturally responsive mental health promotion/prevention and early intervention services. More information on API Connections can be found at http://www.chaaweb.org/programs/apiconnections, http://acmhs.org , http://cerieastbay.org/web3/index.php

FY 15-16
Impact **Total Prevention Contacts: FY 15/16: 8,708** 3,483 children and TAY 5,305 adults & older adults **Total Prevention Events:** 1,670 (11% increase over FY 14/15 **Early Intervention Clients:168** Within the many API communities there's a high degree of stigma regarding mental health. These numbers above and the impact narratives below are indicative of services that are targeted and culturally responsive and as such people have been interested and open to attending events and utilizing these PEI services; which has helped to *increase access* to PEI services as well as treatment services if necessary. **ACMHS:** ACMHS strives to reduce MH stigma and strengthen their monolingual API communities *access t*o services through weekly culturally responsive language specific Wellness programs, such as Whole

Health Action Management (WHAM), Vietnamese Wellness Recovery Action Plan (WRAP) group, Cantonese WRAP group, Korean Wellness group, Healthy Food Choice Group, and Knitting for Wellness group. These types of programs create opportunities for API communities struggling with onset and/or ongoing mental health challenges to access services in non-stigmatizing, strength amplifying, and community connectivity in a safe, supportive, and welcoming environment.
ACMHS also collaborated with First Five of Alameda County to provide culturally responsive, developmentally appropriate, and social/emotional strengthening parent-child relationship weekly playgroups and psycho-education groups with Vietnamese, Cantonese, Mandarin, and Cambodian families.

They've continued their efforts by hiring Consumer Interns and Peer Specialists with the supervision of a mental health clinician to provide weekly additional outreach to those isolated at home or fear of accessing services due to stigma.

Additionally, they've provided monthly consultation groups for local providers seeking additional guidance and better understanding on best practice for providing culturally competent/relevant mental treatment and outreach to the API communities in Alameda County.

CHAA:
Creation of a Tongan men's support group to address issues in the Tongan community. Conversations include domestic violence, traditional gender roles, substance abuse, parenting and how to better support one's family.

A monthly support group has continued with Bhutanese women to discuss trauma, family and community violence, and finding hope.
A Monthly Thai culture-based Ethic Class for children has started to help them understand their culture and background. This class helps to support intergenerational dialogue and reduce conflict within the family.

Multiple outreach events have also taken place across newcomer and refugee communities, which have helped increase community knowledge on where to seek culturally relevant care and support.

CERI:
CERI hosted monthly multigenerational cultural events with at least 45 people in attendance per event. Their mental health professionals facilitated their elders teaching the youth about Cambodian traditions including Cambodian dance, cooking and story- telling towards the goal of reducing dropout rates in school, gang, and crime and prostitution involvement. Youth are more likely to be involved in these activities if they are disconnected from their family and traditions

CERI provided 200 hours of home and school visits - helping several of their youth get connected to school counselors so they could get the academic support they needed to succeed in school. Home visits were done with two young men who had probation involvement to help them meet their conditions of probation and attend school.

CERI also conducted 12 psych- education workshops including: drumming circle and importance of music on physical/ mental health wellness, healthy eating, importance of physical activity on mental health, and stigma of mental health and how to normalize mental health needs. The workshops were aimed at educating their children around wellness activities and giving their youth mental health tools to reduce risky behaviors

Challenges:
The PEI demands from the API communities well-exceeded the contracted amount for this program. API consists of 27% of Alameda County's total population and consists of over 40 distinct language and cultural groups. During FY15-16, ACMHS was over-capacity for Early Intervention services, serving 124 active clients when they're contracted to serve 60. In addition to high needs, the new moderate-severe criteria for specialty mental health treatment programs funded by Medi-Cal and the waiting list or lack of language capacity for behavioral services in FQHCs or HMOs for the mild to moderate has contributed to this increase in demands for UELP Early Intervention service.
A major challenge to conducting ongoing community work is *helping people understand the importance of mental health wellness and prevention.* Communities are focused on obtaining a stable job and housing. Wellness and prevention are secondary needs. CHAA is addressing this challenge by integrating access to concrete resources while also offering PEI services. They also try to capitalize on local issues that are important to the community and create dialogue spaces that integrate mental health topics within these issues.
An external issue for both of the providers for this program, as well as many others, face is staffing capacity. For FY 15/16, only one of CHAA's staff was full-time. The remaining paraprofessional staff were at 50% or less. This is extremely challenging given the high need of these unserved and underserved communities and limited resources and language support in other systems.
As a result, staff often feel overburdened in their community work and have less time to complete paperwork in a timely manner.

FY 16-17	FY 16-17
For FY 16/17 API Connections will continue to outreach and engagement multiple un and underserved API communities through collaboration with other agencies, increasing language capacity, assisting in translating mental health wellness products into API languages, hosting support groups, hosting WRAP groups Additionally, on top of ACMHS' bilingual outreach brochures in Chinese, Khmer, Korean and Vietnamese, they continue to disseminate the "Know the Signs" statewide suicide prevention brochures in Chinese, Khmer, Korean, Vietnamese, Lao and Tagalog. As part of API Connections CHAA supports mental health and wellness in three priority areas: mind/body healing, social and cultural integration, and fair and equitable work. These areas are critical for the well-being of refugees and newcomers (a segment of the API community that CHAA is charged with serving). Their culturally sensitive approaches include:	All of the UELP programs, of which these three agencies are, will be put out for public bidding in FY 17/18. Therefore there are no proposed changes for this year. Projected people served: **FY 16/17: 10,014** 4,005 children & TAY 6,009 adults & older adults **FY 17/18:** TBD based on results from RFP

workshops in native language, using sites that are familiar and accessible to the communities, addressing topics that are core to the newcomer experience, and integrating cultural experiences and practices from one's home country into current practices here in the U.S. CERI continues to offer five ongoing support groups- one for young men age 11-15, one for young woman age 14-18, one for latency age children 6-11, a group to Afghan young men ages 16-18, and a co-ed LGBT friendly study group-which was created at the request of several of their young women who receives support through CERI. The young women have gay and lesbian friends that attended Oakland Tech High School with her. She wanted her and her friends to have a safe place to study and complete homework, while also providing community for the youth. Two of these youth have since graduated and are receiving partial scholarships to attend college. Another one of the youth is completing a full-time 3 month internship at Highland Hospital. All the groups give the children a sense of community, connection to other Cambodian immigrant youth and an adult who they trust and can confide in when they need extra help. Research shows that having at least one caring adult in a child's life is one of the most important protective factors against a myriad of risky behaviors including alcohol and drug use, risky sexual behaviors, teen pregnancy, etc.	

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

FY 15-16

Impact

Total Prevention Contacts:
FY 15/16: 9,904
3,961 children and TAY
5,943 adults & older adults

Total Prevention Events:
1,544 (29% increase over 14/15)

Early Intervention (EI) Clients:70

Hume Center:
The Hume Center's PEI services continue to grow here are two examples:
They expanded their services through Irvington high school where a huge need for services was identified for the South Asian students owing to high academic expectations by parents and high levels of stress among students
Providing consultation to agencies and organizations who also serve the South Asian population. Through consultation, staff can better help their clients and address early mental health needs. Consultation helps strengthen the process by understanding the client's needs. High levels of satisfaction were reported by the staff of agencies where they provided services.

Afghan Coalition: The biggest success of the year was that the Afghan Coalition was able to open an Afghan Wellness Center (AWC). This center provides a comfortable and private environment that allows the program to provide quality services to clients that address their mental health needs in a culturally sensitive manner.
Implementing the appointment system for client services has changed the perspective of the community members toward mental health services from the AWC without fear of exposure to the community. The clients are very satisfied with the services that are being provided by the program. For example, this year we had a 53-year-old unmarried client. The client lived with her father who was suffering from a mental health challenge. She was very shy and did not want anyone to know about her situation. She stated that "at your previous location I was not comfortable coming to talk about my problems, but at the new office I feel more comfortable sharing my concerns and worries." After a few sessions, the client demonstrated significant positive changes.
A second large success of this project was the AWC's tutoring/mentoring program for Afghan youth. The project worked closely with youth/adults to engage them in activities on both a psychological and intellectual level. The AWC was able to attend to academic concerns while also educating them about mental health and the services available to them. Many parents were pleased and expressed how their children improved not only academically, but also noticed a positive shift in behavior.

It was also a successful year for the AWC's outreach events. One of the most successful outreach events held was the Ramadan Kick-Off event, which was held in collaboration with the community groups: Afghan Cultural Society, Afghan Professionals Network, Daunish Cultural Society, Lemar TV and Afghan Seniors Association of the Bay Area. Over 50 youth (5-18) and their families attended.

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 mental health jargon and utilizing community leaders to introduce and speak about various mental health topics.
There has also been a challenge around the commitment to long term support groups due to the stigma for mental health that is prevalent in the South Asian community. Interest in "groups" is typically expressed at community outreach events but few people tend to actually participate. Instead the Hume Center has provided support through workshops which do not require participants to identify themselves as going through a challenge and yet benefit from information and support around it.

However there is still a need for more support groups particularly for seniors and parents. So this program will continue to look for innovative engagement strategies.
Overall an additional challenge for both of these programs as well for other prevention programs with good language capacity is that the needs exceed the services. Many individuals and families have social service, financial, vocational, legal needs that these PEI programs do not work on but because of language capacity the community members seek out these PEI programs. So these ethnic/linguistic focused programs have had to become knowledgeable about all of the different kinds of community resources in order to create good linkages, however this takes a good deal of time.

FY 16-17	FY 16-17
Both of these programs rely on outreach to connect with their communities. The approaches that they've utilized is to outreach by using non-psychological terminology to connect with people and help the community overcome the stigma of mental health. Additionally, outreach workers have used compassion and to normalize that mental health challenges exist on a spectrum for all individuals as everyone has experienced the ups and downs of mental health, including stress, grief and depression. Also programs use analogies to help explain concepts of mental health for example (when we keep shoving a container with materials it eventually will fill up and the things will start overflowing and we compare this to feelings and how keeping feelings bottled inside will eventually lead to overflowing). The community mental health specialists continue to outreach and engage the various South Asian communities in order to reduce stigma and discrimination, increase access to mental health	All of the UELP programs, of which these 2 agencies are part of, will be put out for public bidding in FY 17/18. Therefore there are no proposed changes for this year. Projected people served: **FY 16/17: 11,389** 4,555 children & TAY 6,834 adults & older adults **FY 17/18:** TBD based on results from RFP

services and provide consultation and engagement. For FY 16/17 the AWC is continuing to build on its relationships with the Afghan Elderly Association, ASABA, the Afghan Coalition Women's support group and many other community groups. The program did a total of 64 community presentations, workshops and discussions in FY 15/16 and is hoping to increase this work in FY 16/17. The goal is to provide audiences with a good understanding of mental health, self-care, and overall wellbeing.	

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 the "Native American Prevention Center." A majority of the program activities take place on site at the S.A.G.E (Spirit, Art & Culture, Guidance and Encouragement) Center. To date this program, has been very successful in providing culturally appropriate mental health promotion/prevention and early intervention services to the Native American community.

FY 15-16
Impact **Total Prevention Contacts:** **FY 15/16:** **3,087 (45% increase from the previous year)** **1,235** children and TAY **1,852** adults & older adults **Total Prevention Events:** **478** **Early Intervention (EI) Clients:9** The S.A.G.E. Center has had a number of impactful projects during this time period including: 1) FY 15/16 started off strong with their Gathering of the Lodges (GOTL) event. GOTL invites community members and substance abuse lodges from across California to participate in the celebration of sobriety and wellness. The event hosted upwards of 200 individuals and provided workshops on health and mindfulness exercises to self-care. The event ended traditionally, with the count down and "shout outs" celebrating individual sobriety from 40 plus years down to the minute. 2) NAHC continues to be successful in using Traditional Consultants throughout the year. These consultants are used to provide language to mental health topics that resonate with their members.

For example, using traditional stories to explain things often times works better with our members than sharing research. Using language that's relatable and understood by member's helps with retention and helps to inspire motivation more than research studies or a presentation by someone members do not see themselves in.

Challenges:

The NAHC PEI program has struggled a bit this year with staff turnover at the leadership level. New leadership has been hired so it's the hope that this program will continue to thrive.

As with many of the UELP programs the challenge of overcoming mental health stigma as well as trauma is always present.

This program has been able to mitigate this challenge through cultural interventions, which alleviate social and health problems in Native communities. In the Native worldview, wellness is viewed as "maintaining balance" with the natural environment and harmony in human relationships. Restoring balance is the goal of ceremonial healing ("doctoring") by traditional medicine people. Native Americans have a relational worldview, rooted in tribal culture. Every event in one's circle of life relates to all other events regardless of time and space. Interventions are focused on bringing the person back into balance.

FY 16-17	FY 16-17
NAHC continues to use creative strategies to introduce the concept of mental health therapy to members. Traditional arts groups weave in lessons and guest speakers provide introductions to mental health in a setting that's comfortable such as their Men's Drum group. They often have a Mental Health intern sit in on the group and fully participate with the lead facilitator. Through the interns full participation members build relationships and engage on a peer level. These interactions have provided a face to their mental health work. It brings their clinicians out of the office and into interaction with members in different settings. It also allows their members to humanize their behavioral health clinicians and fosters opportunities to build relationships so important to matriculation into therapy services. In FY 16/17 NAHC would also like to increase participation in their wellness program offerings. They have goals to double participation through a series of controlled Plan Do Study Act (PDSA) cycles. NAHC hopes to identify interventions that will engage members into participating in their	All of the UELP programs, of which NAHC is one of, will be put out for public bidding in FY 17/18. Therefore there are no proposed changes for this year. Projected people served: **FY 16/17: 3,550** 1,420children & TAY 2,130 adults & older adults **FY 17/18:** TBD based on results from RFP

group activities. These interventions will include outreach and in-reach calls utilizing their panel management systems and improved marketing materials for easier member navigation to groups.	

PEI 12. Suicide Prevention and Trauma Informed Care

Program Description: Crisis Support Services of Alameda County (CSS) is a nonprofit, volunteer-based crisis intervention and suicide prevention agency. They provide a variety of mental health services to a wide range of persons in varying degrees of crisis. Services include crisis hotline, school-based suicide prevention training, community gate keeper trainings and consultation, Mental Health First Aid, teen text line, Trauma Informed Care (TIC) trainings, grief counseling for all ages and crisis event counseling. *Their primary mission is to assist people in emotional distress, to offer supportive counseling to those in crisis and to prevent suicide.*

CSS is leading the way for suicide prevention centers across the nation in providing sensitive and timely services to people impacted by traumatic stress. Trauma-Informed Care (TIC) is a person-centered response that focuses on improving functioning over curing mental illness, i.e. “fixing” something “broken”. CSS utilizes a wide range of TIC components and responses when working with all of their clients, but predominantly with those affected by traumatic loss, particularly suicide and homicide bereavement.

See ATTACHMENTS:

- Crisis Support Service of Alameda County, Text Line Program, Year End Report FY 2015-16
- Crisis Support Service of Alameda County, Community Education Program, Year End Report FY 2015-16
- Crisis Support Service of Alameda County, Clinical Program, 2015-16 Annual Report
- Crisis Support Service of Alameda County, Crisis Line Program, Year End Report, FY 2015-16

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

For FY 15-16

Impact
Clients Served FY 15/16):

24 hr. Crisis Line responded to 64,977 calls (up from 60,734 calls in FY 14/15) on the 3 Alameda County call lines (24 hour Crisis Line, Al Co. Behavioral Health ACCESS Afterhours Lines, National Suicide Prevention Lifeline.)

For the Crisis Line Program alone 201 volunteers and interns contributed over 20,008 hours (up from 18,720 hours in FY 14/15) on the crisis lines this year

The Teens for Life (TFL) Youth Suicide Prevention program served 9,121 youth through 310 presentations at 29 schools in 11 out of the 18 Alameda County School Districts.

Post TFL training:

- 83% strongly agreed or agreed with the statement "*I can recognize if someone close to me is feeling suicidal."* As compared to only 46% pre training.

- *83%* 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." As compared to only 65% pre training.*

The Youth Crisis Text Line served 310 unduplicated clients during 578 crisis texting sessions, which is similar to FY 14/15 data.

A few quotes from youth using the line:

At the beginning of one session a texter wrote: "***I haven't told anyone about this because I feel like I don't feel comfortable telling others face to face and I just feel like there's a huge boulder that is crushing me and no one is there to help***".

At the end of a session another texter summed up well why we do what we do: "***Thanks for being here for me, I feel safe***".

The group and individual counseling program served a total of 472 clients (265 youth, 139 older adults, and 68 grief counseling clients) for a total of 6,161 sessions -all through the lens of being trauma informed and for many individuals addressing the traumatic issue within the counseling sessions.

Compared to the previous year, CSS served 6 fewer clients, however they provided 742 more counseling sessions and 45 more logistical and/or supportive telephone calls.

Community Education and Gatekeeper Trainings served 971 adults through 37 trainings.

Post training, 84% strongly agreed or agreed with this statement *"I know how to intervene with a suicidal person."* As compared to only 25% pre training

MH Consultation Trainings (including MHFA, Bullying, Suicide Prevention, Trauma Informed Systems, etc.) served 773 adults through 22 presentations.

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

For current FY 16-17	For upcoming FY 17-18
In FY 16/17 all of the suicide prevention programs and trauma informed care strategies are going strong. For youth, there appears to be strong connection between the TFL suicide prevention trainings and increased knowledge about the text line resource. This is evidenced through youth mentioning the TFL presentations when using the text line. Trauma Informed Care Additionally, at the request of AL Co. CSS implemented a 4-hour "floor training" on trauma-informed care principles for county staff and its community partners. In the first quarter of FY 16/17 four trainings have been conducted for over 160 people. The CSS Crisis Committee wrote this value statement to provide a framework for working with their callers. *We believe that recovery is possible for everyone.* *We acknowledge that our understanding of caller's lives is necessarily imperfect. Thus we must listen deeply and be willing to change course when callers redirect us. We seek to incorporate caller input and feedback into policies and practices whenever possible.*	No planned changes Projected people served, not including crisis line clients: • **FY 16/17: 13,900** 12,900 children & TAY 1,000 adults & older adults • **FY 17/18: 14,500** 13,500 children & TAY 1,000 adults & older adults

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

We seek to build a person-centered, collaborative model for communicating the needs and wishes of our callers. We wish to empower3 the callers to define their own wellness. Our goal is for caller profiles to convey a holistic picture of our callers and who they wish to become. *We recognize the devastating impact of trauma on individuals and seek to honestly explore the effects of trauma in our interactions with callers. We will actively work towards minimizing further traumatization of our callers. We must recognize and address not only the caller's traumas but also strive to examine and understand our own responses to trauma.* *Finally, we wish to honor the courage required in reaching out to a stranger for help. We strive to pursue our work with the same courageous spirit.* Based on the data from the crisis text line these are the areas where youth are struggling the most: Loneliness/isolation Anxiety/stress Depression Non-suicidal self-injury CSS continues to develop and solidify a number of new collaborations including: 1) their partnership with the Oakland Police Department (OPD) where they're a trainer for their Crisis Intervention (CIT) class, and 2) La Clinica de la Raza where a youth intern program has been established.	

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

PEI 13: Family Education and Resource Center

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 15-16

Impact:

Facilitated (52) Family Caregiver Support Group meetings

Facilitated (20) Peer Support Group meetings for Transitional Age Youth

Instructed (2) Family-to-Family classes (24 sessions total)

Tabled (34) Community Outreach Events

Attended (180) IEP meetings

Attended (108) Court appearances / meeting clients at court

(36) In-service presentations

Presented (9) Crisis Intervention Trainings (CIT) for law enforcement

Presented (14) Consumer / Family panel trainings to California Highway Patrol Officers throughout Bay Area (estimate: 350-400 officers)

Presented (4) Mental Health First Aid trainings

Participated in (2) Bright Young Minds Conference for youth

Presented (30+) trainings on mental health and WRAP at schools (elementary, middle, high school, college level)

Challenges:

Challenge: Engaging TAY.

Strategy: having peers their own age talk about mental health, stigma reduction and provide appropriate resources.

Challenge: Housing resources.

Strategy: continue to work with clients (getting on wait-lists, Eden I&R, share current information (housing bond measure), provide tenant resources)

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

Challenge: Early discharge from a psychiatric facility.

Strategy: try to be in communication with the facility / treatment team ASAP (but all depends when clients contact us / find us) – assist clients with completing and submitting an AB 1424; inform clients on AB 1194.

For current FY 16-17	For upcoming FY 17-18
The number of children, TAY, adults, and/or Older Adult to be served. • FY15/16 Total Clients: 2,652 • FY16/17 Total Client Projection (+10%): 2,917 • Children: 292 • TAY: 437 • Adults: 2,042 • Older Adults: 146	The number of children, TAY, adults, and/or Older Adult to be served. • FY17/18 Total Client Projection: 3,209 • Children: 321 • TAY: 481 • Adults: 2,246 • Older Adults: 160

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

PEI 14. 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 15-16

Impact

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.

In FY 15/16 this program

- Reach out has increased the number of community facilities by 2
- Reach Out has increased it pool of new volunteers by 3, 2 of the new volunteers are individuals who have participated in Reach Out visits

Berkeley Drop In Center provides vital services for mental health clients who are also experiencing chronic homelessness and SUD issues. The center offers ongoing housing services, payee representation for consumers, daily food, peer support groups, and other referral services.

In FY 15/16:

- Berkeley Drop In Center has partnered with Best NOW and Berkeley Mental Health to provide group facilitation trainings for consumers.
- Berkeley Drop In Center has partnered with a community Psychologist interested in provider therapy sessions at no cost.

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.

- Reaching Across received the Senators award for excellent service delivery in the city of Fremont
- Reaching Across has increased participant diversity to better reflect the multiple cultures within

Fremont

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

Tenant Support Program has increased community housing partnerships including access to winter Shelter referrals and case management support

FY 16-17

In FY 16/17 the Jay Mahler Center was added to the Reach Out program's list of presentation sites.

Reach Out

- 16/17 Reach Out will evaluate current topics, consumer satisfaction and agency partnerships
- 16/17 Reach Out will include more physical wellness tools to all of presentations

Berkeley Drop In Center

- 16/17 Berkeley Drop in Center will provide Weekend hours to meet the needs of consumers during the winter months. Out homeless population are subjected to cold weather exposure during shelter closed hours
- 16/17 Berkeley Drop in Center will increase community workshop opportunities to reflect the shift in service population

PEI 15. Asian Pacific Islander staffing to ACCESS

Program Description: In FY 15/16 this Access and Linkage Program was run by the local community-based organization Asian Community Mental Health Services. Due to financial issues and quality of care this program was transferred to Asian Health Services in FY 16/17. However, even with a new provider the program intent has remained the same, which is to 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. The overall the goal is for these access and linkage services is to prevent initial or re-occurring psychiatric hospitalizations.

FY 15/16 Outcomes, Barriers and Challenges:

Impact: For FY 15/16 this ACCESS program provided over 800 screening, information and referrals for the API community. In addition they served 117 unique clients for short term crisis stabilization services and 4 clients were referred further to their specialty mental health program.

Upon discharge, ACMHS often refers clients to multiple other services including: medication management services, family psychotherapy, Level III Services, their own EPSDT program, legal

services, prevention programs, community resources, Social Services Administration (SSA) for food stamp benefit information and to their own Specialty Mental Health (SMH) program.

Challenges: There are many linguistic and cultural challenges, however these bullets are the two most prominent ones:

- Inadequate bilingual API behavioral health providers, and
- Lack of culturally responsive community wellness/safety net programs for individuals who do not or no longer meet specialty mental health services criteria.

Stigma also continues to be a barrier and challenge in the Asian and Pacific Islander communities and because of this many do not seek out services.

FY 16-17 Plans:

As mentioned above in the opening narrative this program moved from Asian Community Mental Health to Asian health Services which has cause a slight disruption in services and documentation of services. However, in the second part of FY 16/17 services have stabilized and staff capacity is increasing.

For FY 16/17 they expect to screen and provide information to 900 individuals and serve between 120-150 clients.

FY 17-18 Plans:

For FY 17/18 they estimate to serve 130 clients. This program may go out for a public bidding process in FY 17/18, but this hasn't yet been completely determined.

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

PEI 16. Latino staffing to ACCESS

Program Description: This Access and Linkage Program is run by the community based organization, La Familia, and provides screenings, referrals and crisis stabilization treatment for the Latino community for adults who are 18 and over, lack health coverage and are monolingual Spanish speakers. In addition to these core services the program also provides short term follow-up care when clients are discharged from a psychiatric hospital. The overall the goal is for these crisis stabilization services to prevent initial or re-occurring psychiatric hospitalizations.

For previous FY 15-16 Outcomes, Impact & Challenges:

- For FY 15/16 this ACCESS program received 133 requests for services of which 85 were uninsured. Of the 133 requests we provided direct services to 97 (73%) unduplicated clients.
- Many uninsured and undocumented clients were also were able to get connected to primary care through referrals from this ACCESS Program. Primary care referrals are mainly to Hayward Wellness and Tiburcio Vasquez Health Center. Through these referrals, many clients successfully applied to Medi-Cal or HealthPac.
- Upon discharge, this ACCESS Program often refers clients multiple other services including: medication management services, family psychotherapy, Level III Services, their own EPSDT program, legal services, prevention programs, community resources (their own community outreach services and other community programs) and to their own Specialty Mental Health (SMH) program. In 15/16 they referred 3 clients to their SMH program.

Challenges:

- Requests for services exceed their capacity to provide services. They only have 1.5 FTE for the ACCESS Program.
- Most of their ACCESS clients are monolingual Spanish speakers who are undocumented, making it difficult to refer to public mental health, housing support or employment services.
- There are not enough appropriate providers in Alameda County who can serve this population due to cultural, linguistic or economic reasons. Because of this, there are some cases that we extend treatment beyond stabilization until we can secure appropriate care and find it clinically appropriate to discharge.
- Stigma continues to be a barrier and challenge in the Spanish speaking community and many do not seek out services.

Current FY 16-17:

Due to the ongoing increase of the Latino community and lack of Spanish speaking providers in Southern Alameda County, we project an increase of request of services of 5 to 10% a year. This is based on previous year's trends.

For FY 16/17 we expect to serve 112 clients.

Since July of this year, La Familia started an In Home Outreach Team (IHOT). So linkages and referrals are occurring between this ACCESS program and IHOT. They already have one IHOT case who has been open in their ACCESS Program.

For upcoming FY 17-18:

For FY 17/18 we estimate to serve 129 clients. No planned changes to the program.

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

PEI 17. TAY Wellness Resource Center at Youth Uprising

Program Description: The TAY Wellness program at Youth Uprising consists of a team of 2 full time mental health clinicians, a mental health intake intern and H&W director. Under the MHSA Wellness contract, these clinicians provided individual, family and group therapy services to TAY ages 13-24, prioritizing uninsured TAY between the ages of 16-24. In addition to therapy support the Wellness team supports TAY around basic needs including housing, food and shelter to minimize barriers to therapy engagement associated with these needs. YU Wellness Programs 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 result in a broad definitions 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 14-15

Current Strengths:

Triple C: "*Cool Calm Collective"* Group is YU's alternative to "Anger Management". Therapist, Aaron Smith engages TAY in group activities around mood management, positive coping and mindfulness. Triple C is offered year round.

WRAP group: In collaboration with **PEERS,** YU began hosting and offering a Wellness Recovery Action Plan (WRAP) in January 2014. 6 TAY have engaged in this offering and are working on their personal 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 time between referral for service and service contact. The current intern is a YU alumni, who is currently in a psychology doctorate program. She is bilingual and increases program capacity to engage monolingual 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. We are still searching for a qualified clinician, with priority of adding Spanish language capacity to the wellness team.

Group referrals.
Only on occasion, have received external referrals for group services. For example, group homes or probation officers will refer TAY for group supports, who are not already engaged in YU Services. Group offers rarely reach full capacity and could use an increase of referrals from sources external to YU programming.

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

For current FY 15-16	For upcoming FY16-17
FY15-16 45 Caseload TAY 250 unduplicated TAY **Current Strengths:** **"***Artful Healing"* Group is YU's therapeutic arts group for TAY with pay. In partnership with CHO, this groups is focused on creating an ever growing art installation for Oakland Children's Hospital **Q&A Group:** *"We Out! Here"* YU began offering a support group for LGBTQ-identified Youth. They will also host a series of events related to the mission of supporting LGBTQ youth and allies and building community. **Current Challenges** **Staff Vacancy** TAY Wellness program has experienced staff transitions and reclassifications. Dr. Carole Dorham-Kelly has transitioned out of YU and the Executive Team has extended an offer to Dr. Eugene Hightower as Director of Health and Wellness. Dr. Hightower will join the staff November 15, 2016. Aaron Smith, Wellness Manager is transitioning to the Senior Career Coach position at YU. The vacancy is actively being recruited and we expect to fill the position By November 30, 2016.	**FY16-17** 45 Caseload TAY 250 unduplicated TAY

PEI 18. Behavioral Health Medical Home

Program Description: Provide BHCS consumers with serious mental illness timely access to primary health care services in Alameda County Adult Mental Health Community Support Centers (CSC).
FY 15/16 Program Outcomes to Date and Plans: During FY2015/2016, the PATH Project entered its sixth year, and has been able to increase its participant enrollment to over 325 consumers enrolled at the Oakland and Tri-City Adult Community Support Centers with a participant retention rate over 80%. In September, 2016, 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 370 enrolled Level I program participants.
In September, 2015, BHCS contracted with 8 FQHCs to provide Integrated Behavioral Health care coordinators to serve as part of the primary care team and at assist BH patients get timely access to primary care services, and primary care patients needing access to specialty behavioral health services.

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 16/17 Program Plans:
Implement the PATH Project at Eden Adult Community Support Center by April, 2017, and operate two half day primary care clinics at the site by August, 2017, with 60 enrolled program participants.

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 17/18 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 part of the PATH Project for sharing patient health information on a timely basis.
Monitor PATH Project Primary Care staff to ensure that they are billing Medi-Cal for the client services at the BHCS, adult community support centers.
Implement the PATH Project at Eden Adult Community Support Center by April, 2017, and operate two half day primary care clinics at the site by June 30, 2017, with at 45 enrolled program participants.

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
In December, 2016, the Oakland PATH Project's Nurse Care Coordinator position became vacant. The position is for a Registered Nurse and requires an individual with excellent care coordination skills and ability to work well with not only primary care providers but also behavioral health clinicians.

The implementation of a half time behavioral health primary care service at the BHCS Gail Steel Wellness and Recovery Center in Hayward, California, in collaboration with Tuburcio Vasquez Health Center (TVHC) is being delayed until BHCS completes the opening of the Eden Mental Health Clinic's PATH Clinic. The immediate need for a fourth PATH Project Primary Care Clinic in the Hayward/ San Leandro area will be determined with input from TVHC on if they feel that there is enough patients in the area that are in need of access to a medical home.
BHCS is continuing to work with the Alameda Health Consortium and HCSA to develop ways to share and access the physical and behavioral health information of consumers served by their network of community health centers and behavioral health services so that the PATH Project can monitor the impact of integrated care on emergency room utilization, hospitalizations (psychiatric and medical), and criminal justice services.

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

PEI 21. Wellness Centers

Program Description: The Wellness Centers are designed as an exit strategy for participants who are on intensive case management teams and full service partnerships in Alameda County as they develop their wellness and recovery plans and link with natural and community supports. The main program goals are focused on helping individuals create a fuller life in the community without the need of more intensive mental health services. Each individual is supported in developing their own recovery goals for wellness and community living. The monthly team meetings focus on the participant's successes in achieving progress in the 8 domains of wellness in their life. This is reviewed in these meetings together with a Case Manager, a Peer Counselor, an Employment Coordinator, a Psychiatrist and any one in the participant's community who can help them to achieve their goals that are developed out of the team meeting format.

The main interventions are the following:

1. Team meetings, which occur monthly as needed to develop action steps based on needs to help individuals transition from center based supports to community based supports;
2. Classes and Workshops based on the domains of wellness to assist individuals in learning the skills necessary to transition to community services
3. Employment Services with the Individual Placement and Support (IPS) model to assist individuals in attaining gainful employment in the jobs of their choice
4. Psychiatric support from a wellness and recovery oriented psychiatrist to assist the individual's to transition to community based care
5. Support individuals to attain and achieve independent living in permanent housing places of their choosing.

FY 15/16 Outcomes, Impact and Challenges:

From April through June the Wellness Centers continued to see a high volume of sign-ins that have mirrored the previous quarter (6776). The total sign-ins for the year across all Wellness Centers was 20,883.

All four Wellness Centers saw increased utilization throughout the year with a total increase that doubled from Q1 (3366) to Q4 (6776). Note, Q2 = 3678, Q3 = 7060.

The peer community at the centers themselves participating in the outreach effort has been tremendously successful in bringing in individuals new to the center. BACS continues to outreach regularly to partnering service providers in the community, and more importantly presenting to potentially interested participants at SRO's, HSP and group homes near to the Wellness Centers.

The Wellness Centers hosted Best Now! and FACES for Change interns to promote professional peer development and youth workforce development for high-risk communities of color.

The Wellness Centers continue to partner with the POCC, NAMI, FERC, NA, Best Now!, and Bonita House, as well as host service team and ACT teams for meetings with participants that they serve. At Towne House and at Hedco the teams have partnered with BALA and HAC to educate participants of their benefits and services. These partnerships have supported the word-of-mouth effort to bring awareness of the services at the Wellness Centers.

FY 16/17 Progress:

For the first quarter of FY16-17 (Q1) the BACS Wellness Centers continued to see a high volume of sign-ins that mirrored the attendance trends of the previous quarters (6142). TAY represent approximately 7% of daily visits, Older adults represent approximately 26% of daily visits
*Data collected from Hedco is extrapolated data due to technological issues with the center's sign-in kiosk. Data was extrapolated from hand-written sign-ins and the electronic sign-ins that could be recovered. An anecdotal observation of daily attendance at Hedco during Q1 suggests no significant drop off in attendance from Q4-FY16 (50) to Q1-FY17 (37) than the recorded data suggests.

Valley and South County Wellness Centers continued to experience the most dramatic increase in utilization. South County increased its utilization by 30% from Q4-FY16.

Total Transitional/Triage Case Management caseloads at the Wellness Centers increased by 20 cases. Total Medications Support Only (DOORs) clients increased by 95 cases!

Peer councils of the centers have impacted the outreach effort and have successfully brought in individuals new to the center. BACS continues to outreach regularly to partnering service providers in the community, and more importantly presenting to potentially interested participants at SRO's, SIL, HSP and group homes near to the Wellness Centers. PES case managers at JGPH and with CJMH at Santa Rita are also referring clients with identified mental health needs to the Wellness Centers.

The Wellness Centers is hosting two new FACES for Change interns to promote professional peer development and youth workforce development for high-risk communities of color.

The Wellness Centers continue to partner with the POCC, NAMI, FERC, NA, Best Now!, La Clinica and Bonita House, as well as host service team and ACT teams for meetings with participants that they serve. The Valley Wellness Center has developed a strong collaboration with Valley CRP and the service team there and is regularly drawing referrals and interest from their participants.

At Towne House and at Hedco the teams have partnered with BALA and HAC to educate participants of their benefits and services. These partnerships have help to create culturally specific and sensitive program offerings at our centers.

Areas of Growth & Challenges:

While BACS is excited to receive these consumers as well those that are previously unconnected to services, we are also looking forward to serving more participants of service teams and FSPs. BACS will continue to outreach to those providers and looks forward to continued support from BHCS in bringing awareness of services available at the Wellness Centers.

In the new fiscal year BACS will be integrating health screening at the Wellness Centers with a full-time nurse rotating through the centers.

Hedco Wellness Center experienced a technical failure of the kiosk iPads used to capture daily census data for an extended period during Q1 FY16-17. The technical issue impacted data collection and thus data from this quarter collected at Hedco is extrapolated using other means, such as hard copy written sign-ins. BACS recognizes the fallibility of the data and has corrected the issue going forward.

B. PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES

FY 17/18 Plans:
BACS is shifting is focus on group facilitation and community activities to connect with more TAY to increase access to BHCS services.

Wellness Centers are developing Peer Counsels to drive activities, community agreements, and safe spaces at the centers.

BACS is investing in new technology to continue tracking vital data to inform the continuum of care, adjust to the needs and trends of the community while preserving a low barrier access to service.

BACS anticipates growth in attendance at all Wellness Centers to slow and maintain to current levels, with increased participation with TAY consumers.

C. INNOVATIVE PROGRAMS SUMMARIES

Program Description: Innovative Programs

FY 16-17 Plan Update:

Round Three Innovative Grant Cycle (INN3)

After completion of 23 Innovation Grant projects, two Learning Conferences were held to highlight the Round Three Innovative (INN3) project findings and innovative project deliverables. On January 22, 2016 the INN 3 Learning Conference presented ten projects and final project deliverables which serve Isolated Adults and Isolated Older Adults. On March 24, 2016, the INN 3 Learning Conference, highlighted thirteen grant projects that serve the LGBTQI2S community. Total of twenty-three workshops shared their project implementation, program designs and training curricula with community members and stakeholders. Over 400 individuals attended the INN 3 conferences. Attendees included consumers, family members, providers, county staff and other public employees and other community members. Stakeholders were also engaged in conducting the conference and participating in the grantee workshops.

After the INN 3 learning conferences, evaluation of project outcomes were conducted from March - November. Grantees and conference participants (i.e., consumers, family members, providers, and county staff) completed satisfaction surveys of their experience with the Innovation Grant process. BHCS staff collaborated with UC Berkeley to conduct evaluation of the Innovation Grants process. Members of the MHSA Stakeholder Group reviewed the INN 3 projects and provided feedback. BHCS staff evaluated the INN 3 projects on the effectiveness of outcomes and how the projects can be implemented in the public mental health system.

As a result of the evaluation and feedback process, BHCS has implemented the Community Based Learning program which utilizes the INN 3 project tools, program designs and training curricula to provide technical assistance and training to community based organizations throughout Alameda County to improve cultural responsive ways to serve the LGBTQI2S community and Isolated Adults and Isolated Older Adults.

The following are INN3 grant projects that developed innovative program designs to address the needs of Isolated Adult and Isolated Older Adult Consumers**:**

Project Name	Grantee	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	CJM Associates / Center for Family Counseling/ Bay	Family Healing: engage the family and isolated consumer through a 12-week workshop series using narrative based storytelling and

Family Members/Loved Ones	Area Community Services (BACS)	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 LGBTQI2S grant projects (below) developed an innovative 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.

C. INNOVATIVE PROGRAMS SUMMARIES

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), and Community Health for Asian Americans' Pacific Islander Community Advocacy	Utilize Native American and Pacific Islander traditional cultural practices to bring Native American Two Spirit 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.

Round Four and Round Five Innovative Grant Cycles

ACBHCS is currently in the planning phase for the Round Four Innovative Grant Project. BHCS will implement pilot projects for two topics:

C. INNOVATIVE PROGRAMS SUMMARIES

1) **INN Round 4a: Personal Technology for Mental Health**
   Learning Question: How can the use of desktop and mobile applications improve engagement and access to mental health services?

2) **INN Round 4b: Mental Health Services Workforce – Education Internships**
   Learning Question: How can a BHCS internship program with high school and undergraduate college students increase diversity in the mental health service workforce?

3) **INN Round 5a: Community Based Treatment Transition Team (CT3)**
   Learning Question: How would the CT^3 , with short term community based treatment with services and supports 1) improve mental health and physical health outcomes, 2) increase access and engagement to services, 3) increase retention, and/ or 4) reduce recidivism and/ or hospitalizations for consumers/ clients?

4) **INN Round 5b: Improving Mental Health Services Utilization for Asian/ Pacific Islanders (API)**

   In Alameda County, API have a very low rate of utilization of mental health services, compared with other people groups. To address this need, BHCS has commissioned a consulting project to conduct a demographic analysis through literature review and data analysis, and gather stakeholder feedback through focus groups and individual interviews. The final reports will provide BHCS with an analysis of the specific needs of the target population, which would inform the development of learning questions for potential inquiry funded by Innovation grants; to recommend outreach and engagement strategies; and to provide strategies of building capacity for providers serving API community.

Innovation Grant projects are anticipated to begin outreach to applicants in early 2017 and begin project implementation in the Spring 2017. Projects are anticipated to be completed by Summer 2018.

D. WORKFORCE, EDUCATION & TRAINING PROGRAM SUMMARIES

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 15/16 Outcomes, Impact & Challenges:

- The WET team administered and implemented previously approved Workforce Education and Training (WET) strategies such as the Graduate Intern Stipend Program, Consumer and Family Training, Education and Employment and High School Career Pathways activities, and the State Mental Health Loan Assumption Program (MHLAP)

- WET manager provided oversight of the High School Career Pathways contract with La Clinica de La Raza, and also the Bay Area Regional Partnership contract. Alameda County Behavioral Health Care Services (BHCS) serves as the fiscal sponsor and employer for the state funded Regional Partnership Program

- BHCS continues to serve as the fiscal sponsor for the Bay Area Regional Partnership program as outlined in the OSHPD Agreement Number 14-5004, which will include passing through the funds to California Institute for Behavioral Health Solutions (CIBHS). WET manager will continue to provide contract oversight

- WET manager continued to work with BHCS Prevention and Early Intervention (PEI) Coordinator on a proposed training plan submitted by Community Health for Asian Americans (CHAA). WET funded this pilot mental health workforce development model for Alameda County's unserved and underserved new and emerging immigrant and refugee communities

- The WET team collaborated with various primary applicant organizations including BHCS Consumer Empowerment Unit, Berkeley City College (BCC) – Public and Human Services Program, Mentoring in Medicine and Science (MIMS), Community Health for Asian Americans (CHAA) and Diversity in Health Training Institute on applying for the following grants as a

collaborative partner:

- OSHPD Mini Grants –Mentoring in Medicine and Science, Community Health for Asian Americans (CHAA) and Diversity in Health Training Institute– all three partners received funding
- OSHPD Peer Employment and Placement RFA – BCC received funding
- Prepared standard service agreement with BHCS and the University of California, San Francisco (UCSF), School of Medicine to provide behavioral health education and clinical training to Fellows from UCSF Public Psychiatry Fellowship (PPF) Program. This agreement provides an opportunity for fellows to consider public mental health as a career choice with an objective of recruiting viable candidates into BHCS system of care. BHCS Crisis Residential Program (CRP) program or the Trust Clinic will provide PPF fellow(s) beneficial educational opportunity at the CRP outpatient/crisis clinic or at the Trust Clinic, at the same time, enable BHCS to develop a recruitment pipeline for BHCS system of care in need of psychiatrists
- WET Staff continued to provide administrative functions for Children's System of Care (CSOC), Adult System of Care (ASOC) and Criminal Justice Mental Health Services/Conditional Release Program (CONREP) internships
- WET manager served on the BHCS Training RFP Review Committee. Reviewed and scored grant applications
- 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 staff served on various BHCS advisory committees, such as the Consumer and Family Member Employment workgroup, BHCS Training Committee, Merritt/Laney College Disability Student Services Stakeholders Committee, WET Regional Partnership Steering Committee, Pool Of Consumer Champions Employment Taskforce
- Organized and held an annual WET strategic planning meeting with WET team
- Consumer and Family Employment Liaison was transferred from Workforce Development to the Consumer Empowerment Department (CED) on May 23rd 2016; new title - Employment Liaison
- Challenge – BCC administration decided to terminate the OSHPD Peer Employment and Placement contract
- WET is participating as a program partner in the implementation of the Alameda County Whole Person Care Plan. Alameda County has been approved by the California Department of Health Care Services to implement its Whole person Care Plan

- WET team continued to administer and implement WET strategies
- WET team continued to prioritize, develop and implement projects based on the workforce needs assessment survey outcomes
- Continued to evaluate WET program impact and needs; based on program outcomes and data, continue to enhance and implement activities to achieve WET goals

FY 16/17 Anticipated Changes:

- BHCS WET does not expect any significant program implementation changes during FY 16-17

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 15/16 Outcomes, Impact & Challenges:

WET Employment Liaison and community based providers have developed and implemented the following activities:

- Estimated 142 consumer and 86 family employees in Alameda County and community based organizations (CBO)
- Provided ongoing employment opportunities as a list serve for consumers, family members and providers to share with people with lived experience
- Convened ongoing Consumer & Family Employment Work Group meetings to learn, discuss and problem solve consumer and family employment content & issues
- The Family Education Resource Center provided Leadership and Family Advocate Training Programs
- Implemented annual BEST Now! Consumer Employment Training Program with six-month Internships. 21 participants graduated.
- Consumer and Family Employment Liaison provided ongoing participation and support of CIBHS' Greater Bay Area Workforce Collaborative Steering Committee

D. WORKFORCE, EDUCATION & TRAINING PROGRAM SUMMARIES

- Researched viability and developed proposal to establish an Alameda County "Job Board" website
- Partnered with BHCS Consumer Empowerment Team & Mental Health Association of San Francisco (MASF) in their application for OSHPD Peer Personnel Preparation RFP. The purpose of the Peer Personnel Preparation 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
- Partnered with the Consumer Empowerment Department (CED) & Alameda County Pool Of Consumer Champions (POCC) to coordinate and implement the Academic and Employment Resource Expo; 65 individuals and10 organizations participated
- Collaborated with CED, POCC, and Berkeley City College's (BCC) Public & Human Services Programs to coordinate and implement two outreach meetings promoting BCC Public and Human Services Programs for 20 individuals
- Continued collaboration and partnership with the Consumer Empowerment Department (CED) and its employment efforts specific to behavioral health employment, with particular connection to the POCC's Consumer Employment Advisory Taskforce. Provided the committee employment opportunities as well as employment training opportunities and a role on the CFM Workgroup.
- Estimated 267 consumer providers and 63 family employees in regular, contracted, and stipend positions in Alameda County and community based organizations
- Provided employment opportunities list serve for consumers and family members
- Convened and facilitated ongoing Consumer & Family Employment Work Group meetings to learn, discuss and problem solve consumer and family employment content & issues
- Coordinated and provided Supervisorial Training: "Welcoming and Partnering with Consumer Family Employees", 24 supervisors participated
- Liaison partnered with CED to support and provided employment-readiness events such as The Benefits Workshop with the Consumer Employment Advisory Taskforce (CEAT), on July 31st 2015 with 33 participants
- Family Leadership and Family Advocate Training Programs were provided through the Family Education Resource Center (FERC)
- BEST Now, a program with ACNMHC, provided peer specialist training program with 6 month internships: 18 graduates, June 9, 2016
    - Ongoing marketing and support of BEST Now's employment skill-building workshops
- Liaison collaborated with Bay Area Peer Professional Network (BAPPN) awarded in March 2014 for Peer Personnel Preparation, providing requested information and other needs
- Continued collaboration and partnership with the Consumer Empowerment Department and its

employment efforts specific to consumers in behavioral health, with particular connection to the POCC's Consumer Employment Advisory Taskforce (CEAT). Ongoing provision to the committee of employment and training opportunities. Additionally, a representative from CEAT served on the CFM Workgroup

- Collaborated with CED, the Consumer Employment Advisory Taskforce, the POCC, and BACS to coordinate and implement the Annual "Employment Clothing Boutique" providing free employment-ready clothing for consumers and interviewing tips and techniques; April 15th 2016; 29 recipients signed-in
- Coordinated and collaborated with consumer leaders to provide a Bay Area Forum on SB614 State Peer Certification to educate, advocate, and advise our community on January 29th 2016 regarding State Peer Certification; 167 attendees
- Liaison co-spearheading planning workgroup to develop peer specialist trainings to build knowledge, skills and abilities; in collaboration with the Consumer Empowerment Team Leadership, Family Empowerment Team Leadership, and the WET Manager
- Liaison was transferred from Workforce Development to the Consumer Empowerment Department (CED) on May 23rd 2016; new title is: Employment Liaison, Consumer Empowerment Team Staff

FY 16/17 Anticipated Changes:

- For FY 16/17 estimated 220 consumer providers and 70 family employees, regular, contracted, and stipend positions, in Alameda County and community based organizations (CBO)
- Employment Liaison to increase collaboration with Office of Family Empowerment to support their employment efforts
- With the transition to the CED, the Liaison's role will be evolving and will have a larger scope of responsibilities; more than building consumer employment in behavioral health
- Hiring efforts will increase with the Peer Mentorship Program (Mentors on Discharge) hiring mentors to assist consumers at John George Psychiatric Pavilion
- With the support of the CED, hiring efforts will increase with the implementation of the new Peer Respite Program, given the need for qualified peer specialists
- Liaison to provide assistance, as needed and directed by CED, with implementation of Peer Navigator Pilot Program by FY 16/17
- Liaison to provide technical assistance, training, and support, as needed, in the implementation and development of the new Peer Respite Center and its peer specialist staff

- Liaison to implement Employment and Academic Expo with CED, and its Consumer Employment Advisory Taskforce in July 2017
- With direction and support from CED, Liaison will provide ongoing support to consumers enrolled in the new medical assistant program
- Liaison will continue co-spearheading planning workgroup to develop peer specialist trainings to build knowledge, skills and abilities of peer specialist; and will assist with implementation and training
- "Consumer & Family Employment Work Group" to be changed into a function of the Consumer Empowerment Department and will be developed and implemented as an educational & supportive skill building workgroup for consumers currently employed in the mental health field to support employment retention and growth
- Provide Family Leadership and Family Advocate Training Programs through the Family Education Resource Center (FERC)

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 15/16 Outcomes, Impact & Challenges:

- Provided over 80 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 and evaluate 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

- Continued to provide 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 and evaluate 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.

- Collaborated with the Innovations (INN) Learning Conference staff for Round 3 of grantee activities to plan and implement an INN Learning Conferences in January and March 2015 for Isolated Adults and Older Adults and the Lesbian, Gay, Bi-Sexual, Transgendered & Queer (LGBTQ) populations.

- Continued to identify, provide and evaluate specialized training for staff of ACBHCS Alcohol/Other Drug providers.
- 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

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

- Continue to collaborate with the Innovations (INN) Learning Conference staff for Round 3 of grantee activities to plan and implement two INN Learning Conferences; scheduled for January 22, 2016 for Isolated Adults/Older Adults grants and March 24, 2016 for LGBTQI2-S grants

- 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)

D. WORKFORCE, EDUCATION & TRAINING PROGRAM SUMMARIES

- Reapply for reauthorization to provide Continuing Medical Education (CME) credits for physicians and other medical staff through the Institute of Medical Quality
- Continue to manage and enhance the Graduate Intern Stipend Program
- Continue to manage and update the Intern onboarding manual as needed
- Launched the fifth cycle of Graduate Intern Stipend Program. Current cycle included Clinical Psychology student interns pursing a Doctorate degree
- Implemented a summer program for the undergraduate career pathways program
- Continue collaborating with UCSF on developing the PMHNP student internship program
- Continue providing technical and administrative functions and support to Children's System of Care (ASOC) with the addition of the Adult System of Care (ASOC) and Conditional Release Program (CONREP) and the development of a new internship program with BHCS Pharmacy Department
- Developed memorandum of understanding with CSU East Bay, SFSU and UC Berkeley, Social Work Programs, CSU Northridge and Western New Mexico University
- Collaborated, facilitated and processed contractual agreements for three schools: Touro University, University of the Pacific, Massachusetts College of Pharmacy and Health Sciences for upcoming Pharmacy internship program with BHCS Pharmacy Department

FY 16/17 Anticipated Changes:

- Establish and create a BHCS Internship Policy that will encompass all departments and units providing internship training opportunities
- Create an intern information form specifically for internship assignments and needed information not provided on current application
- Find new and more effective ways to promote internship opportunities within the county and with the community based organizations
- Continue providing technical and administrative functions and support to CSOC with the addition of the ASOC and CONREP and Pharmacy Department
- Continue to manage and update the Intern Onboarding Manual as needed

4. Internship Program

Program Description: Coordinates academic internship programs across the ACBHCS workforce. Meets with educational institutions to publicize internship opportunities and provides training to Internship Programs.

FY 15/16 Outcomes, Impact & Challenges:

- 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
- Hired new Internship Coordinator in August 2014
- Launched third round of Graduate Intern Stipend Program in August 2014 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. Provided guidance on how to be a successful BHCS intern as past interns from various Children's System of Care (CSOC) programs shared their experience and stories
- Offered trainings to twelve graduate student interns on Cognitive Behavior Therapy with Youth,

Mindfulness Training, Motivational Interviewing, Working with Schools

- Continued to develop and implement the Psychiatric Nurse Practitioner (PMHNP) internship program in collaboration with the University of California San Francisco (UCSF), School of Nursing (SON)

- Outreached to select County clinic managers and community based organization (CBO) program directors to promote PMHNP program, identify interest, and address capacity issues

- Developed new placement sites and identified preceptors to provide supervision to students

- Conducted a workforce employment survey among BHCS Graduate Intern Stipend Awardees (recruitment strategy) to find out how many of them are currently employed within Alameda County in a behavioral health career. Data from awardees was collected from the 2011/12 - 2014/15 cycles. Of the 108 awardees, 46% responded. Of those, 48% are currently working in Alameda County. Awardees represent the ethnic and linguistic diversity within Alameda County

- Developed memorandum of understanding with San Jose State University (SJSU), Social Work Program

- Created and developed Intern Onboarding Procedural Manual to provide a reference tool and resource guide to supervisors and expedite the onboarding process clinical supervisors and student interns.

- Continue to manage and enhance the Graduate Intern Stipend Program

- Continue to manage and update the Intern onboarding manual as needed

- Launched the fifth cycle of Graduate Intern Stipend Program. Current cycle included Clinical Psychology student interns pursing a Doctorate degree

- Implemented a summer program for the undergraduate career pathways program

- Continue collaborating with UCSF on developing the PMHNP student internship program

- Continue providing technical and administrative functions and support to Children's System of Care (ASOC) with the addition of the Adult System of Care (ASOC) and Conditional Release Program (CONREP) and the development of a new internship program with BHCS Pharmacy Department

- Developed memorandum of understanding with CSU East Bay, SFSU and UC Berkeley, Social Work Programs, CSU Northridge and Western New Mexico University

- Collaborated, facilitated and processed contractual agreements for three schools: Touro University, University of the Pacific, Massachusetts College of Pharmacy and Health Sciences for upcoming Pharmacy internship program with BHCS Pharmacy Department

FY 16/17 Anticipated Changes:

- Establish and create a BHCS Internship Policy that will encompass all departments and units providing internship training opportunities
- Create an intern information form specifically for internship assignments and needed information not provided on current application
- Find new and more effective ways to promote internship opportunities within the county and with the community based organizations
- Continue providing technical and administrative functions and support to CSOC with the addition of the ASOC and CONREP and Pharmacy Department
- Continue to manage and update the Intern Onboarding Manual as needed

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 15/16 Outcomes, Impact & Challenges:

BHCS has developed and implemented the following activities:

- Planned, organized, and co-hosted the first Bright Young Minds (BYM) conference on March 16, 2015, in collaboration with Alameda County Health Pipeline Partnership (ACHPP), California Institute for Behavioral Health Solutions (CiBHS), Family Education Resource Center (FERC), Oakland Unified School District (OUSD), and Merritt College. It was a ground-breaking conference and more than 140 high school students from diverse and under-represented communities participated to explore behavioral health care career options
- Second Bright Young Minds (BYM) conference planned and co-hosted on November 4, 2015 at Samuel Merritt University, in collaboration with ACHPP, CiBHS, FERC, and OUSD. 160 students from diverse ethnic and under-represented communities participated in exploring

behavioral health care career options

- June – July 2015: Provided behavioral health workshops to 30 high school and college students at the Mentoring in Medicine and Science (MIMS) summer program. During their seven week training and internship program, WET coordinated activities, such as workshops in various mental health topics, a panel presentation, "speed mentoring" with a variety of behavioral health care professionals, and site visits to CBO service sites

- Collaborated with Berkeley City College (BCC), Public and Human Services Program, on the Peer Personnel Training and Placement grant. BCC as the primary applicant received the grant for
  $500, 000 for training and placement of people with lived experience

- BCC continued to teach wellness, recovery and resiliency focused curriculum- Introduction to Behavioral Health (HUSV 117) which was developed and written by BHCS

- The WET Manager served on California State University East Bay's School of Social Work Advisory Committee and Berkeley City College's Public and Human Services Advisory Committee

- Developed and provided a three unit curriculum on Co-Occurring Conditions to BCC for curriculum committee's review and approval

- BCC integrated the Co-Occurring Conditions curriculum into their existing health education classes

- The curriculum is currently being reviewed by BCC and the Peralta Community College curriculum committee and will be forwarded to the State Chancellor's office for final review and approval

- Co-hosted third Bright Young Minds (BYM) conference on March 23, 2016 at Cal-State East Bay to expose and encourage economically and educationally disadvantaged and or underrepresented high school students to pursue careers in behavioral health. Collaborators are ACBHCS, ACHPP, CiBHS, FERC, Cal State East Bay STEM Program, and Hayward Unified School District. Target student participation is 150 from the Hayward, San Leandro, San Lorenzo, and Castro Valley Unified School.

- Hosted a planning group to discuss ideas and strategies to provide undergraduate students an opportunity to get an in-depth understanding about mental/behavioral health careers

- Offered summer internship opportunity to 30 undergraduate students who are pursuing education in the fields of Human Services, Sociology, Psychology, Social Work or Nursing

- Community Health for Asian Americans (CHAA) implemented a pilot mental health paraprofessional leadership training program for unserved and underserved new and emerging immigrant and refugee communities funded by WET. This program is an extension of the

existing MHSA PEI-funded API Connections program which serves unserved Asian and Pacific Islanders.
To date, of the original 13 interns, 5 graduates found employment in the Mental/Behavioral Health field at La Clinica, Lao Family Agency, CHAA and a Bhutanese Community Program in Oakland

- Provided advanced training in "primary care psychiatry" to eight primary care providers in collaboration with the UC Davis Train New Trainers (TNT) Primary Care Psychiatric Fellowship Program

- Currently providing clinical education and experience to one selected UCSF Psychiatric Fellow at the BHCS Trust Clinic

- Working in collaboration with the Merritt College, Medical Assisting Program to create educational opportunities for BHCS consumers to enroll in the Medical Assisting Program

- Collaborated with the Alameda County Health Care Services Agency, Alameda County Health Care Pipeline Program, Oakland Unified School District and the Greater Bay Area Mental Health and Education Workforce Collaborative to provide a one day conference for high school students to have an introduction to behavioral health careers in March 2016. 75 high school students from diverse and under-represented communities participated to explore behavioral health care career options

- WET in collaboration with HCSA, ACHPP and OUSD participated in a 5-week summer internship for high school students from OUSD. 23 tenth and eleventh grade students were exposed to a variety of health careers and opportunities

- WET provided teacher externship opportunity to five OUSD teachers in collaboration with HCSA

- Collaborated with Chabot Community College, Mills College, McClymonds High School, Albany High School and Mentoring in Medicine and Science to provide education activities related to introducing students to careers in Behavioral Health Care. Over 150 students from diverse ethnic and under-represented communities participated in exploring behavioral health care career options

- Co-hosting the fourth Bright Young Minds (BYM) conference on November 9, 2016 at Samuel Merritt University to expose and encourage economically and educationally disadvantaged and or underrepresented high school students to pursue careers in behavioral health. Collaborators are ACHPP and CiBHS

- 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

- Continue offering co-occurring conditions classes at BCC, Public and Human Services Program

- Continue implementing Mental Health High School Career Pathways Project including organizing additional conferences on introducing high school students to behavioral health career

FY 16/17 Anticipated Changes:

- Contract extension for La Clinica de la Raza, Inc. to continue implementing the High School Behavioral/Mental Health Career Pathways Project for additional 12 months

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 15/16 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 updated the existing eligibility criteria for the Loan Assumption Program, with an emphasis on increasing workforce diversity and language capacity as well as addressing hard to fill positions and skill sets

- 38 clinicians in County and contract Community Based Organization (CBO) settings received up to $10,000 towards their outstanding student loans

- Conducted a workforce employment retention survey among Alameda County MHLAP awardees from 2009 – 2014 cycles. The goal was to find out how many of them retained employment within Alameda County in a behavioral health career. Of the 106 awardees, 62% responded. Of those, 89 % are currently working in Alameda County. Awardees represent the ethnic and linguistic diversity within Alameda County

D. WORKFORCE, EDUCATION & TRAINING PROGRAM SUMMARIES

- Provided three MHLAP technical assistance application workshops to county and CBO staff
- Continue to provide employment verification support to applicants and serve as the liaison between applicants and State MHLAP staff
- BHCS Graduate Intern Stipend Program (recruitment strategy)
    - Launched and administered the third round of the stipend program in August 2014 with a focus on interns across system
    - Awarded 35 stipends in the amount of $6,000 for 720 internship hours. Of the 35 awardees, 74% represent the diverse communities of Alameda County
- BHCS continued to partner with OSHPD to implement the State Mental Health Loan Assumption Program (a vital retention strategy)
- Provided two MHLAP technical assistance application workshops to county and CBO staff
- Continue to provide employment verification support to applicants and serve as the liaison between applicants and MHLAP staff
- 51 clinicians in County and contract Community Based Organization (CBO) settings received up to $10,000 towards their outstanding student loans
- Launched the 4th and 5th cycles of the BHCS Graduate Intern Stipend Program in August 2015 and 2016
- In 2015, awarded 31 stipends in the amount of $6,000 for 720 internship hours worked. Of the 31 awardees, 80% represent the diverse communities of Alameda County
- Explored the feasibility of participation in the federally designated California Health Professional Shortage Area (HPSA) State Loan Repayment Program (SLRP)

FY 16/17 Anticipated Changes:

- BHCS WET does not expect any significant program implementation changes during FY 16-17