MENTAL HEALTH SERVICES ACT ALAMEDA COUNTY

FY 2025-2026

ANNUAL PLAN UPDATE (APPROVED)



Approved by the Alameda County Board of Supervisors
on October 7, 2025

Behavioral Health Department
Alameda County Health

MENTAL HEALTH SERVICES ACT: FY25-26 ANNUAL PLAN UPDATE

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MESSAGE FROM THE ACBHD DIRECTOR



Welcome to the Fiscal Year (FY) 2025-2026 Mental Health Services Act (MHSA) Program and Expenditure Plan Update. This is the final year of our Alameda County Behavioral Health Department MHSA Three-Year Plan. This pivotal time marks both the culmination of MHSA as we know it and a bridge towards the future under the Behavioral Health Services Act (BHSA).

As the Director of the Alameda County Behavioral Health Department, I am profoundly grateful for the dedication and partnership of our stakeholders, community members, and employees. Together, we have made significant strides towards our shared vision of accessible, equitable, and culturally responsive behavioral health services. For example, during FY 24-25 we acquired and closed on the capital property for the African American Wellness Hub; we expanded Peer Respite services for the Re-entry community through the opening of a new peer respite program; and we successfully implemented a second round of Capacity-building grants for our mental health and substance use disorder provider network. Our focus remains steadfast on addressing the growing and complex needs of our communities while adhering to our guiding principles: Community Collaboration, Cultural Responsiveness, Consumer and Family Empowerment, Integrated Services, and a Wellness and Recovery orientation.

This final MHSA Plan Update highlights our progress and reflects on the impact of your collective input. Notably, together, we've championed innovative programs, supported individuals on their recovery journeys, and addressed systemic inequities. These accomplishments underscore the transformative power of the expansive twenty-year MHSA framework and remind us of the importance of maintaining our momentum as we transition into the BHSA era.

In this year of significant transition, our department is preparing for the implementation of Proposition 1 in July 2026. BHSA will usher in both changes and opportunities, including expanding Full-Service Partnerships (FSP), re-evaluating programs to incorporate substance use disorder services, and ensuring a seamless integration of the forthcoming housing initiatives. Our focus will remain on building a robust, sustainable infrastructure that prioritizes the well-being of those we serve.

As we reflect on this historic moment in the field of behavioral health, I encourage all stakeholders, community members and employees to continue sharing your insights and experiences. Your voice is vital as we continue to chart the course for a more inclusive and resilient behavioral health system. Community engagement will remain central to our planning process, and we are committed to keeping you informed and involved.

Thank you for your continued partnership and dedication to this transformative work.

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

With gratitude,

Karyn L. Tribble, PsyD, LCSW
Director, Alameda County Behavioral Health Department

Alameda County Behavioral Health Mission and Vision

Our Mission

To support and empower individuals experiencing mental health and substance use conditions along their path towards wellness, recovery, and resiliency.

Our Vision

We envision a community where all individuals and their families can successfully realize their potential and pursue their dreams where stigma and discrimination against those with mental health and/or alcohol and drug issues are remnants of the past.

Our Values

A-C-B-H-C-S: Our values represent who we are and who we strive to be!

A **ACCESS** We value collaborative partnerships with peers and consumers, families, service providers, agencies and communities, where every door is the right door for welcoming people with complex needs and assisting them along their journey towards wellness, resilience, and recovery.

C **CONSUMER & FAMILY EMPOWERMENT** We value, support, and encourage individuals and their families to exercise their authority to make decisions, choose from a range of available options, and to develop their full capacity to think, speak, and act effectively in their own interest and on behalf of others they represent.

B **BEST PRACTICES** We value clinical excellence through the use of best practices, promising community-driven ideas, and effective outcomes, including prevention and early intervention strategies, to promote well-being and optimal quality of life. We value business excellence and responsible stewardship through revenue maximization and the wise and cost-effective use of public resources.

H **HEALTH & WELLNESS** We value the integration of psychological, emotional, spiritual and physical health care to promote the wellness and resilience of individuals recovering from the multi-dimensional effects of mental illness and substance use disorders.

C **CULTURALLY RESPONSIVE** We honor the voices, strengths, leadership, practices, language and life experience of ethnically and culturally diverse individuals and their families across the lifespan. We value operationalizing these experiences in our service settings, collaborative treatment planning, and the strategies we use to engage our communities.

S **SOCIALLY INCLUSIVE** We value advocacy and education to eliminate stigma, discrimination, isolation, and misunderstanding of persons experiences mental illness, trauma, and substance abuse disorders. We support social inclusion and the full participation of our clients, consumers, patients, and family members to achieve fuller lives in communities of their choice – where they can live, learn, love, work, play, and pray in safety, security, and acceptance.

In addition, our guiding principles are Community Collaboration, Cultural Competence, Client Driven, Family Driven, Wellness Recovery & Resilience, & Integrated service experience for clients & family.

Alameda County Behavioral Health Care Services Department (ACBHD) is pleased to present the Mental Health Services Act (MHSA) Annual Update for fiscal year 2025-2026.

This Annual Plan Update outlines MHSA program funding, program objectives, and the strategies that were implemented to determine the effectiveness of the MHSA programs. MHSA funding allows for five required components: Community Services and Supports (CSS); Prevention and Early Intervention (PEI); Innovation (INN); Workforce Education and Training (WET), and Capital Facilities & Technology (CFTN).

Final Year of the California's Mental Health Services Act

The Mental Health Services Act was passed by California voters in 2004. MHSA, also known as Proposition 63, is a one percent tax on personal annual incomes exceeding one million dollars. MHSA supports mental health services through five components, described in the paragraph above, for individuals with both mental illness and inadequate access to the traditional public mental health system. Alameda County MHSA Division has focused on serving the population with the following goals and values: improving quality of life, effective services, outreach & family involvement, increasing access, and reducing inequities. Alameda County MHSA funds programs for: individuals with serious mental illness (SMI) and/ or severe emotional disorder (SED), individuals not served/underserved by current mental health system. Services must be in a voluntary setting and cannot be used to provide services in jail or a locked facility and cannot replace existing program funding or being used for non-mental health programs.

This plan will reflect the final year of MHSA. There have been numerous success stories throughout the decades, which are highlighted later in this plan.

Behavioral Health Services Act

In March 2024, the California voters passed Proposition 1, which includes the Behavioral Health Services Act (BHSA). The Behavioral Health Services Act aims to build upon existing efforts to support vulnerable populations with severe mental health conditions and substance use disorders (SUDs), focusing specifically on individuals with the most significant needs. BHSA shifts focus from shift from prevention, intervention, and treatment across the mental health spectrum to focus on the **most severely mentally ill individuals**. BHSA also introduces strategies and resources to address housing stability, substance use disorders, initiatives to increase accountability and transparency, and early intervention programming to prevent mental illness and substance use disorders from becoming severe and disabling.

Beginning July 2026, BHSA funding components will replace MHSA funding components. The new BHSA funding components include (1) Housing Interventions (30%), (2) Full-Service Partnerships (35%) and (3) Behavioral Health Services & Supports (35%).

The Alameda County Behavioral Health Department (ACBHD) is in the process of receiving and analyzing information from the State of California Department of Health Care Services (DHCS). As more information is disseminated, Alameda County will continue to analyze existing programs to determine sustainability under the new BHSA guidelines and to prepare for program migrations from MHSA to BHSA.

Expanded CPPP under BHSA, New format for Three Year Integrated Plan

The Community Program Planning Process (CPPP) under BHSA will play a more significant role in program planning, planning execution and community involvement. DHCS has indicated that the CPPP will have an expanded stakeholder group of 24 groups who represent diverse viewpoints. To facilitate a smooth transition to BHSA requirements, ACBHD began engaging the expanded stakeholder list in fall 2024 to provide education, build relationships, acquire data, and allow stakeholders to provide feedback on key planning decisions. ACBHD is committed to incorporating meaningful stakeholders and community feedback in areas such as mental health and substance use disorder policy, program planning and implementation, monitoring, workforce, quality improvement, evaluation, health equity,

and budget allocations. The methods ACBHD utilized to acquire meaningful stakeholder feedback and community engagement included: public comment, public hearings, stakeholder workgroups and committees, listening sessions, focus groups, surveys, key informant interviews or engaging with subject matter experts, training & education, and outreach.

Additionally, a new format for the Three Year Integrated Plan will be required under BHSA. The first Integrated Plan will be submitted to DHCS on July 1, 2026. The Integrated Plan will need to be approved by the Alameda County Board of Supervisors Health Committee and the Alameda County Board of Supervisors. The Three-Year Integrated Plan will include fiscal expenditures, program reporting and monitoring, transparency requirements, and the new CPPP (listed above). The Integrated Plan and BHSA requirements are public and set by DHCS. The Integrated Plan will be submitted through a DHCS online portal and is subject to public comment. More information will be provided on BHSA as DHCS finalizes the BHSA Policy Manual.

Program Update and Changes

Several critical areas were identified and prioritized through the planning process, and focused on a spectrum of behavioral health services and support needs. A variety of key cultural and community-centered strategies, forensic alternatives, crisis stabilization programming and engagement, and support strategies targeting persons most challenged by serious mental illness were prioritized. These programs include, but are not limited to:

- Continued analysis and transition of Service Team Case Management Model to Full Service Partnership Model
- New Outreach and Engagement Pilot: Project Pet
- Implementation Status of two Forensic Focused INN Programs
- Implementation Status of Final INN Project: Psychiatric Advance Directives (PADs Phase II)
- Completion of the MHSA required Capacity Assessment
- African American Wellness Hub Update
- MHSA Technology Project (TN1)
- MHSA Community Investment Opportunity: Second Round

Mental Health Services Act Expenditures

The importance of MHSA support is well known to our department, as it's currently 26% of the overall ACBHD budget. For State Fiscal Year (FY) 25/26, ACBHD set aside up to $227,631,576 million in budget authority, which is just slightly higher than the previous fiscal year of 2024-25 at $216,803,036 but is 16% higher than the FY 23/24 budget. ACBHD has been able to continue this positive budget trajectory due to increased allocation amounts from the State.

Closing

In summary, ACBHD leaders are actively reflecting on the impact and successes of MHSA and how it has transformed mental health in Alameda County. ACBHD is grateful that MHSA has had a positive influence on generations of residents, and we look forward to new opportunities to serve Alameda County residents under BHSA. ACBHD is optimistic about the benefits that BHSA can provide, such as the inclusion of substance use services, housing interventions, and early intervention programming. Our leadership recognizes that there will be a transition phase as we transition into the new funding components and, importantly, we look forward to including the community as we embark upon this significant change. Our goal is to maintain enhanced stakeholder participation to ensure that ACBHD is able to incorporate the voices of the many culturally and geographically diverse communities, stakeholder and advocacy groups and providers throughout our large and vibrant County. We are pleased to share the final MHSA Annual Plan Update FY25/26 with our community, to celebrate the past accomplishments under MHSA, and to look toward the future together, in ongoing partnership and collaboration.

Summary of Changes From Previous MHSA Plan Update (FY 24/25)

Alameda County Behavioral Health Department (ACBHD) began implementation of its MHSA Plan in 2007 upon receipt of the approval of our Community Services & Supports (CSS) component plan by the California Department of Mental Health. Subsequently, ACBHD received approval of four additional component Plans: *Prevention & Early Intervention (PEI); Workforce Education & Training (WET) Capital Facilities and Technology (CFTN) and Innovation (INN)*, which account for the full MHSA funding received by Alameda County1. The below programs are planned for implementation over the next several fiscal years. Small icons have been added to each summary to denote if a project is in the development phase, is in process or has been or is about to be implemented.

 = in process  = in development  = about to be implemented

I. Community Services and Supports (CSS)

a. Continued analysis of Case Management Models for alignment with Proposition 1 required Intensive Case Management services

b. New Outreach and Engagement Pilot: Project Pet

II. Prevention and Early Intervention (PEI)

No changes to the PEI component from FY 24/25

III. Innovations (INN)

a. Implementation of final approved INN Program

IV. Workforce, Education and Training (WET)

No changes to the WET component from FY 23/24

V. Capital Facilities and Technological Needs (CFTN)

a. African American Wellness Hub Update

b. Electronic Health Record System Update

VI. MHSA Community Investment Opportunity: Second Round

I. Community Services and Supports (CSS)



Continued analysis of Case Management Models for alignment with Proposition 1 required Intensive Case Management services

Per the language under the Behavioral Health Services Act in Proposition 1, within the Full-Service Partnership component each county will be required to provide eligible adults and older adults, with two levels of outpatient coordinated care depending on individualized need for service intensity. The two levels are Assertive Community Treatment (ACT), a stand-alone evidence-based practice (EBP) which is the highest

intensity level, and FSP Intensive Case Management (ICM), which can be a standardized step-down level from ACT, or provided in order to avert the higher ACT level of care.

FSP ICM is for individuals who may not meet ACT eligibility criteria but still have significant behavioral health needs and can benefit from intensive outpatient supports. Individuals stepping down from either the ACT model FSP services or an FSP ICM who no longer meet the threshold for FSP level of need can receive outpatient mental health (MH) and substance use disorder (SUD) services, which will be funded through Behavioral Health Services and Supports (BHSS) component starting in FY 26/27.

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

New Outreach and Engagement Pilot: Project Pet

In FY 25/26 ACBHD will plan and launch Project Pet. This is an innovative mental health outreach, engagement, and referral program strategy that leverages the human-animal bond and supportive connections between people and their pets as a path to connect individuals living with behavioral health challenges to treatment and other supportive services and to increase protective factors such as resilience and stability. In the engagement process, Project Pet delivers resources, such as pet food and pet wellness resources, basic veterinary resources and referrals, and the opportunity to learn dog training as a basic skill and as an integration between mental health and animal welfare.

Project Pet is a new contractor to BHD and will be fiscally sponsored by Felton Institute's Scaling and Optimization Service Technical Assistance Division. This innovative project aligns with and supports ACBHD's True North metric of *delivering high quality programming that adapts to the emerging needs of participants.*

II. Prevention and Early Intervention (PEI)

No changes to the PEI component from FY 24/25

III. Innovation (INN)

Implementation Status of two Forensic Focused INN Programs

In January 2023, ACBHD received approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) for two new forensic focused 5-year pilot programs. Brief descriptions are listed below. Please see the INN section for additional details. For full program proposals please see the Appendix of the FY 22/23 MHSA Plan Update.

INN 7: Forensic Alternatives: Clinical Focus

The planning and implementation for two of the three services and is underway. Final development for one area remains outstanding (Forensic Crisis Residential Treatment) as ACBHD's CBO partner is awaiting additional funds to be released from the Behavioral Health Continuum Infrastructure Program (BHCIP). The Forensic Crisis Residential Treatment program is a combination of MHSA INN funds and BHCIP funds. This project is a collection of three (3) integrated services that are intended to prevent incarceration and divert individuals from the criminal justice system into the mental health services. The services include:

= in process = in development = about to be implemented

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

INN 8: Forensic Alternatives: Peer Focus

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

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

Please see the INN section for more information on these programs.

Implementation Status of Final INN Project: Psychiatric Advance Directives (PADs Phase II)

INN 9: Psychiatric Advance Directives (PADs Phase II)

In November 2024 the Mental Health Services Oversight and Accountability Commission approved ACBHD's proposal to join Phase II of the statewide multi-county Psychiatric Advanced Directive (PADs) Project. A PAD is a legal document that details a person's preferences for treatment decisions during a mental health crisis.

The PADs Innovation project is a time-limited, multi-county effort that seeks to implement the training and use of PADs across multiple counties, with the goal of developing a standardized PAD training, digital template and platform to create and access PADs.

Phase II will begin in Fiscal Year 25/26 and will include the digital template pilot phase. Up to 15 counties, including Alameda, will be participating in Phase II, representing one-quarter of the counties in the State of California.

Alameda's PADs commitment is for 3 years with a budget of $3M dollars. These funds will be encumbered and will not be at risk for reversion when the Behavioral Health Services Act is implemented on July 1, 2026.

For more information please visit the project's website PADs CA - Psychiatric Advance Directives and or watch this 5-minute video: https://youtu.be/cy8GAAVrxh8.

IV. Workforce, Education and Training (WET)

WET Action 2: Completion of the MHSA required Capacity Assessment

The ACBHD WET unit completed the MHSA required workforce needs assessment survey mid FY 24/25. This assessment will help inform any program implementation changes during FY 25-26 and beyond. Per

the California Code of Regulations, each county shall conduct the Workforce Needs Assessment at least once every five years. The assessment covers the education and training needs of its Public Mental Health System workforce and identifies and evaluates current workforce needs. Specific requirements can be found here. This most recent assessment can be found in the appendix of this Annual Update.

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

V. Capital Facilities and Technological Needs (CFTN)

African American Wellness Hub Update

In FY 24/25 ACBHD, in partnership with the Alameda County General Services Agency (GSA) department, purchased a property at 1912 Martin Luther King Jr. Way in Oakland for the development of the African American Wellness Hub Complex (HUB). The Hub will be designed to serve as a space where those in need of services may walk in to receive and benefit from consistent, reliable and welcoming services that are culturally reflective and engaging. The overarching goal will be to support individuals through services that aim to prevent crises, or acute service needs, by facilitating a collaborative and person centered location with services provided by a team dedicated to equitable and culturally appropriate services.

As a next step in the development process, ACBHD, GSA and the Alameda County Board of Supervisors are in discussion regarding construction and renovation ideas and associated costs. The MHSA Team will post additional updates on its website (ACMHSA.org) when they are available

MHSA Technology Project (TN1) update under CFTN

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

Implementation of new billing system: ACBHD continues to partner with the vendor Streamline Healthcare Solutions, LLC, to implement a fully integrated billing system on the SmartCare Platform to replace INSYST (our department's legacy registration and billing platform). Streamline and the integrated SmartCare Platform continue to work on the functionality necessary to ensure staff and contracted providers work together within a robust and comprehensive system.

SmartCare is currently in use, however there are still changes and upgrades needed in order for the system to operate in a smooth and efficient manner. The ACBHD IS Team is working with the vendor on an ongoing basis to rectify these issues.

Procurement process for new Behavioral Health Management Information System (EHR) (non- billing portion): ACBHD is set to begin planning the procurement process in 2025 for the additional clinical components of an EHR system. An informational update on this process will be shared once the process is finalized.

VI. MHSA Community Investment Opportunity: Second Round

In FY 23/24 ACBHD developed a new, time-limited opportunity for the intention to invest a total of $10,000,000 of unexpended MHSA and 2011 Realignment funds, into our community-based organization (CBO) contracted provider community. This opportunity was highly successful in terms of increasing staff retention, creating comfortable, welcoming and safe facilities, increased technology capacity and increased access to services through expanded transportation. See the Appendix section for a summary report on Round One.

= in process = in development = about to be implemented

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

Each contracted provider will be eligible to apply for up to $90,000 through an official procurement request process called a Request for Pre-Qualification (RFPQ). The eligible areas of funding include:

1. System Transformation and Legislative Change Capacity Building initiatives will support system transformation and legislative change related to Senate Bill (SB) 43, CARE Court, Proposition 1, and Cal AIM (California Advancing and Innovating Medi-Cal) payment reform and documentation requirements. These initiatives may include program enhancements, training, consultation/technical assistance, and program development.

2. Workforce Support will fund priorities such as enhanced staff recruitment, onboarding, and retention activities, including signing and one-time retention bonuses.

3. Infrastructure, Technology, and Renovations will fund expenditures such as computer systems, software, hardware, or facility renovations to benefit clients and staff. This category will be funded with MHSA Capital Facilities and Technological Needs (CFTN) funding.

4. Transportation Supports will fund costs such as replacement or new vehicles, or repair of existing vehicles. Bidders must demonstrate that all ongoing operational costs of vehicles will be covered, as contract adjustments for ongoing costs related to purchases of vehicles made with FY 25-26 Enhancement Funds will not be included during the annual contract renewal process.

5. Health Equity Supports and Coordination will support CBOs in key areas such as trauma informed trainings or capacity building, consultation and technical assistance, translation and promotion of culturally responsive materials, enhancement of diversity programs, and development of culturally tailored services.

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

MHSA Funding Summary



The MHSA Funding Summary highlights expenditures for the Fiscal Year 2025-2026. The first page of the fiscal sheets provides a summary of the overall spending from the MHSA fund. The remaining pages of the fiscal summary provide insight into the different components of MHSA: Community Services and Supports, Prevention and Early Intervention, Innovation, Workforce Education and Training, and Capital Facilities and Technological Needs.

FY 2025/26 Mental Health Services Act Annual Update Funding Summary

County: Alameda Date: Date: 9/18/25

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2025/26 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	93,082,969	4,343,618	13,171,835	1,972,432	11,827,036	
2. Estimated New FY 2025/26 Funding	105,255,906	26,313,976	6,924,731			
3. Transfer in FY 2025/26[a/]	(19,000,000)			8,000,000	11,000,000	
4. Access Local Prudent Reserve in FY 2025/26						
5. Estimated Available Funding for FY 2025/26	179,338,875	30,657,595	20,096,566	9,972,432	22,827,036	
B. Estimated FY 2025/26 MHSA Expenditures	164,707,058	25,842,594	5,187,745	9,371,675	22,522,504	
G. Estimated FY 2025/26 Unspent Fund Balance	14,631,817	4,815,001	14,908,821	600,757	304,532	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2025	14,593,038
2. Contributions to the Local Prudent Reserve in FY 2025/26	0
3. Distributions from the Local Prudent Reserve in FY 2025/26	0
4. Estimated Local Prudent Reserve Balance on June 30, 2026	14,593,038

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

FY 2025/26 Mental Health Services Act Annual Update Community Services and Supports (CSS) Funding

County: Alameda

Date: 9/18/25

		Fiscal Year 2025/26					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs							
FSP 3	Support Housing for TAY	3,703,750	3,645,010	58,740			-
FSP 4	Greater Hope Project	5,224,161	3,213,359	2,010,802			-
FSP 10	Housing Services	25,449,597	24,149,389	507,105			793,103
FSP 11	Community Conservatorship	819,645	409,823	409,823			-
FSP 12	Assisted Outpatient Treatment	887,949	443,975	443,975			-
FSP 13	CHANGES	3,840,534	3,814,912	25,622			-
FSP 14	STRIDES	3,839,021	3,789,522	49,499			-
FSP 16	Connections FSP	1,174,913	527,184	647,729			-
FSP 17	East Bay Wrap 8-18	1,035,822	623,928	411,894			-
FSP 18	Homeless Engagement	5,382,752	5,364,157	18,595			-
FSP 19	North County Senior Homeless	4,166,700	2,486,707	1,679,993			-
FSP 20	Lasting Independence Forensic Team	3,703,324	3,681,714	21,610			-
FSP 21	Prevention, Advocacy, Innovation, Growth, and	1,851,657	1,811,086	40,571			-
FSP 22	Justice and Mental Health Recovery	5,298,744	3,375,268	1,923,476			-
FSP 23	Adult Service Team	13,428,646	6,118,684	7,309,962			-
FSP 24	TAY Forensic FSP	1,860,549	1,860,549	-			-
FSP 25	Care Court FSP	2,820,768	2,820,768	-			-
Non-FSP Programs							
OESD 4A	Mobile Integrated Assess Team for Seniors	1,173,998	571,225	602,774			-
OESD 5A	Crisis Response Program	9,137,548	8,100,848	861,647			175,052
OESD 7	Mental Health Court Specialist Program	1,123,813	960,837	162,976			-
OESD 8	Juvenile Justice Transformation of Guidance Clinic	203,219	142,253	60,966			-
OESD 9	Multisystemic Therapy	1,035,030	1,035,030	-			-
OESD 11	Crisis Stabilization Service	13,686,037	9,655,286	4,030,751			-
OESD 14	Staffing to Asian Population	1,916,777	1,444,379	472,399			-
OESD 15	Staffing to Latino Population	975,499	633,631	341,869			-
OESD 17	Residential Treatment for Co-occurring Disorders	2,057,235	2,057,235	-			-
OESD 18	Wellness Center	9,655,383	8,544,645	1,107,973			2,766
OESD 19	Medication Support Services	5,131,114	3,828,228	872,057			430,829
OESD 20	Individual Placement Services	7,418,870	4,749,145	2,669,725			-
OESD 23	Crisis Residential Services	7,020,650	3,550,969	3,469,681			-
OESD 24	Schreiber Center	446,060	312,242	133,818			-
OESD 25	Behavioral Health - Primary Care Integration Project	11,983,986	10,543,447	1,168,562			271,977
OESD 26AB	Culturally-Responsive Treatment Programs for African-American Community	807,587	594,617	212,970			-
OESD 27	In Home Outreach Team	5,482,843	4,750,109	732,734			-
OESD 28	SAGE Case & Care Management	2,968,615	1,336,271	1,632,344			-
OESD 30	Peer Respite	1,204,953	1,090,389	114,564			-
OESD 31	1st Onset	1,528,122	735,371	758,613			34,138
OESD 32	Suicide Prevention/Crisis Line	1,075,165	1,075,165	-			-
OESD 33	Deaf Community Counseling Services	328,153	146,576	181,577			-
OESD 34	School-Based Behavioral Health	577,518	577,518	-			-
OESD 35	Community-Based Mental Health Outreach &	3,085,226	2,944,406	140,820			-
OESD 36	Presumptive Transfer Project	762,973	762,973	-			-
OESD 37	Re-entry Treatment Teams	8,877,862	5,507,021	3,370,840			-
OESD 38	SSI Advocacy & Support Services	2,387,670	1,228,206	236,533			922,931
OESD 39	Intensive Care Coordinaion Servcies	1,703,468	1,009,827	693,641			-
OESD 40	Capacity Building Funds	722,634	722,634	-			-
CSS Administration		24,474,545	17,935,904	6,323,702			214,939
CSS MHSA Housing Program Assigned Funds		24,637	24,637	-			-
Total CSS Program Estimated Expenditures		213,465,722	164,707,058	45,912,929	-	-	2,845,734
FSP Programs as Percent of Total		51.30%					

FY 2025/26 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: Alameda

Date: 9/18/25

		Fiscal Year 2025/26					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention							
PEI 1A	School-Based Mental Health Consultation in Preschools	1,083,785	961,854	121,932			-
PEI 1B	School-Based Mental Health Access & Linkage in Elementary, Middle, & High Schools	1,095,156	1,095,156	-			-
PEI 1C	Early Childhood Mental Health Outreach & Consultation	1,040,319	1,000,000	25,236			15,083
PEI 1D	Unaccompanied Immigrant Youth Outreach	826,466	706,060	120,406			-
PEI 4	Stigma & Discrimination Reduction Campaign	1,855,800	1,855,800	-			-
PEI 5	Outreach, Education & Consultation for Latino Community	1,941,931	1,672,974	268,957			-
PEI 6	Outreach, Education & Consultation for Asian Pacific Islander Community	3,185,088	2,604,173	502,776			78,140
PEI 7	Outreach, Education & Consultation for South Asian/Afghan Community	1,447,480	1,248,293	199,187			-
PEI 8	Outreach, Education & Consultation for Native American Community	353,500	210,122	109,973			33,406
PEI 9	Outreach, Education & Consultation for Middle Eastern Community	750,444	694,023	56,421			-
PEI 10	Outreach, Education & Consultation for African Community	353,381	282,702	70,679			-
PEI 12	Suicide Prevention/Crisis Text Line	2,134,994	2,134,994	-			-
PEI 17AB	TAY Resource Centers	983,176	983,176	-			-
PEI 19	Older Adult Peer Support	340,974	339,119	-			1,855
PEI 20A-G	Culturally Responsive PEI programs for the African American Community	2,362,530	2,353,823	-			8,707
PEI 22	LGBT Support Services	1,805,352	1,805,352	-			-
PEI 24	Sobrante Park Comm Proj	350,000	350,000	-			-
PEI 25	Trauma Informed Servcies	188,792	188,792	-			-
PEI 26	Mental Health Applications	308,999	308,999	-			-
PEI 28	Community Prevention Programming	2,482,735	2,482,735	-			-
PEI Programs - Early Intervention							-
PEI 3	Mental Health for Older Adults, Geriatric Assessment & Response Team	1,449,525	1,014,668	434,858			-
PEI Administration		2,118,185	1,549,781	568,404			-
PEI Assigned Funds							
Total PEI Program Estimated Expenditures		28,458,612	25,842,594	2,478,828	-	-	137,190

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

County: Alameda

Date: 9/18/25

		Fiscal Year 2025/26					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs							
INN 7	Forensic Alternatives: Clinical Focused	1,037,483	1,037,483	-			-
INN 8	Forensic Alternatives: Peer Focused	2,841,493	2,841,493	-			-
INN 10	Psychiatric Advance Directives	1,023,335	1,023,335	-			-
		-					
		-					
		-					
		-					
		-					
INN Administration		362,292	285,434	63,688			13,170
Total INN Program Estimated Expenditures		5,264,603	5,187,745	63,688	-	-	13,170

FY 2025/26 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Component Worksheet

County: Alameda

Date: 9/18/25

		Fiscal Year 2025/26					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs							
Action 1	Workforce Staffing & Support	1,433,601	1,003,521	430,080			-
Action 2	Training/Technical Assistance	3,610,168	3,610,168	-			-
Action 3	Mental Health Career Pathways	1,461,914	1,461,914	-			-
Action 4	Residency/Internship	511,000	511,000	-			-
Action 5	Financial Incentive	2,785,072	2,785,072	-			-
WET Administration							
Total WET Program Estimated Expenditures		9,801,755	9,371,675	430,080	-	-	-

FY 2025/26 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Alameda

Date: 9/18/25

		Fiscal Year 2025/26					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Program - Capital Facilities Projects							
CF2	Respite Bed Expansion	3,200,000	3,200,000				
CF5	AA Wellness Hub	2,000,000	2,000,000				
CF6	A Street Shelter Project	100,000	100,000				
		-					
		-					
		-					
		-					
		-					
CFTN Program - Technological Needs Projects							
TN1	Behavioral Health Management System	9,948,789	9,948,789				
TN3	County Equipment & Software Update	1,875,712	1,875,712				
TN4	Consulting Services	1,541,685	1,541,685				
TN5	Capacity Building Funds	1,961,294	1,961,294				
		-					
		-					
		-					
		-					
		-					
CFTN Administration		2,707,177	1,895,024	812,153			
Total CFTN Program Estimated Expenditures		23,334,657	22,522,504	812,153	-	-	-

Demographics



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

Alameda County sits in the center of the East Bay shoreline, squarely ensconced on its northern, eastern, and southern borders by Contra Costa, San Joaquin, and Santa Clara Counties, respectively. It's 739-square mile footprint contains 14 cities, 6 census designated places, and 16 unincorporated communities [1]. These cities run the gamut of human habitations, ranging from the thriving, dense urban streets of Oakland to the idyllic, grassy foothills surrounding Livermore and nearby unincorporated areas. The various locales also host a varied array of industries, ranging from transportation and logistics, healthcare, and technological pursuits.

Alameda's residents boast a diverse range of demographic characteristics. Its population, estimated by the US Census to be 1,622,188 people [2], is split almost evenly amongst men and women (49.6% and 50.4%, respectively) [3]. Further enriching its diverse composition is the fact that Alameda County does not contain one single Census-designated racial majority, and many residents identify as multi-racial (See Figure 1) [4]. Additionally, 23.4 % of Alameda residents identify as Hispanic or Latino [5]. Over 51% of residents speak only English, but 49% report speaking another language, such as Spanish (16.6%), an Asian-Pacific Islander language (20.3%), or an Indo-European language (9.4%) [6] (see Figure 2). Regarding age, most (60%) Alameda County residents are adults aged 25 to 69 years old; roughly 30% of the population is under 25, while approximately 10% is over 65 years old [7].

Figure 1.

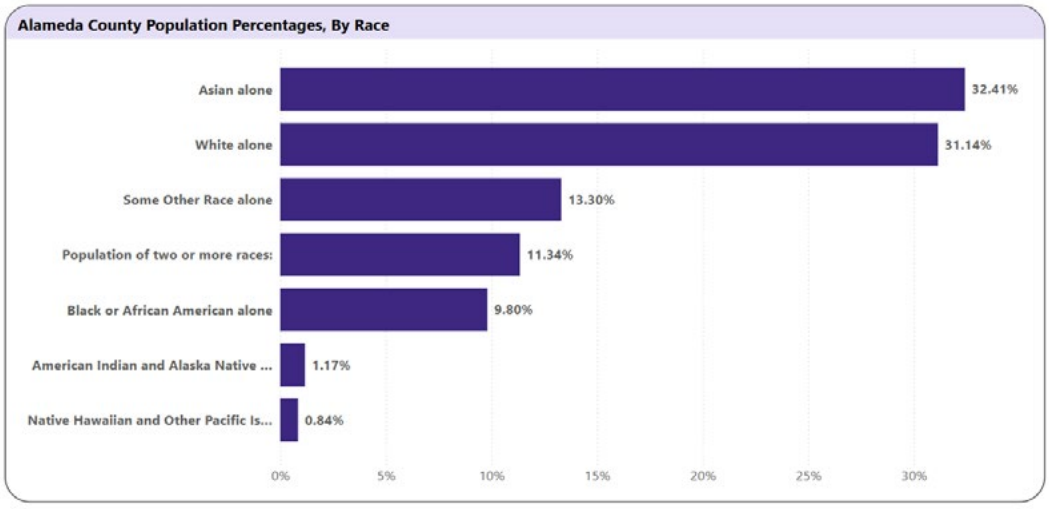
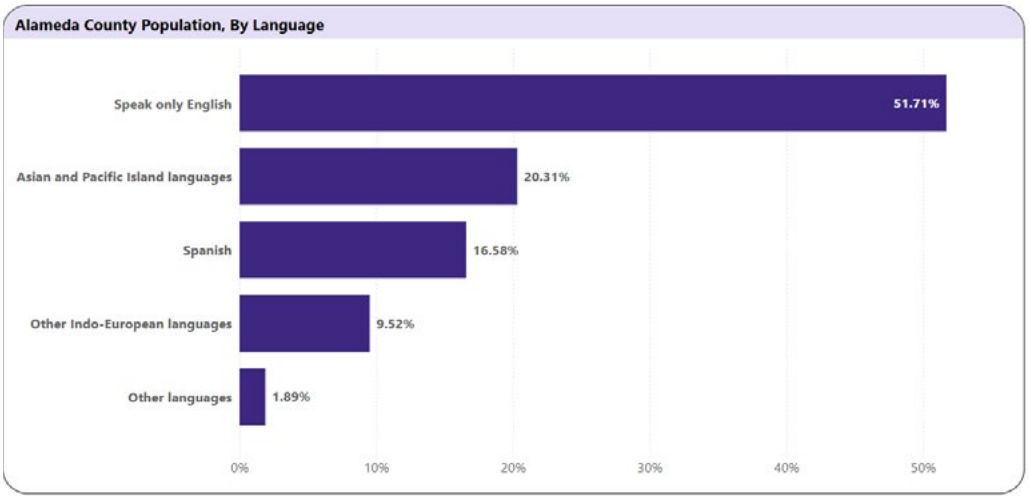


Figure 2.

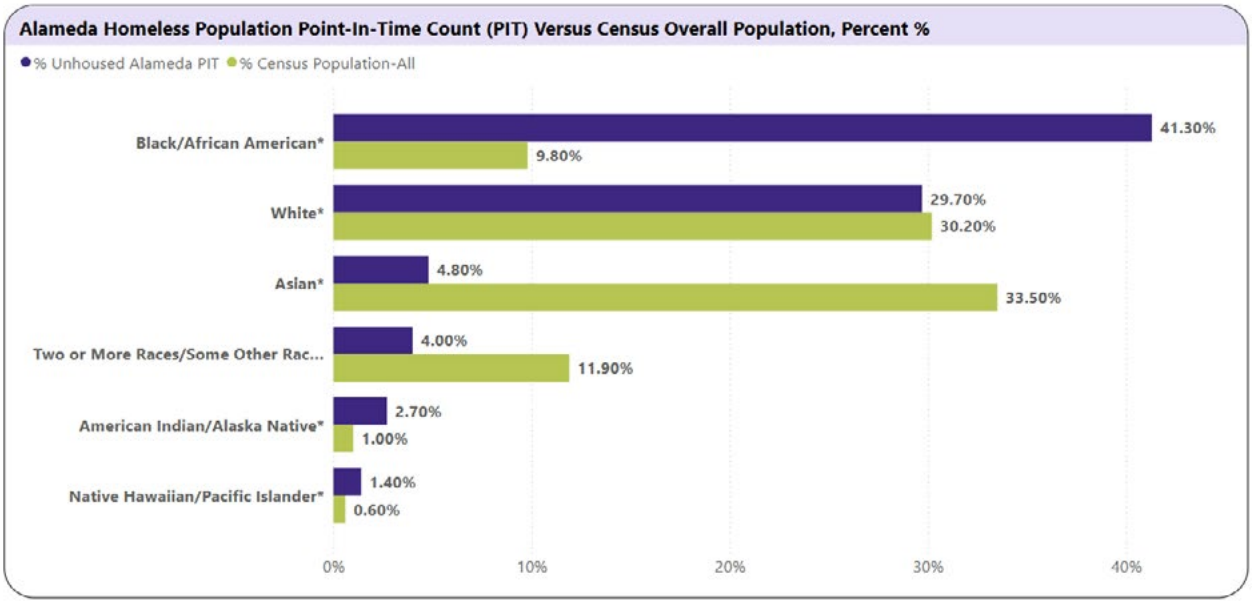


Housing/Living Status

While Alameda County offers substantial industrial opportunities for its residents, many of these folks also face challenges regarding their housing and living situation. Although Alameda has the lowest median rent of the five core Bay Area Counties1, almost 46% of residents rent their homes, and of these folks, 49% pay rents greater than or equal to 30% of their gross income [8] [9] [10]. When juxtaposed against the fact that Alameda has the second-lowest per capita income in the core Bay Area ($63,000), a picture emerges showing a significant amount of Alamedans grappling with limited resources to meet human needs such as housing [11].

Beyond this, the 2024 Alameda County Point-In-Time count of the homeless population indicates that almost 10,000 Alamedans live either without shelter (n= 6,343) or in a marginal sheltered situation (n =3,107) [SOURCE 10]. The data also indicates racial disparities with respect to the homeless population demographics: Black Alamedans represent 40% of the homeless population, but only 10% of the overall population of the county. A similar, although statistically smaller, effect is also observed for Native American Indians/Alaska Natives (2.70% unhoused versus 1% overall) and Native Hawaiians/ Pacific Islanders (1.40% unhoused versus .60% overall) [12] (see Figure 3).

Figure 3.



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

Mental Health Challenges/Needs

Alameda County residents face several mental health challenges as well. Almost a full quarter (23.8%) of adult residents surveyed by UCLA Center for Health Policy Research report a work impairment. Additionally, 25.50% of these respondents reported needing help with mental health challenges, and 17.10% reported experiencing serious psychological distress. In all three of these measures, Alameda reported mental health challenges and needs prevalences at rates second only to San Francisco with respect to the five Core Bay Area counties [13] .

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

Other indicators indicate mental and behavioral health challenges as well: according to the University of Wisconsin Population Health Institute's County Health Rankings & Roadmaps latest release, Alameda County has the second-highest drug overdose mortality rate (902.00 per 100,000) amongst the core Bay Area counties, and third highest rates for suicide (8.63 per 100,000) [17]. In terms of raw numbers, Alameda County experienced 768 suicide deaths during this period, second only to Santa Clara County [17]. Given these statistics, the fact that it has the third-highest mental health provider-to-persons ratio amongst the core counties, despite having the second-highest population, belies the need for further development and augmentation of the county's behavioral health workforce [17] (see Figure 4, see also Table 1).

Please click here to see more ACBHD Health Equity system level data.

Figure 4.

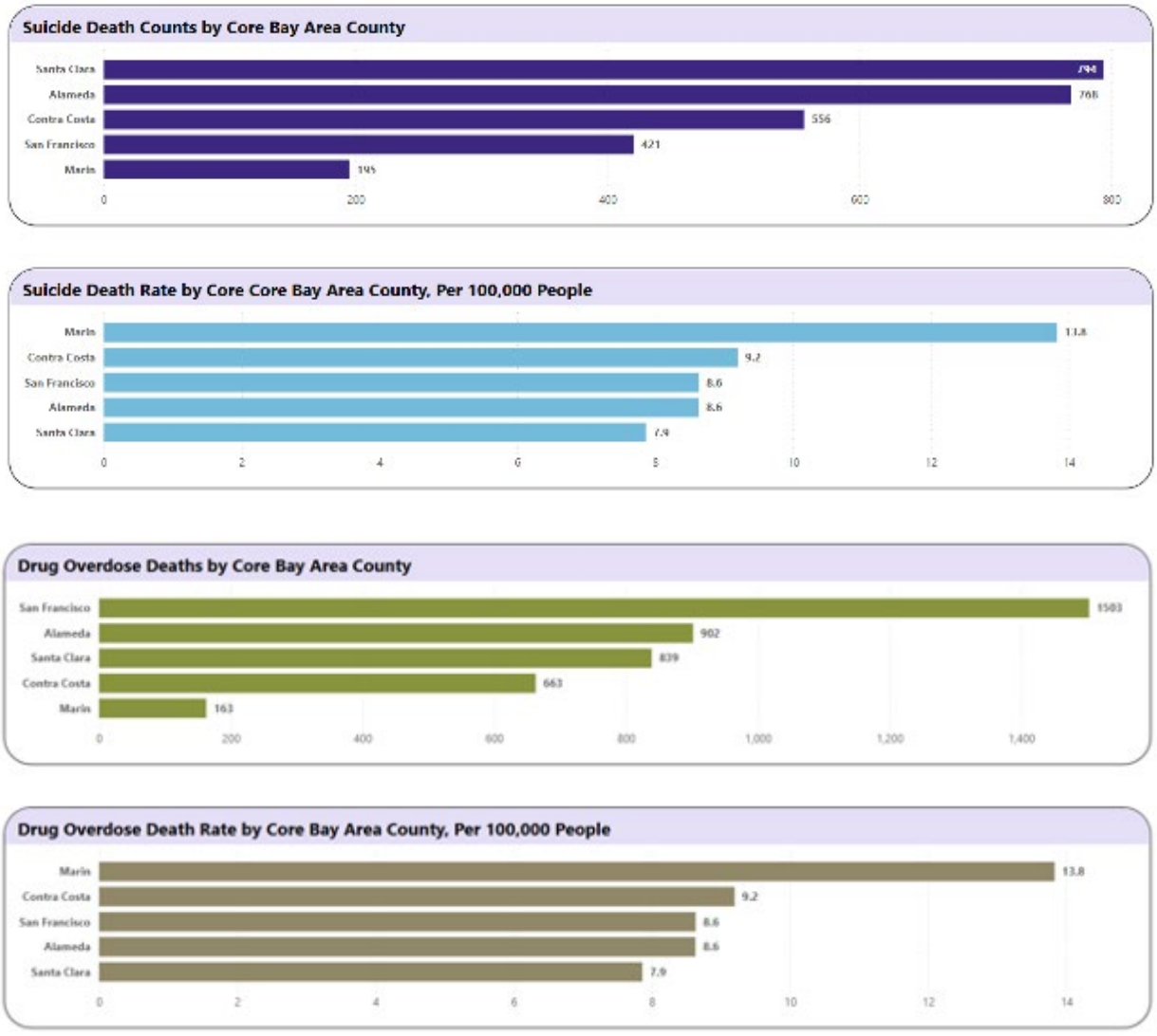


Table 1.

County	Persons-To-Mental Health Providers
Alameda	133:1
Contra Costa	249:1
Marin	110:1
San Francisco	92:1
Santa Clara	230:1

Regarding children and young adults (people aged 6 to 24 years old), data from Alameda County Behavioral Health (ACBH) data services indicates overutilization of services relevant to the general population. Children aged 6 to 17 years compose 13.98% of the overall County population but make up 24.94% of the Alameda County Mental Health services population [7] (See Figure 5). Medi-Cal penetration rates at the County levels are used to measure whether a given group of people is being adequately served with respect to mental and behavioral health needs. Data from both Alameda County and the California Department of Health Care Services indicates that, for people the under the age of 21 years, Medi-Cal penetration falls short of CDHCS-set "serious emotional disturbance (SED)" prevalence rates [14] (See Figure 6). In this case, the fact that all the major language groups fall beneath the state prevalence levels indicate that this population is not being adequately served [15]. Data from Alameda County Behavioral Health's Health Equity Division also supports this observation: children ages 0 to 15 years old have a 128% behavioral health service rate, indicating that the actual number of individuals receiving services from ACBHD providers exceeds the estimated number of individuals from a population who are at high need for behavioral health services [18].

Figure 5.

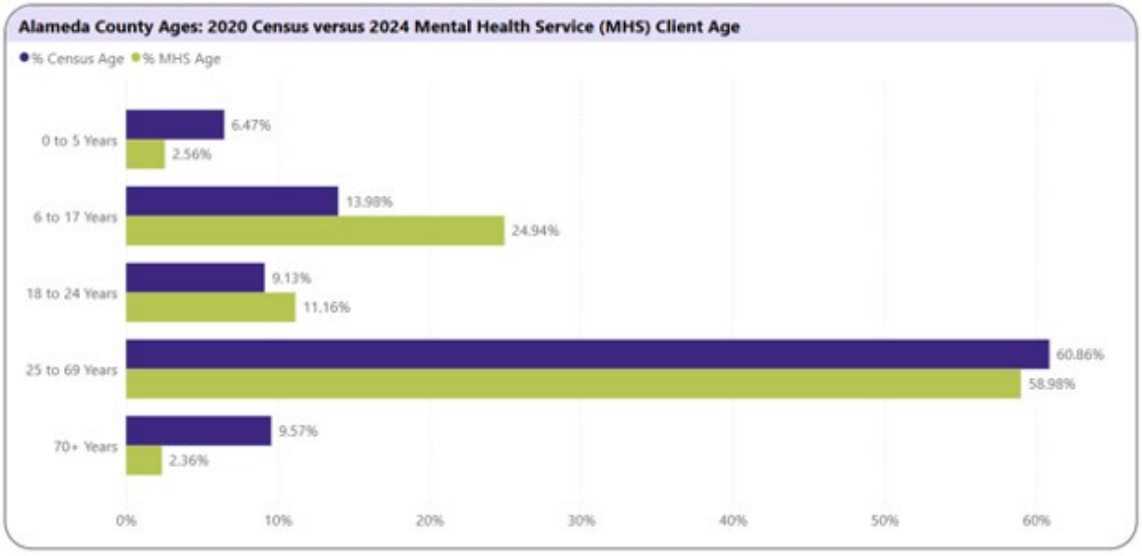
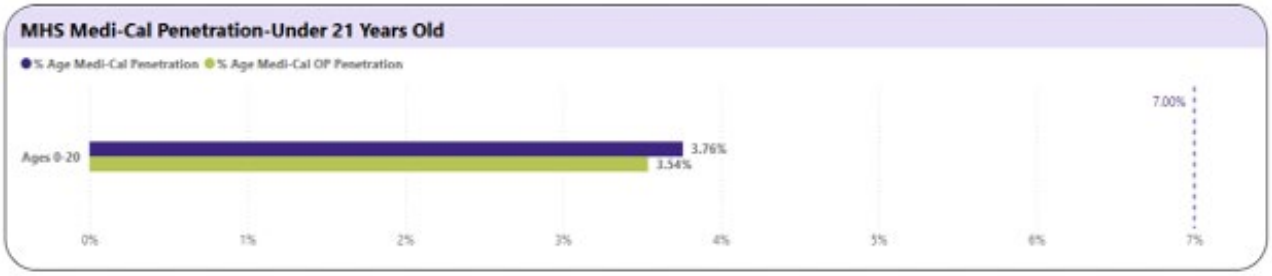
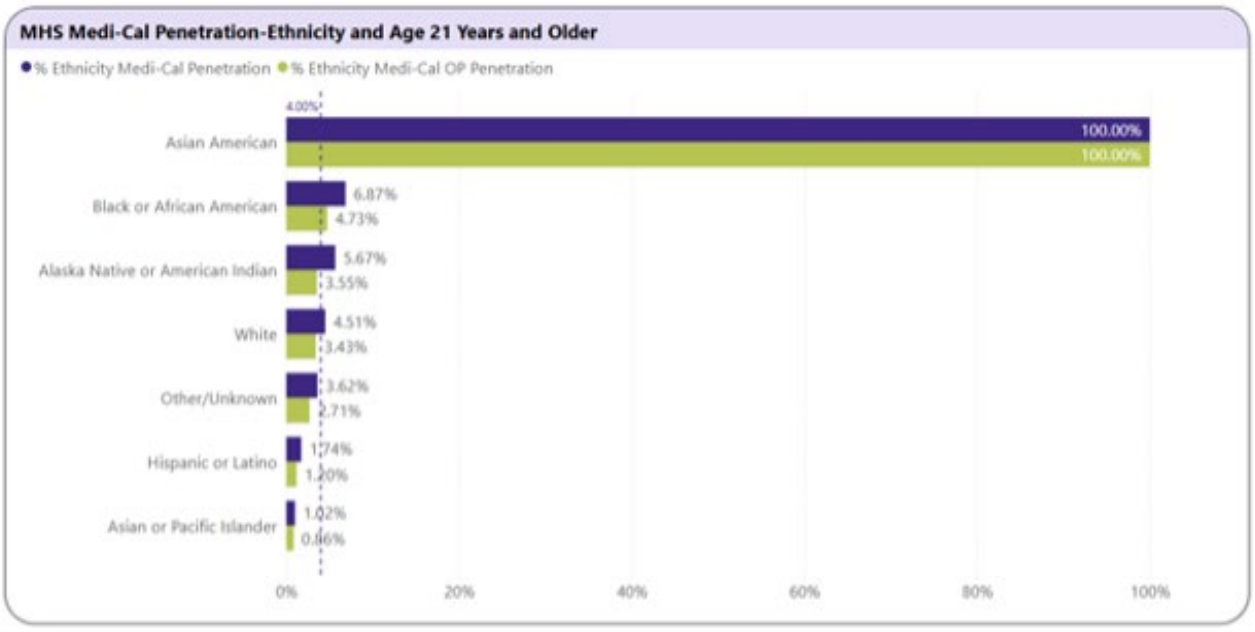


Figure 6.



A similar effect is also observed for person over 21 years old, with virtually all racial groups falling short of state the CDHCS threshold (note: the ACBH Data Services team refers to this variable type as "ethnicity" but combines Census-designation for both race and ethnicity) (See Figure 7). Similarly, the only language group with a Medi-Cal penetration rate exceeding this threshold for 4% "serious mental illness (SMI)" is English, and it only exceeds it partially, as its outpatient Medi-Cal penetration rate is below this number [15] (See Figure 8). When sliced by language groups, the Medi-Cal penetration rates both Farsi and English speakers exceeds the state-set SMI 4% prevalence rate, but all other groups fall below this number [16]. Medi-Cal penetration rates sliced along racial and ethnicity lines yield a similar profile: certain groups, such as Asian American, Black, American/Alaskan Native and meet or exceed the SMI prevalence rate level, but Others/Unknown, Hispanic, and Asian or Pacific Islander-identified people have Medi-Cal penetration rates below the 4% level [16]. In all cases, it bears repeating that Medi-Cal penetration rates falling below CDHCS threshold indicate that a given demographic may not be receiving adequate mental or behavioral health care services.

Figure 7.



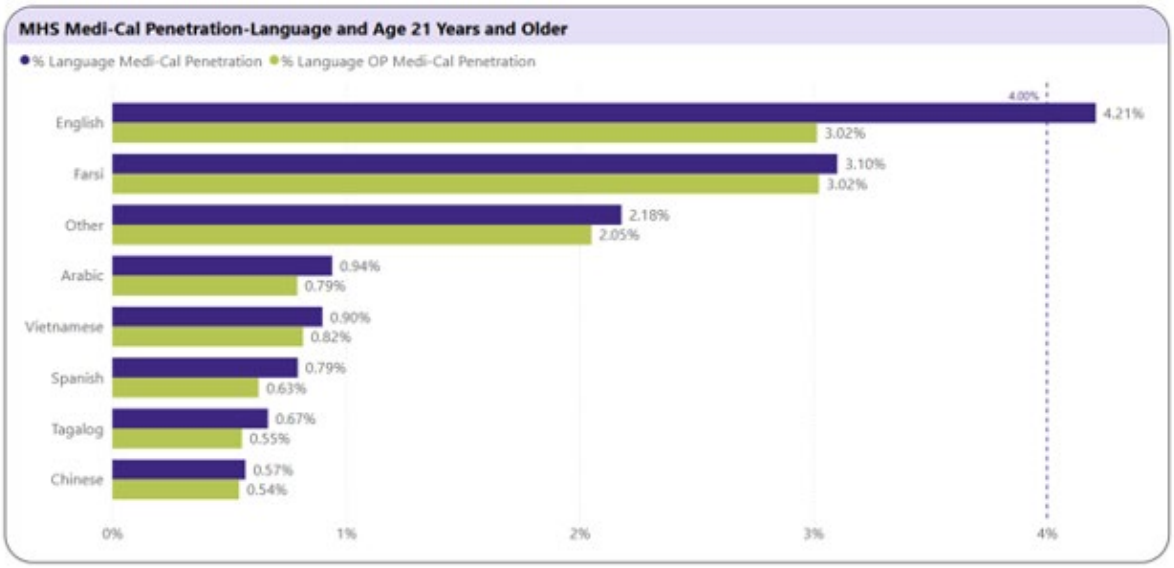
Data from the California Department of Health Care Services' ongoing Behavioral Health Continuum Infrastructure Program (BHCHIP), as well as its oversight of the Opioid Settlement Program, demonstrates both the County's need for behavioral health-related housing and pragmatic solutions to meet it. As shown in Table 2, funds from these two programs will be used to augment the number of beds and residences that will be used in addressing the housing needs of individuals experiencing behavioral

health challenges [19]. For example, adult mental health bed capacity will double under new approved expenditure plans, growing from 16 beds to 32. Similarly, significant growth with respect to projected capacity increases occurs in other settings as well (see Table 2). In addition to the approved growth figures, ACBH has pending proposal submissions to augment medical and psychiatric unit medical detox beds (6 beds) and gerontology beds (20 beds); SUD sobering centers, detox, and residential services (100 beds); and 4 medical/psychiatric beds at UCSF Children's Hospital Oakland [19].

Table 2.

Modality of Service	Current Capacity Beds/Units	New (Approved) Beds/Units	Total
Adult MH Residential	16 beds	32 beds	48 beds
Adult SUD Residential	176 daily beds	63 daily beds	239 daily or 695 beds annually
Crisis Residential Treatment	45 beds	32 beds	77 beds
Crisis Stabilization Unit	23-30 slots daily	16 slots	23-46 slots
Locked Mental Health Rehabilitation Center (MHRC)	211 beds	100 beds	311 beds
Permanent Supportive Housing	26 units	TBD based on Prop 1 Bond	TBD
Housing Support Program-Board and Care	19 homes	1 new home added 1/1/25	20 homes

Figure 8.



To address these and other behavioral health disparities and challenges, the Alameda County MHSA deploys a yearly Community Program Planning Process (CPPP). This process aligns behavioral health programming with the community stakeholder input to best meet the desires and needs of Alameda County residents' behavioral and mental healthcare needs. Leveraging a data-driven framework encapsulating 11 community-identified areas of need, the MHSA team works with diverse groups of people to strategically deploy programs and systems, in the form of workplans, in the following MHSA component areas: Community Supports and Services (CSS); Innovative Programs (INN); and Prevention and Early Intervention. Over 71 active workplans serve approximately seventy thousand individuals with an endowment exceeding $150 million dollars, placing Alameda County in a strong position to ensure that all its residents, irrespective of financial resources, will receive consistent, competent, and culturally appropriate behavioral health care (See Table: Clients Served by Component).

Moreover, the data and input captured during this and previous CPPP efforts, as well as that acquired and analyzed over the course of its daily operations, will position Alameda County to meet the new challenges and expectations set forth by the voter-approved Behavioral Health Transformation legislation. This legislation, which goes into incremental effect January 2025, promises to re-imagine and modernize California's behavioral health care system. Using a blend of programmatic and infrastructure targets and policies, these laws will impart a philosophical shift on this system, focusing on the most pressing needs of those living with serious behavioral health challenges. With its dedication to stakeholder engagement and data-driven practices, Alameda County will play a leading role in fulfilling this promise to both its own citizens and the broader body politic of California.

Clients Served by Component

MHSA Component	Clients Served (Estimate)	Work Plans	Budget
CSS	91,630	28	$154.8M
PEI	69,305	21	$26.2M
INN	New INN programs are in start up phases	3	$6.2M

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

Referenced Studies for FY 25 26 Alameda County Profile Demographic Section can be found in Appendix C-1.

MHSA Community Program Planning Process (CPPP)



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

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

The CPPP Process for the MHSA Update (FY25/26)

The MHSA Annual Plan Update FY2025/2026 Community Program Planning Process (CPPP) took place from August 15, 2024, to January 2, 2025. The CPPP was conducted across Alameda County Board of Supervisor districts to capture the different geographical regions and demographics of Alameda County. The MHSA team chose to implement the expanded 24 stakeholder list from BHSA to help guide community engagements. Although this strategy was more labor intensive, this strategy will be beneficial in the near future since new relationships with organizations and community groups have now been established. It is important to note that the MHSA Senior Planner followed and fulfilled the current MHSA CPPP stakeholder requirements by engaging 350+ organizations and community stakeholders through flyers, surveys, listening sessions, workgroups, street outreach, public comment outreach and events. In previous years, participants have had an impact by contributing recommendations and in some years led to new MHSA funded programs such as Project Pet, Early Intervention Programs for LGBTQI and the Second Round of Capacity Building Project Grants. The program planning and relationship building is ongoing and involves gathering data on participant satisfaction to guide future funding decisions and allocation. Please see below for the CPPP FY2025/2026 diagram:

The CPPP Process for the MHSA Update (FY25/26)



July 2024 – August 2024

- Evaluate previous successes, incorporate upcoming requirements, expand community relationships, and improve reporting
- Utilize MHSA Stakeholder Group and CPPP Committee to Plan and implement community engagement

September 2024 – January 2025

- Community Input Surveys
- Listening Sessions
- Key Informant Interviews
- Community Engagement Meetings

February 2025 – September 2025

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

Community Feedback & Identifying Community Needs

The MHSA team conducted a series of Listening Sessions, Key Informant Interviews, and a multilingual Community Input Survey to acquire community feedback and data. The community input data gathered through the CPPP was guided by the 11 categorized areas of community need. The categorized areas of community need help standardize surveys and conversations with community members, staff, and civic leaders. Participants ranked their top categorized needs and proposed strategies and solutions to address services gaps. The purpose of the survey and the listening sessions was not to provide service information, advice, or solve systems issues; rather, these open dialogues created a vehicle for participants to learn more about MHSA and partake in facilitated discussions to add more context to needs and to offer recommendations to gaps in services. To ensure equity and accessibility, the CPPP was available in English, Spanish, Chinese and Vietnamese.

The MHSA Senior Planner facilitated 28 listening sessions, 4 community engagement meetings and 777 community input surveys.

Listening Sessions – The MHSA team conducted 28 Listening Sessions (LS). The MHSA CPPP is guided by a required list of stakeholders that must be engaged. This is the final year of the Mental Health Services Act (MHSA), and the Behavioral Health Services Act (BHSA) begins in several months, BHSA will have an expanded stakeholder list. To build relationships with the expanded stakeholder members, the Senior Planner engaged and outreached to the new 24-member stakeholder list outlined in BHSA legislation. This strategy is useful because BHSA CPPP stakeholder engagement begins in Spring 2025 and as a result of this outreach effort new relationships have been established. Additionally, a Demographic Survey was used to capture insights and demographic profiles from the Listening Session participants.

Community Input Survey – The MHSA team conducted a 24-question survey that was available in digital format and paper format and collected 777 surveys. The survey was shared with consumers, Alameda County residents, community leaders, nonprofits, clinics, and mental health groups, advertised on social media and with Alameda County employees. The survey was offered in English, Spanish, Vietnamese and Chinese. The Community Input Survey is available in Appendix B6.

MHSA Continuous Improvement

The MHSA Continuous Improvement model consists of identifying improvement, engaging stakeholders, planning changes, applying changes, gathering community input, analyzing outcomes, replicating positive changes and repeating successes. The MHSA Annual Plan Update (FY25/26) was created and written by the ACBHD MHSA Division and the Finance team. The plan was approved by the ACBHD Executive Leadership, planning, and fiscal staff in consultation with the ACBHD Mental Health Advisory Board. ACBHD posted the plan on two websites: http:// www.ACBHDcs.org/mhsa-doccenter/ and https://acmhsa.org/reports-data/#mhsa-plans on April 1, 2025 – May 16, 2025, for forty-five (45) days for public comments. To increase plan awareness and outreach, targeted emails were sent out to various Stakeholder Groups: Mental Health Advisory Board, Alameda County Consortium of Mental Health providers. The Outreach and Engagement Plan can be found in Appendix B-1. These community engagement methods enabled Alameda County residents to express their opinions, needs, and requests of the mental health services Alameda County offers. The MHSA Team analyzed data from the various community input strategies to provide insight to ACBHD leadership and the public.

Categorized Areas of Community Need in Alameda County:

1. Access, Coordination and Navigation to Services - this category captures the needs of diverse cultures and identities such as race/ethnicity, language, LGBTQIA+, veteran status and age related to accessing mental health and substance use services, including community knowledge and education, language capacity, and successful connection to services after an emergency.

2. Behavioral Health Workforce - this category captures the needs related to recruiting, developing, supporting and maintaining a sufficient multilingual clinical and peer workforce.

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

4. Housing Continuum - this category captures the housing needs for individuals living with behavioral health challenges ranging from housing interventions and support needed to maintain housing.

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

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

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

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

9. Needs of Family Members - this category captures the ongoing stress, frustration and isolation family members can feel in taking care of their loved ones including navigation issues, need for 24/7 access to inpatient and outpatient psychiatry services, suicide prevention, caregiving support, and other related trauma services.

10. Needs of Veterans - this category captures the mental health and housing needs of Veterans: Alameda County has the 4th highest number of homeless veterans, and 2nd highest number of unsheltered homeless veterans in California. Veterans have a higher rate of poor mental health, high suicide rates, mental health stigma, lack of navigation support, lack of veteran support groups and social isolation.

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

Community Program Planning Process Committee

The MHSA CPPP Planning Committee (MHSA CPPP-PC) consists of 13 members of ACBHD employees, Providers and Community Stakeholders who meet regularly to guide and discuss CPPP activities. The MHSA CPPP-PC helps prepare, coordinate and participate in the MHSA community outreach efforts. The CPPP-PC provides input, expertise, and their professional network to ensure the continuity of services, implement assessment instruments and promote administrative transparency for all community outreach efforts. A detailed list of meeting activities can be found in Appendix A-2.

Name	Organization/Program Unit	Seat/Role
Tracy Hazelton	MHSA, Division Director	Alameda County Behavioral Health Department
Shanina Shumate	Health Human Resource Education Center (HHREC), MHSA Program Manager	CBO Provider
Odessa Caton	MHAAC Family Education Resource Center (FERC), Director	CBO Provider, Families
Noah Gallo	MHSA, Senior Planner	Alameda County Behavioral Health Department
Mark Walker	Swords to Plowshares, Deputy Director of East Bay Programs, MHSA Stakeholder Group Member	Veterans
Jon Balentine	Director, Second Chance (Recovery Residence, OS/IOS)	CBO Provider, SUD
Ingrid Chung (LCSW)	Asian Health Services, Clinical Program Manager	CBO Provider
Gina Lewis	Family Member/MHAB Member	Peer Advocate
Gavin O'Neill	Superior Court of California, County of Alameda, Collaborative Courts, Principal Analyst	Collaborative Courts, Justice Involved Individuals
Danielle Guerry	Clinical Director, Telecare	Collaborative Courts, Justice Involved Individuals
Carolina Guzman	Quality Improvement and Accreditation	Alameda County Public Health Department
Carole Wang	Mental Health Association for Chinese communities (MHAACC), Sr. Deputy Director	CBO Provider
Brian Godwin	MHSA, Data Analyst	Alameda County Behavioral Health Department

MHSA Stakeholder Group

The MHSA Stakeholders Group has been formed pursuant to Section 5848(a) of the Mental Health Services Act which requires that each plan and update shall be developed with local stakeholders that are diverse, inclusive, representatives and are accountable to the principles of community planning in the Mental Health Services Act.

The Mental Health Stakeholders Group (MHSA SG) consists of 22 mental health peers that are adults and seniors with severe mental illness, families, providers of services, law enforcement agencies, education, substance use providers, social service agencies and other important interests.

The MHSA SG meets on the 4th Friday of the month and has met 11 times in 2024. The meetings are open to the public to attend and provide comments and discussion. A detailed list of meeting activities can be found on Appendix A-1.

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

Table 4: Listening Sessions, Key Informant Interviews, and Community Engagement

Engaged Entity	Date	Region	Stakeholder Group	Children	TAY	Adults	Older Adults	Type of Engagement
AANHPI	10/24/2024	Countywide	Providers	x	x	x	x	Listening Session
ACBHD Pride Coalition	11/6/2024	Countywide	Providers	x	x	x	x	Presentation
Adults and Senior Services	10/24/2024	Countywide	Providers			x	x	Listening Session
Alameda County Office of Education School Steering Committee	11/6/2024	Countywide	Providers	x	x			Listening Session
CareConnect Women's Group	11/12/2024	Countywide	Peers, Providers			x	x	Listening Session
CHCN FQHC BH Directors	10/8/2024	Countywide	Health Care	x	x	x	x	Listening Session
CHCN Integrated Care Coordinators	10/25/2024	Countywide	Health Care	x	x	x	x	Listening Session
City of Berkeley	1/2/2024	Berkeley	City				x	Survey
City of Fremont	10/4/2024	Fremont	City	x	x	x	x	Listening Session
City of Hayward	12/6/2024	Hayward	City, Law Enforcement	x	x	x	x	Listening Session
City of Livermore	11/1/2024	Livermore	City	x	x	x	x	Survey
City of Newark	11/21/2024	Newark	City	x	x	x	x	Survey
City of Oakland	12/3/2024	Oakland	City	x	x	x	x	Survey
Civic Corps	10/11/2024	Countywide	Peers		x	x		Listening Session
Community Based Organizations	10/22/2024	Countywide	Providers	x	x	x	x	Listening Session
Core Mental Health Services	10/17/2024	Countywide	Providers	x	x	x	x	Listening Session
CPPP Advisory Group	10/17/2024	Countywide	Providers	x	x	x	x	Listening Session
Cultural Responsiveness Committee	11/19/2024	Countywide	Providers	x	x	x	x	Presentation
Disability and Regional Center Listening Session	12/5/2024	Countywide	Disability, Regional Center	x	x	x	x	Listening Session
District Health and Wellness Leads	10/3/2024	Countywide	Education	x	x			Listening Session
Early Childhood Mental Health	10/18/2024	Countywide	Early Childhood, Youth	x	x			Listening Session
HHREC - Black Women Media Wellness Project	11/9/2024	Countywide	Peers, Providers		x	x	x	Listening Session
HHREC Board	11/21/2024	Countywide	Providers			x	x	Listening Session
HomeMatch	11/4/2024	Countywide	Providers			x	x	Listening Session
Jay Mahler	11/12/2024	Countywide	Peers		x	x		Listening Session
La Familia	12/23/2024	Countywide	Providers	x	x	x	x	Listening Session
Managed Care Plans	10/18/2024	Countywide	Health Care	x	x	x	x	Listening Session
MHSA Stakeholder Group	11/15/2024	Countywide	Providers	x	x	x	x	Listening Session
NAMI Tri-Valley	11/16/2024	Tri-City	Families	x	x	x	x	Listening Session
Social Services Forum	10/29/2024	Countywide	Social Services	x	x	x	x	Listening Session
South County Partnership	11/18/2024	South County	Health Care	x	x	x	x	Presentation
St. Marys Center	10/8/2024	Oakland	Older Adults			x	x	Listening Session
UELP Meeting	11/13/2024	Countywide	Providers	x	x	x	x	Listening Session
Veteran's Listening Session	12/11/2024	Countywide	Veterans		x	x	x	Listening Session
Youth Homeless Advisory Board	11/1/2024	Countywide	Housing	x	x			Listening Session
Partnerships for Trauma Recovery	12/8/2023	Oakland	X	X	X	X		Youth, TAY, Adults, Older Adults
Veterans Collab Court	10/27/2023	Oakland			X	X		Veterans

The **28** Listening Sessions were successful at targeting the MHSA required stakeholder groups: Adults, Seniors, Families, Providers, Law Enforcement, Education, Social Services, Veterans, Health Care Organizations and other important interests. Listening Sessions consisted of targeted stakeholders in both in-person and virtual meeting formats. **265** community stakeholders participated in the FY25/26 MHSA CPPP and provided meaningful participation for strategies and solutions to mental health needs. Listening Session Participants were provided with a demographic survey to help gather additional data on their background. The Listening Sessions were uniformly structured beginning with an MHSA overview presentation, then participants had the opportunity to rank the categorized needs and share their input and recommendations for Alameda County to improve mental health services.

Participants were categorized into appropriate stakeholder categories depending on their self-reporting, background/job function and the listening session they attended. In Figure 1 data is reflective of the Listening Sessions participants and their role: Providers (38%), Peers (23%), Education (18%), Families (8%), Not listed (4%), Prefer not to answer (2%), City Representatives (2%), Health Care (2%), Disability (2%), Veteran (1%), Faith community (1%), Law Enforcement (1%). In Figure 2 data is reflective of the Listening Sessions by Stakeholder Group: Providers (64%), Peers (11%), City Representatives (7%), Education (7%), Families (4%), Peers & Providers (4%), Veterans (4%).

Figure 1: Participants by Stakeholder Group (n=265)

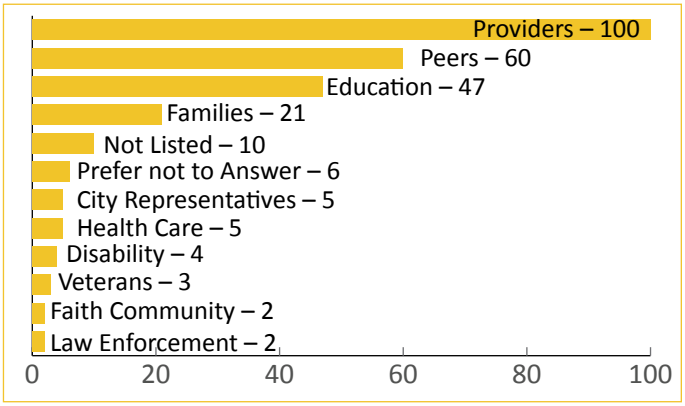
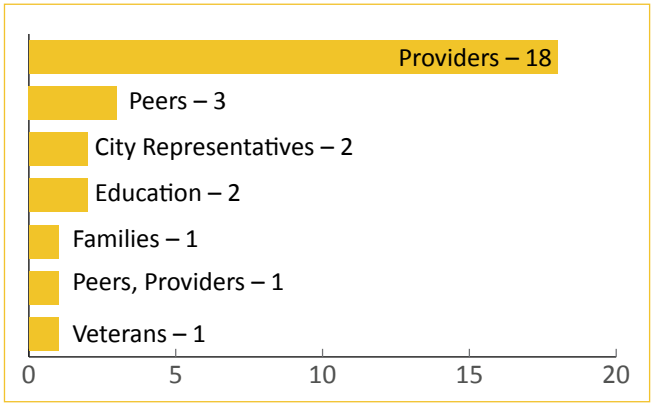
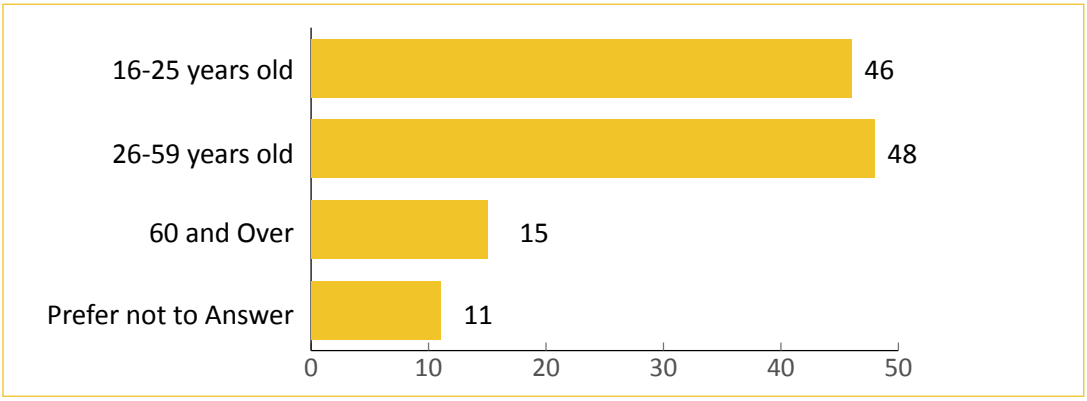


Figure 2: Sessions by Stakeholder Group (n=28)



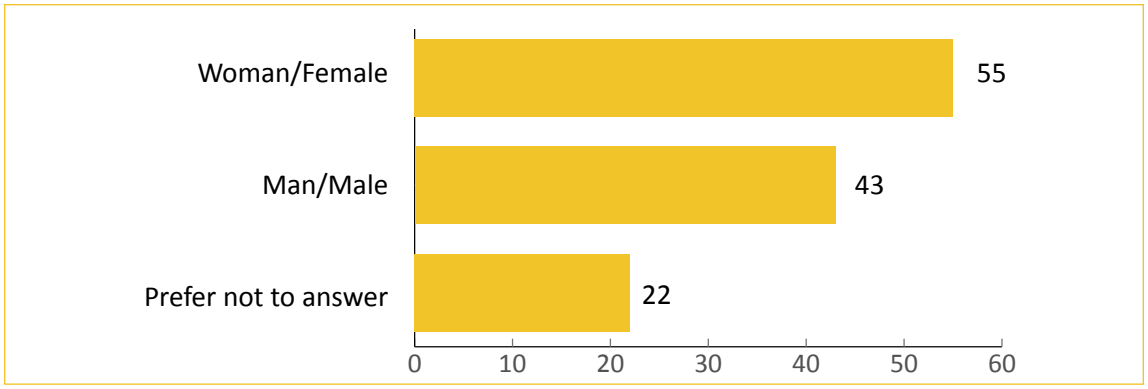
The ages of the participants that completed the demographic survey: ages 16-25 (38%), ages 26-59 (40%), 60 and over (13%) and chose not to answer (9%).

Figure 3: Participant's Age Groups (n=120)



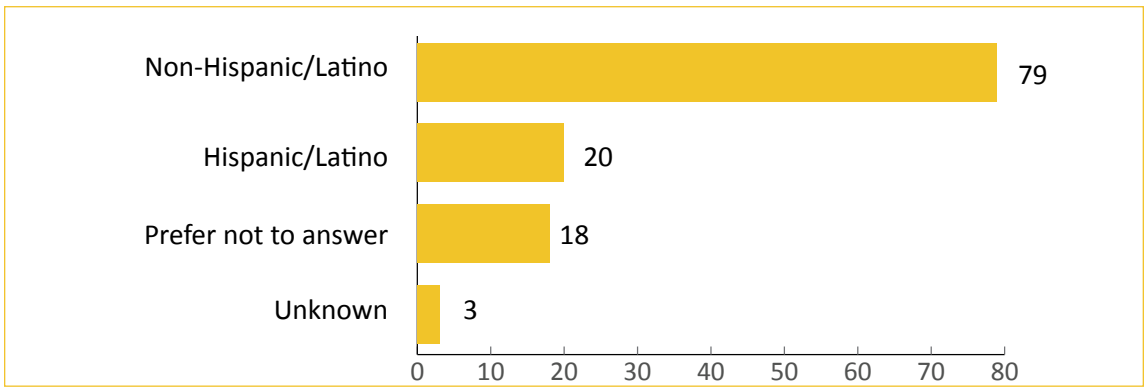
The gender of the participants that completed the demographic survey: Woman/Female (46%), Man/ Male (38%) and chose not to answer (18%).

Figure 4: Participant's Gender Identity (n=120)



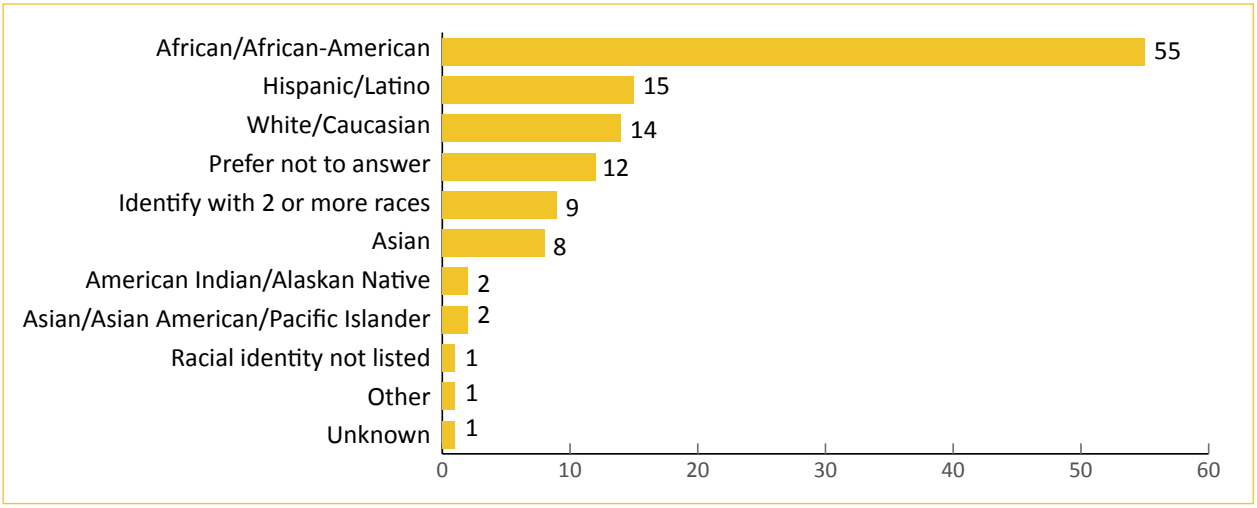
The ethnicity of the participants that completed the demographic survey: Non-Hispanic/Latino (66%), Hispanic/Latino (17%), Chose not to answer (15%), Unknown (3%).

Figure 5: Ethnicity (n=120)



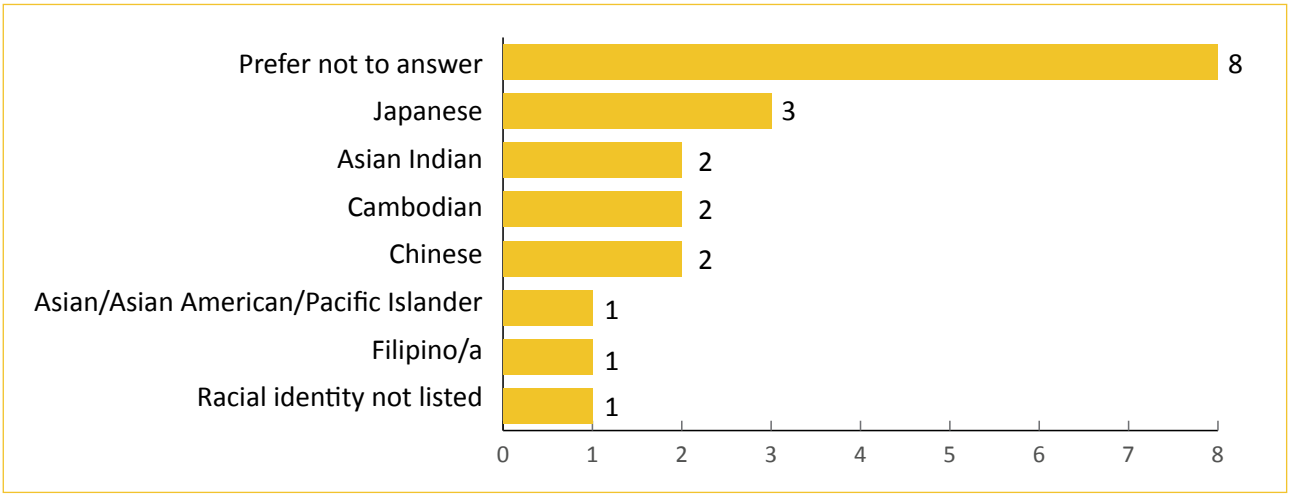
The race of the participants that completed the demographic survey: African/ African American (46%), Hispanic/Latino (13%), White/Caucasian (12%), Asian (7%), Prefer not to answer (10%), multi-racial (8%), Asian/Asian American/Pacific Islander (2%), Racial identity not listed (1%), American Indian/ Alaskan Native (1%), Other (1%), Unknown (1%).

Figure 6: Race (n=120)



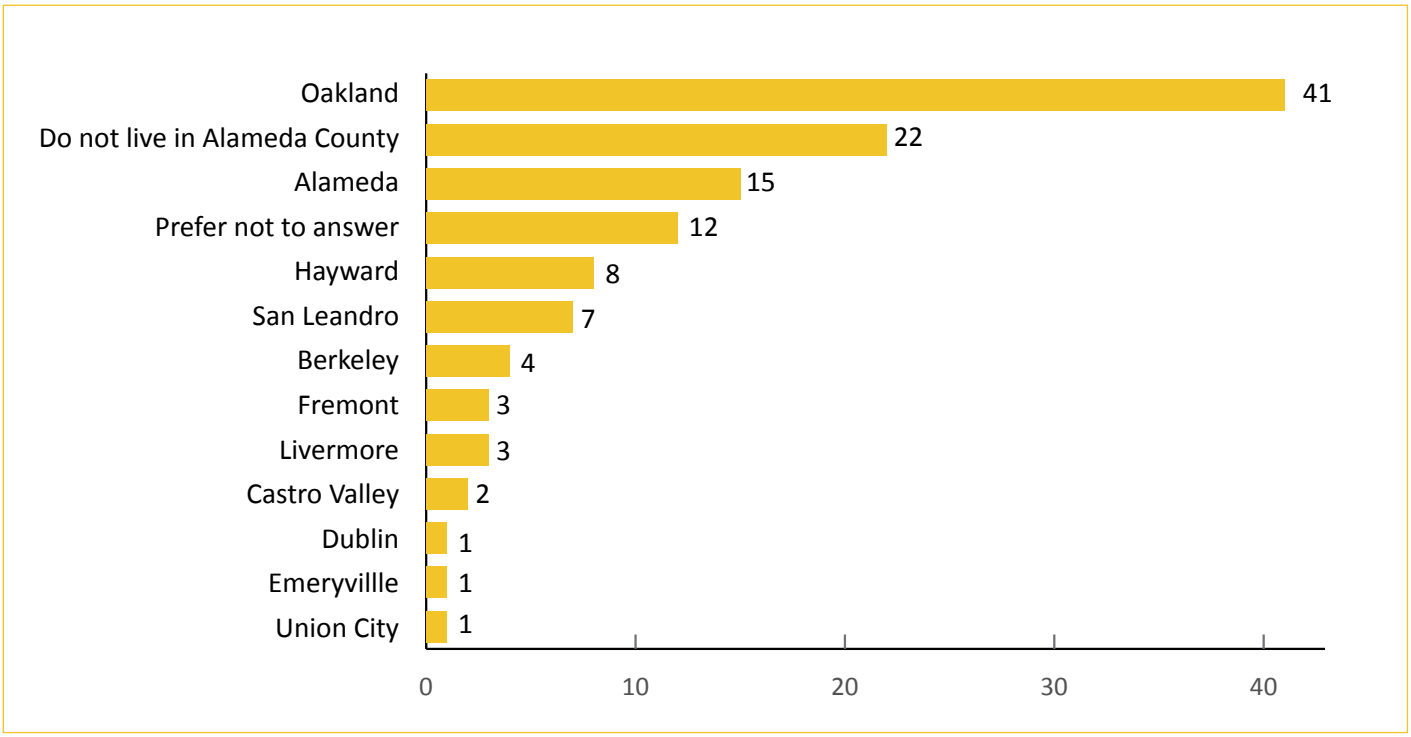
The Asian or Pacific Islander participants that completed the demographic survey indicated their ethnicity: Prefer not to answer (40%), Japanese (15%), Asian Indian (10%), Cambodian (10%), Chinese (10%), Asian/ Asian American/Pacific Islander (5%), Filipino/a (5%), Racial identity not listed (5%).

Figure 7: Asian or Pacific Islander Participant's Ethnicity (n=20)



The participants that completed the demographic survey indicated their place of residence: Oakland (34%), Do not live in Alameda County (18%), Alameda (13%), Prefer not to answer (10%), Hayward (7%), San Leandro (6%), Berkeley (3%), Fremont (3%), Livermore (3%), Castro Valley (2%), Dublin (1%), Emeryville (1%), Union City (1%).

Figure 8: Participant's City of Residence (n=120)



Recurring Themes from Listening Session

Crisis Services – Additional resources to help individuals with immediate support when experiencing a mental health crisis. Offering additional interventions to help individuals stabilize and to prevent the situation from escalating.

Resource Navigation – Ensuring individuals have access to resources either through their current program or additional navigation centers strategically placed throughout the county.

Early Psychosis – Additional programs located throughout the county designed to identify, intervene and treat individuals with early psychosis symptoms, including providing care to prevent a long-term disability.

Housing for People with Mental Health Challenges Need for expanded housing solutions combined with mental health support to help individuals maintain wellness and stability.

Support for Individuals Who are at Risk – Developing and being innovative to provide additional support systems to meet the mental health challenges of the individuals that are at risk such as those that are prone to a substance use disorder, the disability population, school age population, LGBTQ individuals, veterans, re-entry population, elderly and foster care youth.

Prevention and Early Intervention Programs Expanding programs aimed at preventing mental health issues from occurring or escalating by providing early interventions and support for individuals of all ages.

Services That Match the Level of Need – Making available, providing services and outreaching for programs that address and match the individual's mental health or substance use condition from preventive to intensive level of care.

Help with Unmet Basic Needs – Programs and outreach services that address an individual's essential needs for recovery such as food, shelter, vocational services and clothing.

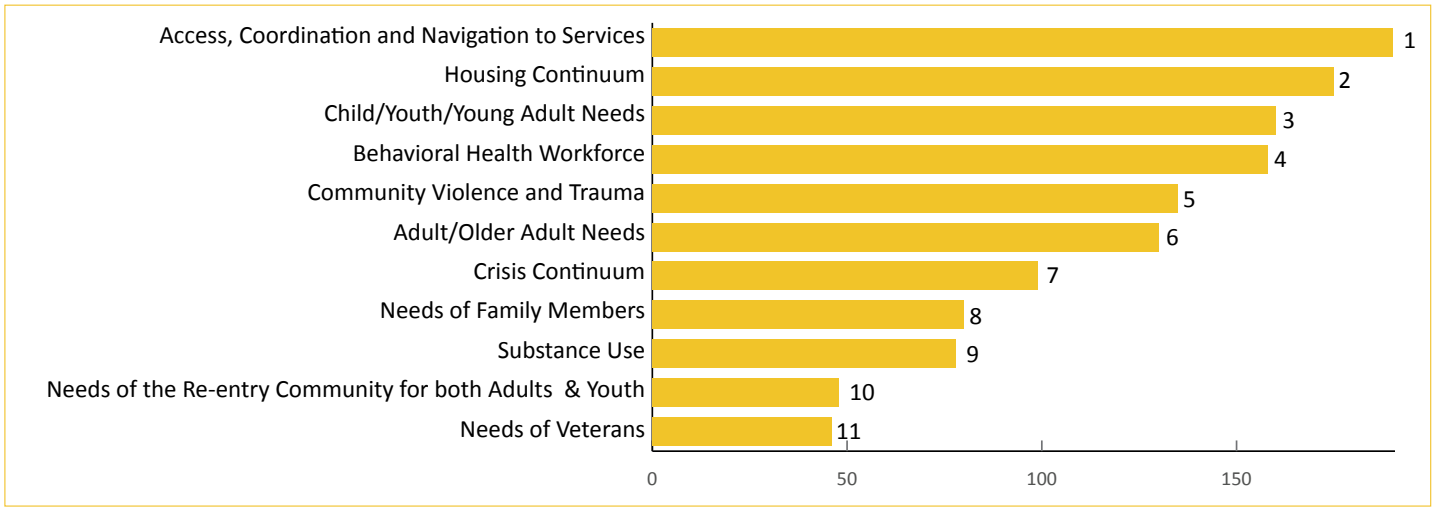
Improve Appointment Availability – Ensure that appointments for mental health services are available, possible solutions can be expanding the wait times, hours of availability, additional locations, and reducing waitlists.

Providers Who Look Like the Community Promoting a diverse workforce that reflects the cultural, racial and socio-economic makeup of the community to ensure trust and connection.

MHSA Listening Session Participants Rankings

During the Listening Sessions participants were asked to rank their top 3 choices for the categorized areas of need. Once the participants' ranking was recorded then participants shared strategies and solutions to help Alameda County address each of these needs. In the various graphs above it has been shown that the MHSA team was able to acquire feedback from the MHSA required stakeholder groups. Below are the results of the categorized needs ranked in order as provided in the listening session by stakeholders:

Figure 9: Areas of Need Ranking: Greatest to Least (n=265)



Below are the top ranked categorized needs and their most common identified strategies and solutions (per listening session results):

1. Access, Coordination and Navigation to Service (score=190)
2. Housing Continuum (score=178)
3. Child/Youth/Young Adult Needs (score=167)
4. Behavioral Health Workforce (score=163)

Listening Session Analysis

Rank #1: Access, Coordination and Navigation to Services

- **Provide additional resources** to help clients, families, and caregivers to navigate the behavioral health system to ensure that they can access services and resources in a timely manner for themselves or loved ones.
- **Increasing the accessibility of mental health resources**, mental health education, program resources through a user friendly searchable online directory. These are necessary for both clients and families to reduce barriers and connect effectively with the services in a timely manner.
- **Opening up navigation centers throughout the county** can help address mental health stigma, improve client access and coordination, and improve the efficiency of care navigation. These centers will serve as key points for guidance and support.
- **Ensuring access and availability to bilingual services and culturally competent services** is vital to help clients meet and sustain their mental health needs.
- **Integrate services to expand the behavioral health workforce** to help address clients' needs, especially for clients with housing instability and or co-occurring mental health and substance use disorders.

Rank #2: Housing Continuum

- **Provide additional housing supports**, safe spaces, and ongoing case management to help individuals address housing needs before instability begins, particularly amongst older adults with fixed incomes, foster youth, people with medical conditions, disabilities and non-English speakers.
- **Faster integration of individuals into housing** by decreasing wait times for vouchers, strengthening solutions that support board and care settings to independent community living, and enacting policy reforms to reduce barriers providing timely housing solutions.
- **Extend the transitional rent for longer than 6 months and provide housing interventions** such as rental subsidies, operating subsidies, family housing, shared housing and recovery housing.
- **Additional funding for housing programs and housing navigation centers** to help prevent housing instabilities at the first sign of potential living arrangements disruptions.

Rank #3: Child/Youth/Young Adult Needs

- **Implement early intervention programs to help identify potential challenges children may face, allowing for timely prevention and support.** Provide additional resources and implement strategies for program providers and schools to help youth cope with mental health challenges such as depression, stress, creating family boundaries and addressing unsolved generational trauma.
- **Addressing mental health needs early and often** can yield better outcomes than solely relying on regular school-based programs. A comprehensive 12-year mental health program (grades 0-12) could effectively identify and address diverse needs of children. Recommendations include enhancing the presence of social workers and counselors, funding activities, and raising salaries for these workers.
- **Additional emergency youth stabilization centers** are critical for youth who require hospitalization. It is important to have early intervention and prevention strategies incorporated into their stay to prevent future crises and improve long term outcomes.
- **Expansion of bilingual mental health services** can help ensure that non-English-speaking families are connecting with services, sometimes kids are the only one that speak English in the household.
- **Requirement of additional training courses for providers** on how to identify and address mental health needs of developmentally disabled individuals who require continued support.

Rank #4: Behavioral Health Workforce

- **To retain providers there is a need for workforce development programs that provide adequate training and support.** To help reduce burnout, strategies such as workload caps and increasing pay are incentives that can help recruit and make jobs competitive for workers.
- **Expand peer specialist programs and higher pay and opportunities.** Some of the feedback from the community was that peer specialists are opting for online positions that offer better compensation and benefits.
- **Provide incentives to ensure that the workforce is bilingual and culturally aligned.** Financial incentives with living wage adjustments can help ensure that there is enough staffing to meet the clients' needs.
- **Participants expressed a significant concern about staffing levels** for behavioral health workers and being fully staffed to support individuals of all ages with their mental health needs.
- **Establish recurring workgroups** where providers and county leaders can come together to discuss workforce recruitment and retention strategies.

Summaries of Listening Sessions

Asian American, Native Hawaiian, Pacific Islander (AANHPI)

The AANHPI group indicated that there is a growing need for integrative services for clients that require mental health support. The aging AANHPI population faces challenges of finding these services as well as housing and finding affordable housing. Some of the group voiced interest in retrofitting board and care facilities to meet the needs of the aging population and unhoused population. There is a decrease in qualified behavioral health workers that are knowledgeable of the AANHPI population and that speak different languages. Clients are having difficulty finding continued resources that facilitate access to Medi-Cal and or substance use disorder programs. Also, undocumented families are requiring support in financial management, housing, and healthcare access to better adapt to their new environment.

Adult and Senior Services

The Adult and Senior Services listening session consisted of 7 providers who met with MHSA staff to discuss the mental health needs of the Adult and Senior services community they serve. Providers served different parts of the county and reflected on the needs of the Housing Continuum and Adult/Older Adult needs as the top needs of the communities they serve. The listening session shared different ideas on how to strengthen advocacy amongst the Adult/Older Adult population to combat stigma and ensure necessary support. Housing has remained a top need as the adult/older adult population have faced increasing housing costs. There is a growing need for a navigator that can assist adults/older adults in finding resources and supportive services in a timely manner.

Alameda County of Education School Steering Committee

The MHSA team presented to the ACOE School Steering Committee to learn more about the mental health needs of the school age population. Educators will be a required stakeholder group under BHSA requirements. The top needs of the TK-12 school age population were child/youth needs, access and coordination to services and the behavioral health workforce. Several members of the group stated that teachers are not trained or well equipped to handle behavioral health needs of students in the classroom and that more support is needed. Participants also stated that families use schools to learn more about community services and that it is important for school staff to be knowledgeable of county resources. Participants also stated that substance use amongst Youth has grown and there needs to be meaningful collaboration between school and county systems so Youth can receive the help they need in a timely manner.

CareConnect Women's Group

The CareConnect listening session consisted of a mix of peers and providers. Participants agreed that a more comprehensive support network is crucial for enhancing community well-being and safety. The growing older population requires improved services and support for adults and seniors, including enhanced access to geriatric psychologists for a better quality of life, reliable transportation for healthcare and social events to reduce isolation, urgent attention to homelessness, support systems for the reentry community focused on rehabilitation and employment to lower recidivism. Participants also expressed the need for targeted programs for families offering guidance, emotional support, and streamlined access to services for veterans addressing their specific needs.

Community Health Center Network (Federally Qualified Health Centers) Behavioral Health Directors Meeting

The MHSA team met with Behavioral Health Directors from the Federally Qualified Health Centers (FQHC's) of Alameda County that are represented through the Community Health Center Network. The top needs of the 8 FQHC's were discussed along with solutions that Alameda County can provide support for which are: behavioral health workforce, access, coordination and navigation services, and community violence to trauma. Behavioral Health Directors expressed the need for more support to hire, grow and retain a licensed and multilingual behavioral health workforce. In some cases, stipends will be needed as incentives to ensure staff is properly licensed and can bill for services. There is also more need for SUD services and there are gaps in services for individuals that have a co-occurring mental health and SUD diagnosis. There is a growing need to have more crisis support for suicidal clients and to help

protect staff from issues that may arise. Also, discussed was how clients are cycling through the system of care and the need for step down diagnosis support, this issue continues to grow and hopefully will be addressed under BHSA.

Community Health Center Network (Federally Qualified Health Centers) Integrated Care Coordinators

The MHSA team met with the Integrated Care Coordinators from the Federally Qualified Health Centers (FQHC's) of Alameda County that are represented through the Community Health Center Network. The top needs of the 8 FQHC's were housing, behavioral health workforce, substance use services, and ensuring patients had access to care. Patients have expressed difficulty in applying for affordable housing and having access to people that can help them with the process. Turnover in qualified staff has been an issue in ensuring patients are getting medical, mental health and substance use services. Overall, the Care Coordinators aim to assist patients in a timely manner while improving clients' social determinants of health.

City of Fremont

The MHSA team met with leaders from the City of Fremont Human Services Division who had questions on the housing opportunities under MHSA and planning for housing changes under BHSA. Fremont is interested in accessing more funds for housing to address the aging population and the growing homeless population. Fremont also mentioned their top needs under MHSA as Housing Continuum, Adult/Older Adult Needs, Access, Coordination and Navigation to Services, Behavioral Health Workforce, Child/Youth/Young Adult Needs and the Crisis Continuum.

City of Hayward

The MHSA team met with Dr. Emily Young of the City of Hayward who oversees the Youth Family Services Bureau and School Resource Officer Programs. The top needs of the City of Hayward are the Crisis Continuum, Child/Youth/ Young Adult Needs and Access, Coordination and Navigation to Services. Dr. Young expressed the need for the continuation and possible expansion of preventive programs to help young people with their mental health needs while building life skills. There was also discussion of how effective preventive programs can alleviate and limit youth justice involvement. The City of Hayward is looking for ways to have non law enforcement responses for individuals dealing with mental health issues. They are also looking for ways to find and reengage the people that come to them for services and whose situation has not improved. Overall, the discussion was effective on how to help serve youth and young adults as well as inviting the MHSA team to events hosted by the City of Hayward and local nonprofits.

Civic Corps

The Civic Corps Listening Session took place with 53 participants in small groups of 10. The participants are trainees of the Civic Corps program, and the majority are young adults. Trainees discussed how addressing their mental health needs feels overwhelming, but participants recognize it is an essential journey toward healing and transformation. Some participants shared that their mental health journey begins with awareness, acknowledging the patterns that have been passed down through generations such as: generational trauma, unresolved trauma, breaking generational belief on mental health (boundaries, depression), breaking generational behaviors that have caused trauma. Throughout the listening session trainees agreed that services that tackle housing issues, substance abuse, and the impacts of community trauma and violence have to be addressed to foster a resilient and thriving environment and community.

Community Based Organizations

The MHSA team met with 10 providers in a listening session focusing on Community Based Organizations. During the listening session organizations shared their challenges and provided solutions to ACBHD staff. To address these challenges, it is important to create an environment (macro and micro) where families and individuals feel supported; resources are available; connections to services are readily available to address the complex needs of families and individuals. During the listening session it was stated that goals can be achieved by implementing comprehensive, community plan which includes access to community services in native languages. Increasing access to navigation tools and resources is vital for helping families connect with the appropriate services. Partnering with local organizations to navigate these resources confidently and incorporating mental health programs within schools and communities.

Core Mental Health Services

The MHSA team organized a group of 9 mental health providers from across the county to provide input on the top needs of their clients and community. The top needs from the providers were access, coordination, navigation to services, behavioral health workforce, child/youth/young adult needs, crisis continuum and needs of family members. Providers stated the need to address the social determinates of health for clients while making the mental health services directories accessible for clients. Providers mentioned that the need for multilingual staff has risen in recent years and clients seek staff that are culturally aligned to them. Providers had numerous questions on BHSA and how the early intervention regulations will affect their program and if outreach and linkage will be included in the scope. Providers detailed how their staff needs stipends to obtain their licensures as well as looking for student loan forgiveness options. Overall, the providers were eager to participate in the listening session and provide feedback from their community as well as voice questions and concerns on the upcoming BHSA implementation.

CPPP Planning Committee

MHSA legislation requires that counties institute a Community Program Planning Process – Planning Committee (CPPP-PC) that helps guide community input and outreach. Members of the CPPP-PC are listed above and consist of providers, veterans, law enforcement, health care organizations, seniors, providers of alcohol and drug services and family members. The CPPP-PC provided feedback indicating the top mental health needs of the county as being housing continuum, needs of family members, behavioral health workforce and needs of the reentry community. Housing is a top need for the community but especially for veterans, veterans need to have housing as part of their care to stabilize and improve their mental health. The veteran community states there are collaboration gaps between the VA and other resources/quality of care with the county and state. The CPPP-PC also stated that the behavioral health workforce has had position turnover, and this has impacted client service delivery. The group also expressed concern about the crisis continuum and the lack of transitional housing when folks are discharged from jail.

Disability and Regional Centers

The MHSA team conducted a Listening Session with providers from Disability and Regional Centers. These providers were interested in learning more about MHSA and BHSA and providing input from their experience working with the disability community. The top needs were child/youth/young adult needs, crisis continuum, behavioral health workforce and the housing continuum. Providers mentioned that there needs to be services and training specifically on how to address the disability population and their mental health issues. Providers mentioned that there needs to be a program or stabilization unit for disability youth who seek immediate care in hospital emergency rooms. Providers have seen a rise in substance use amongst the disabled population and some clients with mental health issues are taking substances unaware of the harm to them. The listening session was organized by the Regional Center of East Bay and included providers from other agencies. Overall, the providers were able to express input and look forward to the increased collaboration to help the disability community.

District Health Wellness Leads

The MHSA team met with the District Health Wellness Leads monthly meeting. The group consisted of behavioral health professionals and school leaders that work in TK-12 schools. The top categorized needs from the group were child/youth/young adult needs, access, coordination, navigation to services, community violence and trauma, housing continuum and the behavioral health workforce. The group focuses on youth and the need for behavioral health interventions in the classroom and beyond. The group also voiced concerns that students are not getting behavioral health treatment at home and in some instances witnessing or being victims of trauma and bringing those issues to school. For some youth the threat of deportation is weighing on their family as well as finding stable access to housing. Some parents use the school staff as navigators to find neighborhood resources and services. The group also expressed interest in keeping updated and influencing policy in the early intervention model of BHSA.

Early Child Mental Health

MHSA team attended the Early Childhood Mental Health Providers meeting and virtually presented. The

top needs of the organizations were child/youth/young adults, access, coordination, navigation to services, community violence and trauma, needs of family members, crisis continuum, and the behavioral health workforce. There is an increasing need for behavioral health services for the early childhood population which often starts with the parents being aware of services that are available to them with or without insurance. Families are having difficulty navigating and finding available services and are using the primary school to become more knowledgeable. Community violence has played a role as a top mental health issue because some of the families are witnessing violence or are victims of violence.

HHREC Black Women Media Wellness Project

Participants agreed on the interrelatedness of the 11 categorized areas of community needs that aim to support individuals, families, and community intersectionality's, focusing on children's health and stable home environments while addressing social determinants for older adults. Key points included the importance of mental health encompassing family care, self-care, and spiritual well-being. Recommendations emphasized hiring more social workers and counselors, funding activities, and improving salaries. Participants voiced the need for more community support, early assessments, and crisis strategies were made to enhance resilience, while addressing basic needs like homelessness and mental health. Access for individuals with disabilities is essential to reduce family stress, with strategies prioritizing support for children, parents, teachers, and veterans. Collaboration with religious institutions is also suggested to assist community members.

HHREC Board of Directors

The Listening Session included members of the Board of Directors of HHREC. Participants stated that by working together, agencies can leverage their collective expertise and resources to find effective solutions. However, there must be coordination amongst the agencies. Accessibility: Services should be mobile-friendly and offer alternative communication methods, with assistance for scheduling. Workforce Development: Cultural and linguistic awareness is needed to diversify the workforce. Support for Vulnerable Populations: Access to services is vital for those with mental health challenges and victims of violence, especially in the justice system. Community support programs are essential for violence reduction, focusing on youth transitioning from the justice system.

HomeMatch

In this listening session, participants discussed innovative housing approaches that prioritize early intervention to prevent crises, emphasizing the importance of on-site case management and support programs for families to strengthen relationships and community ties. Key points include the increasing demand for housing, the vital role of preventative services, and the need to support family caregivers within a continuum of care. Finally, HomeMatch staff stresses the need for effective coordination of services to help older adults navigate available resources and find the appropriate support for their needs.

Jay Mahler Recovery Center

The MHSA team conducted an in-person listening session with clients at Jay Mahler Recovery Center. The top needs expressed by the participants were child/youth/young adult needs, housing continuum, crisis continuum and needs of the reentry community. Participants expressed that behavioral health programs need to meet youth and young adults before severe mental illness begins. Housing was a top need of the group with many participants believing that housing is the first step to improving mental health. When housing is provided to behavioral health clients more community support and building security is needed to ensure a healthy living space. The group also expressed additional needs for the reentry community to prevent recidivism and to ensure that case workers made proper referrals that connected clients to resources.

La Familia

The MHSA Senior Planner met with La Familia CEO Aaron Ortiz to discuss current needs of the community and providers. The conversation discussed strategies to bring together providers from different services to help clients access services in a timelier efficient manner. Solutions discussed were workgroups and recurring meetings so providers can learn from each other's successes. This led to the next topic of the need for retaining current providers and recruiting from a dwindling workforce pool. Also, discussed was the upcoming BHSA changes and invitations to workgroups La Familia participates in.

MHSA Stakeholder Group

The MHSA team facilitated the Listening Session and presented the categorized areas of community needs to the group and obtained their votes and feedback.

The participants discussed the need for an improved Housing Continuum: to have a holistic approach, affordability to broader level of people not only the unhouse but including both housed and students who are struggling and are living in their cars. And for those with mental illness in treatment that there's an expectation for supportive housing that's beyond care with rules and guidelines to follow. It was suggested to have language that states "Supportive Housing Continuum;" and should involve transportation, access to social services and the need for workforce development on people with severe mental health illness.

The Substance Use Disorder (SUD) in Prop. 1 was brought up and they mentioned that sometimes the realm of Mental Health (MH) and SUD does not always work together, so it was suggested that there should be more robust conversation on both sides.

A focus to have Veteran allotted budget not just replacement from the State and Local government dollars, but specific mainstream funding for all Veterans that would mainly cover SUD, MH issues, BH issues etc. Since VA doesn't serve all Veterans and all their needs e.g. FSP requires a subcontract with Veterans Support Organization in order to obtain funding to serve the Veterans need.

The overall top three (3) votes of topics were identified and summarized. After which participants were given the opportunity and elucidated their choices and articulated additional concerns.

NAMI Tri-Valley

The MHSA team and HHREC Outreach Consultant led a listening session at NAMI Tri Valley located in Livermore. The majority of attendees were family members who lived in the Tri Valley area and had family members in the behavioral health system. The top needs of the attendees were access, coordination, navigation to services, housing continuum and the crisis continuum. Attendees stated that families and consumers should obtain appropriate services early on to avoid misdirection, misunderstanding and time wasted. There is also interest in building a navigation HUB in the Tri Valley area. Housing costs in the region are high, making it crucial to ensure that housing is affordable and accessible for everyone. Attendees stated that they strongly believe that a lack of stable housing can significantly impact an individual's mental health. Lastly, there was a consensus belief that law enforcement should go through routine training to handle mental health and substance use clients.

Social Services Forum

The MHSA Team organized and met with different social services providers. The providers represented different regions of the county and different demographics. The providers expressed their top needs of their community: access, coordination, navigation to services, child/youth/young adult needs, behavioral health workforce, adult/older adult needs, and needs of the reentry community. Vocational services are needed for young adults and the reentry community and also a growing need with the older population wanting to return to the workforce. Accessing services from providers who were knowledgeable of the county system and multilingual is a top need. Providers also addressed housing concerns for the new immigrant population and the retiring older adults. Providers also stressed additional collaboration with the upcoming BHSA changes to ensure programming is not disrupted.

St. Mary's Senior Center

The MHSA team kicked off the CPPP Stakeholder Engagement Process by meeting with St. Mary's Center. The Older Adult population will be a key stakeholder in the upcoming BHSA processes and with St. Mary's Center developing more mental health programming and affordable housing units – we look to revisit the site in the spring to hold more focus groups. The St. Mary's Center indicated the top needs of the older adult community being substance use, behavioral health workforce, community violence and trauma and young adult needs. St. Mary's Center has a growing population of older adults who look forward to the peer-to-peer groups to help address depression, isolation, loneliness and to be informed about services available to them. Older adult clients are also interested in workforce opportunities as most of them have retired and now are looking to reenter the workforce. St. Mary's would like the county to build modules in their immediate neighborhood to serve the older adult and homeless populations.

UELP

The MHSA team met with UELP providers who primarily served the Latino community. Providers spoke about the wide range of clients they serve from older adults to youth to the new immigrant population. There is an also increase in the number of languages they serve, and the county phone helplines should reflect this. Young adults and youth are experiencing violence and coming to providers seeking immediate consultation with mental health professionals. There is a need for behavioral health workforce that can relate to the clients, speak the language and navigate the county services to assist the client in a timely manner.

Veterans Listening Session

The MHSA team sought feedback from the veteran community and providers throughout the CPPP through listening sessions and surveys. During this listening session, the top requests were the needs of veterans, access, coordination and navigation to services, and the crisis continuum. There are requests for additional veteran serving housing support specifically transitional housing. There are community member requests to coordinate with the VA to develop programs to help find veterans that need help. Requests for more 30-day stabilization beds and the programs provide supportive services. Additionally, there have been requests for improvements to the current website to help clients search for and find services. Overall, community feedback has centered around helping veterans access services and helping veterans find stable housing.

Youth Advisory Board (YAB) – Housing and Homelessness

The MHSA team met with the facilitators of the Youth Advisory Board (YAB) for Alameda County. The YAB seeks to encourage and uplift youth representation to identify barriers to increasing housing stability. The YAB facilitators spoke with MHSA representatives about the need for housing for young adults to prevent homelessness due to housing costs. The top needs from the group were child/youth/young adult needs, housing continuum, access, coordination, navigation services, and community violence and trauma. Housing is a top need for young adults because it provides them with stability to take care of their education, health, and other services and serves as the foundation for broader health. The YAB facilitators expressed the need for continued collaboration with the MHSA team and we are planning to organize a listening session in Spring 2025 with members of the Youth Homeless Advisory Board.

Community Outreach & Engagement Materials














WE WANT TO HEAR FROM YOU!
Help shape and impact Alameda County's mental health system!
Community Program Planning Process
for the Alameda County Mental Health Services Act FY 25/26 Annual Plan Update
Behavioral Health Department
Alameda County Health
Mental Health Services Act (MHSA)
Alameda County Behavioral Health
HHREC
HEALTH & HUMAN RESOURCE EDUCATION CENTER
MHSA INVITES YOU TO TAKE THE COMMUNITY INPUT SURVEY
SURVEY IS AVAILABLE IN THREE LANGUAGES
English Spanish Chinese
Select the language of your choice on the right side of the beginning portion of the survey
CLICK HERE TO TAKE THE SURVEY
Or scan QR Code to take the survey
For more information go to www.ACMHSA.org


CHÚNG TÔI MUỐN NGHE Ý KIẾN CỦA QUÝ VỊ!
Giúp định hình và tác động đến hệ thống sức khỏe tâm thần của Quận Alameda!
Quy Trình Lập Kế Hoạch của Chương Trình Cộng Đồng
để Cập Nhật Kế Hoạch Thường Niên Năm Tài Chính 2025/2026
cho Đạo Luật Dịch Vụ Sức Khỏe Tâm Thần Quận Alameda
Behavioral Health Department
Alameda County Health
Mental Health Services Act (MHSA)
Alameda County Behavioral Health
HHREC
HEALTH & HUMAN RESOURCE EDUCATION CENTER
MHSA MỜI QUÝ VỊ THAM GIA KHẢO SÁT Ý KIẾN CỘNG ĐỒNG
KHẢO SÁT CÓ SẴN BẰNG BA NGÔN NGỮ
Tiếng Anh Tiếng Tây Ban Nha Tiếng Trung
Chọn ngôn ngữ mà quý vị muốn ở bên phải trong phần đầu của khảo sát
NHẤP VÀO ĐÂY ĐỂ THAM GIA KHẢO SÁT
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Everyone Welcome!
Provide Feedback!
Join Us Online!
Mental Health Services Act
Stakeholder Engagement Forums
You are invited to participate in the Community Program Planning Process!
This process helps determine how Alameda County allocates funds for mental health programs.
We want to hear your voice! Your input and personal experience are welcome!
The community's feedback will be included in the MHSA Annual Plan Update FY25/26.
Click links below to join the meeting on the day/time of each!
Core Mental Health Services – 10am Thursday October 17
Community Based Organizations – 10am Tuesday October 22
Adult & Senior Services – 10am Thursday October 24
Social Services & Welfare – 10am Tuesday October 29
Public Safety & Justice – 10am Tuesday November 5
Education – 10am Thursday November 7
Health Care & Insurance – 10am Thursday November 14
Youth – 4pm Tuesday December 10
Veterans – 10am Wednesday December 11
Regional & Governmental Entities – 10am Thursday December 12
Families – 10am Friday December 13
Early Childhood – 10am Tuesday December 17
Disability Population – 2pm Tuesday December 17

Most survey respondents were made up of adults aged 26-59 (63%), older adults aged 60 and over (22%) and transitional age youth ages 16-25 (9%), while 71% identified as woman/female, 19% identified as man/male, and 4% identified as transgender, gender queer/gender fluid, two-spirit or non-binary. See Figure 1 & 2.

Figure 1: Participant's Age Groups (n=777)

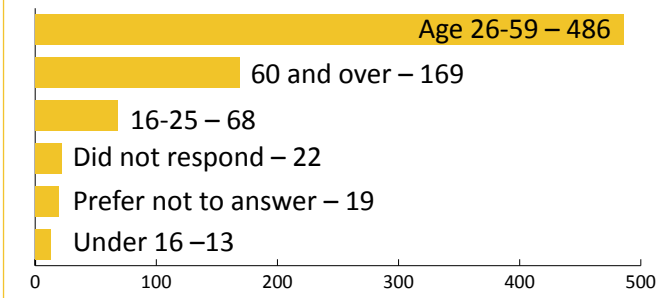
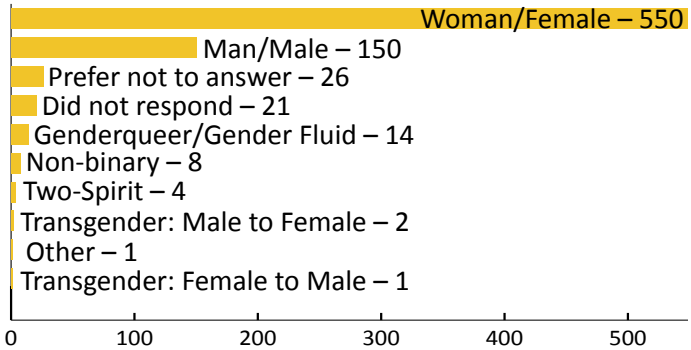
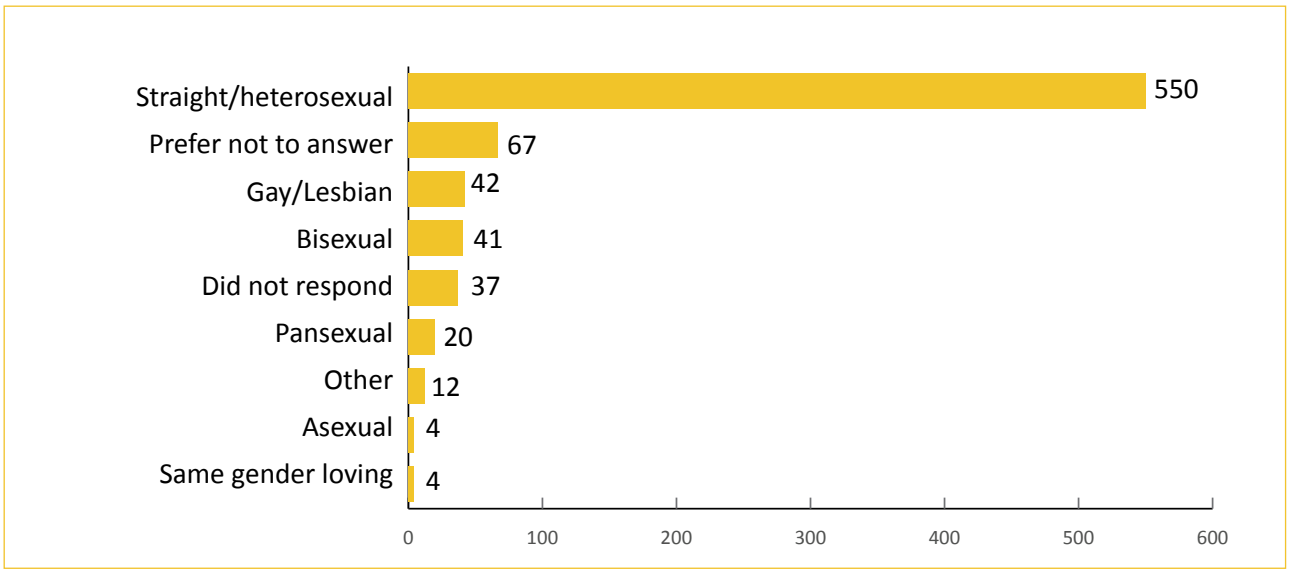


Figure 2: Participant's Gender Identity (n=777)



Survey participants were asked to optionally provide information about their sexual identity. Most survey respondents (71%) identified as straight/heterosexual, (14%) identified under one of the LGBTIQA+ identities and (9%) preferred not to answer or provided a blank answer to this question. See Figure 3.

Figure 3: Participant's Sexual Identity (n=777)



65% of survey respondents reported being a resident of Alameda County, while 26% stated they worked in Alameda County and 13% were a part of the behavioral health, SUD or wellness workforce. 40% of survey respondents reported Oakland as their city of resident residence or place of work, while 12% of respondents stated living or working outside of Alameda County. Other participant residence locations included Hayward (10%), Alameda, Fremont, Berkeley, and San Leandro (each with 5-9% of responses respectively), while other cities represent less than 5% of survey responses. See Figure 4a and 4b.

Figure 4a: Resident, Workforce and Relations to Alameda County (n=777)

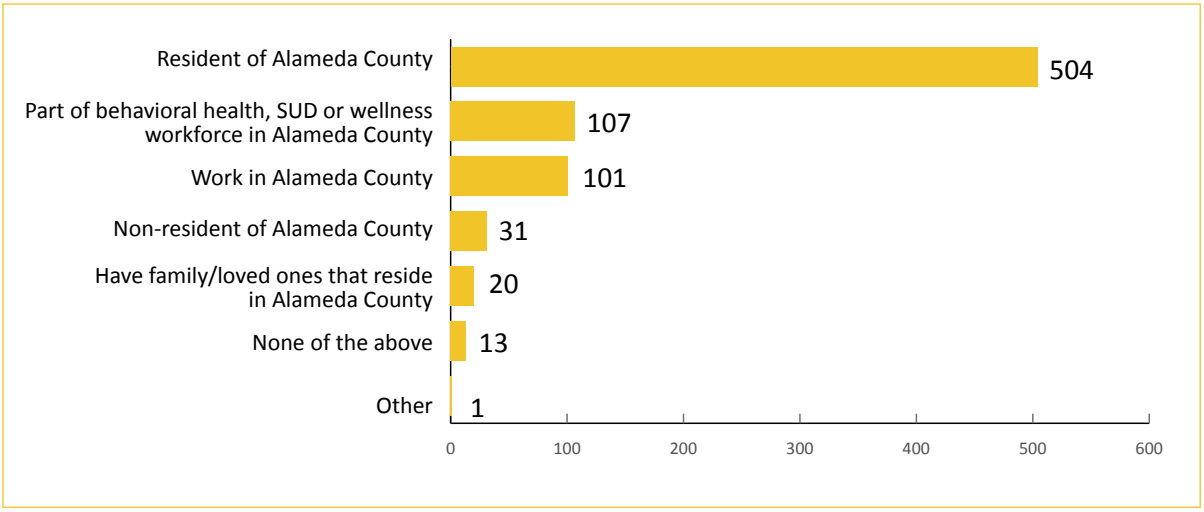
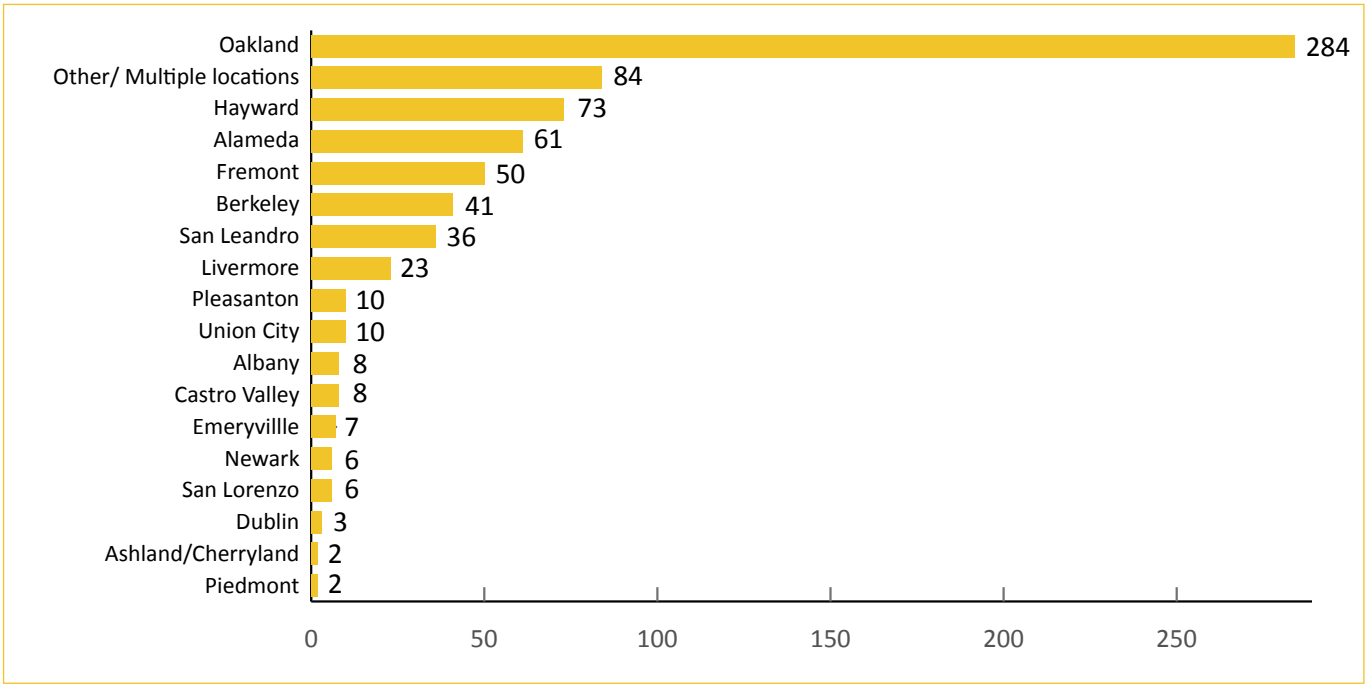
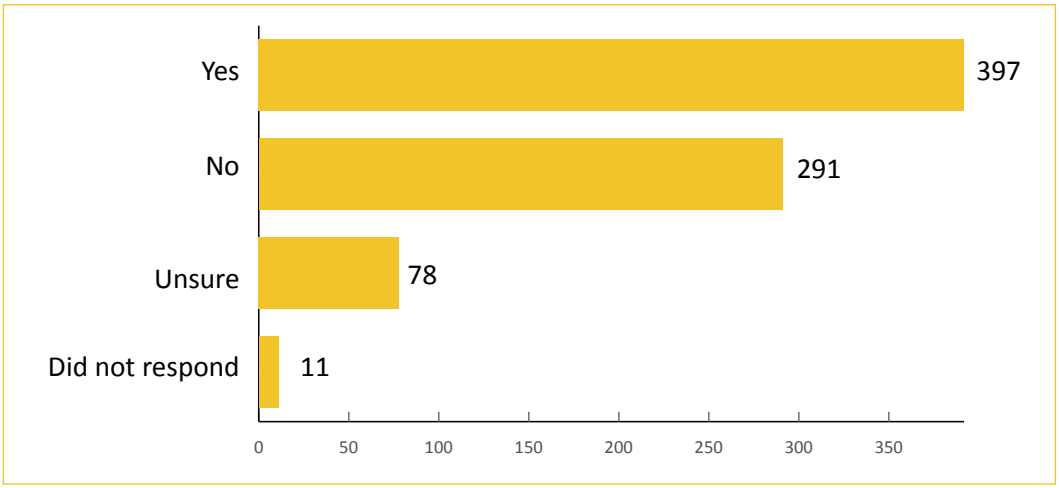


Figure 4b: Participant's City of Residence (n=777)



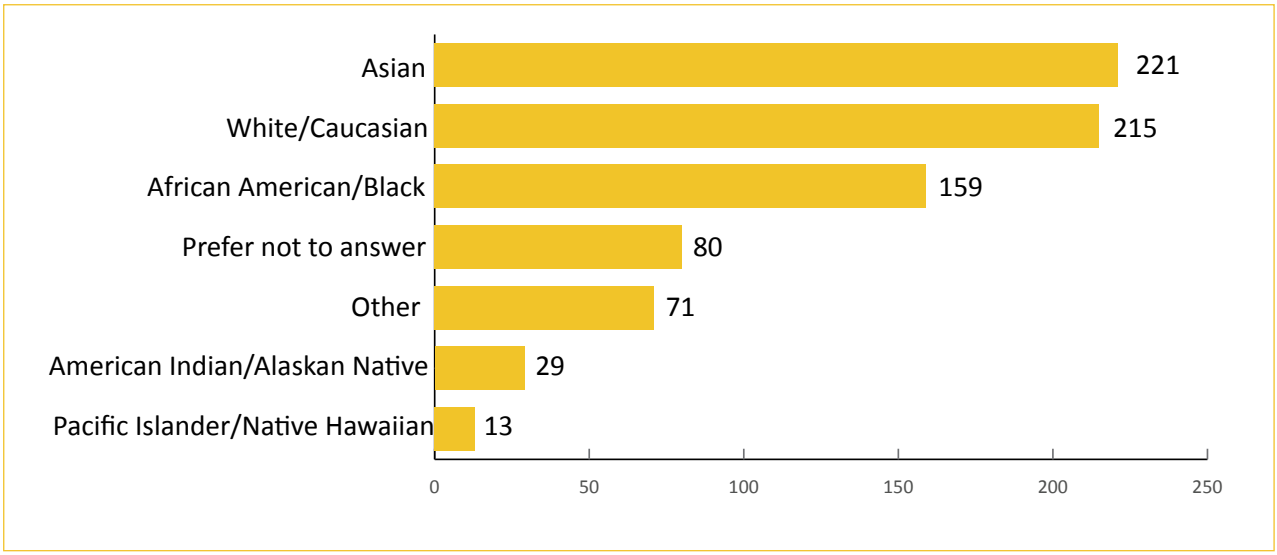
To get an idea about behavioral health care service (mental health or substance use) utilization and/or service familiarity, survey participants were asked if they or someone close to them uses behavioral health care services in Alameda County. 51% responded Yes, while 38% responded No. The remaining 11% of respondents were Unsure or did not provide an answer to this question. See Figure 4c.

Figure 4c: Behavioral Health Care Services Utilization (n=777)



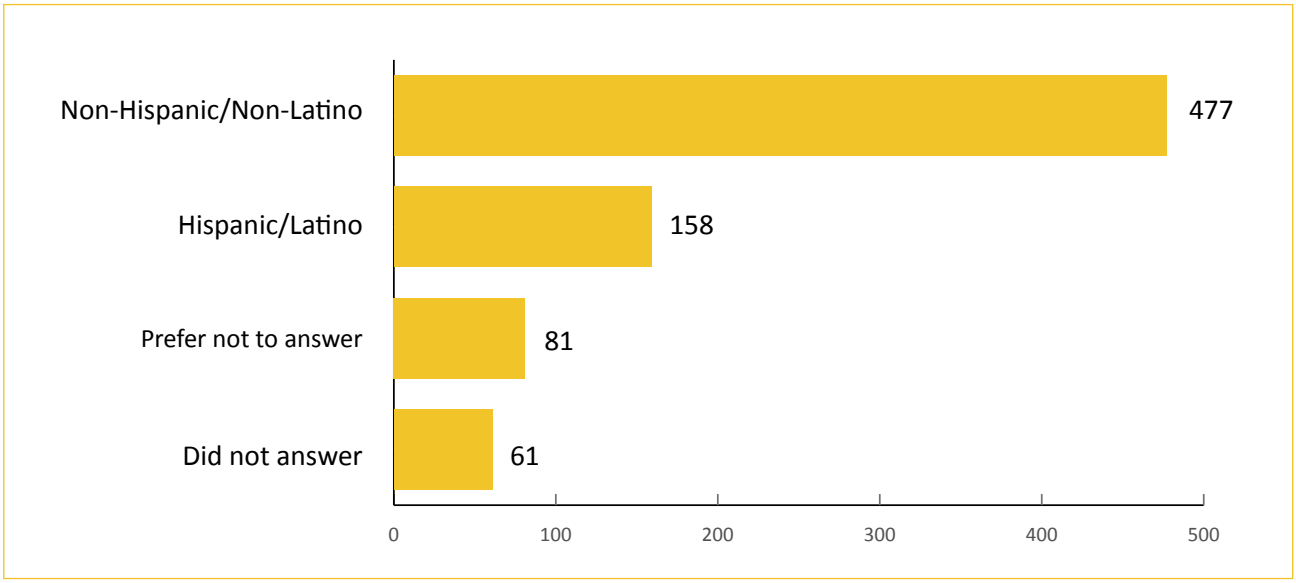
Survey respondents were asked to specify their race, and the most frequently chosen racial identification was Asian (28%), followed by White/Caucasian (28%), African American/Black (20%), American Indian/Alaskan Native (4%), and Pacific Islander or Native Hawaiian (2%). While 9% of respondents selected 'other,' 10% of respondents opted not to answer this question. See Figure 5.

Figure 5: Race (n=777)



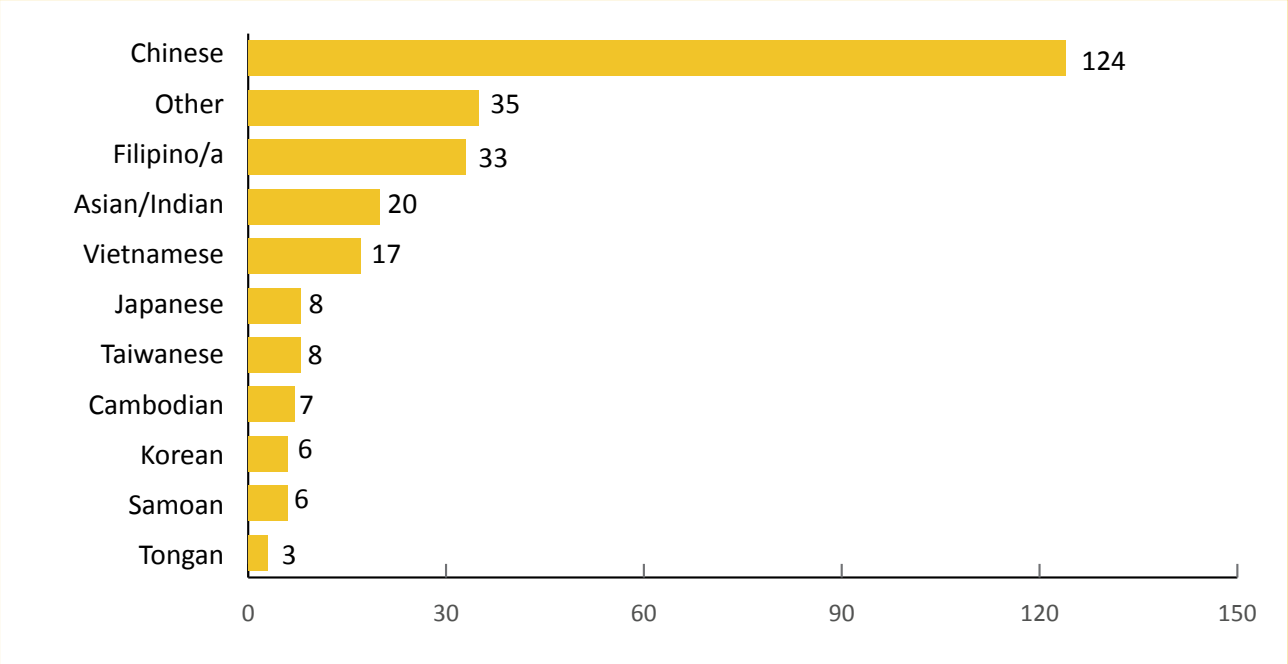
Regarding ethnicity, the survey found that 61% of respondents identified as Non-Hispanic/Latinx, while 20% identified as being Hispanic/Latinx. See Figure 6.

Figure 6: Ethnicity (n =777)



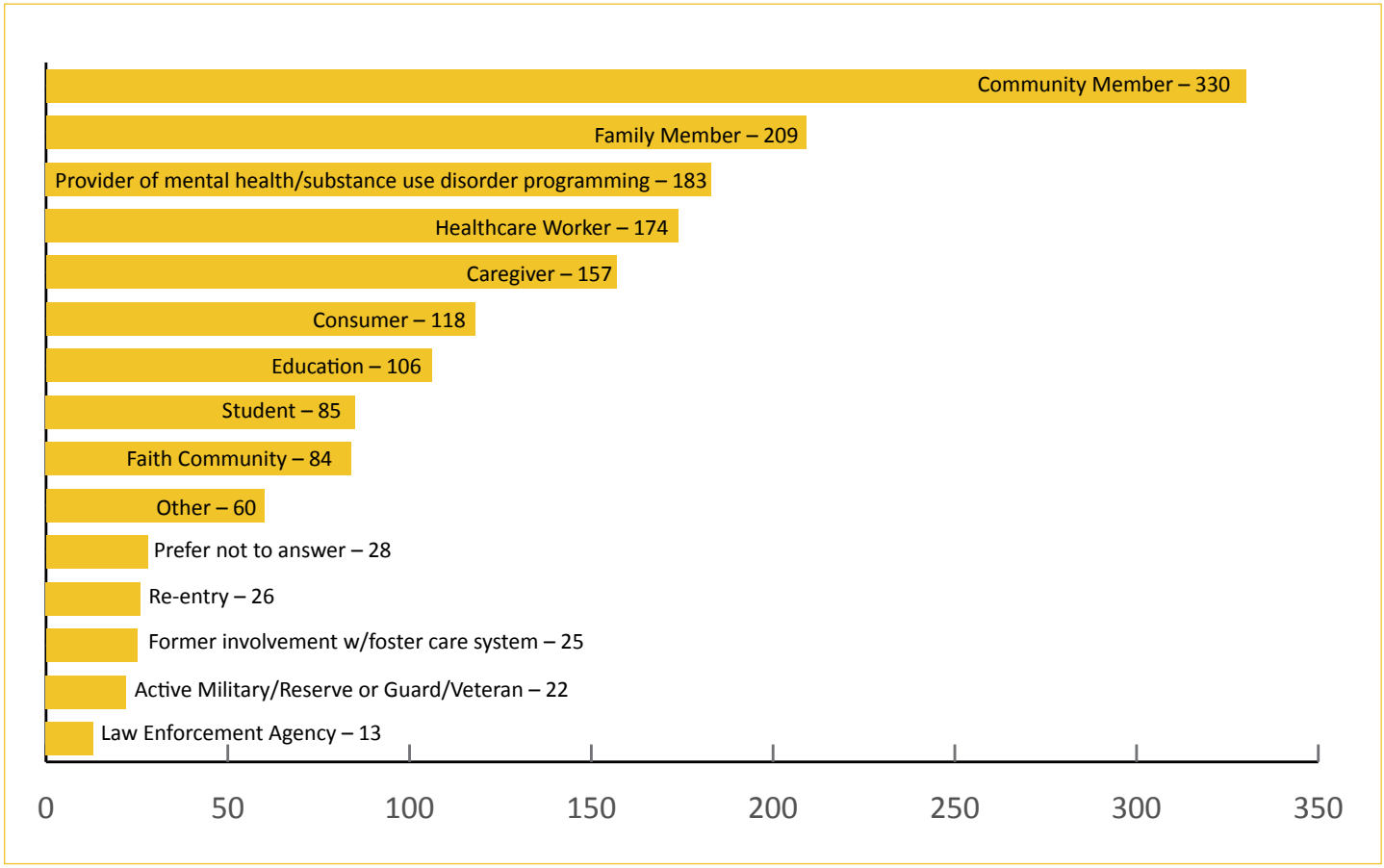
Out of the 267 participants who selected an Asian or Pacific Islander nationality or country of origin, the top specified groups included Chinese (46%), followed by Other (13%), Filipino/a (12%), Asian/ Indian (8%) and Vietnamese (6%). Refer to Figure 7.

Figure 7: Asian or Pacific Islander Participant's Nationality or Country of Origin (n=267)



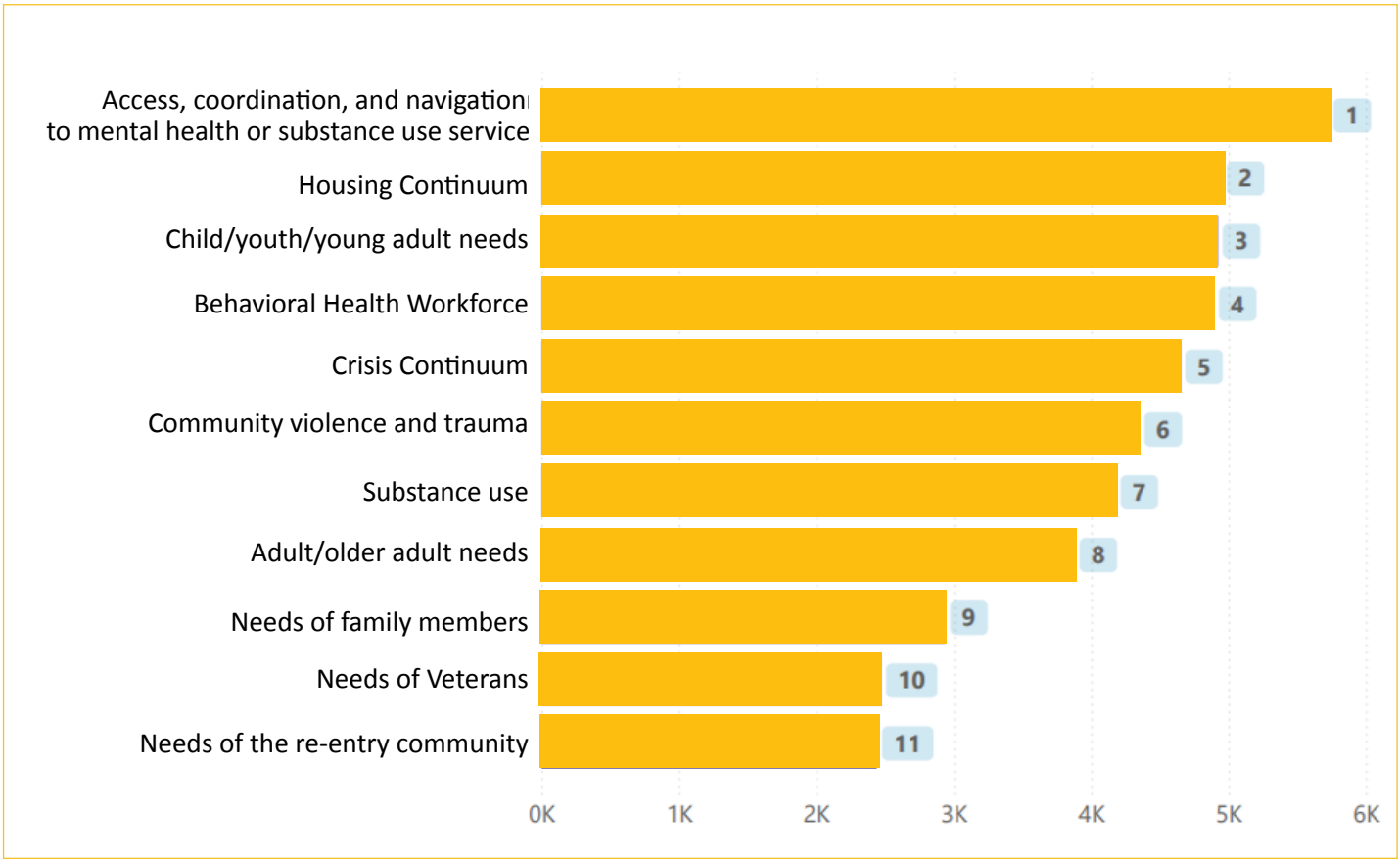
Participants were asked what stakeholder group they represented and most identified as a community member (43%), family member (27%), followed by provider of mental health or substance use disorder programming (24%). See Figure 8.

Figure 8: Participant's Stakeholder Group (n=777)



The 24 question Community Input Survey is a tool that MHSA uses to facilitate identifying key areas of interest and concerns about mental health in Alameda County. The Community Input Survey is robust and an important part of the Community Planning Process for the MHSA Annual Plan Update FY25/26. The survey was available on the www.achmsa.com website and in paper format from September 5, 2024 – January 2, 2025. The survey was available in English, Spanish, Vietnamese, and Chinese. To create the survey questions the MHSA team partnered with ACBHD stakeholders and community stakeholders. The survey questions focused on gathering community feedback on program effectiveness, cultural competence, consumer satisfaction levels and recommendations for service improvement. One section of the community input survey allows participants to rank the 11 categorized community needs in order of importance and provide strategies and solutions. See Figure 9 for ranking results.

Figure 9: Areas of Need Ranking: Greatest to Least (n=777)



On the following pages are the top ranked community needs and their most common identified strategies and solutions (per survey results):

1. Access, Coordination and Navigation (score= 5721)

2. Housing Continuum (score= 4944)

3. Child/Youth/Young Adult Needs (score= 4915)

Rank #1: Access, Coordination and Navigation to Services

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

- **Simplify and Streamline Access to Services:** Reduce bureaucratic barriers by simplifying access points and reducing service wait times. Implement a user-friendly process where individuals in crisis can quickly connect with the appropriate service provider.
- **Invest in Culturally and Linguistically Competent Services:** Increase investment in mental health services that are culturally and linguistically appropriate to serve diverse populations, particularly those with limited English proficiency or from underserved communities.
- **Integrate Mental Health Services with Case Management:** Combine mental health services with case management to provide wraparound support, helping individuals navigate the mental health system, access services, and address related barriers (e.g., housing, transportation, legal).
- **Implement Robust Navigation, Centralized Coordination and Outreach Services:** Fund community-based organizations (CBOs) to provide navigation services and establish access and navigation teams, creating simple roadmaps for individuals to access care and coordinate appointments.
- **Create a Comprehensive Resource Database for Crisis Situations:** Develop a centralized, real-time database of mental health resources accessible by caseworkers, outreach teams, and other service providers for immediate referrals and warm hand-offs.
- **Promote Interagency Collaboration and Referrals:** Foster better intercommunication and collaboration between mental health agencies to streamline referrals, share knowledge of available services, and ensure patients receive the most appropriate care for their needs.

Rank #2: Housing Continuum

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

- **Increase Affordable Housing Inventory:** Provide more housing vouchers to make housing affordable for low-income and unhoused individuals. Offer incentives to developers to create affordable housing and tiny homes. Build more affordable housing units. This includes converting abandoned properties into housing near amenities like public transit, grocery stores, and parks.
- **Develop Housing Near Existing Hot Spots:** Focus on building housing where the unhoused community already resides (e.g., under highways, in parks) to avoid displacement and increase accessibility.
- **Provide Coordinated Supportive Services On-Site:** Establish on-site facilities essential services such as drinkable water, showers, sewage, medical clinics that include links to mental health services, substance use treatment, and benefits applications (EBT, SS/DI, GA).
- **Improve Transitional Housing Quality:** Enhance the quality of transitional housing, ensuring these spaces are clean, safe, properly supervised and with fewer restrictions (e.g., later curfews, safe storage for personal belongings, outdoor spaces for smoking).
- **Incorporate Harm Reduction and Trauma-Informed Care:** Integrate harm reduction approaches and trauma-informed mental health care into temporary housing options, ensuring services are provided with dignity and support, not just shelter.

Rank #:3 Child/Youth/Young Adult Needs

Addressing the needs of children, youth and young adults emerged to be of critical importance. While two other areas of need were ranked higher, many felt there were not sufficient resources for this population and that addressing mental health during this important stage of life has an immeasurable impact. Survey respondents identified potential strategies and solutions to address the needs of this vulnerable population.

- **Integrate Mental Health Services in Schools:** Expand school-based mental health resources, ensuring access for children, youth, and young adults. This includes providing therapists in schools, training teachers to recognize mental health needs, and offering counseling services for young children showing signs of behavioral or mental health issues.
- **Strengthen Prevention and Early Intervention Programs:** Increase funding for early intervention programs that support children (0-5 years old) showing early signs of social/emotional difficulties, especially those from vulnerable family situations, to prevent long-term mental health issues.
- **Support Youth-Led and Peer-Based Programming:** Encourage youth-led mental health programs and peer-based support groups that resonate with young people, offering incentives for participation and helping them navigate mental health challenges.
- **Develop Coordinated Care Systems Across Education, Health, and Social Services:** Integrate mental health services with daycare, schools, and physical health services to create a coordinated care system. This should include prevention and intervention strategies for behavioral crises and access to short-term stabilization beds
- **Family-Centered Mental Health Services:** Integrate family therapy into mental health services for children and youth, ensuring that families are involved in treatment plans. Create opportunities for parents and caregivers to be directly involved in school-based mental health initiatives and provide ongoing education and training for parents and caregivers on how to recognize signs of mental health distress in children and how to offer appropriate support.

SUCCESS STORIES

LAMAR MITCHELL



Lamar Mitchell is a native Oaklander who grew up in the Fruitvale Diamond District. Currently, Lamar is an aspiring screenwriter, film producer, poet and author of two books. But in 1996 when he began to hear voices his life took a turn that led him on a six-year journey of mental illness and instability.

He describes himself as hitting "rock bottom" when the voices in his head had him walking up and down the streets of Berkeley screaming. From there he spent time in Napa State Hospital where he worked with therapists and others who he called allies. They believed in him and helped him to grow optimistic about the future of his life. Diagnosed with paranoid schizophrenia he credits his recovery with opening his creativity and says with pride, "writing is a creative remodeling of your consciousness. I grow when I write, it feeds my wellbeing."

In 2016 Lamar joined the Peers Organizing Community Change (POCC) an Alameda County consumer advocacy group. He supports his mental health through proper medication, regularly speaking with a therapist, positive socializing and being active in the community. As an advocate and leader, he uses his own experiences to uplift and encourage others and describes this time in his life as repaying his karmic debt. Lamar works as a Community Expert where he supports others to maintain their mental wellness. He knows his work can be literally life-saving. Lamar advocates for mental health awareness, continually fights stigma by maintaining his own mental stability. Lamar encourages others to trust themselves, to be confident, brave and fearless. He also says, "You don't know how powerful you can be or how a kind gesture can impact someone's day."

SUCCESS STORIES

BARBARA HOWARD



Barbara Howard willingly accepts her assignments. Her belief in a higher power, being connected to God and knowing that something exists greater than herself has guided her for over twenty years of helping others in the community. “My Lord, my ancestors, my family and friends help keep me going. I truly believe I was born to make a difference.” Born into a family of Black business owners, early on her parents instilled into Barbara to take care of the community. She credits mentors who frequented her family-owned bakery in San Francisco’s Bayview District with teaching her about hospitality and providing good service to everyone, no matter how challenging.

Barbara says, “being sick and tired of being sick and tired of not loving herself,” motivated her to leave a domestic violence situation and to get away from the rampant drug use of the late 1980’s. She recalls when she considered suicide as a way out and how a gospel song on the radio interrupted her thoughts and how love for her two children led to her next assignments.

She sees her success in changing her life as not just her own story but something to share. Her next assignments were to inspire, encourage and motivate others to make positive changes in their lives. Barbara’s first job was delivering workshops at Oakland Tech High School for teen parents and then becoming a 180-Degree life coach in five elementary schools teaching social and emotional skills. She became a writer for a local newspaper. She is the founder of the Juneteenth Festival in Oakland’s Hoover District, a community-oriented festival held for the past 18 years.

Barbara believes everybody is somebody and will continue to help others build their tool box of self-help strategies. She supports her own mental wellness through maintaining her peace of mind, knowing that she is of value and holding on to her culture. Her goal is to leave a legacy of caring for the community and the next generation.

SUCCESS STORIES

CAROLE AND REGINA



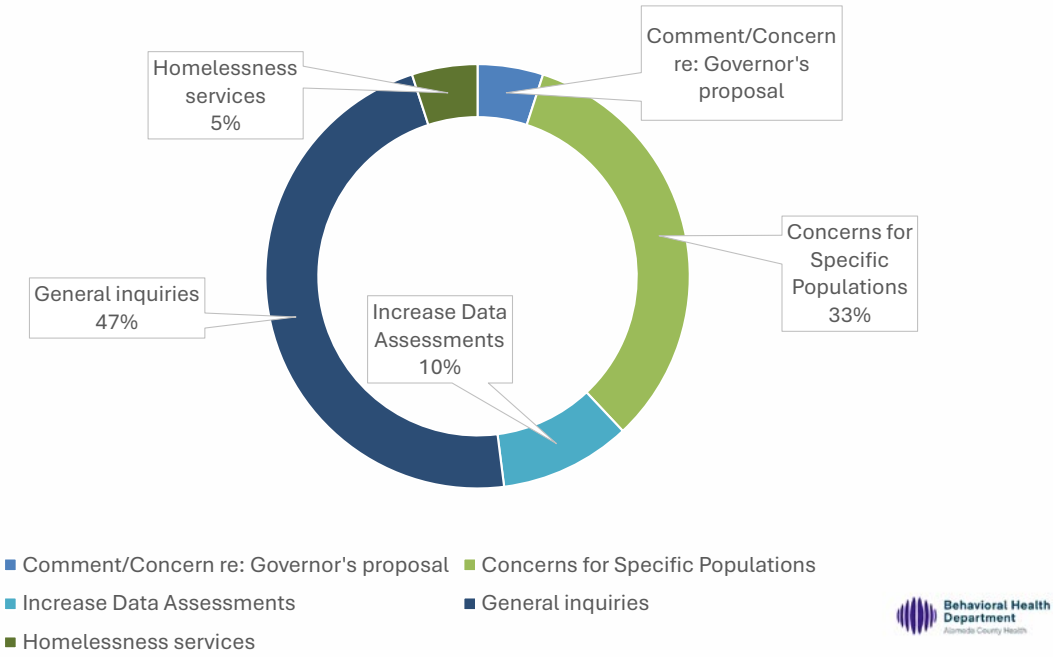
When Regina was 16, while volunteering as a camp counselor she was hit by a falling tree. The accident resulted in a traumatic brain injury. She experienced physical and cognitive issues such as headaches and memory issues. Her recovery was difficult and she developed mental health challenges from PTSD. Her mother Carole wanted to support Regina through these challenges and began studying about mental health and the brain. Carole, along with other Chinese families attended Chinese NAMI Family to Family classes and support groups. Carole went on to co-found Mental Health Association Chinese Communities (MHACC), an Alameda County-based mental health nonprofit with offices in Oakland, Castro Valley and Fremont and from the beginning Regina has helped support MHACC's growth.

In the 1980's Carole immigrated from Shanghai with $75 and built a successful fashion label in New York which sold in stores such as Neiman Marcus and Nordstrom. She has years of experience in business and the fashion industry, but helping people was always a primary motivation in her work. Transitioning to non-profit work in mental health was a big change, but Carole found it extremely fulfilling. She pursued and earned a Non-profit Management Certificate from Duke University to help support her current work. Carole's learned there are many different components to recovery and what works will vary from person to person. She knows this may include medication, therapy and holistic practices. She believes that an important first step is knowledge. "If you don't understand the nature of the mental health challenge, it's hard to figure out how to address them," Carole says.

Regina, in addition to the PTSD developed from her traumatic accident for many years dealt with generalized anxiety disorder and experienced panic attacks. She tried various treatments including medications and different styles of therapy. Through therapy, she learned more about herself and how to manage her symptoms. She continues to do research and try new things to help with her anxiety and self-care. She found forms of exercise that she enjoys such as yoga and dance. She finds sticking to regular routines, spending time with friends, and doing hobbies like knitting helpful in maintaining her mental wellness.

After her brain injury knitting became a big part of Regina's recovery. In the hospital, the pastor from their church brought a scarf knitted by church members to provide her comfort. Carole and Regina thought it was funny because it was the middle of summer, but it was indeed comforting to have something handcrafted with love. After she came home, one of the first things Regina relearned was how to knit. She had lots of yarn at home from her Mother's previous work as a knitwear designer. Knitting was a source of calm while Regina went through her brain injury recovery, and continues to be a self-care practice to this day. She is also very grateful to have supportive family and friends who helped her through the hard times and who are always there to talk and listen.

MHSA Public Comment Themes



LOCAL REVIEW PROCESS

The MHSA Annual Plan Update FY25/26 (DRAFT) was made available to the public on two websites: https://acmhsa.org/reports-data/#mhsa-plans and https://www.acbhcs.org/plan-administration/mental-health-service-act/mhsa-doc-center/. The MHSA Plan Update FY25/26 was approved by ACBHD Executive Leadership, planning staff and fiscal staff in consultation with the ACBHD MHSA Stakeholder Group and the Mental Health Advisory Board. The MHSA Annual Plan Update FY25/26 was written and developed by the ACBHD MHSA Division in collaboration with the Finance Division. The public was notified through website posting and a targeted specialized marketing campaign to various Stakeholder Groups (Mental Health Advisory Board, Alameda County Consortium of Mental Health providers, Alameda County MHSA Stakeholder Group, etc.) A copy of the marketing plan can be found in Appendix B-1 Marketing & Outreach Plan. On Monday May 19, 2025, the Mental Health Advisory Board hosted a public hearing regarding the Annual Plan update and provided a final opportunity for public comment. To read the complete list of public comments and responses please see Appendix I. The MHSA Annual Plan Update FY25/26 was presented to the Alameda County Board of Supervisors Health Committee on June 9, 2025, and approved by the Alameda County Board of Supervisors on October 7, 2025.

FY25/26 MHSA 45-DAY PUBLIC COMMENT RESULTS

The MHSA Annual Plan Update FY25/26 (DRAFT) goes through a 45 day Public Comment period from April 1, 2025 – May 16, 2025. The general public is allowed to view the Plan and leave input to edit or change parts of the Plan. The Public Comment process yielded 21 comments. Public Comments were organized into 5 categories: General Inquires (10 comments), Concerns for Specific Populations (8 comments), Increase Data Assessments (2 comments), Homelessness Services (1 comment), Comment/Concern re: Governor's proposal (0 comments). These comments were presented and discussed at the MHSA Public Hearing on 5/19/2025.

Closing Remarks

The MHSA Community Program Planning Process was successful in engaging the community and ensuring participation from a diverse set of community groups and providers throughout Alameda County. The Community Input Survey, Listening Sessions, Key Informant Interviews, Presentations and Public Comment were all critical tools in helping Alameda County gather meaningful community feedback and stakeholder participation. In the FY25/26 CPPP we estimate that we collected data directly or through providers representing over 100,000 residents of Alameda County. The Listening Session participants this year were a mix of client focus groups and providers from different regions. Surveys collected this year (777) verses last year (611) illustrates the MHSA team's success in increasing community participation. Furthermore, the MHSA Senior Planner sought to implement the BHSA expanded list of 24 stakeholders, in comparison the MHSA stakeholder list consists of 10 stakeholders. This new procedure set the framework for the FY25/26 CPPP which created new community partnerships and built on existing community relationships. This stakeholder list adoption will be important since the first BHSA CPPP will need to begin in March - May 2025.

Another key takeaway from the CPPP FY25/26 was the community's heightened awareness of upcoming changes to MHSA through BHSA. This provided an incentive for the community to be more vocal about current and future mental health and substance use services. The increase in the number of surveys completed and providers requesting listening sessions points to the community wanting to be involved in helping shape Alameda County mental health and substance use services. Overall, the CPPP for the MHSA Annual Update Plan FY25/26 was extensive, diverse, including all geographical regions and age groups of the county, and opened up new partnerships that will be vital for the community to be heard under BHSA.

Community Services & Supports (CSS) Program Summaries



The Community Services and Supports (CSS) is the largest component, which is focused on community collaboration, cultural competence, client, and family driven services & systems and wellness & recovery. CSS uses funds for direct therapeutic services and supports to adults with severe mental illness (SMI) and children with severe emotional disturbance (SED).

Community Services and Supports | Extending Our Hand

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As of FY 24/25, Alameda's CSS component funds 14 Full Service Partnerships (FSP) programs (1,095 slots), including our Community Conservatorship and Assisted Outpatient Treatment (AOT) programs; all using the Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) evidenced-based treatment model. A new FSP was added in FY 24/25 to provide services to clients enrolled in the Care Court program. This FSP is run by the nonprofit Bay Area Community Services (BACS).

Additional FSP slots will also become available as the ACBHD Service Teams (case management/ medication support) are transformed into FSPs. These service teams have slowly been transitioning into the FSP model as funding has been available with the goal of completion being in FY 25/26. Under BHSA regulations, these FSPs will be the tier that follows the tier of ACT and FACT FSP programming.

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

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

I. The Crisis System of Care;

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

III. The two ongoing age-based Systems of Care which serve four age groups:

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

CSS Components: CSS provides funding and direct services to individuals with severe mental illness (SMI) and/or severe emotional disturbance (SED) and is comprised of two service areas: Full Service Partnerships (FSPs) and Outreach Engagement/System Development (OESD) programs.
Service Recipients: Individuals living in Alameda County living with or in recovery from an SMI (adults) and/or SED (children/youth).
Service Delivery Approaches: FSPs provide wrap around or "whatever it takes" services to consumers, who are called partners. OESD programs cover multiple treatment modalities and services including: outpatient treatment; crisis response; crisis stabilization and residential care; peer respite; behavioral health court; co-occurring substance use disorders; integrated behavioral health & primary care; integrated behavioral health & developmental disability services, and in-home outreach engagement teams. CSS programs focus on community collaboration, cultural competence, client and family driven services and systems and wellness. Housing and housing support are also included in the CSS component as FSP 10.
Referral Process: All individuals seeking services are screened and referred through the ACBHD ACCESS system by calling 1-800-491-9099.
Outcomes: CSS programs address one of the following priorities developed in the community planning process: Reduce homelessness; Reduce involvement with justice and child welfare systems; Reduce hospitalization and frequent emergency medical care; Promote a client- and family-driven system; Reduce ethnic and regional service disparities; Develop necessary infrastructure for the Systems of Care.

Who does FSP serve?

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

What are FSP services?

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

What is the relationship between FSP and ACT programs?

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

ACT Fidelity Review Trend Data

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

Total face to face contacts

Community engagements

Natural support contacts

Average face to face contacts

Average number of minutes per face to face contact per week

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

Our findings show a gradual increase in fidelity. Below are the averages across all teams.

	High Fidelity Metric Benchmark	2021	2022	2024*
Total number of Face to Face contacts [S4] & [S1]	120	53.5	70.6	90.7
Total number of Face to Face contacts in the community [S1]	72	43.1	61.5	68.7
Average number of Natural Support contacts [S6]	2.0 contacts	1.4	1.53	1.6
Average number of weekly face to face contacts [S5]	3	1.354	1.75	2.4
Average number of minutes per week face to face contacts [S4]	85	41.98	48.1	63.2
Percentage of cases that had face to face visits with multiple staff in a 2 week period [H2]	60%	73%	83%	77%

*Note: 2023 data was not collected due to system capacity issues.

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

State ID#	Population	Organization/ Program Name	Referral Guidelines	Capacity	Budget/Cost per Client FY 23/24	Clients Served FY 23/24
FSP 16	**Child/ Youth**	Seneca: Alameda Connections 0-8	Serves birth to 8-year-old consumers county wide	20	$831,724/ $27,724	30 Youth
FSP 17	**Child/ Youth**	Fred Finch Youth Center (FFYC): East Bay Wrap 8-18	Serves 8 to 18-year-old consumers county wide	20	$832,738/ $23,792	35 Youth
FSP 3	**TAY**	FFYC: STAY	Serves 18-24-year-old consumers in North & Central County	100	$3,370,283/ $43,208	78 TAY
FSP 21	**TAY**	Bay Area Community Services BACS: PAIGE (Prevention, Accountability, Innovation, Growth, Empowerment)	Serves 18-24-year-old consumers in South & East County	50	$1,684,943/ $30,088	56 TAY

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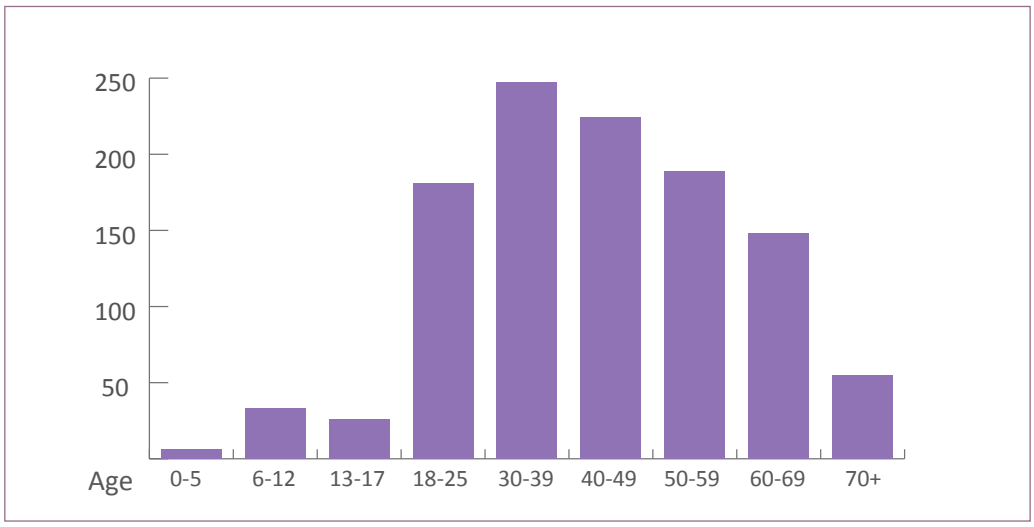
State ID#	Population	Organization/ Program Name	Referral Guidelines	Capacity	Budget/Cost per Client FY 23/24	Clients Served FY 23/24
FSP 24	**TAY**	BACS: RISE	Serves 18-24-year-old consumers county wide with a history of chronic justice involvement.	50	1,220,021/ $58,096	21 TAY
FSP 13	**Adult**	Telecare: CHANGES	Serves 18+ year old consumers county wide	100	$3,374,043/ $11,634	290 Adults
FSP 14	**Adult**	Telecare: STRIDES	Serves 18+ year old consumers county wide	100	$3,860,338/ $36,765	105 Adults
FSP 4	**Adult Homeless**	Abode: Greater Hope	Serve 18+ year old consumers county wide who meet HUD homelessness criteria	150	4,992,872/ $28,694	174 Adults
FSP 18	**Adult Homeless**	BACS: HEAT (Homeless Engagement Action Team)	Serve 18+ year old consumers county wide who meet HUD homelessness criteria	150	$4,993,861/ $28,700	174 Adults
FSP 20	**Adult Forensic**	BACS: LIFT (Living Independent Forensic Team)	Serve 18+ year old consumers county wide with a history of chronic justice involvement.	100	3,369,896/ $29,560	114 Adults
FSP 22	**Adult Forensic**	Telecare: Justice and Mental Health Recovery (JAMHR)	Serve 18+ year old consumers county wide with a history of chronic justice involvement.	100	$4,698,581/ $39,483	119 Adults

State ID#	**Population**	**Organization/** Program Name	**Referral Guidelines**	**Capacity**	Budget/Cost per Client FY 23/24	Clients Served FY 23/24
FSP 19	**Older Adult**	BACS: Circa 60	Serves 60+ year old consumers county wide with co-morbid healthcare support needs.	100	$3,296,823/ $33,301	99 Older Adults
FSP 12	**Adult**	Telecare: Assisted Outpatient Treatment (AOT)	Serves 18+ year old consumers county wide in need of court assisted support in addition to FSP services	30	$805,396/ $17,136	47 Adults
FSP 11	**Adult**	Telecare: Community Conservator-ship (CC)	Serves 18+ year old consumers county wide in need of a community conservatorship in addition to FSP services	25	$743,442/ $27,534	27 Adults
TOTAL				**1,095**	**$37,588,666**	**1,369 (increase from 1,021 in FY 22/23)**

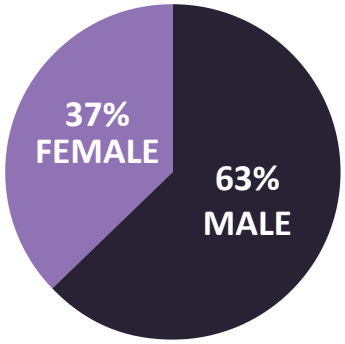
FY 23/24 FSP Demographic Data

During FY 23/24, 1,369 individuals were served in one of ACBHD's FSP programs. The FSP service utilization trend continues to incrementally increase year over year by anywhere from 2% to 15%. Below are demographics on partners served between July 1, 2023 and June 30, 2024.

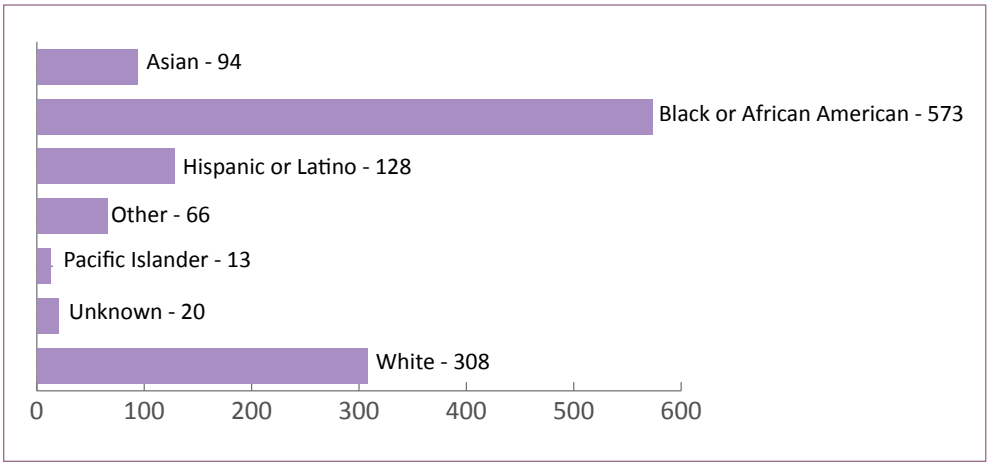
AGE



GENDER



RACE/ETHNICITY



1 All data is derived from the ACBHD billing and tracking system called INSYST unless otherwise noted. Additionally, at the time this report was generated performance metrics for FY 23/24 were not complete due to the ongoing implementation of a new billing system called SmartCare. Once all provider data entry is complete this section will be updated.

REGION OF RESIDENCE

Fiscal Year	Region	Clients	% of Clients
FY 2023-2024	1. North	774	56%
	2. Central	446	32%
	3. South	65	5%
	4. East	34	2%
	5. Out of County	60	4%
		1,379	**100%**
North: Albany, Berkeley, Alameda, Oakland			
Central: Hayward, Castro Valley, San Leandro, San Lorenzo, Ashland/Cherryland			
South: Union City, Newark, Fremont			
East: Dublin, Pleasanton, Livermore			

This is a success story from the newest FSP called **RISE** that serves justice-involved Transition Age Youth (TAY) ages 18-24 who are experiencing serious mental illness and other significant challenges in Alameda County.

Yes, we strongly believe our partners are better off because the county jail is not the ideal place for the TAY population to receive mental health services.

One 19 yr old man joined the RISE team while still incarcerated. When released there was a restraining order in place from his father and he was unable to visit his family home due to violence he perpetrated while using substances/not taking psychotropic medications. We were able to advocate for this partner to be admitted to Behavioral Health Court (BHC) and find him alternative housing at one of 2 licensed board and cares for TAY in Alameda County. Due to his ongoing involvement with treatment and engagement with BHC, he has been able to make amends with his father, have the restraining order dropped, and move back in with his family where he supports his mother in caring for his 2-yr old sister and his ailing grandfather.

All of the staff on RISE are excited about the potential of this program to change the lives of individuals living with severe mental illness who have ended up receiving most of their mental health care inside of a jail.

The RISE program is operated by the agency Bay Area Community Services (BACS), more information on them can be found at their website: bayareacs.org



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

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 16

PROVIDER NAME: Seneca Family of Agencies

PROGRAM NAME: Alameda Connections

Program Description: Alameda Connections serves children and their families who are experiencing difficulties in any number of areas including: parent-child relationship problems, at risk of losing school placement, at risk of CPS involvement, and/or behavioral issues with their child. Founded on the Principles of Wraparound, Alameda Connections provides unconditional care that is family centered, individualized, culturally responsive, and strengths-based. Our approach focuses on supporting young children and their families by providing services in the child and family's natural environment, including in the home, at school/daycare, and in the community. Our program hopes to reduce stress for caregivers and facilitate positive, healthy parent/child interactions and relationships; strengthen families by enhancing natural supports and providing help with navigating service systems; provide developmental guidance and behavioral coaching to families to promote healthy development and emotional regulation; connect families to resources in their communities; and provide crisis intervention and concrete assistance with problems of living.

Target Population: Alameda Connections serves the youngest Alameda County children (ages 0-8) who are experiencing difficulties in school and/or may need intensive support services to stabilize.

FY 24/25 Budget: $1,121,109 **Cost per Client:** $37,370

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 30 Youth

How Well Did We Do?

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

Our program works to reduce stigma related to mental health by providing services on our clients' terms – in the community and during flexible times to meet the needs of our children and families. We work very hard to focus on the families' goals for services and build relationships through the delivery of practical/tangible support (financial, transportation, etc.). We give families the control over who becomes a part of their Family Team and let their vision for their

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child and family drive the focus of team meetings. For some families, we provide a Family Partner who has personally experienced challenges with their own children (CPS, IEPs, etc.) in order to validate the caregivers' experiences and show them that receiving mental health support is valuable.

Create a Welcoming Environment: In order to create a welcoming environment, we work to meet families where they are most comfortable – in their own home, at a public park, or a coffee shop. We recently moved our offices to a new location which is more welcoming to families – including having a playground for children, a Koi Pond, ample outside areas, and comfortable offices. While we still meet with families primarily in the community, some families have appreciated having a beautiful and quiet place to come to for appointments. We regularly offer to bring food to appointments in order to create a sense of community and safety. We strive to have a diverse staff team in order to be able to reflect the diversity of our client population. Our staff works to talk openly about issues of difference, systemic oppression, and to validate the experiences of our often-marginalized children and families. Over the past year, we have primarily provided services in-person; however, we are able to pivot and use telehealth when illness arises, or a family can't meet in person.

III. Language Capacity for this Program:

We provide services in the families' preferred language (English and/or Spanish). We use a combination of bilingual staff (Support Counselor, Family Partner) and interpretation services to support our Spanish-speaking families. This year, we served 27 English-speaking families and 3 Spanish-speaking families.

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

IV. FY 23/24 Challenges: Over the past year, our program has seen an increase in the number of children and families who are homeless or struggling to keep their housing. Homelessness impacts children in a variety of ways, including increased stress, lack of predictability, less sleep, increased absences from school, etc. While our program has ways to support families in accessing housing resources, we do not have special abilities to obtain housing for families and the process to secure housing can be lengthy. Additionally, school systems continue to be very stressed, under-staffed, and slow to respond to IEP requests. While we continue to work incredibly hard to collaborate with school systems, it has felt more challenging since the return from COVID as many school districts struggle to meet the needs of children with complex mental and behavioral health needs. Lastly, we've noticed the challenge of creating a larger team around children and families who are largely socially isolated. Our goal is to work in the short-term to create longer-term supports for children and families; however, it is often challenging to do this when so many families lack natural

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supports. We continue to work with caregivers to expand their social networks, but it is a noticeable challenge. All three of these challenges – homelessness, stressed school systems, and social isolation – can make it harder for us to close cases as well since we want to ensure that children and families have the support, they need in place to thrive.

Is anyone better off?

V. FY 23/24 Client Impact:

Here is a case story submitted by one of our Care Coordinators that highlights some of the interventions provided by Connections and the successes the youth and family were able to achieve during the course of treatment. *(Client's name has been changed to protect identity).*

Maddie was referred to our program by her school-based therapist due to concerns regarding her acting-out behaviors in the home and school settings, including developmentally inappropriate tantrums requiring "hour-long restraints." There was also significant concern regarding the stress-level at Maddie's home. Although Maddie lived with her biological mother, aunt, cousin, and grandmother, due to her mother's significant mental health challenges, Maddie's grandmother was her primary caregiver. At the time of the referral, tension between Maddie's grandmother and aunt was very high and sometimes culminated in physical altercations and the police being called to the home. Maddie struggled to cope with the familial conflicts.

Our Care Coordinator worked hard to build relationships with Maddie's grandmother and school team to assess Maddie's needs and interventions to address them. She worked to support grandmother's financial needs and to help her consider where Maddie's behaviors might be coming from. Our support counselor worked directly with Maddie and grandmother to establish hygiene and self-care routines (supported by visuals) to address challenges in the home. The support counselor also practiced regulation skills and addressed self-esteem issues with Maddie. The care coordinator collaborated closely with Maddie's school therapist and began to offer dyadic sessions (with the therapist) to Maddie and her grandmother to process stressful events and related feelings, as well as, to strengthen the attachment between them. Our care coordinator worked to secure funding for Maddie to attend some summer camp programming and additional after school enrichment programs to increase Maddie's positive sense of self.

As tensions between adults in the home continued to persist, our care coordinator worked to include the whole family in treatment by extending case management support to Maddie's aunt which ultimately resulted in Maddie's aunt securing housing for herself and her daughter in a program for women and young children. Once her aunt was able to move out, her relationship with Maddie's grandmother improved significantly and tension in the home reduced greatly. Maddie's escalations at home also reduced and the team begam to focus on preparing Maddie for her transition to middle school. Our care coordinator supported grandma in visiting potential middle schools, completing necessary enrollment paperwork, and reached out to the new school

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to develop relationships and ensure that Maddie was able to access therapeutic support at her new school. The care coordinator scheduled and facilitated a meeting between grandmother, Maddie, and new school staff before the end of the school year to help reduce Maddie's anxiety and support home-school connection.

When WRAP services closed in June of 2024, Maddie's explosive behaviors at home had reduced significantly, she expressed excitement about her transition to middle school, and her grandmother expressed gratitude for all the ways that our program had addressed the needs of the whole family system.

VI. Projections of Clients to be Served:

FY 24/25	20-30
FY 25/26	20-30

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 17

PROVIDER NAME: Fred Finch Youth and Family Services

PROGRAM NAME: East Bay Wrap

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

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

FY 24/25 Budget: $988,641 **Cost per Client:** $28,246

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 35 Youth

How Well Did We Do?

II. Please Describe Ways that the Program Strives to Reduce Mental Health Stigma:
There are many ways in which EBW is striving to reduce mental health stigma. The team is staffed with youth and parent partners who have lived experience. Families have reported that having a staff team member who has navigated similar struggles helps them to feel less judged and "able to be themselves" thus creating a more therapeutic environment for permanent change to occur.

EBW also provides advocacy and psychosocial education about the three stigmas of mental health (public, self and systemic) to families, participants, and natural supports to reduce stigma and shame around accessing mental health services. EBW staff are encouraged to use each participant's preferred language of people first vs identity first language in reference to their mental health challenges and disabilities. Using a participant's preferred identity language actively empowers EBW participants and their families to realize that their mental health challenges and disabilities are important parts of their identity that should be held without shame while also acknowledging the intersectionality of their many identities.

FF is also improving organizational and individual cultural competency through education, training, workforce development, hiring strategies, and policy changes.

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III. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

IV. FY 23/24 Challenges:

Wraparound programs are very challenging to staff. It was a struggle to maintain consistent and stable staffing during this time period. Fred Finch using creative ways to recruit new staff and retain the staff that EBW has.

Is anyone better off?

V. FY 23/24 Client Impact:

EBW AC exceeded the contracted number of enrollees for the 1st time since the program started. At least 75% of Participants improved in 1 or more domains on the CANS. Half of AC participants (50%) improved in the Strengths and Risk Behaviors domains. Other areas of growth as indicated by CANS data include the following:

- Life Functioning Highest Ever: 63 % of participants improved
- Behavioral Highest Ever: 63 % of participants improved
- Strengths Highest Ever: 63 % of participants improved
- Risk Factors Highest Ever: 50% of participants improved
- Cultural Factors Highest Ever: 25% of participants improved

VI. Projections of Clients to be Served:

FY 24/25	40
FY 25/26	50

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 3

PROVIDER NAME: Fred Finch Youth and Family Services

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

Program Description: The STAY Program is located in Oakland and serves participants throughout Alameda County. The majority of services are provided in the community. The program provides clinical case management, crisis intervention, individual rehab, peer mentoring, medication management, IPS employment support, housing assistance, collateral support for families, and skill building and socialization groups.

Target Population: The STAY Program target group is Transition Age Youth ages 18 to 24 with serious mental health conditions.

FY 24/25 Budget: $3,332,950 **Cost per Client:** $42,730

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 78 Transition Age Youth (TAY)

How Well Did We Do?

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

STAY provides community-building events at least monthly for program participants so that participants may develop a natural support system and co-learn helpful independent living skills. These groups typically occur in natural or enjoyable community locations, such as parks, lakes, beaches, museums, restaurants. STAY offers a welcoming and inviting environment on campus and in the community by meeting with participants where they prefer to meet as well as providing a space with couches and pillows to relax at the office site. STAY values the collective approach to healing as well as lived experience; staff support participants and chosen families through psychoeducation, advocacy, linkage to resources, and normalizing of experiences through family partner and peer services.

III. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

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IV. FY 23/24 Challenges:

Staffing shortages as well as the length of time it takes to onboard staff once an offer is accepted impacts service provision. For example, peer mentors and psychiatric nurse practitioners have been in clearance process for multiple months, delaying their start date. Also, referrals have been slowly approved by county ACCESS. In the final quarter of 2023-2024, for example, only 6 participants were referred and opened to STAY services. Many individuals are leaving the area, at least one referred person speaking to the income and housing insecurity of the Bay Area as a reason for moving. Systemic barriers, such as food, housing, income insecurity as well as health disparities seem to drive participants and staff away from living in the Bay Area.

Is anyone better off?

V. FY 23/24 Client Impact:

Individualized Placement and Support (IPS), employment and education services as well as housing were also enhanced in the last year. Nine STAY participants moved from homelessness into permanent housing this year. In addition, three participants maintained their permanent housing from the year prior. Through IPS services, one participant who previously had dropped out of high school was able to try community activities, including a baking program, and through associated confidence building, made a plan to re-enroll in school and is doing so in the fall. Another participant has secured their dream job as a professional piercer. On the road to securing this job, this participant created a portfolio to present to potential employers and also gained a great deal of work experience through multiple training programs and internships with the support and encouragement from their employment specialist.

VI. Projections of Clients to be Served:

FY 24/25	75
FY 25/26	75

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 21

PROVIDER NAME: Bay Area Community Services (BACS)

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

Program Description: Contractor shall provide full service partnership services within the philosophy of 'whatever it takes' to Alameda County Transition Age Youth (TAY) who live with serious mental illness. Clients shall be those individuals at high risk of re-hospitalization who could live in the community if comprehensive services and concentrated supports were available to accommodate their needs.

Target Population: Clients will include TAY individuals who are homeless or at risk of homelessness, have been involved in the criminal justice system, have co-occurring substance use and / or physical health disorders, frequently use hospitals and other emergency services, are at risk of institutionalization, and / or have limited English proficiency. Contractor shall serve individuals who are sex offenders.

FY 24/25 Budget: $1,766,267 **Cost per Client:** $31,540

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 56 Transition Age Youth (TAY)

How Well Did We Do?

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

a. **Reduce mental health stigma:** PAIGE team staff are committed to using recovery-centered language, meeting participants where they are at, providing psychoeducation as necessary, and normalizing participants struggles. We view ourselves as partners in our participant's recovery journey and provide safe, judgement free spaces for our participants to process their feelings. Our services are built around the goals that participants have for themselves, and we view participants as experts on how their mental illness effects their lives and how mental health symptoms show up for them. We provide psychoeducation to families and other natural supports so that participants can be better supported in ways that do not reinforce societal stigmas around mental health. We also connect participant's family members and supports to groups like NAMI and FERK so that they can receive support for themselves, as well as resources and information. PAIGE team schedules regular community outings for our participants with the goal of creating opportunities for new experiences,

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support participants in feeling welcome and able to navigate new places, and to spend time with staff and peers in the community. Many PAIGE participants attend the same outings and have become friends. We support with smaller group outings for participants who have gotten to know each other and staff have witnessed participants supporting each other in coping with mental health symptoms.

b. **Create a welcoming environment:** The PAIGE team values our participants need to feel safe, respected and welcomed. We are able to offer services at Wellness Centers, participant's homes, out in nature, and various other places in the community that participants can choose. With our current increased staffing we are able to support participants who struggle to be in large groups or public spaces to enjoy our group and community outings by assigning a staff member who can take them home if they start to feel overwhelmed or are no longer able to engage in the activity. PAIGE team practices a person-centered approach, Harm-Reduction and Trauma-Informed Care to support participants at any stage in their recovery journey. PAIGE also embodies a multicultural approach as a we serve a diverse population and understand the importance of how cultural aspects may influence mental health, especially when working with families.

III. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

IV. FY 23/24 Challenges:

PAIGE team faced challenges around access to housing and access to SSI repeatedly throughout the last year. We have participants who have lived at the only TAY residential treatment center for as long as they are allowed (1 year, or 18 months with an extension) and there are limited to no options once their time is up. We have had to place participants in motel rooms while we try to find housing options so that we can avoid our participants experiencing homelessness for the first time in their lives. We have multiple participants who struggle to live in crowded environments due to MH symptoms and due to not feeling comfortable living with older adults. There are 2 TAY licensed board and cares in the county and the beds are limited. Many of our participants would greatly benefit from the supports that licensed housing provides – medication management, meals, etc, but we are not able to access those supports for the majority of our participants. We have experienced many of our participants being denied for SSI the first time they apply. We refer them to BALA or HAC for support with appeals but the waitlists at both organizations are very long. We have paid for housing and daily needs of many of our participants because there are no other financial resources available – many of our partners have GA which is a few hundred dollars per month.

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Is Anyone Better Off?

V. FY 23/24 Client Impact:

One significant success story is a young woman who will be aging out of TAY services in Sept 2024 and graduating to a lower level of care. She joined the PAIGE team in 2019 after multiple traumas and suicide attempts. Throughout her time with the PAIGE team, she began to isolate at home less, she was able to manage mental health symptoms to the point that she has not had a psychiatric hospitalization since 2018. This participant initially refused to develop social supports outside of her home due to distrust of others but today she earns her own income dog walking and dog boarding. She continues to engage in individual therapy but is managing mental health challenges without psychotropic medications. She manages her own finances, medical/healthcare, and is able to advocate for supports she needs.

The PAIGE team has been able to graduate multiple partners to a lower level of care. We have celebrated 1 partner earning his high school diploma and supported 2 partners in enrolling in GED courses. One of our partners completed a dental assistant program and is now working full time at a dentist's office in her first job. We have been able to support several partners enroll in college courses.

VI. Projections of Clients to be Served:

FY 24/25	60
FY 25/26	60

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 4

PROVIDER NAME: Abode Services

PROGRAM NAME: Greater HOPE FSP

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

Target Population: Greater HOPE provides services for chronically homeless adults.

FY 24/25 Budget: $4,733,745 **Cost per Client:** $27,205

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 174 Adults

How Well Did We Do?

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

a. **Reduce Mental Health Stigma**

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

For 6 months of the year, our participants benefitted from our IPS Employment Specialist who was able to successfully engage with employers to link participants to jobs. Our Employment Specialist spent several hours in the field weekly, engaging employers about the benefits of hiring our program participants, and how to successfully manage this population. Our Employment Specialist was able to help at least five participants obtain jobs and engaged with over 18 employers in our community.

Our staff strive to be present in the community and show partnership in addressing the Mental Health needs of our participants. One of the ways we have done this is by attending community meetings to learn of concerns from business and residents, addressing these concerns by providing education and insight into what mental health looks like and strategies for engagement with those who live with it.

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b. **Create a welcoming environment:**
From our lobby we provide participants with food, water, coffee, hygiene supplies, clothing and a staff to greet them daily from their FSP Program. We meet monthly with our Consumer Advisory Board, comprised of current participants, to gather feedback regarding their experiences coming to our office and engagement levels of staff. We seek, receive, and incorporate feedback around what they liked (warm food, coffee, etc.) and what could be improved (increased staff size so that participants have more variety of engagement and less turnover).

III. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

We have staff who are fluent in English and Spanish. For other spoken languages, we utilize the Language Line.

IV. FY 23/24 Challenges:

Hiring and staffing has continued to be a significant challenge during the past year. We have experienced five vacancies across 3 ACT teams, including one Program Manager. There has continued to be a reduction in applicants for Management and Clinical positions in particular. We continue to work with a behavioral health recruiter specifically for clinical positions and have been able to hire a new Co-Occurring Specialist, a Housing Navigator, and a Peer Support Specialist this year.

Is anyone better off?

V. FY 23/24 Client Impact:

The team continues to see an increase in graduating participants to lower levels of care. Eight participants stepped down in the last year. Several participants had been with Greater HOPE for over 5 years. One participant successfully completed Behavioral Health Court, became stably housed in the community, and was able to reunite with her adult children after many years. She manages her medication, has part time employment, and is considering a vocational program to learn some new skills. She graduated to a lower level of care and is able to navigate the community with ease.

VI. Projections of Clients to be Served:

We project to remain at full capacity in the next fiscal year and if awarded more slots to fill those slots quickly as well.

FY 24/25	**150**
FY 25/26	**150**

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

PROVIDER NAME: Abode Services

PROGRAM NAME: Rental Subsidies and Landlord Liaison Program

Program Description: The Rental Assistances and Landlord Engagement (RALE) (formerly called Landlord Liaison) Program is designed to cultivate and sustain relationships with property owners and property management companies (landlords) with the goal of encouraging them to accept additional tenants who are referred through the Coordinated Entry System when vacancies occur, and to recruit new landlords who are willing to make rental units available to homeless people with disabilities who are participating in scattered site Permanent Supportive Housing (PSH) programs with MHSA and HUD funded subsidies. The RALE Program provides landlord incentives and risk mitigation for damages and operates a 24/7 hotline available to all owners and property management companies in the program that may be utilized for crisis needs, property management needs, and problem solving.

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

FY 24/25 Budget: $3,870,000 **Cost per Client:** $4,510

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 858 Adults (206 with subsidy management and 652 without subsidy management)

How Well Did We Do?

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

The program supports participants with their goals of living independently. As housing challenges arise due to someone's mental health, Abode quickly assesses the need to support their mental health and links them to their case manager/Tenancy Sustaining Services for support. Abode provides support around housing barriers as well as the choice of where to live whenever possible. The housing team is diverse and connects with the participants by meeting them where they are at. RALE team is also part of Housing and Homelessness Services' Supported Housing Learning Collaborative and participates in various trainings on client engagement, tenant

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centered practices, building leadership at housing sites and the power of lived experience. In addition, the RALE team is trained in harm reduction and trauma informed and cultural affirming practices. The team also does not share mental health statuses with new or existing landlords.

a. **Provide Language Capacity for this Program: Abode** utilizes a language line that is available for all staff.

III. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

IV. FY 23/24 Challenges:

- Scheduling case conferences that include the participant to discuss housing related needs, relocation requests and to address challenges. Some participants do not have the skills to engage in their housing retention plans and sometime lack insight into their problematic behavior causing lease violations.
- There are many challenges Abode faces when it comes to housing searches. Staying withing Fair Market Rate for some of our programs can be difficult and Abode is seeing an increasing need for 1st floor and ADA units for our aging population. At times, this can delay a participant from moving into a unit that can support them in being successful.
- Staff transition can cause delays in responding to housing providers. Housing Providers do not always respond immediately to tenant needs when emergent issues arise.
- There is a significant lack of Board and Care, SNIFs, and ADA units available for seniors and/or individuals unable to care for themselves.
- Reduced funding to return the unit to passable condition while the tenant still resides in the unit.

Is anyone better off?

V. FY 23/24 Client Impact:

Vast majority of participants that we serve have remained housed and when challenges have come up, we have provided the support to move into a suitable location. Over 90% of RALE participants remained stably housed in FY 23/24.

A Success Story:
Client is a participant in the RALE Voucher program: He first moved into his unit under OHA EHV towards the end of 2021. He successfully remained housed while maintaining a good relationship with his Housing Provider. Due to the decline in safety of the area, he reached out to his housing

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team and has successfully navigated the challenging process of requesting a transfer voucher, and then a port to another area. He is currently pending relocation and did so on his own with minimal support. Once his new unit has passed BHA HQS, he will begin moving into his new unit.

VI. Projections of Clients to be Served:

FY 24/25	290 with subsidy management and 700 without subsidy management = 990
FY 25/26	290 with subsidy management and 700 without subsidy management = 990

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

PROVIDER NAME: Abode Services

PROGRAM NAME: Project Homeless Outreach for People Empowerment (HOPE) Program (Tri City Area)

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

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

FY 24/25 Budget: $434,642 **Cost per Client:** $1,168

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 372 Adults

How Well Did We Do?

II. Describe Ways that the Program Strives to Reduce Mental Health Stigma:
HOPE expanded workforce to hire people with lived experience for greater connection during outreach and engagement. HOPE staff are well integrated in the Counties they serve in Alameda County including First Responders. As a tool of building connections and creating a welcoming space, HOPE team provide range of resources such as tents, sleeping bags, food, clothes to transportation support and move in costs. HOPE team also take a series of trainings around Harm Reduction, Trauma Informed Care, Peer Support.

III. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

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IV. FY 23/24 Challenges:
HOPE team struggled to hire and retain staff which has impacted quarterly outreach and engagement goal. The program manager position has been vacant since early 2024. This has made it challenging to onboard and train new staff with the right support in place.
Encampment closures shifted work from engagement to emergency relocation planning which shifts the focus to repaid relocations and crisis planning. Some people who were being outreached were no longer accessible due to frequent changes in location.

Environmental Crises: Winter heavy rains and flooding and summer heatwaves shifted focus to disaster planning and preparation instead of housing problem solving.

Is anyone better off?
HOPE team's strong presence in the community with the unhoused and community partners led to stronger collaboration during encampment enclosures and environmental crises. Monthly and sometimes weekly collaborative strategy meetings were held to discuss role and action items. HOPE team was able to use funds for move in cost for unhoused participants who obtained housing.

V. FY 23/24 Client Impact:

Process measures: HOPE Team exceeded the amount of engaged clients.

Quality measures: HOPE TEAM captured 100% of clients who enter/exit the program, 84% have Coordinated Entry Assessments (CEA) with 94% completing the CEA within 6 months of entering the program.

Impact measures: 50% exit the project with one or more non-cash benefits and 83% exit with insurance.

V. Projections of Clients to be Served:

FY 24/25	300-370
FY 25/26	300-370

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

PROVIDER NAME: Alameda County Health (ACH) Housing & Homelessness Services (H&H), Housing Services Office (HSO) and multiple subcontractors

PROGRAM NAME: Housing Solutions for Health

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

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

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

FY 24/25 Budget: $515,537 **Cost per Client:** $10,968

How Much Did We Do?

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

There are 175 MHSA units across 24 sites. Across those sites, 24 attrition units were filled through Coordinated Entry (CE) in FY 23/24.
Housing Assistance Fund (HAF) served 47 unique clients

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How Well Did We Do?

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

Alameda County uses The Housing First model, this approach is instrumental in reducing mental health stigma by identifying vulnerable adults over the age of 18 with serious mental health diagnoses that can live in the least restrictive and integrated setting.

III. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**:

IV. FY 23/24 Challenges:
Overall lack of affordable housing continues to be a challenge.

Is anyone better off?

H&H operates a number programs:

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

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9. Rental Assistance and Landlord Engagement (RALE) Program recruits and works with landlords and property managers in the private rental market settings to acquire safe, decent and affordable housing countywide and retain units securing long-term housing for clients who have previously had barriers to locating affordable housing or maintaining long term tenancy;
10. Staff involvement and financial support toward countywide efforts focused on addressing homelessness.
11. MHSA affordable housing project application preparation in partnership with nonprofit affordable housing developers.

V. FY 23/24 Client Impact:

Coordinated Entry System: The County's Coordinated Entry System (CES) for addressing homelessness, formalized in 2017, underwent significant changes in FY22/23 and continued uptake by community members and providers in FY23/24. Coordinated Entry ensures coordinated and equitable access to the resources managed by the Homelessness Response system. Any household experiencing homelessness has access to housing problem solving services, and potentially flexible funding to support with creative housing solutions. Households needing more extensive interventions can move deeper into the Coordinated Entry workflow and at each step along the way providers have information that can be shared transparently so that housing resolution plans can be successful, and people are able to take informed next steps. Ongoing collaboration and coordination will be needed to ensure the maximum effectiveness of CES. Much larger investments in affordable and supportive housing are needed by multiple levels of government to ensure individuals with serious mental illness have a place to call home.

No Place Like Home (NPLH): During FY 23/24, H&H worked collaboratively with cities, other county departments, and affordable housing developers towards increasing housing opportunities through state funded No Place Like Home (NPLH) Program efforts of creating more supportive housing for homeless individuals with a serious mental illness. Counties must commit to providing supportive services to NPLH tenants for a minimum of 20 years. NPLH set aside units will be restricted as affordable to the NPLH target population for a minimum of 55 years; referrals will be facilitated through the Coordinated Entry System. In total, 505 NPLH units will be brought online within Alameda County and will support expansion of units dedicated to those experiencing homelessness and SMI. As of the end of FY 23/24, a total of 195 NPLH units within 9 sites have come online.

Housing Assistance Fund: The HCSA Housing Assistance Fund provides one time, or short-term financial assistance for housing costs for applicants who are receiving specialty mental health services from Alameda County Behavioral Health Care Department (ACBHD) or one of its contracted service providers.

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Applicants must be either homeless or at risk of losing their housing and working with an ACBHD-approved provider aiding in stabilization of housing situation as well as prepare the Housing Assistance Fund application. Funds may be used for: back rent/arrears that a client owes and must be paid to avoid an eviction; Security deposit on a new place to live and/or first month's rent, or short-term/temporary housing payments while permanent housing or stable income is being secured. All payments are made to third parties (landlords, property managers or hotel/motel operators). During FY 23/24, a total of 47 unique clients were supported within the Housing Assistance Fund.

VI. Projections of Clients to be Served:

FY 24/25	52 HAF
FY 25/26	57 HAF

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

PROVIDER NAME: Alameda County Health Housing & Homelessness Services (H&H), Housing Services Office (HSO) and multiple providers

PROGRAM NAME: Housing Support Program (HSP)

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

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

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

FY 24/25 Budget: $6,851,822 **Cost per Client:** $23,226

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 295 Adults

How Well Did We Do?

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

HSP provides a network of services throughout Alameda County to enhance resident options. HSP providers offer supported care in a home-like environment and offer roommate matching when possible. HSP operators receive annual training on Mental Health First Aid, Crisis Planning and Prevention, and privacy training. County liaisons provide coaching and support on best practices on housing problem-solving and retention.

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III. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☒ **Chinese** ☒ **Korean** ☒ **Vietnamese** ☒ **Tagalog** ☒ **Farsi**
☒ **We use the Language Line** ☒ **Other**: Mandarin, Portuguese

IV. FY 23/24 Challenges:

Licensed Residential Care homes continued to face several challenges in FY 23/24. HSP providers report difficulties in recruiting and retaining adequate staff levels, as the population presents a high level of needs. Referring agencies and community partners also experienced high turnover which impacted care coordination leading to increased psychiatric and medical crises. HSP providers continue to highlight increased costs such as food, utilities, etc. which impacts their bottom line. Additionally, substantial increases in insurance costs and limited business insurance options is a significant challenge for HSP providers. Board and care operators also sustained serious financial losses when tenants and/or their service providers failed or refused to pay rent. The operators have limited options to collect or move their tenants out for failure/refusal to pay rent. In a small percentage of tenants, their crisis episodes did not resolve in a timely manner or with desired outcome, which has led to Community Care Licensing (CCL) investigation and a negative mark on their public record.

Is anyone better off?

V. FY 23/24 Client Impact:

HSP owners and operators have been in business, on average, over 10 years. Their dedication and commitment to working with Alameda County Behavioral Health Department (ACBHD) participants has help reduce severity of mental health symptoms; improved daily functioning; improved overall health status; promoted housing stability increased community connections/social networks; increased sense of purpose and meaning in life; reductions in mental health service costs and utilization of crisis, inpatient, and locked facilities; reduced tobacco use.

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

HSP providers with the support of their county assigned liaison, systemize admission, housing stability and discharges from the home. Homes were cooperative in evaluating and admitting residents and worked closely with service teams to address challenging behaviors. Many programs accepted 75% or more of referred high needs/risk applicants from Villa, Mortan Baker and other sources. They retained that percentage in their housing over the course of the year.

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Most of the tenants received crisis intervention in a timely manner during crisis episodes. Many tenants were able to engage socially in the communities where they now live. Some operators reported higher housing retention rates due to increased collaboration with community partners, planned care coordination and access to crisis support programs. Through the established network and system coordination homes were able to admit residents who were hard to place due to their complex medical needs as well as those individuals stepping down from State hospitals.

Over 10% of residents in HSP have lived at their current housing for over 10 years. This shows the dedication of the homes, and the satisfaction of the clients served. Flexibility within HSP allows for transfers when a home cannot meet the need of residents. Tier 2 and 3 bed availability were fully utilized in FY 23/24 and H&H and ACBHD are working to add an expanded level of services during the next fiscal year. Additionally, one new HSP provider will be added to the portfolio in the next fiscal year with 20 additional beds.

During FY 23/24, 12 HSP providers were awarded a Community Care Expansion Project (CCEP) grant for facility upgrades.

VI. Projections of Clients to be Served:

FY 24/25	325
FY 25/26	358

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: North County Housing Connect, Housing Navigation Program

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

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

FY 24/25 Budget: $828,152 **Cost per Client:** $15,057

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 55 Adults

How Well Did We Do?

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

Oakland Project Connect (OPC) has a strong engagement and outreach component of services. OPC use strength-based case management services to provide low barrier and responsiveness to care. Staff received training in the following areas: Older Adults Series of Trainings, Working Effectively with the LGBTQIA, Restorative Justice and Justice, Equity, Diversity and Inclusion and Opioid and Naloxone Training and Cultural Competence.

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

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

IV. FY 23/24 Challenges: BACS OPC experienced recruitment and retention challenges for this program which impacted their ability to serve more of the target population and maintain relationships with a transient population. Ongoing shortage of affordable housing in Alameda

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County led to short term solutions and ongoing rapid rehousing. OPC target population is single adults but experienced an influx of single adults with minor children. The portfolio for housing for families is extremely limited. For individuals who are employed, income does not meet the income minimum threshold for rent-reasonable housing.

Is anyone better off?

7 OPC enrollees found permanent supportive housing
3 were placed in rapid re-housing.
2 gained competitive employment
3 were placed in interim housing directly from the streets
3 enrolled in substance use disorder treatment facilities and recovery houses.

V. FY 23/24 Client Impact:
Process measures: 55 unique individuals served

Quality measures: 89% received Coordinated Entry Assessment (CEA) within 3 months of enrolling into OPC, average time from housing navigation into permanent and interim housing is between 14-18 months.

Impact measures: 57% increase income within 12 months entry into the program, 85% receive one or more non cash aid benefits such as WIC, Cal Works or Cal Fresh, 95% obtain medical insurance, 65% exit to permanent or interim housing at discharge and 88% saw a decrease in hospitalization and crisis episodes upon enrolling into BACS OPC.

VI. Projections of Clients to be Served:

FY 24/25	53-70
FY 25/26	53-70

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Rental Subsidies and Landlord Liaison Program

Program Description: The Rental Assistances and Landlord Engagement (RALE) (formerly called Landlord Liaison) Program is designed to cultivate and sustain relationships with property owners and property management companies (landlords) with the goal of encouraging them to accept additional tenants who are referred through the Coordinated Entry System when vacancies occur, and to recruit new landlords who are willing to make rental units available to homeless people with disabilities who are participating in scattered site Permanent Supportive Housing (PSH) programs with MHSA and HUD funded subsidies. The RALE Program provides landlord incentives and risk mitigation for damages and operates a 24/7 hotline available to all owners and property management companies in the program that may be utilized for crisis needs, property management needs, and problem solving.

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

FY 24/25 Budget: $3,870,000 **Cost per Client:** $24,807

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 156 Adults

How Well Did We Do?

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

Since RALE providers are not case managers, program staff work with assigned case managers (if available) in an effort to ensure clients have the best mental health support that is needed to maintain their housing. Program staff have learned how to refer clients to Tenancy Sustaining Services and mental health resources and case management and uphold the spirit of Housing First principles. RALE team is also part of Housing and Homelessness Services' Supported Housing Learning Collaborative and participates in various trainings on client engagement, tenant centered practices, building leadership at housing sites and the power of lived experience.

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In addition, the RALE team is trained in harm reduction and trauma informed and cultural affirming practices. The RALE team also does not share mental health statuses with new or existing landlords and refers to clients as partners throughout their programs.

III. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
All BACS partners in the RALE Program speak English and staff are able to easily communicate with each of them. If needed, BACS have access to GLOBO Language Solutions; which provides over the phone multilingual interpretation services to individuals who are non-English speaking or limited English proficient
☐ **We use the Language Line** ☒ **Other**: GLOBO Language Solutions

IV. FY 23/24 Challenges:

BACS RALE team continues to have concerns related to PSH case managers (CM) and service providers; specifically, as it relates to clients who are closed or "graduate" from these services, lack of support when needed, clients needing a higher level of support, poor communication/collaboration and Case Managers (CM) and staffing issues that result in disruptions in continuity of support. Having PSH Service Providers present at RALE monthly team meetings; has allowed the RALE team to be more informed on how to submit referrals (if/when necessary) and which programs may best fit the needs of clients. There were also concerns that RALE Housing Locators were not being informed of client deaths in a timely manner. With the majority of client deaths that occurred during this fiscal year, case managers had been notified but had not communicated the information to the RALE team in a timely manner. More frequent check-ins with CM and clients will surely help with the timeliness of these types of notifications.

While BACS RALE team does not get thoroughly involved in eviction processes, there were a few landlords who had expressed their dissatisfaction with our program. This was specifically related to clients whose program participation and subsidy payments were terminated. These unhappy landlords had to, unfortunately, start evictions due to clients not leaving the property after our subsidy and the client's participation in our program had ended.

Is anyone better off?

V. FY 23/24 Client Impact:

156 partners maintained their housing through long term tenancy or rehousing efforts with our RALE program.

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VI. Projections of Clients to be Served:

FY 24/25	175
FY 25/26	175

Success Stories: BACS team has had several success stories to share:

"VS had a stroke one year ago and went through a year of rehabilitation in a nursing facility. He was recently rehoused on the one-year anniversary of his stroke and is now actively painting and doing art work in his shiny new studio apartment, which has a gym and pool to aide his rehabilitation."

"DS has been in her unit going on 5 years. She keeps the floor polished and everything put away neatly. She's happy to share coffee or tea with a guest and serve drinks in her fine China teacups. She has slowly been planning out how she wants her yard to look, what she will plant, and she enjoys chatting and telling stories with anyone who will listen."

"MB was quite the flirt when he was young. But now in his older years, he requires a wheelchair to get around his board and care; where he shares a room with a roommate. He can be seen still flirting with the female residents there, trading cookies and cigarettes, and spending time with other residents outside in the yard where they watch a group of friendly rabbits hop over the lawn and in between flowers. The residents seem to find the rabbits quite enjoyable to spend time with when they are not going out on group outings or playing bingo."

"AG moved into a clean, bright apartment one year ago and boasted how big the kitchen is, plus he loves the old wood floors, the dark wood rails, and inlays of that architectural time period. Today he takes walks around the historic Lake Merrit, has made friends with his neighbors, and is practicing up on his cooking skills."

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

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

PROGRAM NAME: Berkeley Housing: USV/Harrison House Singles

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

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

FY 24/25 Budget: $317,899 **Cost per Client:** $6,763

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 47 Adults

How Well Did We Do?

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

BOSS Harrison House shelter is located in Berkeley area in low traffic environment appealing to applicants who want privacy and limited stimulation. Harrison House provides shelter for families and single adults with mental health diagnoses and co-occurring disorder. Harrison House uses Alameda County shelter standards to promote a welcoming environment using Housing First principles. Harrison House residents are integrated in the daily operations of the shelter such as chores and lunch distribution, staff at the site promote community development and wellness activities through a menu of services from Health and Wellness groups which include daily walks, information sessions from health care partners to holiday and birthday celebrations and life skills development.

III. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**

☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

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IV. FY 23/24 Challenges:

Harrison House has experienced community violence which impacted staff and residents and led to increased safety features at the site. Harrison House has struggled to maintain and retain a trained workforce at site. Harrison House team is re-establishing internal controls to ensure they are meeting contract deliverables and supporting residents to move toward stable long-term housing. Finding affordable housing in the Bay Area is difficult for residents with extremely low income or zero income.

Is anyone better off?

Harrison House staff stabilized in the 4th quarter of FY 23/24 and worked to re-establish a system of completing CES assessment and housing navigation support. Harrison House continues to be a desired location for applicants and the last of FY 23/24 saw a stabilized group of residents who were working toward housing stabilization. Toward the end of FY 23/24, two residents obtained permanent supportive housing, 1 resident returned to the family home and 1 resident was referred to a more supported housing setting. Despite the ongoing changes at the site, BOSS maintains working relationships with community partners such as Berkeley Mental Health, community-based health organizations and initiated new partnerships with the public library and local food bank.

V. FY 23/24 Client Impact:

Process Measures: Met contract deliverables for serving unduplicated household and met bed night utilization.
Quality Measures: 100% on capturing entry/exit on HMIS, 100% of resident income status was captured entry/annually and exit.
Impact Measures: 47% saw increased income at exit or annually, 62% exit with one or more of the following at discharge, WIC, Cal Works or Cal Fresh and 84% exit with insurance.

VI. Projections of Clients to be Served:

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

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

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

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

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

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

FY 24/25 Budget: $743,258 **Cost per Client:** $19,057

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 39 Adults

How Well Did We Do?

II. Please Describe Ways that the Program Strives to Reduce Mental Health Stigma:
Casa Maria is a low barrier quick access interim housing project that uses a Housing First Model to admit and provide services for some of the most vulnerable individuals who are unhoused. Casa Maria staff meet residents where they are and move at the resident's pace. The staff at Casa Maria involve residents in daily activities at the site while partnering with their supportive network to ensure residents feel safe and comfortable at the site. Residents have private and semi-private space and couples are welcomed. Services as needed are available at residents request. Staff also received training on Mental Health First Aid, Harm Reduction Model, Critical Time Intervention and De-Escalation Trainings.

III. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

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IV. FY 23/24 Challenges:

Casa Maria experienced a period in FY 23/24 with staffing instability which impacted the collaborative network. Casa Maria staff served fewer residents because two units were offline. One created long term support for a couple and the other was offline due to repairs. Residents were impacted by community trauma (violence, theft) outside of the building. Residents experienced a longer length of stay due to new lease up, fewer permanent supportive housing opportunities and longer length of time from screening to move in.

Is anyone better off?

75% of residents moved into long term or positive housing opportunities, one of the long term couples obtained first housing as a family and new Casa Maria staff worked to re-established trust with residents and strengthened collaboration with community partners. Services include life skills training, community engagement and celebrations while leveraging internal resources within the agency help promote stability and resource sharing.

V. FY 23/24 Client Impact:

Process Measures: Met all their contract deliverables including 18 people moving into permanent supportive housing within 6 months of admission into Casa Maria.
Quality Measures: 90% entered in HMIS at entry and exit, 100% income status was captured at entry, annual assessments and exits and 100% was assessed through Coordinated Entry Assessments within 3 months of admission.
Impact Measures: 40% had increased income by exit, 87% had one or more non-cash aid, WIC, Cal Fresh or Cal Works. 100% exited with insurance.

VI. Projections of Clients to be Served:

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

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

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

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

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

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

FY 24/25 Budget: $804,691 **Cost per Client:** $14,117

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 57 Adults

How Well Did We Do?

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

SCHP uses the County's Shelter Standards and Housing First Model to provide interim housing for some of the County's most vulnerable populations experiencing homelessness, mental health crises and substance use disorder. SCHP staff receive annual trainings in best practices: Motivational Interviewing, Critical Time Interventions, Harm Reduction, Cultural Humility, De-Escalation and Trauma -Informed Care along with gender and cultural based trainings like Working with Trans and Gender Non-Confirming Populations, Impact of Discrimination on Mental and Physical Health for African Americans. This site also received training for Naloxone Rescue Training.

III. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

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IV. FY 23/24 Challenges:

SCHP experienced an increase in long stayers due to limited housing options, residents with limited income and zero income, housing authority barriers with documents expiring while people were waiting for briefings and/or inspections. SCHP experienced increased self exits and AWOL due to substance use issues.

Is anyone better off?

46% of SCHP residents obtained permanent supportive housing, SCHP reported 3 residents reunified with family and returned to family home. SCHP team leveraged internal programs for residents' needs and goals such as BOSS employment center, Wellness Center and Trauma Center. SCHP maintained relationships with community partners such as the Food Bank which provides nutritional classes, volunteers to maintain community garden on site, and nightly activities such as movie night and karaoke.

V. FY 23/24 Client Impact:

Process Measures: Nearing its target number of 90% occupancy, SCHP met contract goals on securing housing for individuals within 6 months and serving 57 unique individuals.

Quality Measures: 100% entry/exit was captured in HMIS, 100% income status captured at entry/annually and at exit, and 100% had Coordinated Entry Assessments within the first 3 months at the site.

Impact Measures: 91% obtained and retained one or more of the following benefits: WIC, Cal Fresh or Cal Works, 100% insurance at exit and 46% exited to permanent supportive housing.

VI. Projections of Clients to be Served:

FY 24/25	**24-48**
FY 25/26	**24-48**

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

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

PROGRAM NAME: Supported Independent Living

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

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

FY 24/25 Budget: $353,385 **Cost per Client:** $10,096

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 35 Adults

How Well Did We Do?

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

Building Opportunities for Self-Sufficiency (BOSS) has a portfolio of permanent supportive housing (PSH) for individuals with serious mental health diagnoses and co-occurring disorder. BOSS has a mission to help formerly unhoused individuals who are poor with disabilities achieve health and self sufficiency by addressing the root causes of poverty and homelessness. BOSS employs staff with lived experiences in key roles throughout their programs. The staff at the PSH sites receive annual trainings in the following areas: Motivational Interviewing, Harm Reduction Strategies, Critical Time Interventions and Trauma Informed Care. The PSH staff are also part of Alameda County's Supported Housing Learning Collaborative, a peer-to-peer network of housing providers sharing techniques and strategies for housing intervention and retention. Each of the PSH sites have a welcoming approach for new residents, host groups and activities on site to promote community development and provide a safe space for feedback from residents. BOSS promotes strong inter-agency resource sharing and connections. Many of the residents at the PSH sites receive housing, employment or personal development services from various BOSS agencies.

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III. Language Capacity for this Program:

☐ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

IV. FY 23/24 Challenges:

The Transition Age Youth (TAY) site experienced a fire in 2022 that took 4 units offline. In 2023 BOSS reported ongoing and long-term delays with the fire damaged rehab projects. The staff at the site reported morale was low and residents struggled with living in an environment with a constant reminder of the fire. BOSS PSH sites are impacted by the larger issues within the community. Two residents at different sites died from substance use overdose and another resident witness the murder of her brother near her home. Affordable Housing and housing voucher options are limited especially for individuals who are already housed. BOSS residential services experienced high staff turnover rates and shifts to the culture at the sites, which frustrates tenants. In addition, one project experienced pest infestation Which took a year to resolve.

Is anyone better off?

BOSS tenants did not experience eviction and many work with the BOSS team to find emergency rental assistance programs to resolve back rent. BOSS has a high retention rate for the housed. Two tenants obtained mainstream vouchers and graduated from PSH. The TAY project reported 3 of the residents were employed or attending community college.

V. FY 23/24 Client Impact:

Process Measures: Two of the three BOSS PSH projects met or exceeded their goals for unduplicated residents.
Quality Measures: 100% of the entry/exit information was entered into HMIS.

Impact Measures: 80% of tenants in BOSS PSH projects were enrolled in one or two programs: WIC, Cal Works or Cal Fresh, 100% had health insurance.

VI. Projections of Clients to be Served

FY 24/25	**32-38**
FY 25/26	**32-39**

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

PROVIDER NAME: East Oakland Community Project

PROGRAM NAME: Crossroads

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

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

FY 24/25 Budget: $397,613 **Cost per Client:** $11,694

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 34 Adults

How Well Did We Do?

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

EOCP is centrally located in the community of Oakland and serving the area's most vulnerable families and single adults. The EOCP approach is personalized, compassionate and dignified with a goal of healing its community. EOCP staff receive training in evidence-based practices with a focus on understanding and respecting diverse cultural backgrounds. EOCP staff completed the following trainings: Working with Trans and Gender Non-Conforming Clients, Trauma-Informed Approach-Cultural Humility, Harm Reduction Practice and Mental Health First Aid and De-Escalation. EOCP use Housing First Model to welcome people into the shelter regardless of their sobriety status and engagement in health and behavioral health services.

III. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

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IV. FY 23/24 Challenges:

Early part of 2023-2024 saw quick entry/exits due to complex behavioral health needs and people struggling with sobriety. This contributed to the low 26% of residents obtaining permanent supportive housing and 48% exiting to the streets. In addition, EOCP saw a 3 month time frame of limited referrals and low enrollment, providers cited the neighborhood as a trigger or the location was not safe for individuals. Admission pauses due to COVID outbreak also impacted the amount of people served. EOCP saw decreases in housing opportunities for residents at the shelter, especially for populations with zero income or Cal Fresh only. Public benefits agencies had lengthy waitlists for individuals applying for disability benefits (on waitlist 8 months or longer).

Is anyone better off?

EOCP maintained staff during FY 23/24, their harm reduction specialist did outreach and engagement for group and individual supports. EOCP was able to maintain 9 stayers and 6 exited to permanent supportive housing, returned to family home or transitioned into short term housing. One of the public benefits agencies meet with EOCP residents weekly to for engagement and tracking of referrals. EOCP strengthened its relationship with other community partners such as Behavioral Health Department to support residents to remain safely in the shelter. EOCP continues to screen and admit applicants the same day they receive the referrals.

V. FY 23/24 Client Impact:

Process Measures: Met or exceed standards for unduplicated household served and bed nights.

Quality Measures: 100% entry/exit data captured in Homeless Management Information Systems (HMIS) and 100% income captured at entry/exit in HMIS, nearing target of 70% getting Coordinated Entry Assessment in HMIS within the first 3 months of enrollment.

Impact Measures: 80% of residents retained income at entry/exits, 71% of residents obtained or maintained at least one of these benefits: WIC, Cal Fresh or Cal Works and 96% obtained or maintained insurance.

VI. Projections of Clients to be Served:

FY 24/25	**25-40**
FY 25/26	**25-40**

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

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

PROGRAM NAME: Flexible Housing Subsidy Pool - Rental Assistance Program

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

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

FY 24/25 Budget: $500,000 **Cost per Client:** $10,204

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 49 Adults

How Well Did We Do?

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

Alameda County Coordinated Entry System (CES) help identify eligible candidates for Flex Funding Subsidy Pool. Alameda County uses The Housing First model and along with CES, this approach is instrumental in reducing mental health stigma by identifying vulnerable adults over the age of 18 with serious mental health diagnoses that can live in the least restrictive and integrated setting. This program supports housing in scatter sites, mixed economy units, and care facilities in a diverse landscape. This fosters inclusivity, breaking down barriers and community building with a broader community.

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III. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

IV. FY 23/24 Challenges:

Alameda County Person In Time (PIT) Count shows on any given night over 9,000 people are unhoused. The needs of our targeted populations exceed the available subsidies. A stabilized workforce is needed for landlord engagement, housing navigation and ensuring expediency with initiating subsidies.

Is anyone better off?

Yes, 36 of the 44 remain in subsidized housing through this program.

V. FY 23/24 Client Impact:

During FY 23/24 The Housing Choice Vouchers are still being leveraged for this group. Two individuals used their Section 8 vouchers for new units including relocating to a different County of choice.

VI. Projections of Clients to be Served:

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

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 11

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: Community Conservatorship (CC) Program

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

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

FY 24/25 Budget: $780,614 **Cost per Client:** $28,911

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 27 Adults

How Well Did We Do?

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

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

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

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

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III. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

IV. FY 23/24 Challenges:

As with most programs, Telecare continues to struggle with finding and securing affordable housing for participants. Telecare has proactively developed relationships with area board and care operators to develop an MOU for a couple of Telecare specific homes to increase collaboration and access. Despite these efforts, there is still a lack of affordable housing in Alameda County.

Additionally, finding and securing supportive housing with medical services such as diabetes management and medication support continues to be challenging.

Staffing also continues to be a struggle, especially for psychiatrists and nurse practitioners.

Recently we have also struggled with connecting partners to primary care providers. The FQHCs in Alameda County are having a staffing crisis. Partners are waiting months to get established and requiring urgent care or emergency care while they wait.

Is anyone better off?

V. FY 23/24 Client Impact:

CC partner John was discharged to the community and program after nearly 10 years in acute and subacute hospital stays including Napa and Villa Fairmont. CC team began building a therapeutic relationship with him while he was still in Villa and supported his preparation to discharge and return to the community. He has been engaging well with the team and is able to articulate his needs and concerns. He is engaged with Options outpatient SUD treatment to maintain his sobriety. He is engaged with IPS for support around his educational goals. He has reconnected with his family and is re-establishing supportive relationships with them. John is taking his medications and working with CC team psychiatrist for on-going stability. John is also building strong relationships within his board and care home. CC program has assisted him in connecting with Bay Area Legal Aid and continuing to work on his SSI benefits application. He was recently approved for his benefits and is connected with the Alameda County Sub-payee program to continue to manage his rent and budget. John has been successfully living in the community without any hospitalizations or police contact for over a year.

VI. Projections of Clients to be Served:

FY 24/25	28
FY 25/26	28

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 12

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: Assisted Outpatient Treatment (AOT) Program

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

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

FY 24/25 Budget: $845,666 **Cost per Client:** $17,992

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 47 Adults

How Well Did We Do?

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

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

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

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

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III. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

IV. FY 23/24 Challenges:

As with most programs, AOT continues to struggle with finding and securing affordable housing for participants. Telecare has proactively developed relationships with area board and care operators to develop an MOU for a couple of Telecare specific homes to increase collaboration and access. Despite these efforts, there is still a lack of affordable housing in Alameda County.

Additionally, finding and securing supportive housing with medical services such as diabetes management and medication support continues to be challenging.

Recently we have also struggled with connecting partners to primary care providers. The FQHCs in Alameda County are having a staffing crisis. Partners are waiting months to get established and requiring urgent care or emergency care while they wait.

Is anyone better off?

V. FY 23/24 Client Impact:

A partner who AOT has been working with over the last year has reached several accomplishments. Martin previously had several failed attempts to engage in programming and spent many years living homelessly in the Fremont area. He has no family and no benefits. He is hearing impaired, and this impacts his ability to connect and engage in his treatment. Alameda County worked with AOT program to coordinate an in person ASL interpreter to meet with Martin and the team twice a week which has resulted in strong relationship building and engagement in treatment. Martin agreed to a hotel stay and has been housed for the last year. He is working with Bay Area Legal Aid to get his benefits. He has been approved and is moving forward with his benefits to ensure long-term stability. Martin has also been willing to try medications and is currently taking both oral and a long acting injectable to improve his symptom management. Martin has been able to stabilize and engage in mental health treatment for the first time in more than 10 years and is doing well in the community.

VI. Projections of Clients to be Served:

FY 24/25	50
FY 25/26	50

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 13

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: CHANGES

Program Description: Telecare CHANGES is an adult Full Service Partnership located in the Eastmont Town Center in Oakland, CA. The CHANGES FSP provides comprehensive treatment and support services using the Assertive Community Treatment (ACT) service delivery model in which services are delivered by an integrated team including case managers, a vocational specialist, a peer support specialist, a psychiatrist, and a nurse. Services provided by the FSP team include mental health services including individual and group rehabilitation, medication support, nursing support, and targeted case management. The latter service links the individual consumer to needed resources and supports in the community such as housing, benefits, and medical/dental services. Individuals assigned to the CHANGES FSP team can expect to meet with a team member at least twice a week. Additionally, 80% of the team services are delivered in the community.

Target Population: The CHANGES FSP serves adult Alameda County residents, 18 years of age or older, with serious mental health conditions or significant functional impairments in one or more major areas of functioning, who are at high risk of re-hospitalization and/or frequent users of acute psychiatric services.

FY 24/25 Budget: $3,863,220 **Cost per Client:** $13,321

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 290 Adults

How Well Did We Do?

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

III. Language Capacity for this Program:
☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

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IV. FY 23/24 Challenges:

The Changes/Visions program experienced multiple challenges this previous fiscal year. Challenges included turnover of program leadership, namely the Program Administrator which hindered consistency and stability of program. Fortunately, Telecare and was able to leverage its resources to bring in a Floating Administrator to hold over and stabilize the program in the absence of losing its previous Administrator. Telecare has now hired a new permanent Administrator with a 7/22/24 start date.

In January, the facility that Changes/Visions is located in experienced a flood which resulted in significant damage and displaced Changes/Visions. Eastmont mall was able to provide Telecare with a temporary space upstairs while repairs were underway. Unfortunately, the space was not conducive to providing services onsite, and was difficult for employees to adapt to. The program was able to return to our original offices after 4 months of displacement.

Lastly, the program has had a great deal of difficulty in hiring new employees, namely Case Managers due to market conditions such as a very low pool of qualified candidates. For example, for 1 Case Manager job positing, Telecare received only 4 potential applicants in the span of 3 months. In response to market conditions, Telecare has increased salary ranges to be competitive within the market and offers sign-on bonuses to attract potential qualified applicants.

Is anyone better off?

V. FY 23/24 Client Impact:

Adam is a 30-year-old Caucasian male living in a SRO home. Adam has been with Changes/Visions for several years and has a history of maladaptive alcohol use. Adam has been in precontemplation stage of change for years and has a history of falling while intoxicated that caused acute paralysis of his legs. Adam's psychosis causes delusions that made him believe that he was shot. The Case Management team worked with BACS to connect him to assisted living to support his physical recovery, payee services to assist with financial management, and medication management through the Changes/Visions medical team. Case Managers met with Adam weekly to address his treatment goals and build motivation to change his alcohol use, as well as support Adam with his psychical therapy appointments. In conjunctions with Changes/Visions efforts, Adam has regained ability to walk, and significantly decreased his alcohol use. Adam now lives in his own apartment and is living independently.

VI. Projections of Clients to be Served:

FY 24/25	250-350
FY 25/26	250-350

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 14

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: STRIDES

Program Description: STRIDES is a full service partnership program based on the Assertive Community Treatment model. Our program offers collaborative treatment planning, risk assessment and safety planning, psychosocial assessments, symptom management skills training, medication management support, housing and residential treatment referrals, 24/7 crisis support, and collateral services for care coordination.

Target Population: STRIDES serve individuals (adults, age 18+) who are diagnosed with a severe mental illness, high utilizers of mental health services, and considered to be at great risk for psychiatric hospitalization.

FY 24/25 Budget: $3,860,338 **Cost per Client:** $36,765

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 105 Adults

How Well Did We Do?

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

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

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

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

III. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☒ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

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IV. FY 23/24 Challenges:

As with most programs, STRIDES continues to struggle with finding and securing affordable housing for participants. Telecare has proactively developed relationships with area board and care operators to develop an MOU for a couple of Telecare specific homes to increase collaboration and access. Despite these efforts, there is still a lack of affordable housing in Alameda County, especially with finding housing operators who are understanding and know how to support participants presenting with mental health symptoms and challenges. Additionally, finding and securing supportive housing to serve participants with comorbid medical needs, such as diabetes management and medication supports, continues to be challenging.

Lastly, with recent CalAIM changes, which has impacted our ability to bill/receive reimbursement for travel time, as well as increase training around the use of new service billing codes, we have dedicated an extensive amount of time to train our staff and restructure the way in which we provide services. For example: Despite being a community-based program who pride ourselves in mitigating participants' risks and rehospitalization through timely community based supports and assessments, we've started to transition our psychiatric providers to a Telepsych model to increase service billing. While the effects are not yet clear, collateral reports from staff who are facilitating these Telepsych calls have reported decreased/shorter engagement with our psychiatric providers as they are less engaged via phone/video calls.

Is anyone better off?

V. FY 23/24 Client Impact:

"Ray" was admitted to STRIDES in April 2023 through Alameda County ACCESS Program due to having limited success in Behavioral Health Court (collaborative diversion court for individuals with misdemeanor charges and who have a psychiatric diagnosis), repeated episodes of arrests (violence towards others) and psychiatric hospitalizations, limited medication adherence, non-engagement with mental health service team, and struggled with unstable housing and periods of homelessness. While Ray was initially ambivalent in his engagement with treatment services, through repeated outreach and engagement efforts, we were able to successfully build rapport with him. Currently, he is working full time as a Cashier Lead in a local grocery store. He has maintained housing for almost a year in a Single Room Occupancy hotel near our office. He has had no rearrests since joining our program and recently graduated from Behavioral Health Court due to his continued engagement in treatment and no re-offenses. He has shared how grateful he is for the STRIDES team as he attributes his current successes to the supports he received from STRIDES.

VI. Projections of Clients to be Served:

FY 24/25	100-105
FY 25/26	100-105

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 18

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Homeless Engagement Action Team (HEAT)

Program Description: Provides full service partnership services within the philosophy of 'whatever it takes' to Alameda County homeless adult residents who live with serious mental illness. Clients shall be those individuals at high risk of re-hospitalization who could live in the community if comprehensive services and concentrated supports were available to accommodate their needs.

Target Population: Clients will include individuals who are homeless or at risk of homelessness, have been involved in the criminal justice system, have co-occurring substance use and / or physical health disorders, frequently use hospitals and other emergency services, are at risk of institutionalization, and/ or have limited English proficiency. Contractor shall serve individuals who are sex offenders.

FY 24/25 Budget: $5,134,784 **Cost per Client:** $29,510

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 174 Adults

How Well Did We Do?

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

a. Reduce Mental Health Stigma: HEAT works with participants by using a client-centered approach to collaborate with their families and other natural supports to meet participants where they are at in terms of recovery, insight, and ability to manage symptoms. HEAT provides psychoeducation to families and other natural supports to assist the partner in receiving comprehensive care, provide linkage support to receive much needed support (NAMI, Towne House Wellness Center, HEDCO Wellness Center). As part of the HEAT service model the participant's natural supports are drawn in as stakeholders in their care and contributors to the treatment. This Wraparound approach supports building community around the participant and empowers their voice and choice while reducing the isolation that so frequently accompanies severe mental health challenges. We also provide opportunities for partners to engage in their communities through

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outings such as ticket's to A's games, The Oakland Zoo, and a once a month BACS Summer BBQ that has food trucks, a barber and hair braider, a masseuse and a DJ. We believe that outings like these build community, decrease isolation, and foster a sense of belonging in the clients.

b. Create a Welcoming Environment: HEAT is flexible in location, meeting time, and engagement style to support participants and natural supports to feel comfortable in a wide range of settings. The HEAT team meets with participants in the community, their residence, wellness centers or other BACS locations. HEAT staff are trained in Crisis De-escalation, Harm-Reduction and Trauma-Informed Care principles to provide services in a whole-person manner. Cultural responsivity is a core axiom of the care provided by the team as the HEAT team was designed with Culturally and Linguistically Appropriate Services (CLAS) standards in mind.

III. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

IV. FY 23/24 Challenges:

One of the biggest challenges the HEAT team faced this year was low staffing, which impacted client engagement and the team's ability to meet with each client in-person four times a month. However, in the beginning of 2024 the HEAT team grew exponentially, and for the first time since before the pandemic, the team is staffed at full capacity. This includes positions that have been historically difficult to fill including two nurses, two employments coordinators, and an in-person psychiatric provider, which all contribute to a transdisciplinary approach to providing services to our clients. What began as a challenge quickly shifted into one of the team's greatest strengths throughout the year. Another barrier to care has been access to dual-diagnosis treatment facilities. There seems to be a lack of resources, which is critical for participants in order to be successful in treatment when substance use is a major factor. Last, for the team, it has been a challenge to log into CG/SmartCare due ongoing changes and transition, which has created a barrier for staff to submit their documentation on time.

Is anyone better off?

V. FY 23/24 Client Impact:

Once we were fully staffed, several barriers were lifted and the HEAT team was able to engage and provide services to our partners with greater frequency and diversity, reflecting the true ACT model. As a fully staffed team, HEAT has been able to implement a multidisciplinary approach to

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client care, providing different levels of skill and expertise so that care is catered to each individual client. Psychiatry, primary care, and medication management were also great accomplishments of the HEAT team this year. The team was able to provide in-person psychiatry services as pandemic restrictions decreased, and this in turn improved outcomes and client engagement with psychiatric services. The in-person aspect has greatly improved client attendance of appointments as they are able to connect with the provider in a more visceral way. The HEAT team was able to link over 80% of the partners to primary care services within the last year, improving their overall well-being, decreasing pain and discomfort, and linking them to the care that they need and deserve.

HEAT had a truly monumental success story this year. A partner since 2018 was referred to the HEAT program due to his history with the legal system and increased incarcerations making him less stable in the community. The partner's mother began noticing mental health symptoms when he was 4 years old. The partner presents with an intensive history of incarcerations due to violent behaviors in the community. He has also repeatedly broken windows at Towne House due to outburst and destructive behaviors. Overwhelmed, the partner's mother was unable to provide housing support for him, which led the partner to chronic street homelessness. The HEAT team connected the partner to ABODE and the partner was housed in 2019. Unfortunately, due to becoming incarcerated, the partner lost his housing voucher costing him hi housing through ABODE. The team worked with the partner and with Homestretch and the coordinate entry system for housing matches. After some time working with the team, the partner was able to identify his triggers and engage in successful community outings – those outings included A's games, The Oakland Zoo and Town House Wellness summer parties. The partner's relationship with his mother has significantly improved to where she welcomed him back home and they are now living together again. The partner now supports his mother to her medical appointments and schedules his own medical appointments independently. The partner's mental health symptoms have also decreased dramatically in the past year, making is possible for him to be more independent in the community with no episodes of hospitalizations or incarcerations.

VI. Projections of Clients to be Served:

FY 24/25	250
FY 25/26	250

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 20

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Lasting Independence Forensic Team (LIFT)

Program Description: Provides full service partnership services within the philosophy of 'whatever it takes' to Alameda County adult residents who have been involved with the criminal justice system and live with serious mental illness. Clients shall be those individuals at high risk of rehospitalization and/or reincarceration who could live in the community if comprehensive services and concentrated supports were available to accommodate their needs.

Target Population: Clients shall be adults who have been involved with the criminal justice system and will include individuals who are homeless or at risk of homelessness, have co-occurring substance use and / or physical health disorders, frequently use hospitals and other emergency services, are at risk of institutionalization, and / or have limited English proficiency. Contractor shall serve individuals who are sex offenders.

FY 23/24 Budget: $3,532,544 **Cost per Client:** $30,987

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 114 Adults

How Well Did We Do?

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

As reported last year, LIFT has centralized the structure of the "TDM" or "Team Decision Meeting" to actively involve our partners, their families, other natural supports, and direct support staff (housing, mental health, and medical) in order to optimize our client-centered approach to supporting our clients and helping them reach their goals. In addition to this, LIFT has coordinated with housing partners to develop housing stability meetings that apply the TDM model to support partners in maintaining their housing. LIFT provides psychoeducation to families to support them in supporting their loved ones, provides brokerage services to receive much needed support and develops community through group outings in the community such as hikes, going to the beach, summer baseball game outings, and outings to the county fair, movies, and art festivals. In addition to BBQ's, block parties, trips to the zoo, museums, the beach, and number of other activities, LIFT continued to implement multiple DBT groups as well as small groups, pizza and games to expand its community integration efforts as a part of its wrap around support programs

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in order to empower clients to address challenges with others and in the context of a relaxed and welcoming environment. LIFT also developed a robust curriculum of an ongoing SUD group that we are excited to launch next year. We believe that it is crucial for our partners to understand that they are not alone in their struggles and that they can have the support of other people facing similar mental health challenges. This creates an empowering environment that helps to reduce the stigma around mental health.

III. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☒ **Other**: Hindu

IV. FY 23/24 Challenges:

One of the most notable challenges observed during the 23/24 FY involved acute and subacute treatment facilities releasing partners prematurely, resulting in a high degree of recidivism, poor placement outcomes, and longer periods of de-stabilization. This impacts housing stability for partners and the efficacy of outpatient treatment as partners do not reach the degree of stabilization to improve the course of treatment. As a result, a very high number of partners cycled frequently through hospitalization and subacute facilities.

Consistently, the rampant availability of substances in the community and at a wide range of housing sites (e.g., board and cares, independent living, SRO, PSH, and SLE sites) contributes to poor outcomes to individuals seeking recovery and/or housing stability. There are currently no known SLE's through CenterPoint that serve registered sex offenders, which in effect eliminates inpatient recovery for RSO clients within the county. Limited sober living environments also result in very sluggish placement rates, which is a major challenge for clients seeking treatment.

Additionally, housing for clients requiring an FSP level of care and support is limited. Licensed board and care scarcity has resulted in long wait times for placements, as partners are waitlisted despite high level of need. Similarly, PSHs are scarce and do not provide the level of care needed to sustain a high percentage of clients requiring an FSP level of support. Lack of placement options for registered sex offenders continues to contribute to homelessness within our program. Some of the most difficult cases have involved partners with SMI and severe physical health issues, resulting in a deficient degree of support for some individuals who need it the most.

This year, LIFT also noticed an increased frequency of referrals of incarcerated individuals who did not appear interested in treatment. A combination a higher acuity and ambivalence on the part of referrals has resulted in challenges to engagement and outreach and a risk of higher client turnover within the program.

Finally, changes in the documentation and billing system countywide carried with it a number of

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technical challenges beyond the control of the program. Currently, we have received reports that changes to the program code, metrics, and other important data remain dependent on our own internal data tracking, as the county is not operating with up-to-date, fully functioning data systems.

Is Anyone Better Off?

V. FY 23/24 Client Impact:

Severe mental illness severely impacts our partners' ability to connect independently to resources such as housing, employment, education, legal resources, SSI/disability income and other benefits, the DMV, medical/primary care services, psychiatric services, and a whole range of other important resources. LIFT profoundly impacts partners in connecting to these resources. Partners are supported daily in connecting to benefits through social service for Cal Fresh, GA, and Medi-Cal documentation, primary care and other medical services, dental services, clothing and hygiene resources, housing services such as CES/Coordinated Entry, HSP referrals to licensed board and cares, independent living sites, SROs, emergency shelters, etc. In addition, many of our partners have limited resources and skills to safely engage in healthy, fun, and meaningful activities without support. LIFT has supported several partners in connecting to employment and volunteer work over the past year, as well as vocational programs (e.g., cooking classes) and supported on fun and enriching community outings including trips to art fairs, baseball games, movies, hikes, and the beach.

As a forensic program, we have supported multiple partners in graduating behavioral health court and diversion court programs in the last year, and we continue to support 6 of our partners through these programs in order to encourage treatment over incarceration. Currently LIFT has supported 4/5 of its partners in connecting to and/or maintaining permanent housing placements, not including shelters and subsidized long term emergency shelter placements which account for a significant portion of the remainder of LIFT's census.

LIFT has also achieved a high level of stabilization for a number of our partners. While LIFT has only graduated 2 of its partners during the 23-24 FY, LIFT is actively supporting at least 4 additional partners in prep for graduation during the next FY, with 1 currently opened to ICM as of July 2024.

LIFT continues to partner with housing partners to provide structured wrap around support in order to support partners in maintaining housing and managing ADLs while at the same time deepening our relationship with housing partners to the benefit of the community and the populations we serve. Regular housing stability meetings continue in conjunction with PSH, board and care, and independent living housing staff in order to promote stable housing.

VI. Projections of Clients to be Served:

FY 24/25	110	**FY 25/26**	120

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 22

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: Justice and Mental Health Recovery (JAMHR)

Program Description: JAMHR is a full-service partnership program based on the Assertive Community Treatment model.

Target Population: JAMHR serve individuals with severe mental illness who have a history of justice involvement, are high utilizers of mental health services and who are considered to be at great risk for psychiatric hospitalization and recidivism.

FY 24/25 Budget: $3,065,364 **Cost per Client:** $25,759

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 119 Adults

How Well Did We Do?

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

JAMHR staff are trained in working with partners in a 'power with' stance, to help our clients understand that they are empowered actors in their own recovery journeys. We model this type of interaction when we meet partners with their loved ones other community stakeholders. We believe in the dignity of risk and our partners' right to fail. We discuss external as well as internalized stigma with partners. We utilize Telcare's Recovery Centered Clinical System to engage partners in conversations about their identity and their values. We encourage community stakeholders to address our partners directly, rather than our staff when in community settings. We directly discuss with our partners the impacts of their symptoms on their lives and help them come up with strategies to manage their symptoms in such a way as to minimize disruption in the achievement of their goals.

III. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☒ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

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IV. FY 23/24 Challenges:

Is anyone better off?

V. FY 23/24 Client Impact:

JAMHR partner 'Daniel' is a 31 year old man who was experiencing extreme irritability and some paranoid thought, with other members of his residence, and eventually was evicted. With the help of MHSA housing funds, we helped Daniel get a room at a local motel where he could take a break from congregate living. Because he had a trusting relationship with our staff, he agreed to accept his oral medications from us when we went to visit him daily, 7 days a week, for three weeks. After that period, he was better able to manage his emotions and his interpersonal relationships, so we helped him get his own room in a single room occupancy hotel, supplemented with housing funds. At the SRO, he practiced his independent living skills, he made friends and worked with our vocational specialist using the IPS vocational model to get a full-time market-rate job at a local drug store. Eventually, he was offered private insurance through his employer, which he accepted, but unknown to us, he was unable to access his psychiatric medications and experienced a setback, once again experiencing the same irritability and paranoid thoughts. He was asked to leave his job. JAMHR staff helped him access MediCal again and advocated for a short stay at a MHRC. He is now discharged from the MHRC, living in a supported environment, socializing and doing well, and working towards getting a new job.

VI. Projections of Clients to be Served:

FY 24/25	130
FY 25/26	140

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 23

PROVIDER NAME: Asian Health Services (AHS)

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

Program Description: This program supports clients by building and teaching coping skills, living skills, creating easy access to psychiatric care, and providing housing resources. These services assist adults with SMI to decrease or even diminish mental health symptoms in order to integrate into a community, successfully. Another important purpose of the Service Team program is to avoid and eliminate repeated patterns of psychiatric hospitalizations for our client adults. The service design includes anywhere from weekly to monthly contacts of direct service. (Formerly known as program number OESD 29)

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

FY 24/25 Budget: $3,094,050 **Cost per Client:** $12,229

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 253 Adults

How Well Did We Do?

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

AHS strives to reduce mental health stigma through various methods. We focus our efforts on recruiting, training, and retaining bilingual/bicultural clinicians who understand the language, cultural dynamics, and the community's values. A majority of our clinical staff provides treatment services in the clients' native languages, which often are barriers to care. We provide culturally relevant support/peer groups that enhance engagement and create an environment where individuals can connect, share experiences, and reduce feelings of hopelessness and shame. We organize outreach programs that normalize mental health services and portray them as a sign of strength and self-care through in-person events, social media, and videos. On our social media and video platforms, we use culturally appropriate examples and stories to normalize conversations about mental health within families and social circles. We also partner with vetted local community leaders, religious figures, or elders to champion mental health awareness and reduce stigma.

III. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☒ **Chinese** ☒ **Korean** ☒ **Vietnamese** ☒ **Tagalog** ☐ **Farsi**

☒ **We use the Language Line** ☒ **Other**: Japanese, Khmer, Mandarin, Mien. We use both language line and qualified staff for interpretation services.

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IV. FY 23/24 Challenges:

AHS grappled with sustaining staffing levels throughout this fiscal year. We had multiple staff on leave due to VISA employment and/or personal issues, and two psychiatrists moved out of state. We also had two staff return to graduate school. Recruitment of qualified staff has been a continued challenge. This impacted our ability to take on new case assignments throughout the year. Community members often sought help later, presenting with severe psychiatric symptoms, making it difficult to stabilize and arrange urgent services with limited resources. AHS established a Behavioral Health Training Academy in 2023, and we have been able to hire three bilingual/bicultural interns from this program. The program will help increase capacity for care for the upcoming fiscal year. Implementing Smart Care billing system created barriers for clinicians to complete services accurately, leading to delays and increased stress. Fortunately, the staff has acclimated to the new billing system.

Is anyone better off?

V. FY 23/24 Client Impact:

Mrs. H suffers from severe depression, passive suicidal ideations, anxiety, poor sleep and appetite, poor concentration, catastrophizing, lack of motivation, and somatization. Due to her ongoing struggle with chronic pain, she is unable to work and receives monthly SSI benefits. Mrs. H isolated herself from friends and family and does not have a social supportive network due to perceiving herself a burden to others. She also experiences guilt for not being able to provide her children with more than the essentials due to the family's limited budget. Her husband is only able to work part-time, manual labor, due to language barriers and mobility issues. Their combined monthly income is barely sufficient to cover their current expenses. Her symptoms have exacerbated since the pandemic, and due to her children being robbed several times in recent months when out in the community. These symptoms continue to impact her daily functioning. In the past, the AHS clinician has encouraged Mrs. H numerous times to attend the food distribution held at Wilma Chan Park. Mrs. H always refused, citing struggles with her pride and dignity. In recent weeks, Mrs. H's chronic pain has worsened, making grocery shopping even more difficult. AHS recently started a food pantry service and Mrs. H was willing to utilize the services with the clinician's encouragement and support. The experience felt like "grocery shopping" - Mrs. H was delighted that the products were fresh and culturally appropriate. Her eyes welled up as she informed her clinician, "I am so grateful. With the cost of inflation, these groceries have probably saved my family of 4 over $100. That may not seem like a lot to other people, but in my family, every penny counts." This experience demonstrates AHS's commitment to comprehensive client care and providing our community with culturally relevant support. Finally, Mrs. H's willingness to process her financial limitations and their impact on her mental health in recent therapy sessions marks a significant breakthrough.

VI. Projections of Clients to be Served:

FY 24/25	286
FY 25/26	286

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FULL-SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 23

PROVIDER NAME: Felton Institute

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

Program Description: The Older Adult Service Team supports client recovery through a holistic and strength-based approach that considers the overall bio-psycho-social needs of older adult clients. All consumers are 60 years or older. With a significant number of older adults needing this level or service, creating a team to focus on the unique needs of the older adult population was a priority. Service Teams are multi-disciplinary and coordinate community-based services to provide individually customized mental health care for people experiencing frequent setbacks or persistent challenges their recovery. The overarching goal is for clients to attain a level of autonomy within the community of their choosing.

Target Population: This program serves older adults (age 60+) who have moderate to severe mental illness impairments resulting in at least one significant impairment in an important area of life functioning. All clients must meet specialty mental health criteria with impairments in the moderate to severe range.

FY 24/25 Budget: $1,335,116 **Cost per Client:** $19,927

How Much Did We Do?

I: FY 24/25: Number of Unique Clients Served: 67 Older Adults

Connection to a primary care medical provider is particularly important for older adults, given the increased medical needs and the complex interactions between psychiatric, cognitive, and medical issues. The contract requires that OAST support at least 75% of our clients to see their PCP at least once during the fiscal year. 65% of our clients had contact with their medical care providers, with many attending multiple appointments with medical care providers; we hope to improve this number going forward by utilizing supports including IHSS, ECM, and insurance-based transportation options (e.g. Alameda Alliance and Paratransit transport to medical appointments).

How Well Did We Do?

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

OAST and Felton Institute highly value reducing stigma around mental health issues. As a team,

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both in team meetings and with our clients, we try to talk openly about this subject to normalize accessing mental health services as part of overall wellness management. We talk to clients about how a psychiatric diagnosis is no different than another medical diagnosis (e.g. you take medication to control your diabetes, so taking medication to control your Bipolar I Disorder is similar). We are cognizant of the language we use with clients, family members, and other community members and try to educate people whenever possible about why it is important to talk about mental health and use non-judgmental language. OAST staff strives to educate each other about mental illness and substance use disorders through continuous trainings. OAST uses a harm reduction approach where we examine our own judgment and thinking and treat everyone with dignity and respect. We offer support and encouragement and meet the clients where they are at.

III. Language Capacity for this Program:

During the fiscal year, language capacity for this program was mostly English, with some Spanish. We also utilize the language line to communicate with Spanish speaking clients.

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

IV. FY 24/25 Challenges:

Consistent staffing was, unfortunately, somewhat of a challenge during parts of the year. We were without a case manager, medical staff and clinical case management for the earlier part of the year.

By the end of the fiscal year OAST's direct service staff was fully staffed.

Social determinants of health amongst our clients are the biggest challenge with servicing our caseloads. Housing resources and medical services continue to be a barrier when it comes to integrated work with primary care and care providers due to communication issues. The lack of medication/medical support, and true supportive housing in the unlicensed board and cares continue to be an area of challenge.

V. FY 24/25 Client Impact: Is anyone better off?

We support clients to reduce stress, ward off anxiety and depression, and reduce the risk of homelessness, some physical health concerns and social determinants of health by providing individual therapy and case management services.

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Client success story: DeLa - This client is a 68-year-old woman with bipolar 1 disorder and a history of alcohol and stimulant use disorders. She had disengaged with office-based psychiatric and medical care in 2022 and went on to suffer debilitating stroke in the summer of 2023. She received little to no psychiatric care during the months she spent at SNF and was discharged due to her disengagement from physical rehab there. When she was discharged home in February 2024, she was severely depressed, bedbound, and without home equipment or support. Through diligent outreach, OAST reengaged her in medication management and psychotherapy and advocated to get home health rehab, good-quality IHSS support, transportation, and Meals on Wheels in place. Her depressive symptoms are now greatly improved. She has been able to participate in home rehab such that she reasonably hopes to walk again, and she has reestablished care with her PCP that supports improved adherence to meds that significantly reduce her risk for recurrent stroke.

VI. Projections of Clients to be Served: Per our contract, the goal is to service 90 clients.

FY 24/25	90
FY 25/26	90

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 23

PROVIDER NAME: Bay Area Community Services (BACS)

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

Program Description: This program supports clients by building and teaching coping skills, living skills, creating easy access to psychiatric care, and providing housing resources. These services assist adults with SMI to decrease or even diminish mental health symptoms in order to integrate into a community, successfully. Another important purpose of the Service Team program is to avoid and eliminate repeated patterns of psychiatric hospitalizations for our client adults. The service design includes anywhere from weekly to monthly contacts of direct service. (Formerly known as program number OESD 29)

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

FY 24/25 Budget: $1,457,737 **Cost per Client:** $10,123

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 144 Adults

How Well Did We Do?

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

Care Coordinators in the ICM Program have profound influence on care and attitudes towards care throughout the entire mental health ecosystem in Alameda County, where stigma still exists even within providers and community partners who serve our mutual population. Our staff are trained to hold a "whatever it takes" stance while brokering care with all providers to overcome not only stigma from mental health diagnoses, but also negative history from our participants' "rap sheet" where many are well-known around the county and often refused services or housing due to their troubled past. We have found that the best way to overcome stigma and "blackballing" towards our participants is to approach providers and partners will a carefully thought-out plan of action and rich discussion of the human aspects of the participant's current situation in a way that paints a picture of how significant change and growth is still, and always possible for our partners.

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III. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**

☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

IV. FY 23/24 Challenges:

ICM saw a high volume of client turnover this year, with clients leaving services due to successful graduation to a lower level of care, refusal of services, leaving the service area or passing away. This has made capacity for a high volume of new referrals, who often present with acute mental illness and high risk for crisis. As FSP programs across the county reach capacity, the adult level 1 becomes a backstop for individuals who may struggle to stabilize with a lower level of care. The team has responded to this by employing a wrap-informed model where each client receives both clinical and MHRS support, Team Decision Meetings are conducted to communicate plans for care, and where leadership is often closely involved with guidance of treatment.

Is anyone better off?

V. FY 23/24 Client Impact:

Of the participants who were closed to services during this fiscal year, 20 graduated successfully to a lower level of care or total independence, 6 were escalated to FSP and 8 exited services due to death, refusal or leaving the service area. Approximately 6% of active participants lack housing, down from 15% at the start of the fiscal year.

VI. Projections of Clients to be Served:

FY 24/25	150
FY 25/26	150

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 23

PROVIDER NAME: La Clinica de la Raza

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

Program Description: This program supports clients by building and teaching coping skills, living skills, creating easy access to psychiatric care, and providing housing resources. These services assist adults with SMI to decrease or even diminish mental health symptoms in order to integrate into a community, successfully. Another important purpose of the Service Team program is to avoid and eliminate repeated patterns of psychiatric hospitalizations for our client adults. The service design includes anywhere from weekly to monthly contacts of direct service. (Formerly known as program number OESD 29)

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

FY 24/25 Budget: $1,776,206 **Cost per Client:** $36,249

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 49 Adults

How Well Did We Do?

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

La Clinica reduces stigma by using non-stigmatizing language and interchanging the terminology of mental health with emotional well-being, allowing for a more receptive message to be communicated. For example, sadness (tristesa) is a topic used to engage community members, rather than approaching discussions with mental health language terms such as “depression”. La Clinica emphasizes the improvement in well-being, recognizing disequilibrium, and providing tools and resources for establishing emotional well-being, physical health, and supportive, healthy relationships in one’s life. La Clinica also normalizes mental health symptoms and promotes recovery through treatment. La Clinica supports individuals and families in becoming active participants in their own healing process by drawing upon their own talents, skills, knowledge, interests, dreams, passions, culture and connections.

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III. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

IV. FY 23/24 Challenges:

La Clinica lost 2 clinical staff (.85 FTE) in September, in addition to the two clinicians who resigned in May of 2023, and it was challenging to hire new clinicians. In May 2024, we were able to onboard one new clinician (50% FTE). Another challenge is that our sister clinic in the south county has not been able to take referrals for clients in their catchment area, which has required La Clinica to triage clients for the entire county.

Is anyone better off?

V. FY 23/24 Client Impact:

La Clinica provided support to a Latina mom. This support has enabled her to maintain her employment for another year. With linkage to continuous primary care and psychiatric medication support, she has been able to achieve a promotion in her work. Additionally, her stability has meant that she can now meaningfully participate in family therapy to improve her role as a parent.

VI. Projections of Clients to be Served:

FY 24/25	142
FY 25/26	142

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 23

PROVIDER NAME: La Familia Counseling Center

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

Program Description: This program supports clients by building and teaching coping skills, living skills, creating easy access to psychiatric care, and providing housing resources. These services assist adults with SMI to decrease or even diminish mental health symptoms in order to integrate into a community, successfully. Another important purpose of the Service Team program is to avoid and eliminate repeated patterns of psychiatric hospitalizations for our client adults. The service design includes anywhere from weekly to monthly contacts of direct service. (Formerly known as program number OESD 29)

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

FY 24/25 Budget: $1,387,559 **Cost per Client:** $14,919

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 93 Adults

How Well Did We Do?

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

Our program is deeply committed to reducing the stigma associated with mental health issues. We have implemented several strategies to address this challenge:

Client Empowerment

- **Client Stories**: We share success stories of clients who have overcome mental health challenges, highlighting their resilience and the effectiveness of our support services.
- **Peer Support Groups**: We facilitate peer support groups where clients can share their experiences and support each other, fostering a sense of community and understanding. One such group meets every Friday at our facility, providing a safe space for individuals facing mental health challenges to connect and support one another.

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Training and Education for Staff

- **Staff Training**: All staff members receive ongoing training on cultural competence, stigma reduction, and how to create a welcoming environment for clients with mental health issues. This continuous education ensures that our staff are equipped to provide the highest quality of care and support.

Family and Caregiver Support

- **Therapy and Support Groups**: We provide support to families and caregivers by referring them to therapy or other support groups. This helps them understand mental health issues better and learn how to provide effective support.
- **Collaborative Safety Plans**: When clients allow, we work together with their families and caregivers to create safety plans. This collaboration helps direct caregivers provide better support, reducing the likelihood of crises and hospitalizations.
- **Medication Education**: We offer medication education to direct caregivers whenever possible, ensuring they are informed about the treatments their loved ones are receiving.

By implementing these strategies, we strive to create a more inclusive and understanding community where mental health is prioritized, and stigma is significantly reduced. Our commitment to continuous improvement ensures that we remain at the forefront of providing compassionate and effective mental health services.

III. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

IV. FY 23/24 Challenges:

During the fiscal year 2023/24, our program faced several significant challenges that impacted our ability to deliver services effectively. These challenges included:

High Staff Turnover

- **High Turnover Rates**: We experienced a high turnover of personnel, which disrupted the continuity of care for our clients and placed additional strain on our remaining staff.
- **Difficulty in Recruitment**: Finding qualified personnel was challenging due to a shortage of candidates with the required training and experience. Many potential employees lacked the specific qualifications needed to meet our standards.
- **Competitive Salaries**: The community we serve offers more competitive salaries than we can provide, making it difficult to attract and retain talented staff.

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Training Requirements

- **Training Needs**: Our new hires require comprehensive training to meet our service standards and understand the needs of our clients. This training period is crucial but time-consuming, delaying the full integration of new staff into our team.

Client-Staff Relationship Building

- **Time to Build Trust**: Clients need time to build trust and establish a connection with new staff members. Frequent staff changes have made it challenging for clients to feel secure and supported, impacting on their overall treatment experience.

Is anyone better off?

V. FY 23/24 Client Impact:

Throughout the past year, our department has made steps in providing comprehensive mental health and support services to our community. Our offerings include:

- **Case Management**: We provide individualized case management services to ensure that each client receives the tailored support they need.
- **Therapy**: Our licensed therapists offer individual therapy sessions, addressing a wide range of mental health issues helping our clients to prevent crisis and hospitalizations.
- **Psychiatric Services**: We facilitated access to psychiatrists for our clients, ensuring they received appropriate medication management and psychiatric evaluations.
- **Medication Management**: We closely monitored and managed clients' medications to optimize their treatment outcomes.
- **Basic Services and Benefits Connection**: We assisted clients in applying for and renewing essential benefits such as CalFresh and Medicare, ensuring they have access to necessary resources.
- **Skills Training**: We taught clients coping skills to better manage their mental health and improve their overall quality of life.
- **Mental Health Check-ins**: Regular check-ins were conducted to monitor clients' mental health status and provide ongoing support and to prevent hospitalizations.
- **Treatment and Safety Plans**: We collaborated with clients to develop comprehensive treatment and safety plans, ensuring they have a structured approach to managing their mental health.
- **In-Person and Virtual Services**: Our services were offered in-person and virtually, providing flexibility and accessibility to our clients.
- **Primary Care Provider (PCP) Connection**: We helped clients connect with their PCPs and supported those who were reluctant to see their PCPs due to severe mental illness (SMI).

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- **Economic Support**: Recognizing the link between economic hardship and mental health, we connected clients with community services that help with rent payments and other financial needs.
- **Employment and Vocational Support**: Through partnerships, we assisted clients ready to find employment or vocational opportunities, which helped build their self-esteem and contributed to their mental stability.

Achievements

- **Increased Client Engagement**: We saw an increase in client engagement with our services, with more clients attending therapy sessions and actively participating in case management.
- **Improved Mental Health Outcomes**: Our clients reported improved mental health outcomes, including better management of symptoms and increased stability, and less hospitalizations.
- **Access to Resources**: A higher percentage of our clients successfully accessed benefits such as CalFresh and Medicare, thanks to our dedicated assistance.
- **Enhanced Quality of Life**: Clients who participated in our vocational support programs reported increased self-esteem and overall satisfaction with their lives.

VI. Projections of Clients to be Served:

FY 24/25	110
FY 25/26	110

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 23

PROVIDER NAME: STARS

PROGRAM NAME: Service Team Program (In transition to an FSP)
Stars Community Services Transition Age Youth Program (TAYP)

Program Description: This program supports clients by building and teaching coping skills, living skills, creating easy access to psychiatric care, and providing housing resources. These services assist adults with SMI to decrease or even diminish mental health symptoms in order to integrate into a community, successfully. Another important purpose of the Service Team program is to avoid and eliminate repeated patterns of psychiatric hospitalizations for our client adults. The service design includes anywhere from weekly to monthly contacts of direct service. (Formerly known as program number OESD 29)

Target Population: This program serves adults (18-24) Transition Age Youth (TAY) who meet criteria for Specialty Mental Health Services typically due to their diagnosis and high utilization of emergency/urgent behavioral health systems. Clients must have Medi-Cal, Medicare, or be uninsured. Private insurance is not accepted.

FY 24/25 Budget: $27,000 **Cost per Client:** $310

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 87 Transition Age Youth (TAY)

- Average daily census 66, 31 admissions, 19 discharges).

How Well Did We Do?

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

- Staff avoid use of overly clinical, depersonalizing and/or stigmatizing language: e.g., refer to individuals, persons first, not diagnoses (e.g., "Schizophrenic") when talking about people and they speak hopefully about recovery and opportunities to build a good life.
- Staff provide services in locations/settings that are preferred by those served (incl. home, school or other community locations (>50%) and via telehealth (30%) and they offer a welcoming environment for persons who come to the office/clinic for services (12%).
- This last year, in alignment with a company-wide initiative, staff collaboratively documented the service process *with the young person themselves* during 76% of all service events!

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III. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

IV. FY 23/24 Challenges:

The ability to recruit, hire and maintain staffing levels continues to be a challenge.

Is anyone better off?

V. FY 23/24 Client Impact:

- The majority of service time (75%) was client-facing (direct care), on average; the most prevalent service type was individual therapy.

- Based on the **Recovery Assessment Scale** (RAS, n=66 matched intake to last available assessment), those served showed modest gains in aggregate on all 6 RAS subscales and the Total score, with 'Goal Orientation', 'Willing to Ask for Help' and the Total Score achieving statistical significance (Paired t-test, p<.00, improvements not likely chance occurrences).

- Summary results from the **Child Adolescent Needs and Strengths** (CANS, n=73 matched intake to last available assessment) are as follows. Please keep in mind that items that do not show reductions often reflect CANS scaling floor effects – too few persons with concerning ratings at baseline to observe reductions. Items trending in the wrong direction are noted and are being reviewed by the program team for potential programmatic QI.
  - Behavioral and Emotional Needs: 7/9 items show desirable symptom reductions with concomitant improvements in functioning. Psychosis and Depression improved and achieved testing significance (McNemar p<.05)
  - Life Functioning: 7/11 items show desirable gains. 'Decision-Making' improves and achieved testing significance (McNemar p<.07). One area for review is 'Living Situation', which worsened slightly (albeit not statistically significant) over time in aggregate. Many young adults live with family, which can be difficult and marked by conflict at times. Some would like to move out, but housing affordability is a severe problem in the Bay Area. Another area for review is Medical/Physical problems which worsened slightly (albeit not statistically significant).
  - Risk Behaviors: 3/8 items show desirable gains. 'Suicide Risk' dramatically decreased (by 59%) and tested significant (McNemar p<.00). Risks associated with 'Non-suicidal Self-Injury' and 'Danger to Others' also decreased.
  - Cultural Factors–1/3 ratings showed a modest desirable gain (no testing significance).
  - Strengths – 8/9 items reflect improvement over time (strengths to build upon), with 'Spiritual/Religious' testing significantly (McNemar p<.06). That the young adults did not show gains on the 'Interpersonal' rating deserves team review and discussion.

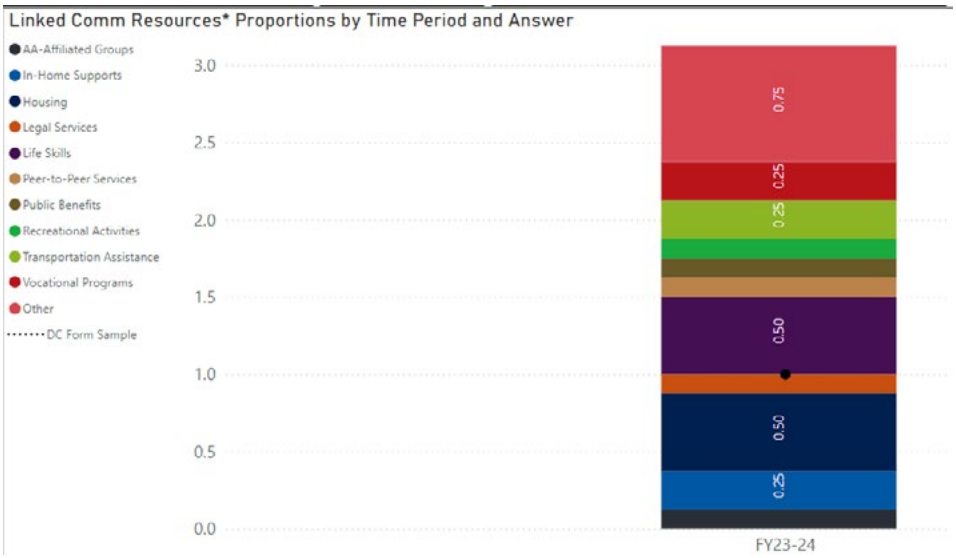
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- Caregiver (Primary) – this scale is not rated as the items do not apply to young adults.
- Trauma – Unlike other CANS domains, the ratings in this domain are categorical 'Yes' or "No' responses. 'Yes' signifies recognition of traumatic experiences. This may relate to prior experiences currently being addressed in treatment (a good development with our trauma treatment providers) or "Yes' may denote new (current/recent) traumatic life experiences. There was a higher proportion of persons reporting 'Yes' over time on 10/12 items and 'Neglect' tested significantly (McNemar p<.06). Stars leadership team will conduct a focus group with staff to better understand and interpret these ratings for potential QI opportunities.

- **Discharge Status Form** was completed on 100% of those served. The following performance indicators are based on this form:
  - 95% of the young adults were situated in home/community settings at discharge (61% family home, 28% independent living, 6% board and care. The remainder (5%) were unknown; however, none were reported to be in a hospital or incarcerated setting.
  - 74% were reported by clinicians based on screenings/assessments to have no/little risk related to substance use/abuse by the time they discharged from the program.
  - 63% of those needing psychiatric medications achieved/sustained adherence to their prescriptions during treatment.
  - 68% received linkages to aftercare behavioral health care upon discharge, predominately (85%) were psychiatry services for medication management.
  - Approximately 40% received linkages to varied types of community resources/supports. These are shown below. Each person may have more than one such linkage.



  - Only n=1 (3%) person required readmission within a year of discharge.

VI. Projections of Clients to be Served:

FY 24/25	80-90
FY 25/26	80-90

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 23

PROVIDER NAME: West Oakland Health Council

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

Program Description: This program supports clients by building and teaching coping skills, living skills, creating easy access to psychiatric care, and providing housing resources. These services assist adults with SMI to decrease or even diminish mental health symptoms in order to integrate into a community, successfully. Another important purpose of the Service Team program is to avoid and eliminate repeated patterns of psychiatric hospitalizations for our client adults. The service design includes anywhere from weekly to monthly contacts of direct service. (Formerly known as program number OESD 29)

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

FY 24/25 Budget: $1,672,953 **Cost per Client:** $16,242

How Much Did We Do?

Baywell Health's specialty mental health program served 103 patients, reflecting the community's growing trust and willingness to seek mental health services. This engagement is a positive indicator of our program's effectiveness in creating a supportive environment where clients feel comfortable addressing their mental health concerns.

I. FY 23/24: Number of Unique Clients Served: 103 Adults

How Well Did We Do?

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

We strive to be a fully staffed team of diverse clinical professionals at Baywell Health, encompassing rehabilitation counseling, psychology, social work, counseling, and psychiatry, plays a crucial role in normalizing mental health care. By integrating behavioral health services into the broader spectrum of health care offerings, the organization emphasizes that mental health is an essential component of overall health, thereby reducing associated stigma.

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III. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

IV. FY 23/24 Challenges:

One of the primary challenges faced in FY 23/24 has been the shortage of clinical staff, which has directly impacted our ability to meet the demand for services. With the current level of staffing, the number of clients we can serve in the Specialty Mental Health (SMH) program is limited, resulting in longer wait times for services and delays in being able to provide services to clients. We have hired a recruitment agency, staffing company, and have tried to connect with community partners, but have continued to struggle with recruiting and retaining qualified staff given our salary limitations.

Is anyone better off?

Our clients are experiencing improved outcomes, demonstrated by their successful transitions to lower and/ or appropriate levels of care. Our ongoing enhancements in program capacity and case management ensure each client receives tailored support, promoting continuity of care.

V. FY 23/24 Client Impact:

Specialty Mental Health (SMH) clients received comprehensive case management support encompassing medical and behavioral health appointments, social and community engagement activities, inter-organizational advocacy, and coordinated transportation. Client feedback indicates high satisfaction with the personalized support provided by case managers, reflecting our commitment to individualized care. Baywell's SMH department is dedicated to enhancing its feedback mechanisms to continually improve client satisfaction and service quality.

FY 24/25	**103**
FY 25/26	**125**

VI. Projections of Clients to be Served:

If our program was able to fill the open Psychiatric Social Worker and Case Management staff positions, Baywell Health's SMH program could better serve emergent clients, expanding capacity approximately 25% in the coming year. Are ongoing recruitment efforts and community referrals will reinforce Bay well's role as a trusted health hub for Alameda County, strengthening access to urgent mental health support.

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 19

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Circa60

Program Description: Provides full service partnership services within the philosophy of 'whatever it takes' to Alameda County older adults who are homeless and who live with serious mental illness. Clients shall be those individuals at high risk of re-hospitalization who could live in the community if comprehensive services and concentrated supports were available to accommodate their needs.

Target Population: Clients shall be older adults (age 60+) who are homeless or at risk of homelessness and will include those who have been involved in the criminal justice system, have co-occurring substance use and / or physical health disorders, frequently use hospitals and other emergency services, are at risk of institutionalization, and / or have limited English proficiency. Contractor shall serve individuals who are sex offenders.

FY 24/25 Budget: $3,882,817 **Cost per Client:** $39,220

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 99 Older Adults

How Well Did We Do?

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

CIRCA60 confronts mental health stigma using a wrap-informed and client-centered engagement process. We have learned that stigmas are best disarmed when people hear the participant's story and can see that there is a comprehensive and person-centered plan of action that is full of hope and strength. The most effective method to accomplish this is through the Team Decision Making process, where strengths, goals, concerns, challenges and action steps are explored by all parties involved, and where all receive and equal opportunity to provide input from a diversity of perspectives.

Additionally, Circa60 meets people where they're at, and the only agenda is to address and support what is important to person whose life is at stake. While we believe that individual responsibility and active participation is critical from our partners, we know that our job is to never stop taking down barriers and providing options, no matter how bleak things may appear.

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We replace shame and blame with accountability and patience, understanding that breakthroughs can come only from the partner's own strengths and creativity.

III. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Spanish, Korean (Unable to check the box)

IV. FY 23/24 Challenges:

Our older adult population is met with a unique set of mental and physical needs that are not currently being met by the ecosystem of services and resources available. Disabled older adults need caregiving, period. The list of barriers to this is extensive but comes down to a lack of supply and lack of funding for specialized care facilities. Disabled elderly adults cannot survive on the street, and the stakes for our system of care to solve this problem are high. Specialized facilities need to be able to manage ADL functioning, ADL functioning, change diapers, dispense medication, manage diabetes, clean laundry, clean bedding, prevent parasite infestation, manage oxygen tanks and other durable medical equipment, provide mental health crisis de-escalation, facilitate daily activity both mental and physical and promote socialization. Each of these domains are not just dignified things to have, they're required in order to keep older adults alive. I would estimate that our current supply of caregiving and specialized facilities meets 25% of the demand for participants over 55. The underserved portion of this population is living in parasite-infested, filthy conditions with poor nutrition, poor medication compliance, almost no daily activity, and dying much faster than anyone should.

Is Anyone Better Off?

V. FY 23/24 Client Impact:
Despite the lack of care facilities described above, 100% of our participants are housed. They are living in the best conditions currently available to them, and our prerogative is to prevent loss of housing by navigating the many deficiencies of care that there are. We work closely with all of the providers and government administrators in our ecosystem of care to be as economic and efficient as possible with the resources given. The 0% homelessness rate is a testament to our team's ability to maintain positive working relationships with our stakeholders so that crisis situations result in collaboration instead of catastrophe.

VI. Projections of Clients to be Served:

FY 24/25	100
FY 25/26	100

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 24

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: RISE - TAY FSP

Program Description: Provides full service partnership services within the philosophy of 'whatever it takes' to Alameda County Transition Age Youth (TAY) who live with serious mental illness. Clients shall be those individuals at high risk of re-hospitalization or re-incarceration who could live in the community if comprehensive services and concentrated supports were available to accommodate their needs.

Target Population: Clients will include TAY individuals who are homeless or at risk of homelessness, have been involved in the criminal justice system, have co-occurring substance use and / or physical health disorders, frequently use hospitals and other emergency services, are at risk of institutionalization, and / or have limited English proficiency. Contractor shall serve individuals who are sex offenders.

FY 24/25 Budget: $1,774,736 **Cost per Client:** $84,511

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 21 Transition Age Youth (TAY)

How Well Did We Do?

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

a. **Reduce mental health stigma**: RISE team staff are committed to normalizing the struggles of individuals with mental health diagnoses and symptoms. We use a person-centered approach, meet individuals where they're at, and lets our partners set the goals for their own treatment. We make efforts to facilitate outings so that participants are able to meet each other, discuss MH symptoms and coping skills and provide opportunities for participants to engage in community offerings and outings. We are able to provide mental health services at Wellness Centers, out in the community, and outside in nature. We provide psychoeducation to participants and their families and also emphasize that our participants are the experts on how their MH symptoms impact their lives. We work closely with families to educate them about anosognosia and refer them to NAMI and FERK so that they can have access to support groups. RISE staff are able to visit participants in jail and always approach participants with judgement free attitudes.
b. **Create a welcoming environment:** RISE staff discuss how to create a welcoming environment with our participants during the intake meeting and ongoing. We request that participants refrain from unsafe behaviors while we're meeting, and we express our commitment to also refrain from unsafe behaviors. We make an effort to determine where our participants feel safe in the community, and we stick to those places while meeting with partners. We let participants know that we can leave anywhere that becomes triggering or

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feels unsafe to our participants. We are able to offer services at Wellness Centers throughout the county.

III. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

IV. FY 23/24 Challenges:

One of the challenges the RISE team faced initially was obtaining approval to visit referred individuals in the jail to offer services. This presented a barrier to locating referred individuals after they were released from jail, often in the middle of the night with minimal resources. We also experienced multiple referred individuals decline services because we were not able to guarantee housing or find affordable/available housing in Alameda County. We have partners who struggle to live in shared housing due to past traumas and other mental health challenges. When we are only able to offer a referral to one TAY residential treatment program, some partners have chosen to live on the streets where they unfortunately feel better equipped to navigate the challenges due to being used to life on the streets.

Is Anyone Better Off?

V. FY 23/24 Client Impact:

Yes, we strongly believe our partners are better off because the county jail is not the ideal place for the TAY population to receive mental health services. We have been able to advocate to the courts for partner's release to CRTs where we then engage and plan for their discharge into the community. One 19 yr old man joined the RISE team while still incarcerated. When released there was a restraining order in place from his father and he was unable to visit his family home due to violence he perpetrated while using substances/not taking psychotropic medications. We were able to advocate for this partner to be admitted to Behavioral Health Court and find him alternative housing at one of 2 licensed board and cares for TAY in Alameda County. Due to his ongoing involvement with treatment and engagement with BHC, he has been able to make amends with his father, have the restraining order dropped, and move back in with his family where he supports his mother in caring for his 2 yr old sister and his ailing grandfather.

The RISE team has been able to advocate on behalf of a 22 yr old man who served 2 years in Santa Rita Jail. We were able to secure a bed at a CRT, schedule his release, pick him up and provide shoes, clothes, a hearty meal and transport him to Woodroe Place. All of the staff on RISE are excited about the potential of this program to change the lives of individuals living with severe mental illness who have ended up receiving most of their mental health care inside of a jail.

VI. Projections of Clients to be Served:

FY 24/25	40
FY 25/26	40

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 4A

PROVIDER NAME: City of Fremont

PROGRAM NAME: Mobile Integrated Assessment Team for Seniors

Program Description: Clients are offered a range of outpatient mental health services including individual, family and group therapy, medication management, case management and crisis services. As clients become more stable they can join a step-down program that supports resiliency and recovery prior to discharge from program. Some clients are trained to become peer coaches to support other clients in need of social inclusion and support.

Target Population: Older Adults (60 years or older) living in the Tri-City area (Fremont, Union City, Newark) or Hayward with moderate to severe mental health diagnosis. Clients also have complicated health conditions with almost 50% of clients having arthritis, 30% with hypertension, 25% with diabetes and high cholesterol.

FY 24/25 Program Budget: $1,173,998 **Cost per Client:** $4,332

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 271 Older Adults

a. 208 AAPI participants were served by attending 28 Mental Health Educational workshops the first 6 months of 2024.

b. The program maintains the following hours of operations: Monday through Friday, 8:00 am to 5:00 pm. (excluding holiday) Program services are available by appointments only on Saturdays.

c. Types of Services:

- Outreach /engagement and health promotion
- Prevention Services
- Outpatient Services:
  i. Mental Health Services
  ii. Case Management /Brokerage
  iii. Medication Support and Management
  iv. Crisis Intervention

How Well Did We Do?

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II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☒ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☒ **Tagalog** ☒ **Farsi**
☒ **We use the Language Line** ☒ **Other**: Vietnamese, American Sign Language 1

III. FY 23/24 Challenges:

- All program clients have co-occurring medical and physical conditions leading to treatment cancellations which may trigger an increase in their mental health symptoms. In addition, due to medical issues, they take many medications, and some clients prefer not to consider adding psychiatric medication to their on-going medication regimen which may add to less efficacy of treatment interventions. In addition, 3 clients passed away in 2023 due to complications of their medical issues.
- With the aging process, some clients compromise their level of independence, through a decline in mobility, increase falls, decline in vision and hearing. Many clients experience loss due to losing family and friends.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

Vignette:
 # 1. Client is a 78-year-old, married, female who is bilingual in English and Filipino. Client was experiencing low mood, poor appetite, difficulty sleeping, lack of energy, loss of interest, physical aches and pains, irritability, and difficulty with making decisions. Client has difficulty with making friends and talking to people. Client attended the AAPI workshop at St. Anne's Catholic Church after she saw the flyer advertised on the bulletin. Client was very shy and had difficulties with sharing her experiences with the group. After attending several workshops client was able to approach the AAPI counselor to schedule a time to talk to the counselor about her mental health issues. Client shared with counselor that she has received therapy in the past but did not continue since the therapist was from a different ethnic background, she felt that the therapist will not understand her issues. Client reported that she was more comfortable talking to this AAPI counselor since they share the same ethnic background. Client stated that after talking to the AAPI counselor about her issues it has helped her to think more clearly about her problems. Client expressed that attending the AAPI workshops has helped to reduce social isolation and she has learned coping skills she can practice when she experiences mental health symptoms.

 # 2: Ms. Y, a 72-year-old, monolingual Mandarin speaking Chinese female. In Oct. 2023, a big dog knocked her down at the parking lot and she was knocked out. She had a big bump on her head and bruises on her body, she was sent to the ER. Fortunately, she had no major health issues. After the incident, Ms. Y had nightmares, there were 3 times she fell out of her bed due to the

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In February 2024, the first 8-week workshop was implemented at a local Low-Income Senior Housing site. To date, AAPI workshops have been implemented in 4 different community sites and 209 AAPI participants attended the workshops.

Program Design:

1. Psycho-educational curriculum was developed for the APPI population.
2. Created a workshop and program flyer about the services available to AAPI population.
3. Coordinated with facilities where older adults naturally congregate to host workshop.
4. Implementation of the psycho-educational workshops.
5. During the workshops, mental health assessment was conducted through sharing personal information or demonstrating mental health symptoms.
6. Risk assessment was conducted as indicated.
7. Project staff offer outpatient mental health services once determined client meets medical necessity.

Project Goals:

1. Increase mental health awareness in the AAPI population to decrease mental health stigma and discrimination.
2. AAPI population to increase access to mental health services as this is the population that underutilizes mental health services.
3. Promote Mental Health Wellness in the AAPI population.
4. Increased advocacy services for the AAPI population.

Program Evaluation:

The project conducted 2 standard GSD-15 surveys before and after the core mental health workshops for the participants and satisfaction survey after the workshops.

Results: Standard GSD-15 were given to 28 participants, and 25 participants completed this scale which is about 63 % of the responses indicated normal response range. After the workshops, the normal response range went up to 73.9 %.

Applicants manifesting mild depressive symptoms is 29.6 %
After the workshops perceived depressive symptoms went down to 21.7 %.
Applicants with moderate depressive symptoms is 7.4 %
After the workshops, symptoms decreased to 4.3 %.

Data collected showed that the workshops had proved to be effective in meeting project goals.

In addition to providing community workshops, SMMH provided 16 additional individual counseling to 16 clients per client's request. Eight participants were referred to other programs both internal and external. Two community members were assessed to meet medical necessity to receive specialized outpatient mental health services from the SMMH program. The rest of the participants were referred to their mental health provider through their insurance.

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Client's Feedback:

- "This is the first time an educational workshop was conducted in my own language".
- The content of the workshops was specific to meet their cultural needs.
- "The content of the workshop gave us an opportunity to learn and understand the western culture and how it compares and what the difference to their own."
- "What we've learned from the workshops, we will share with other older adults in the community."
- "I learned coping skills I can use in times of stress, feeling overwhelmed, anxious and depressed."

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

Senior Mobile Mental Health Program continues to implement existing program structure and staffing.

Please see AAPPI project report above for description of newly expanded program provision.

FY 24/25	55 clients for the Senior Mobile Mental Health We have now 23 clients in our step-down program (Recovery and Resiliency) indicative that more Senior Mobile Mental Health clients are improving and not needing more intensive mental health services. 200 Community members reached with AAPI workshops.
FY 25/26	

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 5A

PROVIDER NAME: Alameda County Behavioral Health

PROGRAM NAME: Crisis Services: Expansion and Transition to Mobile Crisis Team (MCT), Mobile Evaluation Teams (MET), Community Assessment and Transport Team (CATT), and Outreach & Engagement Teams

Program Description: In 2019, Crisis Response Program (CRP) underwent an expansion that transitioned the program into a fully mobile crisis service that responds to 5150 calls, engages with consumers who are in crisis, and assesses consumer needs and conducts follow up post crisis situation. The expansion also added on a third mobile crisis team as well as three post crisis follow up teams. CRP effectively changed it's name to Crisis Services. Currently, all clinical staff work primarily out in the field, which increases community-based crisis prevention and early intervention services, thereby ensuring clients are referred to the appropriate type of mental health services. ACBHD clinical staff work on the Mobile Crisis Teams (MCT) for North County, East County, and South County. In addition, clinicians staff the Mobile Evaluation Team (MET), a partnership with Oakland Police Department and the Hayward Mobile Evaluation Team (HMET), a partnership with Hayward Police Department. Bonita House clinicians staff the third mobile crisis team, the Community Assessment and Transport Team (CATT) along with Alameda County's Emergency Medical Services and Falck. Post crisis follow up teams focus on follow up for clients who have recently been to John George Psychiatric Hospital's Psychiatric Emergency Services (JGPES) Department and the Geriatric Assessment and Response Team (GART) provide mental health linkages to ACBHD's older adult population.

Prior to March 2019, CRP was also an out-patient clinic that provides brief mental health services including case management, targeted crisis therapy, and psychiatry. On average, participants remained in the program for 30-90 days. Once stabilized, participants were transferred to a level of care most appropriate to meet the participant's needs. Consumers who may not need specialty mental health services but need to be connected to a lower level of care such as primary care, substance use treatment, and other community services were also evaluated and referred. However, given the recent expansion of the Mobile Crisis Teams and Outreach and Engagement Teams, the out-patient clinic function of Crisis Services no longer exists.

Target Population: Crisis Services serves residents of Alameda County along the entire lifespan who are living with a serious and persistent mental illness and are in crisis. The MCT, MET, HMET, and CATT Programs provide on-the-spot crisis intervention, psychiatric assessment and evaluation to all ages, and make referrals to other agencies and provides follow-up services. MCT Responds to calls from police, shelters, designated community agencies, and community members throughout Alameda County. The MET and HMET teams pair a police officer with an ACBHD clinician to respond to calls from police dispatch. The CATT teams pair a Bonita House clinician and EMT to respond to calls from dispatch as well.

FY 24/25 Program Budget: $15,271,563 **Cost per Client:** $5,266

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How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 2,900 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☒ **Chinese** ☐ **Korean** ☒ **Vietnamese** ☒ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☒ **Other**: ASL

III. FY 23/24 Challenges: We has quite a few unfilled positions during this fiscal year, including crisis intervention specialists and program specialists. This meant additional tasks for the mgmt. team as well as existing staff in order to run the teams smoothly. However, during the fiscal year, we were able to hire on a program specialist and 7 additional crisis intervention specialists to create a fully staffed team. Other challenges include the lack of data due to YellowFin's inoperability due to the SmartCare implementation. We have had to utilize a significant amount of time to create other sources of data to satisfy funding/data requirements. The last notable challenge was the transition to Five9, a new call center environment. The initial execution was smooth, but staff have experienced problems along the way such as receiving voicemails, issues with connectivity to assistive devices such as hearing aids, translation services, and supervisory permissions.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

Mobile Crisis Units: During this timeframe, the Crisis Services System has expanded from four to five teams, decreasing response time and improving the quality of delivery to East County residents (i.e. Sunol, Livermore, Dublin, and Pleasanton). Crisis Services was also able to hire crisis intervention specialists through the civil service exam process as well as hiring previous interns provisionally, which means the program is fully staffed for the first time since 2018. The Community Assessment Transport Team has also been gearing up to be 24/7 in Nov 2024 and was able to provide services 24 hours Sunday-Wednesday during this reporting period. Clients countywide are now able to request field based psychiatric evaluations at any time of day, every day of the week.

Outreach and Engagement: During this timeframe, Outreach and Engagement staff increased their presence in homeless encampments – starting in April 2024, teams canvassed encampments daily (Monday-Friday) to provide outreach services and encourage potential clients to consent to on-going mental health services. In addition, outreach and engagement staff

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continue to provide daily in-reach to JGPES to offer case management and linkage to on-going mental health services to clients who have recently experienced a mental health crisis. Outreach and engagement teams continue to receive referrals from mobile crisis teams, community members, outpatient providers, hospitals, etc. and provide short term clinical case management and linkages for clients who consent to services.

Community Outreach: During this timeframe, Crisis Services provided 95 community trainings and outreach events for 3,118 individuals including Crisis Intervention Trainings, Verbal De-Escalation, Crisis Services Overviews, Program Specific Presentations, Working with Suicidal Callers, etc. Crisis Services staff also tabled at events such as Health Fairs, Church Events, Conferences, etc. Recipients include community members, potential clients, law enforcement officers, mental health providers, peers, internal staff, etc.

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

We are hoping to see an increase in volume of calls from our East County providers including law enforcement, outpatient mental health providers, and community members.

FY 24/25	3,000
FY 25/26	3,100

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 7

PROVIDER NAME: Alameda County Behavioral Health

PROGRAM NAME: Behavioral Health Court (BHC)

Program Description: Alameda County Behavioral Health Court is a 12-24 month program of court oversight and community treatment for persons experiencing severe mental illness whose qualifying crimes result from their illnesses. The goals of BHC are to reduce recidivism and improve the quality of life, and assist severely mentally ill offenders by diverting them away from the criminal justice system and into community treatment with judicial oversight.

Target Population: Justice involved adults age 18 and older with serious mental illness and cooccurring substance use disorder. Individuals must have pending criminal charges that were the result of their symptoms of mental illness. Consumers include Transitional Age Youth, Adults and Older Adults.

FY 24/25 Program Budget: $515,321 **Cost per Client:** $10,306

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 50 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

This fiscal year was particularly challenging for Alameda County Behavioral Health Department's Behavioral Health Court (BH Court). BH Court lost two critical staff members, a licensed Behavioral Health Clinician who provided client support and coordination, as well as a Behavioral Health Clinical Supervisor who was the BH Court's primary lead and liaison with partner agencies. While the transition of these two staff did not impact the BH Court's capacity, it did increase the workload for the remainder of the clinical team. Additionally, BH Court experienced a change in its collaborative partners. Both the longtime Public Defender and the Judge assigned to BH Court transitioned out of their roles. The transition of the. Judge was particularly impactful after years of service and helping to establish the operational guidelines for the Court. However, a new Public Defender and Judge have been assigned to the BH Court and their experience and passion are helping to identify new and exciting opportunities for the BH Court.

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 7

PROVIDER NAME: Court Advocacy Program (CAP)

PROGRAM NAME: Mental Health Court Specialist

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

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

FY 24/25 Program Budget: $290,280 **Cost per Client:** $4,147

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 70

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:
ACBHD's Court Advocacy Program (CAP) had two significant transitions in staff this fiscal year. Both a licensed Behavioral Health Clinician and the program's Behavioral Health Clinical Supervisor left the program for promotional opportunities. The loss of these two-program staff impacted the ability of the other CAP clinicians to maintain a regular presence in some of the Court hearing in which the team typically participates.

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Is Anyone Better Off?

IV. FY 23/24 Client Impact:

This fiscal year a client was served by a Clinician from the Court Advocacy Program (CAP). The client has been receiving mental health services in Alameda County since they were approximately 15 years old, where their first services were in the Juvenile Hall. The client was diagnosed with schizophrenia, and
most recently found Incompetent to Stand Trial for a misdemeanor. As a result, the client was referred to ACBHD's Court Advocacy Project for a placement recommendation.

The client was somewhat participative in treatment, but mostly relied on their mother to engage their treatment team. The client's mother was the caregiver, case manager, and tireless advocate. The client had been connected to an outpatient treatment team that mostly provided services in their offices/clinic, which made it difficult for the client to engage in treatment.

The ACBHD CAP clinician determined the client needed a higher level of care and re-referred the client to ACBHD's ACCESS unit. ACCESS assessed the client and determined they met criteria to be served by a Full-Service Partnership (FSP) program, which is the highest level of community-based care. The client was assigned to Bay Area Community Services (BACS) and their Living Independently Forensic Team (LIFT) program. The LIFT FSP team provided regular outreach and support to help the client stay consistent with their medication and remain stable, as well as helping them to participate in court hearings via Zoom. Although it was a struggle at times, the unwavering support of the LIFT FSP helped the client eventually completed the court process and successfully have all charges dropped from their record.

During the client's engagement with the CAP Clinician and LIFT FSP, the client did not require psychiatric hospitalization and did not return to jail, a major shift for the client in their last 15 years of treatment. This progress would not have been possible without the comprehensive mental health services the client received from ACBHD and the LIFT FSP team. Recently, the client's mother reached out to the CAP Clinicians to express her deep gratitude for helping the client get into the appropriate level of care to meet their needs.

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

FY 24/25	70
FY 25/26	85

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 7

PROVIDER NAME: Alameda County Collaborative Courts

PROGRAM NAME: Mental Health Court Specialist (also known as Telecare Alameda Court Collaborative (ACC) Program #358)

Program Description: The MHSA-funded Telecare Alameda Court Collaborative (ACC) program supports the Office of Collaborative Court Services (OCCS) which manages eight treatment courts in Alameda County. These treatment courts serve an average of 180 justice involved clients at any given time (over 350 annually) who need substance abuse and mental health treatment services. The ACC team screens, refers, and coordinates mental health services within the Alameda County Behavioral Health system of care. This includes contacting clients to coordinate service linkage, completing written referrals, supporting warm handoffs to new providers, maintaining contact with clients and providers as needed, initiating treatment team meetings, engaging in court hearings and pre-court staffing meetings, and assisting clients with discharge planning.

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

FY 24/25 Program Budget: $290,280 **Cost per Client:** $1,022

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 284 unique Adult participants in eight collaborative courts were served during fiscal year 2023-24

How Well Did We Do?

Screening, linking, and supporting ongoing mental health services for treatment court participants: Telecare's Alameda Court Collaborative (ACC) program offers mental health screening, referral, and ongoing mental health case management for all participants in Alameda County treatment courts. During FY 23/24, the team increased from one MHSA funded position to five positions (three full time and two half time clinicians). This enabled greater service coverage including advocacy for court participants within all court settings under the Office of Collaborative Court Services (OCCS) and in community and residential programs. The ACC team expanded to include a mental health navigator, a resource specialist, mental health assessor, mental health coordinator, and clinical director. Weekly holistic case conferencing and bi-weekly consultation sessions with court case managers and court teams were conducted to define and

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meet behavioral health needs of court clients. In addition to ensuring that court participants were offered an evidence-based mental health screen at intake, the ACC team offered as-needed mental health case management for veterans and family treatment court clients. New tools such as client-based court treatment plans, including client-centered strengths and needs assessments were piloted across courts, providing the blueprint for whole-person care.

Immediate support – In FY 23/24, the ACC team screened 85.7% of incoming criminal treatment court participants utilizing an evidence-based screening tool. Criminal treatment court participants were screened and referred to various levels of mental health care within Alameda County including full-service partnership (FSP), and Level I service teams Notably, 50% of participants engaged in criminal treatment courts are referred from in-custody. The ACC team supports discharge efforts for these participants including medication coordination, referrals to crisis residential programs and linkage to community health programs. The ACC team coordinates co-occurring services with court case managers to ensure that participants' SUD and mental health service needs are addressed concurrently. For the three civil family treatment courts under OCCS, the ACC team meets with the court case managers regularly to review their caseloads and support efforts to link them with their Department of Children and Family Services contracted mental health services. A member of the ACC team is also present in court hearings to provide immediate support and encouragement for treatment court participants. In this circumstance, the ACC clinician follows up directly after court with a participant and offers them brief counseling services and referral for additional supports.

Effective screening – The mental health assessor, a master's level clinician, conducts the evidence-based mental health screen form III (MHSF III) which identifies the court clients' most pressing mental health needs. The assessor gains critical information about participants' preferences for mental health services and their areas of strengths and needs in areas like housing, employment, education, social-connectedness, dental and physical health. With consent from the participant to disclose what they feel comfortable about, this information is shared with rest of the mental health team in a weekly consultation group where consensus is formed in matching the participant to the most appropriate care team or community resource. The tables below depict the proportions of participants screened by gender and race/ethnicity.

ACC Team Screening by Participant Race/Ethnicity		
Race/Ethnicity	**Count**	**Percentage**
African American	26 of 30	86.7%
Latino/Hispanic	16 of 19	84.2%
White	14 of 16	87.5%
All Other Races	7 of 7	100.0%
Total	63 of 72	87.5%

There are no statistically significant differences between participant gender or race/ethnicity.

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ACC Team Screening by Participant Gender		
Gender	Count	Percentage
Female	14 of 18	77.8%
Male	51 of 58	87.9%
Non-binary	1 of 1	100.0%
Total	66 of 77	85.7%

Client-centered referral process – The team is trained in Telecare's Recovery-Centered Clinical System (RCCS) which focuses on the power that each client has to shape their health through supportive exploration of their hopes and dreams for their future. Plans for service connection are built with each participant, based on conversations and mutually agreed-upon treatment goals. The master's level Navigator completes referrals and checks back with participants and the providers to which they were referred to ensure that they are effectively linked to support. Emails and meetings are initiated by the Navigator to introduce treatment providers across SUD, mental health, and criminal justice spheres.

The tables below show the proportions of participants referred to mental health services by gender and race/ethnicity. The proportion of males referred to mental health treatment is higher than that of females and African American and Latino/Hispanic participants are referred at rates substantially higher than Whites and participants of all other races.

ACC Team Referrals to Tx by Participant Gender		
Gender	Count	Percentage
Female	7 of 18	77.8%
Male	51 of 58	87.9%
Non-binary	N/A	
Total	58 of 76	76.3%

ACC Team Referrals to Tx by Participant Race/Ethnicity		
Race/Ethnicity	Count	Percentage
African American	16 of 30	53.%
Latino/Hispanic	9 of 19	47.4%
White	5 of 16	31.3%
All Other Races	2 of 7	28.6%
Total	32 of 72	44.4%

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Trauma informed courts – As advocates for participant health and wellness, the ACC team members are critical participants in the multidisciplinary treatment court team. They attend pre-court planning sessions to assist the team with trauma informed communication and strategies to engage participants most effectively during the court session. They are also present to meet incoming participants and begin assessing and planning for their mental health services from their first court hearing. For FY 23/24, the ACC Clinical Director began meeting with the treatment court judges on a weekly basis to offer consultation and to problem-solve any court challenges related to a safe and therapeutic environment for participants. This has included how the judge may most effectively communicate with participants who are intoxicated or emotionally overwhelmed in the court setting or how to describe expectations clearly to those that are having trouble engaging in treatment. In FY 23/24 members of the ACC team attended trainings to enhance their ability to reduce vicarious trauma within the court setting. The clinical director has worked with various members of the court team to mitigate trauma hazards including coaching to share only minimum necessary information, setting clinical consultation times with attorneys, and refining what is appropriate or may be potentially triggering content to discuss in the treatment court setting.

Pre-court staffing meetings
Before each collaborative court session, a member of or multiple members of the ACC team participates in a pre-court meeting in which each client and their needs are discussed. The ACC team may share information about participants' engagement and progress in mental health services so that the court team can reinforce their treatment goals. They are also available to strategize adjustments in participants' treatment needs such as a need for additional mental health supports or changes in level of care needs.

II. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

The mental health team has continued to strive to meet the needs of all incoming participants while being challenged by fluctuating staffing patterns. During FY 23/24 it was difficult to hire clinicians with the training and skills necessary to meet the needs of an increasingly troubled and unhoused population.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

Additional Information:
Success Story – A male client with a history of unmet mental health needs, a significant history

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of exposure to trauma, and a recent major medical diagnosis was referred and accepted into Felony Adult Drug Court. At the point of acceptance, he was struggling with significant depression and resource limitations which lead him to struggle to care about his life, complete necessary acts of daily life, or tend to his medical needs. He reported making use of emergency rooms to meet medical needs and being highly isolated and using substances daily to try to manage the significant stress he experienced. He recognized that he needed to change his substance use and accepted placement in an intensive outpatient treatment program. The mental health team referred him to a reentry treatment team and organized treatment team meetings. Reentry services provided him with counseling and case management support for vocational, educational, and financial needs. He was able to complete his treatment programs and transition to lower levels of care successfully. At a 6-month follow-up from intake assessment, he reported greatly reduced interference from mental health concerns, greater satisfaction with interpersonal relationships, and having met additional life goals which he had set for himself. He graduated on schedule from Adult Drug Court sober and connected with mental health and reentry resources, and positively engaged with new vocation and educational opportunities.

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

FY 24/25	As state and local policies balance growing concerns around the need for reduced reliance on incarceration and a desire to respond to criminal behaviors, the need for treatment courts will expand. There will be an increase in referrals for participants that have a high need for support around basic needs such as housing, physical and dental health, and employment. We anticipate that the census will increase to about **300** unique individuals in the next fiscal year.
FY 25/26	We project that we will be providing direct services within residential and recovery residences to support the influx of those with co-occurring needs into the treatment courts. (approx. 300 individuals)

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 8

PROVIDER NAME: Alameda County Behavioral Health

PROGRAM NAME: Juvenile Justice Transformation of the Guidance Clinic

Program Description: Provides in-depth assessment and treatment for youth in the juvenile justice system. Coordinates referrals and linkages to mental health services in order to ensure seamless continuity of care when discharged from juvenile hall to community based providers.

Target Population: Youth ages 12-18 years old who are involved in the juvenile justice system and their families.

FY 24/25 Program Budget: $192,745 **Cost per Client: $**554

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 348 Youth

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:
The Guidance Clinic faced several staffing challenges during the 2023-2024 fiscal year. First, the Guidance Clinic has struggled to attract interested clinicians to fill a current vacancy, resulting in fewer clinicians having to cover a slightly higher number of youths detained in the Juvenile Justice Center (JJC). Also, this fiscal year, the two roles that provide leadership support to the Guidance Clinic, the Behavioral Health Clinical Manager and Juvenile Justice Health Services Director, both left their county positions to take explore new professional opportunities. The transition of these two critical roles has impacted staff morale and program oversight, and despite aggressive recruitment, Alameda County Behavioral Health Department has not been able to identify interested candidates. Despite these challenges, Guidance Clinic staff continue to provide critical assessment services to detained youth in order to inform reentry services and to ensure continuity of care for youth.

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Is Anyone Better Off?

IV. FY 23/24 Client Impact:

Soon after being brought back into detention, a youth began exhibiting some concerning mental health symptoms. The youth was very paranoid and apprehensive about engaging with Guidance Clinic staff. After collaborative efforts between Guidance Clinic staff and Alameda County Probation staff (who operate the JJC), the Guidance Clinic clinical team was able to encourage the youth to participate in an assessment. After the clinical assessment the Guidance Clinic treatment team quickly conferred and determined the youth was likely experiencing their first psychotic break. Due to the youth's increasing symptoms and risk of self-harm, the treatment team decided to place the youth on an involuntary psychiatric hold. After receiving clinically appropriate treatment, the youth was able to return to the JJC where they participated in treatment more frequently. Thanks to the treatment teams efforts the youth has remained stable and is now awaiting placement in a short-term residential therapeutic setting.

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

FY 24/25	350
FY 25/26	350

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 9

PROVIDER NAME: Seneca Family of Agencies

PROGRAM NAME: Multi-Systemic Therapy (MST)

Program Description: Multi-Systemic Therapy (MST) is a unique, goal-oriented, comprehensive treatment program designed to serve multi-problem youth in their community. MST interventions focus on key aspects of these areas in each youth's life. All interventions are designed in full collaboration with family members and key figures in each system- parents or legal guardians, school teachers and principals, etc. MST services are provided in the home, school, neighborhood and community by therapists fully trained in MST. Therapists work in teams and provide coverage for each other's caseloads when they are on vacation or on-call. MST therapists are available 24 hours a day, seven days a week through an on-call system (all MST therapists are required to be on-call on a rotating schedule). Treatment averages 3-5 months.

Target Population: Youth (ages 0-21) referred who are on probation in Alameda County and are at risk of out of home placement due to referral behavior and living at home with a parent or caretaker.

FY 24/25 Program Budget: $1,035,030 **Cost per Client:** $28,751

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 36 Youth

How Well Did We Do?

II. Language Capacity for this Program:
We provide services in the families' preferred language (English and/or Spanish). This year, we served 28 English-speaking families; 26 were English speaking and we had 4 Spanish-speaking families.

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

II. FY 23/24 Challenges:
During the bulk of FY 23/24 we had had two MST clinicians, down from four the previous fiscal year. Additionally, the number of referrals to the MST program remained low, which had an

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increase, which has allowed us to hire a new MST clinician with plans to hire another clinician soon.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

Here is a case story submitted by one of our clinicians that highlights some of the interventions provided by MST and the successes the youth and family were able to achieve during the course of treatment. *(Client's name has been changed to protect identity.)*

Client Joe

The clinician collaborated with a young man referred to the MST program by the Alameda Probation Department. The youth manifested externalized aggression towards property and others, resulting in adverse effects on his academic performance and social interactions with educators and peers. At the time of referral, the youth exhibited substantial challenges within his home environment, displaying aggression towards his mother. Consequently, judicial authorities placed him in the care of extended family members until his behavioral stability was achieved.

Throughout the course of treatment, MST services endeavored to enhance the youth's comprehension of the underlying factors influencing his intense emotional states and outbursts, and to foster the acquisition of healthy coping mechanisms. The focus of intervention further encompassed the amelioration of familial dynamics by mitigating reactive communication, addressing triangulation, and augmenting the empathetic understanding of the youth by his caregivers. A pivotal juncture in the treatment process transpired when the youth became proficient in articulating the impact of his impulsive behaviors on his affective states, cognitions, and conduct. This afforded the family an opportunity to engage in conversations pertaining to the tacit determinants of the youth's irate and despondent episodes that precipitated his disruptive behaviors.

Subsequent to the completion of services, the youth's aggression had substantially declined, enabling his return to his mother domicile, while the family continued to progress in fostering prosocial communication and adeptness in conflict resolution. Furthermore, the youth demonstrated the acquisition of coping strategies aimed at attenuating his hyperarousal responses to familial conflicts. Due to these advances and sustainable support, the youth was dismissed from the probation department at the end of the treatment plan and graduated from the MST program.

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

FY 24/25	30-40
FY 25/26	30-40

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 11

PROVIDER NAME: Bay Area Community Services, Inc.

PROGRAM NAME: Crisis Stabilization Unit (CSU) and Crisis Residential Treatment (CRT): Amber House

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

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

FY 24/25 Program Budget: $5,382,469 **Cost per Client:** $6,180

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 871 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

Although a struggle within the entire field of mental health services, adequate staffing and turnover remained the biggest struggle throughout the fiscal year for Amber CSU. As a result of the 1:4 clinician-to-client ratio, Amber CSU frequently reached capacity despite having open physical beds.

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Is Anyone Better Off?-

Amber CSU strives to maintain low-barrier access to care. In one particular case, Amber CSU served on more than one occasion, an individual (F39) who sought crisis services in an effort to gain support to refrain from substance usage and escape a domestic violence situation where she was being trafficked. On her most recent visit to Amber CSU in 04/2024 she was agreeable to a referral to Amber CRT where she was able to commit to being sober, adjust her medications, really work on her insight and coping skills, establish stability, get connected to long-term crisis case management and housing, and is now in the process of reconnecting with her children that were removed from her custody some time ago. This client was initially resistant to this stage of change which was reflected in her repeat returns to Amber CSU, but through each presentation she was able to work with the clinical staff and identify and develop goals and work towards them with support. Recently, she contacted Amber CSU staff to thank us for our support during that time in her life and inform us of her progress in getting reconnected w/ her children and maintaining steady employment now as an in-home caregiver.

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

FY 24/25	1,200
FY 25/26	1,800

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 11

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: Crisis Stabilization Unit (CSU): Willow Rock

Program Description: The Willow Rock Crisis Stabilization Unit (CSU) is an unlocked, specialty mental health program for medically stable youth ages 12 to 17 years. The CSU also functions as the Alameda County Receiving Center (Welfare and Institutions Code 5151) for youth who are placed on a WIC 5150/5585 civil commitment hold in Alameda County. All youth arriving at the Willow Rock Crisis Stabilization Unit receive a physical health and a mental health assessment, and are provided ongoing assessment, crisis intervention and crisis stabilization services prior to discharge to the community or transfer to an inpatient psychiatric facility.

Target Population: The Willow Rock CSU serves medically stable youth ages 12 to 17 years experiencing a mental health crisis. The program may serve up to a maximum of ten clients at a time. Youth may arrive on a WIC 5585 civil commitment hold or as a voluntary "walk-up" from the community.

FY 24/25 Program Budget: $5,762,755 **Cost per Client:** $9,325

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 618 Youth

As the year progressed, we saw this figure increase as the community became increasingly aware that the Youth CSU was reopened.

How Well Did We Do?

The upgrades to the HVAC system have been completed with improved temperature control. The youth and staff are more comfortable in the temperature-controlled unit.

The Youth CSU was painted with no disruption to service. The staff report being very pleased with the refreshed look of the program. New furniture has been ordered and is pending delivery

II. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

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Staffing remains a challenge, as it is elsewhere in the state. Additionally, the regulatory structure of CSU's (being highly dependent on nurses but with no nurse managers) creates barriers with onboarding and development of nurses who are brand new to the field. We're working with Corporate Nurse Leadership teams to address this challenge.

We're seeing a drastic increase in both youth with eating disorders and neurodivergence. Depending on the degree of severity, these can present a challenge at a CSU and subsequent bottle necks in the system of care. I recommend a work group with various stakeholders to identify plans to support these youth in being appropriately placed and/or communication pathways that make it known when clinical challenges impact movement.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

Client satisfaction scores are at 92% (surveys are offered at discharge).
Volume of referrals and flow has increased as the FY progressed and, hopefully, providing much needed relief to the

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

FY 24/25	700
FY 25/26	800

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 14

PROVIDER NAME: Asian Health Services (AHS)

PROGRAM NAME: ACCESS Staffing to Asian Population

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

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

FY 24/25 Program Budget: $1,741,027 **Cost per Client:** $963

How Much Did We Do?

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

- Screening/linkage – served *349* unduplicated intake clients with 1,268 service contacts.
- Crisis stabilization outpatient treatment - served unduplicated *55* clients.
- Outreach/psychoeducation – served *1,403* community members through in-person events.
- MH awareness on social media platforms – reached 25,526 viewers on social media.

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☒ **Chinese** ☒ **Korean** ☒ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☒ **Other**: Khmer, Mien, Japanese, other Asian languages

III. FY 23/24 Challenges:

- Post-pandemic help-seeking patterns have increased the demand for remote services,

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- posing new challenges. The hybrid workplace model allows intake staff to screen and link services over the phone, with in-person screenings and safety planning conducted by appointment.
- Community members engaged with mental health wellness materials through in-person outreach and social media campaigns, but this did not translate to increased help-seeking via the ACCESS service line.
- AAPI clients often sought help later, presenting with severe psychiatric symptoms, making it difficult to arrange urgent services with limited resources.
- There was a shortage of culturally responsive MH providers, and filling staff openings was challenging. Clinicians' efforts were stretched thin across clients under the ACCESS Treatment Program and other BHCS services.
- Challenges have arisen with the transition to CalAIM/Smart Care, CPT codes, Screening Tools and Transition of Care Tools, impacting operations, documentation, and billing.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

- Provided screening and service linkage services to 346 intake clients with 1,268 contacts, connected with appropriate level of services, conducted safety planning for S/I and H/I.
- Delivered MH treatment to 55 clients with assessment, treatment planning, medication support, individual therapy/rehab, group rehab, collateral, and case management services.
- Outreached 1,403 community members via 11 community events and 25,526 viewers with audience-targeting wellness materials on social media platforms.
- Coordinated with AAPI-CBOs to foster trust building/working partnership and promote effective referral processes.
- A case study “JJ is an English-speaking, queer-identifying Asian American female referred to the ACCESS program by her primary care physician due to increased depressive mood. Born in Korea, she moved to the US at the age of 3 with her mother and older sister. She exhibits symptoms of depressive disorder that impair her social interactions. She has a history of sexual abuse, school bullying, and chronic health issues that challenge her ability to keep up with school tasks and social functioning. Due to past trauma and depressive mood, she has had suicidal plans and self-harm behaviors. JJ joined the ACCESS program to learn coping skills for mood regulation She faces challenges balancing Korean and Western cultures and often finds it hard to express herself fully due to language barriers. Through play, expressive art, and sand tray therapies, JJ explores her deeper self. Actively engaged in therapy, she also receives case management and individual rehab. She now feels supported, calmer, and can identify triggers.”

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Given the uncertainty and unpredictability of staff transitions and the challenges in recruiting qualified bilingual applicants, we are using the same projections for the next two years.

FY 24/25	Linkage 600 clients / Outreach: 1,875 clients plus media audience (1,313 service hours) Outpatient treatment: 130 clients (3,691 clinician hours / 322 medication support hours)
FY 25/26	Linkage 600 clients / Outreach: 1,875 clients plus media audience (1,313 service hours) Outpatient treatment: 130 clients (3,691 clinician hours / 322 medication support hours)

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 14

PROVIDER NAME: Multi-Lingual Counseling Center

PROGRAM NAME: Staffing to Asian Population

Program Description: MH Svcs for Afghan Immigrant and Refugee

Target Population: Afghan Immigrants and Refugees

FY 24/25 Program Budget: $175,750 **Cost per Client:** $1,598

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 110 Adults

How Well Did We Do? We fulfilled the requirements that we were expected to fulfill.

II. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☒ **Farsi**
☐ **We use the Language Line** ☒ **Other**: Dari, Pashtu

III. FY 23/24 Challenges:

Making sure client understand the importance of participating in their therapy sessions and receiving mental health services to manage their mental health symptoms.

Is Anyone Better Off? More than 60% of clients reported improvement**.**

IV. FY 23/24 Client Impact:
During fiscal year 23/24 our two case managers at Multilingual Counseling Center Inc served more than 100 Afghan new commers at our Newark office. Two the families that we helped brief stories are below:

One of the newcomer family consists of a single mother of five daughters ranging from ages 8 to 17. The girls were helped to enroll in schools near their home. The mother was helped by a case manager to participate in parent teacher meetings at daughters' schools. Family was helped to fulfill basic needs by locating food banks, donations center at different Mosques to assure essential needs were met.

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empowered to manage taking care of her five daughters, she and three of her daughters participated in receiving mental health services individual and family to help with PTSD symptoms and their adjustment to a new country. Before ending services, the family have completed case management services as well as mental health services. In our last session the mother reported happiness regarding living in the USA and showed appreciation for her daughters to have the opportunity to get an education, which they would have been deprived of in Afghanistan for just a being woman.

Mr. A came to Multilingual Counseling Center Inc for case management and mental health services for experiencing PTSD symptoms due to leaving his home and family in Kabul Afghanistan and escaping to save his life. Our case manager was able to secure employment for Mr. A as a security guard. Our mental health staff helped him how to manage his symptoms of PTSD and live in his present life instead of living in his past trauma. He completed a year of mental health treatment and at the present time has the skills to manage his symptoms of PTSD and manage his finances with his current job to support his family.

With the help of Multilingual Counseling Center Inc., the families above and many more have been able adjust to their new life in the USA and use coping skills to manage their mental health symptoms.

The combination of services that Multilingual Counseling Center Inc offers like case management, obtaining resources and employment search, plus mental health services have been the key to our success.

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

FY 24/25	120
FY 25/26	130

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 15

PROVIDER NAME: La Familia Counseling Center

PROGRAM NAME: ACCESS Staffing to Latinx Population

Program Description: ACCESS Staffing to the Latino Population program operates a designated intake and referral phone line to screen and evaluate callers for medical necessity and determine appropriate service levels for community members requesting mental health services. ACCESS through La Familia Counseling Center also provides short-term crisis stabilization outpatient services for clients in crisis to reduce utilization of higher levels of care.

Target Population: ACCESS Staffing to the Latinx Population receives call from consumers and family members of consumers of mental health services who identify as Latinx living in Alameda County. The consumers can range in age from children (age 0-15) to older adult (60+). The ACCESS line provides Spanish language speaking/culture mental health screenings to get clients connected with appropriate level of services, and obtaining related information for their medical record.

FY 24/25 Program Budget: $975,499 **Cost per Client:** $15,008

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 65 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

One challenge was that the program has capacity for two therapists, and one of those positions remained vacant for the 2023-2024 fiscal year. There has been a larger agency and county and beyond challenge to fill therapist positions specifically for positions for bilingual Spanish and English speaking therapists. We did have three therapist interns join the ACCESS program this 2023/2024 year via La Familia's Multi Cultural Training Institute that accepts students from

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graduate or doctorate school programs to receive training and provide therapy. Our ACCESS interns this past year were able to gain experience in therapy and provide compassionate support and therapy in Spanish to their assigned clients. All our interns were bilingual Spanish and English speakers. And all the program's staff are bilingual Spanish and English speakers. An update on our second vacant staff therapist position is that it will be filled starting September 2024. Many of the clients that presented for services this year had psychosocial stressors of inter-partner violence experiences. Our staff therapist and interns were trained to provide therapeutic support and resources to clients who experience or experienced inter-partner violence. We have had an increase in client clients presenting with severe mental health symptoms who were able to be assessed, provided information about their mental health symptoms and also received treatment and referred to longer term therapy if they agreed.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

Clients received psychotherapy in either of their preferred languages (or both) bilingual Spanish and English therapy. Clients receive compassionate therapy and receive an assessment. Clients gain an awareness of their mental health symptoms, and learned coping skills, and are linked to ongoing mental health treatment if needed. Many of our clients report improvement in their mental health symptoms. Clients also receive knowledge of community resources and support to link to those resources when needed.

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

FY 24/25	100
FY 25/26	100

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Wellness Centers: HEDCO House

Program Description: Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system. They provide step-down service for individuals transitioning from ACBH specialty mental health services in an environment of inclusion and acceptance in facilities that are commonly managed and staffed by consumers who provide or arrange for peer support. Wellness Centers are contracted providers who perform outreach and engagement; offer outpatient services such as mental health services, case management/brokerage, crisis intervention, medication support/dispensing; provide peer support and wellness services; and Tenant Support Services (TSP) for those with housing insecurity. Wellness Center personnel are trained in HarmReduction and Trauma-Informed Care principles to meet the participant where they are at in a wholeperson manner. Cultural responsivity is a core axiom of the care provided by the team as the program was designed with Culturally and Linguistically Appropriate Services (CLAS) standards in mind.

Target Population: The BACS Wellness Centers provide services to adults (ages 25+) experiencing mental health challenges. These individuals may or may not be currently enrolled in ACBH specialty mental health programs (such as Service Teams, Full Service Partnerships, etc.). * There is also a Wellness Center provided by BACS that provides services to TAY (ages 16-24).

FY 24/25 Program Budget: $833,766 **Cost per Client:** $213

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served:
There were 1,138 unique clients in Q1, 688 unique clients in Q2, 822 unique clients in Q3, and 1,262 unique clients in Q4. Total of 3,910 Adults.

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☒ **Vietnamese** ☐ **Tagalog** ☒ **Farsi**
☐ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

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III. FY 23/24 Challenges:

Hedco Wellness Center have faced significant challenges related to the complex needs of partners, particularly those experiencing homelessness or housing instability. The inability to meet basic needs, such as stable housing, has placed a considerable burden on many individuals within the community, exacerbating existing mental health challenges. Additionally, staff has been observing a concerning trend of drug overuse among some of Hedco partners, which has led to an increase in overdosing episodes. These challenges underscore the critical importance of addressing the root causes of homelessness and providing comprehensive support to individuals grappling with substance use disorders and mental health issues. Many of our partners are experiencing homelessness or housing instability. It has been challenging to match individuals with transitional places since there are few options to fit and the overwhelming need in the area. Our team continues to explore alternative options to support our partners, and we are hopeful that things improve, and additional services will be available soon. Managing staffing has also presented challenges when there is staff turnover, particularly in ensuring that all newly hired staff members are adequately trained and versed in the services and standards of care for the center. Despite these challenges, we have successfully implemented comprehensive training programs to ensure that all staff members are equipped with essential skills, including Trauma-Informed Care and Crisis De-Escalation techniques. This investment in staff development not only enhances the quality of care provided but also strengthens Hedco's capacity to meet the evolving needs of participants.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

At Hedco Wellness Center, we've embraced a comprehensive approach that strongly emphasizes **mental health, well-being, learning, partnership, and community building**. This year, our initiatives have spanned multiple categories to ensure holistic support for our partners. Below is a breakdown of the critical programs and efforts we've implemented:

Cultural and Community Engagement

Hedco celebrates multiculturalism year-round as we proudly hosted events for **Hispanic/Latinx Heritage Month**, combining it with our very first **Community Connect Event**. This celebration created a space for our partners to explore their cultural identities, fostering inclusion and pride within the community. These celebrations are part of a broader effort that includes cultural events like **Juneteenth**, **Fourth of July**, **Mother's Day**, and **Father's Day**, which serve as therapeutic interventions, offering emotional resilience and social support. Moreover, Hedco holds a **monthly community meeting** where partners have the opportunity to be heard, share feedback, and voice concerns. This aligns with our program manager's **open-door policy**, allowing for open communication and reinforcing trust between staff and partners.

Interdisciplinary Approach and Partner Collaboration

This year, we enhanced our **interdisciplinary approach** by implementing weekly triage meetings with leadership members from the **PAIGE and LIFT behavioral programs**. This collaboration enables us to address mental health needs more comprehensively and ensures that each partner receives well-rounded care through coordinated efforts. To help partners reach mental stability

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by meet their basic needs, Hedco team has prioritized utilizing the Housing Problem Solving approach to support participants with resolving their housing crisis. Staff has successfully link participants to housing through connections with landlords and becoming familiar with local properties/apartments.

Health and Well-Being Initiatives

Hedco Wellness Center continues to prioritize our partners' physical and mental health. We provide **healthy and substantial homemade breakfasts and lunches** daily, ensuring our partners receive meals while cultivating a welcoming community environment. These meals are not just for sustenance but also for fostering relationships and promoting well-being. In addition, our **Shower Day** and **Laundry Day** programs offer essential hygiene services, which help partners maintain dignity and personal hygiene and serve as therapeutic interventions that foster social connection. These days are about more than providing basic services—they create opportunities for social interactions that combat isolation, empower our partners, and offer practical and emotional support.

Physical Environment Enhancements

We recently revitalized the **patio area** at Hedco, transforming it into a beautiful, functional space with new furniture and tasteful décor. This upgraded outdoor area has become a central hub where partners gather daily, relax, and build community. The positive changes reflect our commitment to creating a welcoming and dignified environment where emotional well-being is nurtured.

Partnership and Community Collaboration

Hedco maintains strong ties with local vendors and organizations, enhancing the reach and effectiveness of our programs. Our **collaborative efforts** extend to engaging local businesses and wellness centers to ensure our partners have access to a wide range of resources and services. Hedco's PM partnered with Janssen (a Johnson & Johnson pharmaceutical company) to offer a workshop-lecture series about HIV de-stigmatization, prevention, treatment, trends, etc. The series runs for approximately eight sessions, and it targets regular partners and members of the community.

Holistic and Therapeutic Support

We also focus on building strong **therapeutic relationships** with our partners. Staff members at Hedco practice **empathetic listening** and **rapport-building** to create a supportive and calming environment. These strong relationships help prevent crises, reduce the need for emergency interventions, and promote long-term wellness and stability.

In summary, Hedco Wellness Center is committed to meeting our community's diverse and evolving needs through **cultural engagement, health initiatives, interdisciplinary collaboration, and therapeutic support**. By embracing multiculturalism and fostering partnerships, we provide a holistic and compassionate environment where our partners can heal, grow, and thrive.

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

FY 25/26	8,250
FY 26/27	8,300

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Wellness Centers: Fremont

Program Description: Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system. They provide step-down service for individuals transitioning from ACBH specialty mental health services in an environment of inclusion and acceptance in facilities that are commonly managed and staffed by consumers who provide or arrange for peer support. Wellness Centers are contracted providers who perform outreach and engagement; offer outpatient services such as mental health services, case management/brokerage, crisis intervention, medication support/dispensing; provide peer support and wellness services; and Individual Placement and Support (IPS) Supported Employment services.

Target Population: The BACS Wellness Centers provide services to adults (ages 25+) experiencing mental health challenges. These individuals may or may not be currently enrolled in ACBH specialty mental health programs (such as Service Teams, Full Service Partnerships, etc.). * There is also a Wellness Center provided by BACS that provides services to TAY (ages 16-24). Additional Requirements for IPS Supported Employment:

Contractor shall work with individuals who have expressed interest and motivation in pursuing competitive employment, regardless of their employment readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.

FY 24/25 Program Budget: $687,955 **Cost per Client:** $248

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served:
In Q1 there were 519 unique clients served, in Q2 646 unique clients were served, in Q3 661 unique clients were served, and in Q4 948 unique clients were served. Total of 2,774 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

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The Wellness Center staff has experienced challenges related to updates on operations tasks. There has been a shift due to increases in operations hours to include weekends, which along with staff departures has contributed to challenges when trying to increase staffing. Another major challenge for South County this year was the unexpected suspension of Laundry Services on several occasions, which is an essential service many of our partners depend on.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

During this year the Fremont Wellness Center experienced a major change with the extension of our operating days. Partners have expressed being grateful that the center started opening on weekends. The Center continues to partner with multiple community organizations to offer a variety of services for partners. Partners are able to access community resources onsite. We have found that continuous communication with community service providers allows for our partners to receive much needed support and access to services in a way that truly supports them. The center continues to provide housing and financial assistance as well as improved group activities to keep our partners focused on wellness. The Financial Literacy program turned out to be a breakout group, partners reported enjoying learning how to become debt-free, increasing their credit score, and learning how to save with little income. The center continues to work with our housing navigation department once a month to provide an in-depth presentation of the housing available in Alameda County. The center continues to provide connections to healthcare, employment, housing, and benefits, as well as mental and behavioral health services with partner agencies.

Our staff continue to provide a Whole Life approach to our services using the following:
Physical: Providing a resting area, healthy meals, showers, and clean clothing.
Emotional: Connection to long-term therapy, meditation, mindfulness and stress reduction.
Social: Providing in-person opportunities for connection and encouraging involvement through group activities and assisting with routine tasks at the site.
Spiritual: Exposure to meditation and positive affirmation techniques
Intellectual: Providing opportunities to enhance and develop cognitive functioning
Environmental: Creating spaces that support wholistic health benefits for the community
Financial: Support with flexible funding resources and access to benefit services
Occupational: Connection to employment and training services

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

FY 24/25	10,000
FY 25/26	10,504

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Wellness Centers: Townhouse

Program Description: Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system. They provide step-down service for individuals transitioning from ACBH specialty mental health services in an environment of inclusion and acceptance in facilities that are commonly managed and staffed by consumers who provide or arrange for peer support. Wellness Centers are contracted providers who perform outreach and engagement; offer outpatient services such as mental health services, case management/brokerage, crisis intervention, medication support/dispensing; provide peer support and wellness services; and Tenant Support Services (TSP) for those with housing insecurity. Wellness Center personnel are trained in Harm-Reduction and Trauma-Informed Care principles to meet the participant where they are at in a whole-person manner. Cultural responsivity is a core axiom of the care provided by the team as the program was designed with Culturally and Linguistically Appropriate Services (CLAS) standards in mind.

Target Population: The BACS Wellness Centers provide services to adults (ages 25+) experiencing mental health challenges. These individuals may or may not be currently enrolled in ACBH specialty mental health programs (such as Service Teams, Full Service Partnerships, etc.). * There is also a Wellness Center provided by BACS that provides services to TAY (ages 16-24). Additional Requirements for IPS Supported Employment: Contractor shall work with individuals who have expressed interest and motivation in pursuing competitive employment, regardless of their employment readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.

FY 24/25 Program Budget: $1,113,609 **Cost per Client:** $167

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 6,672: Majority were Adults, with 6 TAY clients and 87 Older Adult clients served.

How Well Did We Do?

Quality Measure *(Percent of Clients agree or strongly agree with the statement)*	**FY 23/24 Data Results**	**Quality Objective**
"I like the services that I received here" on the Mental Health Statistics Improvement Program (MHSIP) survey	Data under review	At least 85%

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II. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:
Over the last fiscal year, Towne House Wellness Center has identified several program areas with growth opportunities. Towne House currently offers a variety of services, such as nutritional counseling, stress management, mindfulness programs, fitness classes, personal training, holistic health, alternative medicine offerings, wellness workshops, and educational seminars, which we plan to expand and enhance to meet the needs of our clients better. We plan to expand our employment support at the center to improve our services further. We have received feedback from many partners who expressed a desire to start or return to work, and we want to take advantage of this opportunity to support as many partners as possible in achieving financial independence. Expanding our employment services is a great way to enhance our partners' overall health and well-being. We're currently hiring an employment coordinator for Towne House, and we anticipate growth in this area once they join the team. Moreover, we're collaborating with community members to launch a monthly health fair. The event will provide STI testing and offer ESA pets to those who require an emotional support animal for coping with stress.

In addition, Towne House Wellness Center has dealt with the challenge of aiding Seniors and families and supporting women affected by domestic violence in this quarter. To address these issues, the center could collaborate with local organizations or government agencies that specialize in assisting families and seniors. This collaboration would provide the center with additional resources and support to better meet the needs of this specific population.

Additionally, offering educational programs and workshops to raise awareness about the challenges of undocumented families and advocate for their rights and access to essential services could also be beneficial. This proactive approach could enable the center to serve this vulnerable population better and contribute to finding constructive solutions for their challenges.

Is Anyone Better Off?

IV. FY 23/24 Client Impact: Towne House Wellness Centers' primary objective is to promote physical and mental well-being in the community. BACS is pleased to report that we have introduced several new wellness programs and activities that have generated a growing interest among local residents. As a result, Towne House experienced increased utilization of our wellness services. The collaborations with local healthcare providers and organizations have enabled Towne House to expand the range of wellness services and resources available to the community. to achieve our goal of promoting physical and mental well-being in the community. Towne House Wellness Center has introduced a range of programs to enhance wellness. These include Milieu therapy, which fosters partner-to-partner social connections, and concierge service offers

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unparalleled support by delivering ongoing guidance and access to resources. Towne House continued to offer a monthly calendar of activities focusing on a more holistic approach to mental wellness this fiscal year. This approach incorporates various groups introducing yoga, breathing exercises, art visualization, mindfulness, community wellness walks, and transparency talks.

Also, Towne House concluded with their summer series of "Community Connect" events, which provide an opportunity to connect with the community through self-care. Last Fall and Winter, Towne House organized an incredible Fall and Winter Holiday event, which welcomed around 100-150 attendees comprising individuals and families. The event was a huge success, and everyone had a great time engaging in various fun-filled activities and enjoying mouth-watering food. The Fall/Winter holiday parties consisted of:

- Complimentary food and drinks
- Santa Clause
- Family Portraits
- A live DJ.
- A food pantry
- A photo booth.
- Much-needed community interaction.

Towne House provides a comprehensive nutrition program that includes breakfast, lunch, snacks, and access to a food pantry. Seasonal fruit is also available all day. Towne House understands the importance of being mindful and present in the moment. Towne House offers continuous psychoeducation to help individuals cultivate mindfulness and develop a deeper awareness of their thoughts, emotions, and surroundings. The aim is to empower people with the necessary tools and knowledge to lead a more fulfilling and meaningful life. Community, partnership, collaboration, and buy-in are at the core of the team's values. Towne House is passionate about working with partners to achieve mutual goals, so they make sure to check in with them every month to hear their valuable feedback. Together, they know they can create something truly remarkable! By obtaining feedback from the partners, they can comprehend their requirements and make the most of their valuable insights. The clothing pantry is a vital resource that Towne House has established with great pride, as it caters to the needs of our partners. This fosters a sense of support and equips them with the necessary resources to thrive. Towne House is pleased to announce the continuation that leverages the support of partner volunteers to enhance the wellness center.

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

FY 24/25	6,000
FY 25/26	6,000

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Wellness Centers: Valley

Program Description: Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system. They provide step-down service for individuals transitioning from ACBH specialty mental health services in an environment of inclusion and acceptance in facilities that are commonly managed and staffed by consumers who provide or arrange for peer support. Wellness Centers are contracted providers who perform outreach and engagement; offer outpatient services such as mental health services, case management/brokerage, crisis intervention, medication support/dispensing; provide peer support and wellness services; and Tenant Support Services (TSP) for those with housing insecurity. Wellness Center personnel are trained in Harm-Reduction and Trauma-Informed Care principles to meet the participant where they are at in a whole-person manner. Cultural responsivity is a core axiom of the care provided by the team as the program was designed with Culturally and Linguistically Appropriate Services (CLAS) standards in mind.

Target Population: The BACS Wellness Centers provide services to adults (ages 25+) experiencing mental health challenges. These individuals may or may not be currently enrolled in ACBH specialty mental health programs (such as Service Teams, Full Service Partnerships, etc.). * There is also a Wellness Center provided by BACS that provides services to TAY (ages 16-24). Additional Requirements for IPS Supported Employment: Contractor shall work with individuals who have expressed interest and motivation in pursuing competitive employment, regardless of their employment readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.

FY 24/25 Program Budget: $631,188 **Cost per Client:** $31,559

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 20 unique Adult clients were served.

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

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III. FY 23/24 Challenges:

An ongoing challenge throughout the year is supporting client's in managing their behaviors at the center. We have had several new clients start attending Valley regularly. Adjusting to new clients with various behaviors has been challenging. Valley staff has continued to connect clients to mental health resources to help them adjust to their new reality, as well as encouraging partners to practice healthy coping skills to manage their anxiety and maintain their overall health and wellness.

Is Anyone Better Off?

IV. FY 23/24 Client Impact: One of our primary initiatives is promoting whole-body wellness through a holistic approach. Clients participate in community bike rides and swimming and are offered healthy meals. Activities include meditation for mental health, group discussions on positive coping skills, and various wellness activities focusing on breathing, nutrition, hydration, exercise, sleep, hygiene, and socialization. Clients are encouraged to journal, engage in peer discussions, and participate in community outings. Valley Wellness Center continues to be a trusted source of information, alleviating stress and anxiety among our participants this quarter. Valley launched a successful wellness fair this year, during which clients engaged with behavioral health resource providers, employment services, Bay Area Community Health services, and access to free haircuts and grooming. Valley Wellness has continued to meet the needs of the community through referrals and outreach. Valley continues to receive donations from community members and actively distributes the donations throughout the community and BACS network. The staff at the wellness center have encouraged the participants to take charge of their well-being by being active and eating well.

Valley maintains a close partnership with Pathway Community Church, which provides monthly supplies and food for our clients. This partnership receives positive feedback from participants. Additionally, Valley collaborates monthly with Cornerstone Church and City Serve for outreach, significantly impacting participants by reducing isolation, food-related anxiety, and depression. Valley continues to partner with Eden which is a program for clients going through court-ordered drug treatment programs. We also remain actively involved with Tri-Valley organizations such as NAMI, the City of Pleasanton Homeless Outreach Committee, the Livermore Police Department, and the Bay Area Community Health and Vineyard 2.0.

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

FY 24/25	4,456
FY 25/26	4,500

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: Bonita House

PROGRAM NAME: Wellness Centers: Casa Ubuntu

Program Description: Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system. They provide step-down service for individuals transitioning from ACBH specialty mental health services in an environment of inclusion and acceptance in facilities that are commonly managed and staffed by consumers who provide or arrange for peer support. Wellness Centers are contracted providers who perform outreach and engagement; offer outpatient services such as mental health services, case management/brokerage, crisis intervention, medication support/dispensing; provide peer support and wellness services; and Individual Placement and Support (IPS) Supported Employment services.

Target Population: The Bonita House Wellness Centers provide services to adults (age 25+) experiencing mental health challenges. These individuals may or may not be currently enrolled in ACBH

specialty mental health programs (such as Service Teams, Full Service Partnerships, etc.). Additional Requirements for IPS Supported Employment: Contractor shall work with individuals who have expressed interest and motivation in pursuing competitive employment, regardless of their employment readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.

FY 24/25 Program Budget: $939,041 **Cost per Client**: $18,058

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 52 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

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The program was challenged with maintaining a full staff which impacted the number of services that could be provided.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

Casa Ubuntu continued to provide 3 program groups daily M-F. The groups that were provided were an hour.15 min Morning check -in group that provided clients with an opportunity to check in related to their mental, physical, emotional and spiritual status daily. The second and Third groups of the day varied in content and ran 1-1.5 hours. The group subjects and focus were Art and music therapeutic groups, Mindfulness, anger management, stress management and emotions expression, Latino wellness group session 2x weekly, CBT, Fun in recovery and Stages of change. We have maintained our daily lunch program for program participants. The clients participated in 2 conferences and attended other community outing's collaborating with other community players and supporters. Qualifying client were also provided with individual counseling sessions with Master level MSW, MFT and LPCC Trainees who are supervised by a license supervisor.

16 clients were surveyed for the fourth quarter of 23/24 fiscal year. Out of the 16 clients surveyed 14 reported "I can deal more effectively with my daily problems as a result of the services provided at Casa Ubuntu Wellness Center".

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

FY 24/25	40
FY 25/26	50

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: Bonita House

PROGRAM NAME: Wellness Centers: Berkeley

Program Description: Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system. They provide step-down service for individuals transitioning from ACBH specialty mental health services in an environment of inclusion and acceptance in facilities that are commonly managed and staffed by consumers who provide or arrange for peer support. Wellness Centers are contracted providers who perform outreach and engagement; offer outpatient services such as mental health services, case management/ brokerage, crisis intervention, medication support/dispensing; provide peer support and wellness services; and Individual Placement and Support (IPS) Supported Employment services.

Target Population: The Bonita House Wellness Centers provide services to adults (age 25+) experiencing mental health challenges. These individuals may or may not be currently enrolled in ACBH specialty mental health programs (such as Service Teams, Full Service Partnerships, etc.). Additional Requirements for IPS Supported Employment: Contractor shall work with individuals who have expressed interest and motivation in pursuing competitive employment, regardless of their employment readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.

FY 24/25 Program Budget: $466,397 **Cost per Client:** $1,896

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 246 Adults

How Well Did We Do?

This year has been overwhelmingly successful, a testament to our collective efforts and dedication. The number of clients has risen by 200 from the previous year.

In this last quarter (April ’24-June’24), our client numbers expanded to an additional 100 unique clients from the quarter before, bringing the total number of clients served throughout the ‘'23-‘24 fiscal year to 246. In the first three quarters of the year, BWC was already experiencing a 400+% increase in clients from the entire ‘'22- ‘23 fiscal year; an additional 100 clients in the last quarter is astounding.

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This unprecedented client expansion can be credited to a motivated staff, intensive group facilitation training, revamped programming, space redesign, program outreach, sidewalk marketing, to-go meals, and hot breakfast and lunch. In the ’ '23-’24 fiscal year, BWC hired three new employees: a new Program Manager, Barbara Barry, an Expressive Arts Therapist MA student, Gayla Biggers, and a Support/Outreach Specialist, Tomas Salazar. Possibly, our most important offering is a team invested in getting to know each person who walks through our door.

The BWC serves the whole gamut of DSM diagnoses. Serving such a generalized population can be challenging. BWC has created a broad offering of services and environments within the center to reach each client where they are in their wellness. Despite our increased numbers and need for a more extensive staff to meet the increase, each team member knows each client personally.

Daily logs and weekly meetings are implemented to share our observations and communications with clients, keeping each team member abreast of problems and successes. We observe clients using the center begin to navigate life more easily due to our inclusive and accepting atmosphere that turns no one away and intentionally reaches out to connect deeply.

At a services level, we connect individuals with local organizations such as HAC to assist with housing and entitlement navigation and BMH to receive case management, psychiatric care, and licensed therapy. We work with the ACHCH to gain a greater understanding and training regarding our client's needs and available county services. We also use the medical and legal services provided by the Downtown Berkeley Library branch. Group outings are organized to take clients to the library once a month when these specialized services are offered. Finally, BWC began partnering with Just Fare (a local catering company) to provide hot lunches and boxed food at the end of 2023. This donation from Just Fare is priceless and crucial to our program and community as full bellies assist peaceful minds.

Of note is BWC’s expanded and thoughtful group programming, which is designed to assess client needs and be adaptive. Group programming focuses on insight into MH matters, socialization skills, hope, and compassion. We offer programming that appeals to various dispositions and interests: music groups, therapeutic art groups, a weekly MH book club, a DBT group, and many more. The group programming now runs on a 10-week schedule. This design fosters intentional internal critique of groups to better assess, add, and pivot based on observations from the previous semesters.

The center also strengthens client work skills such as orderly thinking, following directions, and working with a team by providing “volunteer” slots. Clients are invited to get involved in their BWC community by helping with daily lunch service, cleaning up, and greeting fellow clients at the door. Through this volunteer program, some clients have been provided work references and letters of recommendation to assist with job searches and judiciary matters.

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Berkeley Wellness Center has had an outstanding year. Client numbers have nearly quintupled, programming has been revamped, and the BWC has new management, a full-time expressive arts therapy MA student, and an outreach specialist.

II. Language Capacity for this Program:

☐ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

Is Anyone Better Off?

Our clients are distinctly better off after availing themselves of BWC's services. What is profoundly heartening about this year's expanded client base is that most individuals served become regular clients using the center several times a week, if not daily. Many initially come in for coffee or lunch but stay because the atmosphere is calm and inclusive. After a few visits, even the most reticent client typically begins to partake in higher socialization, therapeutic programming, and personal meetings with counselors. After spending time at the center, clients experience an increased sense of self and ability to navigate life's waters. Clients who would not speak when they first arrived now share openly with others; some have found employment and housing, and some have enrolled in GED classes or community college. Some clients open up about mental health issues and ask for help for the first time, and others use our services to support a program of wellness in which they are already actively engaged.

By presenting ourselves to a frequently disenchanted population as an example of a system that can help, we see clients become open to psychiatric and social services. Through participation at BWC, clients begin to think about a future for themselves that was previously unimaginable. Our final quarterly report survey shows that 92% of our clients surveyed "like our services" at the highest level of satisfaction, and 76% report being better able to navigate daily life issues at the highest level of satisfaction.

IV. FY 23/24 Client Impact:

There have been so many successes at BWC this year! Here is one case study.

After living at a motel shelter for three months, a daily client received an eviction notice for non-payment. This housing placement had ended four years of homelessness. Our client, already suffering levels of anxiety that were prohibitive of taking steps to gain entitlements for rent money, was terrified and became immobilized to take positive action. He immediately left his space without reading the eviction notice and slept on cardboard in the doorways of downtown

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Berkeley for two weeks. Unfortunately, for our client, within 24 hrs., the impact of receiving an eviction notice and moving out on the street resulted in previously unobserved symptomatic auditory hallucinations.

Our staff worked with him daily to obtain more information about his eviction notice but faced much resistance from the client, stemming from hopelessness and anxiety. After much encouragement, one-on-one meetings with staff, multiple assisted phone calls to the property management, an assisted visit to a community-based legal team, and accompaniment to his home to obtain the eviction notice, it was determined that the eviction had not yet gone into effect. He worked with a community lawyer and BWC staff, created new terms with his property manager, and was finally returned to his house.

This eviction was directly related to his lifelong severe anxiety, which had prevented him from gaining SSI entitlements and setting up income-based rent rates. With the help of our team, he made a mental shift and began to accept help from a housing advocate and community lawyer. We are thrilled to report that he is now in the process of receiving his long-due entitlements and creating a more independent and stable life.

In the two weeks he was on the street, the client suffered an incredible decline in physical and mental health. Within 48 hours of being returned to his house, his auditory hallucinations dramatically declined, his Blood Pressure dropped, and he returned to his baseline disposition of calm, kind, and curious. Without services such as BWC and its dedicated counselors, this elderly and infirmed client would have been held captive by his mental health disorder and ended up on the street with a low chance of survival.

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

FY 24/25	350
FY 25/26	450

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: Peer Wellness Collective (Network of ACNMHC)

PROGRAM NAME: Wellness Centers

Program Description: Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system. They provide step-down service for individuals transitioning from ACBH specialty mental health services in an environment of inclusion and acceptance in facilities that are commonly managed and staffed by consumers who provide or arrange for peer support. Wellness Centers are contracted providers who perform outreach and engagement; offer outpatient services such as mental health services, case management/brokerage, crisis intervention, medication support/dispensing; provide peer support and wellness services; and Tenant Support Services (TSP) for those with housing insecurity.

Target Population: Network of ACNMHC Wellness Centers provide services to some TAY and Adults (ages 18+) who identify as being behavioral health consumers in programs funded through ACBH. They make it a priority to serve behavioral health consumers who: Have histories or current conditions of psychiatric disabilities; are identified or labeled as having severe mental illness (SMI) or severe mental stress; have experienced (or are at risk of experiencing) repeated psychiatric hospitalizations, treatment placements, or episodes of incarceration in the criminal justice system; are experiencing housing insecurity; and those who are experiencing problems with alcohol and/or other drug abuse.

FY 24/25 Program Budget: $1,209,035 **Cost per Client:** Data not provided

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: Data not provided

How Well Did We Do?

a. **Reduce Mental Health Stigma:** PWC provides active peer support through peer- ran groups focusing on a wide range of wellness topics including life skills and wellness tools such as WRAP and Taking Action community engagements through presentations hosted by consumers active in their recovery journey, meaningful work activity through volunteer and employment opportunities. Housing advocacy and intensive case management provided by individuals who have lived experience receiving mental health services and/or has experienced homelessness.

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b. **Increasing Peer Support Services:** PWC is a leader in providing Medi-Cal Peer Certification training, documentation training, and Peer Specialist employment supports
c. **Create a Welcoming Environment: PWC** maintains a welcoming environment by having front desk staff who are trained Peer Support Specialist, a safe space to connect with other peers. We provide a warm presentation by offering casual seating; a program volunteer is there to greet consumers when they arrive and a safe and clean waiting space. All of our sites provide water, coffee, snacks and a listening ear. A variety of brochures about PWC individual programs, we provide a variety of mental health recovery-oriented materials and a Navigation Specialist to help peers find what they need. We maintain a clean/sanitized environment.

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☒ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

- PWC continues to struggle the staff retention due to unstable and unsafe work environment. We are currently planning to relocate.
- PWC continues to face challenges with grant opportunities. We are currently working towards Medi-Cal billing

Is Anyone Better Off?

- Currently, PWC can only measure successes when members return to share

IV. FY 23/24 Client Impact:

- Increase access to 80-hour Peer Specialist and 40-hour specialty trainings (Crisis and Housing)
- Increase access to scholarships and additional trainings

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

FY 24/25	3500
FY 25/26	3500

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 19

PROVIDER NAME: Hiawatha Harris, M.D., Inc./Pathways to Wellness Medication Clinic

PROGRAM NAME: Medication Support Services

Program Description: Pathways to Wellness provides the following clinic-based services based on the acuity client of needs to promote successful transition of patients to primary care; 1. Medication Support Services; 2. Issuing medication prescription(s) for the right drug therapy; 3. Administration of injectable medication, when applicable; 4. Evaluation and monitoring; 5. Mental Health Services, and 6. Outreach efforts made in the field by a psychiatric nurse specifically in North County to meet client demand; 7. Children support services for medication and case management.

Target Population: Pathways to Wellness provides services to children (5-9 years old), adolescents (10-17 years old), and adults (18-59 years old) who have moderate to severe mental illness impairments resulting in at least one significant impairment in an important area of life functioning. All clients must meet specialty mental health criteria with impairments in the moderate to severe range. All clients are referred by Alameda County Acute Crisis Care and Evaluations for System-Wide Services (ACCESS). Services are provided in North County, South County and East County, located in Oakland, Union City and Pleasanton.

FY 24/25 Program Budget: $3,097,086 **Cost per Client:** $1,114

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 2,780 Adults **Number of new admissions:** 803

How Well Did We Do?

Increasing Wellness and Health Outcomes: We have been providing health interventions that reduce the impacts of systemic oppression by recognizing the impact on diagnostic and treatment decisions for the seriously mentally ill population across the age span and identifying the role of culture in symptom presentation and expression. For the entire year, we were able to provide expedient and accessible psychiatric evaluations to new client referrals with an average of 5 days between the time of referral and the appointment. By having immediate access to an evaluation, clients have increased engagement and commitment to treatment. We connected 100% of our clients to a Primary Care Physician and coordinated care within the first 30 days of treatment. Our focus is to reduce health disparities among our client population and increase holistic wellness and reduce health-related conditions. We are also active participants in the

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county's pilot program to accept and facilitate warm handoffs on new referrals who are in need of immediate services. Pathways has had an excellent track record contributing to the reduction of the wait time from referral to admission as a direct result of participating in this pilot program.

Reduce mental health stigma: We reduce mental health stigma by hiring staff who are diverse, culturally competent, and understand, embody, and implement the standards of the CLAS model of care. This includes a commitment to reduce mental health stigma through utilizing client-centered assessment, strength-based services, trauma-informed care, and culturally competent training. We continue to offer client centered engagement with community events dedicated to the clients. Including a mental health awareness picnic where staff serve clients food, games, and dance contests.

Client Centered Assessment: is an ongoing service activity of gathering and analyzing collaborative information with the client. Together, we help the client build community resources and tertiary interventions to reduce harm and increase resiliency. Assessment includes, but is not limited to, one or more of the following: medical necessity, mental status determination, analysis of the client's clinical history, gathering relevant cultural issues, analysis of behaviors and interpersonal skills, and a review of family dynamics and diagnosis. Assessments view the client from a comprehensive social-cultural lens, keeping in mind the daily stressors a client may go through, specifically if they are from an underserved population. Utilizing a social justice perspective of how race, class, culture, sexual orientation, and gender identity impact a person's expression of symptoms and we ensure that clients are diagnosed correctly. We account for the impact of how these qualifiers can drive diagnosis including African Americans being disproportionally diagnosed with schizophrenia and other psychotic disorders when instead they have a trauma disorder. We at Pathways to Wellness differentiate between cultural and functional paranoia in symptoms and encourage an accurate portrayal of client symptoms. By focusing on what the client is experiencing in the world as who they are, we can differentiate between what is the client's symptoms and what is the malady of systemic racism. This way, we can treat the person and not the illness of the institutions in which they continually encounter.

Trauma Informed Care: In alignment with the MHSA standards of treatment and care, Pathways to Wellness utilizes trauma-informed care, which includes program participant empowerment and choice, collaboration among service providers and systems, and ensuring physical and emotional safety and trustworthiness for program participants. When a client has been exposed to abuse, neglect, discrimination, violence, and adverse experiences, they are at risk for health-related issues, especially mental health complications. By acknowledging the client's life experiences, our providers improve patient engagement, treatment adherence, medication management, and potential mental health recovery.

Strength Based Model: Our Strengths Based Model uses a set of values and philosophy of practice that encourages clients to become experts in their own mental health recovery. This includes the potential to recover from adversity through mutually identified strengths,

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community resources and other opportunities. Program staff and providers assist clients in assessing their strengths, establishing meaningful goals, and developing a recovery plan. Pathways to Wellness encourages program clients to recover from mental health and reclaim their lives. We focus on client strengths rather than deficits to increase self-worth and enhance the potential for mental health recovery. We encourage the participant to be an expert of their own recovery. We encourage a collective treatment approach as primary and essential while working together as copartners.

We provide ongoing culturally responsive trainings for our staff and our communities at large to better engage and serve African American consumers which represents the largest client population at Pathways. These trainings are provided to both our staff and to our community. We train providers about the complexity of trauma within the African American population and how to best serve their psychiatric and biopsychosocial needs.

Create a welcoming environment: Our welcoming environment includes providing client- driven comprehensive community-based specialty mental health services. We support adults ages 18 years and older living with a serious mental illness, at risk of or experiencing homelessness, who may also have a co-occurring substance use disorder, and/or who may be engaged in the criminal justice system. Our services implement a phased approach with the provision of intensive services during the early phase of treatment. When applicable, we see clients frequently within their first 90 days in order to ensure they are out of crisis and stabilized on their medications and have community resources. Our waiting rooms are set up so that clients may experience a welcome home environment with decaf coffee and water provided daily, special food luncheons once a month, clothing and food drives, as well as our yearly mental health picnic for clients, and our consumer council that encourages participation from consumers. Clients are provided with art supplies while they wait for their appointments and are met with our engagement team to ensure they have their needs met and are welcomed.

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☒ **Chinese** ☒ **Korean** ☒ **Vietnamese** ☒ **Tagalog** ☒ **Farsi**
☒ **We use the Language Line** ☒ **Other** Sign Language

III. FY 23/24 Challenges:

After the implementation of SmartCare, we no longer have access to the daily county reports (also known as 120 reports) on client hospitalizations or incarcerations. For 25 years, our agency relied on these reports as a key component of our daily program model. The sudden elimination of this report has significantly hindered our ability to quickly identify and engage clients who have recently experienced a crisis. Early engagement following a hospitalization can reduce the likelihood of future crises. Additionally, the increase in the severity of referrals has escalated the level of engagement required to maintain stabilization. Ongoing challenges throughout this fiscal

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year with Physician recruitment and other professional staff positions due to the staffing crisis throughout the Bay Area.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

Clients have transitioned back into more face-to-face services with returning appts. at their clinic location. Clients have struggled with increasing violence in their communities within Alameda County and have had more chronic stress as a result. Ongoing stressors related to limited housing and resources also contributed to the level of stress clients are impacted by.

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

FY 24/25	2,800
FY 25/26	2,800

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 19

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: STEPS Program

Program Description: STEPS of Alameda County is a short term, intensive community support service for individuals who suffer from a mental illness, many of whom would otherwise require extended care in institutional settings. Services are designed to enhance the lives of individuals living with mental illness and guide them on their healing process. The mission of STEPS is to facilitate the transition of high risk, hard-to-place Alameda County Behavioral Health clients into the community while reducing their length of stay in Alameda County psychiatric facilities.

Target Population: Adults (ages 18-59) diagnosed with a severe mental illness. STEPS' goal is to serve high utilizers of Alameda County mental health services. Members referred to STEPS will have utilized at least three psychiatric emergency room visits and/or at least one month of inpatient psychiatric care within the past year. Priority will be given to members who have met these criteria for 2 years in a row.

FY 24/25 Program Budget: $753,353 **Cost per Client:** $11,244

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 67 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:
As with most programs, Telecare continues to struggle with finding and securing affordable housing for participants. There is still a lack of affordable housing in Alameda County. Additionally, finding and securing supportive housing with medical services such as diabetes management and medication support continues to be challenging.

Recently we have also struggled with connecting partners to primary care providers. The FQHCs in Alameda County are having a staffing crisis. Partners are waiting months to get established and requiring urgent care or emergency care while they wait.

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Is Anyone Better Off?

IV. FY 23/24 Client Impact:

When Jane started with STEPS, she was homeless and living out of her car. She was not taking medications and was actively self-harming by cutting several times a week resulting in frequent crisis presentations to area ERs and psych hospitals. During her work with STEPS, she was able to find a supportive board and care home to help her stabilize on medications and live in a supportive environment. She has reduced self-harm and crisis presentations, having only 1 ER presentation in 3 months. She has found and secured employment in her chosen field. Jane is building strong and supportive relationships in the community to help her stay on track to reach her goals.

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

FY 24/25	70
FY 25/26	75

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 20

PROVIDER NAME: Bonita House

PROGRAM NAME: Service Team/Individual Placement Services (IPS)

Program Description: Supported Independent Living Program is an interdisciplinary outpatient mental health program providing case management and rehab services to clients. The IPS component of the program sees work and preparing to work through acquiring job skills as a mental health intervention. The Employment Specialist collaborates with the case management, nursing and clinical staff to support clients in achieving their mental health and employment goals.

Target Population: Adults in Alameda County (18+) with severe mental illness (SMI) as well as individuals with co-occurring disorders.

FY 24/25 Program Budget: $2,290,221 **Cost per Client:** $109,058

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 21 Adults

How Well Did We Do?

Of the 12-client served, 7 resumes were developed, 9 new job interviews w/n 23/24, 2 remained with their current employer.

II. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

Co-occurring MH & SA issues affecting motivation, focus and job readiness, ambivalence, limited education or skill gaps. Job retention unrealistic expectations inconsistent engagement lock of stable housing.

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Is Anyone Better Off?

Several clients were able to increase their executive functioning and quality of daily living and make appointments.

IV. FY 23/24 Client Impact:

Some clients can obtain and sustain work, an increase in client motivation, encouragement, hope, and self-esteem.

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

FY 24/25	10
FY 25/26	10

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 20

PROVIDER NAME: Center for Independent Living (CIL)

PROGRAM NAME: Individual Placement Services (IPS)

Program Description: Work incentives, benefits counseling. By working collaboratively with the ACBH Vocational Program, we offer training and technical support resources, training events, strategize

Target Population: Adult participants in ACBH Wellness Centers' IPS programs.

FY 24/25 Program Budget: $122,941 **Cost per Client:** $13,660

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 9 Adults

How Well Did We Do?

II. Language Capacity for this Program: The Work Incentive Benefits counselor only speaks English but can use the Language Line and/or ASL interpreters to provide oral interpretation. The counselor can also provide links to and/or printed copies of online work incentive benefits information that is in Spanish.

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:
CIL did not have a dedicated WIB counselor throughout 2023/2024 due to challenges in obtaining qualified work incentive benefit counselor applicants. This significantly impacted our ability to provide work incentive benefits counseling. In August 2023, CIL's interim director Bob Hand met with the ACBH Program Contract Manager, Eileen Hamlin, to inform ACBH that CIL had not been able to fill the open position with a qualified benefits specialist for the previous 6 months due to the .5 FTE hour limit and low pay rate and therefore we were requesting changes to the contract. In September 2023, CIL submitted, as requested, an informal narrative proposal to ACBH for increased hours to 1.0 FTE and an increase in funding and in early January received a proposal from ACBH that would increase hours to 1.0 FTE and increase funding for higher pay. During this period, CIL's program manager Robin Earth was only able to provide benefits counseling to participants who were referred to CIL by their ACBH employment counselors and she provided benefits information to ACBH employment counselors upon request. While the county

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position as a 1.0 FTE position with a higher pay rate. We received an increase in qualified applicants and in May 2024 CIL was able to hire someone for the ACBH WIB position and enrolled her in an intensive training program via the YTI Online "Work Incentive Planning and Utilization for Benefits Practitioners Certificate Series" running from 6/3 – 8/2. On June 24, 2024, CIL was informed that additional ACBH funding for the CIL Work Incentive Benefits counseling program had been secured for FY 24/25. CIL's new Work Incentive benefits counselor Carly Gibbs will begin providing benefits counseling on August 5, 2024. CIL expects that in FY 24/25 our benefits counselor will provide work incentive counseling services to a significantly higher number of ACBH participants through focused outreach and presentations to partner agencies about work incentives and about CIL's work incentive benefit counseling program.

Is Anyone Better Off?

IV. FY 23/24 Client Impact: In Q3, a participant and the employment specialist from Fred Finch STAY met via Google Meet with WIB program manager Robin Earth to learn whether the participant had been approved for SSI or for SSDI. She had applied for both, but only been approved so far for one, and did not know which type of benefits she had received. She learned from Robin how to easily determine which type of benefits payment she received by checking the date of the deposit: SSI is deposited on the 1st (or 31st if 1st falls on a Sunday or holiday.) SSDI is usually deposited on the 3rd of the month or a later date. In a follow up appointment 2 months later, she reported she was now receiving both SSI and SSDI and had concerns about the SSI $2000 resource limit. She learned in the appointment about ABLE accounts and how that if she opened an ABLE account, such as CalABLE, she could save up to $100,000 without affecting her SSI benefits. The information was then also emailed to her, with links to the CalABLE website. She was grateful for the information. She said she wasn't ready to look for employment yet but would like to speak to a benefits counselor again once she is closer to seeking employment. Thanks to the CIL WIB program, she is now more knowledgeable about the type of disability benefits that she has, the value of ABLE accounts to save money above $2000 without affecting SSI eligibility and knows there are work incentives that allow people to work without necessarily losing all their benefits. She also knows she can obtain more support with ABLE accounts and work incentives from CIL if/when she needs it.

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

FY 24/25	200
FY 25/26	240

Now that CIL has a 1.0 FTE work incentive benefits counselor on board and COVID appointment barriers have decreased, we project that CIL will be able to serve 200 clients in FY 24/25 and increase to 240 in FY25/26 if the contract is renewed.

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 20

PROVIDER NAME: Alameda County Vocational Services

PROGRAM NAME: Individual Placement Services (IPS)

Program Description: The ACBHD Vocational Program (ACVP) is a county operated direct service program which is part of the Alameda County Behavioral Health System of Care. ACVP is one of four units under the umbrella of Vocational Services (Including units for Supported Employment Training and Technical Assistance, CalWORKs Mental Health, Administrative and ACVP Direct Service).

ACVP is imbedded in 18 county operated and community based specialty mental health programs (including Conditional Release, the TRUST Clinic, Asian Health Services, Casa Del Sol, La Familia Counseling Center, Fred Finch Youth and Family Services, West Oakland Health Clinic, Schrieber Center, Supported Housing).

The model of Supported Employment used by ACVP is evidence-based Individual Placement and Support (IPS). Our service approach is to partner with program participants and engage them around their unique interests and needs in finding a job, meet them in their community to identify employers, obtain and retain jobs, while continuing to collaborate with their clinical team and significant others to aid in their success. After a consumer is working, ACVP continues to work with them until the job is secure and the individual is satisfied with the job match. If they want a different job or lose the one secured, we keep working with them as long as they are interested and motivated to work. There is a "zero exclusion" approach to recruiting participants for services, which means that as long as they have expressed interest and are action oriented toward work, they will be engaged despite any presenting barrier.

Target Population: Assists youth (16-17 years old), Transitional Age Youth (TAY- 18-24 years old), and Adults (18-59 years old) and Older Adults (60+ years old) in finding and keeping competitive work using the Evidence Based Practice of Individual Place and Support- Supported Employment. IPS services span from the Tri-Valley, Tri-City and mid-county locations.

FY 24/25 Program Budget: $4,541,802 **Cost per Client:** $16,456

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 6 TAY, 268 Adults, 2 Older Adults

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How Well Did We Do?

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☒ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:
Staffing challenges around recruitment carry over from the previous fiscal year and continue to be a significant obstacle for ACVP. At the end of the fiscal year 2024, four of nine Employment Specialist (ES) positions were unfilled representing a 40% staff vacancy rate. However, as of 2Q25 the unit has hired two new Employment Specialists and was actively in the process of hiring two additional ES staff using the Alameda County Provisional employment process (a status which allows for faster track hiring and can lead to Permanent employment status via traditional civil service process; Alameda County has not had recruitment for ES was over two years ago).

Vocational Services Management has also taken proactive measures to review and revise job descriptions and minimum qualification criteria for both Employment Specialist and Mental Health Specialist and advocating for an active recruitment with human resources. Revisions specifically to the Employment Specialist minimum qualification will result in the ability to attract greater numbers of qualified candidates with broader work experience and skillsets.

ACVP is also implementing changes to the program's operational structure for better positioning within the ACBHD systems of care and to streamline Supported Employment services using the "No Wrong Door" approach in alignment with CalAIM initiatives.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:
On a monthly average ACVP has a 36% job placement rate. Competitive employment rate percentage is the number of clients in the ACVP IPS program who worked a competitive job in the community (monthly number of people working divided by the total number of people open to the IPS program). Benchmarks set by the Westat IPS Collaborative include 30% fair standard, 40% good standard, and 50% exemplary standard.

ACVP helped clients start 77 new jobs during FY 23/24 as well as maintain 51 positions with existing employers, for a total of 128 jobs (see full list of employers and positions at the end of report).

Employment is considered an important social determinant of health and a milestone in the recovery process of people with severe mental illness. Exclusion of people with SMI from the workforce is high and among those who are unemployed, and studies show two-thirds express a strong desire for work. These individuals comprise a clear target group for SE interventions.

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Case-in-point example of how employment supports are utilized as a mental health intervention:

Ray's Recovery Journey Through Employment

Ray's story is a testament to the power of unwavering support and personalized care. When he first came to ACVP, he was grappling with the deep wounds of a traumatic sexual assault in addition to a complex array of challenges. These included PTSD, major depressive disorder (MDD), obsessive-compulsive disorder (OCD), ADHD, extreme poverty, and an undiagnosed learning disability.

His journey was further complicated by job losses, difficulties with education, exposure to gang involvement and substance use at home, a twin brother who shared their tiny room and frequently discussed joint suicide, rotating and temporary clinicians, and the isolating impact of the pandemic.

Despite these barriers, the ACVP Supported Employment team remained committed to providing Ray with the resources and support he needed to achieve his vocational goals. Working closely together, the team explored various therapeutic approaches, connected him with specialized programs, and offered consistent encouragement. Throughout this process, the team validated his experiences and emphasized his strength and resilience.

A turning point came when Ray began to heed the advice of his clinical support and recognized the importance of taking proactive steps for his own recovery. With the guidance of his dedicated employment specialist and a focus on his employment preferences, Ray secured a job at Walgreens where he thrived despite his ongoing challenges. However, the pandemic's toll and the loss of his TAY support system led to loss of employment and a significant wellness setback.

The ACVP team responded swiftly, linking Ray with an ECM (Enhanced Care Management) resource for his medical needs, a licensed therapist for in-person therapy, and successfully advocating for a higher level of support through an Alameda County Service Team. While his challenges are ongoing, Ray's progress demonstrates the transformative power of compassionate care and a belief in his ability to overcome adversity. With comprehensive support in place, Ray regained his footing and began to pursue employment once more.

Today Ray is working at Lucky's, a significant milestone in his recovery. He is employed as a front-end clerk and loves working, as it provides him a routine with meaningful activity and an income. It is an encouraging working environment as well and Ray gets assurance when needed from his manager. For example, Ray was recently feeling insecure about his work performance compared to his peers and his manager told him, “Don’t to worry about what other people may or may not think – I’m the manager and I see the work you do. I believe you are doing a great job!” That was all Ray needed to hear for him to feel safe and supported.

The next clinical challenge is to develop a plan that reduces clinical and vocational support without triggering abandonment issues and potential self-sabotage. Ray is now advocating for

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himself more than ever and has recently undergone a complete neurological workup to gain a better understanding of his mental health. His goal is to know himself and his challenges at a deeper level and build a long-term clinical and vocational strategy.

He still holds onto the same aspirations he had when he started working with ACVP: to own his own home in Hayward, have a family, and take care of his twin brother. Ray is a wonderful example of how needing and meeting the vocational needs of people can coalesce into the best of what it means to be human.

V. FY 23/24 Projections of Clients to be Served: 276

ACVP is projected to serve 270+ unique clients each of the next two years based on a rolling four-year average of actual/estimated clients served.

FY 24/25 (Est.)	270
FY 25/26 (Est.)	273

Employers:

ACE PARKING MANAGEMENT, INC
ADDUS HEALTHCARE
AIRPORT TERMINAL SERVICES
ALL CITY MANAGEMENT
ALLIED, UNIVERSAL EVENTS
AMAZON
ARAMARK
ARCH T-MOBILE
BALANCE STAFFING
BANFIELD PET HOSPITAL
BEAUTIFICATION COUNCIL
BEST BUY
BLOCK BY BLOCK PROGRAM
BOSS
BRENDAS
BURLINGTON COAT FACTORY
CATTLEMENS
CENTRIA AUTISM
CHAMPION'S CURRY
CHILDCARE CAREERS
CHILI'S RESTAURANT
CHIPOTLE MEXICAN GRILL
CLUTTER
COLD STONE CREAMERY
CONTEMPORARY SERVICES CORP
CONTRACTOR'S WAREHOUSE
CO-OP CAREERS
CRUMBLE
CVS PHARMACY
DANIEL'S JEWELERS
DD'S DISCOUNT
DEPUTY SHERIFF'S ACTIVITY LEAG.
DOLLAR TREE
DOORDASH
DRAXLMAIER
EASY 8 MOTEL
EDEN HEALTHCARE
EDIBLE ARRANGEMENTS
ELDER ASHRAM SENIOR FACILITY
EMPLOYMENT FOR SUCCESS
EXPRESS PIZZA
FEDERAL EXPRESS
FEDEX
FINE LITE INC
FOOTLOCKER
FREMONT MARRIOTT
GHIRADELLI CHOCOLATES
GOODWILL
GRAND LAKE KITCHEN
HAYWARD HILLS HEALTHCARE
HOME DEPOT
ICE CITY SMOKE AND GIFT
IMG CORPORATION
IN-N-OUT BURGER
INTL HOUSE - UC BERKELEY
ISLAND PACIFIC
JACK IN THE BOX
JIFFY LUBE
KOHLS
LANDMARK VILLA
LITTLE CEASARS PIZZA
LIVERMORE 13 CINEMA
LUCKYS
MADE FROM SCRATCH
MANHEIM SF BAY AUCTION
MARSHALLS
MICHAEL'S
MINISO
MISSION PARADISE
MOTIVATE LLC
NOAH'S BAGELS

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OAKLAND INTERNATIONAL AIRPORT
OAKLAND UNIFIED SCHOOL DIST
OAKMONT OF MARINER POINT
PALAMERICAN SECURITY SERVICES
PALO ALTO MEDICAL FOUNDATION
PANERA BREAD
PAPASAN ROLLS AND BOWLS
PARADIES LAGARDERE
PET SMART
PIEOLOGY
RALEYS
RAMEN 101
ROOTS COMMUNITY HEALTH
ROSS DRESS FOR LESS
ROVER.COM
RUBY BRIDGES ELEMENTARY SCHOOL
SAFEWAY
SALVATION ARMY
SAVER'S THRIFT SUPERSTORE
SEAFOOD 88 MARKET
SEAFOOD CITY
SECURITAS
SENIOR ALTERNATIVES
SEPRAGEN CORPORATION
SONOMA INSURANCE
SOUTH COUNTY SECURITY
ST. FRANCIS NURSING HOME
SUNTERNAL SOLAR
THE BEUTIFICATION COUNCIL
THE MEAT COMPANY INC
THE UPS STORE
TLG SECURITY GUARD SERVICES
UPS
WALGREENS
WING STOP
YMCA

Positions:

Assembly Line Worker
Asset Protection
Assistant for the Elderly/Disabled
Auction vehicle specialist
Banquet Server
Care Giver
Cashier
Catering Assistant
Childcare Provider
Clerk
Companion/Sitter
Concession Staff
Cook
Counselor
Courtesy Clerk
Crew Member
Cross Guard
Custodian
Customer Service Associate
Desk clerk
Digital Marketing Captain
Donation Attendant
Driver
Emancipator
Floor Recovery Staff
Food Service Worker
Freight Associate
Hostess
Housekeeper
Janitor
Job Developer
Kitchen assistant
Lot Associate
Medical Assistant
Oil Change Technician
Package Handler
Pet Care Assistant
Pet Hotel Attendant
Prep Cook
QA Analyst
Ramp Agent
Receptionist
Restaurant Associate
Retail Associate
Sales Associate
Sales Representative
Sanitation Engineer
Security Officer
Server
Service clerk
Stand Worker
Stock Clerk
Store Clerk
Street Sweeper
Substitute Teacher
Teacher
Teacher's assistant
Team Member
Technician
Utility Crew
Valet Parking Attendant
Warehouse Associate

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 23

PROVIDER NAME: REFUGE

PROGRAM NAME: Crisis Residential Services

Program Description: REFUGE offers a 24-Hour facility for TAY consumers in crisis. A supervised residential facility for mental health treatment program that includes full-day social rehabilitation services for TAY who need additional support as they step down from a restrictive setting into the community. REFUGE has 13 beds and offers residential treatment up to 6 months.

Target Population: REFUGE serves TAY consumers between 18 years of age and 25th birthday who are living in Alameda County (including those who are homeless or at risk for becoming homeless); are enrolled in Health Program Alameda County (HealthPAC County) or Full-Scope Medi-Cal eligible; who meet medical and service necessity criteria for specialty mental health services; require a transitional period of adjustment after a psychotic episode, and/or stepping down from hospitalization/restrictive setting before returning to the community; are ambulatory and free of communicable diseases; are able to participate in 4+ hours of group programming daily; who have the ability to pay for room and board (program can support client in obtaining benefits); and have been authorized for services by ACBH.

FY 24/25 Program Budget: $1,734,121 **Cost per Client:** $69,365

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 25 Transition Age Youth (TAY)

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

We continue to have challenges with stabilizing clients who refuse to take their medication and become psychotic, and or aggressive. We have had a great collaboration with their partnering agency, giving them time to stabilize at the CRT and sometimes it extends their stay with us and others it does not.

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Is Anyone Better Off? Yes

IV. FY 23/24 Client Impact:
We have a 70% program completion rate where the client reaches their goals and find permanent housing. Hoping to increase in the next year.

V. FY 23/24 Projections of Clients to be Served: 25

FY 24/25	25
FY 25/26	25

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 24

PROVIDER NAME: Alameda County Behavioral Health

PROGRAM NAME: Schreiber Center

Program Description: The Schreiber Center (http://www.acphd.org/schreiber-center.aspx) is a specialty mental health clinic developed in collaboration with Alameda County Behavioral Health, the Regional Center of the East Bay, and Alameda County Public Health Department. The center is dedicated to serving the mental health care needs of adults living with intellectual and developmental disabilities and a serios mental illness. The team of professionals specializes in supporting clients with complex behavioral, emotional, and/or psychiatric needs.

Target Population: The Schreiber Center serves the mental health care needs of adults (ages 18-59) and older adults (60+) with intellectual and developmental disabilities. The Schreiber Center also serves residents of Alameda County, ages 18 and up, who are clients of the Regional Center of the East Bay (RCEB). Clients must also meet the specialty mental health criteria and have a covered behavioral health care plan to be considered eligible for services.

FY 24/25 Program Budget: $423,999 **Cost per Client:** $8,833

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 40 Adults, 8 Older Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

The Schreiber Center was largely impacted by clinical and clerical staffing challenges which limited referral reviews, intake assessments, and consistency in clerical support. The Schreiber Center has been without a full-time clinician since October 2022, in which the existing clinician transitioned to a supervisory role overseeing the program. The current clinical supervisor has held a small caseload of therapy clients, and our part time psychiatrist has been consistent throughout the FY 23/24. Recruitment and interviewing were conducted throughout the year

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but had been unsuccessful in finding the right fit for the role. During the periods in which the Schreiber Center's clerical position was vacant, temporary staffing was used to fill the role until a permanent clerk was onboarded in December 2023. In February 2024, a significant flood occurred at the Schreiber Center office suite in the Eastmont Town Center. As a result, the team has had to pivot to remote work and sharing temporary office space to see clients for in person appointments. This also has impacted ability to conduct intake assessments as regularly as anticipated. The Schreiber team is looking forward to moving back into their regular site at the end of this year and is scheduled to welcome a new clinician to the team in October 2024.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

Schreiber Center clients are noted to benefit from services anecdotally as well as evidenced by improvements in measurable treatment results. A majority of our clients have experienced significant periods of stability with a decrease in hospitalizations and engagement with crisis services. Clients benefit from additional time allotted for medication management appointments and regular engagement with their care teams by our psychiatrist. Clients who engage in our mental health counseling are offered skills to help prevent future mental health distress and crises and report wanting and benefiting from our services. Schreiber clients report developing personal insight into their diagnosis and often improve relational and life skills. Our interventions also are noted to increase feelings of hope and resiliency. Schreiber also collaborates with other parts of our system and this benefits clients who may have an intellectual or developmental disability and are receiving services in other areas of our system.

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

FY 24/25	50
FY 25/26	50

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Multiple Federally Qualified Health Centers (FQHCs)- Asian Health Services (AHS)

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Care Coordination

Program Description: To serve AAPI community with mental health services within Asian Health Services and utilizing outside community resources. We strive to connect patients with their individual mental health needs.

Target Population: Our target population is all ages. However, our Adult Care Coordinator is focused on adult ages 22 to older adults.

FY 24/25 Program Budget: $161,363 **Cost per Client:** $203

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 793 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☒ **Chinese** ☒ **Korean** ☒ **Vietnamese** ☒ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☒ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

1. Limited Internal Resources
At the start of the fiscal year, BH clinicians had very limited availability, resulting in long waitlists (30+ patients for therapy, 40+ for MoCA screenings). While all waitlisted patients were eventually assigned to clinicians, their schedules remained constrained, delaying care.

2. Limited External Resources:
Efforts to connect patients to external therapy options are hindered by severe resource shortages. Many patients face months-long waits and return to AHS IBH due to the lack of viable alternatives.

3. Language and Accessibility Barriers:
Most community facilities cater only to English-speaking individuals, and there is a critical shortage of MediCal-accepting therapists fluent in Asian languages, making it difficult to address the needs of our diverse patient population.

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County ACCESS has reported limited resources, further prolonging the time BH clinicians must manage patients under their care.

5. Insufficient Staffing:

The growing number of BH referrals exceeds current staffing capacity, forcing more patients to be referred to external agencies that also struggle with long waitlists

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

Case Study from Quarterly Report (Q4)

A 24-year-old Cantonese-speaking female patient presented with psychosis, depression, irritability, and intermittent explosive disorder. Her mental health symptoms had been deteriorating, leading to multiple incidents of physical abuse towards her 59-year-old mother in the past few months. The mother attempted to call the police several times, but they were unable to take the patient to the Emergency Department or John George Psychiatric Hospital. The Integrated Behavioral Health Care Coordinator (IBHCC) also supported the mother, who was dealing with anxiety, depression, and family stress. There were several violent incidents, including the patient throwing a cup at her mother's head, chasing her mother at night with a wooden stick and hitting her head, locking her mother out of the house, and physically pushing her, causing injury. The patient also made verbal threats to harm her mother. Despite follow-up appointments scheduled by our Behavioral Health (BH) clinician and primary care physician (PCP), the patient refused to engage with them and declined all services. Consequently, IBHCC facilitated a three-way call with the patient's mother to County ACCESS to request In-Home Outreach Team (IHOT) services. IBHCC provided detailed information about past and recent incidents to the ACCESS clinician and supported the mother during the ACCESS screening.

After connecting the mother with IHOT services, IBHCC continued to follow up closely to ensure IHOT staff attended to their needs. IBHCC also communicated with the IHOT supervisor to provide updates and receive case progress information. With IBHCC's additional information, IHOT connected the patient to the Assisted Outpatient Treatment (AOT) Team, a court-mandated response team that provides six months of services, extendable to 12 or 18 months. Their goal is to connect the patient to long-term mental health services. During interactions with the mother, IBHCC noticed that she often got off-topic and minimized her daughter's symptoms. IBHCC explained the roles of various providers (Case Manager, PCP, BH clinician, IBHCC, IHOT, and AOT teams) and guided her on how to communicate effectively with different providers. The mother also mentioned financial difficulties and a desire to apply for social benefits such as Food Stamps and Supplemental Security Income (SSI) for her daughter. IBHCC connected her to their case management team for benefit applications and referred her to the Asian Health Services Food Pantry for fresh food.

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Throughout this process, IBHCC consulted with multiple stakeholders, including BH clinicians, BH clinical supervisors, the Specialty Mental Health (SMH) director, ACCESS clinicians, and Adult Protective Services (APS) clinicians. Currently, the patient is receiving services from the AOT Team, while the mother continues to see our BH clinician and case manager.

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

FY 24/25	1,200
FY 25/26	1,400

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Multiple Federally Qualified Health Centers (FQHCs)- Axis Community Health

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Care Coordination

Program Description: Provide Behavioral Health Support and Care to all Axis Community Health Behavioral Health Patients focused on increasing patient centered care coordination across multiple departments and programs.

Target Population: Mild to Moderate Outpatient Behavioral Health Treatment Patients, Adults 18+

FY 24/25 Program Budget: $97,020 **Cost per Client:** $120.67

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 804 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

As our care coordinator needs increase, we have also increased our staffing, which leads to increased need for management and supervisory support. The person in this position has been promoted and we will likely need to re-hire for this specific position.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

A referral for a 22-year-old White male came from one of our IBH clinicians for psychological testing. The IBHCC supported patient by scheduling him with a medical provider in order to facilitate request since AAH requires paperwork signed by an MD. The IBHCC consulted with the

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IBH clinician who filled in all the MH information on the referral form. The IBHCC ensured testing referral was completed and sent and then communicated with AAH to ensure pt was referred to an agency for testing. The referral process took several weeks of coordination follow up and was complicated due to AAH requiring the additional documentation from the MD and due to lack of AAH contracted providers, miscommunication with patient around these complexities. Referral is still pending with AAH for well over a month.

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

FY 24/25	800
FY 25/26	800

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Axis Community Health

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Axis

Program Description: ACBH is supporting the startup of a **Mental Health Urgent Care** Service for East County/Tri-Valley residents through the use of MHSA one-time funds in Fiscal Year 2021/2022 with potential for additional funding in future fiscal years. The proposed Axis Community Health, Mental Health Urgent Care Center will be available to all members of the community, regardless of income or insurance status. Individuals and families with urgent mental health needs will be able to call for same-day appointments. Like a medical urgent care setting, the MH Urgent Care Center will provide assessment and timely connection to services in a setting that is less costly than an emergency department.

Target Population: Community members in need of urgent mental health care.

FY 24/25 Program Budget: $675,000 **Cost per Client:** $635.59

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 1,062 community members (age not reported)

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

Hiring enough therapists had been difficult this past year and we ran approximately .5 FTE therapist short until the end of the fiscal year. We are now fully staffed. We are also continuing to have difficulty locating longer-term and sustainable funding for the program but are working with local elected officials and partner agencies in order to address the gap in cost.

Is Anyone Better Off?

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IV. FY 23/24 Client Impact:

- 20 y/o Latina female with a history of DV and pregnant as a result of SA. Pt had a suicide attempt after learning of pregnancy and received therapy services through bridge. Pt was connected with Tri-Valley Haven for individual counseling and support group resources

- 20 y/o female, presenting with substance abuse, depression, disordered eating patterns, and trauma. Stabilized in Bridge - abstinent from opioid use, improved self-esteem, functioning well in school, developing increased support network, and transitioned to IBH clinician.

- 57 y/o long term therapy services at Axis, both of which he was very against, prior to bridge services.

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

FY 24/25	750
FY 25/26	750

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Multiple Federally Qualified Health Centers (FQHCs)- Bay Area Community Health (BACH)

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Care Coordination

Program Description: Provide Behavioral Health Support and Care to all Bay Area Community Health (BACH) Behavioral Health Patients focused on increasing patient centered care coordination across multiple departments and programs. This includes psychotherapy and telepsychiatry services, via in-person and telehealth visits.

Target Population: Mild to Moderate Outpatient Behavioral Health Treatment Patients, Adults 18+

FY 24/25 Program Budget: $503,778 **Cost per Client:** $131

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 3,843 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☒ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☒ **Other**: We have behavioral health providers who can communicate in English, Mandarin, Hindi, Gujarati, and Spanish. Our Behavioral Health Care Coordinators (BHCCs)/Community Health Workers (CHWs) speak Spanish, Punjabi, and Tagalog. Additionally, we make use of translation services (GLOBO and Propio) to offer services in other languages as well.

III. FY 23/24 Challenges:

We have experienced challenges related to hiring Behavioral Health (BH) Providers. Many candidates prefer remote positions. We have placed significant emphasis on recruitment of in-person Providers and staff retention because some grants particularly require in-person BH Providers. To address this gap, we have hired many unlicensed providers like Associate Clinical

Social Workers (ASWs), which leads to the challenge of not having enough licensed staff to provide clinical supervision. This further leads to reduced patient time for our licensed providers,

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so, they have enough time to co-sign notes, provide clinical supervision, and follow up with their supervisee on other pertinent issues.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

In Q1, a warm connection was requested for an unhoused patient. The patient needed psychotherapy and psychiatry services. Our BHCC coordinated with the patient's primary care team to connect them to behavioral health and psychiatry services during the appointment. The BHCC coordinated with clinic staff to reserve a room for the patient to use for psychotherapy and psychiatry appointments to ensure patient confidentiality. Our BHCC also provided resources for food, shower facilities, and shelters to the patient. The patient successfully utilized the psychotherapy and psychiatry services along with the resources shared.

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

FY 24/25	5,713
FY 25/26	4,673

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Bay Area Community Health (formerly known as Tri-City Health Center)

PROGRAM NAME: BH-Primary Care Integration Project: Fremont PATH

Program Description: Bay Area Community Health (BACH) operates a Federally Qualified Health Center (FQHC) to provide co-located services at the Oakland Adult Community Support Center (OCSC) operated by ACBH. The project provides coordinated, integrated health care to adults with serious mental illness. The project is called "Promoting Access to Health" (PATH) and has a Wellness Program to provide group health education and encourage socialization.

Target Population: PATH services are offered to all adults (18-59) and older adults (60+) assigned to the service team at the support center.

FY 24/25 Program Budget: $141,908 **Cost per Client:** $1,867

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 76 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

1. PATH staff has been trying to get access to ACBHCS's Clinician Gateway so we can verify current medications.
2. The loss of the fax machine at our PATH program site has made it very difficult for BACH PATH staff to correspond with ACBHCS via fax. Alameda County IT department is working on giving the PATH staff access to their new faxing system, but it has been delayed.

Is Anyone Better Off?

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IV. FY 23/24 Client Impact:

One of our patients attending the day groups has had a problem with urinary incontinence. Due to this, he was not going to be allowed to attend his day groups because people were offended by his odor.

PATH program helped him connect with a Primary Care Physician (PCP) at BACH who was able to refer him to a urologist. Ultimately, he received treatment and continues to attend the day groups without any issues.

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

FY 24/25	85
FY 25/26	90

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Multiple Federally Qualified Health Centers (FQHCs)- La Clinica de la Raza

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Care Coordination

Program Description: Provide Behavioral Health Support and Care to all La Clinica Behavioral Health Patients focused on increasing patient centered care coordination across multiple departments and programs.

Target Population: Mild to Moderate Outpatient Behavioral Health Treatment Patients, Adults 18+

FY 24/25 Program Budget: $193,738 **Cost per Client:** $576

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 336 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☒ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☒ **Farsi**
☒ **We use the Language Line** ☒ **Other**: Mam

III. FY 23/24 Challenges:

1. Difficulty finding mental health providers within Alameda Alliance network, who are Spanish speaking and patients being placed on long wait lists.
2. Difficulty navigating State Disability Insurance with patients who were denied a claim.
3. Increase in need for adults 21 years+ for Autism Diagnosis ADHD evaluations, medication management, in general, more so if patients are Spanish speaking only.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

Patients' complex needs are addressed through case management by providing culturally responsive supportive counseling. This supports patients in accessing community resources that

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impact their overall health, as well as linkage to specialty mental health services and treatment programs.

Case study:
40-year-old Hispanic male, history of post-traumatic stress disorder and anxiety, had HealthPAC in January. Treated by IBH Clinician while awaiting linkage to higher level of care services via Alameda County ACCESS. IBH CM assisted the patient with follow-up, calling ACCESS with the patient to ensure they received HealthPAC referral done by IBH Clinician. The first time that IBH CM and patient called ACCESS, they mentioned that the referral had not been received. IBH CM communicated the outcome to IBH Clinician, and the referral was re-sent to ACCESS. Later, in January, Medi-Cal expanded benefits to all adults regardless of immigration status. The patient was able to apply and successfully enroll into Medi-Cal and selected Alameda Alliance as their health plan. Alameda County ACCESS introduced their Transition of Care Tool form and requested for all providers to send this form after a patient was being referred to a higher level of care. IBH CM worked collaboratively with IBH Clinician to refer the patient to ACCESS with a Transition of Care Tool. March 2024-April 2024: IBH CM followed-up with the patient who communicated they were successfully linked to Multilingual Counseling Center for frequent and long-term therapy services. After the patient was referred, they informed IBH Clinician that they were experiencing challenges with scheduling an appointment. IBH CM supported patient with calling Multilingual Counseling Center and the patient was able to successfully schedule an appointment with one of their Spanish-speaking clinicians.

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

FY 24/25	340
FY 25/26	340

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: The Alliance for Community Wellness dba La Familia Counseling Center/Early Childhood Integrated Program

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Silva Clinic

Program Description: The Silva Clinic provides mental health services (i.e., screening, assessment, collateral, individual and group therapy, family engagement, individual and group rehabilitation, and plan development), crisis intervention, and case management/brokerage. Treatment includes additional Family Partner services. Providing specialized early childhood mental health services within the context of children's families/caretakers in the Central and South Alameda County area. Services range from very brief assessment to short-term treatment lasting typically from nine to 12 months in duration. The Integrated Health Program works in close collaboration with the client's pediatrician and medical support staff and shall provide primarily on-site, short-term services. In addition, clients may, when approved as clinically appropriate, continue to be seen by the Early Childhood Mental Health (ECMH) Program for longer-term services that are primarily home-based.

Target Population: Children, age 0-8, and their families and or caregivers.

FY 24/25 Program Budget: $101,187 **Cost per Client:** $5,059

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 20 Youth

How Well Did We Do?

II. Language Capacity for this Program: 9 English, 11 Spanish

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

Out of 20 clients served, 9 closed this year and of those 6 showed full or partial completion of goals. Other closing reasons involved moving of the family; lack of family engagement and change of therapist due to availability.

III. FY 23/24 Challenges:

This year's program challenges included having 2 full time staff out on maternity leave for 6 months each, and then returned in January 2024; Health issues with two staff that had medical surgeries and were out 3-5 months during the fall; and we continue to have an opening for one clinical position without any viable applicants to fill it. Other challenges were changes at the Early Childhood Integrated- Silva Clinic program since the Covid pandemic. The staffing of pediatricians and medical personnel at the clinic has been inconsistent. Long term relationships with the medical personnel and our staff therapists had been built over the

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Oakland-PATH/LifeLong Medical Care

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Eastmont

Program Description: LifeLong Medical Care operates a Federally Qualified Health Center (FQHC) to provide co-located services at the Oakland Adult Community Support Center (OACSC) operated by ACBH. The project provides coordinated, integrated health care to adults with serious mental illness. The project is called "Promoting Access to Health" (PATH) and has a Wellness Program to provide group health education and encourage socialization.

Target Population: PATH services are offered to all adults (18-59) and older adults (60+) assigned to the service team at the support center.

FY 24/25 Program Budget: $127,227 **Cost per Client:** $420

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 303 Adults

How Well Did We Do?

We have had 160 client encounters and have been able to provide care for clients in person and via telehealth. We have been able to provide onsite phlebotomy and vaccinations.

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

Because the space where our clinic is located was flooded, we were displaced from our original home clinic site. We were privileged to have been given the opportunity to share space with our Eden clinic and our clients did not have any lapse in care.

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Is Anyone Better Off?

IV. FY 23/24 Client Impact:

Many of our new clients have been out of care for some time and are oftentimes fearful regarding their physical health. We engage with them and walk them through each diagnostic tests, referrals and physical exams, while also collaborating with their case managers and psychiatrists. We had a client that told us

that they were unable to donate blood because they were told that they were HIV positive. One of our providers ordered lab tests to verify what the client revealed. A viral load was performed, and it was discovered that the client never had HIV and that they were misdiagnosed. We have also helped to identify cancer in patients who were able to begin treatment. We have screened 22.69% of our clients for BMI and 46.22% for hypertension as well as 39.39% of our client screened for cholesterol and 41% screened for diabetes.

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

FY 24/25	350
FY 25/26	350

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Oakland-PATH/LifeLong Medical Care

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Eden

Program Description: LifeLong Medical Care operates a Federally Qualified Health Center (FQHC) to provide co-located services at the Oakland Adult Community Support Center (OCSC) operated by ACBH. The project provides coordinated, integrated health care to adults with serious mental illness. The project is called "Promoting Access to Health" (PATH) and has a Wellness Program to provide group health education and encourage socialization.

Target Population: PATH services are offered to all adults (18-59) and older adults (60+) assigned to the service team at the support center.

FY 24/25 Program Budget: $187,357 **Cost per Client:** $1,511

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 124 Adults

How Well Did We Do?

We have had 92 client encounters and have been able to provide care for clients in person and via telehealth. We have been able to provide onsite phlebotomy and vaccinations.

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

One of our clients who has been with us for a while would always complain about someone taking her blood. After multiple visits, the client agreed to let the PATH MA draw her blood. The clients' lab results indicated that the client had severe anemia and needed a blood transfusion.

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We have screened 20.65% of our clients for BMI and 29.68% for hypertension as well as 33.55% of our clients screened for cholesterol and 40.65% screened for diabetes.

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

FY 24/25	142
FY 25/26	150

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Multiple Federally Qualified Health Centers (FQHCs)- LifeLong Medical Care

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Care Coordination

Program Description: Integrated Behavioral Health Care Coordinators (IBHCCs) connect patients with behavioral health (BH) services both within our organization (LifeLong Medical Care) and in the community. They make appointments for patients, call other organizations together with patients, and follow up on appointments and referrals. They are the "glue" of our behavioral health teams and help bridge medical and behavioral health care.

Target Population: All patients referred to behavioral health services from primary care providers. These referrals are for patients of all ages, genders, and races.

FY 23/24 Program Budget: $193,738 **Cost per Client:** $120

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 1,608 Adults

How Well Did We Do?

Quality Measures	FY 23/24 Data Results	Contract Quality Objective Benchmarks
Percent of clients who receive service referrals from the Care coordinator out of all clients who received care coordination services from the Care Coordinator.	100%	At least 60%

II. Language Capacity for this Program: Our IBHCCs are bilingual and fluent in English & Spanish.

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

Scheduling changes have complicated appointment management, with some patients preferring in-person visits and others preferring telehealth. BH Staff shortages at West Berkeley have led to referrals through community BH resources, and the merging of clinics has increased patients load and exposed a shortage of Spanish-speaking therapists, requiring adjustments to referral process.

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Is Anyone Better Off?

IV. FY 23/24 Client Impact:

One of our IBHCCs recently helped a Spanish-speaking patient who needed assistance in connecting with long-term talk therapy. The CHW contacted the patient and scheduled a time to help them navigate their health plan.

Despite the patient's prior attempts to connect with services, they were unsuccessful. During the call with the health plan representative, the CHW explained the difficulty in finding a therapist. The representative provided two options to the patient - connect with a case manager or try a third-party telehealth service, which was covered by their health plan. The patient opted for the telehealth service and was transferred to a telehealth service line, where they were assisted in setting up an account. The process took around an hour due to the multiple calls, explaining the situation to the representatives and an interpreter being present on the call. However, the patient was successfully set up for services in the end

VI. FY 23/24 Additional Information:

Our IBHCC team has diligently worked to support patients and deliver behavioral health services. They demonstrated commitment to adhering to new policy regulations, especially those pertaining to minor consents and recent changes in county insurance and related challenges.

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

FY 24/25	1,650
FY 25/26	1,700

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Alameda County Health Care for the Homeless (ACHCH)/LifeLong Medical Care

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: TRUST Clinic

Program Description: The TRUST Clinic is a multi-service clinic designed to improve the health status of people who are homeless, including providing assistance with housing and income supports.

Target Population: Homeless, low-income adults, with chronic mental and physical health disabilities and/or clients of an Alameda County Behavioral Health Care service team; and not currently engaged in primary care elsewhere or have would be better served by the integrated primary care at the Trust Clinic.

FY 24/25 Program Budget: $3,176,761 **Cost per Client:** $1,957

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 1,623 Adults

How Well Did We Do?

The Trust Clinic reduces mental health stigma by having a service delivery model that integrates behavioral health care in a primary care setting. Clinic services are trauma informed, and all staff, from the waiting room to the nurses, receive annual training to maintain best practices in integrated care. Behavioral health clinicians, psychiatrist, recovery support counselors and health coaches are available daily for both low barrier walk-in and scheduled care.

The Lifelong Trust Clinic reported a total of 17,821 visits in FY 2023-24, which entail a variety of clinical and supportive services provided to patients. The Trust Clinic staff works closely with Street Health Outreach teams that proactively support patients with navigation and accessing care at the clinic; these are patients who have unmet physical and mental health needs, and who are residing in encampments and other unsheltered settings.

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

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III. FY 23/24 Challenges:

1. **Staff retention, hiring, and turnover.** Trust Clinic staff turnover and retention continues to be a challenge. LifeLong Medical Care, as a non-profit community health center, has to compete for staff in the current competitive health care job market, which is still experiencing shortages for key positions system-wide. LifeLong is constantly filling vacancies due to retirements, and staff leaving for other higher paying, less stressful positions.

2. **Community violence/crime**. Levels of community violence in the downtown Oakland area remain high and have presented challenges for patients and staff of the Trust Clinic. Staff continue to receive threats, and cars are broken into frequently. The Trust Clinic remains a challenge in terms of operations and security.

3. **Mortality rate among people experiencing homelessness**. Trust Clinic providers report that demonstrating clinical outcomes/improvements is challenging due to the high rate of premature death in the overall population including the Trust Clinic patient population, due to homelessness and mental illness.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

Clinic Services

In FY23-24, the Trust Clinic served 1,623 patients, providing 17,821 visits including 6,366 non-clinical supportive (enabling) services. The Trust Clinic continues to prioritize expanded Medication Assisted Treatment (MAT) for substance use services onsite, utilizing a team of social workers to support patients with SUD services. In addition, the use of telehealth practices has improved access of patients to behavioral health services, in addition to the onsite service modality.

Patient Story

C.C. is a 34-year-old Caucasian man with a history Bipolar I Disorder, complex PTSD, Methamphetamine Use Disorder, Hearing Impairment, Visual Impairment and Clubfeet. At presentation, he had been unhoused since age 16, was not connected to any services, was in a manic episode with psychotic features and was frequently hospitalized at John George. He was incredibly vulnerable due to his hearing and visual impairments and was frequently the victim of violence. On intake, his PCP referred him to the Trust Clinic podiatrist and psychiatry team, connected him with his Health Wellness Coach to assist with obtaining hearing aids and glasses, did a warm hand-off to the Behavioral Health Provider of the Day. A psychiatrist met with him that week, started medication, and he is now stable on a Long-Acting Injectable antipsychotic medication, which is administered monthly by a Trust Clinic RN. The psychiatrist referred him to

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ACCESS, and he is now engaged with an FSP team. The psychiatrist also referred him to a therapist at the Trust Clinic, and they are starting to do EMDR to address his complex PTSD. The FSP team recently housed him at a Community Cabin site. He now has hearing aids and glasses, is engaged in care, and frequently comes to the Trust Clinic to obtain a bag of groceries and attend the Men's Group.

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

FY 24/25	1,700
FY 25/26	1,750

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Multiple Federally Qualified Health Centers (FQHCs)- Native American Health Center

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Care Coordination

Program Description: Provide Behavioral Health Support and Care to all Native American Health Center (NAHC) Behavioral Health Patients focused on increasing patient centered care coordination across multiple departments and programs.

Target Population: Mild to Moderate Outpatient Behavioral Health Treatment Patients, Adults 18+

FY 24/25 Program Budget: $ 97,020 **Cost per Client:** $533

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 182 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

The biggest challenges faced this year have been related to response times from specialists. CC often does not have phone calls answered, must be on hold for hours, or never receives calls back from voicemails left at numerous specialists throughout Alameda County. The other challenge that is related to this is many specialists have such long waitlists that it can take months before a member can be seen for care.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

During the 3rd quarter, CC had a member who had been taken to the emergency room via

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ambulance and ended up with a bill over 3,000 dollars. Member was not sure how to go about this and had been keeping bill to herself. Member was referred over to CC services for financial help since member was already struggling financially, she could not afford to pay the bill amount, considering not payment plan was an option per the ambulance company. CC was unsure of what to do since this was a first time coming across this sort of problem. CC attempted to research different charities that might be able to help however it seemed like most are out of funding or member situation did not qualify. CC requested support from colleagues and was reminded that HPAC does cover ambulance rides as long as member was taken to a county hospital. CC called Highland Hospital and was not given any leads on how to go about it so CC called HealthPac and was told that if were to send the bill from the ambulance along with members HPAC identification number that HPAC would take care of it. CC was able to have member come in and have CC email a copy of both requested documents.

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

FY 24/25	190
FY 25/26	200

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Multiple Federally Qualified Health Centers (FQHCs)- Tiburcio Vazquez

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Care Coordination

Program Description: Provide Behavioral Health Support and Care to all Tiburcio Vasquez Behavioral Health Patients focused on increasing patient centered care coordination across multiple departments and programs.

Target Population: Mild to Moderate Outpatient Behavioral Health Treatment Patients

FY 24/25 Program Budget: $161,363 **Cost per Client:** $33

How Much Did We Do?

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

In FY 23-24 Behavioral Health Care Coordinators provided 18,645 services to 4,873 unique Adult patients.

How Well Did We Do?

II. Language Capacity for this Program:

☒ English ☒ Spanish ☐ Chinese ☐ Korean ☐ Vietnamese ☐ Tagalog ☐ Farsi
☒ We use the Language Line ☐ Other: Click or tap here to list your language.

III. FY 23/24 Challenges:

- Linking Medicare patients to specialty services for therapy (mod-severe)
- Connecting Adult patients to RCEB or other agencies for psychiatry services or therapy services addressed to pts with specific dx (ASD, intellectual disabilities)
- Connecting pts to ACCESS services with the new assessment questionnaire used. Some of the questions are confusing and pts might not answer appropriately
- Transition of Care tool has been a huge challenge
- Finding intensive case management services for our pts who need more hand holding
- Difficulty connecting pts to eating disorder programs

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Is Anyone Better Off?

IV. FY 23/24 Client Impact:

- Having in-house psychiatry services has helped us provide pts with the care they deserve at a timely manner, rather than having to refer out and have pts wait
- Medicare pts now have access to psychiatry services, specifically medication management
- Our Spanish speaking pts have access to a Spanish speaking PMHNP, this has been an excellent service we provide to our pts.
- An additional Spanish speaking therapist, was a great addition and success, as our SPN wait list decreased

Case Study:

In July 2023, Care Coordinator (CC) received an urgent internal Integrated Behavioral Health Program (IBHP) referral from a Primary Care Practitioner (PCP) to assist a 30-year-old female patient in connecting with therapy and psychiatry services. From the PCP note, pt had a Gad-7 score of 19 and PHQ-9 of 22 and was experiencing passive suicidal ideation (SI). CC called pt to follow up on the referral; when pt answered, they stated they were at work and very busy but were interested in services. CC agreed to call back later.

CC called pt back in the afternoon, and Pt was very grateful and appreciative for the returned call. Pt asked CC to clarify the difference between therapy and psychiatric services. CC provided collaborative psychoeducation between different mental health services and answered any questions. After discussion, pt was interested in both services. CC went over all options available for pt. Pt agreed to go on IBHP waitlist and was scheduled with TVHC's new Psychiatric Mental Health Nurse Practitioner (PMHNP) for an initial psych evaluation. CC texted pt with additional resources for therapy and psychiatry. Pt was informed of the Crisis Line and Warmline to have places to call when experiencing SI as well. CC normalized and validated feelings and encouraged pt to utilize resources or call CC back for additional support. Pt was very appreciative of CCs explanation of all services and support in connecting to services. Pt stated they would utilize Crisis Line and would call CC back if needed.

Since the conversation with CC pt has been regularly seen by TVHC PMHNP for medication management to treat severe episodes of recurrent major depressive disorder. The patient was also connected with a TVHC Behavioral Health Specialist (BHS) for counseling services and consistently attended appointments. PCP, PMHNP, and BHS are working together to offer integrated health to meet all the pts health care needs.

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

FY 24/25	4,000
FY 25/26	4,000

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Multiple Federally Qualified Health Centers (FQHCs)- West Oakland Health Council

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Care Coordination

Program Description: Provide Behavioral Health Support and Care to all West Oakland Health Council Behavioral Health Patients focused on increasing patient centered care coordination across multiple departments and programs.

Target Population: Mild to Moderate Outpatient Behavioral Health Treatment Patients, Adults 18+

FY 24/25 Program Budget: $97,020 **Cost per Client: $**129

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 750 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

One significant challenge we face is managing our large waiting list in relation to our limited therapist availability. Recently, we added several therapists to the program, which we hope will help alleviate some of the backlog.

The large referral queue continues to pose difficulties due to the high demand for services and the limited availability of therapists. Additionally, a significant number of patients either do not return calls or require services beyond the mild to moderate scope of our program. This increases the need for coordination with their primary care providers (PCPs) to ensure they are referred to ACCESS or other more suitable programs.

In addition to limited provider capacity, high caseloads and the emotional demands of working with clients in crisis can lead to staff burnout and high turnover rates. It is challenging to maintain a robust system for immediate crisis intervention and management, particularly in resource-

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constrained environments. Collaborating with medical departments to manage the in-facility presentation of patients in crisis and facilitate de-escalation is also crucial.

We are committed to address these current key areas of focus:

1. Managing the large referral queue alongside clinician caseloads.
2. Improving staff retention and meeting program needs for both staff and clients.
3. Tracking and monitoring crisis interventions.
4. Providing patient de-escalation training for staff.
5. Ensuring collaborative care with medical and other behavioral health department programs.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

73 % of clients receive referral services from the IBHCC and were assisted in getting connected to services out of all clients who receive care coordination services from the IBHCC.

Case Study

I had the privilege of working with an 18-year-old patient and his father, who services to manage the patient's bipolar disorder. The patient had recently moved to the area from another city and county to live with his father. This case exemplifies the value of coordinated care and the impact of supportive clinical relationships in promoting patient well-being.

During our initial meeting, it became clear that the father was a strong advocate for his son, who appeared withdrawn and quiet unless prompted by his father. My colleague and I conducted a thorough assessment of the patient's needs in a private setting. We determined that the first critical step was to establish local care, which required updating their insurance information. We facilitated this process by escorting the family to the Patient Services Manager, who provided direct support to accomplish this task.

Two weeks later, the family returned to thank us for our assistance in connecting them with Baywell. During this follow-up meeting, the father expressed concerns about acute crisis incidents that had occurred while they were waiting for services to begin. In response, I provided the family with referral resources for two inpatient care providers: John George Psychiatric Hospital and Sutter Alta Bates Summit Medical. The patient and his father expressed relief and satisfaction in having these inpatient resources as part of their care plan. Building rapport with the patient and his father was rewarding. Ensuring they had access to the necessary resources for managing bipolar disorder underscored the importance of accessible and comprehensive IBH services.

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

FY 24/25	750
FY 25/26	750

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Alameda Health Consortium (AHC)

PROGRAM NAME: Pediatric Care Coordination Pilot

Program Description: In FY 21/22 ACBH began supporting an 18-month pilot to introduce care coordination activities for the pediatric systems within eight local Federally Qualified Health Centers (FQHCs) in Alameda County. Each FQHC will hire 1-2 care coordinators (11 care coordinators in total). The Pediatric Care Coordinator will be responsible for linking pediatric clients to medical, behavioral, and social services in a preventative and comprehensive manner. This position will act as the liaison between the client and the community, and will serve to dissolve the silos between the Medical and Behavioral Health departments within the FQHCs. This role will also work to support young clients with the basic health and social needs to minimize their risks for entering the criminal justice system as adults. The AHC will serve as the centralized hub for these care coordinators, providing technical assistance, peergroup formation, and problem-solving for the duration of this program. Furthermore, AHC will embed a process and outcome evaluation to assess impact, effectiveness, and long-term potential of the Pediatric Care Coordinator Program.

Target Population: Clients of the FQHC's that are 0-18 yrs of age.

FY 24/25 Program Budget: $2,198,971 **Cost per Client:** $463

How Much Did We Do?

I. **FY 23/24: Number of Unique Clients Served:** 4,747 Youth and TAY
- Number of young clients receive universal Behavioral Health, trauma, and/or pediatric screenings: *2,986*
- Number of young clients who have experienced adverse childhood experiences (ACEs) referred to appropriate follow-up resources: *738*

How Well Did We Do?

PCCs continued to provide support to their pediatric patients and their families throughout FY23-24. In FY23-24, the PCCs made over 4,000 connections to wraparound preventive services. They also supported almost 3,000 patients with universal behavioral health, trauma, and/or pediatric screenings. Most of our PCCs work with those that screen positively for ACEs, connecting over 700 of those patients to appropriate follow-up resources. We also continued to hear about patient success stories (see Appendix B) as well as positive feedback from pediatric providers (see Appendix C). Similar to last year's survey data, the majority of survey responses indicated that

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the PCCs have had high impact on the following:

1. Alleviating the time, they would have otherwise spent on care coordination and navigation for pediatric patients and their families
2. Reducing provider burnout
3. Connection with other departments within their respective clinics
4. Connection with services outside of their respective clinics
5. General support to them as pediatricians

Many providers' comments emphasized the importance of the PCC role on the pediatric care and general clinic operations.

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☒ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

There was a decrease in the total amount of connections to care, screenings, and follow-up resources compared to the pilot's previous year. In FY23-24, the health centers experienced challenges around data reporting and retention, leaving some quarters without data to report. However, even with the decrease in reported connections, the number of minutes care coordinators spent with their patients was similar to the estimated minutes in FY22-23. Conversations with PCCs confirmed that this number remained similar because they are receiving more complex cases, which take more of their time.

Is Anyone Better Off?

IV. FY 23/24 Client Impact: Our team has continued to hear about the positive impact the PCCs are making on their clients and families. Below are two brief examples of positive client interactions with two of the PCCs:

Example 1: A 4-year-old Caucasian male was referred by his pediatrician who lives with his mother, father, and two younger siblings in a hotel. Patient is nonverbal and his mom states he points to things when he wants something or comes and gets her. He also has sensory issues and mom reported he is a picky eater. At the time of referral, mom also stressed to the PCC she had an issue with keeping up with appointments as the family only had one vehicle and dad needed to use it to go to work. The PCC assisted Mom by referring patient to Help Me Grow and supported communication with AAH for Autism Testing and ABA services. Mom was also given AAH transportation contact information to assist with rides to medical appointments. Additionally, Mom was given contact information for City Serve to help with housing for the family. PCC followed up and learned the family recently moved into housing.

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Example 2: A Pediatric Care Coordination referral was submitted for a 12-year-old patient who is struggling with obesity, failing classes and history of attendance issues. Patient does not have alot of at home support, grandmother is legal guardian. Due to lack of background information, there was a lot of going back and forth to figure out how we can best provide care for patient. PCC connected with school to gather information and requested school provide free clipper card to patient as stated in school website. Also, requested school counselor reconnect with patient to provide tutoring services once again. Patient was scheduled for an in-person appointment with grandma where we were able to gather more information and provide patient and family with guidance. PCC scheduled lab appointment for patient and referred to a program that not only provides hands on support but also helps youth connect with various services including counseling and support groups.

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

FY 24/25	4,000-6,000
FY 25/26	4,000-6,000

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 26A

PROVIDER NAME: Training and Technical Assistance on Accurate Diagnosis and Appropriate Medication Treatment and Healing Practices for African Americans

PROGRAM NAME: Hiawatha Harris, M.D., Inc./Pathways to Wellness Medication Clinic

Program Description: Hiawatha Harris, M.D., Inc./Pathways to Wellness Medication Clinic designs and delivers culturally responsive services and technical assistance support to help psychiatric prescribers who provide medication assessment and support to African American adults (18-59) living with mental health issues. The culturally responsive curriculum was developed to address the topics of: 1. Stigma around mental health problems in the African American community that can lead to delays in or termination of treatment; 2. Medication issues such as over/under prescribing, incorrect dosage and side effects; 3. Historical trauma of African Americans; 4. Health disparities impacting African American communities; 5. Bias and racial stereotypes; 6. Understanding barriers to accessing mental health services; 7. Knowledge of community holistic interventions such as spiritual, family, and community support; and 8. Strategies for provision of more culturally responsive and congruent services.

Target Population: Alameda County psychiatric prescribers who are identified by ACBH who provide services to adults who identify as African American, ages 18-59 who have moderate to severe mental illness impairments resulting in at least one significant impairment in an important area of life functioning.

FY 24/25 Program Budget: $381,647 **Cost per Client:** $436

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 875 Adults

- Total number of training hours: 28
- Number of AATA trainings offered: 8
- Number of Technical Assistance trainings offered to the community: 6

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☒ **Other**: Sign Language Interpreter

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III. FY 23/24 Challenges:
The AATA team continues to face challenges transitioning our presentations from virtual to live formats.

Since the pandemic, we have observed a stronger preference among participants for virtual training sessions over in-person ones. This year, we conducted a hybrid training session where participants could interact directly with the speaker, who also addressed questions from attending behavioral health clinicians. This session attracted 30 in-person attendees and 200 Zoom participants. To increase attendance from Alameda County providers, we have been intensively marketing the AATA program within the community, resulting in a 20% increase in outreach to providers this fiscal year. To ensure that pertinent information from our speakers reaches the providers attending our trainings, we have added a new feature to our website that offers participants a written review of the presentation, which they can use in their clinics.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:
A total of 3.5 Continuing Education (CE) credits were awarded to 294 licensed participants from Alameda County, which includes LCSWs, LMFTs, AMFTs, ASWs, PhD/PsyDs, Registered Nurses, and Nurse Practitioners. The training sessions were attended by staff from Alameda County Behavioral Health, local adult and children's community-based organizations (CBOs), alcohol and other drug (AOD) program staff, personnel from five different Federally Qualified Health Centers (FQHCs) in Alameda County, as well as physicians from local hospitals. The training provided through our AATA program will help these licensed participants directly improve the overall quality of care for African American individuals with mental illness. Our board-certified psychiatrists and psychologists, nationally recognized trainers, addressed healthcare disparities and the impact of implicit bias on services received by the African American population. This year, the team offered a variety of topics that emphasized the often-overlooked environmental impacts on behavioral health clients who receive services in Emergency rooms, outpatient programs, residential settings, and jails.

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

FY 24/25	900
FY 25/26	1,000

Future Trainings for Fiscal Year 2024-2025

- November 22, 2024: Navigating Anxiety: Mental Health Challenges and Resilience in the African American Community

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- January 2025: Intersectional Experiences, Stigma-related Stress, and Behavioral Health Among Black/African American LGBTQ+ Individuals
- February 21, 2025: Healing and Hope: Addressing Mental Illness and Trauma in Homeless and Incarcerated African American Adolescents
- March 28, 2025: Geriatric Mental Health and Substance Use: Addressing Unique Challenges for African American Seniors
- April 25, 2025: Mental Health and Justice: Navigating the Intersections of Social and
- Reproductive Justice for African American Patients in the Pursuit of Equity (in-person & virtual)
- May 23, 2025: Breaking Barriers: The Impact of Homelessness on the Mental Health and Education of African American Adolescents
- June 20, 2025: Addressing Mental Health Challenges Among African American Women: Treatment Strategies for Support and Empowerment (in-person & virtual)

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 26B

PROVIDER NAME: ROOTS

PROGRAM NAME: AfiyaCare

Program Description: AfiyaCare provides mental health services, case management/brokerage and crisis intervention. Services are provided to accomplish the following goals: 1. Help clients to address stressors and enhance their mental and emotional wellbeing; 2. Connect clients immediately to resources to meet urgent and essential needs; 3. Connect clients with short- and long-term support services; and 4. Reduce hospitalization, incarceration, and other emergency services.

Target Population: AfiyaCare serves adults who identify as African American, ages 18-59, with a serious mental illness (SMI), that have a history of involvement with the criminal justice system, which may include individuals previously engaged in mental health crisis, residential, and/or outpatient services.

FY 24/25 Program Budget: $425,940 **Cost per Client:** $8,191

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 52 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

- Psychiatry Follow-Up: Many clients struggle to find and maintain a consistent relationship with a psychiatrist, which affects their ability to adhere to a regular medication schedule. Our clinicians are actively working with clients to help them become comfortable communicating with our psychiatry consultant, ensuring they feel informed about various psychiatric medications.
- Engagement Challenges with Severe Symptoms: Clinicians are finding it challenging to keep clients engaged who are experiencing more severe behavioral health

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symptoms. Clinicians have started focusing on having more skill-building sessions to keep the clients engaged.

- Coordination Difficulties with External Care: Clients have difficulty keeping track of their paperwork, resources, and information from outside agencies, making it difficult for navigators and clinicians to collaborate with the clients' external care and support team.

Is Anyone Better Off?

Our program exceeded the projected number of members served for the fiscal year with 52 active members. Additionally, the percentage of members who have a reduction in admissions to jail and John George Psychiatric Hospital remains far above the goal of 60%, at 91% and 100% respectively. AfiyaCare Navigators and Clinicians continue to meet with both established and new members. During the 2023/24 fiscal year, AfiyaCare staff connected members to extensive resources, including but not limited to housing, food assistance, primary care, behavioral health care, clothes for interviews, benefits (CalFresh, Medi-Cal, & General Assistance), hotel vouchers, transportation, employment assistance, ID vouchers, hygiene kits, and diapers. Members are also able to access psychiatric services and in-person groups.

The AfiyaCare program staff have enhanced collaboration and workflows for both internal and external referrals. Additionally, they conduct mini training sessions during meetings to ensure that processes and workflows are clear and efficient for all staff members.

- **Billing and service entry**: there has been significant effort in streamlining processes and workflows on Afiyacare client billing. Services have been entered in the Smartcare System. The outcome yields quality of data and enhances collaboration.
- **Referral Workflow:** Improvement has been made on how referral processes work by improving both communication and data quality. This led to at least 30% of clients' appointments since the implementation.
- **Tickets and Troubleshooting:** New navigators and clinicians have been added to the Smartcare system with new staff IDs, which allow the program to track navigation services provided to our clients.
- **Mini Training:** We've been incorporating short training sessions and go over standard Afiyacare forms

IV. FY 23/24 Client Impact:

- AfiyaCare client **SG**, who was previously on probation, engaged in the AfiyaCare program for 9 months. SG's navigator and therapist were able to work with SG and assist her with completing her GED, getting accepted to Laney College. SG is currently enrolled to attend summer and fall classes at Laney College, to pursue a degree in education. SG was able to receive a laptop through AfiyaCare flex funds to assist her with her studies.

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- AfiyaCare client **RA,** experienced several significant improvements in his life while engaged in the AfiyaCare program, including transitioning to a new, more fulfilling role at his job, which has greatly improved income and decreased his stress levels. With an increase in income, RA was able to purchase a car and started to drive for Uber, providing him with additional income and flexibility. Throughout the program RA stayed engaged in therapy and was able to keep a positive outlook while getting through his barrier which highlights his resilience and ability to find silver linings in challenging situations.

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

FY 24/25	We project and strive to serve a minimum of 40 unduplicated clients per year. In addition, we aim to maintain a panel of 25 unique clients at any point in time throughout the year.
FY 25/26	We project and strive to serve a minimum of 40 unduplicated clients per year. In addition, we aim to maintain a panel of 25 unique clients at any point in time throughout the year.

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 27

PROVIDER NAME: Abode Services

PROGRAM NAME: In-Home Outreach Team (IHOT)

Program Description: The In-Home Outreach Team (IHOT) provides outreach and engagement services to adults with untreated mental illness, with the intention of connecting them with psychiatric care and other community supports. Each IHOT team consists of: a clinical lead, a licensed eligible clinician, two peer advocates, and one family advocate enabling them to have multiple and varied perspectives with which to relate to the participants and their families. This unique factor helps with finding new ways to engage folks otherwise considered resistant or reluctant to engaging in mental health services. IHOT visits participants in their home, hospitals, jails, and in the community to encourage them to engage in mental health treatment. Their goal is to reduce the impact of untreated mental illness in these adults and provide support or their families. The intention of referral and linkage is to help prevent an increase in symptoms, added impairments, or need for more hospitalizations. The teams schedule appointments with participants, family members, friends, and other providers, as well as assist with connections to community resources.

Target Population: IHOT serves adults (ages 18-59) with severe mental illness, who are not currently engaged in mental health treatment or have become disengaged, who are considered resistant or reluctant to participating voluntarily and present with a variety of barriers that prevent them from connecting to mental health services and other community resources. IHOT serves adults throughout Alameda County.

FY 24/25 Program Budget: $655,264 **Cost per Client:** $8,401

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 78 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☒ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☒ **Farsi**
☒ **We use the Language Line** ☒ **Other**: Boost Lingo within agency

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III. FY 23/24 Challenges:

Team did not have a clinician for entirety of fiscal year, aside from June 2024. This does not include Licensed Clinical Program Manager but impacted team functionality and services rendered.

Team had trouble linking clients to appropriate behavioral health services via ACCESS due to system impaction, having to wait upwards of two months to receive referral for therapy/psychiatry. This resulted in clients being held on caseload longer than 90 days as contracted and added constraints to team capacity/availability.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

Team sought new resources to better serve our clients while MHS system remained impacted. This includes Peer resources, inhouse services via PCP, and out of pocket services that were manageable by client and/or their care givers. Team advocated for clients while in PES, inpatient, incarcerated, and in ICU/SNF to be linked to appropriate services and higher levels of care. This included teletherapy, psychiatry, and Level 1 or FSP. Although rereferrals were still prevalent, team had greater success rate in linking repeat clients to long-term providers.

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

FY 24/25	100 (Expected increase due to CARE Court)
FY 25/26	150 (Expected increase due to increase in psychiatric infrastructure)

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 27

PROVIDER NAME: Bonita House

PROGRAM NAME: In-Home Outreach Team (IHOT)

Program Description: The In-Home Outreach Team (IHOT) provides outreach and engagement services to adults with untreated mental illness, with the intention of connecting them with psychiatric care and other community supports. Each IHOT team consists of: a clinical lead, a licensed eligible clinician, two peer advocates, and one family advocate enabling them to have multiple and varied perspectives with which to relate to the participants and their families. This unique factor helps with finding new ways to engage folks otherwise considered resistant or reluctant to engaging in mental health services. IHOT visits participants in their home, hospitals, jails, and in the community to encourage them to engage in mental health treatment. Their goal is to reduce the impact of untreated mental illness in these adults and provide support or their families. The intention of referral and linkage is to help prevent an increase in symptoms, added impairments, or need for more hospitalizations. The teams schedule appointments with participants, family members, friends, and other providers, as well as assist with connections to community resources.

Target Population: IHOT serves adults (ages 18-59) with severe mental illness, who are not currently engaged in mental health treatment or have become disengaged, who are considered resistant or reluctant to participating voluntarily and present with a variety of barriers that prevent them from connecting to mental health services and other community resources. IHOT serves adults throughout Alameda County.

FY 24/25 Program Budget: $655,264 **Cost per Client:** $5,080

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 129 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

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III. FY 23/24 Challenges:

Acclimation to the billing component of EHR and need for increase of fiscal budget for more staff to increase enrollment capacity to expand services.

Is Anyone Better Off?

BB was a recently assigned male aged 54 with Bi-Polar d/o, disengaged in services with a long history of forensic and psychiatric encounters along with several linkages to outpatient services dating back as far as 1983. Client's mental health continued to decline as a result BB struggled with hopelessness, medication adherence, and following through with mental and physical health care. Family relations became increasingly strained which led to BB being unhoused as result BB became amendable to services thereby reaching out and working with IHOT ultimately getting linked to a full-service partnership. BB's quality of life has improved, receiving on-going case management. BB is currently housed and actively engaged in services allowing BB to focus on self-care and reconnecting with family.

IV. FY 23/24 Client Impact:

At least 55% of engaged clients were successfully linked to outpatient mental health services or rehabilitation and recovery services within the first 90 days.

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

FY 24/25	We expect to meet the contracted guidelines of 3,525 hours of MAA billable outreached and engagement; 25-30 unduplicated clients served (point intime); at least 50 unduplicated clients served annually; one family or caregiver group per week.
FY 25/26	We expect to meet the contracted guidelines of 3,525 hours of MAA billable outreached and engagement; 25-30 unduplicated clients served (point intime); at least 50 unduplicated clients served annually; one family or caregiver group per week.

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 27

PROVIDER NAME: La Familia

PROGRAM NAME: In-Home Outreach Team (IHOT)

Program Description: The In-Home Outreach Team (IHOT) provides outreach and engagement services to adults with untreated mental illness, with the intention of connecting them with psychiatric care and other community supports. Each IHOT team consists of: a clinical lead, a licensed eligible clinician, two peer advocates, and one family advocate enabling them to have multiple and varied perspectives with which to relate to the participants and their families. This unique factor helps with finding new ways to engage folks otherwise considered resistant or reluctant to engaging in mental health services. IHOT visits participants in their home, hospitals, jails, and in the community to encourage them to engage in mental health treatment. Their goal is to reduce the impact of untreated mental illness in these adults and provide support or their families. The intention of referral and linkage is to help prevent an increase in symptoms, added impairments, or need for more hospitalizations. The teams schedule appointments with participants, family members, friends, and other providers, as well as assist with connections to community resources.

Target Population: IHOT serves adults (ages 18-59) with severe mental illness, who are not currently engaged in mental health treatment or have become disengaged, who are considered resistant or reluctant to participating voluntarily and present with a variety of barriers that prevent them from connecting to mental health services and other community resources. IHOT serves adults throughout Alameda County.

FY 24/25 Program Budget: (ACBH will complete)

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 76

How Well Did We Do?

Quality Measures	FY 23/24 Data Results	Contract Quality Objective Benchmarks
Percent of clients who receive their first face-to-face visit from IHOT team members within three days of the team receiving the referral.	**89%**	**At least 80%**
Percent of clients who receive weekly face-to-face Services.	**86%**	**At least 90%**

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ensuring that all clients receive accurate and timely information. Staff training on utilizing these language resources has been well-received, enhancing our overall service quality. Despite facing some challenges, such as occasional delays and gaps in service, we have taken proactive steps to address these issues and plan to further expand our language support. Moving forward, we aim to continue improving our multilingual services and explore technological advancements to better serve our diverse client base.

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**

☒ **We use the Language Line** ☐ **Other**: Arabic

III. FY 23/24 Challenges:

Our challenges have centered around staffing shortages and not having sufficient staff to operate this program. For six months, we had only one administrative staff member without a supervisor. Despite these difficulties, we successfully navigated the year, ending it on a positive note by onboarding three new staff members and serving 76 clients.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

Impact Measures	FY 23/24 Data Results	Contract Impact Benchmarks
Percent of engaged clients who successfully link to outpatient mental health services or rehabilitation and recovery services within the first 90 days of referral	**59%**	**At least 50%**

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

FY 24/25	**150**
FY 25/26	**150**

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 27

PROVIDER NAME: STARS Behavioral Health Group

PROGRAM NAME: In-Home Outreach Team (IHOT)

Program Description: The In-Home Outreach Team (IHOT) provides outreach and engagement services to adults with untreated mental illness, with the intention of connecting them with psychiatric care and other community supports. Each IHOT team consists of: a clinical lead, a licensed eligible clinician, two peer advocates, and one family advocate enabling them to have multiple and varied perspectives with which to relate to the participants and their families. This unique factor helps with finding new ways to engage folks otherwise considered resistant or reluctant to engaging in mental health services. IHOT visits participants in their home, hospitals, jails, and in the community to encourage them to engage in mental health treatment. Their goal is to reduce the impact of untreated mental illness in these adults and provide support or their families. The intention of referral and linkage is to help prevent an increase in symptoms, added impairments, or need for more hospitalizations. The teams schedule appointments with participants, family members, friends, and other providers, as well as assist with connections to community resources.

Target Population: IHOT serves Transition Age Youth (TAY) (ages 16-24) with severe mental illness, who are not currently engaged in mental health treatment or have become disengaged, who are considered resistant or reluctant to participating voluntarily and present with a variety of barriers that prevent them from connecting to mental health services and other community resources.

FY 24/25 Program Budget: $567,627 **Cost per Client:** $12,077

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: In Fiscal Year 23-24, Stars served 47 unduplicated Transition Age Youth (TAY). Of the 47 enrollments; 33 of these enrollments opened this Fiscal Year

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☒ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

The program recruited staff to offer multi-lingual services that meet the county threshold

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languages. IHOT has Spanish and Tagalog speaking staff and a language line for other non-English speaking clients. All client-facing written materials were translated into the county threshold languages.

III. FY 23/24 Challenges:

Stars, as many other programs in the county, were impacted by the transition from Insyst to SmartCare. This transition led to a delay in receiving accurate client information. In turn, IHOT relied on collateral support to get in contact with clients. Family engagements varied on a case-by-case basis. The trend throughout the year with family engagement includes families who were either completely disengaged or families who did not trust the system and created barriers between our team and the clients. This year also saw an overall decrease in referrals received from Alameda Access. To combat this, IHOT increased community collaboration by hosting or participating in 67 different outreach and engagement efforts with other providers throughout Alameda County.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

Quality/ Impact Measures	FY 23/24 Data Results	New Contract Benchmarks
Percent of clients who receive first face-to-face, *in person,* visit from IHOT team members within three days of referral.	100 %	≥80%
Percent of clients who receive weekly face-to-face services	100 %	≥90%
Percent of engaged clients who successfully link to outpatient mental health services or rehabilitation and recovery services within the first 90 days of referral.	55.3 %	≥50%

Client Story:

The client was referred to Stars TAY IHOT by Alameda County ACCESS on behalf of the client's mother, who reported that the client was experiencing increased psychotic symptoms, including paranoid thoughts, increased physical and verbal aggression towards the mother, sitting in the shower under scalding hot water, disrobing and going out into the community in the middle of the night without transportation or a means of communication. The client had a history of arrest for trespassing on private property miles away from home. IHOT began outreaching the client's mother, who set up the initial appointment for the IHOT team to meet her son. Upon seeing the

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team, the client fled and AWOL'd. He was later hospitalized at Fremont Hospital, denying any mental health need or services. He was discharged home but ended up at JGPP a few days later, but he agreed to continue meeting with the IHOT team. He continued to deny any mental health needs or symptoms and only reported that he wanted to get away from his mother, who he reported, was making up stories about him. After a few visits, the client started to trust the IHOT team and agreed to services during his stay in Crisis Residential Treatment after his discharge from JGPP. The client signed consents with BACS Paige in a warm handoff session and agreed to adhere to his mother's conditions to return home. Initially, the client was ambivalent about taking medications, but he agreed to start medications with his new service team. The client engaged with his new service team successfully and his mother was receptive to feedback from the IHOT family advocate. The client was discharged within 86 days of opening and was successfully connected to a service team. The client reported that he felt heard and supported throughout the process and expressed significant gratitude for the services he received.

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

FY 24/25	60
FY 25/26	70

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 27

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: Adult Recovery, Outreach and Connection (AdROC) Program

Program Description: Telecare AdROC is a short-term (90 days) outreach-evaluation-triage program serving adults who are not already connected to the ACBH System of Care. AdROC members include individuals who are homeless or at risk of homelessness, have co-occurring substance use and/or physical health disorders, frequently use hospitals and other emergency services, are at risk of institutionalization, and/or have limited English proficiency. AdROC conducts in-reach and engagement at inpatient facilities, CSUs, and CRPs, and conducts outreach and engagement to community locations and providers. AdROC staff provide linkages, supports, and resources to help clients stay in the least-restrictive , most selfsufficient, and recovery-oriented settings; reduce the need for inpatient and emergency room care; and improve mental health outcomes. Services are delivered by a team of case managers, peer support specialists, a team lead, and a clinical director. Services provided by the AdROC team including individual and group rehabilitation, crisis intervention, plan development, individual and group therapy, and targeted case management. The latter service links the consumer to needed resources and supports in the community such as housing, benefits, therapy, medication, and medical/dental services. 80% of the AdROC services are delivered in the community. AdROC is located in the Eastmont Town Center in Oakland, CA.

Target Population: AdROC serves adult Alameda County residents, 18 years of age and older, who appear to be experiencing a mental health crisis; and/or are affiliated with one of the AdROC referral sources; and who are not already connected to the ACBH System of Care.

FY 24/25 Program Budget: $877,598 **Cost per Client:** $5,102

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 172 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

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III. FY 23/24 Challenges:

The AdROC program experienced multiple challenges this previous fiscal year. Challenges included turnover of program leadership, namely AdROC Team Lead and Program Administrator which hindered consistency and stability of program. Fortunately, AdROC was quickly able to promote a new Team Lead from within Telecare and was able to leverage its resources to bring in a Floating Administrator to hold over and stabilize the program in the absence of losing its previous Administrator. Telecare has now hired a new permanent Administrator with a 7/22/24 start date.

In January, the facility that AdROC is located in experienced a flood which resulted in significant damage and displaced AdROC. Eastmont mall was able to provide Telecare with a temporary space upstairs while repairs were underway. Unfortunately, the space was not conducive to providing services onsite and was difficult for employees to adapt to. The program was able to return to our original offices after 4 months of displacement.

Lastly, the program has had a great deal of difficulty in hiring new employees, namely Case Managers due to market conditions such as a very low pool of qualified candidates. For example, for 1 Case Manager job positing, Telecare received only 4 potential applicants in the span of 3 months. In response to market conditions, Telecare has increased salary ranges to be competitive within the market and offers sign-on bonuses to attract potential qualified applicants.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

Sam, a Hispanic adult female presented as selectively mute with a history chronic homelessness. Sam was admitted to John George Hospital (JGH) for grave disability. After being stabilized at JGH, Sam was connected to ADROC for case management assistance, medication management and therapy. Sam had a history of interpersonal conflict with family at home, and non-compliance with psychiatric medication. These factors made it a challenge for Sam's family to assist and live with Sam in the same household. After the AdROC case managers met with Sam, they were able to reconnect Sam with her mother to increase and improve her support system. AdROC case managers were also able to successfully connect Sam to medication services to improve medication adherence and stabilization. Lastly, AdROC was able to connect Sam with therapeutic services and Sam is currently on a wait list to have her own therapist.

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

FY 24/25	120-180
FY 25/26	120-180

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 27

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: Transition Age Youth Recovery, Outreach and Connection (TAY ROC)

Program Description: Telecare TAY ROC is a short-term (90 days) outreach-evaluation-triage program serving TAY youth who are not already connected to the ACBH System of Care. TAY ROC members include transition age youth who are homeless or at risk of homelessness, have co-occurring substance use and/or physical health disorders, frequently use hospitals and other emergency services, are at risk of institutionalization, and/or have limited English proficiency. TAY ROC conduct in-reach and engagement at local inpatient facilities, CSUs, and CRPs. The team also provides outreach and engagement to other locations and organizations where TAY experiencing mental health crises are likely to be found. TAY ROC staff provide linkages, supports, and resources to help clients stay in the least-restrictive , most selfsufficient, and recovery-oriented settings; reduce the need for inpatient and emergency room care; and improve mental health outcomes. Services are delivered by a team of case managers, peer support specialists, a team lead, and a clinical director. Services provided by the TAY ROC team include individual and group rehabilitation, crisis intervention, individual and group therapy, plan development and targeted case management. The latter service links the consumer to needed resources and supports in the community such as housing, benefits, medication, therapy, and medical/dental services. 80% of the TAY ROC services are delivered in the community. TAY ROC is located in the Eastmont Town Center in Oakland, CA.

Target Population: TAY ROC serves TAY youths 16 to 24 years of age who are Alameda County residents, who appear to be experiencing a mental health crisis; and/or are affiliated with one of the TAY ROC referral sources; and who are not already connected to the ACBH System of Care.

FY 24/25 Program Budget: $129,326 **Cost per Client:** $,1280

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 101 Transition Age Youth (TAY)

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

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III. FY 23/24 Challenges:

The TAYROC program experienced multiple challenges this previous fiscal year. Challenges included turnover of program leadership, namely TAYROC Team Lead and Program Administrator which hindered consistency and stability of program. Fortunately, TAYROC was quickly able to promote a new Team Lead from within Telecare and was able to leverage its resources to bring in a Floating Administrator to hold over and stabilize the program in the absence of losing its previous Administrator. Telecare has now hired a new permanent Administrator with a 7/22/24 start date.

In January, the facility that TAYROC is located in experienced a flood which resulted in significant damage and displaced TAYROC. Eastmont mall was able to provide Telecare with a temporary space upstairs while repairs were underway. Unfortunately, the space was not conducive to providing services onsite and was difficult for employees to adapt to. The program was able to return to our original offices after 4 months of displacement.

Lastly, the program has had a great deal of difficulty in hiring new employees, namely Case Managers due to market conditions such as a very low pool of qualified candidates. For example, for 1 Case Manager job positing, Telecare received only 4 potential applicants in the span of 3 months. In response to market conditions, Telecare has increased salary ranges to be competitive within the market and offers sign-on bonuses to attract potential qualified applicants.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

James, a 21-year-old African American male was admitted to John George Hospital (JGH) with a diagnosis of unspecified psychosis. James has a mother who lives out of the area, and grandparents who live locally. James' parents were paying his rent for a studio apartment. Prior to hospitalization James had stable employment and was on track to go to college. However, on his 21st birthday, James consumed alcohol which drastically began changing his personality to being paranoid, rude, and defensive. Things continued deteriorating for James resulting in James quitting school, and getting fired from his job. James began shutting down, getting overwhelmed, and becoming increasingly disrespectful towards others. James was eventually admitted to JGH after being found in the community disorganized, and unable to care for self. Once stabilized at JGH, TAYROC Case Managers began working with James connecting him to medication management services and therapeutic services which have both helped to stabilize James. Additionally, Case Managers were able to facilitate James reconnecting to his family to improve and reestablish his support system. James is also currently on a waitlist for employment assistance for James to re-enter the job market.

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

FY 24/25	100-200
FY 25/26	100-200

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 28

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Success At Generating Empowerment (SAGE)

Program Description: The Success At Generating Empowerment (SAGE) Program is designed to serve individuals who are in the process of obtaining Social Security Income (SSI) for their qualifying behavioral health (and other disabilities) and who need ongoing clinical care coordination and support as they navigate the challenging bureaucracy while they are managing symptoms related to a behavioral health disorder. Individuals receive assessment, person-centered treatment planning, and ongoing counseling, clinical care coordination, linkage, and peer support. As individuals are awarded SSI benefits, they become stable and effective at managing their own lives. Individuals are then linked with ongoing natural and community-based supports for ongoing support. The program has a multidisciplinary staffing model that includes 50% clinical care coordinators and 50% peer counselors- people with their own lived experiences that can walk alongside someone to navigate the challenges of the system.

Target Population: SAGE serves adults (ages 18-59) and older adults (60+) who have a qualifying behavioral health diagnosis and are in the process of obtaining SSI benefits through local legal advocacy firms, Homeless Advocacy Center (HAC) and Bay Area Legal Aid (BALA). All participants live in extreme poverty, at or are under 10% Area Median Income (AMI). Many individuals are exiting jails or hospitals. The majority of individuals are homeless.

FY 24/25 Program Budget: $2,968,615 **Cost per Client:** $12,019

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 247 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **Other**: We use the Language Line

III. FY 23/24 Challenges:

Staff retention is a crucial challenge that many programs face, and it can have a significant impact

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 30

PROVIDER NAME: La Familia Counseling Center

PROGRAM NAME: Sally's Place Peer Respite

Program Description: Sally's Place is a Peer Respite Home and is the first and only of its kind in Alameda County. It is staffed by peers, in alignment with the objectives of our local agencies- Pool of Consumer Champions (POCC) and the Alameda County Accelerated Peer Specialist Program (ACAPS). Guests receive support from compassionate peer staff and can stay for up to 14 days. Sally's Place Peer Respite is a voluntary, short-term program that provides non-clinical crisis support to help people find new understanding and ways to move forward with their recovery. It operates 24 hours per day in a homelike environment.

Target Population: Sally's Place serves adults, 18 years of age or older, who are experiencing mental health concerns or distress, have an identified place to stay in Alameda County at the time of intake (which could include a shelter), are able to manage medical needs independently and who voluntarily agree to engage in services.

FY 24/25 Program Budget: $1,204,953 **Cost per Client:** $10,478

How Much Did We Do?

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

a. Sally's Place has provided Peer Support Services to 115 unduplicated new guests (Adults) and re-admitted 33 (Adults) guests that had returned who required more support either with referrals or respite services.

How Well Did We Do?

II. Language Capacity for this Program:

a. We strive to keep our staff as diverse as possible and 40% of staff is bilingual (Spanish/English). When guest arrive to Sally's Place and there is a language barrier we connect the guest to the Language Line, staff can access interpreters speaking many languages via phone – and most languages are available on-demand at 1 -855- 938-0124. We also enlist the support of other organization bilingual staff for a more personal approach when available.

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☒ **Other**: Bilingual organization staff.

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III. FY 23/24 Challenges:

We continue to face the ongoing challenge from previous years of not meeting our KPI of 1000 remote support calls. Despite doubling our numbers since Fiscal Year 22-23, we still fall short by approximately 50%. To address this issue, we have developed a new procedure aimed at improving this KPI. This includes assigning a "case load" to each of our full-time staff members to foster stronger relationships with clients and ensure consistent scheduling of calls. We anticipate that this approach will lead to an increase in the number of remote supports calls for Fiscal Year 24-25.

Is Anyone Better Off?

At Discharge 74 out of the 148 clients completed our satisfaction survey. Out of those clients 47 responded with Strongly agree to overall wellness once discharging from Sally's Place.

Rating	Overall Wellness
Strongly Agree	47
Agree	12
Neutral	9
Disagree	3
Strongly disagree	3

IV. FY 23/24 Client Impact:

a. During the fiscal year 2023-2024, our records show no pre-program hospital nights and no post-program nights. These results highlight our success in helping our clients avoid hospitalizations. Our program is supporting those individuals who are considering psychiatric hospitalization and assist with their return home feeling well. Feedback from follow-ups has been positive, with clients reporting improved mental health and well-being. The feedback also indicates satisfaction with Peer Support services compared to clinical-based alternatives.

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

FY 24/25	144
FY 25/26	144

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 31

PROVIDER NAME: Felton Institute

PROGRAM NAME: (RE)Mind and BEAM - Early Psychosis Programs (formerly PREP Alameda)

Program Description: The Felton Early Psychosis Programs - (re)MIND® and BEAM - formerly known as PREP Alameda, provide evidence-based treatment and support for transition age youth (TAY) who are experiencing an initial episode of psychosis or severe mood disorder. The programs provide outreach and engagement, early intervention, and outpatient mental health services that include the following categories: mental health services, case management/brokerage, medication support, crisis intervention. In addition, (re)MIND® and BEAM Alameda also provide Individual Placement and Support (IPS) supported employment and education services. The program goals of (re)MIND® and BEAM Alameda are designed to delay or prevent the onset of chronic and disabling psychosis and mood disorders; reduce individuals' hospitalizations and utilization of emergency services for mental health issues; improve the ability of program participants to achieve and maintain an optimal level of functioning and recovery as measured by functional assessment tools; connect participants with ongoing primary healthcare services and coordinate healthcare services with individuals' primary care providers; increase participants' educational and/or employment success; increase meaningful activity as defined by the individual; decrease social isolation; and assist participants with advocating for adjustment of medications to the minimum amount necessary for effective symptom control.

Target Population: Transition Age Youth (TAY) ages 15-24, who are experiencing the onset of first episode psychosis associated with serious mental illness (SMI) and severe mood disorder.

FY 24/25 Program Budget: $1,528,122 **Cost per Client:** $1,528

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 60 Transition Age Youth (TAY)

How Well Did We Do?

Quality Measures	Quality Objective Target	Quality Objective Result
Percent of clients who receive two or more visits within 30 days of episode opening date	85%	98.3%
Percent of clients who receive four or more visits within 60 days of episode opening date	85%	98.3%
Percent of clients who receive services in their sixth month in the program	75%	100%

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Quality Measures *(cont.)*	Quality Objective Target	Quality Objective Result
Percent of direct services provided in community-based locations, outside of clinic offices, which are convenient for clients	75%	72.3%
Percent of clients who have a current primary care provider/ physician	50%	68.3%
Percent of clients on medication who receive at least one medication visit each 90 days	75%	84.9%

The Felton (re)MIND® and BEAM programs met all Quality Objectives but one, which it nearly met, to providing at least 75% of direct services outside of the clinic and convenient for youth, achieving 70.5% of services being provided outside of the clinic. However, program participants are encouraged to choose the location of their services within limited exceptions (i.e. groups, some medication service, etc.) and choosing to be seen at the clinic may indicate that it is the most convenient location for them.

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

The primary challenge faced by the program was recovering from the previous fiscal year's challenge of staff vacancies and the impact those vacancies had on the program's census. With new clinical staff starting in August 2023, the program focused on working through its waitlist and building its census. During the first half of the year, the program admitted nine (9) new individuals into the program. During this same period of time, the program discharged twelve (12) individuals from the program. Of these twelve (12), eleven (11) graduated from the program and one (1) was found ineligible following comprehensive assessment. The second half of the year, however, was a period of growth for the program. Program staff admitted twenty-one (21) new individuals into treatment. During quarters 3 and 4, the program also discharged a total of seventeen (17) youth, thirteen (13) of which were graduates, one (1) was found ineligible, and three (3) transitioned prior to completing the program (2 moved out of the service area and one declined services despite staff's sustained outreach efforts). While the program experienced challenges throughout the course of FY2023-24, there are major successes to acknowledge as well as a positive projection into FY2024-25.

- A testament to the model and to the quality of the staff doing the work, the program graduated twenty-four (24) out of twenty-nine (29) discharges, an **82.7% successful completion rate**.
- It is projected that FY2024-25 will be a year of growth.

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- The program is currently operating at the level of growth carried forward by the momentum of the second half of FY2023-24 (21 admissions compared to 9 admissions during the first half of the year).
- Barring early graduations, the program's current census has six (6) individuals slated for program completion/graduation in FY2024-25.
  - As a result, it is expected that census growth will remain throughout FY2024-25 and carry forward into FY2025-26.

In addition to the growth resulting from more admissions and fewer discharges, program staff and leadership are engaging with community partners through educational presentations to develop, enhance, and reinforce referral networks. One of the benefits of this outreach campaign will be improved incoming referrals, decreasing the level of time and effort that staff put into initial screening for assessment eligibility, a non-reimbursable activity. During FY2023-24, 64.7% (44 of 68) of referrals were ineligible due to factors such as county of residence, age, insurance status, and duration of illness.

Is Anyone Better Off?

Hospital Reductions: During FY 23/24, there were 36 youth who received services for 12 months or more. Of these 36 youth, 25 individuals had at least one admission to CS, PHF, or psychiatric hospital in the previous 12 months before enrollment. 19 out of these 25 youth (76.0%) showed reduction in the total number of crisis stabilization or inpatient services episodes.
The program nearly met the target goal of 80% reduction, coming close by achieving 76.0%. Of the remaining 6 youth who did not experience a decrease in CS, PHF, or psychiatric hospital admissions, 2 also did not experience an increase during their most recent 12 months in the program. **Accounting for both those who experienced a decrease and those that did not experience an increase, the percentage of positively impacted clients is 84.0%.**

IPS Services: The Impact Objective for IPS services is to have at least a 30% employment rate, with an average of 1 new job placement per month. During FY 23/24, 29 out of 60 individuals received supported employment and education services. 16 out of 29 individuals successfully engaged in competitive employment, resulting in a **job placement of 55.2%; this surpassed the programs' Impact Objective of 30% for IPS services**. In addition, **IPS staff facilitated 15 new job placements in this 12-month period; this exceeded the Impact Objective of 1 job placement per month.** Finally, 17 of these 29 participants (58.6%) also received educational services; many returned to high school and college.

IV. FY 23/24 Client Impact:

This is the account of an 18-year-old Salvadoran American cis-gender young adult from Hayward. The individual and their family were referred to Felton in December of 2023 after they began developing psychotic symptoms earlier that Fall. Symptoms began with hearing the voices of classmates and escalated over time to paranoia. Increased paranoia led to regular sleep disruption, and they would converse and argue with their voices, day and night. By the time they reached (re)MIND services, they

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were experiencing severe functional decline and disorganization resulting in social isolation and disengagement with school.

This youth made the most of their time with the program, engaging in individual psychotherapy sessions (CBT for Psychosis) with their therapist, medication services, and supported employment and education services (IPS model). As a result of the services they received, they were able to manage their symptoms, engage in physical exercise and other self-care activities, and re-engage in high school, ultimately graduating with honors. They recently obtained employment at a local business. They are preparing to start college in the Fall with plans to study engineering and are getting ready to graduate from (re)MIND services.

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

FY 24/25	100
FY 25/26	100

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 32

PROVIDER NAME: Crisis Support Services of Alameda County

PROGRAM NAME: Suicide Prevention Crisis Line

Program Description: The Suicide Prevention Crisis Line is a 24-Hour Crisis line provided by Alameda County Crisis Support Services to provide: Crisis counseling in order to reduce the incidence of suicidal acts; lessen the number of psychiatric hospitalizations needed by individuals with suicidal thoughts; resolve crises; decrease self-destructive behavior; and increase awareness of suicide risk factors.

Target Population: The Suicide Prevention Crisis line provides a 24-Hour phone line for assistance to people of all ages and backgrounds during times of crisis, or their families, to work to prevent the suicide. Translation is available in more than 140 languages. We also offer teletype (TDD) services for deaf and hearing-impaired individuals.

FY 24/25 Program Budget: $867,000 **Cost per Client:** $23

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served:
Collectively we responded to 38,228 calls. There were 705 duplicated callers (89.5%) of medium-high risk calls were deescalated over the phone without the use of police intervention. The time spent on the phone through outreach was 17,813 minutes. Our total talk time has increased from 6.1% to 10.2% in the last year.

How Well Did We Do?

II. Language Capacity for this Program:

☐ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☒ **Other**: We have hired several bilingual speakers this year and now have an examination for those counselors to qualify. This examination makes them certified to take bilingual crisis calls.

III. FY 23/24 Challenges:

We continue to rely heavily on Global for translation. There are instances where the wait time for a translator can be long, the translator is not trained in first person translation and does not translate exactly from the consumer to the counselor.

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Is Anyone Better Off?

The advent of additional bilingual staff allows us to be less reliant on translation services and provide better care for our callers.

A suicidality rating of 3, 4 or 5 is considered medium to high risk for a suicide attempt or suicide death. The caller had a specific plan, access to means, or has already harmed themselves. **A total of 788 calls from 521 unique callers were rated with medium-high suicide risk**. 415 med-high risk callers or 79.7% utilized the crisis lines more than once this year. In 39 med-high risk calls, the caller mentioned firearms as a means to suicide. Though we saw a decrease in high-risk callers, there was a greater proportion of unique callers who had multiple calls with our center.

IV. FY 23/24 Client Impact:

During the last fiscal year, we were able to serve 38,228 people who contacted our lines. We are serving more people with mental health concerns than ever before and reaching more people before they are in crisis. We served 9% more people who chose to contact us again for support. We were able to spend more time on the phone with people experiencing distress and discomfort. Finally, we were able to de-escalate 91.5% of medium-high risk calls over the phone without the use of police intervention

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

FY 24/25	39,000
FY 25/26	40,000

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 32

PROVIDER NAME: Crisis Support Services of Alameda County

PROGRAM NAME: Zero Suicide Program

Program Description: The Zero Suicide program includes 4 components: Hospital follow-up, Survivors of Suicide Attempt groups, Educational presentations at Santa Rita Jail, and outreach and education to health providers.

Target Population: Each of the four components listed above has a specific population that it works to reach in an effort to address those working with high risk populations or to support individuals directly who are at high risk for dying by suicide due to recent hospitalization or history of an attempt.

FY 24/25 Program Budget: $208,165 **Cost per Client:** $242

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 859 Adults

How Well Did We Do?

Zero Suicide in Correctional Settings: This past year, we provided 15 suicide prevention trainings to Santa Rita civilian staff - nearly 1-2x a month per their training schedule with no missed presentations.

Zero Suicide Primary Care: We provide 21 workshops to healthcare providers most of which were virtual and hosted by our agency. In addition, we provide workshops to: Bay Area Community Health (new contact), Tiburcio Vasquez, Alameda Health System, Children's Hospital, and Center for Healthy Schools & Communities. This year we added a new curriculum to our menu for Pediatricians. We also are now set up to provide CEs for nurses which has resulted in increased registration and attendance.

The Hospital Follow-up Program: served an average of 6 new clients per month for a total of 78 new clients. Clients engage in telephone support sessions on a weekly basis free of charge. Every client is provided with at least 6 sessions over a time period of 6 to 8 weeks. This year, 343 outreach calls were made. Clients are not obligated to finish all sessions and are allowed to discontinue services at any time. The most challenging clients to serve are those experiencing homelessness. Clients experiencing homelessness often do not have a private space for carrying out their sessions.

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Furthermore, they are often overwhelmed by the stress of being unhoused. Unhoused clients additionally deal with disconnected phone services or stolen phones at a higher rate. When unhoused clients are temporarily housed in a shelter, the crisis counselor is able to reach the client at the shelter's landline. But clients are typically only in shelters for 2-weeks. Once unhoused clients leave shelters, maintaining regular weekly contact becomes increasingly challenging.

The demographics of the program reflect a high level of need in Oakland, which was the residence of the majority of the clients (32) which the second most represented being Hayward with 18 clients. The gender ratio was nearly split between male and female identified callers. Limited information was collected regarding racial and ethnic identity, but the data that was able to be collected suggests that the program services a diverse range of clients, with the highest reported percentage identifying as Latino/a.

The predominant languages spoken by clients were English and Spanish. Other languages spoken by clients were Hindi, Farsi / Dari, Vietnamese, Tongan, Mandarin, and Cantonese.

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:
An ongoing challenge is attendance rates for hosted workshops. While registration rates tend to be high, the percentage of attendees is low. There could be several reasons for this, including the time and day of the week (workshops are scheduled typically during the traditional lunch hour), time availability for intended audiences, and having a repetition of only 4 workshop offerings. However, the registration numbers and the amount of folks signing up for the interest list lets us know that while there are still barriers to attendance, there is an interest for these workshops. In the upcoming fiscal year, it may be helpful to diversify the days/times of workshops. Another challenge has been having clinics and health centers request in person or virtual presentations for their staff, like they do in other Community Education programs. While we are finding success in hosted workshops, being able to train an entire staff at an organization can allow for all employees to be receiving consistent training and messaging around suicide prevention and can encourage internal conversations around policies and procedures. These are important factors to suicide-related patient care.

For Hospital Follow-Up, clients dealing with repeated suicide attempts and admits to JGPH is at times a challenge. More specifically, it is a challenge when such clients either do not receive a referral for escalated care, or do not accept a referral for escalated care. Sometimes clients receive referrals but refuse to accept them due to the pressures of returning to work or duties at home. When this happens, the Hospital Follow-up Counselor supports the client with a slightly elevated vigilance to support the client in managing increased symptoms. The HFU counselor will hold

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space for the client and encourage the client to reconsider acceptance of the referral. If the client agrees to more care, the counselor will collaborate with the client to retroactively accept the initial referral from JGPH, and coordination ensues. The sessions will then restart once the client is discharged from the escalated level of care.

Is Anyone Better Off?

Success story from Hospital Follow Up:

Upon receiving support via the Hospital Follow Up (HFU) program, clients demonstrate a lower suicide attempt (SA) relapse rate. The HFU program allows clients to have access to a low barrier and no cost intervention over 6 to 8 weeks following a suicide attempt. HFU clients who utilize just one or all six sessions show great improvement in managing SI, as well as collaborating on creating effective coping strategies and intervention tools. Furthermore, HFU serves as an immediate resource following psychiatric discharge. This immediate resource is an important system barrier to fill, as many HFU clients are not currently in treatment, hence connecting them with providers post discharges can take several weeks. Having a counselor to speak to on a regular basis allows clients to stay treatment motivated, further preventing SA relapse.

**S.F. is an African American transitional age youth (TAY) who attempted suicide due to anxiety and grief surrounding his mother's chronic substance use disorder. S.F. made a suicide attempt in February 2023 shortly after his mother took out a life insurance policy on herself and voiced to her son that she was hoping to die soon. Shortly after this statement, she engaged in several days of non-stop drug usage. During this prolonged relapse episode, S.F. attempted to die by suicide by lethal means. S.F. was admitted to John George and referred to HFU program upon discharge. S.F. completed all six sessions of the HFU program. During the sessions, S.F. expressed that his first suicide attempt was at the age of 13, and it was also related to his mother's drug usage. S.F. gained several coping skills through the HFU program, which allowed him to cope with the stresses of home and school. School was often discussed during the HFU sessions because it was a source of hope for S.F. S.F. went to an adult prison at the age of 17 due to a charge of burglary. Hence, S.F. did not receive his high school diploma. S.F. was released from prison in 2023 after serving a 5-year sentence. The HFU sessions supported S.F. in his ability to build resilience and stay hopeful despite his immediate surroundings. In the HFU sessions, S.F. identified that upon graduating from high school he would like to attend a junior college, and eventually transfer to UC Berkeley.

**A.B. is a 37-year-old Latinx monolingual Spanish speaking man. A.B. attempted suicide by slicing his throat while in the shower. A.B. is in a loving and committed relationship with his partner of the last 18 years, and it was his partner who found him unconscious in the bathroom and called the paramedics. After receiving medical treatment for his severe injury, A.B. was transferred to John George. Upon discharge from John George, A.B. was referred to the HFU program. A.B. identifies as a cis-gendered gay man who came out to his family at the age of 17. The year A.B. disclosed his sexuality, is also the year he came to the United States from Mexico to live with his father. Upon disclosing his sexuality to his father and paternal aunts and uncles, he was immediately ostracized

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by his family and began to experience chronic displacement and homelessness. He began to use alcohol to cope with the depression of the estrangement of his family, as well as the sadness of missing his mother and siblings who remained in Mexico. A.B. completed all of his HFU sessions and gained adaptive coping skills to mitigate his suicidal ideation and anxiety. During A.B.'s HFU sessions, he received citizenship and was able to travel to Mexico for the first time in 18 years. Though this was a joyful time for A.B., it also triggered severe SI, because of the guilt he felt around receiving his citizenship prior to his partner. The HFU sessions afforded him a safe place to process the guilt and cultural bereavement of that stressful time.

IV. FY 23/24 Client Impact:
For Community Education components, in response to the question: What, if anything are you going to do differently as a result of this training?

Training: Managing & Preventing Burnout: "Yes, I am more open minded to approach one of my co-workers showing s/s [signs and symptoms] of burnout"

Training: Safety Planning 101: "I work in a Medical-Psych Unit and have heard of safety plans since most of our patients who are discharged to home have one; however, I never knew what those plans included so this training was extremely helpful. Now, I feel I can help patients create one when needed."

Suicide Prevention in Medical Settings: The Role of Nurses: "Affirming that empathy/connection does make a difference. Also suggesting direct questions rather than "thoughts of harming self"

For Hospital Follow Up component, impact included

- Reduced suicide attempt relapse
- Increased social connectivity
- Increased development of coping skills
- Referrals to live / interactive support groups: Survivors of Suicide Support Group, ORCA, etc.

VI. FY 22/23 Projections of Clients to be Served:
We hope to continue to be part of Santa Rita Jail's training cycle as they've been attempting to shift to online on-demand training for the past 2 years. We hope to continue to provide at least 12 trainings (15 this year) with an avg # of 20-25 people per training. For healthcare providers, outreach has always been a challenge however, since we are now able to provide CEs, we hope to see an increase in our participant #s and aim to provide at least 25 trainings to health care providers during the year.

FY 24/25	850-900
FY 25/26	850-900

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 33

PROVIDER NAME: Felton Institute

PROGRAM NAME: Deaf Community Counseling Services (DCCS)

Program Description: DCCS provides outpatient mental health services, including assessments, individual psychotherapy, family therapy, collateral and indirect services to provide information and referrals to community members.

Target Population: DCCS provides services for residents of Alameda county who have medi-cal, medi-medi or who are medi-cal eligible who are Deaf, DeafBlind, deaf with additional disabilities, late Deafened (those who were born hearing and became Deaf or lost their hearing in adulthood), hard of hearing (those who do not use sign language but use spoken language), from age 5 years to older adults. We also work with parents and family members of Deaf children or adult Deaf children. For the rest of this report, the word: "Deaf" will be used to include all clients with any kind of hearing impairment or loss or preferred communication mode.

FY 24/25 Program Budget: $328,153 **Cost per Client:** $7,458

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 44 (3 Youth, 6, Transition age Youth (TAY), 33 Adults, 2 Older Adults.

How Well Did We Do?

a. DCCS continues to strengthen its partnerships with local and state services to ensure clients receive comprehensive support through our programs. Our collaborative efforts include working with the following agencies:

a.1. DCARA (Deaf Counseling, Advocacy, and Referral Agency), DeafHope, Children and Family Services, California School for the Deaf in Fremont (CSD), Cabot College, and ADARA. Additionally, we consistently coordinate support with Toolworks and Deaf Plus Adult Community (DPAC) to further assist our clients.

a.2. To meet the growing demand for ASL interpreting services, our program has hired a part-time ASL interpreter. This role provides interpretation and transliteration during sessions involving Hard of Hearing and Late Deafened clients, DCCS staff members, and hearing providers within the Felton organization. Additionally, the interpreter handles administrative tasks, including coordinating and securing additional

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a.3. interpreters for extended appointments, and collaborates with the program supervisor and Human Resources to create accessible training materials for deaf staff within the department.

II. Language Capacity for this Program: American Sign Language (ASL)

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☒ **Other**: a. Majority of the client served used American Sign Language. Other unique languages used are English, Spanish (Spoken, and signed) and Farsi (1). DCCS has developed professional relationship with Sign language interpreters in the Bay and provided contracted services to the D/HH community members that we serve.

III. FY 23/24 Challenges:

a. DCCS continues to encounter challenges similar to those highlighted in the previous year's report. Despite our program being one of the most frequently sought-after services for D/HH referrals, we face limitations in serving clients without medical insurance. This is particularly relevant for referrals covered by United Health, Blue Cross, Blue Shield, or Stutter Health.

b. Access to equitable mental health care remains a significant challenge for members of the D/HH community. Clients frequently report difficulties in obtaining accommodations for their language needs, which impedes their ability to engage in programs essential for their mental health. To address this issue, DCCS actively works with referred agencies to provide culturally competent care by consulting with them on the necessary accommodations and support.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

a. A client who was admitted for Major Depressive Disorder last year has shown notable mental and behavioral improvements, according to their assigned clinician. The clinician noted that while the client initially reacted strongly when feeling neglected, they have since become better at recognizing and communicating their needs. The client is now able to express their thoughts and feelings coherently. Additionally, there have been positive changes in the client's social engagement; they are actively involved in a disabled art community, with their work displayed at the Oakland Museum.

b. A former deaf youth, now a transitional age youth, has been receiving mental health care for nearly two years and is approaching the conclusion of their treatment with DCCS. Initially admitted for Severe Major Depression, the client has made significant progress in

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overcoming mental and behavioral challenges. They are now under the care of their immediate family and are actively working towards gaining employment.

c. A transitional age youth who previously struggled with depression and socialization has shown partial improvement before discharge from treatment. Over the course of their sessions, the client became increasingly engaged, compared to their initial appointments. They were able to identify strong support systems and connect with the D/HH LGBTQ community in their local area prior to leaving treatment.

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

FY 24/25	44
FY 25/26	65

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 34

PROVIDER NAME: Alameda Family Services

PROGRAM NAME: School-Based Behavioral Health

Program Description: The Outreach for School-Based Health Centers program is designed to bring awareness and information about how to identify early signs of mental illness in youth and connect those in need with the mental health services offered through the School-Based Health Centers. Efforts are targeted to reach potential responders and youth.

Target Population: Adult potential responders and high school age youth living in Alameda County.

FY 24/25 Program Budget: $145,441 **Cost per Client:** $88

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 1,662 Youth

How Well Did We Do?

During the 2023-24 school year, AFS School-Based Behavioral Health helped reduce mental health stigma and promoted emotional wellness at three different high schools in Alameda Unified and one middle school. Our School-Based Health Center (SBHC) staff, in coordination with our Youth Advisory Board (YAB) Members, organized and facilitated classroom presentations and school-wide tabling events focused on suicide awareness and prevention, healthy relationships, and mental health awareness. Outreach also included workshops, social media campaigns, flyers/signage around campus, fishbowl discussions with clinical staff, and other various activities and events to promote awareness around critical mental health issues for youth. All our outreach efforts were focused on reducing mental health stigma by facilitating open dialogs, where serious topics could be addressed and processed, while also acknowledging and normalizing challenges. Throughout our three large campaigns, as well as our on-going outreach and mental health services, the SBHC staff are able to provide youth with relevant and factual information, how to identify mental health concerns in themselves and community, and how to address these concerns utilizing the larger support network around them. The SBHC also provides all youth who participate with resources and further information on how to seek support at the SBHC, at their school, and within their community. Outreach encourages students to self-refer to therapeutic services, case management, health education, youth development, medical services and all other SBHC services as well.

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II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☒ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☒ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

Although there have been many successful and meaningful events, the 24-25 challenges mirror similar themes from the previous year around how some youth and families perceive mental health information and support. We believe fully in holistic and community healing for mental and emotional wellness and want to engage families and adults in care and understanding youth mental health concerns. We heard from youth about their hesitancy to engage caregivers in their mental health treatment due to their caregiver's cultural and/or religious lens around mental health. Although this continues to be a challenge to reduce stigma and barriers for youth to access mental health, it is one that validates the importance of continuing to increase funding and outreach efforts to expand to a wider audience. Understanding this barrier, we also utilized our community platforms to increase awareness and reduce mental health stigmatization within the Alameda community at large to help connect and expand our audience.

Additionally, another challenge that we are facing is the increasing need for youth mental health services across Alameda County. Hundreds of students seek mental health support through our three School-Based Health and Wellness Centers every year. Of these students seeking support, there is especially a need for lower income families and those who were Medi-Cal eligible to receive quality and accessible mental health care. Unfortunately, we are only able to serve only a small fraction of the youth and families seeking school-based services for mental health support with our own limited resources. Receiving confidential and holistic services with a school-based provider can make a huge difference in the trajectory of a person's life, as we have seen from our current work with students.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

We continue to serve an incredibly bright and diverse student population. In the 23-24 school year, for youth completing a Mental Health screener across all three SBHCs, 72% were youth of color (Asian, Black, Latinx, Native American, Mixed Race), 24% were white, and 4.5% declined to answer. Additionally, in that same group, 39% identified as LGBTQ+ or Questioning. We will continue to promote safety, wellbeing, and inclusivity within all of our outreach and school-based programs to improve mental health outcomes for all students.

Participation in our youth leadership and peer education services continued to grow this year, contributing to the increase in our outreach efforts. Students in our Youth Advisory Board [YAB]

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across the three high schools have expressed that the program provided them with unique opportunities to engage in mental health related topics through discussions and training with school-based staff, as well as through their youth-led projects and activities throughout the school year. YAB participants also shared that they were able to gain relevant knowledge about mental health, helping them to feel more confident in dealing with their own challenges and in supporting others. The opportunity to serve as leaders advocating for the health and wellness of their school community also contributed to improved attendance for several YAB participants. This was most evident with Island High School students who said that their YAB participation helped them feel safer on campus, more motivated to come to school, and better connected to the school community. Island High teachers and administration have not only recognized and celebrated the positive impact of YAB participation on individual students, but also how our overall outreach efforts have contributed to improvements in school culture and climate.

A great example of this is reflected in the experience of one Island student, who had chronic low attendance and poor engagement in class when he was in attendance. Through our outreach efforts and collaboration with school staff, this student was referred to the SBHC by their teacher for health education, specifically around sleep hygiene. The youth began to engage in health education lessons with the clinic coordinator and met for several sessions focused on improving sleep hygiene. The sessions included psychoeducation around sleep, developing a sleep tracker, and a journaling practice. In building this relationship with the clinic coordinator, the youth became more open to other avenues of support on campus, namely that the student chose to participate in Island's Youth Advisory Board. The student became an active member in YAB and continued throughout the school year. Additionally, the youth had a significant improvement in his attendance and engagement, became more socially connected to peers and adults on campus, and ultimately, was able to graduate on time this school year.

Individual impact experienced by our YAB participants is also reflected at a wider level based on the feedback and participation in our outreach campaigns throughout the school year. Our various mental health outreach activities, which included classroom presentations, social media campaigns and awareness fairs, have reached hundreds of students. Based on surveys administered during our activities throughout the year, an average of 96.3% of respondents said that their participation helped them learn more information and resources about mental health related topics. In addition, an average of 98.6% students' respondents expressed that they were better able to identify a person or place they can go to on campus for support.

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

FY 24/25	1,750
FY 25/26	1,900

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 34

PROVIDER NAME: Seneca Family of Agencies

PROGRAM NAME: School-Based Behavioral Health: ASCEND, Prescott, Sequoia and Think College Now

Program Description: MHSA Braided funding for Expansion of School-Based Behavioral Health in the Oakland Unified School District (OUSD). MHSA funding is being braided with Educationally Related Mental Health Services (ERMHS) and Early Periodic Screening Diagnosis and Treatment (EPSDT) funds to provide enhanced (non Medi-Cal billable) mental health services and supports to children in Counseling-Enriched Special Day Classes (CESDC) and two of its School Based Behavioral Health (SBBH) programs in OUSD in order to assist these children and their families in becoming successful in school and at home.

Target Population: Youth attending Counseling-Enriched Special Day Classes (CESDC) and/or two of its School Based Behavioral Health (SBBH) programs in OUSD.

FY 24/25 Program Budget: $85,685 **Cost per Client:** $199

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 430 Youth

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☒ **Other**: UE Clinicians additionally utilize contracted agencies to provide in person/phone interpretation or translation as needed, including Mam

III. FY 23/24 Challenges:
Primary challenges experienced this year were rooted in challenges to finding both time and capacity of teaching staff at ASCEND for planning, collaboration and follow up. Outside of classroom instruction time and prescheduled professional development times, availability for teachers to meet is often limited or met with competing priorities. Additionally, as the year progressed and ASCEND experienced staff transitions, time and capacity became even tighter. The UE clinicians at ASCEND continued to bring and implement creative solutions to timing and capacity barriers including

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building flexibility into their schedules to meet teachers and staff when they can, either planned or in the moment, and forming a committee of support service providers to work together in scheduling their time to best meet and maximize teacher time and availability. UE Clinicians gathered feedback and ideas from teachers to maximize time and scheduling opportunities for collaboration and will be using that information to guide planning with school leadership for the 2024-2025 school year.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

This year, an 8th grade student who participated in the UE Clinician led, middle school newcomer SEL group, showed exceptional growth through participation in the program. Towards the beginning of the group, this student requested to exit the group due to conflicts with other members that had occurred in a different setting. The UE clinician supported the student to remain in the group by emphasizing her value as an important member of the newcomer community at ASCEND and providing a space for conflict resolution within the group setting. Over time, students began showing more respect for each other and for the group norms, and they reported feeling that the group space was an important part of their week at school. As part of the group curriculum, each group member engaged in an individual session with the UE clinician to share about their immigration story before, during, and after their journey to the United States to process their trauma narratives with a focus on the inner strengths and external supports that helped them get through difficult times. The 8th grade student, who originally did not want to be in the group, was highly engaged in this process and reported that it felt good to talk about her story, since she had never fully shared it with anyone before. After the individual sessions, students returned to the group setting to share aspects of their stories with one another. Though students were hesitant to share at first, the 8th grade student supported the conversation by volunteering first to share vulnerable parts of her story, which helped model for other students how they could speak up. Group members were able to bond and create a healing space as they recognized common themes in their stories of being separated from family members before, during, and after their journeys and feeling changes in their personalities after arriving in the US. In addition, the 8th grade student developed strong leadership skills over the course of the group and played an important role in welcoming two new students to the group when they first enrolled at ASCEND after arriving in the US from Central America. Though the group terminated in December following completion of the evidence-based curriculum, teachers have reported the participants have continued to build on the relationships forged during the group and have supported the newest students in integrating into the ASCEND community in both academic and unstructured settings at school.

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

FY 24/25	415-430
FY 25/26	415-430

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 34

PROVIDER NAME: STARS Behavioral Health Group

PROGRAM NAME: School-Based Behavioral Health: East Oakland Pride Elementary School

Program Description: MHSA Braided funding for Expansion of School-Based Behavioral Health in the Oakland Unified School District (OUSD). MHSA funding is being braided with Educationally Related Mental Health Services (ERMHS) and Early Periodic Screening Diagnosis and Treatment (EPSDT) funds to provide enhanced (non Medi-Cal billable) mental health services and supports to children in Counseling-Enriched Special Day Classes (CESDC) and two of its School Based Behavioral Health (SBBH) programs in OUSD in order to assist these children and their families in becoming successful in school and at home.

Target Population: Youth attending Counseling-Enriched Special Day Classes (CESDC) and/or two of its School Based Behavioral Health (SBBH) programs in OUSD.

FY 24/25 Program Budget: $96,474 **Cost per Client:** $462

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 209 Youth

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

There have been several challenges over the course of this school year. There were multiple staff deaths that affected the school community and created additional stress on an overly taxed system. Additionally, the ongoing community violence has had a significant impact on the wellbeing of the students. Over the course of the year, our staff person onsite has noticed an influx of newcomer students as well and limited support available to them. Overall, our staff have observed some challenges with cultural responsiveness and trauma informed approaches amongst the school staff.

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Is Anyone Better Off?

IV. FY 23/24 Client Impact:

Brief Overview of client impact: MHSA services have created the opportunity for providing direct services

to students offering individual student support, group support, and crisis interventions to facilitate risk and safety assessments. Additionally, the impact of trauma and at-risk factors due to continued community violence and the loss of school staff continues to have a direct impact on students and their immediate households. MHSA support has allowed for grief support on campus. Our staff has also observed some challenges with understanding and navigating mandated reporter responsibilities amongst school staff and has been able to provide consultation and training about CPS reporting guidelines.

Case Study: Our staff person on site has noted an influx in newcomer students from Spanish speaking countries and identified a need for additional support for these students. She created and conducted a newcomer support group for the youth, with all sessions held in their native language. The group focused on managing identified risks (self-harm ideation), provided support in teaching affect regulation skills and created space for the youth to explore their migration journey.

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

FY 24/25	215
FY 25/26	215

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 35

PROVIDER NAME: East Bay Agency for Children (EBAC)

PROGRAM NAME: Community-based Outreach & Consultation

Program Description: EBAC's Fremont Healthy Start Program engages, encourages, and trains potential community responders, primarily family members of youth and children but also school staff and community members, about ways to recognize and respond to early signs of mental illness.

Target Population: Adults (18+) who are potential community responders, primarily family members of youth and children but also school staff and community members.

FY 24/25 Program Budget: $91,974 **Cost per Client: $**102

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 902 Youth

How Well Did We Do?

- Our ability to offer a multilingual and multicultural approach significantly enhances client engagement and fosters trusting relationships. Among our 7 staff members, we collectively speak 11 languages.
- Staff meet clients in a stable, quiet and private environment.
- Staff educated clients about mental health challenges and shared stress-reducing activities such as taking walks, breathing in deeply, stepping away from conflict, playing with children, and visiting local parks.
- Staff collaborated with local programs and agencies to assist families with essential needs and provide holiday gifts throughout the year.
- Our program coordinator actively served on the Student Attendance Review Board, where she provided valuable resources to parents.
- Staff assisted the community with over 200 low-income housing applications.
- Because of EBAC's and our program staff's long-standing relationships with city, district, county and community resources and communities, we were able to provide prompt services to clients through mutual referral and collaboration. Further, these partnerships afforded strategic opportunities to increase visibility and awareness of our programs. For example, our contact information is included in the Fremont Unified School District's website and the Kaiser Permanente website.

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II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☒ **Chinese** ☒ **Korean** ☒ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☒ **Other**: Cantonese, Dari, Hindi, Mam, Mandarin, Pashto, Punjabi, Urdu

III. FY 23/24 Challenges:

- A continued lack of counseling services available in Dari, Pashto, Urdu, and Punjabi resulted in long delays for people seeking mental health services. Common challenges included long waiting periods, lack of therapists who speak the client's language, and costs associated with receiving services.
- Staff also were challenged with clients not following up with referrals due to other issues that clients were prioritizing, such as shelter and employment. Other families simply felt too overwhelmed by their challenges and responsibilities to even consider services or self-care.
- Working families are ineligible for services like rental assistance, which exacerbates serious mental health issues.
- We continued to serve many Afghan refugees, whose complex issues cannot be resolved in just two or three visits. Unfortunately, there is insufficient full-time equivalent (FTE) staffing at the program level to effectively meet the needs of this community.
- Staff sometimes become frustrated when referring clients to counseling services that are not available in the client's language, even when the client is willing to attend. Conversely, even when services are available in the client's language, clients may be unwilling to attend due to other priorities.
- Addressing wellness and/or mental health issues among diverse cultural groups was challenging at times. Cultural judgements, perspectives and misconceptions about mental health can influence how people receive the educational information we provide. Because of this, our program places great importance on establishing a bond with each client during the first encounter so as to establish a good rapport.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

- Served 766 unduplicated individuals at risk of developing a mental health problem or serious mental illness.
- Assisted 136 unduplicated individuals exhibiting early signs of developing more severe mental health conditions.
- Served indirectly 899 unduplicated individual family members.
- Provided 2,123 contacts with clients needing services such as assistance with health insurance, food, clothing, public benefits, domestic violence, etc.
- Provided contacts with 85 refugees who needed support with housing, ESL classes,

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driving lessons, school registration and immigration services.

- Worked with clients to create a family goal plan to identify the most helpful services. Offered warm hand-offs to ensure clients felt comfortable in following up with a referral.

We would like to share the below impact story from this program year:

Ms. Garcia, a long-time client of Fremont Healthy Start, has received various forms of assistance over the years, including support with backpacks, health insurance, immigration referrals, and other essential

services for her children who attended Grimmer Elementary School, where our program is located. Although her children are now young adults, Ms. Garcia continues to face challenges. In mid-2023, her husband left the home, leaving her responsible for unpaid rent and bills. Our staff helped her with the PG&E bill and provided advice on filing for divorce.

After achieving her initial goals, Ms. Garcia returned to us with urgent issues: four months of overdue rent and an eviction notice from her landlord. Our Family Resource Specialist promptly referred her to the Core Team for housing assistance. Within an hour, Ms. Garcia was contacted by a case manager at the Fremont Family Resource Center (FFRC), who arranged a meeting at our Fremont Healthy Start site, given her lack of transportation. After completing the necessary forms and meeting with Ms. Garcia, it was determined that she qualified for a year of rental assistance.

Ms. Garcia's mental health, marked by depression, was also addressed. Due to transportation issues, accessing counseling was difficult, so we provided suggestions for stress relief exercises, such as walking or jogging. Despite being recommended for a promotion at work, Ms. Garcia struggled with low self-esteem. We encouraged her to accept the promotion, reinforcing that her supervisor saw potential in her. She is now considering the offer.

Additionally, Ms. Garcia's sons, who also have shown signs of depression and who spend excessive time on video games, are not enrolled in college. We are assisting Ms. Garcia with information on college sessions and referrals for family therapy and encouraging her to motivate her sons to follow up on these opportunities. Although her immediate focus is securing housing, Ms. Garcia is actively engaging with the referrals and continuing to work with the housing case manager to resolve her housing issues. Notably, two of her sons have attended college informational sessions, and family counseling is being considered, marking a significant step forward.

Additional Information:
Lessons learned:

- It is important to recognize that not everyone is immediately open to change or

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understands mental health as our staff do. Building trust with clients who have experienced trauma requires persistence, patience, kindness, and cultural sensitivity. By creating a supportive and understanding environment, staff can gradually earn clients' trust. Once trust is established, clients are more likely to be receptive to discussing mental health issues and exploring available resources. Our staff is dedicated to fostering a safe space where clients feel comfortable and know they can turn to their Family Resource Specialist when they are ready.

- Supporting staff self-care is essential. To address this, staff receive annual training on Compassion Fatigue and Vicarious Trauma.
- EBAC staff provide hands-on support to clients, including detailed guidance on next steps, making phone calls to resources, scheduling appointments, and assisting with document completion. Instead of merely giving clients phone numbers or informational flyers, our staff actively engage in addressing their needs in real time.
- Staff proactively reach out to clients rather than waiting for them to make contact. This approach is more effective, positive, and impactful, ensuring timely support for those in need.
- Newcomers face unique challenges compared to those who have already adapted to life in America. Because EBAC staff are trauma-informed, culturally sensitive, and experienced in assisting newcomers, they are prepared to listen to the client, ask the appropriate questions, offer the right resources, and connect them to the community.
- Understanding cultural nuances is crucial for accurately interpreting clients' perceptions and interactions with services. For example, a quiet client may be seen as reluctant to share information when, in fact, their silence may reflect cultural norms of respect for authority. At cultural events, EBAC staff prioritize cultural sensitivity and respect to better connect with and support clients.

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

FY 24/25	1,000
FY 25/26	1,000

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 35

PROVIDER NAME: Mental Health Association of Alameda County (Family Education and Resource Center [FERC])

PROGRAM NAME: Community-based Outreach & Consultation

Program Description: The Family Education and Resource Center (FERC) is an innovative peer-to-peer program that provides education, advocacy, resources, support and hope to family caregivers of a loved one living with a mental health challenge. FERC is operated by the Mental Health Association of Alameda County (MHAAC).

Target Population: Family members and caregivers of loved ones with a severe mental illness (SMI) or a severe emotional disturbance (SED) living in Alameda County

FY 24/25 Program Budget: $2,418,471 **Cost per Client:** $1,892

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 1,268 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☒ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

Is Anyone Better Off?

Contractual Deliverables are indicated by (D=#)**.** In FY 2023-24 100% of FERC staff were Family Member/Peers and 83% were also Peers. Family Advocates supported 1,278 families, received 1,054 Warmline calls (D=900) and provided 841 (D=800) AB 1424 consultations. FERC provided a Family Member & Consumer Perspective panel for each of the FY 2023-24 OPD Crisis Intervention Team (CIT) Trainings. FERC collaborated with 8 Organizations in programming community outreach events (D=2), provided 8 Mental Health Education trainings (D=4) in English and Spanish educating on: Conservatorship, MH Crisis, Self-Care, Parenting Latinx LGBTQIA+ Children Living with SMI, Community Safety and SMI, Reentry MH and Financial Security, Depression, Anxiety,

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Suicide Prevention. FERC provided 6 community outdoor mental health events for 120 participants. FERC outreach made over 1,000 outreach contacts (D=500) tabling at 20 community resource fairs, 520 follow up contacts (D=400) including delivering 52 mental health Education presentations. The program distributed 4591 printed resources/ materials to the community. FERC provided 60 Monthly Support Groups and provided 44 social support groups (D=10+) with 440 participants. FERC continued to develop 6 Spanish speaking Parent Leader volunteers (D=2-4). In partnership with OFE, these Parent Leaders hosted 17 Parent Cafes in Spanish and 6 Self-Care events with 355 participants. Seven (D=7) FERC Family Leaders participated in county meetings and 25 families participated in two MHSA Focus Groups (Eng/SP). In January 2024 FERC launched a Reentry program; by the end of June 2024, 9 family clients were served.

IV. FY 23/24 Client Impact:

A family advocate (FA) called a mobile crisis team to assess CL's 16yr old daughter for imminent danger. CL spoke no English, had no cultural context with MH and was terrified. FA remained on phone with CL during the assessment. While daughter was in treatment, FA supported CL by teaching self-care/stress relief strategies, educating on bipolar disorder onset. When daughter returned home in treatment, FA supported CL experiencing MH stigma and the family's cultural adjustment to supporting their Loved One. In response to CL's struggle to understand and accept her daughter's sexual identity, FERC provided a panel event with gay identified Latinx community members who spoke about their experiences growing up queer in their families. CL and her elderly mother participated and were visibly moved as they expressed their appreciation for this support.

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

FY 24/25	**2,000**
FY 25/26	**2,200**

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 36

PROVIDER NAME: CalMHSA

PROGRAM NAME: CALMHSA Presumptive Transfer Project

Program Description: Funding to be transferred for the support of providing services to Alameda County foster youth being served outside of Alameda County.

Target Population: Foster youth receiving mental health services outside of Alameda County This is a current mandate for all California Counties.

FY 24/25 Program Budget: $762,973 **Cost per Client:** $8,031

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: Alameda County has received **95** youth from other counties through the Presumptive Transfer process.

Alameda County has placed **160** youth in out of County placements through the Presumptive Transfer process

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 37

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Re-entry Treatment Teams (RTT)

Program Description: The Re-entry Treatment Teams (RTT) are a multidisciplinary treatment and case management program that serves adults who were previously incarcerated or involved in the criminal justice system. The program pairs clinical staff with peer case managers with lived experience in systems impact from the criminal justice system to meet the broad range of client needs. The program uses an eighteen month "critical time intervention"-based framework, providing intensive services and wraparound resources during the initial stabilization phase and then transitions the client to community care and supports.

Target Population: Adults, 18-59 years old, who were involved in the criminal justice system and have a severe mental illness (SMI).

FY 24/25 Program Budget: $2,427,097 **Cost per Client:** $13,559

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 179 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☒ **Chinese** ☒ **Korean** ☒ **Vietnamese** ☒ **Tagalog** ☒ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

a) **Housing:** During the FY 2023/2024, housing emerged as one of the most significant challenges we faced. Finding suitable housing options proved to be a difficult task, and even when housing was located, the costs were often high while our clients' income remained low. Another obstacle we encountered was that the credit expectations set by landlords or housing providers were often higher than what our clients could meet. Additionally, the move-in costs for securing housing were frequently higher than the limit of flex funds available per client. These challenges made it difficult to secure affordable and suitable housing for our clients in the program.

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b) **Psychiatry**: Psychiatry utilization has been a challenge throughout this fiscal year. Many clients have expressed hesitancy in seeking psychiatric help, often citing reasons such as reluctance to take medication or a desire to avoid repeatedly sharing their personal stories. This has resulted in clients frequently missing their scheduled psychiatry appointments. In response to this challenge, our dedicated staff has been working diligently to provide psychoeducation to clients regarding the benefits of psychiatry. They have been actively encouraging clients to at least attend one appointment, emphasizing the importance of seeking professional help for their mental well-being. Despite the difficulties, our staff remains committed to supporting and guiding clients in accessing the necessary psychiatric care they may require.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

As an agency that is committed to doing "Whatever it Takes," we prioritize providing comprehensive and personalized care to everyone we serve. We strive to meet our partners where they are at and address their unique needs. Throughout the past fiscal year, we have achieved numerous successes in supporting our partners. Here are a few examples:

1. Connecting individuals to benefits: We have successfully assisted our partners in accessing various benefits and resources that are crucial for their well-being. This includes helping them navigate the complex application processes and ensuring they receive the support they are entitled to.

2. Supporting employment opportunities: We have been instrumental in helping our partners gain employment. Through our dedicated efforts, we have provided job readiness training, resume building assistance, interview coaching, and ongoing support to ensure our partners secure meaningful employment.

3. Securing permanent housing: We are proud to have played a key role in aiding our partners in finding stable and permanent housing. Our team has worked tirelessly to connect individuals with housing resources, provide housing counseling, and advocate for their housing needs.

4. Developing coping skills: We have supported our partners in identifying and utilizing effective coping skills to manage their symptoms while in social settings. Through individualized support and therapy, we have empowered individuals to navigate challenging situations and enhance their overall well-being.

One of our notable successes from the past fiscal year involves a 26-year-old mother of four who has a significant history of trauma. After enduring several years of living in her car, we were able to support her in securing safe and stable housing for herself and her children. This milestone has

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had a transformative impact on her life. With the burden of homelessness lifted, this mother has been able to thrive in her role as a caregiver. Having a "safe place" for her children has provided a sense of security and stability, allowing her to focus on their well-being. She has embraced her as a mother and has been able to provide a nurturing and supportive environment for her children. Moreover, with the basic need for housing met, this mother has now turned her attention towards her personal goals. She has shown incredible resilience and determination, demonstrating her commitment to personal growth and improvement. Our agency continues to support her in this journey, providing guidance, resources, and assistance in pursuing her aspirations.

The above is just one example of the RTT program's commitment to providing holistic care and going above and beyond to meet the unique needs of each individual we serve. We will continue to strive for excellence in supporting our partners on their journey towards a better quality of life.

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

FY 24/25	190
FY 25/26	200

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 37

PROVIDER NAME: La Familia Counseling Center

PROGRAM NAME: Re-entry Treatment Teams (RTT)

Program Description: The Re-entry Treatment Teams (RTT) are a multidisciplinary treatment and case management program that serves adults who were previously incarcerated or involved in the criminal justice system. The program pairs clinical staff with peer case managers with lived experience in systems impact from the criminal justice system to meet the broad range of client needs. The program uses an eighteen month "critical time intervention"-based framework, providing intensive services and wraparound resources during the initial stabilization phase and then transitions the client to community care and supports.

Target Population: Adults, 18-59 years old, who were involved in the criminal justice system and have a severe mental illness (SMI).

FY 24/25 Program Budget: $491,281 **Cost per Client:** $14,887

How Much Did We Do?

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

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☐ **Chinese** ☐ **Korean** ☐ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☒ **We use the Language Line** ☐ **Other**: Click or tap here to list your language.

III. FY 23/24 Challenges:

Staffing/retention - In July 2023, RTT's long-time Clinical Program Supervisor transitioned out of La Familia, leaving the team without a leader. In August 2023, RTT's Lead Clinician transitioned into the Program Supervisor role to help keep the program afloat, but this left RTT without a FTE clinician to maintain a full caseload. RTT also lost one Peer Counselor in November 2023, but we were able to hire a new Peer Counselor to fill the open position in December 2023. After a year-long search, RTT was finally able to hire a full-time staff therapist this month, who is slated to start on September 16, 2024.

Housing - Housing continues to be the most urgent case management need for many RTT clients.

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However, even clients who have housing vouchers have struggled to find landlords willing to rent to them.

We also have many clients with severe PTSD symptoms, which preclude them from being open to shared housing/shelters. RTT has had to collaborate with other agencies who have pre-existing relationships with landlords/property management companies willing to rent to our clients in order to promote best outcomes, while also advocating directly with housing providers on our clients' behalf.

Psychiatric Evaluations – One quality objective on RTT's SOW is that at least 70% of clients receive a psychiatric assessment within 45 days of intake. This FY, 55% of our clients received a psychiatric assessment during their time in treatment, but only 18% did so within 45 days. The challenge with this measure is that many clients are hesitant to meet with a psychiatrist because they don't want to be "dependent" on meds and/or report a history of negative interactions with psychiatrists. It can take time for clients to build enough trust with staff to become open to a psychiatric assessment. Also, we want to point out that meeting this KPI would likely require a psychiatrist contracted for more than FTE .06.

Caseload capacity - Because RTT's FTE clinician transitioned into the Program Supervisor role in August 2023, RTT was unable to grow its caseload until a new clinical intern arrived, and even following that, openings were intentionally limited since RTT's staff therapist position has been vacant. To address this issue, we are shifting to a more integrated care model, equipping case managers with more active skill-building and motivational interviewing skills, so we can grow our caseload and still provide holistic support to clients as we await the arrival of 2 new MPTI interns and a full-time staff therapist in the Fall.

Low Productivity - The RTT scope of work states that we should provide a minimum of 1,817 total service hours annually. For the FY 23-24, RTT staff provided 1,085.67 total service hours, including 43.59 hours of medication support. This was largely due to the RTT Lead Clinician transitioning into the Supervisor role in August 2023, leaving RTT without a FTE clinician for the remainder of the fiscal year.

Funds for basic needs/support services - Given our low caseload this fiscal year due to lack of clinical staff, we did not experience the same funding concerns and challenges that we experienced in FY 22/23; however, as our caseload increases back up to 40 this year, we anticipate similar concerns may arise.

Is Anyone Better Off?

- In FY 23/24, 100% of new RTT clients had two or more treatment sessions within the first 30 days.
- In FY 23-24, 85% of RTT clients were successfully linked to community-based resources.

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IV. FY 23/24 Client Impact:

A 57-year-old African American male with a physical disability was referred to RTT by his social worker at the Public Defender's Office. At the time of his referral, the client reported a desire for support with family reunification, as well as assistance with addressing his housing challenges (his apartment had mold and ADA non-compliance issues that rendered it inhabitable). At the onset of treatment, the client demonstrated symptoms of anxiety (uncontrollable worry, ruminating), depression (self-isolation, social withdrawal, hopelessness, difficulty making decisions), and complex trauma (alienation, distrust, irritability, low frustration tolerance, impulsivity, mental inflexibility, and a negative worldview). He openly expressed distrust towards staff due to a long history of negative and traumatic experiences in other programs. His primary request before agreeing to work with RTT was for "transparency," an issue that had caused problems in the past, resulting in countless grievances filed against previous providers.

With that in mind, RTT was able to build a strong therapeutic alliance with the client by practicing clear communication and holding the client in unconditional positive regard. The client has consistently attended his case management and therapy sessions, up to three times a week some weeks when extra support has been needed. RTT has focused on helping the client develop social skills and coping skills for when he feels overwhelmed in public spaces. He recently celebrated his birthday with the RTT team at a restaurant near his home, and reported excitement to "feel like a member of society" and "be celebrated as a human by others." He also attended a Juneteenth event with his peer counselor with the goal of facing his fear of public spaces. At the event, he went around to every table, initiating conversations with community-resource providers that he can reach out to in the future. Since then, he has continued to develop more mental flexibility and self-advocacy skills, overcoming the discomfort of working with those he doesn't see eye to eye with in order to get his needs met. After 11 months of searching and many meetings with other providers that had to be mediated by RTT staff, the client is now preparing to sign a lease for a beautiful, fully ADA-compliant home! Now he can use his motorized wheelchair freely and can finally start to focus on his other goals. He reports feeling very excited to have a beautiful space for his daughter to visit him in the future.

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

FY 24/25	Given we have a full-time clinician starting in September 2024 and 2 interns joining RTT in the Fall, we expect that RTT will be able to bring our caseload up to an average of 40 clients
FY 25/26	If we can sustain our staffing, we should be able to continue serving an average of 40 clients

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 38

PROVIDER NAME: Alameda County Homeless Action Center (HAC)

PROGRAM NAME: Alameda County Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) Program Advocacy Services Project

Program Description: HAC Provides SSI/SSDI advocacy to increase the number of Alameda County residents facing moderate to severe mental health issues who are approved for SSI/SSDI benefits. (Formerly known as program number FSP 7)

Target Population: Individuals with moderate to severe mental and individuals released from or about to be released from Santa Rita Jail, Glenn Dyer Detention Facility, or the State prison system.

FY 24/25 Program Budget: $932,817 **Cost per Client:** $1,727

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 540 Adult clients in 556 SSI/SSDI cases

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☒ **Chinese** ☒ **Korean** ☒ **Vietnamese** ☐ **Tagalog** ☒ **Farsi**
☒ **We use the Language Line** ☒ **Other**: We have staff who can communicate in Cambodian/ Khmer, Arabic, Hindi, Punjabi, Urdu, French, and Portuguese

III. FFY 23/24 Challenges:

Continued slowness and unresponsiveness from SSA offices – impacts the same as in prior years. As the FY ends, we have some welcome new challenges. We are adjusting to an increased demand for in person visits to relatively remote locations in the county. This is a welcome challenge, because it is the result of the jails finally being open for in person visits from our staff. These have been off-limits since COVID. Also, we have a new partnership where we do intakes onsite at an inpatient behavioral healthcare facility stared just at the end of this FY.

Is Anyone Better Off?

IV. FY 23/24 Client Impact:

Clients were awarded benefits in 50% of the cases we closed in FY 2024, an increase over last year, where closed cases only resulted in an allowance 40% of the time.

One such client is **JF**. Referred to us by the Alameda County Forensic Behavioral Health team at Santa Rita Jail, JF was 48 at the time of referral and had never received mental health care in the

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community – only in jail. HAC reached out to him, did an intake via video interviews, and started an SSI application on his behalf. We made an appointment for JF to meet his attorney at our office upon his release from jail, but he did not show up. In fact, he did not show up at our office for the next 14 months. However, we were able to get in touch with him on several occasions when he was in jail again during this period, and we pursued appeals when his claim was denied for failure to follow through.

The medical records documenting JF's schizophrenia - while incarcerated only - were not enough to prove disability, so to succeed in getting benefits for JF, we needed to get him into medical treatment or at least an evaluation while he was on the outside. But we couldn't even get him into our office.

JF finally made it to HAC at a time when his attorney was not expecting him and couldn't meet with him, but with encouragement and bus tickets he returned, and retuned again. He continued to come back repeatedly for the next few weeks, allowing us the time to build some rapport, and to get him assessed for the waiting list for supportive housing and for outpatient mental health treatment. But months later when SSA was ready to schedule a hearing in JF's case, we again could not find him. To comply with SSA hearing office procedures, we had to withdraw from the case.

JF next showed up at our office almost a year later. We contacted SSA and found that the judge's denial – issued after JF failed to appear at his hearing -- had only been a month prior. Thus, we had not yet missed the statutory deadline to attempt to proceed with the existing case instead of starting over.

During the ensuing months while the appeal we filed was pending, JF did a fair job of staying in touch and his attorney became better at finding him too. The attorney drove JF to at least half a dozen mental health appointments, providing bus tickets or Lyft rides as his confidence in JF's ability to attend on his own increased. JF's attorney worked with JF's clinicians to get records of treatment and opinions about his ability to function. JF neared the top of the queue for supportive housing about the time of his rescheduled hearing -- now over three years since he was first referred to us. He was in Safe Haven transitional housing – the final step before moving into a permanent housing placement – when his hearing occurred, so JF's attorney now knew exactly where to find him.

JF is now in permanent supportive housing. The SSI he is now receiving allows him to meet the subsidized rent obligation with a modest amount left over each month. The thousands of dollars of retroactive pay he received because HAC pursued an appeal instead of starting over with a new SSI claim allowed him to completely furnish the unit. He remains in outpatient treatment, and he has not been back to jail.

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

FY 24/25	580
FY 25/26	600

> Go back to OESD Report Titles

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 38

PROVIDER NAME: Bay Area Legal Aid (BayLegal)

PROGRAM NAME: Alameda County Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) Program Advocacy Services Project

Program Description: BayLegal Provides SSI/SSDI advocacy to increase the number of Alameda County residents facing moderate to severe mental health issues who are approved for SSI/SSDI benefits. (Formerly known as program number FSP 7)

Target Population: Individuals with moderate to severe mental and individuals released from or about to be released from Santa Rita Jail, Glenn Dyer Detention Facility, or the State prison system.

FY 24/25 Program Budget: $666,409 **Cost per Client:** $2,207

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 302 Adults

How Well Did We Do?

II. Language Capacity for this Program:

☒ **English** ☒ **Spanish** ☒ **Chinese** ☐ **Korean** ☒ **Vietnamese** ☐ **Tagalog** ☐ **Farsi**
☐ **We use the Language Line** ☒ **Other**: BayLegal uses an interpretation service that covers 200+ languages in addition to the languages for which we have in-house coverage.

III. FY 23/24 Challenges:

The Social Security Administration (SSA) and the state Disability Determination Service (DDS) remain understaffed resulting in delays in the processing of applications and appeals and a backlog of pending cases. In particular, the DDS backlog has increased dramatically over the last year, resulting in an average processing time of 200-230 days from the time a case reaches DDS. Because it can take several months for the SSA Field Office to process a case and send to DDS, it is routinely taking one year or more from the time of filing an initial application or a request for reconsideration to the time we finally receive a decision. This significant delay has hindered our ability to close cases and open new ones.

> Go back to OESD Report Titles

Additionally, staff turnover and leaves of absence in late 2023 and early 2024 resulted in lower caseloads for the first half of 2024 as we hired, onboarded, and trained new staff. We are now fully staffed and are aiming for increased capacity for new clients and higher caseloads over the coming months.

Is Anyone Better Off?

BHCS data[1] has previously shown that people who qualify for SSI or Social Security disability benefits experience increased housing stability and are less likely to experience homelessness, incarceration, hospitalization, or need psychiatric emergency services. Formerly incarcerated people are 10 times more likely to experience homelessness than the general population[2]. 70% of people experiencing homelessness in California are formerly incarcerated[3]. The BHCS SSI Advocacy Trust model helps to break this cycle of incarceration and homelessness.

IV. FY 23/24 Client Impact:

Client Success Story 1: BayLegal first met TB in 2015, when she was 56 years old, and helped her file an initial SSI application. At the time, TB was street homeless and suffering from untreated Bipolar and PTSD and addiction after years of abuse at the hands of family, sex traffickers, and intimate partners. BayLegal helped connect TB with psychotherapy, psychiatric medication management, case management, addiction treatment, and primary care. TB's SSI claim went to hearing and was denied in 2017 on the unsupported basis that her drug addiction was material to her disability, even though she had been clean and sober for nearly two years at the time of the decision. BayLegal appealed TB's case to district court and simultaneously helped her file a subsequent SSI application in November 2018. While TB's district court appeal was still pending, her subsequent SSI application was approved in May 2019. In March 2020, BayLegal received a favorable judgment from district court, remanding her claim for a new hearing to determine disability from her initial application date in November 2014 through the established onset of her subsequent claim in November 2018. Due to delays related to the COVID-19 pandemic and SSA hearing office staffing turnover, TB's remand hearing was not held until February 2022 in front of an ALJ with a notoriously low approval rate. It was a contentious hearing and the ALJ requested additional development. BayLegal was able to get in contact with TB's former (and now retired) psychologist, who had treated TB several years earlier, and obtain a letter from him that addressed the ALJ's concerns. In the meantime, BayLegal's housing navigator helped TB get document ready and she was matched with several housing sites. A supplemental hearing was

[1] See, e.g., https://www.acgov.org/probation/documents/SSIAdvocacy_Program&ServicesMeeting_3-22-2018.pdf

https://www.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/172/2019/09/Improving-Effectiveness-of-SSI-SSDI-Advocacy-Program-for-Jail-Incarcerated-Populations-Policy-Brief.pdf

[2] https://www.prisonpolicy.org/reports/housing.html

[3] https://wclp.org/as-california-closes-prisons-we-must-protect-people-who-were-incarcerated-from-falling-into-homelessness/

> Go back to OESD Report Titles

held in April 2023, and we finally received a fully favorable decision on her remanded claim shortly thereafter. However, due to SSA delays and staffing shortages, BayLegal had to advocate with SSA to issue a correct Notice of Award, which was finally issued in October 2023. The same week that TB received her first installment of SSI backpay in November 2023, BayLegal's housing navigator helped her move into her new apartment in permanent supportive housing.

Client Success Story 2: Our office represented PM for almost five years through various applications and levels of appeal, during which time he was incarcerated at Santa Rita Jail and San Quentin. More specifically, our office appealed the ALJ's determination at the initial hearing that client could go back to his prior caretaker work based on his physical impairments only, without considering his significant mental impairments stemming from Schizophrenia, Depression, and PTSD. The Appeals Council remanded PM's case for an additional hearing. In waiting for the remand hearing, PM suffered a stroke which resulted in a Neurocognitive Disorder and further memory and concentration problems. After the remand hearing, in which expert testimony was obtained from an internist and a psychologist, the ALJ awarded SSI and SSDI benefits going back multiple years to the time PM was released from jail.

Client Success Story 3: BayLegal has been working with JD since 2015. He had originally received assistance from BOSS at the initial and reconsideration stages, until they referred him to us. JD suffers from Major Depressive Disorder, Social Anxiety Disorder, and a Learning Disability and receives treatment from Lifelong Medical Care and Bay Area Community Services. We had his original hearings in 2016 and 2017, which resulted in an unfavorable decision. BayLegal appealed his case to the Appeals Council and then Federal District Court, where we received a remand in 2020. JD had his subsequent ALJ hearing in July 2023 and received a fully favorable decision in August 2023, meaning he will receive backpay back to 2015. Over the nine years working with JD, BayLegal has also assisted him with public benefits and housing issues. He is currently in Section 8 housing and receiving SSDI benefits.

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

FY 24/25	270
FY 25/26	240

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Prevention and Early Intervention (PEI)



The Prevention and Early Intervention (PEI) services embrace a preventative approach that engage individuals before the development of mental illness and provides services to intervene early to reduce negative mental health symptoms to reduce prolonged suffering. PEI services emphasize the development, implementation, and promotion of strategies that are non-stigmatizing and non-discriminatory.

The *Prevention and Early Intervention* (PEI) services embrace a preventative approach that engage individuals before the development of mental illness and provides services to intervene early to reduce negative mental health symptoms to reduce prolonged suffering. PEI services emphasize the development, implementation, and promotion of strategies that are non-stigmatizing and non-discriminatory.[1]

PEI programs create partnerships with unserved and underserved ethnic and linguistically isolated communities, schools, the justice system, primary care and a wide range of social, wellness, cultural and spiritual support services and community groups. Services are centrally located where people receive and participate in routine health care, wellness, leisure, educational, recreational, faith, and spiritual healing.

PEI Plan Requirements: The PEI Community Planning Process requires local stakeholders to recognize the following parameters for this funding stream:

- All ages must be served and at least 51% of the funds must serve children and youth ages 0-25 years.
- Disparities in access to services for underserved ethnic communities must be addressed.
- All regions of the county must have access to services.
- Early intervention should generally be low-intensity and short duration.
- Early intervention may be somewhat higher in intensity and longer in duration for individuals experiencing first onset of psychosis associated with serious mental illness.

Service Requirements: Individuals at risk of or indicating early signs of mental illness or emotional disturbance and links them to treatment and other resources. [2]

PEI strategies & Approaches:

- *Outreach* to families, employers, primary care health providers, and others to recognize the early signs of potentially severe and disabling mental illness. The goal is to catch mental health issues in their earliest stages to prevent long-term suffering.
- *Access and linkage* to medically necessary care…as early in the onset of these conditions
- *Reduction in stigma and discrimination* associated with either being diagnosed with a mental health condition or seeking mental health services (MHSA, Section 4, Welfare and Institutions Code (WIC) § 5840(b).
- Prevention and Early Intervention to promote wellness and to foster health, to provide treatment when needed, and to prevent the suffering that can result from untreated mental illness.

1 Proposition 63: Mental Health Services Act 2004
2 MHSOAC PEI Fact Sheet, December 2017

Mental Health Services Oversight & Accountability Commission (MHSOAC) established priorities for the use of County's 2020-2023 Prevention and Early Intervention funds[3]:

• **Childhood trauma prevention and early intervention**, as defined in Section 5840.6(d), address the early origins of mental health needs.

• **Early psychosis and mood disorder detection and intervention**, as defined in Section 5840.6(e), and mood disorder and suicide prevention programming that occurs across the lifespan.

• **Youth outreach and engagement** strategies, as defined in Section 5840.6 (f), that target secondary school and transition age youth, with a priority on partnerships with college mental health systems.

• **Culturally competent and linguistically appropriate prevention and early intervention** as defined in Section 5840.6(g).

• Strategies targeting the mental health needs of **older adults** as defined in Section 5840.6(h).

• **Early identification programming of mental health symptoms and disorders**, including but not limited to anxiety, depression, and psychosis.

Referral Process: Non-clinical PEI programs receive clients through provider outreach and engagement. Outreach is based on location, service geography, staffing capacity, cultural needs, and preferences of the target populations.

Outcomes: PEI programs focus on reducing seven negative outcomes that may result from untreated mental illness: suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes

3 MHSOAC Memo, January 30, 2020

Prevention and Early Intervention Strategies and Priorities[4]

Build protective factors; reduce risk factors for developing a SMI. Improve mental health for people with a greater than average risk of SMI.	***PREVENTION***
CHILDHOOD TRAUMA	Prevention and early intervention to deal with the early origins of mental health needs.
MH treatment, including relapse prevention, to promote recovery for a mental illness early in emergence.	***EARLY INTERVENTION***
EARLY PSYCHOSIS & MOOD DISORDERS	Detection and intervention and mood disorder and suicide prevention programming that occurs across the lifespan.
Engage/train potential responders to recognize and to respond to early signs of a severe and disabling mental illness.	***OUTREACH***
YOUTH OUTREACH AND ENGAGEMENT	Strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs.
Activities that reduce negative feelings, attitudes, beliefs, perceptions and/or discrimination related to MH diagnosis or to seeking MH services.	***STIGMA & DISCRIMINATION REDUCTION***
CULTURE AND LANGUAGE	Culturally competent and linguistically appropriate prevention and intervention.
Activities to connect people with SMI to medically necessary early care and treatment.	***ACCESS & LINKAGE TO TREATMENT***
OLDER ADULTS	Strategies targeting the mental health needs of older adults.
Activities that the County undertakes to prevent MH-related suicide. May be part of Prevention or Early Intervention program.	***SUICIDE PREVENTION***
EARLY IDENTIFICATION	Prevention and early intervention to deal with the early origins of mental health needs.

4 The figure above represents both the PEI strategies documented in the California Code of Regulations (CCR) and the priorities enshrined through SB 1004 *priorities enshrined through SB 1004 to which all counties must adhere*.

Prevention and Early Intervention Strategies and Priorities[4]

Build protective factors; reduce risk factors for developing a SMI. Improve mental health for people with a greater than average risk of SMI.	***PREVENTION***
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EARLY PSYCHOSIS & MOOD DISORDERS	Detection and intervention and mood disorder and suicide prevention programming that occurs across the lifespan.
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EARLY IDENTIFICATION	Prevention and early intervention to deal with the early origins of mental health needs.

[4] The figure above represents both the PEI strategies documented in the California Code of Regulations (CCR) and the priorities enshrined through SB 1004 *priorities enshrined through SB 1004 to which all counties must adhere.*

% Of PEI programs with a focus in each priority area:

(Most programs have multiple priorities.)

CHILDHOOD TRAUMA	**20.51%**
EARLY PSYCHOSIS/MOOD DISORDERS	**0**
YOUTH OUTREACH & ENGAGEMENT	**66.66%**
CULTURE AND LINGUISTIC	**69.23%**
OLDER ADULTS	**38.40%**
EARLY IDENTIFICATION	**69.23%**

PEI Participant Satisfaction and Pre-Post Health Assessment Surveys

Alameda County's Mental Health Services Act (MHSA) Division collaborated with Prevention and Early Intervention (PEI) and Underserved Ethnic Language Population (UELP)5 programs to create optional, electronic, outcome-based surveys (Participant Satisfaction and UELP Pre-Post Health Assessment) aimed at gathering feedback from PEI/UELP participants who have received services (4 or more services for UELP participants, including preventive counseling, community events, workshops, support groups, prevention visits and any services for PEI participants) through MHSA-funded programs.

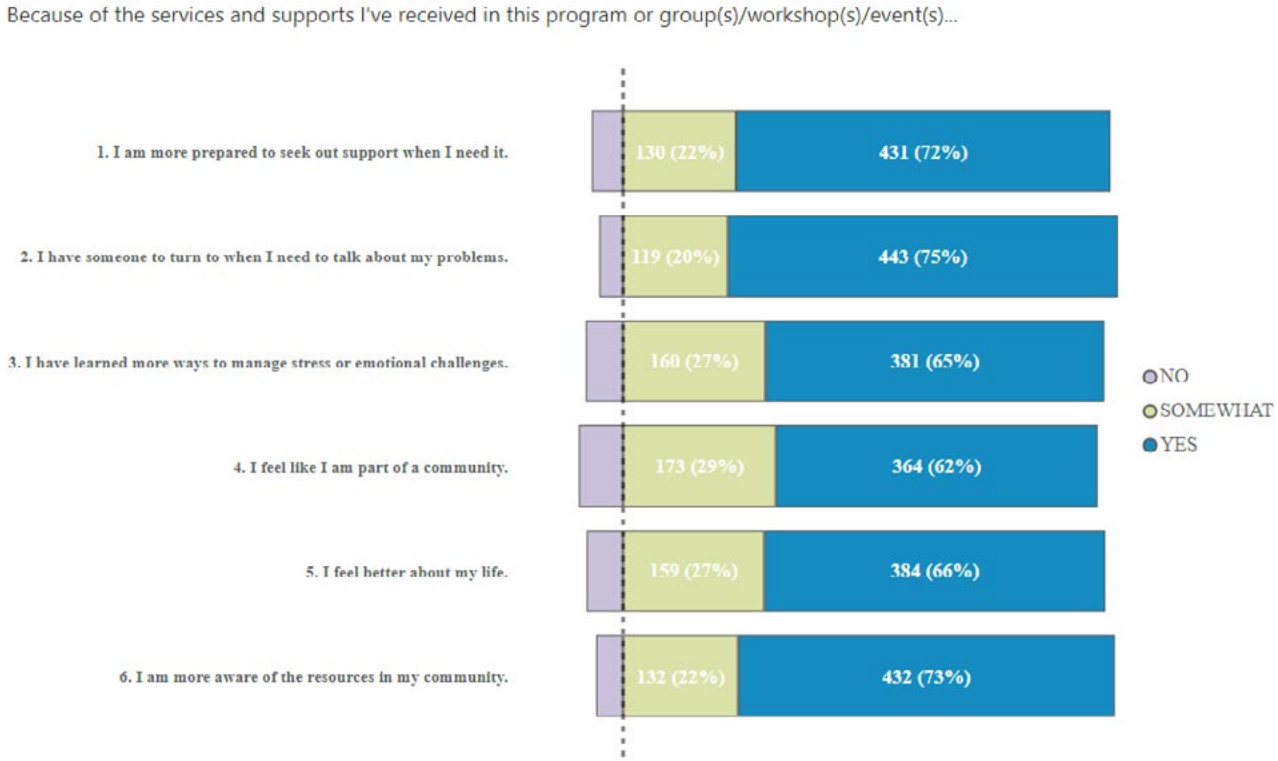
First developed in 2014 and administered in 2015, the survey has undergone multiple revisions from 2016 to 2023. UELP providers vetted, implemented each updated version, and ensured accessibility and equity through language justice by translating the survey into 23 languages. In early 2024, UELP providers participated in a workgroup to evaluate the survey tool, concluding that it would remain unchanged, with updates limited to translation only.

The following data reports focus on key domains such as identity formation, mental health perceptions, community wellness, cultural connections, resource access, transformation of mental health services, and workforce development. Ultimately, we aim to identify strengths and areas for expansion in our services, ensuring we meet the community's and provider's needs as effectively as possible

Providers collected 1412 Participant Satisfaction surveys during the 2024 assessment period. Providers collected 254 completed pre-post Health Assessment surveys during the 2024 assessment period. Outcome data from the Participant Satisfaction and from the Health Assessment surveys appears below.

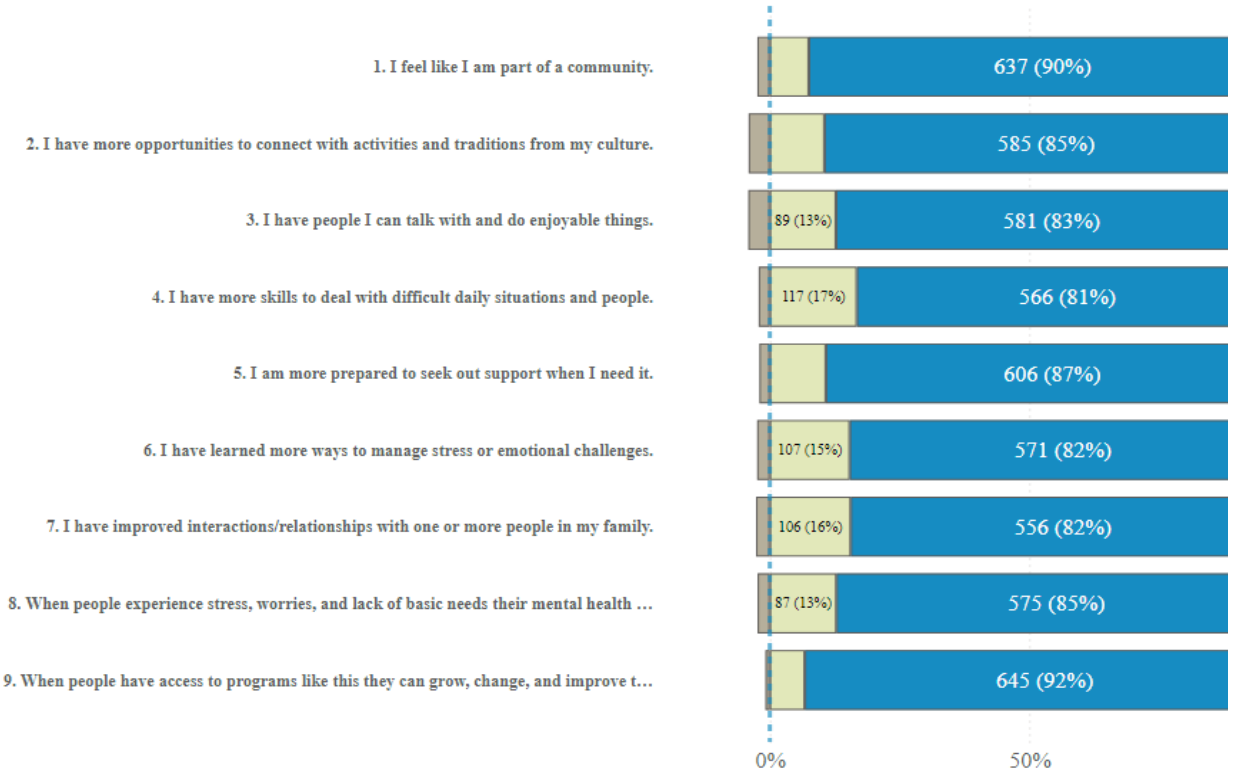
Providers collected 1552 Participant Satisfaction surveys during the 2023 assessment period. Providers collected 173 completed pre-post Health Assessment surveys during the 2023 assessment period. Outcome data from the Participant Satisfaction and from the Health Assessment surveys appears below (please see the full PEI Report in the Appendix D-4 for additional survey data):

PEI Participant Satisfaction Survey Results



Participant Satisfaction survey data indicates that PEI (non-UELP) programs significantly support participants **to have someone to talk to about problems** (75%). Programs further support participants to be **more aware of community-based support resources** (73%) and to be **prepared to seek needed support** (72%). Participants have learned more **ways to manage stress and challenges** (65%), to **feel better about their lives** (66%), and to **feel like a part of community** (62%).

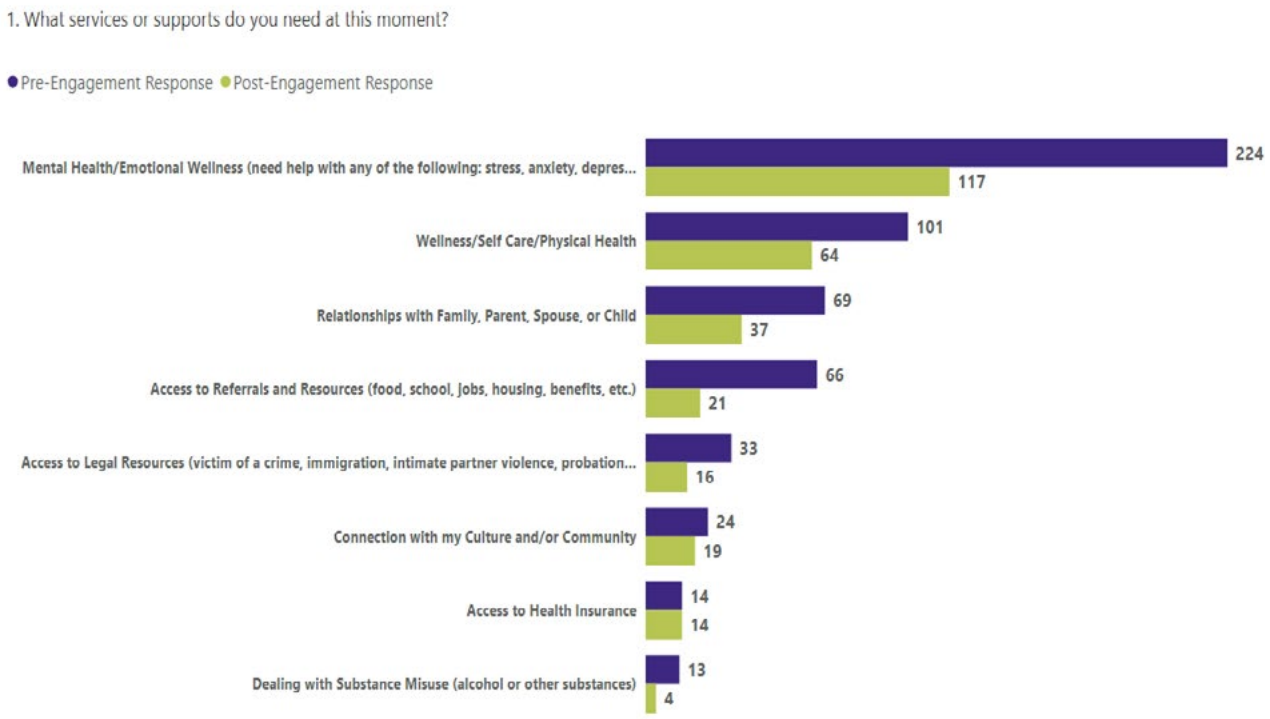
UELP Participant Satisfaction Survey



UELP program participants report a high level of **understanding of the impact of stress and worry on mental wellness** (85%) and a very high level of understanding about **how UELP programs can improve wellness and mental health** (92%). Additionally, these programs significantly support participants to **feel like they are part of community** (90%) and to **connect more with traditions and culture** (85%). The UELP model centers and deeply values ethnicity and language as the primary channel to reach, to build relationships with, and to serve participants. These programs also show significant outcomes in **helping participants to feel more prepared to seek help** (87%) and to **manage stress and emotional challenges** (82%).

Strengths across PEI and UELP programs include support for participants to seek help when they need it and to have people in their lives they can turn to, providing key protective factors for mental wellbeing. Growth opportunities for PEI (non-UELP) programs include increasing support for participants to manage stress and challenges, to feel like part of community, and to feel better overall about life.

UELP Pre/Post Health Assessment Survey



UELP Pre/Post Health Assessment survey data indicates that participant's **need for mental health and emotional wellness services and support was reduced** by 52.2% (pre = 224/post = 117) after receiving services. Significant reductions in needs as a result of receiving services are also shown in other areas, including a 53.6% reduction in **needs for services related to relationships with family, parent, spouse, or child** (pre = 69/post = 37); a 63.4% reduction in n**eeds for services related to overall wellness and health** (pre = 101/post = 64), and a 32% reduction in n**eeds for services related to access to referrals and resources** (pre = 66/post = 21).

Prevention and Early Intervention Summaries[6]

Below are summary descriptions for each MHSA funded prevention and early intervention program. For additional information please see the Annual PEI Report in Appendix D.

PEI: PREVENTION

PEI 1A Blue Skies Mental Wellness Team 326
PEI 1D La Familia Counseling Services 334
PEI 5 Cultura y Bienestar (La Clinica De La Raza) 339
PEI 6 Asian Health Services (AHS) 345
PEI 6 Bay Area Community Health (BACH) 350
PEI 6 Center for Empowering Refugees and Immigrants CERI 355
PEI 6 Korean Community Center of the East Bay (KCCEB) 361
PEI 6 Richmond Area Multi-Services, Inc. (RAMS) 369
PEI 7 Afghan Coalition 374
PEI 7 Afghan Path Toward Wellness - International Rescue Committee (IRC) 379
PEI 7 Filipino Advocates for Justice 383
PEI 7 The Hume Center 388
PEI 8 Native American Health Center (NAHC) 394
PEI 9 Diversity in Health Training Institute (DHTI) 399
PEI 10 Partnership for Trauma Recovery (PTR) 403

PEI: ACCESS AND LINKAGE

PEI 1B Center for Healthy Schools and Communities (CHSC) 417

PEI OUTREACH

PEI 19 Older Adult Peer Support City of Fremont 421
PEI 19 Pacific Center for Human Growth LGBT Services - Older and Out 427
PEI 20C Mental Health Association of Alameda County AAFOP 431
PEI 22 Pacific Center for Human Growth Mentorship 436
PEI 22 Pacific Center for Human Growth Technical Training Assistance 440
PEI 26 HHREC – 10X10 Wellness Campaign 445
PEI 27 HHREC Health Through Art & Black Women's Media Project 451
PEI 28 HHREC Downtown TAY 461

PEI EARLY INTERVENTION

PEI 1C A Better Way Early Childhood Mental Health Outreach and Consultation 466
PEI 22 Side by Side LGBT Support Services 467
PEI 3 Alameda County Behavioral Health Department Geriatric Assessment Response Team (GART) 468
PEI 17B Healthy Schools and Community REACH Ashland Youth Center 473
PEI 24 Roots Community Health Sobrante Park Community Project 477
PEI 17A Youth Uprising TAY 482

[6] For more information on Prevention & Early Intervention see the PEI Annual Report in the Appendix D-1

PEI: STIGMA AND DISCRIMINATION REDUCTION PROGRAMS

PEI 4 Peers Envisioning and Engaging in Recovery Services (PEERS) 486

PEI: SUICIDE PREVENTION

PEI 12 Crisis Support Services of Alameda County Community Education 491
PEI 12 Crisis Support Services of Alameda County Text Line Program 496
PEI 12 Crisis Support Services of Alameda County Trauma Informed Counseling 500
Prevention and Early Intervention: Clients Served by Age Group 505

MHSA Program #	**PEI 1A**
PROVIDER NAME	**Blue Skies Mental Wellness Team**
PROGRAM NAME	**Alameda County Department of Public Health-FHS**

2023-2024

Program Outcomes & Impact Data Report

Program Name:	**Alameda County Department of Public Health**
Organization:	**Alameda County**
Type of Report:	**Annual Data Report**
PEI Category:	**Prevention**

Priority Area (place an X next to all that apply):	
X	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.	
X	Suicide
	Incarceration
	School failure or dropout
X	Unemployment
X	Prolonged suffering
X	Homelessness
X	Removal of children from their homes

Box A: Brief program description.

BSMWT was established in 2015 through a collaboration between the Behavioral Health Department, First 5 Alameda County, and the Public Health Department (ACPHD), with support from the federal Project LAUNCH grant. The program was designed to integrate mental health prevention and early intervention efforts within the Maternal, Paternal, Child, and Adolescent Health (MPCAH) unit. This integration provides home visiting programs with mental health consultation for direct service providers and direct mental health interventions for pregnant women and parents specifically addressing perinatal mood disorders, attachment needs and trauma. Additionally, the Blue Skies program provides access to the Early Childhood Mental Health System of Care and establishes connections to treatment services within Alameda County BHD.

> Go back to PEI Summaries list

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	0
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	42
Number of unduplicated individual family members served indirectly by your program:	109
Grand total of unduplicated individuals served:	151

Box C: Demographics of individuals served this fiscal year through MHSA funding:			
AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	70	Gay/Lesbian	0
Transition Age Youth (16-25 yrs.)	30	Heterosexual/Straight	0
Adult (26-59 yrs.)	51	Bisexual	0
Older Adult (60+ yrs.)	0	Questioning/Unsure	0
Declined to answer	0	Queer	0
Unknown	0	Declined to answer	0
TOTAL	151	Unknown	151
		Another group not listed	0
		TOTAL	151
		If another group is counted, please specify with numbers: *Sexual orientation not collected in database at this time.	
VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes	0	English	122
No	0	Spanish	29
Declined to answer	0	Cantonese	0
Unknown *Veteran status not collected in database	151	Chinese	0
TOTAL	151	Vietnamese	0
		Farsi	0
CURRENT GENDER IDENTITY		Arabic	0
Female	109	Tagalog	0
Male	0	Declined to answer	0
Transgender	0	Unknown	0
Genderqueer	0	Other languages not listed	0
Questioning/unsure of gender identity	0	TOTAL	151
Declined to answer	0		
Unknown *Gender identity not collected on minors 0-5 years old	42		

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Another identity not listed	0	
TOTAL	151	
If another group is counted, please specify with numbers:		

SEX ASSIGNED AT BIRTH		ETHNITICY/CULTURAL HERITAGE (choose one)	
Male	19	If Hispanic or Latino, please specify:	
Female	132	Caribbean	0
Declined to answer	0	Central American	14
Unknown	0	Mexican/Mexican American/Chicano	22
TOTAL	151	Puerto Rican	0
Male		South American	0
		Another Hispanic/Latino ethnicity not listed	42
DISABILITY STATUS		Total Hispanic or Latino	78
Communication Domain		If Non-Hispanic or Non-Latino, please specify:	
Vision	4	African	0
Hearing/Speech	0	African American	58
Another type not listed	0	Asian Indian/South Asian	0
Communication Domain Subtotal	4	Cambodian	0
Disability Domain		Chinese	0
Cognitive (exclude mental illness; include learning, developmental, dementia, etc.)	0	Eastern European European Filipino	Filipino – 2
Physical/mobility	0	Japanese	0
Chronic health condition	0	Korean	0
Disability Subtotal	0	Middle Eastern	0
None	143	Vietnamese	0
Declined to answer	0	Other Non-Hispanic or Non-Latino ethnicity not listed Asian, Unknown Native Hawaiian or Pacific Islander	8
Unknown	0	Total Non-Hispanic or Non-Latino:	68
Another disability not listed: Medically Fragile Infants served by ACPHD Special Start team	4	More than one ethnicity	4

> Go back to PEI Summaries list

TOTAL	151	Unknown ethnicity	1
If another disability is counted, please specify with numbers:		Declined to answer	0
		ETHNICITY TOTAL	151
RACE		If another ethnicity is counted, please specify with numbers: Other Non-Hispanic or Non-Latino ethnicities were Native Hawaiian or Pacific Islander, and Asian-unspecified.	
American Indian or Alaska Native	0	If another race is counted, please specify with numbers: Clients who identify as "Unknown" are mostly of Hispanic ethnicity, and do not usually report race. Other Race – Multi-racial, does not identify primarily as one race.	
Asian	8		
Black or African American	44		
Native Hawaiian or another Pacific Islander	4		
White	10		
Other Race	2		
Declined to answer	0		
Unknown	83		
TOTAL	151		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

Program Successes/Accomplishments of the Past Fiscal Year:

1. Enhanced Staff Training: All team members completed advanced training in perinatal mental health and trauma-informed care.
2. Improved Client Outcomes: 85% of clients reported reduced anxiety and depression symptoms after four months of therapy.
3. Team Expansion: In March 2024, Angela Polk, LMFT, a Blue Skies contractor, joined as a full-time permanent Blue Skies II clinician funded by the federal Health Start grant and who will help expand the client base.
4. Culturally Tailored Interventions: The BSMWT utilized Afrocentric treatment modalities, expanded Spanish-speaking services, created bilingual resources, and conducted outreach to improve accessibility.
5. Professional Support: Case consultation and reflective supervision were provided for staff by the BSMWT to support their professional wellness.
6. Community Partnerships: Partnerships with community organizations were expanded to offer a more comprehensive support network for clients.

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Case Study of a Success the Agency is Particularly Proud Of:
A 28-year-old African American first-time mother was referred during her second trimester. She faced severe anxiety, childhood trauma history, and concerns about racial disparities in maternal healthcare. Feeling overwhelmed, she received weekly counseling, culturally relevant prenatal education, and support from an African American doula. The program also provided postpartum support and healthcare coordination. By her baby's first birthday, she reported improved mental health, greater parenting confidence, and better healthcare system navigation. She bonded with her child, adopted healthy coping strategies, and became an advocate for African American maternal health. This case highlights the program's success in addressing racial disparities, providing mental health support, and empowering participants.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	2 clients were referred to Mental Health Treatment by BSMWT Staff in FY 23-24. The referrals breakdown by agency: 1 - North American Mental Health Services 2 - Individual social worker/therapist 1 - ACCESS 1 - La Familia
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	see above cell for breakdown
E.3: Types of treatment individuals were referred to (list types below):	
Psychiatric evaluation, therapy for anxiety, crisis intervention, alcohol/drug addiction, support after infant loss, couples therapy	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	9
G.5: Average duration of untreated mental illness in weeks:	14 days
E.6: Average number of days between referral and first participation in referred treatment program:	14 days
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
African American/Black birthing and parenting women, Hispanic/Latinx birthing and parenting women, Medi-Cal population.	
F.2: Number of paper referrals to an ACBH PEI-funded program:	54
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	151

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F.4: Average number of days between referral and first participation in referred PEI program:	5 days
F.5: Describe how your program encouraged access to services and follow through on above referrals: The Program supervisor called each referral to explain services and address questions.	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	**Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):**
	Simone Taylor, Behavioral Health Clinician II
	Yesenia Chavez, Behavioral Health Clinician I

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Each UELP program is built on a framework of three core strategies: *1) Outreach & Engagement, 2) Mental Health Consultation, and 3) Early Intervention service*s. These strategies are implemented through a variety of services, including one-on-one outreach events; psycho-educational workshops/classes; mental health consultation sessions with a variety of stakeholders (e.g., families, teachers, faith community, and community leaders); support groups; traditional healing workshops; radio/television/blogging activities; and short-term, low-intensity early intervention counseling sessions for individuals and families who are experiencing early signs and symptoms of a mental health concern.

To address its diversity, Alameda County Behavioral Health Care Services (ACBH) has contracted fourteen programs to provide culturally responsive Mental Health PEI services to state-identified underserved populations, including:

- Afghan Coalition
- Asian Health Services
- Bay Area Community Health
- Center for Empowering Immigrants & Refugees
- Diversity in Health Training Institute
- Filipino Advocates for Justice
- International Rescue Committee
- Korean Community Center of the East Bay
- La Familia Counseling Services
- Native American Health Center
- Partnerships for Trauma Recovery
- Portia Bell Hume Center
- Richmond Area Multi-Service, Inc.

UELP providers offer services in two main categories: 1) *Prevention* services, for clients who are at higher-than-average risk of developing a significant mental illness and 2) *Preventive Counseling (PC)* services, designed for clients who are showing early signs and symptoms of a mental health concern. UELP programs design and deliver services across the following outcomes:

- Forming and Strengthening Identity
  Prevention services enhance self-efficacy.
- Changing Individual Knowledge and Perception of Mental Health Services
  UELP programs are meant to raise awareness and understanding of mental health services and, in turn, decrease internalized stigma.
- Building Community and Its Wellness

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UELP providers continue to create opportunities for clients to build new friendships and support systems within their programs.

- Connecting Individual and Family with Their Culture
  UELP services aim to bolster the connection clients have with their culture by utilizing their cultural norms as a bridge to provide services, including using traditional practices, celebrations, and validations in program activities.

- Improving Access to Services and Resources
  Monolingual or LEP (Limited English Proficiency) populations may experience challenges of navigating the behavioral health care system and accessing services or resources, particularly when they are in need or in crisis. This is extremely important because barriers to access can lead to increased stress, anxiety, isolation, depression, and other mental health concerns.

- Transforming Mental Health Services
  UELP service agencies are determined to provide transformative mental health services. The idea is to move away from the "one size fits all" approach to mental health, emphasizing the use of culturally congruent mental health methods and sensitivities.

- Increase Workforce and Leadership Development
  This outcome is an emerging area of support for mental wellness as the connections between stable employment and mental wellness continue to be emphasized and appreciated by providers and program participants alike.

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MHSA Program #	**PEI 1D**
PROVIDER NAME	**La Familia**
PROGRAM NAME	**Caminos/ Unaccompanied Immigrant Youth**

2023-2024

Program Outcomes & Impact Data Report

Demographic data for this provider is embedded in the demographic data for La Clinica de la Raza, PEI 5.

Program Name:	**Caminos/ Unaccompanied Immigrant Youth**	
Organization:	**La Familia Counseling Services**	
Type of Report:	**Annual Data Report**	
PEI Category:	**Prevention**	
Priority Area (place an X next to all that apply):		
		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach & Engagement
	X	Cultural & Linguistic
		Older Adults
	X	Early Identification of MH Illness
Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.		
	X	Suicide
		Incarceration
	X	School failure or dropout
		Unemployment
	X	Prolonged suffering
		Homelessness
	X	Removal of children from their homes

Box A: Brief program description.
Unaccompanied immigrant youth are minors who undertake perilous journeys across borders to escape extreme violence, traumatic experiences, and economic hardship in their home countries. The Caminos team offers linguistically and culturally responsive, trauma-informed services. These include outreach and preventative counseling, stabilization, early identification of mental health issues, and connections to various resources and support systems. Our approach is tailored to the unique needs of this population, particularly in navigating the challenges of acculturation and new systems.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	154
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	9
Number of unduplicated individual family members served indirectly by your program:	76
Grand total of unduplicated individuals served:	239

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Box C: Demographics of individuals served this fiscal year through MHSA funding:			
AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)		Gay/Lesbian	
Transition Age Youth (16-25 yrs.)		Heterosexual/Straight	
Adult (26-59 yrs.)		Bisexual	
Older Adult (60+ yrs.)		Questioning/Unsure	
Declined to answer		Queer	
Unknown		Declined to answer	
TOTAL		Unknown	
		Another group not listed	
		TOTAL	
		If another group is counted, please specify with numbers:	
VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes		English	
No		Spanish	
Declined to answer		Cantonese	
Unknown		Chinese	
TOTAL		Vietnamese	
		Farsi	
CURRENT GENDER IDENTITY		Arabic	
Female		Tagalog	
Male		Declined to answer	
Transgender		Unknown	
Genderqueer		Other languages not listed	
Questioning/unsure of gender identity		TOTAL	
Declined to answer			
Unknown			
Another identity not listed			
TOTAL			
If another group is counted, please specify with numbers:			
SEX ASSIGNED AT BIRTH		**ETHNITICY/CULTURAL HERITAGE (choose one)**	
Male		**If Hispanic or Latino, please specify:**	
Female		Caribbean	
Declined to answer		Central American	
Unknown		Mexican/Mexican American/Chicano	
TOTAL		Puerto Rican	
Male		South American	
		Another Hispanic/Latino ethnicity not listed	
DISABILITY STATUS		**Total Hispanic or Latino**	

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Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision		African	
Hearing/Speech		African American	
Another type not listed		Asian Indian/South Asian	
Communication Domain Subtotal		Cambodian	
Disability Domain		Chinese	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)		Eastern European	
		European	
		Filipino	
Physical/mobility		Japanese	
Chronic health condition		Korean	
Disability Subtotal		Middle Eastern	
None		Vietnamese	
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	
Unknown		**Total Non-Hispanic or Non-Latino:**	
Another disability not listed		More than one ethnicity	
TOTAL		Unknown ethnicity	
		Declined to answer	
		ETHNICITY TOTAL	
If another disability is counted, please specify with numbers:		If another ethnicity is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native		If another race is counted, please specify with numbers:	
Asian			
Black or African American			
Native Hawaiian or another Pacific Islander			
White			
Other Race			
Declined to answer			
Unknown			
TOTAL			

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

The client is a nine-year-old, cisgender, heterosexual male, and the youngest in his family. The client resides in a home with his biological mother, older brother and sister, as well as his biological

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grandmother. The client emigrated from Mexico, approximately 5 months ago unaccompanied with his siblings. The client was referred to by the administration office, as they reported the client was presenting with grief and sadness and would cry in class out of nowhere. When the therapist met with the mother of the client, she reported that the client had a very hard time passing through the border. The mother reported that the client and his siblings were stuck in the border for three days without food and water and had to do what they could to survive. The mother reports that the client wakes up in the nights, and cries as this is a very traumatic event in his life. The mother of the client has also reported that the biological father of the client has another family with children, and this has been hard for him to adjust to. When the therapist met with the client for their first individual session the client reported that he was always sad and would like to go back to his home country and live in his house in Mexico. He has also expressed worries for the future, as well as his mother's safety as she works in construction and that is a very dangerous employment. Throughout the sessions we have worked in various interventions to help ease and cope with the sadness and anxiety. The client has learned to use both coping skills and grounding techniques that can be used when he is sad. The client has also been guided by the therapist to communicate and explore his emotions in a healthier and positive way. The mother and the teacher of the client have expressed that the client has been able to communicate his feelings and have seen his mood and affect change and he is now happy at times. The client has expressed that he now feels better as he knows how to cope with his sadness, anxiety, and worry. We have also worked on exploring his support system, as well as his strengths. There has been improvement in the client's academics as well and his social circles have improved, and he has peer relationships. The next steps for the client will be to continue to work with the therapist throughout the summer, and then refer out to the clinic for family therapy. In the short time of sessions there has been progress made for the client.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	9
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	0
E.3: Types of treatment individuals were referred to (list types below):	
EPSDT programs and La Familia EPSDT school based mental health services	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	0
G.5: Average duration of untreated mental illness in weeks:	29
E.6: Average number of days between referral and first participation in referred treatment program:	2
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	

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Unaccompanied Immigrant Youth and Children of migrant families	
F.2: Number of paper referrals to an ACBH PEI-funded program:	239
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	239
F.4: Average number of days between referral and first participation in referred PEI program:	2
F.5: Describe how your program encouraged access to services and follow through on above referrals:	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. *(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)*	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Schools	Student, teachers, administrative staff, Parent other school site service providers.
Home visits	Student, Parents
Faith bases organizations	Faith leaders, community members, health promotors.
Community based organizations	Community organizers legal attorney's health care centers.

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MHSA Program #	**PEI 5**
PROVIDER NAME	**La Clinica de La Raza**
PROGRAM NAME	**Cultura y Bienestar**

2023-24

Program Outcomes & Impact Data Report

Program Name:	**Cultura y Bienestar**
Organization:	**La Clinica de La Raza**
Type of Report:	**Annual Data Report**
PEI Category:	**Prevention**

Priority Area (place an X next to all that apply):

	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.

	Suicide
	Incarceration
X	School failure or dropout
	Unemployment
X	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: Brief program description.

Cultura y Bienestar is the prevention and early intervention program in mental health of La Clinica de La Raza. Our program is a collaborative effort between La Clinica de La Raza, Tiburcio Vasquez Health Center and La Familia Counseling Services, which allows us to have a wider reach with 4 sites throughout central and south Alameda County. In addition, our staff delivers services in a multitude of community settings, including schools, senior centers and retirement homes, youth development centers, churches, health centers and other social service provider agencies. Our skilled and experienced team of health educators provide individual psychoeducational and skill building services, as well as stigma reduction and information and referral services to Latinx, Latinx Spanish speaking and Maya Mam speaking families. In addition, we deliver an array of group and community interventions including support groups, workshops, traditional healing workshops, community events and outreach activities.

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Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	249
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	25
Number of unduplicated individual family members served indirectly by your program:	N/A
Grand total of unduplicated individuals served:	N/A

Box C: Demographics of individuals served this fiscal year through MHSA funding:			
AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	1,466	Gay/Lesbian	12
Transition Age Youth (16-25 yrs.)	942	Heterosexual/Straight	1,277
Adult (26-59 yrs.)	5,304	Bisexual	2
Older Adult (60+ yrs.)	2,987	Questioning/Unsure	
Declined to answer		Queer	
Unknown	1,637	Declined to answer	
TOTAL	12,366	Unknown	2,312
		Another group not listed	
		TOTAL	3,603
		If another group is counted, please specify with numbers:	
VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes		English	394
No	835	Spanish	3,098
Declined to answer		Cantonese	
Unknown	2,768	Chinese	
TOTAL	3,603	Vietnamese	
		Farsi	
CURRENT GENDER IDENTITY		Arabic	
Female	8,938	Tagalog	
Male	1,900	Declined to answer	
Transgender	1	Unknown	
Genderqueer		Other languages not listed	111
Questioning/unsure of gender identity		TOTAL	3,603
Declined to answer			
Unknown	1,494		
Another identity not listed	3		

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TOTAL	12,336	
If another group is counted, please specify with numbers:		

SEX ASSIGNED AT BIRTH		ETHNITICY/CULTURAL HERITAGE (choose one)	
Male		If Hispanic or Latino, please specify:	
Female		Caribbean	
Declined to answer		Central American	
Unknown		Mexican/Mexican American/Chicano	3,720
TOTAL		Puerto Rican	10
Male		South American	
		Another Hispanic/Latino ethnicity not listed	6,952
DISABILITY STATUS		**Total Hispanic or Latino**	10,681
Communication Domain		If Non-Hispanic or Non-Latino, please specify:	
Vision		African	
Hearing/Speech		African American	
Another type not listed	243	Asian Indian/South Asian	
Communication Domain Subtotal		Cambodian	
Disability Domain		Chinese	
Cognitive (exclude mental illness; include learning, developmental, dementia, etc.)		Eastern European	
		European	
		Filipino	
Physical/mobility		Japanese	
Chronic health condition		Korean	
Disability Subtotal		Middle Eastern	
None	585	Vietnamese	
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	1
Unknown	2,775	Total Non-Hispanic or Non-Latino:	
Another disability not listed		More than one ethnicity	
TOTAL	3,603	Unknown ethnicity	
		Declined to answer	
If another disability is counted, please specify with numbers:		**ETHNICITY TOTAL**	10,682
		If another ethnicity is counted, please specify with numbers:	
RACE			

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American Indian or Alaska Native		If another race is counted, please specify with numbers:
Asian		
Black or African American	140	
Native Hawaiian or another Pacific Islander	1	
White	264	
Other Race	11,117	
Declined to answer		
Unknown	814	
TOTAL	12,336	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

During fiscal year 2023-24, our program rolled out a newly created stigma reduction program called Brazos Abiertos, which is a homegrown curriculum that we have been working on for the past couple of years. This curriculum will allow us to bring this conversation to our communities in a more consistent manner across our different sites and in a way that is culturally and context relevant to our community and in Spanish. This effort included training 12 promotoras as facilitators as well as all our staff on this new material. Promotoras went out into their communities and reached over 80 community members with this stigma reduction program and program staff at partner agency, Tiburcio Vasquez Health Center, delivered the 4 sessions of this program to a group of participants in Union City. The program had a great reception among participants. In addition, our program in the Tri-Valley region, organized its second annual Mujer Valiosa conference in Livermore in May 2024. This event attracted well over 200 participants, mostly women and some men too, young children and adults and seniors who learned about selfcare, wellness, mental health and traditional healing practices. At our site in Union City, more than 40 women participated in a 12-session personal growth group. This group was designed to help participants improve family relationships, personal resilience, communication and parenting skills, using stories, dreaming, role-playing, and coaching techniques. In Oakland, Cultura y Bienestar continued to reach out to the growing Maya Mam speaking population in the area. This year, we celebrated our 4th annual Maya Mam Art Contest. Through drawing and painting, adults and children in this community had the opportunity to envision a healthier community. Winners of the contest received a price and arts supplies at an awards ceremony, June 2024. This event took place at Fremont High School in Oakland, and it was attended by about 150 members of the Mam community. The event also included traditional food and music and resources and information. Across the different sites we offered programming for Dia de Los Muertos and for other important holidays in our community, including mothers' day and children's day events, Indigenous people's day ceremony and end of the year celebrations. In all, it was a year full of exciting activities for families to learn more about wellness, healing and mental health.

We also continued to provide support to individuals and families with individual psychoeducational and skill building services. A particular case was that of a Spanish speaking male in his 30's, who reached out to our program struggling with depressive mood and self-harm ideation. He heard about our program

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through other community members who recommended he seek help. By the time he reached out to us he was experiencing sadness, lack of motivation to live and self-harm ideation. One of our educators assessed this participant and was able to identify these challenges and consult first with a mental health specialist in the program and then with an on-call therapist at a local outpatient mental health clinic. After hearing the case, they made room in their schedule to assess this participant on that same day. Our educator walked the participant over to the clinic and waited until he was called to see a specialist. The clinic was able to support participant and create a safety plan with him and provide follow up afterwards. To date this participant continues engaged in the program and is doing well.

Another case was that of two sisters who were referred to us for individual support. They had arrived in the country from Nicaragua just a few months before and lost their dad soon after. They were having a difficult relationship with their relatives, and it was not easy for them to open up about their emotions. Fortunately, by the second session with one of our educators, they started to share that their main concern was their mom, who was experiencing sadness and loneliness. They ended up referring their mother for early intervention services to our program. By the time mom ended services with us, she was able to secure a part-time job and was able to communicate and engage with her daughters in a more positive way. They all reported feeling in a much better place, and they even donated their late father's wheelchair to the program.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	**69**
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	**3**
E.3: Types of treatment individuals were referred to (list types below):	
Alameda County ACCESS line, 988, 211, Eden Counseling, La Familia, Traditional Healers, Casa del Sol, Refugee Health Center, School-Based Health Center, ACCESS (Family Path), Highland Hospital Trauma Recovery Center, East Bay Community Law Center.	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	35
G.5: Average duration of untreated mental illness in weeks:	6-8
E.6: Average number of days between referral and first participation in referred treatment program:	30
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
Latinx, Spanish Speaking Latinx, Latinx Immigrants and Maya-Mam Speaking adults, TAY and older adults.	
F.2: Number of paper referrals to an ACBH PEI-funded program:	12

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F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	5
F.4: Average number of days between referral and first participation in referred PEI program:	7
F.5: Describe how your program encouraged access to services and follow through on above referrals: Our teams used different methods to encourage participants to connect with the services they may need, including warm-handoffs to nearby clinics and service providers in which educators will actually walk with participant and support them in making the initial contact to the referred agency. Our program also encourages access to services and follow through on referrals by staying in communication with referred client to ensure they have called and got an appointment or on a waiting list. In addition, there are times when we provide early intervention services and/or support groups to ensure client is being attended until they receive a call back for services.	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Health Care settings including, La Clinica, Street Level Health, Freedom Community Clinic, La Familia	Healthcare providers: 64
Social service settings including Unity Council, Spanish Speaking Citizens Foundation, Eden Youth Center	Social Service providers: 55
University and College Settings	College students: 17
Community settings	Community members at large and leaders: 56

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MHSA Program #	**PEI 6**
PROVIDER NAME	**Asian Health Services**
PROGRAM NAME	**AHS SMH Prevention**

2023 - 2024

Program Outcomes & Impact Data Report

Program Name:	**AHS SMH Prevention**
Organization:	**Asian Health Services**
Type of Report:	**Annual Data Report**
PEI Category:	**Prevention**

Priority Area (place an X next to all that apply):	
X	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
X	Suicide
	Incarceration
X	School failure or dropout
	Unemployment
X	Prolonged suffering
	Homelessness
X	Removal of children from their homes

Box A: <u>Brief</u> program description.
Asian Health Services Specialty Mental Health (AHS SMH) Prevention Program serves East Asian language community residents in Alameda's North County seeking mental health support. Services include community outreach, workshops, individual and community consultations, preventative counseling, and support groups. Services provided are free. Our services are supported by the Mental Health Services Act (MHSA) Alameda County Behavioral Health.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	
Number of unduplicated individual family members served indirectly by your program:	
Grand total of unduplicated individuals served:	0

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Box C: Demographics of individuals served this fiscal year through MHSA funding:			
AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	55	Gay/Lesbian	2
Transition Age Youth (16-25 yrs.)	220	Heterosexual/Straight	108
Adult (26-59 yrs.)	163	Bisexual	
Older Adult (60+ yrs.)	97	Questioning/Unsure	
Declined to answer		Queer	
Unknown	200	Declined to answer	
TOTAL	735	Unknown	625
		Another group not listed	
		TOTAL	735
		If another group is counted, please specify with numbers:	
VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes		English	317
No	173	Spanish	
Declined to answer		Cantonese	177
Unknown	562	Chinese	
TOTAL	735	Vietnamese	
		Farsi	
CURRENT GENDER IDENTITY		Arabic	
Female	371	Tagalog	
Male		Declined to answer	
Transgender		Unknown	
Genderqueer		Other languages not listed	241
Questioning/unsure of gender identity		TOTAL	735
Declined to answer			
Unknown	204		
Another identity not listed			
TOTAL	735		
If another group is counted, please specify with numbers:			

SEX ASSIGNED AT BIRTH		**ETHNITICY/CULTURAL HERITAGE (choose one)**	
Male		**If Hispanic or Latino, please specify:**	
Female		Caribbean	
Declined to answer		Central American	
Unknown		Mexican/Mexican American/Chicano	

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TOTAL		Puerto Rican	
Male		South American	
		Another Hispanic/Latino ethnicity not listed	
DISABILITY STATUS		Total Hispanic or Latino	4
Communication Domain		If Non-Hispanic or Non-Latino, please specify:	
Vision		African	
Hearing/Speech		African American	
Another type not listed	12	Asian Indian/South Asian	499
Communication Domain Subtotal		Cambodian	
Disability Domain		Chinese	
Cognitive (exclude mental illness; include learning, developmental, dementia, etc.)		Eastern European	
		European	
		Filipino	
Physical/mobility		Japanese	
Chronic health condition		Korean	
Disability Subtotal		Middle Eastern	
None	224	Vietnamese	
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	19
Unknown	499	Total Non-Hispanic or Non-Latino:	
Another disability not listed		More than one ethnicity	
TOTAL	735	Unknown ethnicity	213
		Declined to answer	
		ETHNICITY TOTAL	735
If another disability is counted, please specify with numbers:		If another ethnicity is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native			
Asian	499		
Black or African American			
Native Hawaiian or another Pacific Islander			
White	2		
Other Race	21		
Declined to answer			
Unknown	213		
TOTAL	735		

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Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
The Asian Health Services Prevention Program continues to provide culturally sensitive services with bilingual and bicultural staff that help bridge cultural gaps and improve overall wellness. In the past year, we engaged various groups including new parents, children and youth, and seniors. We brought awareness to our mother-to-be groups of postpartum depression and resources. For the 0-5 age group, we curated a culturally relevant workshop "Special Play Time," to support the local preschools to strengthen parent-child relationships. This workshop was well received by parents, school staff, and community members. We collaborated with local senior community centers and medical nurse practitioners to support seniors with health education tips and resources to be aware of dementia and signs of mental illnesses. This integrated approach was provided in their languages and helped to reduce stigma and create a space for support. New infographics focused on East Asian youth were developed to promote healthy lifestyles such as journaling, addressing unhealthy scrolling habits, and communication. The materials were published in four East Asian languages and distributed across the county and social media outlets. Based on the feedback from our community members, a family bonding space was established at a local medical clinic and public library. The space is created to foster healthier parent-youth relationships through mutual support and education. Case study: YC is a 16-year-old born in China and arrived in America with his mother for schooling. YC goes by he, him, pronouns. Due to the linguistic and acculturation barriers, and a history of physical and emotional abuse, YC struggled with mental health symptoms and refused to go to school. He slept through most of the days and played computer games at night. He had become further socially isolated, emotionally unstable, and behaviorally aggressive towards his family over the years. YC also had past suicidal attempts. This case was referred to AHS Prevention due to his family's growing concerns regarding YC's lack of school attendance, behavior, and need for a culturally sensitive provider. As a result, the AHS Prevention counselor connected with YC and the family during home visits providing care in their native language. YC opened up and talked about his struggles with his esteem and sense of shame of being unable to achieve as an honorable student in his home country. YC has progressed significantly, expressed interest in continuing counseling services, and is motivated to return to school after the summer break. The program staff continues to provide highly effective preventative counseling that has helped the clients' symptoms to subside and restore functioning levels.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	0
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	0
E.3: Types of treatment individuals were referred to (list types below):	
n/a	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
E.6: Average number of days between referral and first participation in referred treatment program:	n/a

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Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
East Asian	
F.2: Number of paper referrals to an ACBH PEI-funded program:	23
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	26
F.4: Average number of days between referral and first participation in referred PEI program:	7.5
F.5: Describe how your program encouraged access to services and follow through on the above referrals: **Initiate outreach contact for checking in and early paperwork opening**.	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. *(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)*	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	**Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):**
16 Virtual Workshops + Groups for Community Members, Seniors and M2B	165 live virtual participants, community members
4 In-person Youth Summer Program at AHS clinic	41 children, youth and families
9 In-person Tabling in Oakland Community	838 community members
2 In-person Coffee Time at AHS Pediatric Clinic	122 parents
1 In-person TV Production at AHS clinic/ office building	32 AHS staff
2 In-person Library Events	32 seniors; 17 children, youth, and family
1 In-person Holiday Celebration at the Pediatric Clinic	33 children, youth, and family
1 In-person Tabling at College	38 college students and staff
1 In-person Workshop at Senior Center	29 seniors
Recordings on YouTube	755 viewers
Postings on AHS WeChat	972 viewers
Postings on Prevention IG Account	113 viewers
Postings on AHS FB	13 likes
Short Video at IG Reel	669 views
Each Event promotion via email; 25 events total	480 AHS all staff; 594 community leaders, school, other providers, and CBO

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MHSA Program #	**PEI 6**
PROVIDER NAME	**Bay Area Community Health**
PROGRAM NAME	**Arise: Asian Wellness Project**
2023 – 2024	

Program Outcomes & Impact Data Report

Program Name:	**Arise: Asian Wellness Project**
Organization:	**Bay Area Community Health**
Type of Report:	**Annual Data Report**
PEI Category:	**Prevention**

Priority Area (place an X next to all that apply):

	Childhood Trauma
	Early Psychosis
X	**Youth/TAY Outreach & Engagement**
X	**Cultural & Linguistic**
X	**Older Adults**
X	**Early Identification of MH Illness**

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.

X	**Suicide**
	Incarceration
X	**School failure or dropout**
	Unemployment
	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: Brief program description.

Arise: Asian Wellness Project functions as a program focused on Mental Health Prevention and Early Intervention. Our primary goal is to enhance emotional and mental well-being through educational initiatives and advisory services. We offer cost-free workshops, individualized preventative counseling, support groups, and communal gatherings designed for individuals of all ages, including youth, adults, and families belonging to the East Asian Community residing in Southern Alameda County. Furthermore, we aid participants in accessing care and resources by facilitating connections.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	

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Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	
Number of unduplicated individual family members served indirectly by your program:	
Grand total of unduplicated individuals served:	0

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	16
Transition Age Youth (16-25 yrs.)	20
Adult (26-59 yrs.)	
Older Adult (60+ yrs.)	60
Declined to answer	
Unknown	
TOTAL	96

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	96
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	
Another group not listed	
TOTAL	96
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	
No	96
Declined to answer	
Unknown	
TOTAL	96

PRIMARY LANGUAGE	
English	42
Spanish	
Cantonese	13
Chinese	41
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Other languages not listed	
TOTAL	96

CURRENT GENDER IDENTITY	
Female	58
Male	38
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	96

SEX ASSIGNED AT BIRTH	
Male	38

ETHNITICY/CULTURAL HERITAGE (choose one)
If Hispanic or Latino, please specify:

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Female	58	Caribbean	
Declined to answer		Central American	
Unknown		Mexican/Mexican American/Chicano	
TOTAL	96	Puerto Rican	
Male		South American	
		Another Hispanic/Latino ethnicity not listed	
DISABILITY STATUS		Total Hispanic or Latino	n/a
Communication Domain		If Non-Hispanic or Non-Latino, please specify:	
Vision		African	
Hearing/Speech	5	African American	
Another type not listed		Asian Indian/South Asian	5
Communication Domain Subtotal		Cambodian	
Disability Domain		Chinese	64
Cognitive (exclude mental illness; include learning, developmental, dementia, etc.)		Eastern European	6
		European	
		Filipino	
Physical/mobility		Japanese	
Chronic health condition		Korean	15
Disability Subtotal		Middle Eastern	
None	91	Vietnamese	
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	6
Unknown		Total Non-Hispanic or Non-Latino:	
Another disability not listed		More than one ethnicity	
TOTAL	96	Unknown ethnicity	
		Declined to answer	
		ETHNICITY TOTAL	96
If another disability is counted, please specify with numbers:		If another ethnicity is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native		If another race is counted, please specify with numbers:	
Asian	79		
Black or African American			
Native Hawaiian or another Pacific Islander			
White	6		
Other Race	11		

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Declined to answer		
Unknown		
TOTAL	96	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
Last year, we held the Mid-Autumn Festival at Irvington High School with the help of the school teachers and the student leader who was part of the ongoing support group. It was a great opportunity to promote Arise to the entire student body and staff, and afterward, we had so many students join our regular support group that there were no empty spots left. At the senior center, we first approached by organizing craft activity events rather than workshops to reduce the stigma around mental health. As a result, the Arise program has become the most popular group session among seniors, helping make the API project successful. Case Study: A 15-year-old Chinese immigrant student faced social difficulties and academic stress due to language and cultural barriers. Referred by the school counselor, she joined the Arise support group and participated in 1:1 counseling. Through continuous group sessions and counseling, she gradually became more engaged. Starting last semester, she actively participated in group sessions and volunteered to help other Asian immigrant students. Her involvement showcases the success of the Arise teen support group. She now hopes to study social work as her major in college.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	0
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	0
E.3: Types of treatment individuals were referred to (list types below):	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	5
G.5: Average duration of untreated mental illness in weeks:	2
E.6: Average number of days between referral and first participation in referred treatment program:	10
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
F.2: Number of paper referrals to an ACBH PEI-funded program:	0
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	5

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F.4: Average number of days between referral and first participation in referred PEI program:	10
F.5: Describe how your program encouraged access to services and follow through on above referrals:	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. *(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)*	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	**Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):**
Christmas Festival: Agewell Senior Center	*Approx 200 Senior Community members*
Local Senior Center	*20 Senior Community members*
Lunar New Year: Local High School	*Approx 400 total: high school students, teachers at school, parents*
Senior Apartment	*40 Senior residents*
Online Zoom forum	*Approx 30 Community Health Centers' Staff*
API Project – Collaboration with Chinese Medicine and Mental Health Service	*35 Senior Community members*

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MHSA Program #	**PEI 6**
PROVIDER NAME	**Center For Empowering Refugees and Immigrants (CERI)**
PROGRAM NAME	**ROYA**

2023 - 2024

Program Outcomes & Impact Data Report

Program Name:	**ROYA**
Organization:	**CERI**
Type of Report:	**Annual Data Report**
PEI Category:	**Prevention**

Priority Area (place an X next to all that apply):

X	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.

	Suicide
X	Incarceration
X	School failure or dropout
	Unemployment
X	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: <u>Brief</u> program description.

CERI's UELP program provides holistic, compassionate and culturally resonant prevention and early intervention mental health and wellness to Southeast Asian communities, reaching over 1000 clients, annually. We provide preventative counseling, community events, workshops, and support groups for elders, adults, children, and transitional aged youth who have been impacted by genocide, war, traumatic migration, incarceration and deportation, and other life-altering trauma. CERI is intentional about bringing families together for care management, to strengthen bonds and heal across generations. We link clients to resources and information related to basic needs and human rights, such as housing, voting, food assistance, medical care, legal support, and culturally tailored interventions such as gardening, meditation, art and drama therapy, knitting, and movement. Our model of community mental health nurtures the seeds of leadership, empowering community members to cultivate their strength and reshape the conditions that impact their lives.

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Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	25
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	450
Number of unduplicated individual family members served indirectly by your program:	1200
Grand total of unduplicated individuals served:	1675

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	118
Transition Age Youth (16-25 yrs.)	616
Adult (26-59 yrs.)	827
Older Adult (60+ yrs.)	712
Declined to answer	
Unknown	6
TOTAL	2,279

SEXUAL ORIENTATION	
Gay/Lesbian	16
Heterosexual/Straight	1,221
Bisexual	
Questioning/Unsure	
Queer	6
Declined to answer	
Unknown	1,036
Another group not listed	
TOTAL	2,279
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	9
No	1,362
Declined to answer	
Unknown	908
TOTAL	2,279

PRIMARY LANGUAGE	
English	532
Spanish	2
Cantonese	
Chinese	
Vietnamese	42
Farsi	
Arabic	1
Tagalog	
Declined to answer	
Unknown	
Other languages not listed	1,702
TOTAL	2,279

CURRENT GENDER IDENTITY	
Female	1,562
Male	714
Transgender	1
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	2

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TOTAL	2,279	
If another group is counted, please specify with numbers:		

SEX ASSIGNED AT BIRTH		**ETHNITICY/CULTURAL HERITAGE (choose one)**	
Male		**If Hispanic or Latino, please specify:**	
Female		Caribbean	
Declined to answer		Central American	
Unknown		Mexican/Mexican American/Chicano	
TOTAL		Puerto Rican	
Male		South American	
		Another Hispanic/Latino ethnicity not listed	13
DISABILITY STATUS		**Total Hispanic or Latino**	
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision		African	
Hearing/Speech		African American	49
Another type not listed		Asian Indian/South Asian	2,200
Communication Domain Subtotal		Cambodian	
Disability Domain		Chinese	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)		Eastern European	
		European	
		Filipino	
Physical/mobility		Japanese	
Chronic health condition		Korean	
Disability Subtotal	1,265	Middle Eastern	
None	459	Vietnamese	
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	17
Unknown	555	**Total Non-Hispanic or Non-Latino:**	
Another disability not listed		More than one ethnicity	
TOTAL	2,279	Unknown ethnicity	
		Declined to answer	
		ETHNICITY TOTAL	2,279
If another disability is counted, please specify with numbers:		If another ethnicity is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native		If another race is counted, please specify with numbers:	

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Asian	2,200
Black or African American	49
Native Hawaiian or another Pacific Islander	1
White	3
Other Race	13
Declined to answer	
Unknown	
TOTAL	2,279

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

This year CERI expanded and enhanced services for youth, formerly incarcerated people, adults and elders. By strategically blending MHSA/Measure A funding with other youth focused funding streams, we increased CERI's programs for at-promise youth ages 5 to 26. Now youth can access individual support and care management, wellness and enrichment groups, and social justice and nature-based programs three to four days per week at CERI's office throughout the year. Examples of groups and programs from this year include a youth-led dance group, harm reduction seminar, financial literacy classes, and a summer program in which participants were given the opportunity to apply for an internship component to build leadership and job skills. CERI is also intentional about creating opportunities to connect across generations, with field trips or camping excursions to local sites taking place nearly every month. Opportunities to explore places outside of Oakland help to reduce isolation among elders who are often afraid to leave their homes due to anti-Asian hate crimes locally and for youths and adults to be present with each other and build relationships through storytelling and cooking in new environments away from the stresses of their daily lives. In addition, CERI has Zumba, yoga, and computer literacy programs regularly available for adults and elders at the office. We also have programming for Vietnamese elders available in Fremont held at the Age Well Center two to three times each month as of this year. Our increased focus on formerly incarcerated adults in preventive counseling is strengthened by our expanded intern program, with interns from the communities we serve, using the culturally relevant Internal Family Systems (IFS) modality. This approach resonates with collectivist Southeast Asian cultures, emphasizing the multiplicity of parts within everyone.

We continued to support community members with finding jobs, navigating increased break ins of homes and cars, securing housing, and applying for citizenship, which are all central to feeling healthy and well. This year, due to the growing expertise of our staff in this area, we have been able to reduce barriers for Southeast Asian community members to gain citizenship. We support clients with paperwork, interpretation, attending meetings, preparing for the exam, and have seen between 10 to 15 people become citizens this year, including the wife of one of our very own staff members.

Celebrating diversity at our agency this year was a joy, which we see as a success in bringing together different communities to create a deeper sense of inclusion and connection. We held a combined celebration of Khmer, Burmese and Nepali New Years with our staff and community.

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We began with monk prayers and chants with offerings and final blessings. The rich symbolism of tradition, community, wonderful food and happy greetings brought greater understanding across differences and connection on what is shared. Several Khmer teachers also came to teach our elders and youths about traditional dances during the year, including celebrated Prumsodun Ok, winner of the Hewlett 50 Arts Commission, who honored CERI with an inspiring, creative and ancient dance performance of "A Deepest Blue" at CERI's office. CERI continued to develop more internal infrastructures with front desk staff, moving to a larger office and the rollout of Salesforce to more effectively collect data.

Due to the success of our MHSA/Measure A funded UELP program, we were awarded funding from Hear Us and CalHOPE to strengthen our care management services. Every week there are hundreds of people coming into CERI with care management needs which are now initially addressed by programs funded by Hear Us and CalHOPE. Many of those clients are then referred to relevant UELP services and programs at CERI. The ability to refer both internally and externally to support community members is critical to supporting the wellbeing of refugee and immigrant communities.

Success story: We are proud to share about our youth leader Sophany, a 2nd generation Khmer American, 18 years old, who joined CERI's youth program at the age of 13 when her father was detained by ICE and threatened with deportation. In the years of working with Sophany, we have seen her increase in self-confidence, meet the challenges of being the eldest in her family with grace, attain educational success, make healthy relationship choices, and stay committed to advocacy and social justice work. She has attended political workshops to learn more about the anti-deportation movement, been involved in disaggregating data to better support the Southeast Asian communities, adding the Southeast Asian experiences into the curriculum in schools, written letters to detainees, called the Governor's office and ICE detention centers to release community members and spoken at events and rallies. In her own school, she advocated tirelessly to add a woman's football team; she was successful and was a star player on that team! This year, Sophany, took the initiative to start and lead a Khmer youth dance group to help preserve cultural traditions among Khmer youth locally. Today we can see the dance group performing at community events across the Bay Area. In addition, Sophany, was the 2024 Youth Scholarship Recipient and an Honoree of the Alameda County Women's Hall of Fame, which recognizes outstanding women for their achievements and contributions to Alameda County and its residents.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	2
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	0
E.3: Types of treatment individuals were referred to (list types below): Crisis Team	

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E.4: Unduplicated number of individuals who participated in referred program at least one time:	2
G.5: Average duration of untreated mental illness in weeks:	10
E.6: Average number of days between referral and first participation in referred treatment program:	1
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below): Southeast Asian Refugees and Immigrants	
F.2: Number of paper referrals to an ACBH PEI-funded program:	0
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	0
F.4: Average number of days between referral and first participation in referred PEI program:	0
F.5: Describe how your program encouraged access to services and follow through on above referrals: Although we did not refer clients to other PEI funded programs, we made referrals for clients who needed mental health services longer than one year to our long-term programs funded by Stop the Hate and other private foundations.	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
N/A	N/A

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MHSA Program #	**PEI 6**
PROVIDER NAME	**Korean Community Center of the East Bay**
PROGRAM NAME	**Asian Community Wellness Program**

2023 - 2024

Program Outcomes & Impact Data Report FY:

Program Name:	**Asian Community Wellness Program**
Organization:	**Korean Community Center of the East Bay**
Type of Report:	**Annual Data Report**
PEI Category:	**Prevention**

Priority Area (place an X next to all that apply):

	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.

X	Suicide
	Incarceration
X	School failure or dropout
X	Unemployment
X	Prolonged suffering
	Homelessness
X	Removal of children from their homes

Box A: <u>Brief</u> program description.

Asian Community Wellness Program (ACWP) is a prevention and early intervention (PEI) program funded by Alameda County Behavioral Health Care Services (BHCS) addressing mental health and wellness needs in the underserved East Asian communities. Our goal is to improve access to culturally responsive mental health services, reduce stigma, and strengthen Asian communities' knowledge and experience in wellness practices and community resources. ACWP provide the following services: 1) Outreach and Education, 2) Preventive Counseling, 3) Mental Health Consultation and Training.

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Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	15
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	10
Number of unduplicated individual family members served indirectly by your program:	5
Grand total of unduplicated individuals served:	57

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	32
Transition Age Youth (16-25 yrs.)	50
Adult (26-59 yrs.)	340
Older Adult (60+ yrs.)	1,539
Declined to answer	
Unknown	27
TOTAL	1,988

SEXUAL ORIENTATION	
Gay/Lesbian	12
Heterosexual/Straight	803
Bisexual	
Questioning/Unsure	4
Queer	25
Declined to answer	
Unknown	1,143
Another group not listed	1
TOTAL	1,988
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	
No	154
Declined to answer	
Unknown	1,834
TOTAL	1,988

PRIMARY LANGUAGE	
English	212
Spanish	13
Cantonese	925
Chinese	124
Vietnamese	5
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Other languages not listed	709
TOTAL	1,988

CURRENT GENDER IDENTITY	
Female	1410
Male	531
Transgender	4
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	23
Another identity not listed	20
TOTAL	1,988

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If another group is counted, please specify with numbers:	

SEX ASSIGNED AT BIRTH		ETHNITICY/CULTURAL HERITAGE (choose one)	
Male		**If Hispanic or Latino, please specify:**	
Female		Caribbean	
Declined to answer		Central American	
Unknown		Mexican/Mexican American/Chicano	
TOTAL		Puerto Rican	
Male		South American	
		Another Hispanic/Latino ethnicity not listed	
DISABILITY STATUS		**Total Hispanic or Latino**	28
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision		African	29
Hearing/Speech		African American	
Another type not listed		Asian Indian/South Asian	1,811
Communication Domain Subtotal		Cambodian	
Disability Domain		Chinese	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)		Eastern European	
		European	
		Filipino	
Physical/mobility		Japanese	
Chronic health condition		Korean	
Disability Subtotal	65	Middle Eastern	
None	91	Vietnamese	
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	75
Unknown	1,832	**Total Non-Hispanic or Non-Latino:**	
Another disability not listed		More than one ethnicity	28
TOTAL	1,988	Unknown ethnicity	17
		Declined to answer	
		ETHNICITY TOTAL	1,988
If another disability is counted, please specify with numbers:		If another ethnicity is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native		If another race is counted, please specify with numbers:	
Asian	1,811		

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Black or African American	29	
Native Hawaiian or another Pacific Islander		
White	26	
Other Race	125	
Declined to answer		
Unknown	17	
TOTAL	1,988	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

One of ACWP biggest accomplishments is providing culturally responsive and resonant counseling services to API communities, especially our API youth. Many of the API youth have shared negative experiences in receiving culturally inappropriate services and experience traumas in receiving mental health services in the mainstream systems for the first time, thus leading them to not seeking ongoing mental health care or falling through the cracks in the current treatment mental health system. Through our ACWP program, our bilingual/bicultural Wellness Counselors provided API youth a safe haven for them to share their mental health struggles and cultural challenges from intergenerational conflicts, high academic pressures as API, “Model Minority'' expectations, and shame and guilt of pursuing personal goals that differ from their parents’ desires and expectations, and many more. Our Wellness Counselors were able to empathically listen to them, connect to them, and make them feel heard and validate. Some youths have a lot of misconceptions about mental health services due to stigma. By being able to provide culturally responsive/resonant mental health services, youth were willing to continue counseling services during the school year.

One case example is a youth named Maelin. Maelin is a high school student who feels unseen and unaccepted by their family and school community. Maelin has a history of suicidality and was hospitalized because of that. The treatment following the hospitalization was harmful and traumatizing, as their therapist at that time did not keep confidentiality and was not an advocate for Maelin. Maelin often feels isolated and can only be acknowledged through academic achievement, resulting in high stress levels. Through ACWP services, Maelin learned that the counseling room is a safe haven for them to unapologetically and freely express who they are, what they enjoy, and their cultural identities. A few months after Maelin started their sessions, they wrote a gratitude poem for themselves to recognize all that they have been through and that they are standing here. Maelin said, "To be honest, I've been crying myself to sleep every night consecutively for the past few weeks, and in my loneliness, I came to realize, I'm the one carrying myself through this shit every day. And hey, isn't that something?" Maelin's counseling sessions are on hold during summer as they have a busy schedule and privacy at home is an issue. Maelin continues to reach out when they need support via email, and in one of the emails, Maelin wrote, "thank you for teaching me valuable tools to deal with my emotions and thank you for having been and still being a place of support for me. I sincerely do appreciate it." Maelin is not the only client who has mentioned receiving past therapy that did not help them. Ryu is another client who shared that they had been in therapy in their childhood and felt invalidated by their providers. Both Maelin and Ryu felt

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that their therapists were on the parents' side, telling them to "listen to your parents" and reporting their vulnerability to parents. Therefore, ACWP Wellness Counselors have made it crucial for API youth to feel heard and seen in a safe and confidential manner.

Another accomplishment is accessibility to care for our API youth. Accessible care for youth is not just having providers who work with children and teens. It is allowing youth to receive care without relying on caregivers for consent for counseling, transportation, scheduling, insurance information, and input. Young people just need a place where they can simply be. They need a place where their thoughts are not dismissed by "you're thinking too much" or labeled as "you shouldn't think this way". This is especially important among API youth as stigma and invisibility is one the main issues that API youth do not seek mental health services. In addition, second generation API youth often witness their parents' struggles and recognize their parents' sacrifice, and they worry about being a burden, adding to the list of concerns and to-do's. Some youth who still have family abroad often understand their family's need to provide, support, and appear successful in front of relatives, and hiding their struggles and pain becomes a practice. Being in America in many cases still is seen as a blessing and a luxury, and many second-generation immigrants internalize the idea that they should be grateful, and that someone sacrificed their happiness for them so they must not complain. Sometimes these ideas become "I am not smart enough and I am wasting my parents' efforts" and academic stress becomes overwhelming. Sometimes youth are not given the opportunity to make decisions because they are told the path to success. Phrases like, "my grades are the only thing that makes me feel seen", "my mom is right. I'm a disappointment", and "I have to go to college, I just know that" are common in the counseling room with first- and second-generation immigrant youth, and these often lead to their desire to pause the time, to not exist anymore, or to “die.” KCCEB is proud of providing a culturally resonant, culturally responsive, no wrong door and easily accessible services to API youth where they feel safe, heard, and visible.

Lastly, ACWP is addressing the increasing suicide rate among API youth. A recent 2024 study by Damon et. al, reported that suicide rate among AANHPI youth has double from 3.6% to 7.1% between 1999 to 2021. Their finding indicates that AANPHI high school students in California reported a high prevalence for past year experiences of depressive symptoms (33.9%) and suicide ideation (16.9%). In addition, girls consistently reported higher prevalence depressive symptoms and suicide rate, especially NHPI youth (56.6% depressive symptoms, 30.5% suicide rate) compares to boys (31.2 depressive symptoms and 16.9% suicide rate). Many of the youth that ACWP serve share their struggles of disclosing their suicide ideation due to stigma, worrying about “what will people think about me?”, not to air their “dirty laundry” to the public, being dismissed by parents or adult that they “think too much” and they should focus on their studies. In addition, like many Asian community member, they only talk about suicide in whispers. One Wellness Counselor shared that “my client didn’t talk about their suicidality for the first three month because she didn’t want to worry me.” Due to these struggles, many of our API youth “swallow their pain” as their suicide ideation becomes a dark secret while they continue to suffer in silence. Thus, our ACWP services has become a “lifeline” for many of these youth to share their struggle with suicide ideations and pain. Our Wellness Counselor creates a culturally responsive, supportive, and safe space to talk about their pain, understand and empathize with their struggle of their silence, monitor their progress, and

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support them to reduce their symptoms through various healthy coping mechanisms, and find external support and resources.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	0
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	0
E.3: Types of treatment individuals were referred to (list types below):	
n/a	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
E.6: Average number of days between referral and first participation in referred treatment program:	n/a
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
1. East Asian Community: Chinese, Korean, Japanese, Mongolian, E. Indian (children, youth, TAY, family, adult, and older adults) 2. Southeast Asian: Vietnamese, Khmer (youth & Tay) 3. Pacific Islanders: Filipino (youth & TAY) 4. Other BIPOC: E. Indian, Latinx, African Americans/Black, Mix Race (youth & Tay)	
F.2: Number of paper referrals to an ACBH PEI-funded program:	93
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	57
F.4: Average number of days between referral and first participation in referred PEI program:	3-5 days
F.5: Describe how your program encouraged access to services and follow through on above referrals: KCCEB Wellness Counselors will follow up on referral with a short timeframe (3-5 days) and perform wellness check through prevention visits. During the prevention visits, our bilingual/bicultural Wellness Counselors perform wellness checks with the clients to build rapport, understand their needs, provide psychoeducation, and engage in empathic listening to make sure the client is being heard, understood, supported, and safe. We provide mental health education in a culturally responsive manner and encourage the clients to reach out to the Wellness Counselor to ensure that the clients have access to support. Often, the Wellness Counselors provided 4-6 prevention visits to engage the clients to make them feel more comfortable and ready to access mental health services. In addition, the Wellness Counselors would meet the clients at home, virtual, school, and phone to reduce geographic barriers.	

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Engagement to build rapport and encouragement to access mental health services is provide in their preferred language: English, Cantonese, Mandarin, Korean, Khmer, Vietnamese, Mongolian, etc. to reduce additional linguistic barriers. After rapport building is established, client becomes more receptive to seeking MH services. In most cases, our Wellness Counselor will open their case under early intervention for 12-18 months as needed to provide counseling services to those with mild, moderate symptom (in rare cases – moderately severe) in hope to reduce their symptoms. If their symptoms continue to worsen, the Wellness Counselor will engage and support the clients to seek higher care in the treatment programs.

Once the clients need higher care for treatment services, our Wellness Counselors provided case management service to the clients through linkages and navigation. Our Wellness Counselors will assist client to contact the treatment program for initial appointment and screening, be with the clients when needed to complete the clinical screening, and scheduling of first therapy session for support. Once the clients received their first or second therapy session in the treatment program, the Wellness Counselors performed wellness checks again to check their progress in the treatment program and quality of services before terminating with their client. This process is to ensure that client can receive a smooth and seamless continuation of higher care in the treatment program.

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Cultural & Wellness Events: social & wellness trips, cultural festivals, covid-19 health/vaccine, and youth/family/seniors' health and wellness fairs. Events held KCCEB office, school, senior housing/centers, local community centers, and field	community members and leaders, children, youth, TAY, families and adults and older adults, CBO staff, school staffs
MH Workshops: Understand MH, leadership, mental health stigma, senior safety street smart, emotional wellness, healthy communication, stress management, MH access support, Digital Literacy, and intuit holistic healing art. Event held at KCCEB office, school, specific community center, and CBO partners' center	community members and leaders, youth, TAY and adults and older adults
MH Trainings: accessing culturally responsive resources, cultural and holistic healing. Event held	community based professionals (school-based staff, community-based worker staff, caregivers)

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at KCCEB cultural community space, KCCEB office, virtual and school.	
Mental Health Consultation: MH among youth, access MH Tx, MH Stigma in API comm, MH ref & linkages at school, home, office, and phone	CBO's professionals (school-based staff, community-based worker staff, caregivers, CPS workers) and family members
Newsletters: Selfcare, COVID, cultural/sexual ID & pride, caregivers support, mental health and wellness, healthy bonding	general community members and professionals and CBO's partners
Tabling/Distributing materials: community resources and mental health services resources at school, community festivals and resource fairs, and API cultural events	API & other BIPOC community members and leaders, children, youth, TAY and adults and older adults
Wellness Support Groups: Tai Chi for wellness, Safety Street Smart (English, Chinese & Korean), Jikimee Leadership & Wellness Group, Youth Wellness support at senior housing facilities, office, and school	API & other BIPOC community members and leaders, children, youth, TAY and adults and older adults
PV Home Visits: MH screening, referral, help-seeking encouragement, psycho-ed, and community resource support @ school, phone, virtual, office, and home	API & BIPOC community members and leaders, children, youth, TAY and adults and older adults

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MHSA Program #	**PEI 6**
PROVIDER NAME	**Richmond Area Multi-Services Inc.**
PROGRAM NAME	**Pacific Islander Wellness Initiative**

2023-2024

Program Outcomes & Impact Data Report

Program Name:	**Pacific Islander Wellness Initiative**
Organization:	**Richmond Area Multi Services, Inc.**
Type of Report:	**Annual Data Report**
PEI Category:	**Prevention**

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
X	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.	
	Suicide
X	Incarceration
	School failure or dropout
X	Unemployment
X	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: Brief program description.
Pacific Islander Wellness Initiative (PIWI) is a prevention and early intervention mental health program of RAMS in collaboration with long standing and trusted Pacific Islander community-based organizations. PIWI provides culturally responsive and in-language preventive counseling, psychoeducation, mental health consultation, and outreach and engagement services, including navigation, translation, and interpretation assistance to Pacific Islander residents of Alameda County.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	60
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	0
Number of unduplicated individual family members served indirectly by your program:	0
Grand total of unduplicated individuals served:	60
Box C: Demographics of individuals served this fiscal year through MHSA funding:	

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AGE CATEGORIES	
Children/Youth (0-15 yrs.)	60
Transition Age Youth (16-25 yrs.)	198
Adult (26-59 yrs.)	513
Older Adult (60+ yrs.)	75
Declined to answer	
Unknown	50
TOTAL	896

SEXUAL ORIENTATION	
Gay/Lesbian	5
Heterosexual/Straight	588
Bisexual	1
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	302
Another group not listed	
TOTAL	896
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	5
No	621
Declined to answer	
Unknown	270
TOTAL	896

PRIMARY LANGUAGE	
English	571
Spanish	
Cantonese	
Chinese	
Vietnamese	1
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Other languages not listed	324
TOTAL	896

CURRENT GENDER IDENTITY	
Female	592
Male	289
Transgender	1
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	14
Another identity not listed	
TOTAL	896
If another group is counted, please specify with numbers:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	
Male	

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	

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		Another Hispanic/Latino ethnicity not listed	
DISABILITY STATUS		**Total Hispanic or Latino**	64
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision		African	39
Hearing/Speech		African American	
Another type not listed		Asian Indian/South Asian	45
Communication Domain Subtotal		Cambodian	
Disability Domain	17	Chinese	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)		Eastern European	
		European	
		Filipino	
Physical/mobility		Japanese	
Chronic health condition		Korean	
Disability Subtotal		Middle Eastern	
None	578	Vietnamese	
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	708
Unknown	301	**Total Non-Hispanic or Non-Latino:**	
Another disability not listed		More than one ethnicity	20
TOTAL	896	Unknown ethnicity	20
		Declined to answer	
		ETHNICITY TOTAL	896
If another disability is counted, please specify with numbers:		If another ethnicity is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native		If another race is counted, please specify with numbers:	
Asian			
Black or African American			
Native Hawaiian or another Pacific Islander			
White			
Other Race			
Declined to answer			
Unknown			
TOTAL			

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Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
PIWI successfully met 100% of its deliverables. Our program provided: 31 in person home visits 72 prevention visits 8 hosted community events reaching 269 people 103 clients screened and assessed (RAMS internal objective) 60 unduplicated clients received prevention counseling 53 promotional materials created and shared widely reaching 127,864 people 23 Mental Health Consultations reaching 121 people 12 psychoeducation workshops reaching 121 people 6 Talanoa 4 Wellness (Support Groups) reaching 29 people 11 referrals and successful linkages 4 Cultural Education Workshops reaching 68 people. Case Study: A 26-year-old Tongan female client was referred to therapy by a family relative due to family problems at home, which led to depression over the past year, and stress from her current relationship. During sessions, it became clear that she internalizes stress related to her family, feeling overwhelmed and wanting to escape. As the oldest sibling, she bears most responsibilities, in addition to her work and relationship pressures. She also exhibited PTSD symptoms from witnessing a shooting. The treatment goals included unpacking thoughts and feelings about the shooting, setting boundaries with her family, and navigating her new relationship. After several months of weekly sessions, the client improved her mental health by learning to prioritize her commitments and say "no" to her family when necessary. She successfully processed her fears about the shooting, realizing she did all she could. She also resolved issues in her long-distance relationship and found happiness with a new love interest. The client met all treatment goals and is doing well. The client exceeded the minimum 6 to 8 low intensity, time limited sessions due to the client needing more time to reach a level of comfort to open up about her ways of being, beliefs, patterns, and behavior, and additionally guidance to sort through and understand her emotions and feelings thus building her self-confidence to navigate relationship concerns.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	31
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	0
E.3: Types of treatment individuals were referred to (list types below):	
Since our program is PEI, the data provided for SMI are those we define as "at-risk for" or "possible" SMI. Specialty mental health services, higher level case management, long term, counseling services	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	27
E.5: Average duration of untreated mental illness in weeks:	0
E.6: Average number of days between referral and first participation in referred treatment program:	8

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Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
Pacific Islanders (Samoans, Tongans, Hawaiians, Palauans, Fijians, Chomorros), Youth, TAY, parents, children, seniors, students, athletes, clergy members, community leaders	
F.2: Number of paper referrals to an ACBH PEI-funded program:	103
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	60
F.4: Average number of days between referral and first participation in referred PEI program:	9
F.5: Describe how your program encouraged access to services and follow through on above referrals: We provide clear communication to clients and community members about the importance of mental health and services we offer, including explaining the benefits and outcomes of recommended services and activities. We provide a supportive environment where clients feel comfortable accessing help and support with the staff and our facility. We provide supportive referral coordination by establishing strong relationships with service providers for a warm hand-off, scheduling appointments and other ancillary support. We seek input from clients about the services we offer and track their progress across the time they are engaged in activities and/or counseling. We provide education to raise awareness and empower community members about available services, accessing services, seeking resources, and enhancing their confidence to advocate for themselves and access services to meet their identified needs. PIWI staff engage in deep outreach and engagement activities in Pacific Islander churches, groups, schools, individuals, community and public spaces, and other providers to enhance awareness of PIWI services. PIWI staff hold dual roles as working professionals and also as community members who care deeply about responding and supporting the mental health of their community. Once staff are aware of a death, crisis, or trouble in the community, we reach out to the family with the death, crisis, and trouble to lend our support by offering our services and resources. All staff work as a team to support the clients seeking PIWI services. PIWI staff have the language capacity to communicate with participants and potential participants in their native languages. Furthermore, PIWI staff have also engaged many Pacific Islander parents in the community who are now aware of our services and promoting with others.	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Schools	Coaches: 3; COST specialists: 4; Counselors: 7; Teachers: 6; Student Intervention Specialist: 1; Superintendent: 2; Principal: 2; LCSW: 2

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Churches	Clergy: 11; Youth Leaders: 10; LDS Ward Social Worker: 1
Cultural affinity groups	Kumu Instructor: 2; Parents: 30; Dance Instructors: 2
Colleges	Advisors: 2; Peers: 15; Professors: 3
Community events	Community Leaders: 12; Registered Nurse: 1

MHSA Program # **PEI 7**
PROVIDER NAME **Afghan Coalition**
PROGRAM NAME **Afghan Wellness Project**
2023 - 2024

Program Outcomes & Impact Data Report

Program Name:	**Afghan Wellness Project**	
Organization:	**Afghan Coalition**	
Type of Report:	**Annual Data Report**	
PEI Category:	**Prevention**	
		Priority Area (place an X next to all that apply):
	X	Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach & Engagement
	X	Cultural & Linguistic
	X	Older Adults
	X	Early Identification of MH Illness
		Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.
	X	Suicide
	X	Incarceration
	X	School failure or dropout
	X	Unemployment
	X	Prolonged suffering
	X	Homelessness
	X	Removal of children from their homes

Box A: Brief program description.

The Afghan Wellness Project (AWP) offers Prevention and Early Intervention (PEI) services to individuals, couples, and families at risk of serious mental health issues. AWP aims to reduce stigma through education and awareness, preventing mental illness from becoming disabling. It bridges cultural and language gaps between community members and mental health services. The Afghan Wellness Project serves Afghan new

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arrivals, families under stress, at-risk youth, isolated or trauma-exposed individuals, and those at risk of serious mental health issues. PEI services are provided in Dari, Pashto, and English.
The Afghan Wellness Project's staff provides training, workshops, and presentations to promote mental health and well-being and prevent serious mental health issues. Other important programs include domestic violence prevention and awareness groups, youth tutoring and social programs, women's and men's support groups, cultural events, and assistance with basic needs.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	
Number of unduplicated individual family members served indirectly by your program:	
Grand total of unduplicated individuals served:	

Box C: Demographics of individuals served this fiscal year through MHSA funding:			
AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	1,509	Gay/Lesbian	1
Transition Age Youth (16-25 yrs.)	467	Heterosexual/Straight	4,727
Adult (26-59 yrs.)	4,884	Bisexual	
Older Adult (60+ yrs.)	228	Questioning/Unsure	
Declined to answer		Queer	
Unknown	250	Declined to answer	
TOTAL	7,338	Unknown	2,610
		Another group not listed	
		TOTAL	7,338
		If another group is counted, please specify with numbers:	
VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes	2	English	540
No	1,996	Spanish	
Declined to answer		Cantonese	
Unknown	5,340	Chinese	
TOTAL	7,338	Vietnamese	
		Farsi	1,142
CURRENT GENDER IDENTITY		Arabic	36
Female	4,084	Tagalog	
Male	3,051	Declined to answer	
Transgender		Unknown	
Genderqueer		Other languages not listed	5,620

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Questioning/unsure of gender identity		TOTAL	7,338
Declined to answer			
Unknown	203		
Another identity not listed			
TOTAL	7,338		
If another group is counted, please specify with numbers:			

SEX ASSIGNED AT BIRTH		**ETHNITICY/CULTURAL HERITAGE (choose one)**	
Male		**If Hispanic or Latino, please specify:**	
Female		Caribbean	
Declined to answer		Central American	
Unknown		Mexican/Mexican American/Chicano	
TOTAL		Puerto Rican	
Male		South American	
		Another Hispanic/Latino ethnicity not listed	85
DISABILITY STATUS		**Total Hispanic or Latino**	
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision		African	
Hearing/Speech		African American	
Another type not listed	412	Asian Indian/South Asian	6,761
Communication Domain Subtotal		Cambodian	
Disability Domain		Chinese	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)		Eastern European	
		European	
		Filipino	
Physical/mobility		Japanese	
Chronic health condition		Korean	
Disability Subtotal		Middle Eastern	
None	1,357	Vietnamese	
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	39
Unknown	5,569	**Total Non-Hispanic or Non-Latino:**	
Another disability not listed		More than one ethnicity	
TOTAL	7,338	Unknown ethnicity	
If another disability is counted, please specify with numbers:		Declined to answer	
		ETHNICITY TOTAL	6,807

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		If another ethnicity is counted, please specify with numbers:
RACE		
American Indian or Alaska Native		If another race is counted, please specify with numbers:
Asian	6,761	
Black or African American	14	
Native Hawaiian or another Pacific Islander		
White	4	
Other Race	104	
Declined to answer		
Unknown	455	
TOTAL	7,338	

Box D: Program <u>successes/accomplishments</u> of the past year with one example or case study of a success the agency is particularly proud of.

Most clients express high levels of gratitude and appreciation for the services they receive through the Afghan Wellness Project. Many mental health counseling clients report a high level of satisfaction and improvement of their mental health after they have participated in our counseling programs and psychoeducational workshops/presentations. Some of the examples of positive impact stories are listed below.

A client, exhausted and overcome with emotion arrived at our office in need of support. Staff provided a safe space for her to share her story which revealed she was experiencing the heavy burden of caring for a disabled son and her husband. The client was also navigating the stress and uncertainty of the immigration process. Recognizing the client would benefit from mental health services, she was connected to our Mental Health Specialist for individual counselling and linked to a support group. Our client reported that after attending counseling services she felt her overall wellbeing had significantly improved and found support in the connections she had made at Afghan Coalition.

An Afghan male in his early 40'S was initially hesitant to start counseling as he was concerned it might not help him with his current issues: significant marital problems with his spouse, unemployment, and immigration challenges. Client attended the initial session stating that he did not have much to discuss. A short time later, client was more engaged and decided to continue counseling sessions where he reported high levels of stress, anxiety, and inability to make important life decisions. Client continued with counseling and later reported feeling less stressed and more focused. "I have been having counseling sessions for the past several months, which surprisingly have helped me feel heard and understood."

An elderly Afghan female in her late 60s stated "every Tuesday I keep my phone with me so that I don't miss your call. I look forward to my counseling which has helped me have a more positive outlook and less anxiety".

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Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	4
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	NA
E.3: Types of treatment individuals were referred to (list types below):	
Higher level of psychotherapy services, psychologists, and psychiatrists.	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	4
G.5: Average duration of untreated mental illness in weeks:	UNKNOWN
E.6: Average number of days between referral and first participation in referred treatment program:	7
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
Afghan population including refugees, immigrants, and new arrivals.	
F.2: Number of paper referrals to an ACBH PEI-funded program:	19
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	19
F.4: Average number of days between referral and first participation in referred PEI program:	3-5
F.5: Describe how your program encouraged access to services and follow through on above referrals: Clients are encouraged to discuss their mental health challenges in a non-judgmental and safe environment. The goal is to normalize the use of mental health services and increase awareness about mental health issues. Clients are urged to attend counseling sessions with culturally competent clinicians who can communicate in their native language.	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
25 Site visits to Kennedy High School & Walter's Middle School – Afghan girls support	2 teachers, 1 outreach worker
5 Hayward Unified School District –Afghan student support	1 Teacher, 1 School Resource Counselor, 1 Administrator
4 Virtual Consortium Meetings Afghan Leadership: Asylum & Immigration Issues for New Afghans Housing Issues & Opportunities for New Arrivals	4 Consortium meetings had a total of 423 participants mostly consisting of service providers and community members

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Mental Health & Support for New Arrivals Supporting Afghan Survivors of Torture and Trauma	
7 Community Centers Cultural Events	5 Outreach Worker
2 Health Fairs –Fremont Downtown Center	2 Medical personnel, 4 Service Providers
Weekly Fremont Sport's Complex –Soccer Club	1 Soccer Coach, 2 Volunteers
12 Weekly Women's Group Therapy – Community Kitchen	1 Counselor, 1 Outreach Worker
20 Virtual Parenting Classes	1 LCSW, 1 Outreach Worker
103 Home Visits to Afghan New Arrivals	1 Outreach Worker
28 Social Media Post on Wellness Topics	4,821 impressions

MHSA Program # **PEI 7**
PROVIDER NAME **International Rescue Committee**
PROGRAM NAME **Afghan Path Towards Wellness**
2023 - 2024

Program Outcomes & Impact Data Report

Program Name:	**Afghan Path Towards Wellness**
Organization:	**International Rescue Committee**
Type of Report:	**Annual Data Report**
PEI Category:	**Prevention**

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
X	Suicide
	Incarceration
	School failure or dropout
X	Unemployment
X	Prolonged suffering
X	Homelessness
	Removal of children from their homes

Box A: <u>Brief</u> program description.

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Afghan Path Towards Wellness (APTW): Providing wellness and psychosocial support services to the Afghan community of North Alameda County. Primary services include preventative counseling, psychosocial and educational workshops, community events, socials support groups, wellness assessments, and community provider and leader training.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	30
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	265
Number of unduplicated individual family members served indirectly by your program:	885
Grand total of unduplicated individuals served:	1180

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	65	Gay/Lesbian	
Transition Age Youth (16-25 yrs.)	84	Heterosexual/Straight	713
Adult (26-59 yrs.)	1,444	Bisexual	
Older Adult (60+ yrs.)	63	Questioning/Unsure	
Declined to answer		Queer	
Unknown	11	Declined to answer	
TOTAL	1,677	Unknown	954
		Another group not listed	
		TOTAL	1,667
		If another group is counted, please specify with numbers:	
VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes		English	90
No	109	Spanish	
Declined to answer		Cantonese	
Unknown	1,558	Chinese	
TOTAL	1,667	Vietnamese	
		Farsi	122
CURRENT GENDER IDENTITY		Arabic	89
Female	1,051	Tagalog	
Male	588	Declined to answer	
Transgender	5	Unknown	
Genderqueer		Other languages not listed	1,366
Questioning/unsure of gender identity		TOTAL	1,667
Declined to answer			
Unknown	23		

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Another identity not listed		
TOTAL	1,667	
If another group is counted, please specify with numbers:		

SEX ASSIGNED AT BIRTH		**ETHNITICY/CULTURAL HERITAGE (choose one)**	
Male		**If Hispanic or Latino, please specify:**	
Female		Caribbean	
Declined to answer		Central American	
Unknown		Mexican/Mexican American/Chicano	
TOTAL		Puerto Rican	
Male		South American	
		Another Hispanic/Latino ethnicity not listed	
DISABILITY STATUS		**Total Hispanic or Latino**	
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision		African	
Hearing/Speech		African American	
Another type not listed		Asian Indian/South Asian	1582
Communication Domain Subtotal		Cambodian	
Disability Domain		Chinese	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)		Eastern European	
		European	
		Filipino	
Physical/mobility		Japanese	
Chronic health condition		Korean	
Disability Subtotal	115	Middle Eastern	
None	109	Vietnamese	
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	1
Unknown	1,443	**Total Non-Hispanic or Non-Latino:**	
Another disability not listed		More than one ethnicity	
TOTAL	1,667	Unknown ethnicity	
		Declined to answer	
		ETHNICITY TOTAL	1,583
If another disability is counted, please specify with numbers:		If **another ethnicity** is counted, please specify with numbers:	
RACE			

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American Indian or Alaska Native		If **another race** is counted, please specify with numbers:
Asian	1,582	
Black or African American		
Native Hawaiian or another Pacific Islander		
White		
Other Race		
Declined to answer		
Unknown	85	
TOTAL	1,667	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
One event that our team is particularly proud of was an in-person community event taking place at the Lakeview Oakland Public Library to talk to families about wellbeing and resources at the library they could access to support their families. It was great to see both parents and children interacting with stress management and library activities. We facilitated the session with the library's Youth and Community Events Coordinator. We also continued our collaboration with our internal Resettlement and Placement Cultural Orientation Programming to support new Afghan arrivals.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	6
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	2
E.3: Types of treatment individuals were referred to (list types below):	
Clients were referred to both short term and long-term therapy at community-based 65clinics and behavioral health programs at their local hospitals.	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	3
G.5: Average duration of untreated mental illness in weeks:	16
E.6: Average number of days between referral and first participation in referred treatment program:	30
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
Afghans	
F.2: Number of paper referrals to an ACBH PEI-funded program:	0
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A

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F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referrals: While this year there were no linkages to other ACBH PEI funded programs, in general, APTW strategies for successful linkage to other PEI programs revolve around one-on-one coaching on resources, and education around myths of the risks of seeking mental health support. If and when a client is willing to be referred to another PEI program, the APTW offers to support with transportation, registration, and other logistical stressors that can be barriers. The APTW team also follows up directly with the PEI provider to ensure a smooth transition.	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. *(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)*	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
NA	NA

MHSA Program # **PEI 7**
PROVIDER NAME **Filipino Advocates for Justice**
PROGRAM NAME **Filipino Community Wellness Program**
2023-2024

Program Outcomes & Impact Data Report

Program Name:	**Filipino Community Wellness Program**
Organization:	**Filipino Advocates for Justice**
Type of Report:	**Annual Data Report**
PEI Category:	**Prevention**

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
X	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.	
	Suicide

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	Incarceration
X	School failure or dropout
X	Unemployment
X	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: Brief program description.
FAJ's Filipino Community Wellness Program aims to engage youth, young adults, elder immigrants and low wage workers in healthy, positive, culturally relevant, and inclusive activities that prevent isolation, disconnection, anxiety, fear and hopelessness, and reduces the stigmas associated with use of mental health services.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	NA
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	12
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	75

Box C: Demographics of individuals served this fiscal year through MHSA funding:			
AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	10	Gay/Lesbian	15
Transition Age Youth (16-25 yrs.)	160	Heterosexual/Straight	251
Adult (26-59 yrs.)	75	Bisexual	1
Older Adult (60+ yrs.)	81	Questioning/Unsure	
Declined to answer		Queer	27
Unknown		Declined to answer	
TOTAL	326	Unknown	31
		Another group not listed	1
		TOTAL	326
		If another group is counted, please specify with numbers:	
VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes		English	167
No	131	Spanish	
Declined to answer		Cantonese	
Unknown	195	Chinese	
TOTAL	326	Vietnamese	
		Farsi	
CURRENT GENDER IDENTITY		Arabic	

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Female	212	Tagalog	159
Male	78	Declined to answer	
Transgender	5	Unknown	
Genderqueer		Other languages not listed	
Questioning/unsure of gender identity	1	TOTAL	326
Declined to answer			
Unknown			
Another identity not listed	30		
TOTAL	326		
If another group is counted, please specify with numbers:			

SEX ASSIGNED AT BIRTH		**ETHNICITY/CULTURAL HERITAGE (choose one)**	
Male		**If Hispanic or Latino, please specify:**	
Female		Caribbean	
Declined to answer		Central American	
Unknown		Mexican/Mexican American/Chicano	
TOTAL		Puerto Rican	
Male		South American	
		Another Hispanic/Latino ethnicity not listed	
DISABILITY STATUS		**Total Hispanic or Latino**	3
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision		African	
Hearing/Speech		African American	
Another type not listed		Asian Indian/South Asian	10
Communication Domain Subtotal		Cambodian	
Disability Domain		Chinese	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)		Eastern European	
		European	
		Filipino	301
Physical/mobility		Japanese	
Chronic health condition		Korean	
Disability Subtotal		Middle Eastern	
None		Vietnamese	1
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	
Unknown		**Total Non-Hispanic or Non-Latino:**	

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Another disability not listed		More than one ethnicity	
TOTAL		Unknown ethnicity	
		Declined to answer	
		ETHNICITY TOTAL	315
If another disability is counted, please specify with numbers:		If another ethnicity is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native		If another race is counted, please specify with numbers:	
Asian	307		
Black or African American	2		
Native Hawaiian or another Pacific Islander			
White			
Other Race	17		
Declined to answer			
Unknown			
TOTAL	326		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

Our youth program participants struggled with balancing academics with personal responsibilities, relationship issues, financial and housing instability, while feeling targeted by islamophobia and xenophobia due to the hostile political climate. They were able to channel and redirect challenges through their leadership, an area where the youth program found success this year. Youth were trained to facilitate workshops on how to center mental wellbeing and stand in solidarity with other youth who also face these compounded struggles. Our TAY program faced some challenges holding a hybrid format for some workshops, timing activities in line with seasonal and life events of TAY participants. Successes include strengthened partnerships with local community colleges leading to improved attendance, networks with guest speakers, and the incorporation of regular 3rd space events for community building leading to higher levels of engagement. Workshop topics that resonated well with TAY addressed life conditions that affect mental health include “adulting” (healthy relationships, independence and financial literacy), preventing burnout, and staying centered in a polarized social climate. Our new approach that emphasized collective healing was key. Our elder program saw similar success with their third space events where storytelling, wellness workshops and fun community building activities were the antidote to shyness and isolation our elders often feel. Observations through our preventative counseling program this year revealed that many were attempting to deal with their mental health in isolation. Engaging these clients in our third space events was able to provide needed collective healing and support by fostering a sense of community and solidarity with others. Success story: “Patricia”, who is a regular elder participant, suddenly stopped attending because she was dealing with mental and physical health issues. Our follow up calls to her were unanswered. We continued to call, reached out to her daughter, then visited them in their home. We encouraged her to seek help, be with other people and gradually start doing what she loves to do. Now Patrica is on a solid path towards her wellbeing.

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Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	NA
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	NA
E.3: Types of treatment individuals were referred to (list types below):	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	NA
G.5: Average duration of untreated mental illness in weeks:	NA
E.6: Average number of days between referral and first participation in referred treatment program:	NA
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
Filipino and other AAPI youth, TAY and adult, including immigrants and LGBTQ.	
F.2: Number of paper referrals to an ACBH PEI-funded program:	18
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	26
F.4: Average number of days between referral and first participation in referred PEI program:	7
F.5: Describe how your program encouraged access to services and follow through on above referrals: Access to services was encouraged by offering flexible appointment times and virtual counseling options to accommodate diverse needs. To ensure follow through on referrals, clients were provided with a detailed action plan and conduct regular check ins to monitor progress. Direct support in navigating the referral process and timely reminders were given to help clients stay engaged with their care.	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. *(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)*	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
In person at organization offices in Union City and Oakland, hybrid or virtual. Offsite at Chabot College In Hayward and Ohlone College in Fremont.	3 community outreach workers, 1 mental health specialist.

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Social media	

MHSA Program #	**PEI 7**
PROVIDER NAME	**The Hume Center, Portia Bell Hume Behavioral Health & Training Center**
PROGRAM NAME	**South Asian Community Health Promotion Services Program**
2023-2024	

Program Outcomes & Impact Data Report

Program Name:	**South Asian Community Health Promotion Services**
Organization:	**The Hume Center**
Type of Report:	**Annual Data Report**
PEI Category:	**Prevention**

	Priority Area (place an X next to all that apply):
	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
X	Older Adults
X	Early Identification of MH Illness

	Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.
X	Suicide
	Incarceration
X	School failure or dropout
X	Unemployment
X	Prolonged suffering
	Homelessness
X	Removal of children from their homes

Box A: <u>Brief</u> program description.

When life becomes too overwhelming, that result can bring changes in how an individual thinks, feels and acts. The South Asian program provide specialized prevention and early intervention (PEI) services to the South Asian population to participants across the lifespan. We are the main provider in Alameda County for this population, currently serving Afghanis, Bangladeshis, Bhutanese, Asian Indians including Fiji Islanders, Iranians, Maldivians, Nepalese, Pakistanis, and Sri Lankans. We provide these services in the clinic, home visits, in schools, in the community (community centers, religious establishments, etc.) and through telehealth. To meet the linguistic needs of the population services are provided in English, Hindi, Punjabi, Urdu, Farsi, Dari, Gujarati, Marathi, Tamil, and Nepali.

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These short-term culturally sensitive and language specific services offer support aimed at developing knowledge and skills to work through life challenges effectively. The program also breaks stigmas of mental health through outreach, education and consultation.

Our prevention strategies re-frame mental health and behavioral health care from a pathological perspective to a strength-based, normative, developmental assets focus. Working with immigrants and refugees we understand that they often come from collectivistic cultures, and so we adapt our services so that we are addressing collective wellness, rather than just focusing on individuals within the community. We understand that immigrant and refugee communities rely on their families and community for support in times of distress. Family, community, and religion are a huge part of building resilience for those that we work with. We adjust our approaches to include these protective factors as a part of our work. When we work with immigrant and refugee communities we incorporate these holistic, cultural and religious forms of healing into our services to help build rapport, break stigmas around mental health and increase participation. (Examples: Yoga workshops, Badminton and Soccer groups, Prayer; Meditation). We offer family education and consultation to help educate and increase awareness for families struggling with loved ones with a mental health disorder. We also offer family focused trauma informed care to help address domestic/family violence, immigration trauma and acculturation stress. Our work is focused on strengthening relationships within families and communities. (Offering parent/child workshops, offering community gatherings, engaging families in play through art and games). The goal of the program is to help community members build resilience which can contribute to the prevention of mental health disorders.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	Unavailable
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	Unavailable
Number of unduplicated individual family members served indirectly by your program:	Unavailable
Grand total of unduplicated individuals served:	

Box C: Demographics of individuals served this fiscal year through MHSA funding:			
AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	129	Gay/Lesbian	
Transition Age Youth (16-25 yrs.)	120	Heterosexual/Straight	521
Adult (26-59 yrs.)	502	Bisexual	
Older Adult (60+ yrs.)	85	Questioning/Unsure	3
Declined to answer		Queer	
Unknown	1	Declined to answer	
TOTAL	837	Unknown	313
		Another group not listed	
		TOTAL	837
		If another group is counted, please specify with numbers:	

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VETERAN STATUS	
Yes	
No	399
Declined to answer	
Unknown	438
TOTAL	837

CURRENT GENDER IDENTITY	
Female	404
Male	418
Transgender	
Genderqueer	
Questioning/unsure of gender identity	1
Declined to answer	
Unknown	13
Another identity not listed	1
TOTAL	837
If another group is counted, please specify with numbers:	

PRIMARY LANGUAGE	
English	330
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Other languages not listed	502
TOTAL	837

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	
Male	
DISABILITY STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	3
Communication Domain Subtotal	
Disability Domain	

ETHNICITY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	6
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	153
Cambodian	
Chinese	7
Eastern European	
European	

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Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)		Filipino	
Physical/mobility		Japanese	
Chronic health condition		Korean	
Disability Subtotal		Middle Eastern	
None	509	Vietnamese	
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	525
Unknown	325	**Total Non-Hispanic or Non-Latino:**	
Another disability not listed		More than one ethnicity	
TOTAL	837	Unknown ethnicity	
If another disability is counted, please specify with numbers:		Declined to answer	
		ETHNICITY TOTAL	685
RACE		If another ethnicity is counted, please specify with numbers:	
American Indian or Alaska Native		If another race is counted, please specify with numbers:	
Asian	685		
Black or African American	9		
Native Hawaiian or another Pacific Islander			
White	2		
Other Race	10		
Declined to answer			
Unknown	131		
TOTAL	837		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

Our biggest success and accomplishment this year has been our ability to engage with more families, especially those that have children that are in middle school or high school. By having more family engagement, we have been able to reduce a lot of stigma and barriers towards services. We have also worked through a lot of challenges that immigrant families face regarding intergenerational communication, differences in acculturation, culturally defined definitions around success, and healthy boundaries. We witnessed many shifts within family dynamics that allowed more harmony and appreciation for both collectivistic values and individualistic values. Many of the family members were engaging in individual sessions in addition to family sessions, so that they could work on their individual struggles as well as struggles within the family system. We had many families share their experiences with others and have their loved ones also self-refer to the program to get support. So essentially our

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participants became referral sources and in turn normalized the need for mental health care within the larger community. This year we continued to increase our visibility out in the community. We attended many in-person events. We participated in more than 25 tabling events and several community workshops. We participated as invited speakers in many cultural gatherings, one was at the local Gurdwara (Sikh place of worship) where we engaged the community in understanding mental health from a Sikh lens. We received a lot of positive feedback from that event. Participants shared their gratitude for presenting a model that aligns with their values and beliefs and uses language that they are familiar with. We also hosted an event for South Asian youth that allowed them to express their bicultural experiences through Art, combining what they enjoyed about the American Holiday of Halloween along with what they enjoyed about the Indian Holiday of Diwali. In the Spring we hosted another event for Mother's Day, where we invited Moms and kids to come and reflect on the processes of self-care and engaged them in a bonding activity. We received a record number of invites to different events this year, which made us realize how much progress the community has made in giving mental health importance. Overall, this year has been full of a lot of gratitude, appreciation and support from the community for the opportunities that are offered by our program. Not only from the participants that engage in our services but also by other community organizations, schools, health providers, DV advocates, faith leaders, spiritual healers, city officials across the county and other stakeholders.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	4
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	28
E.3: Types of treatment individuals were referred to (list types below):	
Psychotherapy, Psychological testing, SUD treatment, Intensive Outpatient Services, Step Down programs, spiritual or holistic treatments, programs with specific treatment modalities such as CBT, EMDR, Trauma Focused, Psychoanalysis and Child custody evaluations. These treatments were offered through Washington Hospital, Fremont Hospital, Kaiser, Palo Alto Medical Foundation, Company employee assistance programs, school/college counselors, faith leaders, spiritual healers, community support groups/workshops, other CBO's outside of the ACBH system, and SUD specific programs.	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/a
G.5: Average duration of untreated mental illness in weeks:	N/a
E.6: Average number of days between referral and first participation in referred treatment program:	N/a
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	

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F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
The South Asian program provide specialized prevention and early intervention (PEI) services to the South Asian population to participants across the lifespan. We are the main provider in Alameda County for this population, currently serving Afghanis, Bangladeshis, Bhutanese, Asian Indians including Fiji Islanders, Iranians, Maldivians, Nepalese, Pakistanis, and Sri Lankans. We provide these services in the clinic, home visits, in schools, in the community (community centers, religious establishments, etc.) and through telehealth. To meet the linguistic needs of the population services are provided in English, Hindi, Punjabi, Urdu, Farsi, Dari, Gujarati, Marathi, Tamil, and Nepali.	
F.2: Number of paper referrals to an ACBH PEI-funded program:	10 (not paper referrals, but verbal sharing of referral information for other UELP programs that offered services for communities we do not serve directly (Ex. Afghan Coalition, ARISE, CERI)
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	unavailable
F.4: Average number of days between referral and first participation in referred PEI program:	unavailable
F.5: Describe how your program encouraged access to services and follow through on above referrals: Our admin staff shared information with individuals that identified outside our target population through phone call follow ups. For those that started services with us, but we identified they may benefit more by engaging with another agency, our providers shared information about the programs they wanted to refer individuals to in session and provided space for individuals to share their thoughts about the possible referral. The decision to refer and connect individuals to other services was a collaborative decision between the individuals and their providers. Our providers also worked with the PEI programs that they were referring individuals to so that warm handoffs could be planned. Our providers attempted to follow up through phone calls with referred individuals, however it was difficult to get a hold of individuals after they had already disengaged with our agency. Due to cultural barriers and confidentiality issues, most individuals were not comfortable in sharing with us if they had made an appointment with the new agency and did not disclose if they had already had their first session with the new agency.	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

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K-12 Schools	30+ counselors, 6+ social workers, 8+ principals, nurses, resource officers, district staff, family partners, teachers, teachers' assistants
Colleges & Universities	professors, administration, counselors, staff, unlimited students & community members
Local CBO's	DV advocates, MH providers, Docs, nurses, social workers, peer/resource specialists first responders, volunteers, senior support specialists, Health care providers,
Community/Faith Leaders	100+ leaders in Nepalese, Bhutanese, Punjabi, Persian, Pakistani, Indian, Fijian community
Community Centers & Senior Centers	Unlimited Community Members
South Asian Businesses (Restaurants, Grocery Stores, etc.)	Unlimited Community Members
Religious Places of Worship	Unlimited Community Members
Hospitals	Doctors, nurses, admin, social workers, community specialists, volunteers, students
Libraries	Librarians, Staff, Parents, Children, Community Members
Academic Conferences	Professors, Students (Grad, College, HS, K-12), Parents, Peers, MH providers, Social Workers, Lawyers, Councilmembers, Senators
Listening Sessions	ACBH staff, State of California University Staff, Unlimited CBO's, Community members, CA State capitol- assembly and senate members, etc.
South Asian Focused Agencies	Volunteers, Peer Specialists, Social Workers, IT specialists, Engineers, Community Members
Community Events (Health Fairs, Farmers Markets, Job Fairs, Cultural Festivals, Golden State Warriors game etc.)	Unlimited Community Members

MHSA Program # **PEI 8**
PROVIDER NAME: **Native American Health Center, INC.**
PROGRAM NAME: **Native American Health Center PEI/UELP**
2023 – 2024

Program Outcomes & Impact Data Report

Program Name:	**Native American Health Center**
Organization:	**Native American Health Center, INC.**
Type of Report:	**Annual Data Report**

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PEI Category:	Prevention
Priority Area (place an X next to all that apply):	
X	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
X	Older Adults
X	Early Identification of MH Illness
Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.	
X	Suicide
X	Incarceration
X	School failure or dropout
X	Unemployment
	Prolonged suffering
X	Homelessness
X	Removal of children from their homes

Box A: Brief program description.

We provide integrated emotional wellness programs that center on culture, language, heritage, and holistic and indigenous healing practices. We work towards enhancing participants' protective factors through strength-based cultural and generational resilience activities that are reflective of ethnic and traditional practices and are empowering of individuals, families, and communities to make informed decisions around maintaining or restoring their mental health. We provide services in culturally appropriate languages as needed.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	NA
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	NA
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	NA

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	613	Gay/Lesbian	
Transition Age Youth (16-25 yrs.)	147	Heterosexual/Straight	79
Adult (26-59 yrs.)	231	Bisexual	
Older Adult (60+ yrs.)	173	Questioning/Unsure	
Declined to answer		Queer	
Unknown		Declined to answer	

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TOTAL	1,164	Unknown	1,083
		Another group not listed	2
		TOTAL	1,164
		If another group is counted, please specify with numbers:	

VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes	8	English	1,122
No	752	Spanish	42
Declined to answer		Cantonese	
Unknown	404	Chinese	
TOTAL	1,164	Vietnamese	
		Farsi	
CURRENT GENDER IDENTITY		Arabic	
Female	623	Tagalog	
Male	539	Declined to answer	
Transgender		Unknown	
Genderqueer		Other languages not listed	
Questioning/unsure of gender identity		TOTAL	1,164
Declined to answer			
Unknown			
Another identity not listed	2		
TOTAL	1,164		
If another group is counted, please specify with numbers:			

SEX ASSIGNED AT BIRTH		**ETHNITICY/CULTURAL HERITAGE (choose one)**	
Male		**If Hispanic or Latino, please specify:**	
Female		Caribbean	
Declined to answer		Central American	
Unknown		Mexican/Mexican American/Chicano	
TOTAL		Puerto Rican	
Male		South American	
		Another Hispanic/Latino ethnicity not listed	
DISABILITY STATUS		**Total Hispanic or Latino**	477
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision		African	

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Hearing/Speech		African American	
Another type not listed	108	Asian Indian/South Asian	
Communication Domain Subtotal		Cambodian	
Disability Domain		Chinese	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)		Eastern European	
		European	
		Filipino	
Physical/mobility		Japanese	
Chronic health condition		Korean	
Disability Subtotal		Middle Eastern	
None	228	Vietnamese	
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	571
Unknown	828	**Total Non-Hispanic or Non-Latino:**	
Another disability not listed		More than one ethnicity	
TOTAL	1,164	Unknown ethnicity	
		Declined to answer	
		ETHNICITY TOTAL	1,048
If another disability is counted, please specify with numbers:		If another ethnicity is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native		If another race is counted, please specify with numbers:	
Asian			
Black or African American	83		
Native Hawaiian or another Pacific Islander	571		
White	10		
Other Race	500		
Declined to answer			
Unknown			
TOTAL	1,164		

Box D: Program <u>successes/accomplishments</u> of the past year with one example or case study of a success the agency is particularly proud of.

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A program success that we recently have experienced is the popularity of our Drum Group. We have finally been able to restart our Drum Group that was on hiatus since COVID. Our Drum group was greatly missed and has been well attended. We are working towards implementing new groups as well as brining back a few favorites. As an agency we are excited to announce that NAHC has broken ground on the 3050 Project. This latest development at 3050 will feature 20 dental operatories and a 300-person cultural community center, housed in a state-of the-art 5 story building. The Project, is a partnership with Satellite Affordable Housing associates (SAHA), also includes 76 affordable housing units, addressing the vital needs of dental care, cultural engagement and housing in our community. We are looking forward to the planned opening in the Fall of 2025. The new facility will increase outreach, access, and visibility of our Native American Community.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	N/A
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	N/A
E.3: Types of treatment individuals were referred to (list types below):	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	39
G.5: Average duration of untreated mental illness in weeks:	2
E.6: Average number of days between referral and first participation in referred treatment program:	10
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
F.2: Number of paper referrals to an ACBH PEI-funded program:	39
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	39
F.4: Average number of days between referral and first participation in referred PEI program:	4
F.5: Describe how your program encouraged access to services and follow through on above referrals:	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. *(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)*	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at

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	schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #	**PEI 9**
PROVIDER NAME	**Diversity in Health Training Institute**
PROGRAM NAME	**Sidra Community Wellness Program**

2023 - 2024

Program Outcomes & Impact Data Report

Program Name:	**UELP**
Organization:	**Diversity in Health Training Institute**
Type of Report:	**Annual Data Report**
PEI Category:	**Prevention**

Priority Area (place an X next to all that apply):

	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
X	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.

X	Suicide
X	Incarceration
X	School failure or dropout
X	Unemployment
X	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: Brief program description.

Sidra Community Wellness Program (SIDRA) launched in July 2019. The purpose of SIDRA is to promote healing, wellness and mental health among Middle Eastern and North African communities in Alameda County. We offer preventive counseling, support groups, educational and cultural workshops, community events, and referrals and linkages to promote and support community wellness. We also offer consultations to local organizations.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	n/a

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Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	
Number of unduplicated individual family members served indirectly by your program:	65
Grand total of unduplicated individuals served:	118

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	73
Transition Age Youth (16-25 yrs.)	19
Adult (26-59 yrs.)	36
Older Adult (60+ yrs.)	1
Declined to answer	
Unknown	
TOTAL	129

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	107
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	22
Another group not listed	
TOTAL	129
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	
No	124
Declined to answer	
Unknown	5
TOTAL	129

PRIMARY LANGUAGE	
English	12
Spanish	
Cantonese	
Chinese	
Vietnamese	1
Farsi	23
Arabic	90
Tagalog	
Declined to answer	
Unknown	
Other languages not listed	
TOTAL	129

CURRENT GENDER IDENTITY	
Female	63
Male	66
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	129
If another group is counted, please specify with numbers:	

SEX ASSIGNED AT BIRTH	**ETHNITICY/CULTURAL HERITAGE (choose one)**

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Male		**If Hispanic or Latino, please specify:**	
Female		Caribbean	
Declined to answer		Central American	
Unknown		Mexican/Mexican American/Chicano	
TOTAL		Puerto Rican	
Male		South American	
		Another Hispanic/Latino ethnicity not listed	
DISABILITY STATUS		**Total Hispanic or Latino**	0
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision		African	
Hearing/Speech		African American	
Another type not listed		Asian Indian/South Asian	20
Communication Domain Subtotal		Cambodian	
Disability Domain		Chinese	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)		Eastern European	
		European	
		Filipino	
Physical/mobility		Japanese	
Chronic health condition		Korean	
Disability Subtotal		Middle Eastern	
None	122	Vietnamese	
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	109
Unknown	7	**Total Non-Hispanic or Non-Latino:**	
Another disability not listed		More than one ethnicity	
TOTAL	129	Unknown ethnicity	
		Declined to answer	
		ETHNICITY TOTAL	129
If another disability is counted, please specify with numbers:		If another ethnicity is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native		If another race is counted, please specify with numbers:	
Asian	12		
Black or African American			
Native Hawaiian or another Pacific Islander			

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White	117	
Other Race		
Declined to answer		
Unknown		
TOTAL	129	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
The team's greatest accomplishment this year has been developing a process for getting hard-to-reach clients connected with mental health services. In most initial encounters, clients are not interested in sharing their challenges. In many MENA cultures, talking about your problems with others is seen as shameful. However, the Sidra team has found a way to connect clients with support. A great example of this is a client who was a recent immigrant, facing numerous traumas and challenges upon arriving in a new country. His struggles seemed insurmountable, but then he began utilizing Sidra's services and through various mental health counseling sessions, he began slowly navigating his difficulties. Through constant support and guidance, Client X began to heal from his past traumas and confront his current challenges with newfound resilience. With our mental health specialists offering a safe space to express his emotions and fears. He began learning to understand cultural differences, navigate bureaucratic hurdles, and connect with local support networks. Through the services offered by Sidra, this client became empowered to rebuild his life step by step. Over time, this client gained confidence and started to overcome language barriers, find employment opportunities, and build meaningful relationships in his new community. With Sidra's ongoing support, he not only survived but thrived, becoming a beacon of hope for others facing similar struggles. His success story is a testament to the transformative power of empathy and dedicated mentorship in overcoming adversity.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	N/A
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	3
E.3: Types of treatment individuals were referred to (list types below):	
Mental health providers that provide long term care	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	2
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	30
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	

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F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
Middle Eastern and North African communities, Arabic speaking communities, mothers and grandmothers, youth, transitional age youth, older adults, women, men	
F.2: Number of paper referrals to an ACBH PEI-funded program:	N/A
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	0
F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referrals: N/A	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
School – SFSFU – Exploring College Life	6 staff attended and 5 professors at school
School- Yemeni Revolution Day	4 staff and 4 teachers at school
School- Fall Celebration	7 staff at event
Office- Yalda Event	4 staff at event
School- International Festival OIHS	3 staff and 20 teachers at school
Community Center- Women's Day	4 staff at event
Park- World Refugees and Immigrants Festival	2 staff at event
Park- Kite Event	4 staff at event
Park- BBQ and Sports Event	10 staff at event

MHSA Program #	**PEI 10**
PROVIDER NAME	**Partnerships for Trauma Recovery**
PROGRAM NAME	**African Communities Program**

2023 - 2024

Program Outcomes & Impact Data Report

Program Name:	**African Communities Program**
Organization:	**Partnerships for Trauma Recovery**

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Type of Report:	**Annual Data Report**
PEI Category:	**Prevention**

Priority Area (place an X next to all that apply):

	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.

X	Suicide
	Incarceration
X	School failure or dropout
X	Unemployment
X	Prolonged suffering
X	Homelessness
	Removal of children from their homes

Box A: Brief program description.

Partnerships for Trauma Recovery (PTR) provides culturally sensitive, trauma-informed, and linguistically accessible PEI services, along with community-based healing, to marginalized communities of forcibly displaced youth, women, men, and families from various African countries. While primarily centered in North and South Alameda County, PTR's reach extends beyond these areas. With a steadfast commitment to decolonizing practices and technical excellence, PTR delivers inclusive and comprehensive behavioral health care, as well as short-term, solution-focused psycho-social counseling and case management support for individuals who have experienced violence and persecution in their countries of origin.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness: Please note that we have served 11 new clients and 20 clients who have continued from the previous fiscal year.	31
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	62
Number of unduplicated individual family members served indirectly by your program: Please note that, on average, each individual has 3 family members in their household.	63
Grand total of unduplicated individuals served:	93

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	**SEXUAL ORIENTATION**

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Children/Youth (0-15 yrs.)	24
Transition Age Youth (16-25 yrs.)	30
Adult (26-59 yrs.)	139
Older Adult (60+ yrs.)	20
Declined to answer	
Unknown	
TOTAL	213

Gay/Lesbian	1
Heterosexual/Straight	95
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	115
Another group not listed	2
TOTAL	213

If another group is counted, please specify with numbers:

VETERAN STATUS	
Yes	1
No	196
Declined to answer	
Unknown	16
TOTAL	213

PRIMARY LANGUAGE	
English	51
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Other languages not listed	162
TOTAL	213

CURRENT GENDER IDENTITY	
Female	123
Male	90
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	213

If another group is counted, please specify with numbers:

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	
Male	

ETHNICITY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	

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		Another Hispanic/Latino ethnicity not listed	
DISABILITY STATUS		**Total Hispanic or Latino**	
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision		African	24
Hearing/Speech		African American	
Another type not listed		Asian Indian/South Asian	
Communication Domain Subtotal		Cambodian	
Disability Domain		Chinese	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)		Eastern European	
		European	
		Filipino	
Physical/mobility		Japanese	
Chronic health condition		Korean	
Disability Subtotal		Middle Eastern	
None	186	Vietnamese	
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	181
Unknown	27	**Total Non-Hispanic or Non-Latino:**	
Another disability not listed		More than one ethnicity	
TOTAL	213	Unknown ethnicity	
		Declined to answer	
		ETHNICITY TOTAL	205
If another disability is counted, please specify with numbers:		If another ethnicity is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native		If another race is counted, please specify with numbers:	
Asian			
Black or African American	206		
Native Hawaiian or another Pacific Islander			
White			
Other Race	7		
Declined to answer			
Unknown			
TOTAL	213		

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Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
Enhanced Service Accessibility: Enhance service accessibility by broadening outreach initiatives to reach diverse communities wherever they are, encompassing women, youth, elderly populations, and others in various locations such as schools, churches, coffee shops, and more. Conducted awareness sessions on autism at the Ethiopian Church, engaging 30 educators and focusing on signs, symptoms, causes, and healthcare provider attitudes. PTR and the Eritrean Community for Health and Wellness co-hosted the Eritrean Community Wellness Day, addressing wellness and immigration rights for around 300 community members. Proactive Community Outreach and Destigmatized Mental Health: Community leaders are reaching out seeking support and collaboration, addressing issues like suicidal ideation (Kenyan communities), women's mental health (Eritrean), autism (Ethiopian), and PTSD (Rwandan communities). As a result, community leaders are starting to reach out to us rather than the other way around i.e., suicidal ideation from Kenyan communities, women's MH issues from Eritrean, Autism from Ethiopian, PTSD from Rwandan communities Cultural Sensitivity and Addressed Stressors: Having community leaders for cultural validation before conducting any psyched workshop, event, or educational workshops. Renaming the psyched workshop into an African community gathering. Identified different needs and stressors of the community members and conduct various sessions, a minimum of 12 workshops in a year such as generational gap, breaking stigma, Autism, women's health, Housing, immigration, employment, housing, and access to various public benefits Expanded Strategic Partnerships and Networking: Expanded collaborations and partnerships with service providers such as BRFN, Wellness in Action, AAN, PAN, USF, Center for African Studies, Community Based Associations, CBOs, and others. Involved community leaders directly in activities, with series of consultations and dialogues to understand community-specific needs. Leveraging community assets and potentials, community leaders participate directly in activities as co-facilitators, guest speakers, or community mobilizers. A series of community consultations and dialogues are conducted to understand and address specific community needs. Creativity and originality: in collaboration with CERI, we developed a decolonizing healing series aimed at connecting providers, community leaders, and communities to harness diverse lived experiences, ancestral wisdom, curiosities, and community work. This series focuses on centering ancestral knowledge and joy, highlighting grassroots movements led by community leaders, addressing current community needs, promoting calls to action, amplifying the voices of youth, elders, and families, and developing leadership and empowerment. We use art, poetry, food, music, dance, and joy as forms of healing for mental health issues, comparing and integrating perspectives from the Global North and Global South, as well as Western and Eastern practices. This approach rejects the colonized lens, instead uplifting community-based healing methods. In December 2023 and May 2024, we successfully conducted Series 5 and 6. Additionally, under the pillar of creativity and originality, we organized the Afro-Soccer Wellness Event for the second time, recognizing soccer and other community-led activities as valuable means of healing. Key accomplishments include leveraging resources from approximately five partners, including financial, time, and in-kind support, engaging youth, men, and service providers, and establishing a continuum collaboration with partners for ongoing initiatives. Throughout the event, we promoted wellness by having a collective discourse on the importance of coming together through sports, tabling fliers and

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brochures on mental health resources, and enjoying local artistic performances. Engaged 153 community members, including CBO and faith-based leaders, athletes, football players, men, women, boys, and girls from diverse communities. Annual African Communities Gathering: Organized by AAN, PTR, and collaborators, aligning with the Juneteenth celebration. Engaged 115 community leaders, providing a space for connection, networking, and enjoyment.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	15
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	3
E.3: Types of treatment individuals were referred to (list types below):	
Referred internally and externally for long-term comprehensive therapy services and psychiatric support.	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	12
G.5: Average duration of untreated mental illness in weeks:	4 weeks
E.6: Average number of days between referral and first participation in referred treatment program:	3 weeks
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
African	
F.2: Number of paper referrals to an ACBH PEI-funded program:	10
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	15
F.4: Average number of days between referral and first participation in referred PEI program:	72hrs/3 days
F.5: Describe how your program encouraged access to services and follow through on above referrals: PTR enhances access to services by providing culturally responsive and linguistically accessible support. To ensure this, PTR covers transportation expenses for clients through unrestricted funds and provides interpreters for all clients. If we do not have an existing interpreter, we recruit new ones for this purpose. Additionally, we utilize Alameda County's interpretation services. We encourage service-seeking behavior through our existing outreach strategy, which aims to destigmatize mental health. Our outreach efforts include disseminating information at various community hubs such as churches, coffee shops, hair salons, schools, CBOs, and through community and faith-based leaders. This multi-faceted approach helps enhance awareness and access to our services.	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe

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mental illness provide support, and or refer individuals who need treatment) reached. *(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)*	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
In-person in community settings and virtually via Zoom.	Engaged a total of 485 individuals from the general community, including community leaders, service providers, youth, asylum seekers, and newcomers through various initiatives: 329 participants attended psychoeducation workshops, 34 joined support groups, and 122 received mental health consultations.
Virtual via zoom	A total of 240 service providers, community leaders, activists, and advocates participated in the educational workshops for the Decolonizing Healing Series #4, #5, and #6.
Coffee shops, PTR office, parks, and churches	Supported 62 potential clients showing early signs of mental health issues through mental health prevention visits.
Social media platforms such as WhatsApp, Facebook, and Instagram,	Reached 203 individuals have received information through social media, and they liked and shared flyers, brochures, and other communication materials related to African community programs.

MHSA Program #	**PEI120A**
PROVIDER NAME	**Beats Rhymes and Life Inc.**
PROGRAM NAME	**Beats Rhymes and Life "Prevention Pathways Program"**

2023 - 2024

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Program Outcomes & Impact Data Report

Program Name:	**Prevention Pathways Program**
Organization:	**Beats Rhymes and Life**
Type of Report:	**Annual**
PEI Category:	Prevention

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
X	Youth/TAYOutreach & Engagement
	Cultural & Linguistic
	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.	
	Suicide
	Incarceration
	School failure or dropout
	Unemployment
	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: Brief program description.

Beats Rhymes & Life, Inc. uses the influence of Hip Hop as a catalyst for change and Development. Our curriculum combines youth culture with self psychology, group work and narrative therapy. Our Interventions include 1:1 individual therapy, therapeutic activity groups, mobile studio clinic of the streets, mental health awareness presentations, Life skills workshops and workforce training for young adults.

Beats Rhymes and Life Inc. combines the knowledge of teaching artists, clinicians and peer mentors to best support TAYthrough our Hip Hop Therapy offerings since our inception in 2004.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	988
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	0

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Number of unduplicated individual family members served indirectly by your program:	1,819
Grand total of unduplicated individuals served:	2,807

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	404
Transition Age Youth (16-25 yrs.)	100
Adult (26-59 yrs.)	32
Older Adult (60+ yrs.)	0
Declined to answer	452
Unknown	0
TOTAL	988

SEXUAL ORIENTATION	
Gay/Lesbian	3
Heterosexual/Straight	27
Bisexual	7
Questioning/Unsure	0
Queer	4
Declined to answer	947
Unknown	0
Another group not listed	0
TOTAL	988
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	0
No	52
Declined to answer	936
Unknown	0
TOTAL	988

CURRENT GENDER IDENTITY	
Female	20
Male	26
Transgender	1
Genderqueer	1
Questioning/unsure of gender identity	0
Declined to answer	938
Unknown	
Another identity not listed	1

PRIMARY LANGUAGE	
English	47
Spanish	4
Cantonese	0
Chinese	0
Vietnamese	0
Farsi	0
Arabic	0
Tagalog	0
Declined to answer	936
Unknown	0
Other languages not listed	1
TOTAL	988

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TOTAL	988
If another group is counted, please specify with numbers:	

SEX ASSIGNED AT BIRTH		**ETHNICITY/CULTURAL HERITAGE (choose one)**	
Male	26	**If Hispanic or Latino, please specify:**	
Female	22	Caribbean	0
Declined to answer	940	Central American	0
Unknown	0	Mexican/Mexican American/Chicano	6
TOTAL	988	Puerto Rican	0
		South American	0
		Another Hispanic/Latino ethnicity not listed	0
DISABILITY STATUS		**Total Hispanic or Latino**	**6**
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision		African	0
Hearing/Speech		African American	30
Another type not listed		Asian Indian/South Asian	0
Communication Domain Subtotal		Cambodian	0
Disability Domain		Chinese	0
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)		Eastern European	0
		European	
		Filipino	
Physical/mobility		Japanese	0
Chronic health condition		Korean	0
Disability Subtotal		Middle Eastern	0
None		Vietnamese	0
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	1
Unknown		**Total Non-Hispanic or Non-Latino:**	31
Another disability not listed		More than one ethnicity	3
TOTAL		Unknown ethnicity	0

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		Declined to answer	948
		ETHNICITY TOTAL	988
If another disability is counted, please specify with numbers:		If **another ethnicity** is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native		If **another race** is counted, please specify with numbers:	
Asian		Latinx- 6 More than One Race- 1	
Black or African American	18		
Native Hawaiian or another Pacific Islander			
White	1		
Other Race	6		

Declined to answer	962	***Full Totals Chart for Demographics below***
Unknown		
TOTAL	988	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

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Beats Rhymes and Life Inc had its most successful fiscal year in part to the increase in support from ACBH. We served in total 988 unduplicated TAY when our goal was 470 which is 210% of the goal. This was done in part by participating in more community events and partnerships under the suggestion of ACBH at last year's annual meeting.
Case of Ghost: (client example / point of pride)
Ghost is a nickname of a young adult that we worked with in our PEI programming. Ghost came to BRL with little socialization for a young adult 18-21 yr range. He is male, African American and is from Alameda County. He lives alone with his mother who has raised and home schooled him since he was young. It was due to this isolation that he was uncomfortable in social settings with other young adults around the same age as himself.

When Ghost came to us, he would only wear a mask (a literal mask) which he would never take off. This was true within our TAGs, Ind HHT, Individual Traditional Therapy and community event settings where we served him in. Through the therapy models he expressed aspirations for independence.

Through the 9 months that we worked with Ghost he gained confidence, access to vulnerability, made meaningful connections to peers, improved communication with his mother, made steps to obtain his driver's license and made songs about his self-discovery along the way. He truly used Hip Hop Therapy for his own healing and self-discovery which is the mission of the org.(one of his songs will be included in the folder with this report. Within this song he directly discusses a time that BRL and his peers here supported him in a time of need this past year.) He got awards for "Most Improved" and "Best Effort" within his BRL cohort.

The most telling of Ghost's progress was when he took off his mask for the first time. It was a clear sign that he was accepting himself and is ready to explore his own identity and the world around him. Plans are to continue with Ghost through referral to therapy as well as opening doors for him at BRL for further Ind HHT and Therapeutic Activity Groups.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	0

E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	0
E.3: Types of treatment individuals were referred to (list types below):	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	0

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G.5: Average duration of untreated mental illness in weeks:	0
E.6: Average number of days between referral and first participation in referred treatment program:	0

Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:

F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):

African Americans

F.2: Number of paper referrals to an ACBH PEI-funded program:	0
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	0
F.4: Average number of days between referral and first participation in referred PEI program:	0

F.5: Describe how your program encouraged access to services and follow through on above referrals:

Intensive and Strategic Outreach that scaffold into services.

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***

Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	**Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):**
Oakland High School	Students, staff counselors and teachers
Oakland School for the Arts	Students, staff counselors and teachers
La Pena Cultural Center	Students, staff counselors and teachers
Dublin Wells Middle School	Students, staff counselors and teachers
Castle Works @ Castlemont	Students, staff counselors and teachers
Youth Uprising	Students, staff counselors and teachers
YEP	Students, staff counselors and teachers
Oakland Kids First	Students, staff counselors and teachers
PEERS	Students, staff counselors and teachers

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Chabot College	Students, staff counselors and teachers

EOYDC	Students, staff counselors and teachers
Hella Positive	Students, staff counselors and teachers
Freight and Salvage	Students, staff counselors and teachers
Chapter 510	Students, staff counselors and teachers
Red Heron Studios	Students, staff counselors and teachers
Town Youth Club	Students, staff counselors and teachers
Mosaic Project	Students, staff counselors and teachers
The Commune	Students, staff counselors and teachers
BAY-Peace	Students, staff counselors and teachers
ABO Comics	Students, staff counselors and teachers
Destiny Arts Town Nights	Community members
Crossroads	Community members
Latitude High School	Students, staff counselors and teachers
Covenant House	Youth & staff
Project WHAT!	Youth & staff
Skyline High School	Students, staff counselors and teachers
Arroyo Viejo Recreation Center	Community Members
Allendale Recreation Center	Community Members
First Fridays - Oakland	Community Members
Continental Club (Showcase)	Youth, staff & Community Members
EBAYC	Youth
Hip Hop 4 Change	Community members, staff and youth
Bushrod Recreation Center	Youth & staff
San Antonio Park	Youth
Larkin Street Youth Services	Community members, staff and youth
Reach Ashland Youth Center	Youth
Carter Gilmore Park National Night Out w/ Destiny Arts	Community members, staff and youth
Covenant House	Youth & staff
Youth Spirit Artworks Tiny House Village	Community members, staff and youth
Oakland High School	Youth & staff
Madison Park Academy	Youth & staff

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MHSA Program #	**PEI 1B**
PROVIDER NAME	**Center for Healthy Schools and Communities**
PROGRAM NAME	**School-based Mental Health Access & Linkages in Elementary, Middle & High School**

2023-2024

Program Outcomes & Impact Data Report

Program Name:	**School-based Mental Health Access & Linkages in Elementary, Middle & High School**
Organization:	**Center for Healthy Schools and Communities**
Type of Report:	**Annual Data Report**
PEI Category:	**Access and Linkage**

Priority Area (place an X next to all that apply):	
X	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
X	Suicide
X	Incarceration
X	School failure or dropout
	Unemployment
X	Prolonged suffering
X	Homelessness
X	Removal of children from their homes

Box A: <u>Brief</u> program description.
Coordination of Services Team (COST) is a strategy used to integrate behavioral health and other health care and academic supports for students through a referral and triage process. A universal referral system is used by teachers and staff (and in some instances students and caregivers) to flag students who need support. School staff and service providers collaborate to determine the best intervention or support service for referred students. PEI funds aid in the implementation of COST in 285 schools across 14 school districts in Alameda County.

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Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	5368
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	5803
Number of unduplicated individual family members served indirectly by your program:	0
Grand total of unduplicated individuals served:	11171

Box C: Demographics of individuals served this fiscal year through MHSA funding:			
AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	15029	Gay/Lesbian	8
Transition Age Youth (16-25 yrs.)	5785	Heterosexual/Straight	339
Adult (26-59 yrs.)	0	Bisexual	2
Older Adult (60+ yrs.)	0	Questioning/Unsure	15
Declined to answer	0	Queer	3
Unknown	0	Declined to answer	59
TOTAL	20814	Unknown	4934
		Another group not listed	26
		TOTAL	5386
		If another group is counted, please specify with numbers:	
VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes	NA	English	7812
No	NA	Spanish	4782
Declined to answer	NA	Cantonese	122
Unknown	NA	Chinese	156
TOTAL	NA	Vietnamese	102
		Farsi	104
CURRENT GENDER IDENTITY		Arabic	147
Female	4472	Tagalog	99
Male	5042	Declined to answer	11
Transgender	16	Unknown	1592
Genderqueer	3	Other languages not listed	857
Questioning/unsure of gender identity	168	TOTAL	15784
Declined to answer	8		
Unknown	2448		
Another identity not listed	182		
TOTAL	12339		

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If another group is counted, please specify with numbers:	

SEX ASSIGNED AT BIRTH	
Male	6075
Female	5427
Declined to answer	17
Unknown	1321
TOTAL	12840

DISABILITY STATUS	
Communication Domain	
Vision	68
Hearing/Speech	403
Another type not listed	
Communication Domain Subtotal	471
Disability Domain	
Cognitive (exclude mental illness; include learning, developmental, dementia, etc.)	337
Physical/mobility	9
Chronic health condition	87
Disability Subtotal	433
None	6349
Declined to answer	2031
Unknown	NA
Another disability not listed	1199
TOTAL	10483

If another disability is counted, please specify with numbers:

RACE	
American Indian or Alaska Native	166

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	0
Central American	99
Mexican/Mexican American/Chicano	446
Puerto Rican	3
South American	20
Another Hispanic/Latino ethnicity not listed	6037
Total Hispanic or Latino	6605
If Non-Hispanic or Non-Latino, please specify:	
African	37
African American	496
Asian Indian/South Asian	72
Cambodian	10
Chinese	90
Eastern European	7
European	23
Filipino	221
Japanese	18
Korean	11
Middle Eastern	20
Vietnamese	59
Other Non-Hispanic or Non-Latino ethnicity not listed	763
Total Non-Hispanic or Non-Latino:	1827
More than one ethnicity	49
Unknown ethnicity	3948
Declined to answer	2357
ETHNICITY TOTAL	6354

If another ethnicity is counted, please specify with numbers:

If another race is counted, please specify with numbers: More than one race: 1005 Hispanic or Latino: 8870

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Asian	1704
Black or African American	3019
Native Hawaiian or another Pacific Islander	268
White	1926
Other Race	NA
Declined to answer	388
Unknown	1005
TOTAL	18351

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
Through COST, 20,814 students across 285 schools and 14 school districts in Alameda County were referred and linked to behavioral health services and supports. Despite transitions and leadership changes, districts have sustained and even strengthened COST infrastructure, especially Tier 1 supports. School districts have diversified partnerships and COST staff to comprehensively support student mental wellness. Districts have also streamlined COST documentation and referral processes to improve communication and coordination between schools, community-based organizations and families. Three school districts reported using new methods for COST tracking that increased the effectiveness of connecting students and families to mental health and wrap around supports.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	NA
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	NA
E.3: Types of treatment individuals were referred to (list types below):	
5,803 students with Tier 3 behavioral health needs were referred to school-based mental health treatment programs and non-school based services: individual or group counseling/therapy, crisis intervention, individualized behavior support, family counseling and parent workshops. We do not have access to data that delineates whether individuals were referred to services within or outside of the ACBH system.	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	1877
G.5: Average duration of untreated mental illness in weeks:	NA
E.6: Average number of days between referral and first participation in referred treatment program:	NA
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	

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Transitional-aged youth, foster youth, LGBTQ-identifying youth, boys and young men of color, unaccompanied immigrant youth, food and shelter insecure youth and families, and English as a second language youth.	
F.2: Number of paper referrals to an ACBH PEI-funded program:	NA
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	NA
F.4: Average number of days between referral and first participation in referred PEI program:	NA
F.5: Describe how your program encouraged access to services and follow through on above referrals: Strategies that increase access and follow through include partnerships with family outreach workers, community-based agencies, information sharing through family workshops and professional Learning sessions for staff, and building relationships with students.	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. *(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)*	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	**Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):**
NA	NA

PEI: Outreach Programs

MHSA Program #	**PEI 19 – Older Adult Peer Support**
PROVIDER NAME	**City of Fremont**
PROGRAM NAME	**LGBT Mental Health Peer Support Program for Older Adults**
2023 - 2024	

Program Outcomes & Impact Data Report

Program Name:	**LGBT Mental Health Peer Support Program for Older Adults**
Organization:	**City of Fremont**
Type of Report:	**Annual Data Report**
PEI Category:	**Outreach**
Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis

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	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
X	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.

	Suicide
	Incarceration
	School failure or dropout
	Unemployment
X	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: **<u>Brief</u>** program description.

This program provides services to support LGBT older adults in the community. This provides outreach and prevention services to LGBT seniors who are at risk of developing serious mental health issues and have been negatively impacted by societal stigma. Program aims to reduce isolation by encouraging positive social support system, develop supportive relationship that reduces the risk of prolonged suffering, increase their confidence and independence, promote LGBT community awareness, respect and acceptance in an environment of inclusion and understanding. The program offers 1:1 time with peer coach, educational and support groups and easy access to other needed community resources.

The program developed a group called "Celebrating Diversity Circle" open to community members who wish to acknowledge and celebrate their differences and wish to understand experiences and needs of the aging LGBT seniors, their culture and social norms. This vehicle assists program staff identify LGBT seniors' needs through sharing of cultural experiences, difficult challenges including mental health, success stories of getting older etc. If participants indicated needing additional services from Senior Mobile Mental Health program, referral process will be initiated. The program aims to keep our LGBT seniors socially active by bringing them together in a safe and understanding venue so they can participate in stimulating activities, health and wellness trainings and an opportunity to make lasting connection with their peers and allies.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	10
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	10
Number of unduplicated individual family members served indirectly by your program:	
Grand total of unduplicated individuals served:	10

Box C: Demographics of individuals served this fiscal year through MHSA funding:	
AGE CATEGORIES	**SEXUAL ORIENTATION**

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Children/Youth (0-15 yrs.)		Gay/Lesbian	8
Transition Age Youth (16-25 yrs.)		Heterosexual/Straight	
Adult (26-59 yrs.)		Bisexual	1
Older Adult (60+ yrs.)	10	Questioning/Unsure	1
Declined to answer		Queer	
Unknown		Declined to answer	
TOTAL	10	Unknown	
		Another group not listed	
		TOTAL	10
		If another group is counted, please specify with numbers:	

VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes	1	English	10
No	9	Spanish	
Declined to answer		Cantonese	
Unknown		Chinese	
TOTAL	10	Vietnamese	
		Farsi	
CURRENT GENDER IDENTITY		Arabic	
Female		Tagalog	
Male	7	Declined to answer	
Transgender	2	Unknown	
Genderqueer		Other languages not listed	
Questioning/unsure of gender identity	1	TOTAL	10
Declined to answer			
Unknown			
Another identity not listed			
TOTAL	10		
If another group is counted, please specify with numbers:			

SEX ASSIGNED AT BIRTH		**ETHNICITY/CULTURAL HERITAGE (choose one)**	
Male	10	**If Hispanic or Latino, please specify:**	
Female		Caribbean	
Declined to answer		Central American	
Unknown		Mexican/Mexican American/Chicano	

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TOTAL	10	Puerto Rican	
Male		South American	
		Another Hispanic/Latino ethnicity not listed	
DISABILITY STATUS		**Total Hispanic or Latino**	
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision	1	African	
Hearing/Speech		African American	
Another type not listed		Asian Indian/South Asian	
Communication Domain Subtotal		Cambodian	
Disability Domain		Chinese	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)		Eastern European	10
		European	
		Filipino	
Physical/mobility	2	Japanese	
Chronic health condition	3	Korean	
Disability Subtotal	6	Middle Eastern	
None		Vietnamese	
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	
Unknown		**Total Non-Hispanic or Non-Latino:**	
Another disability not listed		More than one ethnicity	
TOTAL	6	Unknown ethnicity	
		Declined to answer	
		ETHNICITY TOTAL	10
If another disability is counted, please specify with numbers:		If **another ethnicity** is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native		If **another race** is counted, please specify with numbers:	
Asian			
Black or African American			
Native Hawaiian or another Pacific Islander			
White	10		
Other Race			
Declined to answer			
Unknown			

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TOTAL	10	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

I've been working for the City of Fremont Human Services Dept as a Senior Peer Coach. I have a few peers that I work with to help them with problems that arise in their daily lives. I also attend a diversity group meeting every Wednesday.

During my time here I've had some small successes with my peers. Most of those successes have been that I can help them with an emergency. One instance of an emergency was when one of my peers, who has been homeless for a while, was locked out of the trunk of his car. He was in panic mode. He had a dog and the dog's food was in the trunk plus other things that he needed. Neither the trunk lever nor the key was opening the trunk. I told him to come to where I live, and I will help him figure out what to do. Between the two of us we were able to get the trunk open.

There was another incident with the same peer as above. He had been staying in a motel that the city had paid for. The time had to come for him to move out. Hotel policy, by state law, says that he could only stay there 28 days at a time. He was so tired and distraught that he called me and was crying. He felt so sad because of the situation that he was in. Being homeless was new to him. He confided in me that while he and his husband, before he passed away, always had a home to live in. Now that his husband is gone everything has gone awry. He needed to move all his belongings back into the car and check out of the motel room. When he called, I felt so bad for him. I have been in that situation before. Living in a motel and having to move out after 28 days. So, I went to the motel to help him move all his stuff in the room back to his car. When I was done, I went back to the room, and he was sitting there and crying wondering why his life had gotten this bad. I told him of my similar situation and how I managed to get through it and assured him that he can get through it as well. I gave him a big hug and got out him to his car.

Another peer that I was meeting with at the office twice a month really appreciated our chats. He made sure to tell my manager how much he enjoyed our get togethers. He also told her that I had been a very influence in helping him feel better. I guess he's had some rough times in his life and talking to me helped him.

Also, I think that the people that attend our weekly Diversity group meetings like me feel and comfortable around me. Since I came out as a male to female transgender, I wasn't sure how some people would react to me. I feel that my positive personality is the main reason why they like me. This has made it easier to talk with them and help them knowing that they like and trust me. To me that is a success knowing that I can help people when they need it.

The program is partnering with an LGBT couple who has develop a website ready to launch in a couple of weeks called "RainbowNeighbors.org". LGBT Senior community can find out monthly events they can attend or host an event and pages of community resources they may need. Partnership can benefit both LGBT older adults and the community.

There are 10 to 15 community members who are allies to LGBT older adults.

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Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	0
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	0
E.3: Types of treatment individuals were referred to (list types below):	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	0
G.5: Average duration of untreated mental illness in weeks:	n/a
E.6: Average number of days between referral and first participation in referred treatment program:	
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
LGBT older adults and AAPI population.	
F.2: Number of paper referrals to an ACBH PEI-funded program:	0
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	0
F.4: Average number of days between referral and first participation in referred PEI program:	n/a
F.5: Describe how your program encouraged access to services and follow through on above referrals:	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. *(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)*	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters): City of Fremont first responders, Age Well Centers, senior housing, churches, and other mental health providers. We also have an ad in the monthly Age Friendly newsletter that goes to the broader community ~7,000 people.	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
	Age Well Center's staff and managers, case managers, social workers, and student interns.

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MHSA Program #	**PEI 19**
PROVIDER NAME	**Pacific Center for Human Growth**
PROGRAM NAME	**LGBT Services - Older and Out**

2023 – 2024

Program Outcomes & Impact Data Report

Program Name:	**LGBT Services - Older and Out**
Organization:	**Pacific Center for Human Growth**
Type of Report:	**Annual Data Report**
PEI Category:	**Outreach**

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
X	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
	Suicide
	Incarceration
	School failure or dropout
	Unemployment
X	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: <u>Brief</u> program description.
The Older & Out program offers free, 8-week support groups for LGBTQIA+ adults over the age of 55. We provide services virtually and in-person to meet the needs of our community to combat loneliness, provide community, and assist our older adult population to connect with vital resources. Pacific Center partners with the Oakland LGBTQ Center and the North Berkeley Senior Center to provide various Older & Out service locations. Groups are facilitated by trained facilitators, topics may include grief (loss of friends, partners, etc.), aging, invisibility in the LGBTQIA+ community, loneliness, and resilience.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	50
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	50
Number of unduplicated individual family members served indirectly by your program:	0

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Grand total of unduplicated individuals served:			**50**
Box C: Demographics of individuals served this fiscal year through MHSA funding:			
AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	0	Gay/Lesbian	24
Transition Age Youth (16-25 yrs.)	0	Heterosexual/Straight	0
Adult (26-59 yrs.)	2	Bisexual	8
Older Adult (60+ yrs.)	46	Questioning/Unsure	1
Declined to answer	2	Queer	5
Unknown		Declined to answer	3
TOTAL	50	Unknown	0
		Another group not listed	9
		TOTAL	50
		If another group is counted, please specify with numbers:	
VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes	0	English	48
No	2	Spanish	0
Declined to answer	46	Cantonese	0
Unknown	2	Chinese (Mandarin)	0
TOTAL	50	Vietnamese	0
		Farsi	0
CURRENT GENDER IDENTITY		Arabic	0
Female	21	Tagalog	0
Male	17	Declined to answer	0
Transgender	1	Unknown	1
Genderqueer	0	Other languages not listed	1
Questioning/unsure of gender identity	1	TOTAL	50
Declined to answer	2		
Unknown	0		
Another identity not listed	8		
TOTAL	50		
If another group is counted, please specify with numbers:			

SEX ASSIGNED AT BIRTH		**ETHNITICY/CULTURAL HERITAGE (choose one)**
Male	0	**If Hispanic or Latino, please specify:**

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Female	0	Caribbean	0
Declined to answer	50	Central American	0
Unknown	0	Mexican/Mexican American/Chicano	1
TOTAL	50	Puerto Rican	0
		South American	0
		Another Hispanic/Latino ethnicity not listed	0
DISABILITY STATUS		**Total Hispanic or Latino**	1
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision	0	African	0
Hearing/Speech	0	African American	10
Another type not listed		Asian Indian/South Asian	0
Communication Domain Subtotal	0	Cambodian	0
Disability Domain		Chinese	0
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	4	Eastern European	1
		European	17
		Filipino	0
Physical/mobility	4	Japanese	1
Chronic health condition	0	Korean	0
Disability Subtotal	4	Middle Eastern	2
None	12	Vietnamese	0
Declined to answer	1	Other Non-Hispanic or Non-Latino ethnicity not listed	5
Unknown	0	**Total Non-Hispanic or Non-Latino:**	36
Another disability not listed	29	More than one ethnicity	5
TOTAL	50	Unknown ethnicity	
If another disability is counted, please specify with numbers:		Declined to answer	18
		ETHNICITY TOTAL	60
		If another ethnicity is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native	0	If another race is counted, please specify with numbers:	
Asian	1		
Black or African American	0		
Native Hawaiian or another Pacific Islander	0		
White	38		
Other Race	3		

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Declined to answer	3	
Unknown	1	
TOTAL	50	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
In January, we hired our Older Adult Program manager, Mae Petti. With the support of our Older & Out Coordinator, Mae restarted the Older and Out Program and hired six new group facilitators. These new group facilitators were recruited from our pool of talented older adults, which has allowed our groups to be very relatable for the group members. The facilitators were trained by our staff, and they are a mix of men, women, gender diverse, and a few BIPOC folx that are a better representation of our community that we want to see utilizing our services. We were able to recruit new group members and reconnect with old group members after the break. Group members have been able to discuss a variety of topics ranging from isolation, generational trauma, and racism. We have also been able to maintain two social events, one in person at the North Berkeley Senior Center and the other on Zoom. Having these two events allowed us to connect with community members who are some of the most isolated and unable to leave their homes due to COVID's continued impact on our community. We've created a new intake process that we do with all older adult participants in our programs. Through this intake, we can collect information about our group members that we were not collecting before such as assessing their depression and social isolation. This process has also given us an opportunity to educate our elders on additional services Pacific Center offers and refer them to other services outside of our organization as need. This June we, along with seven other community organizations, hosted the first East Bay Senior Pride event, which was a huge success. We had over 100 elders attending, many of whom were past and current group members.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	0
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	0
E.3: Types of treatment individuals were referred to (list types below):	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	0
G.5: Average duration of untreated mental illness in weeks:	
E.6: Average number of days between referral and first participation in referred treatment program:	
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	

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F.2: Number of paper referrals to an ACBH PEI-funded program:	
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	
F.4: Average number of days between referral and first participation in referred PEI program:	
F.5: Describe how your program encouraged access to services and follow through on above referrals:	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. *(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)*	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
NA	NA

MHSA Program # **PEI 20C**
PROVIDER NAME **Mental Health Association of Alameda County**
PROGRAM NAME **African American Family Outreach Project**
2023 - 2024

Program Outcomes & Impact Data Report

Program Name:	**African American Family Outreach Project**
Organization:	**Mental Health Association of Alameda County**
Type of Report:	**Annual Data Report**
PEI Category:	**Outreach**

Priority Area (place an X next to all that apply):

	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.

	Suicide
	Incarceration
	School failure or dropout
	Unemployment

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X	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: Brief program description.
The African American Family Outreach Project (AAFOP) provides virtual and in-person workshops, evening events and a warmline with case management services for African American family caregivers. These culturally sensitive activities provide African American family members with peer support, education about mental health disorders, and information on how to access mental health services in Alameda County. We also operate a monthly support group for African American family caregivers. This monthly forum allows individuals to share their struggles and successes in advocating on behalf of their loved one. The importance of self-care as a means of stress reduction is highlighted in each support group meeting.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	
Number of unduplicated individual family members served indirectly by your program:	67
Grand total of unduplicated individuals served:	

Box C: Demographics of individuals served this fiscal year through MHSA funding:			
AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)		Gay/Lesbian	
Transition Age Youth (16-25 yrs.)	8	Heterosexual/Straight	
Adult (26-59 yrs.)	22	Bisexual	
Older Adult (60+ yrs.)	19	Questioning/Unsure	
Declined to answer		Queer	
Unknown		Declined to answer	
TOTAL		Unknown	67
		Another group not listed	
		TOTAL	
		If another group is counted, please specify with numbers:	
VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes		English	
No		Spanish	
Declined to answer		Cantonese	
Unknown	67	Chinese	
TOTAL		Vietnamese	
		Farsi	

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CURRENT GENDER IDENTITY	
Female	35
Male	32
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	
If another group is counted, please specify with numbers:	

Arabic	
Tagalog	
Declined to answer	
Unknown	67
Other languages not listed	
TOTAL	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	67
TOTAL	
Male	
DISABILITY STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	
None	
Declined to answer	
Unknown	67

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	45
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	2
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino:	47

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Another disability not listed		More than one ethnicity	4
TOTAL		Unknown ethnicity	
If another disability is counted, please specify with numbers:		Declined to answer	
		ETHNICITY TOTAL	
		If another ethnicity is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native		If another race is counted, please specify with numbers:	
Asian			
Black or African American	45		
Native Hawaiian or another Pacific Islander			
White	2		
Other Race	4		
Declined to answer			
Unknown			
TOTAL			

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
We successfully launched our warmline and case management service in February 2024. Family members who complete evaluations of our workshops and evening seminars are encouraged to request support from our warmline if needed. Our case manager worked with two clients. In both cases parents were assisting adult children who do not acknowledge their mental health challenges. The mother could not understand why her child would deny their illness and refuse treatment. Our case manager met with the mother at the Family Education and Resource (FERC) office and sat with her as she watched a video on anosognosia. The client left the office with a better understanding of the daughter's condition along with information on the 5150 process and the importance of maintaining a record of the illness using the AB 1424 form. In another instance, the parent was frustrated with the benefits available via Kaiser private insurance. The case manager discussed the benefits obtaining Medi-Cal coverage for access to Alameda County behavioral health services. Both parents were also referred to our monthly support group. In addition to our warmline/case management service, we also hosted our first evening seminar - Alternatives to Traditional Models of Substance Use Treatment: Harm Reduction Therapy. Participants found the presentation very useful to extremely useful. One attendee is a therapist in private practice who attended to gather information on Harm Reduction Therapy to better assist her clients.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	N/A

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E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	N/A
E.3: Types of treatment individuals were referred to (list types below):	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/A
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
African American Family Caregivers	
F.2: Number of paper referrals to an ACBH PEI-funded program:	N/A
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A
F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referrals:	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
AAFOP Saturday Workshops	709 registered*/ 71 attendees
AAFOP Evening Seminar	23 registered/ 6 attendees
AAFOP Support Group	Approximately 5 attendees per month
AAFOP Warmline/Case Management	2 participants
	Registrations for Feb 17, 2024 workshop:
	Registrants inflated due to glitch between Eventbrite and Zoom. Many registered multiple times - up to 8. Some from out-of-state and foreign countries

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MHSA Program #	**PEI 22**
PROVIDER NAME	**Pacific Center for Human Growth**
PROGRAM NAME	**Peer Mentorship Program**

2023 – 2024

Program Outcomes & Impact Data Report

Program Name:	**Peer Mentorship Program**
Organization:	**Pacific Center for Human Growth**
Type of Report:	**Annual Data Report**
PEI Category:	**Outreach**

Priority Area (place an X next to all that apply):

	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
X	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.

	Suicide
	Incarceration
X	School failure or dropout
	Unemployment
X	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: <u>Brief</u> program description.
The Peer Support program seeks to provide prevention, and early intervention supports to transitional age youth, adults and older adults through peer facilitated support groups for the lesbian, gay, bisexual, transgender, queer, questioning, intersex, and/or two-spirit (LGBTQQI2-S) community. Contractor shall refer clients who may need additional services to resources such as primary health care or advanced mental health services.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	206
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	206
Number of unduplicated individual family members served indirectly by your program:	0
Grand total of unduplicated individuals served:	206
Box C: Demographics of individuals served this fiscal year through MHSA funding:	

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AGE CATEGORIES	
Children/Youth (0-15 yrs.)	0
Transition Age Youth (16-25 yrs.)	23
Adult (26-59 yrs.)	145
Older Adult (60+ yrs.)	32
Declined to answer	6
Unknown	0
TOTAL	206

SEXUAL ORIENTATION	
Gay/Lesbian	39
Heterosexual/Straight	21
Bisexual	24
Questioning/Unsure	19
Queer	17
Declined to answer	5
Unknown	0
Another group not listed	81
TOTAL	206
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	8
No	193
Declined to answer	5
Unknown	0
TOTAL	206

PRIMARY LANGUAGE	
English	199
Spanish	6
Cantonese	0
Chinese (Mandarin)	0
Vietnamese	0
Farsi	0
Arabic	0
Tagalog	0
Declined to answer	0
Unknown	1
Other languages not listed	0
TOTAL	206

CURRENT GENDER IDENTITY	
Female	31
Male	41
Transgender	64
Genderqueer	7
Questioning/unsure of gender identity	6
Declined to answer	2
Unknown	0
Another identity not listed	55
TOTAL	206
If another group is counted, please specify with numbers:	

SEX ASSIGNED AT BIRTH	
Male	0
Female	0
Declined to answer	206
Unknown	0
TOTAL	206

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	1
Central American	2
Mexican/Mexican American/Chicano	23
Puerto Rican	0
South American	5

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		Another Hispanic/Latino ethnicity not listed	36
DISABILITY STATUS		**Total Hispanic or Latino**	67
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision	0	African	2
Hearing/Speech	5	African American	7
Another type not listed		Asian Indian/South Asian	7
Communication Domain Subtotal	5	Cambodian	0
Disability Domain		Chinese	5
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	17	Eastern European	9
		European	51
		Filipino	2
Physical/mobility	1	Japanese	1
Chronic health condition	9	Korean	0
Disability Subtotal	27	Middle Eastern	0
None	161	Vietnamese	1
Declined to answer	1	Other Non-Hispanic or Non-Latino ethnicity not listed	2
Unknown	0	**Total Non-Hispanic or Non-Latino:**	87
Another disability not listed	13	More than one ethnicity	11
TOTAL	206	Unknown ethnicity	
If another disability is counted, please specify with numbers:		Declined to answer	48
		ETHNICITY TOTAL	213
		If another ethnicity is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native	4	If another race is counted, please specify with numbers:	
Asian	15		
Black or African American	9		
Native Hawaiian or another Pacific Islander	0		
White	134		
Other Race	4		
Declined to answer	26		
Unknown	14		
TOTAL	206		
Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.			

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In January, we hired our Older Adult Program manager, Mae Petti. With the support of our Older & Out Coordinator, Mae restarted the Older and Out Program and hired six new group facilitators. These new group facilitators were recruited from our pool of talented older adults, which has allowed our groups to be very relatable for the group members. The facilitators were trained by our staff, and they are a mix of men, women, gender diverse, and a few BIPOC folx that are a better representation of our community that we want to see utilizing our services. We were able to recruit new group members and reconnect with old group members after the break. Group members have been able to discuss a variety of topics ranging from isolation, generational trauma, and racism. We have also been able to maintain two social events, one in person at the North Berkeley Senior Center and the other on Zoom. Having these two events allowed us to connect with community members who are some of the most isolated and unable to leave their homes due to COVID's continued impact on our community. We've created a new intake process that we do with all older adult participants in our programs. Through this intake, we can collect information about our group members that we were not collecting before such as assessing their depression and social isolation. This process has also given us an opportunity to educate our elders on additional services Pacific Center offers and refer them to other services outside of our organization as need. This June we, along with seven other community organizations, hosted the first East Bay Senior Pride event, which was a huge success. We had over 100 elders attending, many of whom were past and current group members.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	0
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	0
E.3: Types of treatment individuals were referred to (list types below):	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	0
G.5: Average duration of untreated mental illness in weeks:	
E.6: Average number of days between referral and first participation in referred treatment program:	
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
F.2: Number of paper referrals to an ACBH PEI-funded program:	
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	
F.4: Average number of days between referral and first participation in referred PEI program:	

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F.5: Describe how your program encouraged access to services and follow through on above referrals:

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. *(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)*	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
NA	NA

MHSA Program # **PEI 22**
PROVIDER NAME **Pacific Center for Human Growth**
PROGRAM NAME **Technical Training Assistance**
2023 – 2024

Program Outcomes & Impact Data Report

Program Name:	**Technical Training Assistance**
Organization:	**Pacific Center for Human Growth**
Type of Report:	**Annual Data Report**
PEI Category:	**Outreach**

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.	
	Suicide
	Incarceration
	School failure or dropout
	Unemployment
	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: Brief program description.

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Outreach services shall provide culturally responsive services which includes engaging and training potential responders and the general population to recognize and respond effectively to early signs of severe and disabling mental illness by reducing stigma and discrimination related to mental health issues, providing services in an environment of inclusion and acceptance, improving and expanding ACBH contracted providers' cultural responsiveness to the LGBTQIA+ community.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	0
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	0
Number of unduplicated individual family members served indirectly by your program:	0
Grand total of unduplicated individuals served:	150

Box C: Demographics of individuals served this fiscal year through MHSA funding:			
AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	1	Gay/Lesbian	11
Transition Age Youth (16-25 yrs.)	15	Heterosexual/Straight	60
Adult (26-59 yrs.)	122	Bisexual	11
Older Adult (60+ yrs.)	11	Questioning/Unsure	0
Declined to answer	1	Queer	23
Unknown		Declined to answer	5
TOTAL	150	Unknown	
		Another group not listed	40
		TOTAL	150
		If another group is counted, please specify with numbers:	
VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes	0	English	140
No	0	Spanish	2
Declined to answer	150	Cantonese	2
Unknown	0	Chinese (Mandarin)	2
TOTAL	150	Vietnamese	0
		Farsi	1
CURRENT GENDER IDENTITY		Arabic	0
Female	78	Tagalog	0
Male	27	Declined to answer	0
Transgender	1	Unknown	0
Genderqueer	2	Other languages not listed	3
Questioning/unsure of gender identity	0	TOTAL	150
Declined to answer	3		

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Unknown	0	
Another identity not listed	39	
TOTAL	150	
If another group is counted, please specify with numbers:		

SEX ASSIGNED AT BIRTH		**ETHNITICY/CULTURAL HERITAGE (choose one)**	
Male	0	**If Hispanic or Latino, please specify:**	
Female	0	Caribbean	1
Declined to answer	150	Central American	1
Unknown	0	Mexican/Mexican American/Chicano	14
TOTAL	150	Puerto Rican	2
		South American	2
		Another Hispanic/Latino ethnicity not listed	2
DISABILITY STATUS		**Total Hispanic or Latino**	22
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision	0	African	16
Hearing/Speech	1	African American	13
Another type not listed		Asian Indian/South Asian	4
Communication Domain Subtotal		Cambodian	0
Disability Domain		Chinese	7
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	2	Eastern European	11
		European	59
		Filipino	2
Physical/mobility	0	Japanese	0
Chronic health condition	11	Korean	1
Disability Subtotal	14	Middle Eastern	3
None	87	Vietnamese	2
Declined to answer	10	Other Non-Hispanic or Non-Latino ethnicity not listed	6
Unknown	17	**Total Non-Hispanic or Non-Latino:**	124
Another disability not listed	22	More than one ethnicity	13
TOTAL	150	Unknown ethnicity	
If another disability is counted, please specify with numbers:		Declined to answer	2
		ETHNICITY TOTAL	150
		If another ethnicity is counted, please specify with numbers:	

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RACE		
American Indian or Alaska Native	1	If another race is counted, please specify with numbers:
Asian	18	
Black or African American	13	
Native Hawaiian or another Pacific Islander	0	
White	85	
Other Race	9	
Declined to answer	6	
Unknown	18	
TOTAL	150	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
Our biggest success has been the retention of quality leaders and trainers in the subject of mental health and wellness. Twelve facilitators from Training Year (TY) 22-23 returned to facilitate trainings with us in TY 23-24. We were fortunate to partner with 19 new facilitators and we plan to grow relationships with them to lead training offerings in TY 24-25. Of the total 31 facilitators we contracted in TY 23-24, 17 (approximately 50%) identify as being queer and/or trans, Black, Indigenous, Mixed Race, People of Color (QTBIMPOC). Our contracted trainers are one of the cornerstones of our training program and it is a program goal to continue to cultivate relationships with QTBIMPOC leaders who hold intersectional experiences. Their lived experience allows these facilitators to critically engage our communities in workshops and trainings that center the mental health and well-being of historically marginalized communities.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	
E.3: Types of treatment individuals were referred to (list types below):	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	
G.5: Average duration of untreated mental illness in weeks:	
E.6: Average number of days between referral and first participation in referred treatment program:	
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	

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F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
F.2: Number of paper referrals to an ACBH PEI-funded program:	
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	
F.4: Average number of days between referral and first participation in referred PEI program:	
F.5: Describe how your program encouraged access to services and follow through on above referrals:	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
NA	NA

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/

MHSA Program #	PEI26
PROVIDER NAME	HHREC - The Health and Human Resource Education Center
PROGRAM NAME	10x10

Program Outcomes & Impact Data Report FY: 23/24

Program Name:	10x10 Wellness Campaign
Organization:	Health & Human Resource Education Center
Type of Report:	Semi Annual
PEI Category:	Prevention

Priority Area (place an X next to all that apply):

	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
☑	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.

	Suicide
	Incarceration
	School failure or dropout
	Unemployment
☑	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: <u>Brief</u> program description.

Over the next 10 years, Alameda County's 10X10 campaign will promote services, activities and policies, incorporating the 8 dimensions of wellness, that seek to increase the life expectancy of mental health consumers by 10 Years. HHREC coordinates and implements this project for Alameda County Behavioral Health Care Services as part of their Mental Health Services Act funding.

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Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	
Number of unduplicated individual family members served indirectly by your program:	
Grand total of unduplicated individuals served:	212

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	2
Transition Age Youth (16-25 yrs.)	79
Adult (26-59 yrs.)	21
Older Adult (60+ yrs.)	26
Declined to answer	
Unknown	84
TOTAL	212

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	212
Another group not listed	
TOTAL	212
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	212
TOTAL	212

CURRENT GENDER IDENTITY	
Female	50
Male	8
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	154
Another identity not listed	
TOTAL	212

PRIMARY LANGUAGE	
English	12
Spanish	6
Cantonese	
Chinese	5
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	189
Other languages not listed	
TOTAL	212

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If another group is counted, please specify with numbers:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	212
TOTAL	212
Male	

DISABILITY STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	
None	
Declined to answer	
Unknown	211
Another disability not listed	1
TOTAL	212

If another disability is counted, please specify with numbers:

RACE	
American Indian or Alaska Native	
Asian	8
Black or African American	42

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	10
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	10
If Non-Hispanic or Non-Latino, please specify:	
African	1
African American	42
Asian Indian/South Asian	1
Cambodian	
Chinese	5
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	1
Total Non-Hispanic or Non-Latino:	
More than one ethnicity	
Unknown ethnicity	152
Declined to answer	
ETHNICITY TOTAL	212

If **another ethnicity** is counted, please specify with numbers:

If **another race** is counted, please specify with numbers:

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Native Hawaiian or another Pacific Islander		
White		
Other Race	4	
Declined to answer		
Unknown	158	
TOTAL	212	

Box D: Program <u>successes/accomplishments</u> of the past year with one example or case study of a success the agency is particularly proud of.
Having the opportunity to hold space again together after three years of isolation sparked the fuel we needed for community connection. We finally had the opportunity to meet participants where they are and support their growth towards wellness. This led to a smooth transition from virtual interactions to hybrid programming. Managed to build a safe healing space for our community members. One of our participants highly expressed her gratitude for finding us and being able to be a part of our community. Thankful for our participants and their testimonies. “I love the way the program was designed to focus on our mental, physical and spiritual wellbeing. It made a big impact on my life and I hope others can take advantage of this”.

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Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	
E.3: Types of treatment individuals were referred to (list types below):	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	
G.5: Average duration of untreated mental illness in weeks:	
E.6: Average number of days between referral and first participation in referred treatment program:	
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below): Older Adults	
Older Adults	
F.2: Number of paper referrals to an ACBH PEI-funded program:	
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	
F.4: Average number of days between referral and first participation in referred PEI program:	
F.5: Describe how your program encouraged access to services and follow through on above referrals:	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. *(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)*	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Urban Peace Movement (Community event)	1 Decarceration Campaign Coordinator 20 Community members

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Bay Peace (Center)	1 Community advocate
Oakland Rising (Organization)	1 Communications Manager
Ella Baker Center For Human Rights (Organization)	1 Communications Director
Civic Corp (Organization)	1 Director , 6 Supervisors, 40 Students
RJOY (Organization)	1 Director
Allen Temple Gardens (Senior Homes)	2 Managers
The Black Neighborhood (Outdoor Hike)	1 Co Founder/President 64 community members
Berkeley Mental Health (Center)	1 Consumer Liaison & Mental Health Commission Secretary 6 staff 10 Community members
Oakland High School	3 Teachers and 30 students
Ryse Youth Center	1 Director of Research and Facilitation 10 students
Homeless Action Center	1 Staff Attorney
Fierce Advocates	1 Health & Wellness Coordinator
Ceres Policy Research	1 Director of Research
Fremont High	1 Media Teacher
67 suenos / Free Our Kids Coalition	1 Organizer
California Black Women's Health Project	1 Program Coordinator
Laney College Wellness Center	1 Wellness Student Services Specialist
Alameda County Nutrition Services	1 Interim Associate Director

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MHSA Program #	PEI 27
PROVIDER NAME	Health & Human Resource Education Center
PROGRAM NAME	Health Through Art

Program Outcomes & Impact Data Report FY: 23-24

Program Name:	Health Through Art
Organization:	Health & Human Resource Education Center
Type of Report:	Annual 23-24
PEI Category:	Prevention

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
x	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
x	Older Adults
x	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
	Suicide
	Incarceration
	School failure or dropout
	Unemployment
	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: **<u>Brief</u>** program description.

Through the program Health Through Art, we reach out to low-income communities (previously through partnerships with schools, community-based organizations, and ACBH non-profits) and facilitate workshops that cater to the communities' needs, where they can use art to freely express their emotions or mental shape. Health Through Art is well known for its work with the Alameda County population, as it hosts the annual "Call for Art," a contest where individuals will submit their best works of art which highlight mental health, and receive rewards if their submissions prove more popular than the others.

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Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	15
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	
Number of unduplicated individual family members served indirectly by your program:	
Grand total of unduplicated individuals served:	15

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	13
Adult (26-59 yrs.)	11
Older Adult (60+ yrs.)	20
Declined to answer	
Unknown	53
TOTAL	**97**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
83	83
Another group not listed	
TOTAL	**83**
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	83
TOTAL	**83**

PRIMARY LANGUAGE	
English	83
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Other languages not listed	
TOTAL	**83**

CURRENT GENDER IDENTITY	
Female	
Male	
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	83
Another identity not listed	
TOTAL	**83**
If another group is counted, please specify with numbers:	

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SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	124
Male	**124**
DISABILITY STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	0
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	0
None	
Declined to answer	
Unknown	
Another disability not listed	102
TOTAL	**102**
If another disability is counted, please specify with numbers:	
RACE	
American Indian or Alaska Native	
Asian	
Black or African American	20
Native Hawaiian or another Pacific Islander	
White	
Other Race	
Declined to answer	
Unknown	104
TOTAL	**124**

ETHNICITY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**0**
If Non-Hispanic or Non-Latino, please specify:	
African	20
African American	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino:	**20**
More than one ethnicity	
61	61
Declined to answer	
ETHNICITY TOTAL	81
If **another ethnicity** is counted, please specify with numbers:	
If **another race** is counted, please specify with numbers:	

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Box D: **Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.**
HTA has managed to partner with nonprofits and a church within this quarter and hosts workshops at their location. We have a Vision Board workshop with CRIL Hayward and with 18 participants who enjoyed the workshop, a bi-weekly workshop with True VIne MInistries Elders, and a three part workshop with the Youths of Fred Finch. We managed to provide art as a tool and as a hobby for people of different groups and have some of these people participate in the 16th Call to Art where we have 20 Participants enter. The success/accomplishments of Health Through Art is that it made a comeback after a period without a program coordinator. Taking over as a program coordinator, I have placed my time and effort into building up the HTA program and workshops for new and returning participants and building communications with other nonprofits. Through emails and zoom video conversations, we are opening collaborations with said nonprofits for HHREC to host HTA workshops and to build other potential collaborations in 2024 and bring in new participants for not only HTA but for HHREC in general.

Box E: **For programs that refer individuals with severe mental illness, please provide information for the categories below:**	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	NA
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	NA
E.3: Types of treatment individuals were referred to (list types below):	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	NA
G.5: Average duration of untreated mental illness in weeks:	NA
E.6: Average number of days between referral and first participation in referred treatment program:	NA
Box F: **For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:**	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
TAY, low-income populations, adults with children, mental health, seniors.	
F.2: Number of paper referrals to an ACBH PEI-funded program:	0
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	Unknown
F.4: Average number of days between referral and first participation in referred PEI program:	Unknown
F.5: Describe how your program encouraged access to services and follow through on above referrals: The HTA program conducted outreach through emails and phone calls to individuals and community-based organizations. Outreach content included flyers and infographics of HTA events and HHREC workshops.	

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Box G: **For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached.** *(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)*	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Fremont Main Library	Receptonist
Youth and Family Services	Receptonist
Tri City Children and Youth Services	Receptonist
Tri City Adult Services	Receptonist at Information Desk
Fremont Family Resource Center	Receptonist at Information Desk
Centerville Librabry	Information Desk
Friends of Children with Special Needs	Information Desk
American High School	Information Desk
Wshington HIgh School	Information Desk
CRIL Hayward	Michael Galvin Program Director of Cril
Hayward Public Library Downtown	Information Desk
Side by Side	No one
Love Never Fails	Security and Worker
Eden Family and Youth Center	Clubhouse Manager
Kennedy Youth Center	Information Desk
James Logan High School	Information Desk
East Oakland Youth Center	People Talked to
BAY-Peace: Better Alternatives for Youth	Ronnie Rice
BAY-Peace: Better Alternatives for Youth	Leliana Rose
Seneca	
Second Chance	email
Berkley Addiction	email
A Better Way	email
East Bay Asian Youth Center	email
Occur Now	email
Children Now	email
Equal Justice Society	email
Mosaic Project	email
Youth Spirit Arts	email
Center for Independent Living	email
East Bay Innovations	email
Creative Growth	email
Roots Community Health Center	email

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MHSA Program #	PEI 27
PROVIDER NAME	Health and Human Resource and Education Center
PROGRAM NAME	Black Women's Media and Wellness Project

Program Outcomes & Impact Data Report FY: 2023/2024

Program Name:	Black Women's Media and Wellness Project
Organization:	HHREC- Health and Human Resource Education Center
Type of Report:	Annual
PEI Category:	Prevention/Early Intervention/ Outreach

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
	Suicide
	Incarceration
	School failure or dropout
	Unemployment
X	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: <u>Brief</u> program description.

The BWMWP increases awareness among African American women and their families and older African American adults about mental health issues, wellness and co-occuring conditions. BWMWP promotes mental health education and community resources, developing and promoting recovery and wellness through relevant culturally appropriate messages about self-care, family involvement and culturally responsive community activities.

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Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	261
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	
Number of unduplicated individual family members served indirectly by your program:	
Grand total of unduplicated individuals served:	261

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	4
Transition Age Youth (16-25 yrs.)	8
Adult (26-59 yrs.)	166
Older Adult (60+ yrs.)	57
Declined to answer	
Unknown	26
TOTAL	261

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	261
Another group not listed	
TOTAL	261
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	261
TOTAL	261

PRIMARY LANGUAGE	
English	261
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Other languages not listed	
TOTAL	261

CURRENT GENDER IDENTITY	
Female	247
Male	14
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	261
If another group is counted, please specify with numbers:	

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SEX ASSIGNED AT BIRTH	
Male	14
Female	247
Declined to answer	
Unknown	
TOTAL	261
Male	
DISABILITY STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	
None	
Declined to answer	
Unknown	261
Another disability not listed	
TOTAL	261
If another disability is counted, please specify with numbers:	
RACE	
American Indian or Alaska Native	
Asian	
Black or African American	233
Native Hawaiian or another Pacific Islander	
White	
Other Race	1
Declined to answer	
Unknown	27
TOTAL	261

ETHNICITY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	1
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**1**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	233
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino:	233
More than one ethnicity	
Unknown ethnicity	27
Declined to answer	
ETHNICITY TOTAL	261
If **another ethnicity** is counted, please specify with numbers:	
If **another race** is counted, please specify with numbers:	

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Box D: **Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.**
This past year, the program was able to release a new edition of its magazine "Crossing the Invisible Line- Addressing Toxic Positivity". The publication covers various topics related to toxic positivity, how it shows up in the Black community and how to overcome the dismissive and damaging culture of obsessive positivity. The goal of the magazine is to encourage women to stand in their truth, practice mindfulness, and voice their true feelings which aids mental health. Our programs/events have also received positive feedback from participants. 80% have reported that they feel more prepared to seek out support when needed. 73% are more aware of community resources and 97% report that they feel like they are part of a community. "Thank you for hosting an event for Black Womens' health. It's so needed" "I am very happy to be here and be connected to other Black sisters" "I love the experience! What a wonderful program! I was reminded how powerful and wonderful we are" "The event was very powerful and a lot of information was given. We need more programs like this." Our participants continue to request more programming and community building activities. Such an activity was completed at this year's POCC conference. BWMWP held space I HHREC's Wellness Room and conducted journaling exercises with participants. This year, our agency is now a HMIS provider. We have started training and are anticipating the opportunity to serve a new demographic of community members.

Box E: **For programs that refer individuals with severe mental illness, please provide information for the categories below:**	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	
E.3: Types of treatment individuals were referred to (list types below):	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	
G.5: Average duration of untreated mental illness in weeks:	
E.6: Average number of days between referral and first participation in referred treatment program:	
Box F: **For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:**	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
Black women in Alameda County	
F.2: Number of paper referrals to an ACBH PEI-funded program:	

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F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	
F.4: Average number of days between referral and first participation in referred PEI program:	
F.5: Describe how your program encouraged access to services and follow through on above referrals: Online magazine is available to program participants that encourages mental health awareness and resources for treatment.	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. *(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)*

Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Wellness Business	**8 business owners**
Health Centers	**8 staff persons and subsequent clients**
Women's Programs	**6 staffs and subsequent clients**
Religious Organizations	**5 religious outreach offices**
Education Institutions	**5 community colleges and schools**
Cultural Centers, Museum, Community Center, Library	**42 locations, information posted in reception area for community members**

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MHSA Program #	**PEI 28**
PROVIDER NAME	**Health and Human Resource Education Center**
PROGRAM NAME	**Downtown TAY**

2023 - 2024

Program Outcomes & Impact Data Report

Program Name:	**Downtown TAY**	
Organization:	**Health and Human Resource Education Center**	
Type of Report:	**Annual Data Report**	
PEI Category:	**Outreach**	
Priority Area (place an X next to all that apply):		
		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach & Engagement
	X	Cultural & Linguistic
		Older Adults
		Early Identification of MH Illness
Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.		
	X	Suicide

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X	Incarceration
X	School failure or dropout
X	Unemployment
	Prolonged suffering
X	Homelessness
	Removal of children from their homes

Box A: Brief program description.
Downtown TAY serves as a resource center to support young adults, with emphasis on African American transitional aged youth, to connect to needed resources that include housing, employment, health care, educational development, mental health wellness and introductions to positive uplifting social networks. Through a wealth of peer led and intergenerational programs, we strive to educate, elevate and inspire TAY (16-25).

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	
Number of unduplicated individual family members served indirectly by your program:	
Grand total of unduplicated individuals served:	

Box C: Demographics of individuals served this fiscal year through MHSA funding:			
AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)		Gay/Lesbian	
Transition Age Youth (16-25 yrs.)		Heterosexual/Straight	
Adult (26-59 yrs.)		Bisexual	
Older Adult (60+ yrs.)		Questioning/Unsure	
Declined to answer		Queer	
Unknown		Declined to answer	
TOTAL	145	Unknown	145
		Another group not listed	
		TOTAL	145
		If another group is counted, please specify with numbers:	
VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes		English	111
No	145	Spanish	
Declined to answer		Cantonese	
Unknown		Chinese	
TOTAL	145	Vietnamese	
		Farsi	

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CURRENT GENDER IDENTITY	
Female	59
Male	34
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	52
Another identity not listed	
TOTAL	145
If another group is counted, please specify with numbers:	

Arabic	
Tagalog	
Declined to answer	
Unknown	34
Other languages not listed	
TOTAL	145

SEX ASSIGNED AT BIRTH	
Male	59
Female	34
Declined to answer	
Unknown	52
TOTAL	145
Male	
DISABILITY STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	
None	
Declined to answer	
Unknown	145

ETHNICITY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	13
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	13
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	9
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	1
Total Non-Hispanic or Non-Latino:	

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Another disability not listed		More than one ethnicity	1
TOTAL	145	Unknown ethnicity	3
If another disability is counted, please specify with numbers:		Declined to answer	
		ETHNICITY TOTAL	145
RACE		If another ethnicity is counted, please specify with numbers: Navajo (1)	
American Indian or Alaska Native		If another race is counted, please specify with numbers:	
Asian			
Black or African American	9		
Native Hawaiian or another Pacific Islander			
White			
Other Race	14		
Declined to answer			
Unknown			
TOTAL	145		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

Downtown TAY has formed numerous connections over the past year, collaborating with various community-based organizations across Alameda County. The program has successfully maintained relationships with both Castlemont High School and Dewey Academy. Outreach to other high schools has also continued, aided by the new members of the Community Advisory Board (CAB). The development of this new board is a particular point of pride for the agency. Our new members are outstanding community figures who have shared their stories, provided health and wellness resources, and created spaces for healing in our communities.

The CAB participated in the Bioneers Conference, which was a transformative experience for everyone involved. This conference reignited the flame of social and climate justice. Our new connection with Bioneers is a highlight for us, as attending this prestigious conference, which draws over 2,000 attendees and has ticket prices exceeding $500, was a significant opportunity. Thanks to the efforts of the Program Coordinator, we secured donated tickets for our youth group. The conference's youth program included enriching workshops such as a restorative justice circle, a youth of color cactus workshop, mural painting, an LGBTQIA mixer, and a very magical open mic. Keynote speakers included Colette Pichon Battle and Dolores Huerta. Our CAB members enjoyed each day of the conference and expressed immense gratitude for the opportunity to attend.

The youth program coordinator for Bioneers greatly appreciated Downtown TAY's presence at the workshops and invited us to host our own workshop at the 2025 Bioneers Conference! Overall,

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Downtown TAY has continued to connect with youth through a variety of health and wellness workshops and has excelled in collaborating with other organizations and spaces that uplift youth.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	
E.3: Types of treatment individuals were referred to (list types below):	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	
G.5: Average duration of untreated mental illness in weeks:	
E.6: Average number of days between referral and first participation in referred treatment program:	
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
F.2: Number of paper referrals to an ACBH PEI-funded program:	
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	
F.4: Average number of days between referral and first participation in referred PEI program:	
F.5: Describe how your program encouraged access to services and follow through on above referrals:	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
NA	NA

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MHSA Program #	**PEI 1C**
PROVIDER NAME	**A Better Way**
PROGRAM NAME	**Early Childhood Mental Health Outreach and Consultation**

2023 - 2024

Program Outcomes & Impact Data Report. New program. No data in 2023/2024

Program Name:	**Early Childhood Mental Health Prevention and Early Intervention**
Organization:	**A Better Way**
Type of Report:	**Annual Data Report**
PEI Category:	**Early Intervention**

Priority Area (place an X next to all that apply):

X	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.

	Suicide
	Incarceration
	School failure or dropout
	Unemployment
X	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: Brief program description.

Prevention and Early Intervention (PEI) services, through an integrated approach that incorporates several evidence-based practices to deliver culturally and linguistically responsive, trauma-informed, and family-oriented education, trainings and consultation on mental health. Services include Developmental screening, assessment, and monitoring; Dyadic (Infant-Parent/Child-Parent) and family therapy; Parent training; Targeted family support services; Infant massage training and bonding classes; Parent education and support groups.

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MHSA Program #	**PEI 22**
PROVIDER NAME	**Side by Side**
PROGRAM NAME	**LGBT Support Services**

2023 - 2024

Program Outcomes & Impact Data Report. New program. No data in 2023/2024

Program Name:	**Lambda Youth Program**
Organization:	**Side by Side**
Type of Report:	**Annual Data Report**
PEI Category:	**Early Intervention**

Priority Area (place an X next to all that apply):

	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.

X	Suicide
	Incarceration
X	School failure or dropout
X	Unemployment
X	Prolonged suffering
X	Homelessness
X	Removal of children from their homes

Box A: Brief program description.

Lambda Youth Program provides services to young people who identify as LGBTQIA+. LAMBDA Project Eden Drop-in Center provides a safe, supportive environment for LGBTQIA+ youth. Early Intervention services through a community-based, youth/peer-driven and culturally responsive services. Comprehensive services for youth include Suicide assessment and prevention support groups; Support for parents, caregivers and families, including information regarding access to therapy, counseling, support groups, and education; Outreach text line. The text line shall provide LGBTQIA+ Y/YA with basic information regarding the drop-in center and services and connect Y/YA to therapeutic support when clients do not feel safe or able to access the drop-in center in person. Resource navigation and linkage to referrals brief low intensity early intervention individual, group therapy and/or counseling for both mental health concerns and substance use/misuse to Y/YA and/or their family. Prevention visits to individuals who are not currently participating in early intervention counseling as means to engage those considering the service for the first time.

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MHSA Program #	**PEI 3**
PROVIDER NAME	**Alameda County Behavioral Health Department**
PROGRAM NAME	**Geriatric Assessment Response Team (GART)**

2023 - 2024

Program Outcomes & Impact Data Report

Program Name:	**Geriatric Assessment & Response Team (GART)**
Organization:	**ACBHD**
Type of Report:	**Annual Data Report**
PEI Category:	**Early Intervention**

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
X	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
X	Suicide
X	Incarceration
	School failure or dropout
	Unemployment
X	Prolonged suffering
X	Homelessness
	Removal of children from their homes

Box A: <u>Brief</u> program description.

The Geriatric Assessment and Response Team (GART) program is a brief therapeutic treatment and case management service for older adults aged 55+ in Alameda County. GART screens and evaluates older adults for behavioral health care needs and provides age-appropriate interventions. The program's goals are to maintain independence, offer an alternative to hospitalization, promote consumer recovery, provide culturally competent services, and integrate care approaches. GART aims to empower older adults, enhance their wellness, and improve their quality of life through linkage to best-matched care.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	83
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	83
Number of unduplicated individual family members served indirectly by your program:	N/A
Grand total of unduplicated individuals served:	83

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	0	Gay/Lesbian	1
Transition Age Youth (16-25 yrs.)	0	Heterosexual/Straight	29
Adult (26-59 yrs.)	16	Bisexual	0
Older Adult (60+ yrs.)	66	Questioning/Unsure	0
Declined to answer	0	Queer	0
Unknown	1	Declined to answer	0

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TOTAL	83

Unknown	53
Another group not listed	0
TOTAL	83
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	0
No	5
Declined to answer	0
Unknown	78
TOTAL	83

PRIMARY LANGUAGE	
English	65
Spanish	1
Cantonese	0
Chinese	3
Vietnamese	0
Farsi	0
Arabic	0
Tagalog	0
Declined to answer	0
Unknown	13
Other languages not listed	1
TOTAL	83

CURRENT GENDER IDENTITY	
Female	30
Male	42
Transgender	0
Genderqueer	0
Questioning/unsure of gender identity	0
Declined to answer	0
Unknown	11
Another identity not listed	1
TOTAL	83
If another group is counted, please specify with numbers:	

SEX ASSIGNED AT BIRTH	
Male	46
Female	36
Declined to answer	0
Unknown	1
TOTAL	83
Male	

DISABILITY STATUS	
Communication Domain	
Vision	0
Hearing/Speech	0
Another type not listed	0
Communication Domain Subtotal	0
Disability Domain	
Cognitive (**exclude** mental illness;	8

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	0
Central American	0
Mexican/Mexican American/Chicano	2
Puerto Rican	0
South American	0
Another Hispanic/Latino ethnicity not listed	1
Total Hispanic or Latino	**3**
If Non-Hispanic or Non-Latino, please specify:	
African	0
African American	9
Asian Indian/South Asian	0
Cambodian	0
Chinese	1
Eastern European	0

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include learning, developmental, dementia, etc.)		European	0
		Filipino	2
Physical/mobility	4	Japanese	0
Chronic health condition	0	Korean	0
Disability Subtotal	12	Middle Eastern	0
None	24	Vietnamese	5
Declined to answer	0	Other Non-Hispanic or Non-Latino ethnicity not listed	29
Unknown	70	**Total Non-Hispanic or Non-Latino:**	46
Another disability not listed	0	More than one ethnicity	17
TOTAL	106	Unknown ethnicity	17
If another disability is counted, please specify with numbers:		Declined to answer	0
		ETHNICITY TOTAL	83
		If another ethnicity is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native	0	If another race is counted, please specify with numbers:	
Asian	12		
Black or African American	15		
Native Hawaiian or another Pacific Islander	0		
White	31		
Other Race	21		
Declined to answer	0		
Unknown	4		
TOTAL	83		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

Over the past year, the Geriatric Assessment Response Team (GART) team has consistently demonstrated its ability to transform lives through swift, adaptable, and comprehensive care. In the 2023-2024 fiscal year, the program received a total of 233 referrals from diverse sources. These sources included hospitals, crisis residential treatment centers, community members, and self-referrals, among others.

A particularly inspiring case illustrates the program's remarkable impact:

A client with a complex history of homelessness, incarceration, and untreated mental health issues was referred to GART by John George Psychiatric Hospital. Despite initial reluctance to engage, the GART team's persistent, client-centered approach gradually built trust. Through a series of carefully coordinated interventions - including crisis stabilization, thorough needs assessment, and innovative housing solutions - the team navigated numerous challenges to achieve positive outcomes.

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When the client's first housing placement fell through, GART's quick thinking and community outreach prevented a return to homelessness. Their ability to leverage partnerships led to an extended stay at a Crisis Residential Treatment center, allowing time for crucial medication adjustments. This flexibility paid off, resulting in significant symptom reduction and ultimately, a successful transition to a more suitable living arrangement.

Throughout the process, GART seamlessly coordinated with various service providers, ensuring a warm hand-off to long-term care. This case exemplifies GART's unique strength: its capacity to bridge gaps in the system, providing a lifeline for those who might otherwise fall through the cracks. By combining rapid response with persistent, holistic support, GART stabilized this client's immediate crisis and laid the groundwork for sustainable recovery and reintegration into the community.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	18
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	N/A
E.3: Types of treatment individuals were referred to (list types below):	
Mental Health Treatment (CSU, CRT, Level 1 clinics, Level 3 clinics, FSP programs, medication clinics)	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	18
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
Geriatric Population ages 55+.	
F.2: Number of paper referrals to an ACBH PEI-funded program:	0
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A
F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referrals: N/A	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment)

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reached. *(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)*	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Virtual PEI providers Meeting	7 mental health professionals
Adult Protective Services Multi-Disciplinary Team/Virtual Meeting	43 mental health and healthcare professionals
Police Department Crisis Intervention Training Orientation	30 Law Enforcement Officers
Faces of the Future, Inc./High School	25 Mental Health Career Exploration Arroyo High School Students
African American Family Outreach Project Virtual Meeting	25 African American Family Outreach Project Program staff
Virtual Presentation	10 SBBH Providers and District Representatives
Mental Health Advisory (Main) Board Meeting	25 mental health Staff
Older Adult Training Virtual Presentation	25 older adult providers
ACBH Executive Leadership Team virtual Meeting	18 Leadership Members
Adult Forensic Mental Health-Jail and virtual presentation	30 mental health professionals
988 Virtual Conference	100-200 Alameda County Crisis Support Services staff/participants/volunteers
HCSA OAD Virtual presentation	250 members
Oakland Public Library	15 Library staff
City of San Leandro Human Services	28 homeless case managers
City of San Leandro BOS Dist. 3 virtual meeting	88 board of supervisor staff members
Oakland Police Department	25 Police Officers
REACH Ashland Youth Center	35 mental health and staff members
Goodness Village Program	25 staff members
Oakland Public Library	148 community members/consumers
East Oakland Senior Center	36 Staff and community members at senior center
Age Well Center at Lake Elizabeth	20 community members
Veteran Affair	90 Workshop participants
Veterans Memorial Building	25 mental health staff members
Various Homeless encampments in Alameda County	91 Community members consumers at various homeless encampments
Various Tabling Events in Alameda County	38 Community Members and Providers
Healthcare for the Homeless Providers Virtual Training	113 Healthcare for the homeless participants/mental health providers/resource specialists
Providers, Children's Specialized Services Virtual Presentation	10 mental health providers
Oakland Police Department	71 Police Officers and civilian Mental Health Workers

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MHSA Program #	**PEI 17B**
PROVIDER NAME	**Healthy Schools and Community**
PROGRAM NAME	**REACH Asland Youth Center**

2023-2024

Program Outcomes & Impact Data Report

Program Name:	**REACH Ashland Youth Center**
Organization:	**Alameda County-Healthy Schools and Communities**
Type of Report:	**Annual Data Report**
PEI Category:	**Early Intervention**

Priority Area (place an X next to all that apply):	
X	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
X	Suicide
	Incarceration
X	School failure or dropout
	Unemployment
	Prolonged suffering
X	Homelessness
	Removal of children from their homes

Box A: <u>Brief</u> program description.
REACH serves youth ages 11 through 24 who live throughout Alameda County with a focus on the Ashland and unincorporated areas, a community that is known for poverty, crime and chronic health conditions. We provide recreation, education, arts, career and health and wellness activities and services. In the process, they develop resiliency and the skills they need to take positive action and thrive, even amidst ongoing personal trauma and social disadvantage.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	77

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Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	96
Number of unduplicated individual family members served indirectly by your program:	88
Grand total of unduplicated individuals served:	261

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	86
Transition Age Youth (16-25 yrs.)	87
Adult (26-59 yrs.)	0
Older Adult (60+ yrs.)	0
Declined to answer	0
Unknown	0
TOTAL	173

SEXUAL ORIENTATION	
Gay/Lesbian	0
Heterosexual/Straight	0
Bisexual	0
Questioning/Unsure	0
Queer	0
Declined to answer	0
Unknown	173
Another group not listed	0
TOTAL	173
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	0
No	0
Declined to answer	0
Unknown	173
TOTAL	173

PRIMARY LANGUAGE	
English	109
Spanish	57
Cantonese	1
Chinese	0
Vietnamese	1
Farsi	0
Arabic	0
Tagalog	0
Declined to answer	0
Unknown	0
Other languages not listed	1
TOTAL	173

CURRENT GENDER IDENTITY	
Female	83
Male	77
Transgender	3
Genderqueer	3
Questioning/unsure of gender identity	0
Declined to answer	3
Unknown	4
Another identity not listed	0
TOTAL	173
If another group is counted, please specify with numbers:	

OPTIONAL: Is it NOT required to specify other languages not listed – but if you want to, the other language is ethnicity: Asian Indian/South Asian.

SEX ASSIGNED AT BIRTH	
Male	0

ETHNITICY/CULTURAL HERITAGE (choose one)
If Hispanic or Latino, please specify:

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Female	0	Caribbean	0
Declined to answer	0	Central American	12
Unknown	173	Mexican/Mexican American/Chicano	60
TOTAL	173	Puerto Rican	1
		South American	4
		Another Hispanic/Latino ethnicity not listed	4
DISABILITY STATUS		**Total Hispanic or Latino**	**81**
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision	0	African	32
Hearing/Speech	0	African American	0
Another type not listed	0	Asian Indian/South Asian	3
Communication Domain Subtotal	0	Cambodian	0
Disability Domain		Chinese	6
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	13	Eastern European	0
		European	1
		Filipino	0
Physical/mobility		Japanese	0
Chronic health condition	2	Korean	0
Disability Subtotal	15	Middle Eastern	1
None	70	Vietnamese	1
Declined to answer	0	Other Non-Hispanic or Non-Latino ethnicity not listed	5
Unknown	87	**Total Non-Hispanic or Non-Latino:**	49
Another disability not listed	1	More than one ethnicity	0
TOTAL	173	Unknown ethnicity	23
If another disability is counted, please specify with numbers: 1 youth [schizophrenia]		Declined to answer	20
		ETHNICITY TOTAL	173
		If another ethnicity is counted, please specify with numbers: Hispanic/Latinx: 4 youth identified as Hispanic/Latinx without additional information Non-Hispanic/Latinx: • Race Black or African American, reported ethnicity as other: 2 • Race other, did not report ethnicity: 1 • Race other, reported ethnicity as other: 1 • Race Native Hawaiian or other Pacific Islander, reported ethnicity as other: 1	
RACE			

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American Indian or Alaska Native	8	If another race is counted, please specify with numbers:
Asian	12	Multiracial: 61 youth Hispanic/Latinx, reported race as other: 52 Non-Hispanic/Latinx, reported race as other: • Ethnicity African: 1 • Another ethnicity not listed: 2 • Declined to report ethnicity: 2 • Unknown ethnicity: 4
Black or African American	45	
Native Hawaiian or another Pacific Islander	1	
White	18	
Other Race	61	
Declined to answer	7	
Unknown	13	
TOTAL	173	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

This year, we were able to graduate 10 young adults from Opportunity Academy (OA), our alternate high school program. OA is a collaboration with REACH and Alameda County Office of Education (ACOE). The case managers supported the teachers by providing clinical case management and advocacy services to the students and mental health consultation and support to teachers and staff. The collaboration has been successful in offering young adults who otherwise would not be able to obtain their GED in a traditional setting.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below: N/A	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	
E.3: Types of treatment individuals were referred to (list types below):	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	
G.5: Average duration of untreated mental illness in weeks:	
E.6: Average number of days between referral and first participation in referred treatment program:	
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below: N/A	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
F.2: Number of paper referrals to an ACBH PEI-funded program:	
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	

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F.4: Average number of days between referral and first participation in referred PEI program:	
F.5: Describe how your program encouraged access to services and follow through on above referrals:	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. *(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.) N/A*	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
NA	NA

MHSA Program # **PEI 24**
PROVIDER NAME **Roots Community Health**
PROGRAM NAME **Sobrante Park Community Project**
2023 - 2024

Program Outcomes & Impact Data Report

Program Name:	**Sobrante Park Community Project**
Organization:	**Roots Community Health in partnership with Higher Ground**
Type of Report:	**Annual Data Report**
PEI Category:	**Early Intervention**

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.	
X	Suicide
X	Incarceration
X	School failure or dropout
X	Unemployment
X	Prolonged suffering
X	Homelessness
X	Removal of children from their homes

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Box A: Brief program description.
Roots Community Health seeks to address long-standing health inequalities in the Sobrante Park community by partnering with the Sobrante Park Residents Action Council and Higher Ground to provide culturally responsive, comprehensive physical and mental health services; education, employment and training; and wraparound services that build self-sufficiency and promote community empowerment. Higher Ground (HG) works with schools in the identified areas to identify students who could benefit from services provided by Roots Community Health Center. They also provide 24 students with college and career readiness through providing youth development training, peer to peer workforce programming that integrates civic engagement and community outreach activities. Sobrante Park's annual MLK day of service is a project they host.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	210
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	0
Number of unduplicated individual family members served indirectly by your program:	326
Grand total of unduplicated individuals served:	536

Box C: Demographics of individuals served this fiscal year through MHSA funding:			
AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	7	Gay/Lesbian	1
Transition Age Youth (16-25 yrs.)	55	Heterosexual/Straight	0
Adult (26-59 yrs.)	125	Bisexual	0
Older Adult (60+ yrs.)	5	Questioning/Unsure	2
Declined to answer	43	Queer	0
Unknown	91	Declined to answer	0
TOTAL	326	Unknown	323
		Another group not listed	0
		TOTAL	326
		If another group is counted, please specify with numbers:	
VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes	0	English	317
No	0	Spanish	9
Declined to answer	0	Cantonese	0
Unknown	326	Chinese	0
TOTAL	326	Vietnamese	0
		Farsi	0
CURRENT GENDER IDENTITY		Arabic	0
Female	156	Tagalog	0

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Male	119	Declined to answer	0
Transgender	0	Unknown	0
Genderqueer	0	Other languages not listed	0
Questioning/unsure of gender identity	0	**TOTAL**	326
Declined to answer	22		
Unknown	29		
Another identity not listed	0		
TOTAL	326		
If another group is counted, please specify with numbers:			

SEX ASSIGNED AT BIRTH		**ETHNICITY/CULTURAL HERITAGE (choose one)**	
Male	169	**If Hispanic or Latino, please specify:**	
Female	130	Caribbean	0
Declined to answer	22	Central American	3
Unknown	5	Mexican/Mexican American/Chicano	120
TOTAL	326	Puerto Rican	0
		South American	0
		Another Hispanic/Latino ethnicity not listed	0
DISABILITY STATUS		**Total Hispanic or Latino**	**123**
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision	0	African	0
Hearing/Speech	0	African American	103
Another type not listed	0	Asian Indian/South Asian	2
Communication Domain Subtotal	0	Cambodian	0
Disability Domain		Chinese	0
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	0	Eastern European	0
		European	
		Filipino	
Physical/mobility	0	Japanese	0
Chronic health condition	0	Korean	0
Disability Subtotal		Middle Eastern	1
None	0	Vietnamese	0
Declined to answer	302	Other Non-Hispanic or Non-Latino ethnicity not listed	51
Unknown	24	**Total Non-Hispanic or Non-Latino:**	157
Another disability not listed	0	More than one ethnicity	1
TOTAL	326	Unknown ethnicity	45

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If another disability is counted, please specify with numbers:		Declined to answer	0
		ETHNICITY TOTAL	326
		If another ethnicity is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native	0	If another race is counted, please specify with numbers:	
Asian	0		
Black or African American	108		
Native Hawaiian or another Pacific Islander	5		
White	0		
Other Race	117		
Declined to answer	51		
Unknown	45		
TOTAL	326		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
The past fiscal year was exciting for Roots Community Health. We are proud to share that we held 23 pop-up markets and served 422 families this fiscal year. At Roots, we strongly believe in the importance of wrap around services. Although providing access to mental health and wellness is the primary deliverable, this service must be boosted by additional efforts that address other needs, like food insecurity and creating safe spaces.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	219
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	60
E.3: Types of treatment individuals were referred to (list types below):	
Referred clients receive weekly one-on-one sessions with mental health providers or, in some cases, participate in group therapy. The type and frequency of treatment are determined by a clinician based on each client's specific needs and treatment level.	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	262
G.5: Average duration of untreated mental illness in weeks:	30 days
E.6: Average number of days between referral and first participation in referred treatment program:	5 to 7 days

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Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
African Americans and individuals of Latino descent who live, work, or attend school in Sobrante Park. Higher Ground targets populations who are BIPOC students who live in the identified area of East Oakland. Their program is a representation of Oakland having several different ethnic groups being present in their student body.	
F.2: Number of paper referrals to an ACBH PEI-funded program:	35
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	3
F.4: Average number of days between referral and first participation in referred PEI program:	5 to 7 days
F.5: Describe how your program encouraged access to services and follow through on above referrals: Through collaboration with our community partners, including the Sobrante Park Resident Action Council, Higher Ground and Madison Park Academy Primary, community members are referred to Roots for a variety of services. A Roots Navigator will then work with the community member to help facilitate matching the appropriate service to meet the needs of the client. The Navigator also conducts regular check-ins with the clients to ensure the efficacy of the service. At Higher Ground's Wednesday workshops, they provide information on Roots services and ways to access the services as part of their announcements. They also discuss stress management and collegiality, which dovetails into friendship conversations and ways to be resilient in the workplace. They focus on transferable mental health coping skills. They disguise these lessons in concepts of the workplace, but they always tie it back to their day to day lives outside work. This is how they can offer additional help and discuss the benefits of getting additional help. They did not have any youth this cycle expressing the need for social and/or emotional support to the level of needing a referral.	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
23 Touchless Pop-up Markets	**5 Roots Staff**
MLK Day of Service	

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MHSA Program #	**PEI 17A**
PROVIDER NAME	**Youth Uprising**
PROGRAM NAME	**Youth Uprising TAY**

2023 – 2024

Program Outcomes & Impact Data Report

Program Name:	**Youth Uprising TAY**	
Organization:	**Youth Uprising**	
Type of Report:	**Annual Data Report**	
PEI Category:	**Early Intervention**	
Priority Area (place an X next to all that apply):		
		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach & Engagement
		Cultural & Linguistic
		Older Adults
	X	Early Identification of MH Illness
Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.		
	X	Suicide
	X	Incarceration
	X	School failure or dropout
		Unemployment
	X	Prolonged suffering
		Homelessness
		Removal of children from their homes

Box A: <u>Brief</u> program description.
Youth UpRising (YU) provides integrated services to youth aged 13 to 24 years old through three core departments: Career & Education (C&E), Health & Wellness (H&W), and Arts & Expression (A&E). Under H&W, we offer individual therapy sessions to support and guide clients. These sessions focus on addressing specific concerns, developing coping mechanisms and fostering personal growth. We also offer Holistic wellness services such as massages and yoga. These practices aim to promote relaxation, reduce stress, and enhance overall physical and mental wellness. Our Healing Circles offer a space for individuals to share experiences and build connections within a community of understanding. These circles provide a platform for collective healing and allow participants to express themselves and receive support from their peers. Wellness Wednesday sessions create a dedicated space for participants to engage in activities promoting physical, mental, and emotional well-being. These sessions encompass various wellness practices, including psycho-education, art activities, recreational activities, and opportunities for personal growth. Aside from program service delivery, YU operates three social enterprises that support youth with robust sector-specific skills in food and hospitality, cleaning services, and digital arts. We believe that through comprehensive programming and direct support from caring adults our youth have been able to develop greater social-emotional skills and tools, reduce stress, and achieve personal goals.

<u>Box B:</u> Number of Individuals served this fiscal year through MHSA funding.

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# of unduplicated individuals served who are at risk of developing a serious mental illness:	86
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	2
Number of unduplicated individual family members served indirectly by your program:	379
Grand total of unduplicated individuals served:	467

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	25
Transition Age Youth (16-25 yrs.)	61
Adult (26-59 yrs.)	
Older Adult (60+ yrs.)	
Declined to answer	
Unknown	381
TOTAL	**467**

SEXUAL ORIENTATION	
Gay/Lesbian	1
Heterosexual/Straight	50
Bisexual	
Questioning/Unsure	1
Queer	1
Declined to answer	2
Unknown	411
Another group not listed	1
TOTAL	**467**
If another group is counted, please specify with numbers: Other, Gender Non-conforming, Transgender	

VETERAN STATUS	
Yes	
No	88
Declined to answer	
Unknown	379
TOTAL	**467**

PRIMARY LANGUAGE	
English	66
Spanish	6
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	1
Unknown	394
Other languages not listed	
TOTAL	**467**

CURRENT GENDER IDENTITY	
Female	39
Male	44
Transgender	1
Genderqueer	
Questioning/unsure of gender identity	1
Unknown	381
Another identity not listed	1
TOTAL	467
If another group is counted, please specify with numbers: Gender non-conforming	

SEX ASSIGNED AT BIRTH	
Male	44
Female	39

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	

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Declined to answer	1	Central American	
Unknown	383	Mexican/Mexican American/Chicano	28
TOTAL	**467**	Puerto Rican	
		South American	
		Another Hispanic/Latino ethnicity not listed	11
DISABILITY STATUS		**Total Hispanic or Latino**	**39**
Communication Domain		**If Non-Hispanic or Non-Latino, please specify: Salvadorian**	
Vision		African	
Hearing/Speech		African American	40
Another type not listed		Asian Indian/South Asian	
Communication Domain Subtotal	0	Cambodian	
Disability Domain		Chinese	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	1	Eastern European	1
		European	
		Filipino	
Physical/mobility		Japanese	
Chronic health condition		Korean	
Disability Subtotal	1	Middle Eastern	2
None		Vietnamese	
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	1
Unknown	466	**Total Non-Hispanic or Non-Latino:**	**44**
Another disability not listed		More than one ethnicity	2
TOTAL	**467**	Unknown ethnicity	382
If another disability is counted, please specify with numbers:		Declined to answer	
		ETHNICITY TOTAL	**467**
RACE		If another ethnicity is counted, please specify with numbers: Polynesian (1)	
		If another race is counted, please specify with numbers: Bi-racial, Latinx & Middle Eastern	

Asian	
Black or African American	40
Native Hawaiian or another Pacific Islander	1
White	1
Other Race	43
Declined to answer	
Unknown	382
TOTAL	**467**

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Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
Our program has achieved significant milestones in providing quality care to the East Oakland community, and throughout Alameda County. We have made great strides in increasing access to preventive counseling, delivering weekly individual sessions to those in need. Our dedication to supporting vulnerable populations has been demonstrated through initiatives like providing bus passes and gift cards to address food insecurities and homelessness among youth and families. Another noteworthy achievement has been the successful facilitation of a groups, empowering young individuals with essential knowledge about healthy relationships, safety, empowerment, identity and boundaries. This has positively impacted the community by promoting emotional well-being and building strong support networks. We are proud to have seen an increase in referrals during this fiscal year, a testament to the growing recognition of the importance of mental health services within the community. Our organization has responded proactively by continuing to establish policies and procedures, conducting risk assessments, and implementing personalized treatment planning to better meet the unique needs of our clients. While challenges have been encountered, our commitment to hiring a bilingual clinician and addressing retention through competitive compensation reflects our dedication to enhancing our staff and services. Overall, we have met our goals and contractual obligations this fiscal year. Our successes this fiscal year have solidified our position as a leading mental health provider in the community, and we look forward to building upon these achievements in the future.
Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:

E.1: Unduplicated number of individuals with severe mental illness referred to higher level of care within ACBH system (i.e., mental health treatment services):	6
E.2: Unduplicated number of individuals with severe mental illness referred to higher level of care outside ACBH system (i.e., mental health treatment services):	2
E.3: Types of treatment individuals were referred to (list types below):	
Outpatient Individual Therapy, Domestic Violence Group, Substance Use Treatment, Psychiatry	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	3

E.5: Average duration of untreated mental illness in weeks:	1
E.6: Average number of days between referral and first participation in referred treatment program:	3-5
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
TAY, African American and Latinx	
F.2: Number of paper referrals to an ACBH PEI-funded program:	42
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	29

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F.4: Average number of days between referral and first participation in referred PEI program:	3-5
F.5: Describe how your program encouraged access to services and follow through on above referrals: To track the success of the referral process, we have a system for monitoring and evaluating the outcomes of referrals. This evaluation involved tracking client attendance and engagement with external services, assessing client satisfaction, and identifying any potential barriers to access.	
Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. *(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)*	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
NA	NA

PEI: Stigma and Discrimination Reduction Programs

MHSA Program #	**PEI 4**
PROVIDER NAME	**Peers Envisioning and Engaging in Recovery Services (PEERS)**
PROGRAM NAME	**Stigma & Discrimination Reduction Campaign- "Everyone Counts"**
2023 - 2024	

Program Outcomes & Impact Data Report

Program Name:	**Stigma & Discrimination Reduction Campaign- "Everyone Counts"**
Organization:	**Peers Envisioning and Engaging in Recovery Services (PEERS)**
Type of Report:	**Annual Data Report**
PEI Category:	**Stigma & Discrimination Reduction**

Priority Area (place an X next to all that apply):

	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
X	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.

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X	Suicide
	Incarceration
	School failure or dropout
	Unemployment
X	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: Brief program description.
The Everyone Counts Campaign (ECC) is multi-strategy program that reduces stigma and discrimination against people living with mental health conditions and promotes social inclusion through three strategies: Empowerment of people with mental health experiences through peer support (Lift Every Voice and Speak speakers' bureau, TAY Wellness, Black Wellness and Resilience, HOPE Asian American Healing Circles, Buried in Treasures hoarding and cluttering groups, and Special Messages groups), Outreach (LEVS speaking engagements, Latine Community Mental Wellness ECC--including action team and anti-stigma support groups, and outreach events), and Communications (website, email, social media).

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	319
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	
Number of unduplicated individual family members served indirectly by your program:	
Grand total of unduplicated individuals served:	319

Box C: Demographics of individuals served this fiscal year through MHSA funding:			
AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)		Gay/Lesbian	4
Transition Age Youth (16-25 yrs.)	39	Heterosexual/Straight	39
Adult (26-59 yrs.)	38	Bisexual	10
Older Adult (60+ yrs.)	27	Questioning/Unsure	3
Declined to answer		Queer	6
Unknown	215	Declined to answer	5
TOTAL	319	Unknown	246
		Another group not listed	6
		TOTAL	319
		If another group is counted, please specify with numbers: She/her (1), female (1), male (1), demisexual (1), pansexual (1), other (1)	
VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes	2	English	54
No	76	Spanish	18

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Declined to answer	
Unknown	241
TOTAL	319

CURRENT GENDER IDENTITY	
Female	109
Male	42
Transgender	
Genderqueer	2
Questioning/unsure of gender identity	1
Declined to answer	
Unknown	161
Another identity not listed	4
TOTAL	319
If another group is counted, please specify with numbers: Nonbinary (4)	

Cantonese	4
Chinese	1
Vietnamese	
Farsi	
Arabic	
Tagalog	1
Declined to answer	
Unknown	232
Other languages not listed	9
TOTAL	319

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	319
TOTAL	319
Male	

DISABILITY STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	2
Physical/mobility	4

ETHNICITY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	2
Central American	2
Mexican/Mexican American/Chicano	10
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	2
Total Hispanic or Latino	**16**
If Non-Hispanic or Non-Latino, please specify:	
African	1
African American	8
Asian Indian/South Asian	6
Cambodian	
Chinese	4
Eastern European	1, 1, 8
European	
Filipino	
Japanese	2

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Chronic health condition	1	Korean	
Disability Subtotal	7	Middle Eastern	
None	38	Vietnamese	
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	2
Unknown	235	**Total Non-Hispanic or Non-Latino:**	33
Another disability not listed	32	More than one ethnicity	8
TOTAL	319	Unknown ethnicity	262
If another disability is counted, please specify with numbers: Unspecified (21), bipolar (2), PTSD (1), mental health (4), depression/anxiety (1), schizoaffective (1), emotional challenges (1), trauma (1)		Declined to answer	
		ETHNICITY TOTAL	319
		If **another ethnicity** is counted, please specify with numbers: Latino (2),	
RACE			
American Indian or Alaska Native	3	If **another race** is counted, please specify with numbers: More than one race (9), Latino or Hispanic (23), Other unspecified (3)	
Asian	25		
Black or African American	60		
Native Hawaiian or another Pacific Islander			
White	35		
Other Race	35		
Declined to answer			
Unknown	161		
TOTAL	319		

Box D: Program <u>successes/accomplishments</u> of the past year with one example or case study of a success the agency is particularly proud of.

This year's accomplishments included strong and enthusiastic participation in Black Wellness and Resilience peer support groups for African Americans, which particularly succeeded in drawing older adults, the launch of the Latine Mental Wellness Everyone Counts Campaign, continued strong engagement with the Lift Every Voice and Speak speakers' bureau, and excellent response to our wellness workshops for transition-age youth.

Participant success: A participant who identifies as a white, gay, cisgender man, 68 years old, living in rent-controlled housing in downtown Oakland, on Social Security but still working part time, was part of PEERS' Buried in Treasures peer support and education group for people with moderate to severe levels of hoarding. His cluttering and hoarding difficulties began 24 years ago after he experienced multiple losses. He came to the program after a traumatic flood in his apartment, which destroyed his belongings and jeopardized his housing security. In his words, "The flooding also shone a harsh light upon how the way I was living had gotten out of control and how my hoarding was disadvantaging/impoverishing me

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and had taken over." His hoarding created "a cycle of shame, isolation, and self-judgment as well as…hazardous and unsafe living conditions." He shared that the PEERS Buried in Treasures program provided him with "grounding, concrete steps to take, and helped overcome isolation, fostered community, and nurtured commonality." He said that the peer support exchanged in the group countered "the profound isolation that goes hand in hand with hoarding behaviors."

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	0
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	0
E.3: Types of treatment individuals were referred to (list types below):	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/A
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below): We serve mental health consumers, particularly in the Latine/Latin@ community through the Latine Mental Wellness Everyone Counts Campaign, Asian Americans (HOPE ECC campaign) and African Americans (Black Wellness and Resilience), transition-age youth and community members at large (through our anti-stigma campaigns).	
F.2: Number of paper referrals to an ACBH PEI-funded program:	0
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A
F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referrals: We referred many participants to multiple PEERS programs, but none of these constituted paper referrals for appointments.	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Respondents	

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Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Liberation Through Community	50 primarily Latin@ community members, primarily families
PEERS Wellness Fair	100 community members, primarily mental health consumers
High school wellness fairs (Berkeley, Arise, Alternatives in Action, Arroyo)	101 high school students and their families
Lambda Pride Prom	16 primarily LGBTQ+ youth
Dia de los Muertos	Nearly 100 community members, many of them Latino
Allen Temple Holistic Health Fair	35 members of Allen Temple church and neighbors
NAMI Walk	53 mental health consumers, family members, and friends
La Familia children's event	153 community members, primarily families with children
San Leandro Library Rainbow Resource Fair	27 San Leandro community members
City of Berkeley Be Kind to Your Mind event	50 community members, primarily adult residents of Berkeley

PEI: Suicide Prevention

MHSA Program #	**PEI 12**
PROVIDER NAME	**Crisis Support Services of Alameda County**
PROGRAM NAME	**Community Education**

2023 – 2024

Program Outcomes & Impact Data Report

Program Name:	**Community Education**
Organization:	**Crisis Support Services of Alameda County**
Type of Report:	**Annual Data Report**
PEI Category:	**Suicide Prevention**

Priority Area (place an X next to all that apply):

	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

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Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.	
X	Suicide
	Incarceration
	School failure or dropout
	Unemployment
	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: Brief program description.
The goal of our Community Education Program is to raise awareness that suicide is a public health issue and that our community is a natural safety net for those that are vulnerable to suicide risk. Providing education & training increases knowledge of suicide warning signs, risk and protective factors, and how to help. Another goal is to eliminate the stigma associated with suicide by talking about this openly and increasing the comfort level of our community to engage and provide support.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	18158
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	n/a
Number of unduplicated individual family members served indirectly by your program:	102
Grand total of unduplicated individuals served:	18260

Box C: Demographics of individuals served this fiscal year through MHSA funding:			
AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	1742	Gay/Lesbian	39
Transition Age Youth (16-25 yrs.)	132	Heterosexual/Straight	1492
Adult (26-59 yrs.)	76	Bisexual	136
Older Adult (60+ yrs.)	12	Questioning/Unsure	57
Declined to answer	268	Queer	11
Unknown	16030	Declined to answer	119
TOTAL	18260	Unknown	16355
		Another group not listed	51
		TOTAL	18260
		If another group is counted, please specify with numbers:	
VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes	13	English	88
No	85	Spanish	4
Declined to answer	1	Cantonese	0

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Unknown	18161	Chinese	0
TOTAL	18260	Vietnamese	0
		Farsi	0
CURRENT GENDER IDENTITY		Arabic	0
Female	974	Tagalog	4
Male	951	Declined to answer	2
Transgender	10	Unknown	18161
Genderqueer	0	Other languages not listed	1
Questioning/unsure of gender identity	20	TOTAL	18260
Declined to answer	30		
Unknown	16252		
Another identity not listed	23		
TOTAL			
If another group is counted, please specify with numbers: 8			

SEX ASSIGNED AT BIRTH		**ETHNITICY/CULTURAL HERITAGE (choose one)**	
Male	62	**If Hispanic or Latino, please specify:**	
Female	34	Caribbean	5
Declined to answer	0	Central American	21
Unknown	18164	Mexican/Mexican American/Chicano	333
TOTAL	18260	Puerto Rican	15
Male		South American	15
		Another Hispanic/Latino ethnicity not listed	47
DISABILITY STATUS		**Total Hispanic or Latino**	**436**
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision	0	African	9
Hearing/Speech	0	African American	76
Another type not listed	0	Asian Indian/South Asian	393
Communication Domain Subtotal	0	Cambodian	6
Disability Domain	0	Chinese	184
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	0	Eastern European	20
		European	79
		Filipino	79
Physical/mobility	0	Japanese	7
Chronic health condition	4	Korean	23
Disability Subtotal	4	Middle Eastern	38
None	88	Vietnamese	39

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Declined to answer	3	Other Non-Hispanic or Non-Latino ethnicity not listed	44
Unknown	18165	**Total Non-Hispanic or Non-Latino:**	997
Another disability not listed	0	More than one ethnicity	220
TOTAL	18260	Unknown ethnicity	17188
		Declined to answer	75
		ETHNICITY TOTAL	18260
If another disability is counted, please specify with numbers:		If another ethnicity is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native	38	If another race is counted, please specify with numbers:	
Asian	757		
Black or African American	107		
Native Hawaiian or another Pacific Islander	18		
White	296		
Other Race	289		
Declined to answer	60		
Unknown	16695		
TOTAL	18260		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
1 - Our Bilingual Community Education Trainer got certified to be an Instructor for MHFA - Spanish and provided 3 in-person trainings with community members. These efforts have been in collaboration with a community partner, MHAAC and it's been a great partnership! 2 - Our healthcare program applied to be a provider for CEs for nurses which has already resulted in increased registration and attendance 3 - Our TFL program worked in partnership with youth at 2 schools and provided guidance to youth who created video vignettes that will be incorporated into the youth curriculum. While it's a new component of the curriculum, positive feedback has already been received on its use in the classroom right before the end of the school year.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	n/a
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	n/a

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E.3: Types of treatment individuals were referred to (list types below):	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
E.6: Average number of days between referral and first participation in referred treatment program:	n/a
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
F.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
F.4: Average number of days between referral and first participation in referred PEI program:	n/a
F.5: Describe how your program encouraged access to services and follow through on above referrals:	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Schools	**11, 735 youth, 195 teachers, 147 School MH staff, 72 parents, caregivers, and guardians**
Law Enforcement Settings	**260 LE Officers and Dispatchers**
College settings	**180 College students and faculty**
Correctional Settings	**362 civilian staff**
Healthcare settings	**363 Providers**

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MHSA Program #	**PEI12**
PROVIDER NAME	**Crisis Support Services of Alameda County**
PROGRAM NAME	**Text Line Program**

2023 - 2024

Program Outcomes & Impact Data Report

Program Name:	**Text Line Program**
Organization:	**Crisis Support Services of Alameda County**
Type of Report:	**Annual Data Report**
PEI Category:	**Suicide Prevention**

Priority Area (place an X next to all that apply):

	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.

X	Suicide
	Incarceration
	School failure or dropout
	Unemployment
	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: Brief program description.

The program provides brief crisis intervention and emotional support to individuals via chat/text/sms modality with emphasis on suicide assessment of participating community members including school aged youth and TAY.

Box B: Number of Individuals served this fiscal year through MHSA funding.

# of unduplicated individuals served who are at risk of developing a serious mental illness:	0
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	0
Number of unduplicated individual family members served indirectly by your program:	0
Grand total of unduplicated individuals served:	3369

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	353	Gay/Lesbian	12
Transition Age Youth (16-25 yrs.)	1094	Heterosexual/Straight	76
Adult (26-59 yrs.)	840	Bisexual	301
Older Adult (60+ yrs.)	33	Questioning/Unsure	0
Declined to answer	0	Queer	6
Unknown	2621	Declined to answer	1

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TOTAL	4941	Unknown	4545
		Another group not listed	0
		TOTAL	4941
		If another group is counted, please specify with numbers:	

VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes	2	English	4916
No	2	Spanish	3
Declined to answer	0	Cantonese	0
Unknown	4937	Chinese	0
TOTAL	4941	Vietnamese	1
		Farsi	0
CURRENT GENDER IDENTITY		Arabic	0
Female	1062	Tagalog	0
Male	323	Declined to answer	0
Transgender	4	Unknown	21
Genderqueer	18	Other languages not listed	0
Questioning/unsure of gender identity	2	TOTAL	4941
Declined to answer	0		
Unknown	3522		
Another identity not listed	10		
TOTAL	4941		
If another group is counted, please specify with numbers: 10			

SEX ASSIGNED AT BIRTH		**ETHNITICY/CULTURAL HERITAGE (choose one)**	
Male	624	**If Hispanic or Latino, please specify:**	
Female	67	Caribbean	0
Declined to answer	0	Central American	0
Unknown	4250	Mexican/Mexican American/Chicano	1
TOTAL	4941	Puerto Rican	0
		South American	0
		Another Hispanic/Latino ethnicity not listed	5
DISABILITY STATUS		**Total Hispanic or Latino**	**6**
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision	0	African	153
Hearing/Speech	0	African American	23
Another type not listed	0	Asian Indian/South Asian	25

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Communication Domain Subtotal	0	Cambodian	0
Disability Domain		Chinese	0
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	0	Eastern European	0 0 3
		European	
		Filipino	
Physical/mobility	10	Japanese	0
Chronic health condition	169	Korean	0
Disability Subtotal	179	Middle Eastern	0
None	0	Vietnamese	1
Declined to answer	2	Other Non-Hispanic or Non-Latino ethnicity not listed	1
Unknown	4646	**Total Non-Hispanic or Non-Latino:**	206
Another disability not listed	118	More than one ethnicity	1
TOTAL	4941	Unknown ethnicity	4728
If another disability is counted, please specify with numbers: 118		Declined to answer	0
		ETHNICITY TOTAL	4941
		If another ethnicity is counted, please specify with numbers: 1	
RACE			
American Indian or Alaska Native	0	If another race is counted, please specify with numbers: 8	
Asian	32		
Black or African American	176		
Native Hawaiian or another Pacific Islander	1		
White	1		
Other Race	8		
Declined to answer	0		
Unknown	4723		
TOTAL	4941		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

We experienced tremendous growth in text volume this year from taking 3370 text contacts to taking 5167 text contacts. This is an increase of 53.32% from the year prior. In addition, the number of texters presenting with medium to high risk for suicide increased by 299.26% from the prior year. In response to the significant increase in acuity, text line counselors provided continued care and crisis counseling, resulting in a 296.77% increase of the number of outreach contacts made to texters. To respond to the significant increase in volume, the text line program had to meet the administrative needs of staffing, training, and supervision. Here are some examples of changes we have made to meet these increases in volume, hours, and level of acuity.

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There has been an astounding rise in the number of outreaches offered to text/chat contacts. This is an increase of 296.77% from the year prior. There is a 253.21% increase in contacts speaking to basic needs such as homeless issues, employment, and transportation. There is also an upward spike by 300% of contacts speaking to health concerns from the past year. To meet the infrastructure requirements of this growth in our program services, we hired 6 staff and recruited 1 intern and 6 volunteers in this past fiscal year. Text line counselors are additionally trained in both phone and text crisis counseling, so they can offer both outreach calls as well as outreach texts.

We have increased accessibility to our program services. Our local text line hours and our 988 chat/text services on the CA-statewide queue have expanded to 24 hours, 7 days a week since February 20, 2024.

We increased providing supervision for staff and text volunteers. Staff are provided a weekly group supervision in the form of a pod of up to 8 counselors with either the Text Line Manager or Coordinator as facilitator. Volunteers are offered a volunteer support group in the form of a monthly drop-in virtual space facilitated by a Text Line Shift Supervisor to connect, share, and learn from other text volunteers.

To help keep the text line counselors up to date on program announcements, a weekly newsletter is sent to all counselors in the program.

To stay up to date with transitioning to Unified Platform for 988 Lifeline chat/text, the Text Line Manager and Coordinator created a training checklist and separate flowcharts for chat vs text contacts detailing steps to take from least invasive to emergency procedures.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	NA
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	NA
E.3: Types of treatment individuals were referred to (list types below):	
NA	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	NA
G.5: Average duration of untreated mental illness in weeks:	NA
E.6: Average number of days between referral and first participation in referred treatment program:	NA
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
TAY	
F.2: Number of paper referrals to an ACBH PEI-funded program:	NA

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F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	NA
F.4: Average number of days between referral and first participation in referred PEI program:	NA
F.5: Describe how your program encouraged access to services and follow through on above referrals: Medium to high-risk clients are rated a 3 or above by counselor to be at risk of suicide. We offer an outreach text or call session to confirm if the texter completed the referral. We also refer anyone of a suicide risk of 3 or above to our Lifeline Follow-Up Program.	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. *(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)*	
Number of Respondents	**12 staff, 1 intern, 5 volunteers**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Text Line Service	18 Text Line counselors

MHSA Program # **PEI12**
PROVIDER NAME **Crisis Support Services of Alameda County**
PROGRAM NAME **Trauma Informed Counseling**
2023 - 2024

Program Outcomes & Impact Data Report

Program Name:	**Trauma Informed Counseling (Clinical Department)**
Organization:	**Crisis Support Services of Alameda County**
Type of Report:	**Annual Data Report**
PEI Category:	**Suicide Prevention**

Priority Area (place an X next to all that apply):

	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
X	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.

X	Suicide
	Incarceration

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X	School failure or dropout
X	Unemployment
X	Prolonged suffering
X	Homelessness
	Removal of children from their homes

Box A: Brief program description.
Our program provided individual, group, and family therapy to underserved members of Alameda County. We also provide community grief events to support programs, schools, or families following an unexpected death. Our services are provided at a sliding scale, and no one is turned away for lack of funds. We receive referrals from a variety of community partners, including COST teams at our partner schools.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	184
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	
Number of unduplicated individual family members served indirectly by your program:	
Grand total of unduplicated individuals served:	184

Box C: Demographics of individuals served this fiscal year through MHSA funding:			
AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	32	Gay/Lesbian	27
Transition Age Youth (16-25 yrs.)	12	Heterosexual/Straight	93
Adult (26-59 yrs.)	67	Bisexual	3
Older Adult (60+ yrs.)	40	Questioning/Unsure	
Declined to answer		Queer	1
Unknown	137	Declined to answer	5
TOTAL	264	Unknown	129
		Another group not listed	
		TOTAL	135
		If another group is counted, please specify with numbers:	
VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes		English	95
No	190	Spanish	6
Declined to answer		Cantonese	
Unknown	74	Chinese	
TOTAL	264	Vietnamese	
		Farsi	
CURRENT GENDER IDENTITY		Arabic	

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Female	90	Tagalog	1
Male	37	Declined to answer	
Transgender	8	Unknown	163
Genderqueer		Other languages not listed	
Questioning/unsure of gender identity		TOTAL	264
Declined to answer			
Unknown	129		
Another identity not listed			
TOTAL	264		
If another group is counted, please specify with numbers:			

SEX ASSIGNED AT BIRTH		**ETHNICITY/CULTURAL HERITAGE (choose one)**	
Male		**If Hispanic or Latino, please specify:**	
Female		Caribbean	
Declined to answer		Central American	
Unknown	264	Mexican/Mexican American/Chicano	
TOTAL	264	Puerto Rican	
Male		South American	
		Another Hispanic/Latino ethnicity not listed	
DISABILITY STATUS		**Total Hispanic or Latino**	
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision	6	African	
Hearing/Speech	6	African American	
Another type not listed		Asian Indian/South Asian	
Communication Domain Subtotal		Cambodian	
Disability Domain		Chinese	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	3	Eastern European	
		European	
		Filipino	
Physical/mobility	13	Japanese	
Chronic health condition	5	Korean	
Disability Subtotal		Middle Eastern	
None	49	Vietnamese	
Declined to answer	1	Other Non-Hispanic or Non-Latino ethnicity not listed	
Unknown	101	**Total Non-Hispanic or Non-Latino:**	
Another disability not listed		More than one ethnicity	

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TOTAL	184	Unknown ethnicity	264
If another disability is counted, please specify with numbers:		Declined to answer	
		ETHNICITY TOTAL	264
		If another ethnicity is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native	2	If another race is counted, please specify with numbers:	
Asian	17		
Black or African American	40		
Native Hawaiian or another Pacific Islander	0		
White	54		
Other Race			
Declined to answer	3		
Unknown	148		
TOTAL	264		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
We decided to pilot a new intervention that we refer to internally as a "grief bridge", which is a short term, 6-to-8-week session model that is offered by an intern or staff immediately following contact with the clinical coordinator. The first recipient of this intervention was a 59-year-old woman who lost her husband to suicide three weeks prior. An MSW intern agreed to provide short term therapy focused on stabilization and managing the initial trauma reaction. The client reported that she was not actively suicidal but "did not see a way forward". As with many suicide loss survivors, the client struggled with stigma that impaired her ability to receive social support and experienced a high level of self-blame that complicated her bereavement experience. She was highly responsive to the intern's humanistic and compassionate approach and was transferred to another clinician for longer term therapy once a space was made available.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	
E.3: Types of treatment individuals were referred to (list types below):	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	
G.5: Average duration of untreated mental illness in weeks:	

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E.6: Average number of days between referral and first participation in referred treatment program:	
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
F.2: Number of paper referrals to an ACBH PEI-funded program:	
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	
F.4: Average number of days between referral and first participation in referred PEI program:	
F.5: Describe how your program encouraged access to services and follow through on above referrals:	

Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. *(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)*	
Number of Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Schools, outpatient, in-home, library	**mental health interns**

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Prevention and Early Intervention: Clients Served by Age Group

PEI Prog. #	Provider Name	Program Name	Age/Population Served	TOTAL # of Clients Served	Budget	Cost per Client
PREVENTION						
1A	Alameda Department of Public Health, Blue Skies Mental Wellness Team	School-Based Mental Health Consultation in Preschools	Children, Youth, Adult	151	$385,490	$2552.00
1D	La Familia Counseling Services	Caminos, Outreach, Education and Consultation for Unaccompanied Immigrant Youth	Youth, TAY	239	$826,466	$3,458.00
5	La Clinica de la Raza, Cultura y Bienestar	Outreach, Education and Consultation for Latino Community	Youth, TAY, Adults, Older Adults	12,366	$1,886,931	$152.60
6	Asian Health Services	Outreach, Education and Consultation for Asian Community	Youth, TAY, Adults, Older Adults	735	$353,464	$481.00
6	Bay Area Community Health	Outreach, Education and Consultation for East Asian Community	Youth, TAY, Adults, Older Adults	96	$353,500	$3,682.00
6	Center for Empowering Refugees and Immigrants	Outreach, Education and Consultation for Southeast Asian Community	Youth, TAY, Adults, Older Adults	2,279	$707,000	$310.00
6	Korean Community Center of the East Bay	Outreach, Education and Consultation for East Asian Community	Youth, TAY, Adults, Older Adults	1,988	$396,874	$199.60
6	Richmond Area Multi-Services, Inc.	Outreach, Education and Consultation for Pacific Islander Community	Youth, TAY, Adults, Older Adults	896	$612,250	$683.30
7	Afghan Coalition	Outreach, Education and Consultation for South Asian/Afghan Community	Youth, TAY, Adults, Older Adults	7,338	$560,500	$76.40
7	International Rescue Committee	Outreach, Education and Consultation for Afghan Community	Youth, TAY, Adults, Older Adults	1,677	$533,480	$318.10
7	Filipino Advocates for Justice	Outreach, Education and Consultation for Filipino Community	Youth, TAY, Adults, Older Adults	326	$353,500	$1,084.30
7	Portia Bell Hume Center	Outreach, Education and Consultation for South Asian Community	Youth, TAY, Adults, Older Adults	837	$707,000	$844.70

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8	Native American Health Center, Inc.	Outreach, Education and Consultation for Native American Community	Youth, TAY, Adults, Older Adults	1,164	$353,500	$303.70
9	Diversity in Health Training Institute	Outreach, Education and Consultation for Middle Eastern and North African Communities	Youth, TAY, Adults, Older Adults	129	$750,444	$5,817.40
10	Partnerships for Trauma Recovery	Outreach, Education and Consultation for African Communities	Youth, TAY, Adults, Older Adults	213	$353,381	$1,659.00
20A	Beats, Rhymes, and Life	Beats, Rhymes, and Life	Youth, TAY	988	$870,713	$881.30
20B	Black Men Speak	Black Men Speak	Adults	1145	$371,937	$325.00
20E	Tri Cities Community Development Center	Mental Health Friendly Congregations	Adults	Not available	$304,192	NA
20E	Peers Envisioning and Engaging in Recovery	African American Mental Wellness and Spirituality Campaign (Hope and Faith)	TAY, Adults, Older Adults	78	$304,741	$3,907.00
20F	Restorative Justice for Oakland Youth	Restorative Justice for Oakland Youth	TAY, Adults, Older Adults	909	$583,834	$642.00
28	Health and Human Resource Education Ctr.	10 X 10 Wellness Campaign	Youth, TAY, Adults, Older Adults	212	$208,224	$982.00
28	Health and Human Resource Education Ctr.	Black Women's Media/Health Through Art	Youth, TAY, Adults, Older Adults	261	$268,637	$1,029.30
ACCESS AND LINKAGE						
1B	Center for Healthy Schools and Communities	School Based MH Access and Linkage in Elementary, Middle and High School	Youth	11171	$1,095,156	$98.00
OUTREACH						
19	City of Fremont	Older Adult Peer Support	Adults, Older Adults	10	$73,613	$7,361.00
19	Pacific Center for Human Growth	Older and Out	Older Adults	50	$267,361	$5,347.00
20C	MH Association of Alameda County	African American Family Outreach	TAY, Adults, Older Adults	67	$329,604	$4,919.00
22	Pacific Center for Human Growth	Peer Mentorship	Adults, Older Adults	206	$313,848	$1,523.00
22	Pacific Center for Human Growth	Technical Training Assistance	TAY, Adults, Older Adults	150	$291,504	$1,943.00
28	Health and Human Resource Education Ctr.	Downtown TAY	TAY	145	$418,666	$2,887.00

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EARLY INTERVENTION						
1C	A Better Way	Early Childhood MH Outreach and Consultation	Children	NA (start up in 23/24)	$700,000	
22	Side by Side	Lambda Youth Program	Youth, TAY	NA (start up in 23/24)	$600,000	
3	Alameda County Behavioral Health Dept.	Geriatric Assessment and Response	Older Adults	83	$1,374,881	$16,565.00
17A	Youth Uprising	TAY	TAY	467	$447,943	$959.00
17B	Alameda County Healthy Schools and Communities	REACH Ashland Youth Center	Youth, TAY	261	$535,233	$2,051.00
24	Roots Community Health	Sobrante Park Community Project	Children, Youth, TAY, Adults, Older Adults	536	$350,000	$653.00
STIGMA AND DISCRIMINATION						
4	Peers Envisioning and Engaging in Recovery	Everyone Counts Campaign	Youth, TAY, Adults, Older Adults	319	$1,418,863	$4,448.00
SUICIDE PREVENTION						
12	Crisis Support Services of Alameda County	Community Education, Trauma Informed Counseling	Children, Youth, TAY, Adult, Older Adults	18,444	$1,322,717	$72.00
12	Crisis Support Services of Alameda County	Text Line Program	Youth, TAY, Adults, Older Adults	3369	$812,277	$241.00

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Innovation (INN)



Innovation (INN) Programs are intended to provide mental health systems with an opportunity to learn from innovative approaches. Innovations Programs are not designed to support existing or ongoing programs or services, but rather to provide the mental health system with innovative demonstration projects that will support system change to increase access to services and improve client/consumer outcomes.

Innovation (INN) Programs are intended to provide mental health systems with an opportunity to learn from innovative approaches. Innovations Programs are not designed to support existing or ongoing programs or services, but rather to provide the mental health system with innovative demonstration projects that will support system change in order to increase access to services and improve client/consumer outcomes.

An Innovation Project may introduce a novel, and/or ingenious approach to a variety of mental health practices. Innovation Projects can contribute to learning at any point across the spectrum of an individual or family's needs relating to mental health, from prevention and early intervention to

recovery supports which include supportive housing. An Innovative Project must meet the following criteria:

1. It is new, meaning it has **not** previously been done in the mental health field; Innovation Projects must promote new approaches to mental health in one or more of the following ways:

- Introducing a new mental health practice or approach, or
- Adapting an existing mental health practice or approach, so that it can serve a new target population or setting or modifying an existing practice or approach from another field, to be used for the first time in mental health.

2. It has a learning component, which will contribute to the body of knowledge about mental health.

- The learning component is represented in the application's Learning Question.

Before INN funds can be spent on an INN project, the project idea must be vetted through a 30-day public review process, approved by the County Board of Supervisors, and approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC). The first two steps may take place as part of a Three-year Plan, a Yearly Plan Update or may be implemented as a stand-alone process.

Budget Summary

INNOVATION PROJECTS		
Project Name	**Fiscal Year**	**Projected Budget**
Peer-Led Continuum of Forensic Services	2025-2026	$2,053,577
Alternatives to Confinement Continuum of Forensic Services	2025-2026	$1,639,861
Psychiatric Advance Directives	2025-2026	$876,849

INN Projected Goals

Peer-led Continuum for Forensics and Reentry Services: peer-led services for individuals who are justice involved and suffer or are suffering from mental illness.

Community	*Achieved Goals for FY24-25*	*Projected Goals for FY25-26*
Mentally ill individuals who are justice involved	• Start-up phase completed • Begin providing services to clients • Training for reentry peer specialists	• Project evaluation to begin • Continue outreach and services • Continue group facilitations and trainings

Alternatives to Confinement Continuum Forensic and Reentry Services: clinical led services for individuals who are justice involved and suffer or are suffering from mental illness including arrest diversion. This continuum additionally includes training services for providers who serve the justice involved community to assist with reducing probation and parole violations.

Community	*Achieved Goals for FY24-25*	*Projected Goals for FY25-26*
Mentally ill individuals who are justice involved	• Began procurement for project components • Began contract negotiations	• Conclude procurement process • Conclude contract negotiations • Begin trainings for justice involved providers to assist in reducing probation and parole violations

Psychiatric Advance Directives:

Community	*Achieved Goals for FY24-25*	*Projected Goals for FY25-26*
Mentally ill individuals in Alameda County	• Approval of joining multi-county collaborative Innovation project	• Complete contractual agreements • Begin outreach and engagement of stakeholders • Begin trainings for peers and first responders to train on use of PADs platform

Current Innovation Projects:

Supportive Housing Community Land Alliance

Community Program Planning Process

Forensics: Peer-Led Continuum Forensic and Reentry Services

Alternatives to Confinement Continuum Forensic and Reentry Services*

Approved Innovation Projects:

Psychiatric Advance Directives**

*This project has gone through procurement and is in a contractual process.

**This project is currently in contractual process.

PROJECT NAME: Supportive Housing Community Land Alliance (SHCLA)

Across the Bay Area, an inadequate supply of housing stock, particularly affordable housing, has contributed to rising home prices, rental rates, evictions, displacement and homelessness. Over the past five years, there have been significant declines in the number of licensed board and care facilities, residential hotels, and room and board facilities frequently utilized by individuals living on fixed incomes. Individuals with severe mental illness living on fixed Social Security disability incomes experience some of the greatest challenges in finding and maintaining housing in this region.

Project Description: The Supportive Housing Community Land Alliance (SHCLA) (aka CLA; Land Trust; Land Trust Program), is based on a community land trust model, is a nonprofit, community-based organization designed to ensure community stewardship of land. Community land trusts are often associated with conservation efforts. However, the significant effort to ensure affordable long-term housing through this form of ownership is SHCLA's mission. The SHCLA will acquire land and maintain ownership of it permanently. The SHCLA will enter long-term, renewable leases with residents. If the resident leaves, the resident earns a portion of the increased property value. The remainder is kept by the trust, preserving the affordability and purpose of the property for future households.

This Innovation Project is promoting interagency collaboration for the Alameda County Supportive Housing Community Land Alliance to develop and maintain supportive housing units. ACBHD will be partnering with Alameda County Housing and Community Development Department, housing and real estate legal and financial experts, consumer/client representatives, family member representatives, and existing nonprofit affordable housing developers to develop a land trust focused on supportive housing that incorporates unique aspects to address local conditions.

SHCLA Summary

The Supportive Housing Community Land Alliance (SHCLA) innovation project's five-year term limit terminates in December 2024. However, SHCLA's agreement has been extended by the county's Housing and Homelessness Services (H&H) division.

With this extension, SHCLA continues to work towards several primary objectives and short-term outcomes. The following are the highlights:

SHCLA submitted an application to the City of Oakland for the acquisition of a 24-bed licensed board and care facility serving Transition Aged Youth (TAY). The funding would provide roughly $4M in acquisition funding and the County of Alameda MHSA Innovations grant will serve as a match for the city funds, with the understanding that MHSA funding cannot be used for acquisition. SHCLA is also in discussion with CDFIs including LISC and the Partnership for the Bay's Future Fund regarding our family partnership model.

In December 2024, SHCLA received a Conditional Loan Commitment Letter from Oakland HCD (Housing and Community Development) for an R2H2 loan (City of Oakland Homekey & Rapid Response Homeless Housing Program[1]). SHCLA must meet several conditions before loan closing. However, they are in a good position to complete these tasks within the 60-day period provided in the commitment letter. City of Oakland is conditionally committing a total of $4,758,048 in funding to the project for capital funding for acquisition and rehabilitation.

SHCLA continues to meet with potential partners and collaborators:

- Most significant is a planned partnership with Gentle Heart Care Services. The provider currently serves non-minor dependent residents and is a health service provider and
- Recruitment of board members.

The project's evaluation team, Public Consulting Group (PCG), has completed a second-year evaluation report. This report can be located in the appendix. The report includes an inclusive list of achievements, challenges, and opportunities.

PROJECT NAME: Community Program Planning Process (CPPP)

Project Description: Alameda County Behavioral Health (ACBHD) continues to be fully invested in having a dynamic community process that is inclusive of all community with the County. Community involvement from the residents of the county is essential to Innovation planning and program development. ACBHD has had challenges in its outreach to many of its diverse populations. These challenges include outreach and engagement to unserved and underserved individuals in both urban and rural areas. The County is dedicated to developing a revitalized and improved approach to ensure more meaningful input from all individuals living in the county.The remainder is kept by the trust, preserving the affordability and purpose of the property for future households.

The Community Project Planning Process (CPPP) occurs every three (3) years as per MHSA Innovation regulations along with smaller community input sessions for yearly plan updates. Alameda County's yearly CPPP was held between October 2024 – January 2025 for its MHSA Plan Update FY2025-2026.

Information for the CPPP events and outcomes are documented in this plan update.[2]

1 https://www.oaklandca.gov/topics/city-homekey

2 CCR, 9 CA ADC § 3200, 3200.060, 3200.270, 3200.90, 3300, 3315, 3320 & WIC 5848(a,b,f) & 5604.2(4)

PROJECT NAME: Forensic and Reentry Services

Project Description: Alameda County Behavioral Health (ACBHD) has identified the significant need to support individuals with serious mental health challenges who are involved with the justice system. This is a pervasive and complex issue in Alameda County as well as across the state and nation that requires multiple approaches to address. ACBHD has developed a forensic and reentry plan that sets forth the myriad approaches to be implemented, including systems, collaborative, and program initiatives and interventions. The ACBHD forensic and reentry plan includes the approaches identified and included in these two innovation projects. All services are voluntary and seek to provide voice and choice, particularly in situations where that autonomy may otherwise be limited by arrest and/or incarceration.

Forensic and Reentry Services Summary

Alameda County faces the issue of people with serious mental illness (SMI) experiencing incarceration as one of the most prominent challenges facing the behavioral health and cranial justice communities. It is more likely that an individual will be booked into jail than be engaged in treatment thus creating jails as large mental health institutions.

Two forensic proposals were born out of Alameda County Behavioral Health Services and Forensic System Redesign Plan Update, May, 2021[3]. The two innovation plans, *Peer-led Continuum of Forensic and Reentry Services and Alternative to Confinement Continuum of Forensic and Reentry Services*, arose out of the county's efforts to divert individuals with mental health challenges from the justice system into mental health services. Both innovation plans were developed for and by community stakeholders, including the County's Justice Involved Mental Health Task Force.

a. Peer-led Continuum of Forensic and Reentry Services project contains four programs:

Peer-led Program	Provider	Current Status(?)
Re-entry Coaching	The Copeland Center	Project is in start-up phase
WRAP for Reentry™	Peers Envisioning and Engaging in Recovering Services (PEERS)	Project is in start-up phase
Forensic Peer Respite	LaFamilia	Services projected to begin in February 2025
Family Navigation and Support Services	Family Education and Resource Center (FERC)	Services began in early 2024
Project Evaluator	Procurement has concluded	Contract pending

The Copeland Center is uplifting the ***Re-entry Coaching*** project. This project is in the start-up phase and continues to collaborate with the Office of Peer Support Services. Copeland has created necessary job descriptions for Reentry Coaches and Reentry Coaches Supervisors along with a policy, procedure, and job handbook. Copeland continues to reach out and connect with other non-profits who support individuals released from Santa Rita Jail.

Copeland's immediate plans include setting up a new hire orientation for CMPSS (Certified Medi-Cal Peer Support Specialist, Taking Action for Whole Health and Wellbeing, and Community Inclusion.

WRAP for Reentry™ is being provided by Peers Envisioning and Engaging in Recovery Services (PEERS). Start-up for this project continues as several challenges are addressed. These challenges include working out the curriculum and addressing unexpected staffing issues. PEERS are preparing to work with Black Men Speak regarding hiring and training four WRAP for Reentry™ facilitators beginning in March 2025.

3 http://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_5_10_21/HEALTH%20CARE%20SERVICES/Regular%20Calendar/Item__1_ACBHD_Services_Forensic_sys_5_10_21.pdf

In collaboration with Black Men Speak, outreach partners have been identified. These partners have been identified as Santa Rita Jail, Juvenile Justice Probation Department, Second Chance, and CURY. Contact with these potential partners will begin in January 2025.

The ***Forensic Peer Respite*** has been in a start-up phase since spring 2024. A property was located for purchase in the San Leandro area. The property was partially purchased with a Behavioral Health Bridge Housing grant. There were several tenant improvements that were needed to be completed to ensure that it fulfilled ADA (American with Disabilities Act) requirements. Forensic peer specialists and other required staff are currently being sought. A soft opening is anticipated in January 2025 for possibly up to six clients. It is expected the facility will be fully operational beginning in February 2025.

Family Navigation and Support Services began in early 2024. FERC, who operates under Mental Health Association of Alameda County (MHAAC), has been providing outreach, education, and support through a family centered program. A family centered program will strengthen education, regarding peer information and referral services for family members. Trainings for family members will enable family members to become leaders in County consumer and family groups. FERC will select family members to undergo a period of intensive coaching workshops followed by year-long support.

Per MHSA innovation regulations[4], it is required that a third-party evaluation be completed for lessons learned and outcomes. An evaluation is required because innovation projects have a learning component, which will contribute to the body of knowledge about mental health. Procurement for an evaluator concluded in October 2024. A bidder has been awarded. The contract for the awarded bidder is pending board approval.

b. ***Alternative to Confinement Continuum of Forensic and Reentry Services*** project contains three programs:

Alternatives to Confinement Program	Provider	Current Status
Arrest Diversion/Triage Center	Procurement has awarded bidder	Contract is pending
Reducing Probation/Parole Violations	N/A	Currently in procurement
Forensics Crisis Residential Treatment (CRT)	N/A	Waiting for procurement
Project Evaluator	N/A	Procurement process to begin approximately spring 2025

A contract is pending for the *Arrest Diversion/Triage Center*. This program will provide a location for law enforcement officers to be able to bring an individual with a serious mental illness who would otherwise be arrested and obtain mental health services. The Arrest Diversion/Triage Center will provide an alternative for officers to divert individuals from jail and engage the person in mental health and other needed services.

Reducing Probation/Parole Violations is a program that will provide training for mental health providers. Providers will learn how to work with consumers to understand their justice history; what terms and conditions they have failed to comply with; what services they have been participating in to address their mental health and criminal risk and needs; and what services they are willing to participate in.

The project is in the procurement process. A request for proposal (RFP) was released in December 2024. A standard service agreement will be awarded once bids have been received and reviewed. This project is anticipated to begin in the summer of 2025.

The *Forensics Crisis Residential Treatment* (CRT) is in development. The start date has been tentatively set for spring 2026.

4 CCR, 9 CA ADC § 3915

Per MHSA innovation regulations[5], it is required that a third-party evaluation be completed for lessons learned and outcomes. An evaluation is required because innovation projects have a learning component, which will contribute to the body of knowledge about mental health.

ACBHD will begin procurement for an evaluator approximately late spring 2025.

Psychiatric Advance Directives

Psychiatric Advance Directives (PADs) is a legal document with an individual's specific instructions or preferences regarding treatment, in case of a future mental health crisis in which they might not be able to make their own decisions. PADs are self-directed and detail a person's specific instructions or preferences regarding future mental health treatment. A PAD plans for the possibility that an individual may lose the capacity to give or withhold informed consent to treatment during a mental health crisis.

The Multi-County Mental Health Services Innovation Collaborative pilot project for PADs was approved in 2019. In 2025, there will be fifteen counties who will be a part of this innovation project. The outcomes this project is looking to achieve are improved compliance; increase adherence to treatment requests; increase in individual wellness scores; reduction in incarceration/criminal justice involvement as a result of crisis; and reduction in long-term hospitalization. The website with more extensive information can be located here: https://www.padsca.org/

Phase One of the project will be coming to a close in June 2025. During this phase, the collaborative worked to have a final digital build with the ability to use a "live" PAD. There is to be access to the PAD's information in summary format, based on consent, to first responders and hospital staff. Finalization of a comprehensive Peer Support Specialist training curriculum focused on how to help an individual create a PAD is being sought. Phase Two will test these two key components to ensure that they are fully developed.

The importance of training in how to walk an individual through filling out a PAD cannot be overstated. It is crucial that Peer Support Specialist or other facilitators become proficient, so they can train courts, first responders, hospitals, and crisis teams on how to access and use a PAD. This expertise will allow the project to make a change to the overall behavioral health system. Its impact will improve existing practices for autonomy, self-determination, crisis care, and recovery.

Phase Two, which is the phase that the county will enter, will focus on adding more counties (up to fifteen) of varying sizes to participate. This amount was chosen because it will represent one-quarter of the counties in California. Though a PAD can be utilized by anyone in California living with a behavioral health condition, for the project's purpose, each county is identifying their own priority populations of focus, which may include, but are not limited to, individuals in the following programs or populations:

- Justice-involved, including 90-day reach-in with scheduled to release incarcerated,
- Assisted Outpatient Treatment (AOT),
- Fully Service Partnership (FSP),
- Housing insecure,
- Individuals who visit Wellness Centers,
- Crisis Residential Programs,
- Follow-up after hospitalization (either in-patient or emergency department)
- Non-minor dependents, college students or transitional-aged youth (TAY), including college students and early psychosis intervention,
- CARE Courts, and
- Mobile Crisis.

5 Ibid.

Alameda County's primary focus will be mobile crisis, the unhoused, FSPs, crisis residential programs; justice-involved and CARE courts.

The following table summarizes the county's projected contribution in Phase 2: what the county will be doing, what goals the county is seeking, and who will be the participants:

Activity	Projected Outcome	Participants involved
Live Trainings	First Responders; Peers; other participating systems trained on use of PADs Platform	Project Subcontractors and PAD trained peers
Training Videos and Technical Support	Videos customized for hospitals; LE; Court Systems; Crisis teams	Project Subcontractors
Rollout to test digital web-based platform	Provide user feedback to improve features and functionality of PADs platform	Alameda County Vocational Services (VOC)
Collaboration Meetings	Engagement needs: media, training videos, technical support; and user feedback	All participating Counties' leads: i.e. VOC, Crisis teams, Care Court; participating peers and Subcontractors
Attend bi-annual collaborative held in host county	Technology, marketing, county-to-county, project successes and challenges	All participating Counties' leads: i.e. VOC, Crisis teams, Care Court; participating peers and Subcontractors

Workforce Education and Training (WET)



Workforce Education and Training (WET) develops a workforce for ACBHD that is sufficient in size, diverse, and linguistically capable to deliver services and supports that are culturally responsive to clients and family members.

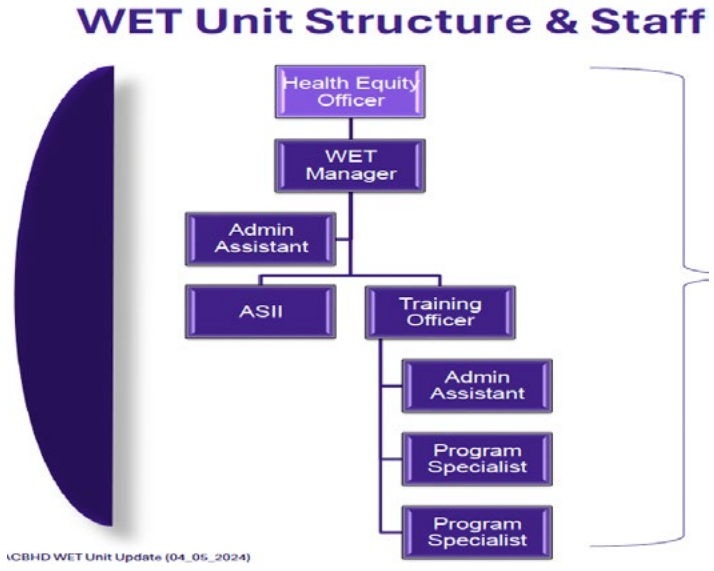
1. Workforce Education & Training (WET) Staffing

Program Description

The Workforce Education and Training (WET) unit is integral to Alameda County Behavioral Health Department's (ACBHD) vision of cultivating a diverse, linguistically capable workforce equipped to deliver culturally responsive services centered on wellness, recovery, and resiliency. By managing the development, implementation, and evaluation of workforce initiatives, the WET unit builds the capacity of ACBHD staff and contracted community-based organizations (CBOs). Through strategic partnerships with peer-run agencies, educational institutions, and local and state entities, the WET team ensures a prepared and adaptable workforce capable of meeting the evolving needs of Alameda County's communities.

FY 23/24 Program Outcomes:

- The WET Team transitioned into the Health Equity Division, aligning workforce development initiatives with the division's mission to promote equity and inclusion across ACBHD.
- Two new Program Specialists were hired, strengthening the WET team's capacity to support workforce initiatives and expand training offerings.
- The 2022 envisioning plan, established by The Director of ACBHD, is actively underway, providing strategic direction for workforce development and systemwide improvements.
- Co-sponsored, alongside the Health Equity Officer, the ACBHD *Building Resilience Together Trauma-Informed Systems 101* training first trainer cohort fostering systemwide trauma-informed practices aimed at improving the workplace.
- Organized a team-building retreat for the WET Unit in November 2024, enhancing cohesion and collaboration within the team.
- Commissioned and completed a comprehensive WET needs assessment in 2024, with findings disseminated to leadership and staff countywide to inform workforce strategies.
- Introduced a de-escalation training designed by The Director ACBHD, which was adopted by Alameda County Health and will serve as a staple training for the agency and ACBHD staff and contracted CBO partners.



- The ACBHD Director, alongside Senior Executives, reaffirmed their commitment to maintaining a robust WET team within ACBHD, despite the transition of WET funding from the state under the new Behavioral Health Services Act (BHSA)

FY 23/24 Program Impact and/or Evaluation:

- **Tailored Training and Development**
  The local WET team continues to design and deliver training programs that align with Alameda County's diverse populations and service needs. This ensures culturally and linguistically appropriate care is provided to clients and families.

- **Community-Centered Workforce Planning**
  The WET team conducted a comprehensive needs assessment in 2024, gathering feedback to address unique challenges within the county and adapt workforce strategies to better serve community priorities.

- **Sustained Focus on Equity and Inclusion**
  As part of the Health Equity Division, the WET team advances initiatives that address systemic barriers, promote belonging, and empower a workforce reflective of the communities served.

- **Capacity Building Across Systems**
  Partnerships with CBOs, peer-run organizations, and educational institutions have strengthened, enhancing the reach and impact of training initiatives for both ACBHD staff and external partners.

- **Adaptability to Local and Legislative Shifts**
  The local WET team remains agile in addressing changes in state legislation, ensuring Alameda County's workforce is equipped to navigate challenges such as workforce shortages and the implementation of trauma-informed practices.

- **Sustained Innovation and Leadership Development**
  By maintaining a local WET team, ACBHD ensures ongoing leadership development and workforce readiness, enhancing resilience and succession planning within the behavioral health system.

FY 23/24 Program Impact and/Evaluation: Share any relevant data collected (demographics on clients, served, etc.) and/or any evaluation highlights.

The 2024 WET Needs Assessment highlights critical challenges and opportunities in Alameda County Behavioral Health Department's (ACBHD) workforce, particularly in recruitment, retention, and pipeline development.

Key Findings

1. **Recruitment Challenges**:
   - Over 60% of providers reported difficulty in filling licensed clinical positions, such as Licensed Clinical Social Workers and Marriage and Family Therapists.
   - The most challenging roles to recruit for were those requiring specialized clinical expertise, reflecting a shortage of highly skilled professionals in the behavioral health sector.
2. **Retention Strengths**:
   - Despite recruitment struggles, most respondents rated their organizations as effective in retaining staff, with 60% reporting retention as "Well" or "Very Well."

- However, burnout and high workloads remain ongoing challenges, particularly for staff serving clients with co-occurring disorders and complex needs.

3. **Pipeline Gaps**:
    - Diversity among interns does not reflect Alameda County's client populations. For example, only 9% of interns identify as Black/African American, compared to their significant representation among clients.
    - Linguistic diversity among interns has also decreased, with notable gaps in languages such as Farsi and Vietnamese, which are essential for meeting emerging client needs.

Chart 1: Difficulty in Filling Open Positions

This chart represents the challenges providers face in recruiting for critical roles.

- **Very Difficult**: 35%
- **Somewhat Difficult**: 25%
- **Difficult**: 35%
- **Not Difficult at All**: 5%

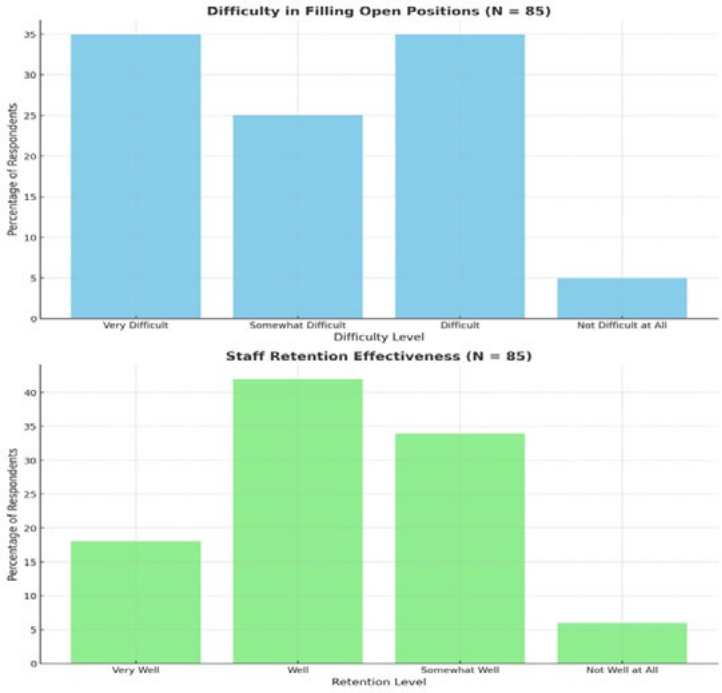
Chart 2: Staff Retention Effectiveness

This chart shows the reported effectiveness of staff retention efforts.

- **Very Well**: 18%
- **Well**: 42%
- **Somewhat Well**: 34%
- **Not Well at All**: 6%

Combined charts provide a snapshot of workforce dynamics, highlighting strong retention efforts but significant recruitment difficulties. The findings underscore the importance of targeted strategies to enhance workforce diversity, pipeline development, and long-term sustainability.

Staff Retention Effectiveness (N = 85)



1. **Difficulty in Filling Open Positions**: Highlights significant challenges in recruiting for critical behavioral health roles, with 35% reporting recruitment as "Very Difficult" and another 35% as "Difficult."
2. **Staff Retention Effectiveness**: Demonstrates that retention efforts are relatively effective, with 60% of respondents rating retention as "Well" or "Very Well," though challenges such as burnout persist.

These insights and visuals emphasize the continued need for strategic interventions to address workforce recruitment gaps and maintain retention momentum.

FY 22/23 Program Challenges

Care Court Implementation:

- **Complexity of Legal Processes**: Staff must learn new workflows, legal terminologies, and court proceedings, requiring comprehensive training.
- **Time Constraints**: Balancing training with day-to-day responsibilities creates scheduling and capacity challenges.
- **Interdisciplinary Coordination**: Collaboration with legal, medical, and social service entities adds layers of complexity.

SB43 (Expansion of Conservatorship Laws):

- **Understanding Expanded Criteria**: Staff need clarity on the new definitions for conservatorship eligibility and documentation requirements.
- **Increased Caseloads**: With more individuals potentially qualifying for conservatorship, staff face heightened workloads while adapting to legislative changes.

SmartCare Initiative:

- **Technology Adoption**: Many staff may lack the digital literacy to effectively use SmartCare tools, requiring extensive technical training.
- **Data Privacy Concerns**: Ensuring compliance with confidentiality and security standards poses challenges as more data is shared electronically.

Behavioral Health Services Act (BHSA) Transition:

- **Shift in Priorities**: The redirection of funding from WET programs to early intervention services creates uncertainty about program continuity and workforce readiness.
- **Knowledge Gaps**: Staff need training to understand BHSA requirements and adapt services accordingly.

Opioid Crisis Response:

- **Specialized Skills**: Training staff in Medication-Assisted Treatment (MAT) and harm reduction requires significant time and resources.
- **Stigma and Resistance**: Addressing internal biases about harm reduction approaches remains a challenge.

Peer and Family Member Certification:

- **Integration Challenges**: Effectively incorporating certified peers and family members into multidisciplinary teams requires cultural and operational adjustments.
- **Role Clarity**: Ensuring staff understand the scope and contributions of peers and family members to avoid role conflicts.

Trauma-System Expansion:

- **Secondary Trauma**: Staff experiencing burnout and vicarious trauma may find it difficult to adopt trauma-informed practices without adequate support.
- **Scalability**: Rolling out training across the entire workforce and partner agencies is resource intensive.
- **Openness of Department**: Can be challenging for systems to evaluate themselves and work towards becoming a more trauma informed, and healing centered department when there is competing interests.

Crisis Response and De-escalation:

- **High-Stress Scenarios**: Training staff to de-escalate volatile situations requires intensive skill-building, which may not immediately yield results.
- **Resource Limitations**: Ensuring that all staff and CBO partners receive standardized de-escalation training can be logistically challenging.

Cultural Competence and Health Equity:

- **Addressing Implicit Bias**: Changing ingrained biases and promoting equity through training is a long-term challenge.
- **Diverse Needs**: Ensuring training content reflects the vast cultural and linguistic diversity of Alameda County's population requires tailored approaches.

Forensics and Justice-Involved Services:

- **Specialized Training Needs**: Staff require knowledge in reentry services, trauma-informed care for justice-involved individuals, and navigating justice system protocols.
- **Systemic Barriers**: Addressing structural challenges like housing and employment for justice-involved individuals complicates service delivery.

Behavioral Health Data and Analytics:

- **Technical Barriers**: Not all staff are proficient in data analysis or electronic health record systems, making it difficult to utilize SmartCare tools effectively.
- **Performance Pressure**: Increased reliance on data for decision-making and reporting places additional demands on staff.

Emerging Legislation and Policies:

- **Constant Updates**: Frequent changes to legislation require ongoing training to ensure staff remain compliant and knowledgeable.

Resource Drain: Keeping up with new policies diverts resources from other essential training and workforce development initiatives.

Anticipated changes for FY 23/24

Workforce

- Focus efforts on **classifications** to ensure alignment with current roles and evolving needs within the behavioral health workforce.
- Develop **policies** to support equitable hiring, workforce stability, and diversity.
- Enhance r**etention** strategies to mitigate burnout and improve long-term workforce sustainability.
- Prioritization of **wellness** initiatives to support staff mental health and resilience.
- Expansion of **internship programs** to strengthen the pipeline of diverse, skilled professionals entering the behavioral health field.
- Increase **outreach** to recruit and retain individuals reflective of Alameda County's diverse populations.

Education

- Strengthen **community** connections to foster collaboration and align workforce initiatives with community needs.
- Expanded partnerships with **stakeholders**, including peers, consumers, advocates, and families.
- Launch **anti-stigma campaigns** to reduce barriers to accessing behavioral health services.
- Develop **promotional literature and brochures** to educate the public and stakeholders about available workforce and training opportunities.

Training

- Focused on **skills development** to ensure staff and partners are equipped to meet the needs of Alameda County's diverse populations.
- Enhance **internship and trainee/practicum programs** to cultivate future behavioral health leaders.
- Strengthen **pipeline initiatives** to address workforce shortages and diversify the field.
- Deliver a range of **workshops** and **toolkits** to support professional growth and workforce competency.
- Provide **Continuing Education Units (CEUs)** and **certifications** to advance staff knowledge and career development.
- Increase engagement with the **public** through skill-building **campaigns** that promote behavioral health awareness and workforce growth.

2. Training & Technical Assistance

Summary of the Training Unit: Approach, and Scope of Work:

The Alameda County Behavioral Health Training Unit (a subsidiary of Workforce, Education & Training) provides a coordinated and consistent approach to training and technical assistance when developing curriculum. Training Unit develops, researches, and provides a broad array of training related to mental health clinical practice, and wellness recovery & resilience.

According to the 2024 WET Needs Assessment, providers reported significant challenges in meeting the complex health and social needs of their clients, compounded by increasing rates of substance use and suicide within the community. These challenges have contributed to staff burnout and a need for comprehensive training and support. To address these needs, the ACBHD Training Unit implemented evidence-based and innovative solutions designed to equip staff and community-based organization (CBO) partners with the necessary tools to navigate these complexities. Trainings emphasized trauma-informed, culturally responsive, and wellness-focused approaches, with a strong focus on advanced clinical practice and peer empowerment. Key training topics included social-substance use, youth and adult mental health, first aid, and cultural humility. This holistic and targeted approach not only enhanced staff's ability to manage their daily challenges but also improved their understanding of themselves and the diverse populations they serve. By prioritizing these efforts, the WET Training Unit fostered a more skilled, resilient, and compassionate workforce capable of delivering high-quality, equitable care.

The training unit maintains several accreditations through which it provides continuing education for various clinical disciplines within Behavioral Health Department. Currently, the training unit is charged with maintaining accreditations for BSS, CPA, CCAPP, BRN and assures that all trainings that offer continuing education credits follow the standards set out through these accreditation bodies.

Training Unit – FY 2023/234 Goals & Outcomes

- Stats for fiscal year 2023 / 2024: (July 1, 2023 – June 30, 2024), the ACBH Training Unit provided or collaborated in a total of **59 training activities** and trained **2171 people consisting of 476 ACBH staff and 1695 contracted community-based organization (CBO) staff.**

- Continuing Education credit: The Training Unit sponsored and provided a total of **125.5 continuing education (CE) credits** to LCSWs, LMFTs, LPCCs, LEPs, Addiction Professionals, and RN's, with **87** of those CE hours including Psychologists.

- The training Unit continues to work with our consulting psychologist to improve the quality of our trainings and to approve Psychologist, Ph. D level continued education trainings. **We were able to approve 87 CE credits with Psychology, up from 68.5 in FY 22/23. The consulting contract with Psychologist enables ACBH to offer PHD level CE credits.**
- Made strides in moving toward a training consultation and development role with our systems of care. Processes include working closely with the System Of Care to ensure that the training being offered targets their specific needs and audiences, then strategize how to offer in system. Then, identify a training vendor, schedule dates and times and continue to offer technical assistance with the System of Care to produce trainings, ensuring that the content matches skill-building needs, and CE accreditation standards.

23/24 Accomplishment – Needs Assessment and Training Series with Systems of Care

- In collaboration with Children & Young Adult System of Care, the Training Unit developed an eight-part eating disorder training series to educate and deepen skills around this needed topic.
    - (Dates: 2/14, 2/21, 2/28, 3/6, 3/20, - 3/27, 4/3,4/10).

- The Training Unit conducted an internal needs assessment with key Forensics system of care staff and identified training topics for skill building in the jail system. The Training Unit specifically scheduled the following topics to meet their clinical needs: Suicide Crisis Intervention, Suicide Assessment and Intervention for Mental Health Professionals (Youth and Adult Versions), Suicide Rates for Individuals Who Are Incarcerated, Intermediate MI Skills for Professionals Working in Law Enforcement and Juvenile Justice.

- In collaboration with the Bright Research Group, the training unit participated in a comprehensive, department-wide needs assessment that included input from stakeholders and CBO agencies. This assessment provided a bird's-eye view of the system's training needs and concerns, offering valuable insights to guide the development and scheduling of future trainings. It now serves as a strategic framework for enhancing our training repertoire and addressing emerging priorities within the system. In our effort to rebrand and restructure training unit, a new program specialist position was created to respond more fully to the needs of our systems through bettered planning, technical assistance and training assessment. The goal is that this restructuring will increase our capacity to take on multiple training roles.

Training Unit: FY 2023/24 Challenges

- Contracting delays
- Staffing shortages and delays in hiring process
- Turnover in staffing and process in Finance and Contracts, which affected timely payment to training vendors.
- Interruptions in hiring and training new staff.
-

Training Unit: FY 2024/25 Updates and Projections

- **Training Calendar Update - FY 2024/25 thus far (July 1, 2024, through December 31, 2024)**, the Training Unit has successfully delivered or collaborated on 17 training activities, reaching 150 ACBH staff members and 564 contracted community-based organization (CBO) staff. Additionally, the Training Unit has provided 41 continuing education (CE) credits to various professionals, including LCSWs, LMFTs, LPCCs, LEPs, Addiction Professionals, and RNs, with 15 of those credits specifically designated for Psychologists.
- The Training Unit will continue to work closely with our Systems of Care to develop and implement training plans aimed at improving service delivery and fostering cultural humility across the department.
- The unit remains adaptable, continuously responding to the changing dynamics within both the Behavioral Health Department and our contracted CBO partners, as well as addressing the evolving needs of the community.

- In response to the system's evolving training needs and clinical practices, the Training Unit is beginning the process of procuring and recruiting new training vendors for FY 2025/26 by launching a Request for Qualifications (RFQ) for trainers.

- As we embark on this new direction, the Training Unit aims to become more agile and efficient in addressing emerging needs. With the addition of two program specialists and an Administrative Assistant experienced in training and development, we are better equipped to respond swiftly and effectively to the shifting landscape of workforce and service delivery needs.

- The Training Unit is prioritizing the delivery of trainings focused on emerging behavioral health issues, such as Proposition 1, SB 43, and the implementation of Care Courts, while continuing to meet the ongoing training needs of our Systems of Care.
- A plan is underway to provide training for non-clinical ACBHD and CBO staff, aimed at enhancing their understanding of service delivery and orientation within the Behavioral Health system, ensuring a cohesive and informed workforce.

- Looking ahead, the Training Unit is committed to building on its strong foundation of Continuing Education (CE) training unit approvals and will continue to coordinate evidence-based, culturally responsive educational events that address the diverse needs of our workforce and the communities we serve.

FY 24/25 Updates - Collaborations to Build and Meet Emerging Training Needs

- SUD specific series (6-8 trainings) for Substance Use providers responding to mental health challenges (such as Harm Reduction, Narcan, Fentanyl Use, De-Escalation for SUD, Co-Occurring Disorder screening, Motivational Interviewing, Trauma-informed care; Suicide Prevention with focus on Dual-Diagnosis)

- Wellness in the Workplace series for all-staff, with trauma-informed and healing-centered approach

- Continue with Eating Disorder series and workshops to develop skill-building

- Older Adult training modules – current and future work

- SOCS to approach for engagement: Peer Empowerment and Family Empowerment – enhance collaboration with these offices to include training topics with a lived-experience lens. Include Certified Peer Specialist in CE certificate distribution.

- In collaboration with the Health Equity Officer the training unit will work to amplify the newest ACBHD "Building Resilience Together: Trauma Informed Systems 101, by supporting the second cohort of trainers ensuring that the Training Officer and program specialists within the training unit are certified trainers and sponsoring monthly BRT/TIS trainings 25/25.

3. Workforce Building – Mental Health Workforce Career Pathways

Program Description

The Workforce Building program is designed to establish a comprehensive career pipeline strategy through partnerships with community colleges, offering an accessible academic entry point for individuals pursuing careers in behavioral health. This program focuses on fostering opportunities for consumers, family members, and students from ethnically and culturally diverse backgrounds, as well as those with an interest in human services education. By supporting education and career development, the program aims to expand the workforce and provide a pathway to meaningful employment within Alameda County Behavioral Health Department (ACBHD).

FY 23/24 Outcomes/Impact/Evaluation/Challenges:

1. PATHWAYS ACADEMY – BEATS RHYMES AND LIFE (BRL)

Pathways Academy's Workforce, Education, and Training trainees gained supervised experience working in mental health prevention programs supporting the very communities they come from, within Alameda County.

WELLNESS IN ACTION (WIA) - 2023/24 Outcomes

Curriculum Development:

- Developed and refined training modules for the Wellness in Action (WIA) program, integrating culturally appropriate methods to support behavioral health promotion and advocacy.
- Created a 10-month Community Advocate curriculum, combining expressive arts, somatic, and experiential methods with advocacy training on topics such as motivational interviewing, cultural humility, and systemic health analysis.
-
- Produced two newsletters, multiple promotional materials, and a community advocacy podcast.

Trainings and Workshops:

- Conducted over 65 hours of training and 24 hours of group consultation for 15 Community Advocate participants.
- Organized public workshops and events, including the Reground Symposium and the Decolonizing Mental Health series.
- Hosted over 10 self-care groups for community health workers to prevent burnout.

Community Impact:

- Grantees facilitated 29 listening sessions and over 65 wellness sessions across diverse communities.
- Reground Symposium showcased participant skills through community events, workshops, and cultural performances.

MSW Intern Program Expansion:

- Grew from 2 interns annually to 6, offering enhanced training on trauma-informed care, motivational interviewing, and somatics.

Impact/Evaluation

- **Program Effectiveness:**
    - 100% of participants in the Mini-Grant fellowship program cycle reported being satisfied or very satisfied with program activities.
    - 80% of self-care group attendees rated the activities as helpful and expressed satisfaction with the support provided by staff.
- **Community Engagement:**
    - The Reground Symposium and advocacy initiatives brought significant attention to mental health challenges within immigrant and refugee communities.
    - Participants demonstrated increased leadership skills through direct advocacy with legislators and systems administrators.
- **Workforce Development:**
    - Curriculum and trainings addressed critical gaps in community mental health by equipping participants with group facilitation, coaching, and advocacy skills.
    - Expanded outreach worker training to support system navigation for underserved populations.

Challenges

- **Sustainability:**
    - Balancing the need for curriculum expansion with limited funding resources required strategic leveraging of county and state funds.
    - Dependence on temporary grants for program implementation raised concerns about long-term sustainability.
- **Workforce and Resource Gaps:**
    - Recruitment and retention of MSW interns and community advocates required additional resources for mentorship and supervision.
    - Outreach worker training needed scaling to other community-based organizations (CBOs) to meet growing demand.
- **Participant Engagement:**
    - Ensuring consistent participation in long-term programs, such as the 10-month Community Advocate curriculum, required significant effort in motivation and support.
- **Burnout Prevention:**
    - Addressing burnout among community health workers remained a pressing challenge, highlighting the need for ongoing self-care initiatives.

2. FACES For the Future

The **Bright Young Minds (BYM) Program** continues to be a transformative initiative designed to engage high school students in behavioral health careers, foster community involvement, and provide mentorship and professional development opportunities. This year's program included multiple components, such as the **BYM Conference**, mentorship, and various student workshops and activities, all aimed at encouraging students to explore careers in mental health and substance use.

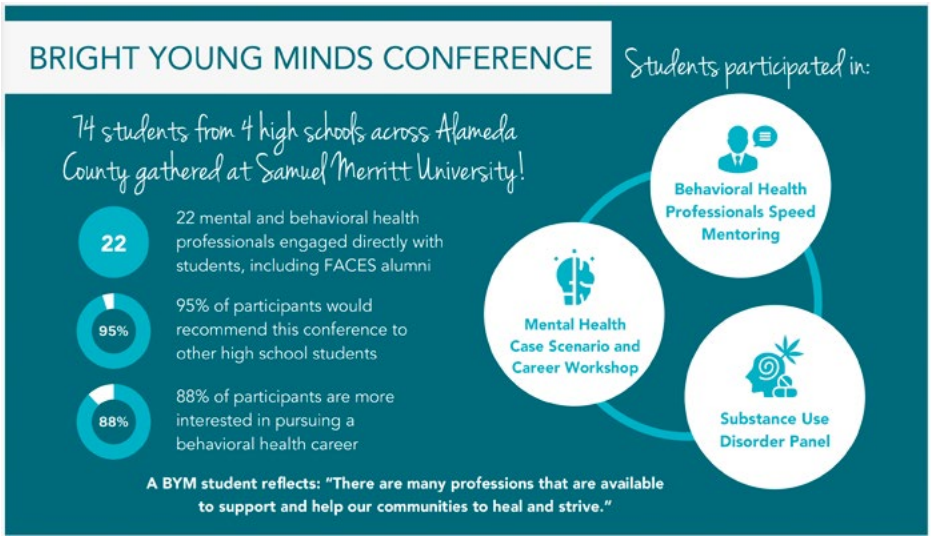


23/24 BYM Outcomes

The Bright Young Minds (BYM) program has made substantial progress in raising awareness about behavioral health careers among high school students, particularly through its BYM Conference and associated mentorship and community engagement activities.

Bright Young Minds (BYM) Conference (April 2024):

- Hosted 74 students from four schools: Arroyo High School, Alameda High School, Life Academy, and Skyline High School.
- 95.3% of students would recommend the conference to a friend.
- 88.4% of students expressed a heightened interest in pursuing a career in mental/behavioral health.
- 76.7% of students reported being able to identify the common signs and symptoms of mental health challenges after the conference.
- 83.7% of students could name at least five mental health professions and describe their job qualifications.



- **Mentorship and Community Engagement:**
    - FACES' Youth Advisory Council (YAC) continued to work with 12 members and executed a fundraising campaign to support virtual mentorship workshops.
    - FACES Alumni have played an integral role in supporting students through mentorship and engagement.

Workshops and Substance Use Education:

- The conference included a substance use disorder panel, which contributed to 95.3% of students feeling better equipped to help themselves or others regarding substance use.
- Students were also exposed to professionals working in the field, which helped inspire their interest in pursuing careers in behavioral health.

Impact/Evaluation

The Bright Young Minds program has had a profound impact on student awareness, understanding, and engagement in behavioral health:

- Student Awareness and Skills:
    - 76.7% of students could identify common signs and symptoms of a mental health challenge.
    - 79.1% learned at least three self-help strategies to improve mental health.
    - 95.3% were able to use knowledge gained from the substance use panel to help others.
- Career Interest and Cultural Competency:
    - 88.4% of students were more interested in pursuing mental health careers after attending the conference.
    - 93% of students reported that they believe behavioral health services are accessible in their communities.

- 46.5% of students noted encountering barriers when trying to access behavioral health services, which highlights the need for continuous improvement in service delivery.

- Feedback and Mentorship Impact:
  Students praised the program, stating they appreciated the diverse mentors and the opportunity to connect with trusted adults in the field. Many also noted that the exposure to different career paths in mental health was enlightening.

23/24 Bright Young Minds Challenges

Despite its success, the Bright Young Minds program faced several challenges:

- Access to Behavioral Health Services:
  While students expressed a belief that services are accessible, 46.5% reported facing barriers to these services. This highlights ongoing gaps in access and service delivery that need to be addressed.

- Mentorship Availability:
  There is a continuing need for professional mentors to support students as they navigate their career pathways. Although the YAC created a fundraising campaign for mentorship, finding and maintaining consistent mentor involvement remains a challenge.

- Program Sustainability:
  As with many youth programs, there were challenges related to funding sustainability and the ongoing engagement of both students and mentors. More long-term investments are needed to ensure that the program can continue to grow and provide consistent support.

Bright Young Minds Success Stories

While there are many impactful stories from the Bright Young Minds program, here are a few key highlights that reflect the positive outcomes for students:

- Student Testimonials and Feedback:
  The Bright Young Minds Conference was a turning point for many students. Not only did they gain valuable insights into mental health careers, but the event also sparked a greater interest in public health. Some of the student feedback includes:

  - "There are many professions that are available to support and help our communities to heal and strive."

  - "All the mentors are diverse with even more diverse backgrounds, so it's easy to have something in common with someone."

  - "How you don't have to always stick with the path you planned going into college and that no matter your major, you can find your way into a career path that you enjoy :)"

  - "The amount of support being provided from the mentors and everyone who came here to speak about public health."

These responses reflect the deep impact the program has had on broadening students' perspectives on career possibilities in mental health and public health, particularly through their engagement with mentors.

- Success of Mentorship Engagement:
  The Youth Advisory Council (YAC) also reported success in expanding mentorship opportunities through their fundraising campaign, which aimed to create a series of virtual mentorship workshops. The campaign was designed to address the growing need for guidance and career counseling, which has been identified as critical to the success of students entering the mental health field. The YAC has been instrumental in fostering a sustainable mentorship network for students involved in the BYM program.

2023/24 - OHLONE COLLEGE ALAMEDA COUNTY, MENTAL HEALTH STUDENT NAVIGATOR TRAINING PROGRAM

The Ohlone College Student Health Center STEP Up Program is a workforce development initiative designed to train community college students to provide peer support in transitioning students from campus-based mental health services to community-based mental health services and other basic needs. The program operates in partnership with six campuses: Berkeley City College, Chabot College, College of Alameda, Las Positas College, Laney College, and Ohlone College. Funded by the Alameda County Behavioral Health's Workforce Development Education and Training Division, the program aims to expand access to mental health resources and support for students while building a pipeline of future mental health professionals.

23/24 Ohlone Navigator Program Outcomes



College Campuses and Their Offered Majors

Campus	Major
Alameda College	Psychology
Alameda College	Fine Arts
Berkeley College	Psychology
Berkeley College	Psychology
Berkeley College	Social Work
Chabot College	Biology
Chabot College	Cognitive Science
Laney College	Political Science
Laney College	Psychology
Laney College	Psychology
Laney College	Journalism
Las Positas College	Biology
Las Positas College	Sociology
Ohlone College	Psychology
Ohlone College	Psychology
Ohlone College	Psychology

1. **Cohort Growth:**

    - **The program doubled its cohort size from 8 navigators in 2022-23 to 16 navigators in 2023-24, with two returning navigators assuming senior roles.**

    - Ms. Gabriela Aguilar, a senior program assistant, supported the program for her third year, focusing on facilitating program meetings, coordinating community-based organization (CBO) showcases, and managing weekly virtual office hours**.**

2. **Case Management:**

    - Navigators managed 61 cases across six campuses, with the highest concentration of cases at Laney College (36%) and Ohlone College (31%).

    - 70% of clients were female, reflecting general trends in help-seeking behavior.

    - 59% of clients required counseling services, 69% needed assistance with insurance coverage, and 20% sought housing resources.

- 67% of clients were successfully connected to resources, while 33% remained unconnected, indicating areas for improvement in outreach and resource relevance.

3. **Learning Outcomes: Navigators showed significant improvements in their understanding of key mental health topics, including:**

    - Warm Hand-off Model: Increased from 2.19 to 4.3 (on a 5-point Likert scale).
    - Whole Person Care: Increased from 2.5 to 4.0.
    - U.S. Healthcare System: Increased from 3.0 to 3.8.
    - Confidentiality and Mandatory Reporting Laws: Increased from 3.56 to 4.1.
    - Continuum of Care Model: Increased from 2.25 to 3.9.
    - Community Mental Health System: Increased from 2.31 to 3.7.
    - Healthcare Coverage Options in Alameda County: Increased from 2.31 to 3.7.
    - Emerging Trends in College Mental Health: Increased from 2.19 to 3.9.
    - Familiarity with Mental Health Agencies in Alameda County: Increased from 2.31 to 3.8.

4. **Confidence in Mental Health Communication and Support: Navigators reported increased confidence in discussing mental health topics and providing support to peers.**

    - Discussing Mental Health Issues: Confidence increased from 4.31 to 4.5.
    - Sharing Crisis Hotline Information: Confidence increased from 4.19 to 4.6.
    - Talking About On-Campus Mental Health Services: Confidence increased from 4.13 to 4.7.
    - Discussing Community Mental Health Services: Confidence increased from 3.81 to 4.2.
    - Discussing Health Insurance Options: Confidence increased from 3.31 to 4.0.
    - Supporting Another Student's Journey to Mental Health Care: Confidence increased from 3 Overall Experience: Rated 3.8 out of 5.
    - Training Satisfaction: Rated 3.9.
    - Support from Program Team: Rated 4.0.
    - Social Activities: Rated 3.7.
    - Mental Health Academies: Rated 3.9 (Summer) and 3.8 (Winter).
    - .88 to 4.3.

5. **Program Satisfaction:**

    - **Navigators expressed high satisfaction with program components:**

Impact/Evaluation

Program Effectiveness:

- Navigators successfully connected 67% of clients to necessary resources, demonstrating the program's effectiveness in addressing mental health and basic needs.
- Significant improvements in navigators' knowledge and confidence indicate robust growth in their ability to support peers.

Community Engagement:

- The program facilitated 61 cases across six campuses, with a focus on mental health, insurance coverage, and housing resources.
- Navigators' efforts contributed to the well-being of students, particularly in addressing mental health challenges and improving access to healthcare.

Workforce Development:

- The program provided navigators with valuable skills and experience, preparing them for careers in mental health and related fields.
- Navigators reported increased confidence in discussing mental health topics, supporting peers, and navigating the healthcare system.

23/24 Navigator Program Challenges

1. **Navigating Health Insurance:**
    - **Many navigators found it challenging to navigate the different health insurance plans that clients had.**
2. **Client Responsiveness:**
    - **Some navigators struggled with clients not responding to outreach efforts, making it difficult to provide consistent support.**

3. **Time Management:**
    - **Balancing the demands of being a student with the responsibilities of being a navigator was a common challenge.**
4. **Bureaucratic Barriers:**
    - **Some navigators faced bureaucratic issues that hindered their ability to deliver navigation services effectively.**
5. **Housing Resources:**
    - **Helping unhoused students find stable housing was particularly challenging due to the lack of accessible resources and the need for referrals.**
6. **Feeling Prepared:**
    - **Some navigators expressed concerns about feeling adequately prepared to handle the complexities of the work while still learning.**

Success Story - Christy Sangpolsit: From Navigator to Mental Health Advocate



Christy Sangpolsit participated in the Mental Health Navigator program for two years, starting as a Navigator in 2022-23 and stepping into a leadership role as a Senior Navigator in 2023-24. With a background in Theatre Arts and Psychology, Christy brought her passion for social justice and mental health to the program, helping her peers access resources, break down stigma, and feel empowered in their healing journeys.

Christy's experience as a navigator was transformative. She shared, *"Being a part of the navigator program helped me break out of the glass box I was in—it was the door that led to many other doors. I was liberated, empowered, and inspired being supported and surrounded by a network of like-minded peers and welcoming mentors in a safe space."*

The program provided Christy with the training and confidence to pursue a career in mental health advocacy. She graduated as the valedictorian with an AA in Psychology from the College of Alameda in 2024 and is now pursuing a degree in Theatre Arts with a minor in Holistic Health at San Francisco State University. Christy's goal is to become a Drama Therapist, focusing on underserved communities.

4. Internships and Doctoral Residencies

The **WET Internship Coordinator** plays a pivotal role in the development, implementation, coordination, and evaluation of the Alameda County Behavioral Health Internship Program. This program is designed in alignment with the California Mental Health Services Act (MHSA) Workforce, Education, and Training (WET) Plan. The coordinator oversees the integration and coordination of academic internship programs across the ACBH workforce, ensuring consistency and quality in internship experiences. Additionally, the role involves proactive outreach to educational institutions to promote internship opportunities, fostering strong partnerships to attract and prepare the next generation of behavioral health professionals.

2023/24 UCSF Public Psychiatry fellowship program

- 23/24 - The UCSF Procurement Contract was amended and extended until 12/24.
- A UCSF Fellow (clinical rotation nurse) for the Trust Clinic residency was also recruited in 2023.

Stanford School of Public Psychiatry Program

- 23/24 – connection with Stanford School of Public Psychiatry was made by ACBH Office of Medical Director.
- Stanford Health Care/Lucile Packard Children's Hospital at Stanford Program Letter of agreement was executed.
- The 1st Stanford Resident Psychiatry Student was recruited in 2024.

ACBH Graduate Clinical Intership Program

- The mission and goal of the internship program is to provide training that optimizes student learning, leadership, and overall support & development. Staff also conduct outreach to educational institutions to publicize internship opportunities.

Graduate Internships: FY 23/24 Program Outcomes

- **Publicity and Outreach**: Partnered with the new social media team to publicize the Graduate Intern Stipend Program on ACBH social media pages for Instagram and Facebook. *(Post attached)*
- **Program Coordination**: The WET Internship Coordinator successfully developed, implemented, coordinated, and evaluated the ACBH Internship Program based on the California Mental Health Services Act (MHSA) Workforce, Education, and Training Plan.
- **Onboarding Management**:
- Facilitated onboarding for Children Young Adult System of Care (CYASOC), Adult and Older Adult System of Care (AOASOC), Adult Forensic Behavioral Health, Vocational Rehabilitation, Nursing, and other ACBH units.
- **Relationship Building**: Strengthened collaboration with HR, Finance, clinical coordinators, intern supervisors, and CBO partners to enhance program efficiency and value.
- **Partnership Expansion**: Initiated collaborative relationships with new colleges, including Palo Alto University, Samuel Merritt College, St. Mary's College, and Howard University to broaden student opportunities.

- **Staff Support**: Participated in the hiring and training of a new TAP administrative assistant, provided guidance for two staff members, and ensured quality outcomes.
- **Resource Manual Updates**: Revised and updated the "Onboarding Resource Manual" to maintain program structure and compliance.
- **Contract Management**: Effectively managed three fully executed contract agreements and amendments to two practicum agreements in collaboration with county counsel.
- **Website Revamp**: Redeveloped and maintained the internship program's online presence for a more user-friendly experience.
- **Survey Enhancements**: Developed a new SurveyMonkey application process and a QR code for quick access.

Graduate Internships: FY 23/24 Program Impact and/or Evaluations

- A total of 15 MSW Intern students were onboarded across ACBH programs:

2023-24 ACBH Intern Statistics– Ethnicity (Number of interns= 15)

Ethnicity	Percentage
Black/African American	27%
Asian	27%
Caucasian	20%
Hispanic/Latino	20%
Multi-Ethnic	6%

  - Children and Young Adult System of Care (CYASOC): 7 interns
  - Adult & Older Adult System of Care (AOASOC): 2 Nursing interns
  - Crisis Services: 6 interns

2022-24 ACBH Intern Statistics– Language (Number of interns= 15)

Ethnicity	Count	Percentage
English	5	33%
Cantonese/Mandarin	0	0%
Spanish	7	47%
Tagalog	0	0%
Vietnamese	1	6%
Other	2	14%

Training Highlights:

- CYASOC interns participated in over 30 hybrid training sessions covering topics such as Early Childhood Assessment, Verbal De-escalation, Suicide Intervention, CBT, DBT, and more.
- In-service training evaluations revealed positive feedback with interns reporting the sessions as highly beneficial.

- Represented ACBH at 4 local internship fairs (Cal State East Bay, USF, SJSU, Golden Gate University).
- Conducted 2-day orientations, including presentations, tours, and group interactions, for a successful internship start.
- Managed mid-year and end-of-year intern engagement surveys to inform future program improvements.

Graduate Internships: FY 24/25 Program Challenges

- Capacity Issues: Limited bandwidth across systems of care, requiring staff to take on additional responsibilities to maintain program integrity.
- Diversity Gaps: Difficulty attracting Native Black American, African American and Latino applicants especially Black/African American male interns.
- Cultural Competence Training: Limited internal capacity to provide cultural competence training for interns and supervisors.
- Recruitment Challenges:
    - Finding interns who speak ACBH threshold languages and reflect Alameda County's cultural diversity.
- Staff availability to cover 2-day orientation events.
- Incentives: Lack of creative incentives for staff to supervise student interns.
  Pipeline Expansion: Need for additional staff to increase capacity and expose interns to a wider variety of ACBH units.

Graduate Internships: FY 25/26 Anticipated Challenges

- **Onboarding Portal Development**:
    - Create a centralized onboarding portal using Citrix ShareFile for efficient document management, scheduling, and communication.
    - Portal features will include:
        - Uploading internship documents
        - Sending welcome emails
        - Providing access to intern files for onboarding paperwork
        - Preparing welcome packets and schedules
- **Policy and Procedure Finalization**: Formalize program policies and procedures to enhance service delivery.
- **Diversity Stipend**: Develop a stipend to promote diversity and inclusion within the program.
- **New Programs**:
    - Launch high school, student certificate, and undergraduate programs in collaboration with CBOs and stakeholders.
    - Reestablish a certificate program for college interns completing their assignments.
- **Background Checks**: Address onboarding challenges by exploring solutions for student background and fingerprint checks.
- **Expanded Training**: Advocate for additional funding to bring in external content experts for cultural competence and other key training areas.

- Conclusion - The ACBH Internship Program has demonstrated significant progress in program implementation, outreach, and impact while navigating ongoing challenges. Through continued collaboration, resource development, and innovative solutions, the program is well-positioned to further expand opportunities and enhance its effectiveness in the upcoming fiscal year.

- **Success Stories:**

"I have had a positive experience with other staff members and in the clinic environment. I have been able to learn from each staff member and have meaningful discussions that make me feel welcome on the team." ***2023-24 Student intern evaluation***

"This year's placement gave me the opportunity to grow as a clinician and establish an amazing understanding of how a level one clinic works and what needs to be done in those clinics. I developed how to use CANS, crisis assessment, pharmacology, mental health diagnosis and DBT in my time at the clinic." ***2023-24 Student intern evaluation***

5. Financial Incentives

Program Description

Offer financial incentives as workforce recruitment and retention strategies, and to increase workforce diversity.

Financial Incentives are offered to eligible clinical staff employed in ACBHD and to graduate interns placed in ACBH and contracted Community-Based Organizations, and who are linguistically and/or culturally able to serve the underserved and unserved populations of the County. The Behavioral Health Loan Repayment Program is for eligible clinical staff who completes a service obligation in public behavioral health in Alameda County.

1. ACBHD Graduate Intern Stipend Program (GISP)

- Offers financial incentives as a workforce recruitment & retention strategy while increasing workforce diversity.
- Financial Incentives are offered to graduate interns placed at ACBH and contracted community-based organizations.
- Retain individuals who are linguistically and or culturally able to serve the underserved and unserved populations of the County.

GISP: FY 23/24 Program outcomes

Graduate Intern Stipend Program Execution: On August 23, 2023, executed and administered the 12th cycle of the Graduate Intern Stipend Program.

- **Award Distribution:** Awarded stipends of up to $6,000 to 23 students for completing 720 internship hours. Of the awardees, 91% represent the diverse communities of Alameda County.
- **Diversity Focus:** Continued emphasis on recruiting interns across systems, including behavioral health interns in primary care settings, and increasing the number of interns who speak threshold languages such as Spanish, Cantonese, Mandarin, Farsi, Vietnamese, and Tagalog.
- **Application and Scoring Updates:**
  - Reviewed, updated, and made changes to the GISP application to align with current guidelines and regulations.
  - Recruited an 8–9-member review panel to evaluate and score applications.
  - Updated and utilized a matrix chart system for distributing applications and scoring information.
- **Financial Collaboration:** Collaborated with the finance team to process stipend claims and distribute payments in accordance with established procedures, protocols, and timelines.
- **Scoring Process:**
  - Once reviewers submitted scores, the Internship Coordinator and WET Manager calculated Part III of the application, combined scores, and updated the GISP database.
  - Created a database of the highest-scoring applicants for final approval by the ACBH Director.
- **Data and Reporting:**
  - Generated yearly GISP language and ethnicity data charts and graphs for statistical purposes.
    - Currently developing policies, procedures, and guidelines for the Graduate Intern Stipend Program.

FY23/24 Graduate Intern Stipend Applicants – Ethnicity

Total Applicants = 38

Ethnicity	#	Percentage
Black/African American	4	10%
Asian	11	29%
Caucasian	8	21%
Hispanic/Latino	14	37%
Other: Arab	1	3%
Total	38	100%

FY23/24 Graduate Intern Stipend Applicants - Language

Total Applicants = 38

Language	#	Percentage
English	10	27%
Farsi	0	0%
Cantonese/Mandarin	4	10%
Spanish	17	45%
Tagalog	1	3%
Vietnamese	2	6%
Other	3	9%
Total	38	100%

- Partnered with the new social media team within our Health Care Agency to publicize the 24-25 Graduate Intern Stipend Program on ACBH social media pages for Instagram and Facebook. *(Post attached)*

- Created and presented a Graduate Intern Stipend rogram presentation to showcase program details, successes, and data.
- Along with the WET team, introduced GISP information to ACBH department units and stakeholders.

FY24/25 GISP Program Challenges

Barriers Experienced and Lessons Learned:

- **Program Promotion:** Finding creative ways to promote and advertise the GISP program to a wider audience.
- **Language Data Updates:** Challenges in receiving timely updates on Alameda County threshold language information.
- **Early Notification:** The need to provide program notifications earlier in the year to assist students with better planning and application preparation.

FY25/26 GISP, Anticipated Program Challenges

Planned Changes and Expected Challenges:

- **Certificate Program:** Re-establishing the certificate program for GISP applicant awardees.
- **Instructional Resources:** Developing an instructional Q&A video to guide applicants through the GISP application process.

- **Client Success Story:**

"Thank you so much! I'm so excited and happy to keep helping the community. This stipend is a huge help!" **(2023-24 GISP awardee)**

"This is excellent news, and I am honored to have been selected. I'm looking forward to taking the next steps and receiving stipend award documentation." **(2023-24 GISP awardee)**

"BRINGING PEOPLE AND RESOURCES TOGETHER"

The Capital Facilities & Technological Needs (CFTN) component of the MHSA "works towards the creation of a facility that is used for the delivery of MHSA services to mental health clients and their families or for administrative offices. Funds may also be used to support an increase in peer-support and consumer-run facilities, development of community-based settings, and the development of a technological infrastructure for the mental health system to facilitate the highest quality and cost-effective services and supports for clients and their families".

ACBHD's MHSA funded Capital Facilities projects are in alignment with Alameda County's Vision 2026. More on this vision can be seen at https://vision2026.acgov.org/index.page

New Projects Approved for funding, implementation FY 25/26

No new CFTN projects have been identified or allocated new funding in FY 25/26. Please see the following section for updates on ongoing CFTN programs and projects that are in various stages of implementation.

Ongoing Projects

During FY 23/24-24/25 the following CFTN projects were in process. These projects were listed as new programs/projects in previous Plan Updates (FY 18/19 and 19/20) and/or the current MHSA Three Year Plan FY 23/24-25/26. Updates on progression of these programs and projects were provided in last year's MHSA Annual Update FY 24/25 under the ongoing section of the Plan. Several of these projects will be completed this fiscal year (FY 25/26) and others will be continued and completed under the Behavioral Health Services Act in FY 25/26 and beyond.

CFTN PROGRAM SUMMARIES

PROJECT NAME: CF2 Respite Bed Expansion and CF4 Alameda Point Collaborative

Project Description: Capital Project Investments to Expand Respite Beds for Individuals with Serious Mental Illness and Physical Health Care Needs and Alameda Point Collaborative (APC) Senior Housing and Medical Respite Wellness Center (AWC). Detailed information can be found in the previous MHSA Three Year Plan FY 23/26 Here.

FY 24/25: As funding is winding down in these two programs, there has been a decision to combine the final amount of funds into CF2 under the general program topic of respite bed expansion.

ACBHD continues to be in collaboration with the Office of Homeless Care and Coordination, a division within the county's parent agency Health Care Services Agency, and will continue to seek new opportunities to develop medical respite opportunities. The remaining funds within this workplan's original six-million-dollar allocation ($3M for medical respite CF2 and $3M for Alameda Pt Collaborative CF4) will be directed towards the Alameda Point Collaborative Project (formerly workplan #CF4) and a new project called the St. Regis. The St. Regis is a building that was purchased by a local non-profit, Bay Area Community Services (BACS), where ACBHD hopes to develop multiple residential mental health services including medical respite. The St. Regis project has been slow to begin as BACS is awaiting their funding from a Behavioral Health Continuum Infrastructure Program (BHCIP) award. More information will be provided as this project develops.

PROJECT NAME:
CF5: African American Wellness Hub Complex

Project Description: The African American Wellness Hub Complex will be a beacon of hope and energy for the African American community in Alameda County. The development of the complex began in FY 20/21 and is ongoing. ACBHD has budgeted a total of $14.8M in one-time funding ($10.7M in MHSA and $4.1M in non-MHSA) to purchase land and/or renovate an existing space.

FY 24/25 Progress: In FY 24/25 ACBHD, in partnership with the Alameda County General Services Agency (GSA) department, purchased a property at 1912 MLK Way in Oakland for the development of the African American Wellness Hub Complex (HUB). The Hub will be designed to serve as a space where those in need of services may walk in and receive and benefit from consistent, reliable and welcoming services, in an effort to prevent crises, divert from more acute services and in order to collaborate with a team dedicated to equitable and culturally appropriate services.

As a next step in the development process, ACBHD, GSA and the Alameda County Board of Supervisors are in

discussion regarding construction and renovation ideas and associated costs. The MHSA Team will post additional updates on its website (ACMHSA.org) when they are available.

PROJECT NAME: CF6. Land Purchase adjacent to the A Street Homeless Shelter

Project Description: In FY 18/19 ACBHD used its AB 114 CFTN funds to purchase a small plot of land next to the A Street Homeless Shelter, which ACBHD has been operating in Hayward since 1988. The subject lot is located at 22385 Sonoma Street immediately adjacent to the existing A Street Shelter.

FY 24/25 Progress: ACBHD, through the General Services Agency (GSA), successfully purchased the land in January 2019. ACBHD had planned to use the lot as additional parking, providing approximately 20 additional spaces to augment the inadequate parking capacity needed to serve employees, residents, visitors and service vehicles. However, through a feasibility study, the cost to develop the parking lot was estimated to be $2.5M for drainage, electrical, fencing, new walkway, etc. Due to funding limitations, ACBHD does not have the funding to support the parking lot project. Since there is a small balance remaining in this workplan there has been a joint decision between ACBHD and the Office of Homeless Care and Coordination to change course and provide additional renovations to the shelter to create a welcoming and supportive environment for clients. These renovations include items such as a kitchen upgrade, painting the facility, new carpet/furniture and electrical re-wiring.

Please note, the garden project, that these final funds were going to be used for (listed in FY 24/25 Annual Update), has been funded by a grant, which is the reason to the pivot back to minor facility upgrades.

Due to continued capacity issues, there has been a delay in the implementation of this project. More information on the implementation and completion of the garden project will be published when available.

PROJECT NAME: TN1. MHSA Technology Project Program Description: Purchase, installation and maintenance of a new Behavioral Health Management Information System (EHR), to include: billing, managed care, e-prescribing functions, data interoperability and functions as needed to support clinical and fiscal operations of ACBHD. Additional expenditures for the necessary support staff during the implementation process, and other projects that provide access to consumers and family members to their personal health information and other wellness and recovery supports.

FY 24/25 Progress:

ACBHD continues to partner with the vendor Streamline Healthcare Solutions, LLC, to implement a fully integrated billing system on the SmartCare Platform to replace INSYST (our department's legacy registration and billing platform). Streamline and the integrated SmartCare Platform continue to work on the functionality necessary to ensure staff and contracted providers work together within and across organizational boundaries.

SmartCare is currently in use, however there are still changes and upgrades needed in order for the system to operate in a smooth and efficient manner. The ACBHD IT Team is working with the vendor on an ongoing basis to rectify these issues.

Procurement process for new Behavioral Health Management Information System (EHR) (non-billing portion): ACBHD is set to begin planning the procurement process for the additional clinical components of an EHR system in 2025. An informational update on this process will be shared once the process is finalized

Additionally, under this component ACBHD has been utilizing CFTN funds for the following items that have assisted ACBHD in being more efficient and effective with utilization and outcome data:

- TN1: Behavioral Health Management Contracting System (to assist with the contracting process), called Apttus (phases 1-4)
- TN1: Computer/Technology Technical Assistance
- TN1:Electronic File Storage and Document Imaging (Veeam Software)
- TN3: County Equipment and Software Update (includes Zoom, Teams and Panoramic software)
- TN4: Clinician's Gateway Interface and consulting services
- TN5: Second Round Capacity Building Funds
- CFTN Administration

Behavioral Health Department
Alameda County Health

Mental Health Services Act (MHSA)
Alameda County Behavioral Health

MENTAL HEALTH SERVICES ACT (MHSA)
STAKEHOLDER GROUP MEETING CALENDAR, 2024

** This schedule is subject to change. Please view the MHSA website for calendar updates.

DATE	TIME	LOCATION	MEETING THEMES
January 26, 2024	1:00pm-3:00pm	Zoom	• Postponed
February 23, 2024	1:00pm-3:00pm	Zoom	• Stakeholder Updates • Review of MHSA Annual Plan Update FY24/25
March 22, 2024	1:00pm-3:00pm	Zoom	• Crisis Response Presentation • Roles and Responsibilities of MHSA SG • BHSA Timeline • Annual Update Public Comment
April 26, 2024	1:00pm-3:00pm	Zoom	• Early Psychosis Presentation • BHSA Updates and Group Input
May 24, 2024	1:00pm-3:00pm	Zoom	• ACCESS Program Presentation • BHSA Updates and Group Input
July 19, 2024	1:00pm-3:00pm	Zoom	• MHSA Updates • MHSA Annual Plan Update FY25/26 Timeline
August 23, 2024	1:00pm-3:00pm	Zoom	• Treatment Courts and Telecare ACC Program Presentation • MHSA FY25/26 Timeline CPPP Updates • BHSA Update
September 27, 2024	1:00pm-3:00pm	Zoom	• Health Equity Division Presentation • MHSA Community Input
October 25, 2024	1:00pm-3:00pm	Zoom	• Vocational Program Presentation • MHSA Outreach Community Updates
November 15, 2024	1:00pm-3:00pm	Zoom	• MHSA Community Program Planning Process review • Update and discussion of survey results
December 20, 2024	1:00pm-3:00pm	Zoom	• African American Family Outreach Project discussion • Stakeholder alignment with BHSA

Behavioral Health Department
Alameda County Health

Mental Health Services Act (MHSA)
Alameda County Behavioral Health

MENTAL HEALTH SERVICES ACT (MHSA)
CPPP-PC GROUP MEETING CALENDAR, 2024

Community Program Planning Process (CPPP) – Planning Committee

DATE	TIME	LOCATION	MEETING THEMES
September 5, 2024	3:30pm-4:30pm	Teams	• MHSA CPPP Overview • Outreach plan • Presentation & Survey development
September 19, 2024	3:30pm-4:30pm	Teams	• Review of MHSA-SG Applications • Survey completion, survey begins • Listening Session protocol & template recommendations • Revision of categorized needs
October 3, 2024	3:30pm-4:30pm	Teams	• Data collection methods • Survey results review • Outreach recommendations • Listening sessions begins
October 17, 2024	3:30pm-4:30pm	Teams	• CPPP-PC Listening Session
October 31, 2024	3:30pm-4:30pm	Teams	• BHSA presentation & update • Listening sessions and survey updates
November 14, 2024	3:30pm-4:30pm	Teams	• Outreach update • Stakeholder engagement recommendations • Listening Sessions results
January 16, 2025	3:30pm-4:30pm	Teams	• BHSA CPPP update from DHCS guidance

Outreach & Marketing Plan:

Alameda County MHSA Community Input & Public Comment



Alameda County MHSA Senior Planner Noah Gallo
Oakland Fruitvale Posada – 12/16/23

Empowering Communities, Improving Mental Health Together

Stakeholders		Providers		Community	

Alameda County MHSA Annual Plan Update FY2025-2026

Brainstorm → **Engage Stakeholders** → **Create Plan** → Execute → Collect Data → Analyze Data → Draw Conclusions

	Target	Cohesive Internal & External Stakeholder Agreement on Outreach	Results
☑	7/24/24 – 1/2/25	Develop committees and meetings to encourage stakeholder collaboration for CPPP Marketing Plan development.	1. Stakeholder Group Meetings 2. CPPP Committee Meetings
☑	8/1/24 – 1/2/25	Develop and implement multilingual MHSA promotion material. Flyer and Community Input Survey is multilingual.	1. Community Input Survey 2. Demographics Survey 3. Email marketing 4. Event outreach and street outreach throughout the county 5. ACMHSA website utilization 6. Outreach to community and providers 7. Social Media marketing 8. Marketing Material distribution digital & print 9. Metrics to track outcomes
☑	8/15/24-1/2/25	MHSA CPPP Outreach & Marketing strategy defining outreach, goals, strategies, metrics, & outcomes. The MHSA strategically engaged a variety of demographics throughout Alameda County to ensure that our community feedback was diverse, inclusive and multilingual.	1. The survey was distributed in digital and paper formats to community groups, leaders, nonprofits, clinics, street outreach, and Alameda County staff. 2. The survey was promoted on the ACMHSA website and on social media. 3. Survey provides respondents to provide direct feedback to the MHSA team.

☑	8/1/24-1/2/25	Community groups identified and contacted to participate in the Community Planning Process.	1. Listening Sessions, Key Informative Interviews (20+ planned) 2. Over 300 organizations contacted. 3. Based on the expanded stakeholder requirements, geographic location, and clients with lived experiences.
☑	8/15/24	ACMHSA.org website enhancement.	1. Community can access information & provide feedback about MHSA programs in Alameda County 2. ACMHSA Website hosts flyers, surveys, MHSA fact sheets, press/media tool kit & program information.

Brainstorm | Engage Stakeholders | Create Plan | **Execute** | Collect Data | Analyze Data | Draw Conclusions

	Target	Promote awareness to Alameda County Residents	Results
☑	8/1/24 - 1/2/25	Community groups engaged to participate in the Community Planning Process.	1. Over 300 organizations contacted. 2. Based on strategic geographic location in the county. 3. Based on the population they serve.
☑	8/15/24-1/2/25	Community outreach through various media channels (*partial list*): 1. Newspapers 2. E-Newsletters 3. Text Messages 4. Event outreach	Community outreach through various media channels: 1. Newspapers a. Bay Area News Group – 59,527 subscribers 2. E-Newsletters a. Asian Health Services – 483 external subscribers, 584 intra email b. HHREC – 548 subscribers c. ACMHSA – 2,541 subscribers d. Swords to Plow Shares – 63 subscribers 3. Event outreach (sample, consistently adding to list) a. Dia de los Muertos b. Healthy Living c. Indigenous Red Market c. Peralta College Student Fairs
☑	8/15/24-1/2/25	Social Media Engagement (*partial list*): 1. HCSA 2. Providers	Social Media Engagement: 1. HCSA a. HCSA Facebook – 5,500 followers b. HCSA Instagram – 1,145 followers c. HCSA Twitter – 8,500 followers
☑	10/28/24-1/2/25	1. Alameda County Internal Efforts 2. Library Participation	1. Alameda County Staff a. Board of Supervisors i. Newsletter – ii. Facebook iii. Instagram iv. Twitter v. WeChat b. HCSA Newsletter – 10,000 subscribers

			c. MHSA Stakeholders – 20 subscribers d. Consumer Family Workgroup – 31 subscribers e. Intranet – 693-2,000 subscribers 2. Library Participation: Alameda Library, Cesar Chavez Library, Dublin Library, Fremont Library, Castro Valley Library, Melrose Library, Dimond Library, Laney Library, Oakland main library, Hayward Library, San Leandro Library, San Lorenzo Library.

Brainstorm | Engage Stakeholders | Create Plan | Execute | **Collect Data** | **Analyze Data** | Draw Conclusions

	Target	Outreach to encourage historically underserved and unserved communities to participate in MHSA funded activities	Results
☑	10/15/24-1/2/25	Conduct Listening Sessions & Key Informative Interviews in different regions in Alameda County. Develop materials, questionnaire, create list of 11 categorized areas of community need, craft culturally appropriate standardized dialogue. Educate providers on MHSA changes, programs, and updates. Encourage providers to facilitate information to their consumers and families.	1. Conduct Listening Sessions and KII's fulfilling the stakeholder participation requirements. Sessions will be held: Core Mental Health Services (10/17/24), Adult and Senior Services (10/24/24), Social Services and Welfare (10/29/24), School District Health Wellness Leads (10/3/24), City of Fremont (10/4/24), Civic Corps (10/11/2024), CHCN FQHC Behavioral Health Directors (10/24), Jay Mahler Recovery Center (11/12/24), NAMI Tri-Valley (11/16/24), UELP (11/13/24), City of Oakland (12/3/24), City of Hayward (12/6/24) and numerous listening sessions with Peers with Living Experiences, and community group fulfilling stakeholder engagement requirements.

Brainstorm | Engage Stakeholders | Create Plan | Execute | Collect Data | Analyze Data | **Draw Conclusions**

	Target	**Educate community on the results of the CPPP MHSA Funded activities**	**Results**
☑	1/16/25-1/31/25	MHSA team reviewed collected data and made recommendations on how to solve community needs.	1. MHSA team analyzed and standardized community response into a reviewable framework. 2. Shared with Agency Leadership. 3. Located in MHSA Plan Update.
☑	1/1/25 - 5/1/25	Team conducts presentations with leadership, providers and peers throughout the spring regarding the MHSA Annual Plan Update.	1. Update MHSA Presentations 2. Update ACMHSA Website 3. Program fund distributions.
☑	1/1/25	Team will begin to transition to the Community Program Planning Process under the Behavioral Health Services Act guidelines and regulations.	

Outreach Plan for Public Comment
MHSA FY 2025-2026 Annual Update Plan

Brainstorm → Create Plan → Engage Stakeholders → Execute → Collect Data → Analyze Comments → Draw Conclusions

	Target	Outreach to obtain Public Comment on the MHSA FY25/26 Annual Plan	Results
⌛	3/1/25-4/1/25	Create Public Comment Outreach Materials.	1. Create Online Survey -3/12/25 2. Create Flyer - 3/12/25 3. Post on ACMHSA, ACBHD Website, ACBHD Webmaster
⌛	4/1/25-5/15/25	Engage community and local partners to encourage feedback and critique of the MHSA FY25/26 Annual Plan.	1. Outreach to local providers/agencies 35 organizations 2. Outreach to MHSA Stakeholder Group 3. Outreach to Community Program Planning Process Committee 4. Community Presentations 5. Newspapers Ads 6. Email distribution campaigns. 7. HCSA Social Media postings. a. Posts on Facebook, Instagram, Twitter in English, Spanish, Chinese 8. Library Flyer postings 4/1/25-5/16/25 9. Alameda Library, Cesar Chavez Library, Dublin Library, Fremont Library, Castro Valley Library, Melrose Library, Dimond Library, Laney Library, Oakland main library, Hayward Library, San Leandro Library, San Lorenzo Library. 10. Board of Supervisor outreach, social media and newsletters
⌛	5/16/25	Incorporate Public Comment recommendations into MHSA FY25/26 Annual Plan.	1. Analysis of public recommendations. 2. Implementation of public recommendations.
⌛	5/19/25	Public Hearing at Mental Health Advisory Board	1. Present MHSA FY25/26 Annual Plan to Mental Health Advisory Board.
⌛	6/25	Board of Supervisor Meeting – Health Committee	1. Discussion 2. Approval of MHSA FY25/26 Annual Plan


¡TOMA LA ENCUESTA EN NUESTRA BIO!
Queremos tu opinión sobre los servicios de salud mental del Condado de Alameda
Behavioral Health

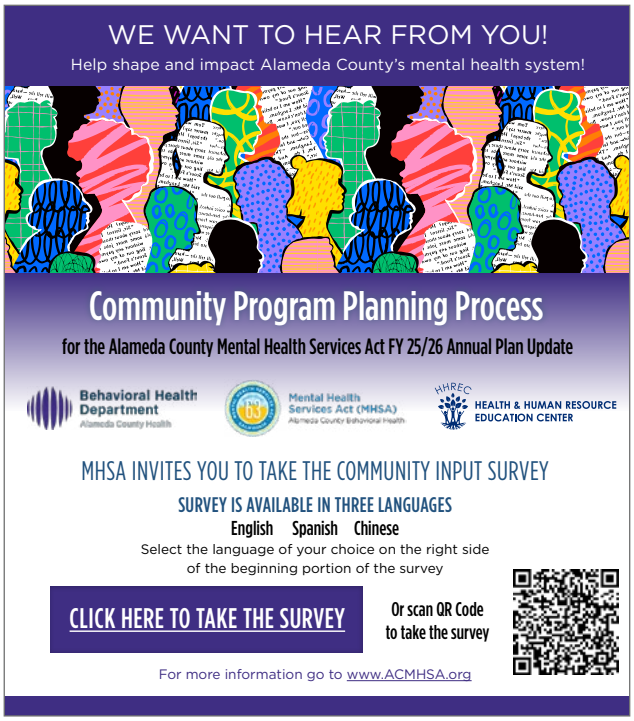

¡Queremos Saber Tu Opinión!
¡TOMA LA ENCUESTA EN NUESTRA BIO!
La División de la Ley de Servicios de Salud Mental (MHSA) del Condado de Alameda quiere saber tu opinión para mejorar los programas de salud mental. Ayúdanos a priorizar necesidades y compartir ideas. La encuesta está disponible en inglés, español y chino (mandarín y cantonés).
Descubre Más en Health.AlamedaCountyCA.gov/ACBHD
Behavioral Health


We Want to Hear From You!
TAKE THE SURVEY LINKED IN OUR BIO!
The Alameda County Mental Health Services Act (MHSA) Division wants your feedback to improve mental health programs. Help us prioritize needs and share ideas. The survey is available in English, Spanish, and Chinese.
Learn more at Health.AlamedaCountyCA.gov/ACBHD
Behavioral Health


FOSTERING COMMUNITY RESILIENCE
Emotional Wellness Month
Learn more at Health.AlamedaCountyCA.gov
Behavioral Health


REMEMBER, YOU ARE NOT ALONE
Mental Illness Awareness Week
Learn more at https://www.acbhcs.org/
Behavioral Health


We Want to Hear From You!
TAKE THE SURVEY LINKED IN OUR BIO!
The Alameda County Mental Health Services Act (MHSA) Division wants your feedback to improve mental health programs. Help us prioritize needs and share ideas. The survey is available in English, Spanish, and Chinese.
Learn more at Health.AlamedaCountyCA.gov/ACBHD
Behavioral Health


WE WANT TO HEAR FROM YOU!
Help shape and impact Alameda County's mental health system!
Community Program Planning Process
for the Alameda County Mental Health Services Act FY 25/26 Annual Plan Update
Behavioral Health Department
Alameda County Health
Mental Health Services Act (MHSA)
Alameda County Behavioral Health
HHREC
HEALTH & HUMAN RESOURCE EDUCATION CENTER
MHSA INVITES YOU TO TAKE THE COMMUNITY INPUT SURVEY
SURVEY IS AVAILABLE IN THREE LANGUAGES
English Spanish Chinese
Select the language of your choice on the right side of the beginning portion of the survey
CLICK HERE TO TAKE THE SURVEY
Or scan QR Code to take the survey
For more information go to www.ACMHSA.org


CHÚNG TÔI MUỐN NGHE Ý KIẾN CỦA QUÝ VỊ!
Giúp định hình và tác động đến hệ thống sức khỏe tâm thần của Quận Alameda!
Quy Trình Lập Kế Hoạch của Chương Trình Cộng Đồng
đề Cập Nhật Kế Hoạch Thường Niên Năm Tài Chính 2025/2026
cho Đạo Luật Dịch Vụ Sức Khỏe Tâm Thần Quận Alameda
Behavioral Health Department
Alameda County Health
Mental Health Services Act (MHSA)
Alameda County Behavioral Health
HHREC
HEALTH & HUMAN RESOURCE EDUCATION CENTER
MHSA MỜI QUÝ VỊ THAM GIA KHẢO SÁT Ý KIẾN CỘNG ĐỒNG
KHẢO SÁT CÓ SẴN BẰNG BA NGÔN NGỮ
Tiếng Anh Tiếng Tây Ban Nha Tiếng Trung
Chọn ngôn ngữ mà quý vị muốn ở bên phải trong phần đầu của khảo sát
NHẤP VÀO ĐÂY ĐỂ THAM GIA KHẢO SÁT
Hoặc quét Mã QR để tham gia khảo sát
Để biết thêm thông tin, vui lòng truy cập www.ACMHSA.org


Everyone Welcome!
Provide Feedback!
Join Us Online!
Mental Health Services Act
Stakeholder Engagement Forums
You are invited to participate in the Community Program Planning Process!
This process helps determine how Alameda County allocates funds for mental health programs.
We want to hear your voice! Your input and personal experience are welcome!
The community's feedback will be included in the MHSA Annual Plan Update FY25/26.
Click links below to join the meeting on the day/time of each!
Core Mental Health Services – 10am Thursday October 17
Community Based Organizations – 10am Tuesday October 22
Adult & Senior Services – 10am Thursday October 24
Social Services & Welfare – 10am Tuesday October 29
Public Safety & Justice – 10am Tuesday November 5
Education – 10am Thursday November 7
Health Care & Insurance – 10am Thursday November 14
Youth – 4pm Tuesday December 10
Veterans – 10am Wednesday December 11
Regional & Governmental Entities – 10am Thursday December 12
Families – 10am Friday December 13
Early Childhood – 10am Tuesday December 17
Disability Population – 2pm Tuesday December 17

Appendix B-3 | Sources of Data to create 11 Categorized areas of Community Need

The following local plans, assessments, evaluation reports, and data were reviewed to identify prominent mental health and substance use needs reported across service sectors and the community. Reviewing relevant and existing behavioral health data as compared to starting from a blank slate allowed the community stakeholders to focus on solutions and strategies for improvement and have an overall asset mindset as compared to being deficit focused. The MHSA and CPPP Planning team prioritized reviewing local data needs and information, but also discussed larger data trends in their assessment.

Alameda County MHSA FY 20-21-22/23 Three-Year Plan

https://acmhsa.org/wp-content/uploads/2021/03/MHSA2020Plan_FINAL_WEB_update_02.pdf

Alameda County MHSA FY 23/24-25/26 Three-Year Plan

California Health Interview Survey (CHIS), University California Los Angeles

https://healthpolicy.ucla.edu/our-work/health-profiles/adult-health-profiles

https://healthpolicy.ucla.edu/our-work/health-profiles/raceethnicity-health-profiles

https://ask.chis.ucla.edu/ask/SitePages/AskChisLogin.aspx?ReturnUrl=%2fAskCHIS%2ftools%2f_layouts%2fAuthenticate.aspx%3fSource%3d%252FAskCHIS%252Ftools%252F%255Flayouts%252FAskChisTool%252Fhome%252Easpx&Source=%2FAskCHIS%2Ftools%2F%5Flayouts%2FAskChisTool%2Fhome%2Easpx

2021 and 2022 Point in Time Homeless Data Count

https://everyonehome.org/main/continuum-of-care/everyone-counts-2022/#:~:text=9%2C747%20people%20in%20Alameda%20County,(1%2C725%20people)%20since%202019.

Alameda County Behavioral Health (ACBHD) Cultural Competency Plan

Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness: June 2023

https://homelessness.ucsf.edu/sites/default/files/2023-06/CASPEH_Report_62023.pdf?utm_id=102035&sfmc_id=1894793

MH and SUD prevalence data FY 21/22, from the California Department of Health Care Services (DHCS), see appendix xx for data

ACBHD Penetration data FY 21/22 and 22/23

Alameda County Perinatal and Infant Health Indicators

https://acphd-web-media.s3-us-west-2.amazonaws.com/media/data-reports/mpca/docs/acphd-mpcah-indicators-slides-feb-2023.pdf

Opioid data, Alameda County

https://acphd.org/opioid-story.html

County Health Status Profiles 2023 https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CHSP2023_Final_Draft_v10.pdf

County Rankings and Road Maps

https://www.countyhealthrankings.org/explore-health-rankings/california/alameda?year=2023

PLACES Local Data for Better Health, hosted by the center for Disease Control and prevention (CDCP)

PLACES: Local Data for Better Health https://www.cdc.gov/places/index.html

Healthy Alameda: https://www.healthyalamedacounty.org/

Suicide in CA 2020: (infographic)

https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/CA%20Violent%20Death%20Reporting%20System%20(CalVDRS)/CalVDRS_SuicideInfograph_2020.pdf

SAMHSA 2022 Report: 2022 National Survey on Drug Use and Health (NSDUH): https://www.samhsa.gov/data/release/2022-national-survey-drug-use-and-health-nsduh-releases#detailed-tables

National Institute of Mental Health, Mental Health information

https://www.nimh.nih.gov/health/statistics/mental-illness

National Alliance on Mental Illness data

https://www.nami.org/mhstats

Anthem Blue Cross 2022 Population Needs Assessment Report

https://providers.anthem.com/docs/gpp/california-provider/CA_CAID_PopulationNeedsAssessmentReport.pdf?v=202211042216

Categorized Areas of Community Need in Alameda County

1. **Access, Coordination and Navigation to Services** - this category captures the **needs of diverse cultures and identities such as race/ethnicity, language, LGBTQIA+, veteran status and age** related to accessing mental health and substance use services, including community knowledge and education, language capacity, , and successful connection to services after an emergency.

2. **Behavioral Health Workforce** - this category captures the needs related to recruiting, developing, supporting and maintaining a sufficient multilingual clinical and peer workforce.

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

4. **Housing Continuum** - this category captures the housing needs for individuals living with behavioral health challenges ranging from housing interventions and support needed to maintain housing.

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

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

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

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

9. **Needs of Family Members** - this category captures the ongoing stress, frustration and isolation family members can feel in taking care of their loved ones including navigation issues, need for 24/7 access to inpatient and outpatient psychiatry services, suicide prevention, caregiving support, and other related trauma services.

10. **Needs of Veterans** - this category captures the mental health and housing needs of Veterans: Alameda County has the 4th highest number of homeless veterans, and 2nd highest of unsheltered homeless veterans in California. Veterans have a higher rate of poor mental health, high suicide rates, mental health stigma, lack of navigation support, lack of veteran support groups and social isolation.

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

Summary of Areas:

Access, Coordination and Navigation to Services

Behavioral Health Workforce

Crisis Continuum

Housing Continuum

Substance Use

Community Violence and Trauma

Child/Youth/Young Adult Needs

Adult/Older Adult Needs

Needs of Family Members

Needs of Veterans

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

Mental Health Services Act
Community Education & Input Meeting

MHSA Annual Plan Update FY 25/26

Presented by:

Alameda County Behavioral Health – MHSA Division

Behavioral Health Department
Alameda County Health

Mental Health Services Act (MHSA)
Alameda County Behavioral Health

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MHSA Listening Session Agenda

Listening Session Purpose: Education and Information sharing about MHSA, Stakeholder Engagement and Information Gathering

Meeting Process for Today:

- Why we are here
- Looking at the many known behavioral health needs
- Wanting to identify/rank problems or areas of need and then focus on *solutions*
- Conducting a ranking process
- Talking about the top 3 areas
- Time for any other comments and feedback
- Demographic Survey
- Wrap Up

Behavioral Health Department

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Meeting and Presentation Agreements

1. BE PRESENT
2. SPEAK FROM YOUR OWN EXPERIENCE
3. ONE VOICE AT A TIME
4. STEP UP, STEP BACK
5. SEEK TO UNDERSTAND AND THEN BE UNDERSTOOD
6. HOLD QUESTIONS TO THE END OF THE PRESENTATION

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Current MHSA Funding Categories

76% — **Community Services & Supports (CSS)**
Direct treatment and recovery services for serious mental illness or serious emotional disturbance
51% Full Service Partnerships

19% — **Prevention & Early Intervention (PEI)**
Interventions prior to the onset of mental illness and early onset of psychotic disorders

5% — **Innovation (INN)**
New approaches and community-driven best practices

Workforce Education and Training (WET)
Education, training and workforce development to increase capacity and diversity of the mental health workforce

Capital Facilities and Technology Needs (CFTN)
Buildings and technology used for the delivery of MHSA services to individuals and their families.

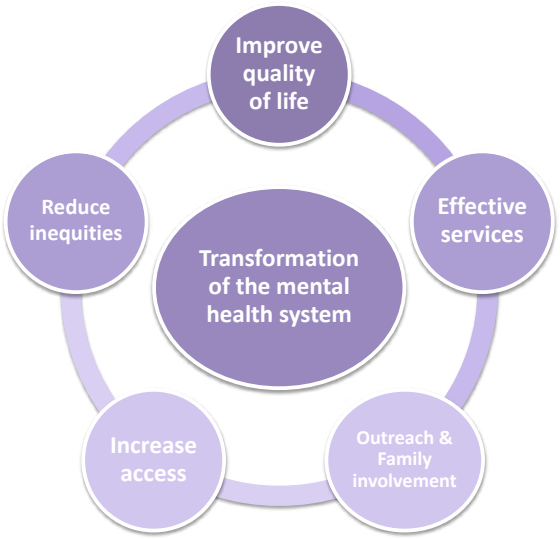
NOTE: 1% tax on personal income over $1M; Alameda County: FY 24/25 Budget: $194M, funds 197 County Civil Service Positions. MHSA is highly leveraged and makes up ~26% of the ACBHD total budget.

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MHSA Goals & Values



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MHSA: Who Does It Serve?

- Individuals with serious mental illness (SMI) and/ or severe emotional disorder (SED)
- Individuals not served /underserved by current mental health system
- Services must be in a voluntary setting, meaning MHSA funds can not be used to provide services in the jail or a locked facility.
- Non-supplantation: MHSA may not replace existing program funding or be used for non-mental health programs.

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Community Program Planning Process (CPPP)

The County shall provide for a CPPP (also known as Community Listening Sessions or Community Input) as the basis for developing the Three-Year Program and Expenditure Plans and Plan Updates*.

The CPPP shall, at a minimum, include:

- Involvement of clients with serious mental illness and/or serious emotional disturbance and their family members in all aspects of the Community Program Planning Process.
- Participation of diverse stakeholders.
- Training/Education on MHSA.

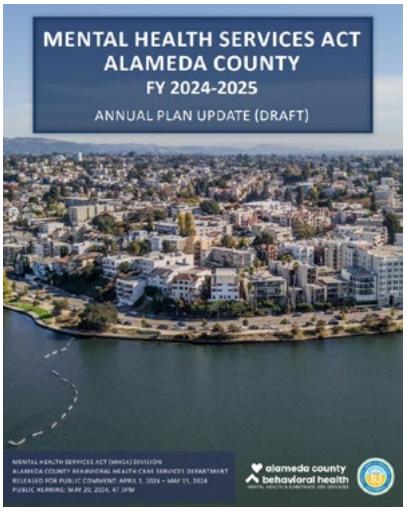
Alameda's Community Listening sessions will conclude January 30, 2025

*Title 9 CCR § 3300

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MHSA Community Input from *Previous* Input Sessions



- **Plan Budget:** $206M (9% increase from FY 23/24)
  - Five program components for FY 24/25.
- Public Comment: April 1st-May 15th 2024.
- Mental Health Advisory Board Public Hearing: May 20, 2024.
- Increased Community Engagement:
  - 36 Listening Sessions attended by 394 Community Members.
  - 611 Survey Responses.
- Multiple Improvements have been made to make the Plan:

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

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Top Area of Need and Strategies & Solutions

Area of Need	Strategies & Solutions
1. **Access, Coordination and Navigation to Services** 	• Establish **community navigation centers** as one-stop shops to provide access, coordination, and navigation to various services. • Support, fund and increase programs that utilize **community navigators**, promoters, and peer support services. • Implement **culturally sensitive and appropriate outreach strategies**. • Develop a comprehensive digital platform and **master directory** containing contact information, assessment details, and available resources for mental health services. • **Prioritize bilingual services** to support multiple languages in the growing client base and improve accessibility for diverse communities. • Develop clear and transparent **referral processes.** • **Centralized care coordination teams:** Establish dedicated teams to navigate patients through the system, coordinate appointments, and advocate for their needs.

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Other High Priority Areas of Need & Strategies/Solutions

Area of Need	Strategies/Solutions
Housing Continuum	• More supportive Housing (short and long term) • Increase PEI programs for homeless
Crisis Continuum	• Prioritize crisis mental health services. • Expand after hour & weekend crisis services • More crisis stabilization beds.
Child/Youth and Young Adult Needs	• Increase and improve engagement strategies. • Address diverse needs of children youth, and young adults. • Strengthen support systems by educating family members.
Behavioral Health Workforce 	• Address work shortages by recruiting from diverse communities. • Expand peer support programs. • Support other nonclinical service models. • Provide funding for training programs. • Provide support to workforce to prevent job burnout and fatigue.

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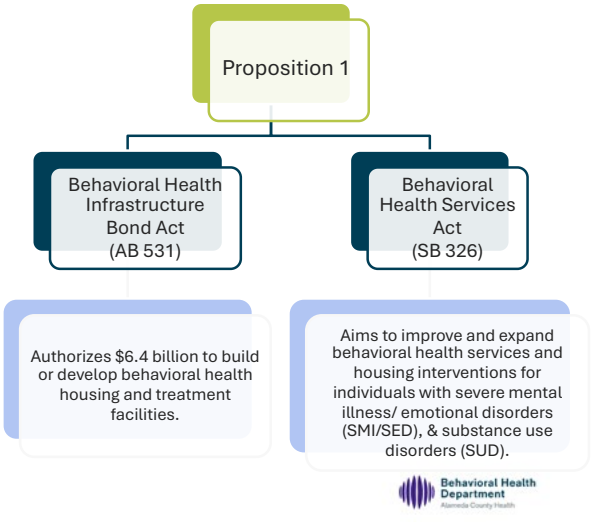
Behavioral Health Transformation

MHSA to Proposition 1 / Behavioral Health Services Act (BHSA)

11

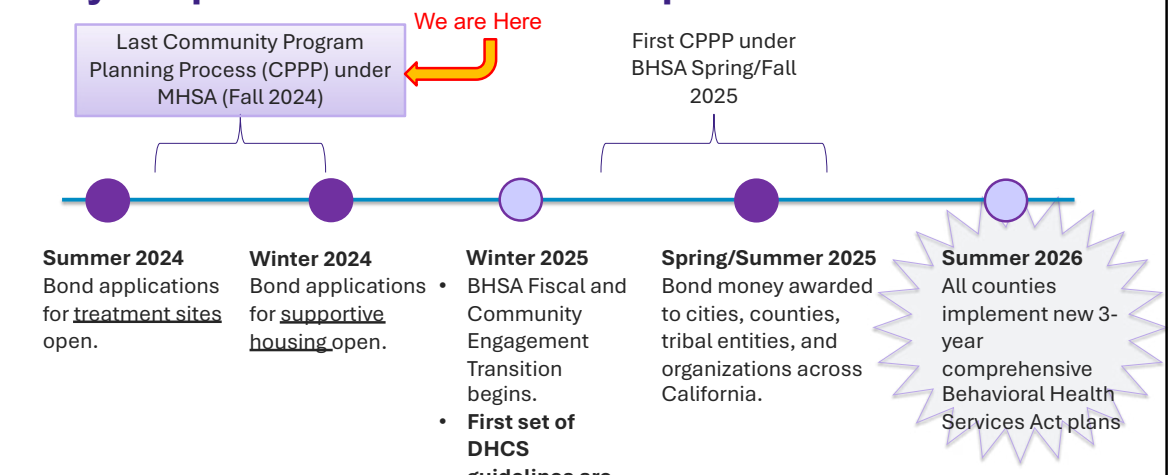
Behavioral Health Transformation (Proposition 1) - Overview

- Philosophical shift from prevention, intervention, and treatment across the mental health spectrum to focus on the **most severely mentally ill individuals**.
- Inclusion of eligible programming for those with substance use conditions.
- Significant focus on housing and homelessness.
- Statewide focus on increased accountability and transparency
- This change builds upon current and ongoing efforts to support vulnerable populations living with the **most significant** mental health conditions and substance use disorders.



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Key Proposition 1 and BHSA Implementation dates*



* As of 5/15/2024 https://mentalhealth.ca.gov/

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Transitioning from MHSA to BHSA Implementation

NEW Resources

- Transitions website: Behavioral Health Transformation (ca.gov)
- New State website: Mental Health for All: https://mentalhealth.ca.gov/
- Alameda County Behavioral Health Department MHSA website: https://acmhsa.org/bhsa/
- California Association of Counties (CSAC): https://www.counties.org/proposition-1

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All Hands On Health (Sept 2024) 14

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Listening Session



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Time to Rank the Three (3) Community Need Areas you would like to talk about today

1. Access, Coordination and Navigation to Services
2. Behavioral Health Workforce
3. Crisis Continuum
4. Housing Continuum
5. Substance Use
6. Community Violence and Trauma
7. Child/Youth/Young Adult Needs
8. Adult/Older Adult Needs
9. Needs of Family Members
10. Needs of Veterans
11. Needs of Re-entry Community

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For more information email us at MHSA@acgov.org or visit us at www.ACMHSA.org

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THANK YOU

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ALAMEDA COUNTY BEHAVIORAL HEALTH Mental Health Services Act (MHSA)
Community Input Survey for FY 25/26 Annual Plan Update

Survey Instructions

English

The MHSA was passed by California voters in 2004 and is funded by a one percent income tax on personal income in excess of $1 million per year. It's designed to expand and transform California's behavioral health system to better serve individuals with, and at risk of, serious mental health issues, and their families. MHSA Programs in Alameda County focus on reducing seven negative outcomes that may result from untreated mental illness: suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes.

The MHSA Division wants your input to help strengthen its mental health and wellness programs to better serve you and your community over the next year. In preparing this survey, we reviewed various existing data sources of community Behavioral Health needs. We'd like your assistance in prioritizing these existing needs and offering us ideas/strategies/solutions to these needs.

There are 24 voluntary questions in the survey and it takes about 10 minutes to complete. All responses are anonymous and optional, you're welcome to leave questions blank. For questions, please contact the MHSA Division at MHSA@acgov.org.

Thank you for your help with this community effort!

1. Please select the one that best applies to you:

- ◯ **Resident of Alameda County**

- ◯ Non-resident of Alameda County
- ◯ I have family/loved ones that reside in Alameda County
- ◯ I work in Alameda County
- ◯ I am part of the behavioral health, SUD or wellness workforce in Alameda County
- ◯ None of the above

2. Do you or someone close to you use behavioral health care services (either mental health or substance use) in Alameda County?

- ◯ Yes
- ◯ No
- ◯ Unsure

3. Are there enough mental health services available in Alameda County in the language(s) you speak from your specific culture/identity background?

- ◯ Yes
- ◯ No
- ◯ Unsure

4. Are you aware of changes coming to mental health services in Alameda County as a result of voters passing Proposition 1 - Behavioral Health Services Act (BHSA)?

- ◯ Yes
- ◯ No

5. If you answered 'YES' to the previous question, if you could move 7% - 14% of overall funding from one category to another: Which category would you move *FROM*?

- ◯ *Housing Interventions* - targets housing individuals who are undergoing homelessness due to serious mental illness, serious emotional disturbance, and/or substance abuse disorder.
- ◯ *Full Service Partnerships* - programs are designed for individuals with serious emotional disturbance (SED) or a severe mental illness (SMI) who would benefit from an intensive service program. The foundation of Full Service Partnerships is doing "whatever it takes" to help individuals on their path to recovery and wellness.
- ◯ *Behavioral Health Services & Supports* - includes crisis, outpatient treatment, early intervention, outreach and engagement, workforce education and training, capital facilities, technological needs, and innovative pilots and projects.

6. Which category would you move the 7% - 14% of funding *TO*?

- ◯ *Housing Interventions* - targets housing individuals who are undergoing homelessness due to serious mental illness, serious emotional disturbance, and/or substance abuse disorder.
- ◯ *Full Service Partnerships* - programs are designed for individuals with serious emotional disturbance (SED) or a severe mental illness (SMI) who would benefit from an intensive service program. The foundation of Full Service Partnerships is doing "whatever it takes" to help individuals on their path to recovery and wellness.
- ◯ *Behavioral Health Services & Supports* - includes crisis, outpatient treatment, early intervention, outreach and engagement, workforce education and training, capital facilities, technological needs, and innovative pilots and projects.

7. From our review, we identified 11 broad areas of community need. Please rank these needs in order of importance from your perspective. (*"1" is most important;*

"11" is least important). For definitions of the Categorized Needs click here.

☐	Access, Coordination and Navigation to Mental Health or Substance Use Services
☐	Behavioral Health Workforce
☐	Crisis Continuum
☐	Housing Continuum
☐	Substance Use
☐	Community Violence and Trauma
☐	Needs of Child/Youth/Young Adult Needs
☐	Needs of Adult/Older Adult
☐	Needs of Family Members
☐	Needs of Veterans
☐	Needs of the Re-entry Community

8. For the Area of Need that you *ranked as #1, most important*, please share any ideas/strategies/solutions to help us improve this area for communities in Alameda County.

9. *What did We Miss?* Please share other concerns or solutions that you have that haven't been mentioned.

10. In which part of Alameda County do you *LIVE and or WORK and or CARE FOR SOMEONE*?

Other (please specify)

11. My AGE RANGE is:

- Under 16
- 16-25
- 26-59
- 60 and over
- Prefer not to answer

12. What language do you primarily receive services in?

13. What is your current *GENDER IDENTITY*?

- Woman/Female
- Man/Male
- Genderqueer or Gender Fluid
- Transgender: Male to Female

- ◯ Transgender: Female to Male
- ◯ Non-binary (neither male nor female)
- ◯ Two-Spirit (a term used by some Native American/Indigenous individuals)
- ◯ Prefer not to answer

Other Gender Identity (please specify)

14. Which of the following *BEST REPRESENTS* how you think of yourself?

- ◯ Straight/heterosexual (not lesbian or gay)
- ◯ Gay/Lesbian
- ◯ Bisexual
- ◯ Same gender loving
- ◯ Asexual
- ◯ Pansexual
- ◯ Prefer not to answer
- ◯ Other (please specify)

15. What is your *ETHNICITY*?

- ◯ Hispanic/Latino
- ◯ Non-Hispanic/Non-Latino
- ◯ Prefer not to answer

16. What is your *RACE*? (Please select all that apply)

- ☐ African-American/Black

- [ ] American Indian/Alaskan Native
- [ ] Asian
- [ ] Pacific Islander/Native Hawaiian
- [ ] White/Caucasian
- [ ] Prefer not to answer
- [ ] Other (please specify)

17. If you marked "*ASIAN OR PACIFIC ISLANDER*" under question 16, please tell us about our nationality or country of origin? (Please select all that apply)

- [ ] Asian/Indian
- [ ] Cambodian
- [ ] Chinese
- [ ] Filipino/a
- [ ] Japanese
- [ ] Korean
- [ ] Samoan
- [ ] Taiwanese
- [ ] Tongan
- [ ] Vietnamese
- [ ] Other (please specify)

18. Which of the following *STAKEHOLDER GROUP(s)*, do you primarily represent? (Please select all that apply)

- [ ] Active Military/Reserve or Guard/Veteran
- [ ] Caregiver
- [ ] Community Member
- [ ] Consumer
- [ ] Education
- [ ] Faith Community
- [ ] Family member
- [ ] Former involvement with the foster care system
- [ ] Healthcare worker
- [ ] Law enforcement agency
- [ ] Provider of mental health or substance use disorder programming
- [ ] Re-entry
- [ ] Student
- [ ] Prefer not to answer
- [ ] Other (please specify)

19. What kind of insurance (if any) do you have?

- ○ I don't have any health insurance.
- ○ Medi-Cal
- ○ Private health insurance
- ○ Medicare
- ○ Medi-Medi (both Medi-Cal and Medicare)
- ○ Decline to answer

20. Do you agree with this statement: My Mental Health Services/Substance Use coverage meets my needs.

- ◯ Yes
- ◯ No
- ◯ Unsure

21. In the past two months, have you been consistently living in stable housing that you own, rent, or stay in as part of a household?

- ◯ Yes
- ◯ No
- ◯ Other (please specify)

22. What types of support services would someone with behavioral health challenges need in order to maintain stable housing?

- ☐ Case Management
- ☐ Employment Support
- ☐ Financial Assistance
- ☐ Legal Support and Advocacy
- ☐ Mental Health Counseling
- ☐ Peer Specialist
- ☐ Re-entry Support
- ☐ Substance Use Counseling
- ☐ Supportive Housing Options

☐ Other (please specify)

23. Please provide your contact information if you'd like to be entered into our raffle.

Full Name	
Agency/Org	
Email Address	
Phone Number	

24.

Thank you again for taking the time to provide your input on the County of Alameda's MHSA Community Survey. We appreciate you! To learn about more ways to get involved, please visit our website at https://acmhsa.org/

This area is to rate the ease of completing this survey with 5 stars being the easiest and 1 star being difficult.

Powered by SurveyMonkey
See how easy it is to create surveys and forms.

Privacy & Cookie Notice

[1] U.S. Census Bureau. "U.S. Census Bureau QuickFacts: Alameda County, California". Accessed on January 17, 2024.

[2] U.S Census Bureau, Population Division. Annual Estimates of the Resident Population for Counties in California: April 1, 2020 to July 1, 2023(CO-EST2022-POP-06), accessed December 29, 2024.

[3] U.S. Census Bureau, U.S. Department of Commerce. "Age and Sex." American Community Survey, ACS 1-Year Estimates Subject Tables, Table S0101, 2023, https://data.census.gov/table/ACSST1Y2023.S0101?q=Alameda County Age Groups. Accessed on December 30, 2024.

[4] U.S. Census Bureau. "RACE." Decennial Census, DEC Redistricting Data (PL 94-171), Table P1, 2020, https://data.census.gov/table/DECENNIALPL2020.P1?g=050XX00US06001&y=2020&d=DEC Redistricting Data (PL 94-171). Accessed on January 2, 2024.

[5] U.S. Census Bureau. "HISPANIC OR LATINO, AND NOT HISPANIC OR LATINO BY RACE." Decennial Census, DEC Redistricting Data (PL 94-171), Table P2, 2020, https://data.census.gov/table/DECENNIALPL2020.P2?g=050XX00US06001&y=2020&d=DEC Redistricting Data (PL 94-171). Accessed on January 2, 2024.

[6] U.S. Census Bureau, U.S. Department of Commerce. "Language Spoken at Home." American Community Survey, ACS 1-Year Estimates Subject Tables, Table S1601, 2023, https://data.census.gov/table/ACSST1Y2023.S1601?g=050XX00US06001. Accessed on December 31, 2024.

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1. https://www.infrastructure.buildingcalhhs.com/ HCIP

2. https://www.dhcs.ca.gov/provgovpart/Pages/California-Opioid-Settlements.aspx

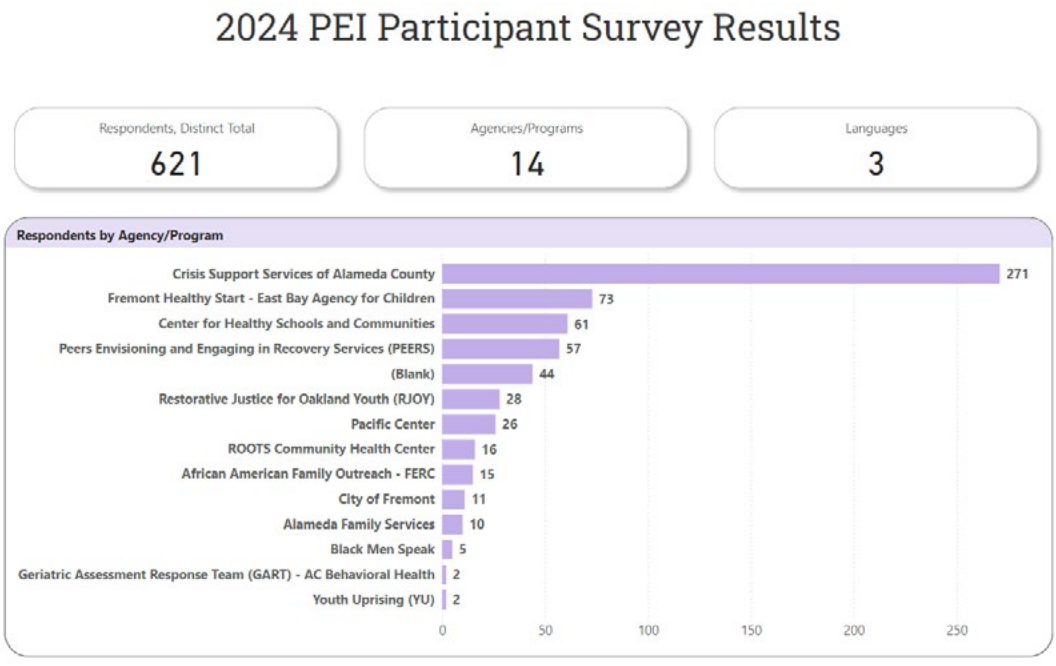
Alameda County's Mental Health Services Act (MHSA) Division collaborated with Prevention and Early Intervention (PEI) and Underserved Ethnic Language Population (UELP) programs to create an outcome-based survey aimed at gathering feedback from PEI/UELP participants who have received services via MHSA-funded counseling services, workshops, community events, and other support programs.

First developed in 2014 and administered in 2015, the survey has undergone multiple revisions from 2016 to 2023. UELP providers vetted, implemented each updated version, and ensured accessibility and equity through language justice by translating the survey into 23 languages. In early 2024, UELP providers participated in a workgroup to evaluate the survey tool, concluding that it would remain unchanged, with updates limited to translation needs only.

The following data reports focus on key domains such as identity formation, mental health perceptions, community wellness, cultural connections, resource access, transformation of mental health services, and workforce development. Ultimately, we aim to identify strengths and areas for expansion in our services, ensuring we meet the community's and provider's needs as effectively as possible.

Please click here to view the PEI/UELP 2024 Participant Survey Results:

Below is an example of participant survey result that can be viewed on the website:



Please also visit click here to view the 2025/2026 PEI Annual Report.

Appendix E-1 | MHSA WET Training Institute Training Calendar FY23/24

TOTAL # Trainings: 59	2023/24 FISCAL YEAR TALLIES July 2023-June 2024		#Attendees: 2171	#BH Staff: 476	# CBO Staff: 1695	#CE Certs distributed: 737	# Psych Certs distributed: 20	# CE's Offered (all) 125.5	Ces W/ Psych: 87
Date	**Training Title**	**Content Area(s) covered**	**#Attendees**	**#BH Staff**	**# CBO Staff**	**#CE Certs distributed**	**# Psych Certs distributed**	**# CE's Offered (all)**	**Ces W/ Psych**
7/1/2023	**July 2023**								
7/12/2023	Child and Family Team (CFT) Facilitator Training (Private Audience, by Invite only)	Clinical/Family relations	18	1	17	11	0	6.0	0.0
7/20/2023	CLAS Standards and Stigma; Discrimination Reduction in Behavioral Health (CLAS - OnTrack)	CLAS	133	15	118	26	0	3.0	0.0
8/1/2023	**Aug. 2023**								
8/31/2023	Trauma-Informed & Culturally-Responsive Practices in Working w/ Asian American, Native Hawaiian & Pacific Islander (AANHPI) Clients *(rescheduled from 5/30/23)*	CLAS	66	13	53	28	0	3.0	0.0
9/1/2023	**SEPTEMBER '23**								
9/12/23 DAY 1	**Older Adult Training and Certification Program (DAY 1 - 6 modules in one day)**	Older Adult Education and Service	69	23	46	28	0	6	0
9/21/2023 DAY 2	**Older Adult Training and Certification Program (DAY 2 - 6 modules in one day)**	Older Adult Education and Service	63	21	42	17	0	6	0
10/1/2023	**Oct. 2023**								
10/13/2023	Child and Family Team (CFT) Facilitator Training (Private Audience, by Invite only)	Clinical/Family relations	11	0	11	3	0	6.0	0.0
10/16/2023	Mental Health Services with Latinx/Latiné Populations An Anti-Racist and Intersectional Approach *(ONTRACK)*	CLAS/LGBTQ	103	5	98	27	0	3.0	0.0
10/27/2023	Law and Ethics for County Healthcare Providers	Legal/Ethical	105	79	26	59	3	6.0	6.0
10/27/2023	Diagnosis and Management of Anxiety African Americans: From Childhood to Young Adult *(Pathways to Wellness/AATA Pgrm)*	AfrAm Tech Assistance Program	96	6	90	32	0	3.5	0
11/1/2023	**Nov. 2023**								
11/2/2023 & 11/3/2023	Suicide Assessment (Youth Focused)	Suicide Intervention	7	0	7	7	0	6	0
11/7/2023	Youth Mental Health First Aid	MHFA	19	10	9	n/a	0	0	0
12/1/2023	**Dec. 2023**								
12/1/2023	Between a Rock and a Hard Place: Intersectional Experiences, Stigma-Related Stress, and Behavioral Health Among African American LGBTQ+ Individuals (AATA program)	CLAS/AATA	67	6	61	18	0	3.5	0
12/1/2023	Eating Disorder Treatment: Best Practices	Youth/Eating Disorder	55	26	29	32	1	6	6
1/1/2024	**Jan. 2024**								
1/12/2024	Suicide Crisis Intervention (Sally Walstrom, trainer)	Crisis and Suicide Intvn	20	4	16	14	1	6	6
1/17/2024	Tackling Tobacco Together:A Deep Dive into Tobacco Cessation Treatment within Priority Populations	SUD Tobacco Cessation	5	0	4	1	0	3	3
1/24/2024	Mental Health First Aid (Adult focused)	MHFA	27	8	19	0	0	0	0
1/26/2024	Self - Care: Perimenopause and Menopause among African Americans (AATA)	CLAS and AfrAm Technical Assistance Pgm	86	15	71	29	0	3.5	3.5
1/30/2024	Learn Techniquest that Support Self and Co-Regulation from a Traua-Informed Perpective (SENECA DOING CEs)	Trauma Informed	23	12	11	13	0	3	0
1/31/2024	Indigenous Perspective on Healing from Historical & Contemporary Trauma (rescheduled from 12/6/23)	CLAS	106	12	94	26	3	3	3
2/1/2024	**Feb. 2024**								
2/16/2024	Youth Mental Health First Aid (MHFA) Training - for OAKLAND USD Teachers and Staff	MHFA	16	0	16	0	0	0	0

2/21/2024 (Rescheduled from 2/14, on Feb 13)	Tackling Tobacco Together: A Deep Dive into Tobacco Cessation Treatment within Priority Populations	SUD Tobacco Cessation	9	0	9	1	0	3	3
2/23/2024	Environmental Impacts on African American's Mental Health (AATA - Pathways to Wellness)	CLAS	91	4	87	32	0	3.5	3.5
2/29/2024	Developing Effective Communication Strategies for Crisis Intervention in Behavioral Health	Communication /DeEscalation	22	17	5	15	0	6	6
3/1/2024	**Mar-24**								
3/6/2024	Community Engagement and Participatory Approaches to Improving Community Health Utilizing Birth Justice as a Case Study (ONTRACK)	CLAS	21	8	13	6	0	3	2
3/8/2024	Adult Mental Health First Aid (MHFA) Training	MHFA	25	0	25	0	0	0	0
3/15/24	Youth Mental Health First Aid (MHFA) Training	MHFA	24	0	24	0	0	0	0
3/20/2024	Tackling Tobacco Together:A Deep Dive into Tobacco Cessation Treatment within Priority Populations	SUD Tobacco Cessation	7	1	6	3	1	3	3
3/22/2024	African American and Youth Homelessness - A Focus on African American Adolescents and Experienced Trauma	CLAS	83	12	71	31	1	3.5	3.5
3/28/2024	Mental Health First Aid (Youth Focused)	MHFA	25	1	24	0	0	0	0
	April 2024								
APRIL 10 2024 **END of Eating Disorder 8-part SERIES** (series ran weekly from **2/14 -4/10 2024**)	Treating Eating Disorders in Children and AdolescentsS (8-part series) WEEKLY DATES: 2/14 - 2/21 - 2/28 - 3/6 - 3/20 - 3/27 - 4/3 - 4/10	Eating Disorders Children/TAY	16	12	4	7	0	12.0	0.0
4/19/2024	Demystifying the Science Behind Psychiatric Medications: Understanding Their Mechanisms of Action and Managing Side Effects in African American Patients (AATA-PTW)	CLAS	130	34	96	48	1	3.5	3.5
4/22/2024	Intermediate MI Skills for Professionals Working in Law Enforcement and Juvenile Justice (Trainer: Sarah Solis, LCSW)	Motiviational Interviewing	14	2	12	6 (2 by ACBH and 4 by ABW)	0	6	6
5/1/2024	**May 2024**								

5/2/2023	Strucural Competency - On Track	CLAS	28	4	24	19	0	3	2.5
May 6 & 7, 2024	ADULT Suicide Assessment and Intervention for Mental Health Professionals	Crisis and Suicide Intvn	54	21	33	23	0	6	6
5/10/2024	CFT (Child and Family Teaming)	Clinical/Family relations	21	0	21	9	0	6	0
5/13/2024	Mental Health First Aid (Youth Focused)	MHFA	0	22	22	0	0	0	0
5/6/2024	What more can we do to help all clients recover from tobacco use challenges?	Tobacco/SUD	13	4	9	3	0	1.5	1.5
5/30/2024	DeColonizing How we Care for Asian Americans_CLAS/OnTrack	CLAS/ Cultural Competency	55	14	41	33	0	3	0
5/31/2024	Suicide Rates for Individuals Who Are Incarcerated: A Disproportionate Detainment of African Americans	Suicide/Crisis/Incarcerated/ AfrAm	176	25	151	59	1	3.5	3.5
6/1/2024	**June 2024**								
6/4/2024	Eating Disorder Treatment: Best Practices (with Dr. Lynn Tracy)	Eating Disorders Children/TAY	41	15	26	20	2	6	6
6/11/2024 - 6/12/2024	YOUTH Suicide Assessment and Intervention for Mental Health Professionals	Crisis and Suicide Intvn	39	12	27	20	4	6	6
1/0/1900	Impact of Discrimination on Mental Health and General Health (Hybrid) (AATA/Pathways to Wellness)	CLAS and AfrAm Technical Assistance Pgm	139	12	127	37	2	3.5	3.5

ACBH – Alameda County Behavioral Health

Join our Internship Program today!

Work alongside licensed professionals, gaining valuable knowledge in therapy, crisis intervention, and mental wellness strategies.



Internship, Fellow and Resident opportunities available:

- Clinical counseling
- Co-occurring disorder (mental health & substance abuse)
- Crisis Intervention & Case Management
- Integrated health care services in Child & Young Adult, Transitional Age Youth, Adult & Older Adult community-based programs.

Scan Here

Contact us!

For additional information please contact us at **acbhinterns@acgov.org** or visit our website **http://www.acbhcs.org/intern-and-trainee-programs/**

Behavioral Health Department
Alameda County Health



Behavioral Health Department
Alameda County Health

STUDENT INTERN INFORMATION FORM

Student Information:

Once you have completed this form, please email it to: ***acbhinterns@acgov.org***

Student Name: Enter first & last name		
TB (Tuberculosis) Clearance: ☐**Yes** ☐**No** **Date of Clearance:** Click arrow, then use calendar		
Languages Spoken (other than English): **Spanish**	**Ethnicity: Please choose one** Click here to enter text.	
Name of School/Institution: Enter name of school		
Major(s): Enter major(s)	**Year Entering Graduate Program:** ☐ **1st Year** ☐ **2nd Year**	
Current Term: ☐**Fall** ☐**Spring** ☐**Summer**		
Field Placement Coordinator: Enter first & last name	**Coordinator's Email Address:** Enter email address	**Coordinator's Phone Number** Enter phone number

Contact Information & Additional Details

Mailing Address:

Street City State Zip Code

Emergency Contact Information:

Name Phone number

How did you hear about this internship opportunity?

☐ **Website** ☐ **County Employee** ☐ **School**

☐ **Internship Fair** ☐ **Other** _____

Behavioral Health Department
Alameda County Health

Memo

Date: August 20, 2024
To: ACBH Staff and Community Partners

Subject: 2024-25 GRADUATE INTERN STIPEND PROGRAM (GISP) APPLICATION NOW AVAILABLE

Alameda County Behavioral Health (ACBH) is pleased to announce that the **FY2024-25** application cycle for the **Graduate Intern Stipend Program (GISP) is now open**!

The application, instructions, and eligibility requirements are posted HERE.

PLEASE INSTRUCT STUDENTS TO COMPLETE AND SUBMIT THE APPLICATION ONLINE ON OR BEFORE THE DEADLINE OF **MONDAY, OCTOBER 14, 2024.**

We are looking for student applicants who meet eligibility requirements and are from diverse backgrounds to help increase the cultural responsiveness of our system, bridge gaps in skill sets, and improve language capacity. Please inform your 2024-25 school year students about this great opportunity to enhance their internship experience.

Each stipend is worth up to **$6,000** for a maximum of 720 internship hours. The stipend amount awarded will be pro-rated if the student works less than the maximum 720 hours.

How the payment for the Graduate Intern Stipend Program (GISP) is calculated based on the number of hours worked:

- **Maximum Stipend**: The maximum stipend amount a student can earn is $6,000.
- **Maximum Hours**: The stipend is tied to a maximum of 720 internship hours.
- **Pro-Rated Stipend**: If a student works fewer than 720 hours, the stipend will be adjusted (pro-rated) accordingly. This means the stipend amount will be less than $6,000 and will be calculated based on the actual hours worked.

For example, if a student works 360 hours, which is half of the maximum hours, they will receive half of the maximum stipend, or $3,000. The exact amount a student receives will depend on the total number of hours they complete during their internship.

For questions, please contact the ACBH Internship Program at:
ACBHInterns@acgov.org

Health.AlamedaCountyCA.gov/ACBHD


Instagram
Log In
Sign Up
2024-2025 Graduate Intern Stipend Program (GISP)
Alameda County Behavioral Health is pleased to announce that the FY2024-25 application cycle for the Graduate Intern Stipend Program (GISP) is now open!
Applications Due:
Monday, October 14, 2024
Graduate Intern Stipend Program
acbhcs.org/plan-administration/graduate-intern-stipend-program/
Behavioral Health
dare2bwell • Follow
dare2bwell Alameda County Behavioral Health is thrilled to announce that the FY2024-25 Graduate Intern Stipend Program (GISP) application is officially open!
We're especially looking for students from diverse backgrounds in order to bridge skill gaps, enhance language capacity, and more.
Submit your application online by Monday, October 14, 2024. You could earn up to $6,000 for your internship!
Don't miss out on this fantastic chance to boost your career while making a meaningful impact.
You can find the application,
10 likes
September 12, 2024
Log in to like or comment.

Behavioral Health Department
Alameda County Health

County of Alameda Behavioral Health Department
Request to pay Graduate Intern Stipend Claim/Invoice

Intern Information:

_____ _____ _____ _____
FIRST NAME MI LAST NAME SUPPLIER ID

_____ ☐ Check if Address changed
ADDRESS

Length of Internship: Hours per week _____ Total hours claimed _____
Period covered (date in MM/DD/YYYY format): From _____ To _____

Instruction to the Claimant:

1. Must meet Internship eligibility criteria and work in an eligible placement site.
2. Must work in an eligible ACBH county program or contracted community-based organization.
3. Must maintain "good academic standing" while enrolled in the university degree program.
4. Must not receive another type of stipend from a different funding source, e.g. Cal SWEC.

Claimant's Certification: *I certify that I qualify for the stipend payment and have worked the required number of internship hours, in accordance with the MHSA Workforce Education and Training (WET) Graduate Intern Stipend Program for FY 2024-25, approved by the Board of Supervisors. Ref. minute order dated 4/25/23.*

_____ _____
INTERN'S SIGNATURE DATE

Intern's Supervisor Certification: *I certify that the intern meets the required eligibility requirement; has exhibited satisfactory performance; and completed the required internship hours. Supporting documents are in our files and will be available upon request.*

_____ _____
INTERN SUPERVISOR'S SIGNATURE DATE

For ACBH W.E.T Unit use: Workforce Education and Training Manager Certification: *I certify that the intern is entitled to receive a stipend in the amount of:*

$ _____. _____ _____
SIGNATURE DATE

For ACBH Finance Unit use: Use Direct Claim Form 110-50, use code 16 (Legally Authorized or Board Approved)

VOUCHER: BHSVC _____ DATE: _____

ACCOUNT: 610464 FUND: 10000 DEPARTMENT: 350513 PROGRAM: 41447 BUDGET YEAR: 2025

PAYMENT HANDLING_____ PAY COMMENTS: _WET Stipend for period covering _____to_____

Reviewed By: _____ DATE: _____

Rev 1.4.25

Behavioral Health Department
Alameda County Health

ALAMEDA COUNTY BEHAVIORAL HEALTH DEPARTMENT

WORKFORCE DEVELOPMENT EDUCATION AND TRAINING

NEEDS ASSESSMENT REPORT

BRIGHT RESEARCH GROUP

Bright Research Group
1211 Preservation Park Way
Oakland, CA 94612
www.brightresearchgroup.com

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Executive Summary

The Alameda County Behavioral Health Department (ACBHD) engaged Bright Research Group (BRG) to conduct the Workforce Development Education and Training (WET) Needs Assessment to assess existing strategies, current gaps, and emerging needs of the ACBHD's workforce. BRG utilized a mixed-methods approach comprised of focus groups with a total of 21 participants, as well as a survey with 85 respondents. The following key findings provide a snapshot of provider perspectives with respect to workforce, education and training needs:

Workforce Capacity and Needs

1. Hiring and recruiting staff reflective of the client population is both a priority and a challenge for community-based providers.
2. There is a shortage of bilingual and racially diverse staff, especially clinicians.
3. Providers who participated in the needs assessment reported experiencing challenges in meeting the complex health and social needs of their clients, which can contribute to burnout.
4. Providers expressed support for the critical role that the family and peer workforce can play in meeting their clients' needs and reported engagement efforts.

Pipeline Programs and Preparation of a Diverse Workforce

1. Intern diversity does not align with the cultural and linguistic diversity of Alameda County's client population.
2. Supervisors and former interns reported mixed levels of satisfaction and effectiveness with the intern program.
3. Providers who participated in the survey offered recommendations to strengthen and improve the ACBHD intern programs.

Training and Education Needs

1. Providers have mixed feedback on current WET unit offerings.
2. Providers have an interest in a variety of training formats and delivery and offered recommendations to improve WET trainings.
3. Providers reported a strong demand for rigorous trainings that enable them to deliver culturally responsive services to Alameda County's diverse client populations and specifically requested advanced clinical-skills training.
4. Providers feel most prepared to meet the needs of Latino/Hispanic communities but reported a need for training to engage clients across other ethnic and cultural backgrounds.
5. Providers expressed frustration with certain elements of the bureaucracy of the behavioral healthcare system and value up-to-date information.

Given these findings, BRG offers the following recommendations:

1. Sustain marketing efforts to promote WET training and education offerings with community-based providers.
2. Continue to offer advanced-skills trainings in topics suggested by providers.
3. Routinely gather training feedback from providers and share format and delivery preferences with contracted trainers to integrate them into future offerings.
4. Sustain training offerings for certified peer specialists and other peer and family professionals to support the professional development of the peer and family workforce.
5. Recruit interns for licensed clinical and case-management roles to address provider-identified workforce gaps.
6. Sustain and develop new strategies to increase the applicant pool of interns so that they better reflect the cultural, linguistic, and ethnic diversity of clients.
7. Share workforce-capacity findings with human resources and systems of care across the ACBHD to adapt hiring and recruiting strategies to address identified needs.

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INTRODUCTION

The vision of the Alameda County Behavioral Health Department (ACBHD) is to ensure that its workforce is sufficient in size, diversity, and linguistic capacity to provide culturally responsive services and supports to clients and their families that center wellness, recovery, and resiliency. To achieve its mission, the Workforce Development Education and Training (WET) unit builds and expands the capacity of staff within the ACBHD and contracted community-based organizations (CBOs). The WET team supports the behavioral health workforce across Alameda County through the following strategies:

- Behavioral Health Career Pipeline Programs
- Retention and Financial Incentives
- Internship and Psychiatry Residency Programs
- Internship and Stipend Program
- Training and Continuing Education

The goal of the WET Needs Assessment is to assess the existing strategies, current gaps, and emerging needs of the ACBHD's workforce. The WET unit engaged Bright Research Group (BRG) to conduct the assessment in 2024. This report documents the key findings and recommendations, which will be used to inform future WET unit programming and training offerings.

LEGISLATIVE LANDSCAPE

The evolving legislative landscape in California is significantly shaping the training and education needs of providers within the ACBHD network and influencing the work of the WET unit. Key legislative changes, such as the implementation of CARE Courts and the amendments to the 5150 hold criteria through Senate Bill 43 (SB 43), are demanding a higher level of expertise and specialization from behavioral health providers. CARE Courts allow for court-ordered treatment plans for individuals with severe untreated mental illnesses, necessitating specialized training for behavioral health workers to effectively engage in the legal processes and deliver integrated care.[1] Additionally, SB 43 expands the definition of "gravely disabled" to include severe substance use disorders and incorporates telehealth assessments for 5150 holds. These changes require providers to be adept in new legal frameworks, telehealth technologies, and the comprehensive management of co-occurring mental health and substance use disorders, highlighting the need for robust evidence-based training programs.[2]

Moreover, the proposed changes under Proposition 1, which aim to redesign the Mental Health Services Act (MHSA), are set to require counties to redirect one-third of mental health dollars to housing interventions, potentially at the cost of broader behavioral health services.[3] With 35% of MHSA funds now earmarked for behavioral health services and supports, and at least 51% of this allocation directed toward early intervention for individuals under 25, the resources available for workforce education and training will be significantly reduced.[3] While the impact of Proposition 1's recent passing is still being determined, county-level leaders across California have concerns about the possible changes in

1. California Lawmakers Approved CARE Court. What Comes Next?," CalMatters
2. Bill Text—SB-402 Involuntary Commitment. (ca.gov)
3. "Understanding Proposition 1," California Budget and Policy Center (calbudgetcenter.org)

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prevention and early-intervention services, particularly for communities of color.[4] Given that the majority of county mental health funding is allocated to community services and supports, counties anticipate that the re-allocation of funding to the state could result in the cancellation of CBO contracts, a reduction in county-level staff, and disruptions in prevention and early-intervention programs and services.[3]

Methods

BRG utilized a mixed-methods approach comprised of a provider survey, a CBO webinar, focus groups, interviews, and a review of background documents.

Method	Sample Size
WET Provider Survey	85
CBO Provider Webinar and Focus Groups	15
SUD Provider Focus Group	6
Key Informant Interviews with WET Leadership	3
Review of Background Documents and Existing Data	N/A

WET Provider Survey

The WET provider survey was an online survey that asked providers to answer multiple-choice and open-ended questions about training needs and priorities, workforce capacity, experience with pipeline programs, and organizational characteristics. Researchers used a "convenience sample," which is a non-probability sampling method used to gather input from a wide range of respondents. Convenience sampling does not guarantee a representative sample. The survey was distributed by the WET team to over 400 ACBHD staff providers and contracted CBO providers, who comprise over 80% of the ACBHD's workforce. The survey was completed anonymously. Respondents were incentivized to complete the survey with a drawing for a $25 electronic gift card. To enter the drawing, respondents completed a separate form that was not linked to their original survey in order to maintain confidentiality.

A total of 85 survey responses were collected, which represents a snapshot of provider perspectives regarding the workforce, education and training needs. There are over 3000 providers in the ACBHD network and results from the survey may not be representative of the general provider population. Most survey respondents described their workplace setting as a CBO (72%) or a community mental health / behavioral health agency (49%). All six of the ACBHD's systems of care were represented across survey respondents. The organizational demographics of respondents are shown in Table 1 below. For workplace setting and system of care, respondents were able to select more than one option. Please see the appendix for additional respondent demographic data, as well as the complete survey instrument.

4. "Update: California Voters Narrowly Approve Prop. 1, Gavin Newsom's Mental Health Overhaul," CalMatters

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Table 1. Organizational Characteristics of Survey Respondents

	N	%
Workplace Setting		
Community-Based Organizations	61	72%
Community Mental Health / Behavioral Health Agencies	42	49%
Hospital	6	7%
School	5	6%
Social Services Agency	5	6%
Substance Use / Outpatient Setting Withdrawal Management	5	6%
Peer Services	3	4%
State and Regional Agency	3	4%
Involuntary Treatment / Substance Use Disorder	1%	1%
Organization Size		
More than 200 employees	28	33%
51–100 employees	24	28%
20–25 employees	17	20%
Under 25 employees	8	9%
101–200 employees	8	9%
System of Care		
Child and Youth Services	67	79%
Adult and Older Adult Services	51	60%
Substance Use	25	29%
Acute and Crisis Services	20	24%
Psychiatry and Nursing Services	19	22%
Integrated Primary Care Services	15	18%
Forensic Services	10	12%

Provider Focus Groups

BRG facilitated a CBO provider webinar to gain insights about general organizational-level workforce and training needs. The WET team recruited 15 providers to attend the webinar. Most participants (93%) described their workplace setting as a community-based organization and/or a community mental health / behavioral health agency. Webinar participants represented all six of the ACBHD's systems of care, with the majority (60%) working in Child and Youth Services.

A separate small-group conversation among SUD providers was held to gain deeper insight about SUD provider specific needs and challenges. The SUD leadership team recruited six SUD providers to attend the focus group. Most participants (50%) served in program management or leadership roles, including program manager and director. Half of the participants had worked at their organization for one to three years, and the other half had tenures of over six years.

A thematic analysis of provider insights was conducted to determine trending themes from both focus groups. These themes were compared to themes across all data collection methods to identify key findings.

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Key Informant Interviews and Background-Document Review

BRG reviewed the ACBHD and WET reports, presentations, and other background documents to better understand WET guiding priorities and the context and role of the WET team. The research team also conducted two interviews with Robert Farrow, ACBHD training officer, to better understand the WET unit's role within the ACBHD. Additionally, BRG conducted one key informant interview with Dr. Karyn Tribble, ACBHD director, to learn more about WET priorities and alignment with broader ACBHD workforce goals. This WET Needs Assessment report documents key findings and recommendations to support the ACBHD in strategically addressing the current gaps and emerging needs of its workforce.

Key Findings: Workforce Capacity and Needs

The ACBHD aims to be intentional in its recruitment and retention efforts, given Alameda County's diversity and ongoing labor challenges in the behavioral health sector. Through the needs assessment, the ACBHD wanted to understand the diversity of the workforce and the existing strategies to recruit and retain a diverse workforce. The WET unit contributes to preparing a diverse workforce through its Behavioral Health Career Pipeline and Internship Programs.

***Finding 1:* Hiring and recruiting staff reflective of the client population is both a priority and a challenge for community-based providers.**

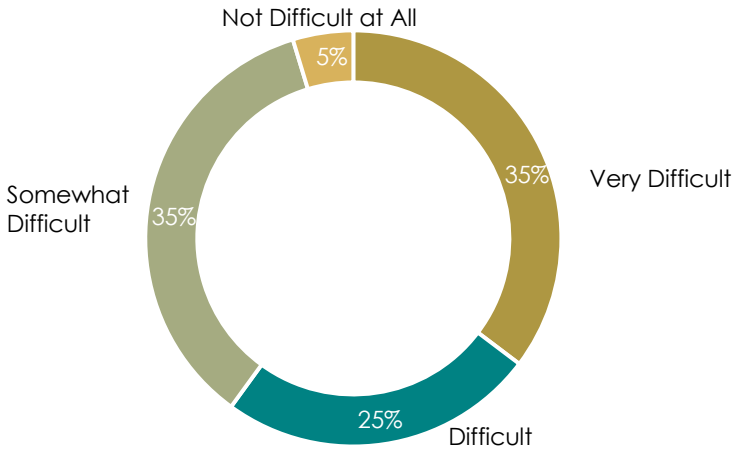
The retention of multilingual and diverse staff is a high-priority workforce need for CBO partners. Providers reported during the CBO provider webinar that they highly value the contributions of multilingual and diverse staff, emphasizing the importance of building a workforce that reflects the demographics of the client populations their organizations serve. More attractive compensation packages offered by government agencies, especially at the county level, draw high-quality staff away from CBOs and compound these issues. These providers also emphasized that the struggle to retain staff is particularly pronounced for SUD counselors, who receive less favorable compensation compared to their mental health counterparts. The bureaucratic duties of the job include substantial paperwork and strict audit protocols, which make these positions less desirable.

> *"There is a large Middle Eastern population in our Newark location, and we have no staff to reflect that population."*

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The challenge of hiring and recruiting staff who match the cultural and linguistic backgrounds of the populations served was also cited as a concern in the WET provider survey. Overall, most providers reported that their organizations retain staff well but face challenges with recruiting and hiring diverse staff. As seen in Figure 1, almost all providers reported some difficulty with filling open positions.

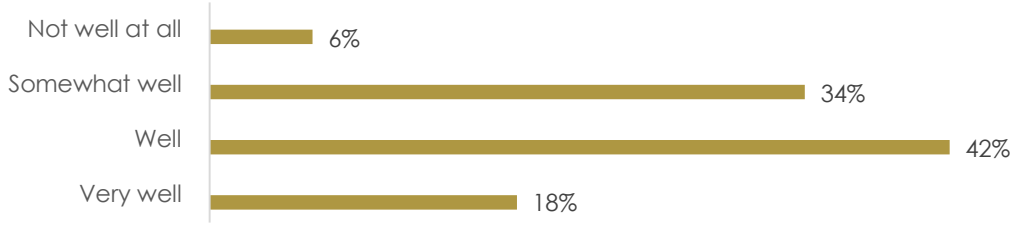
Figure 1. Provider-Reported Difficulty in Filling Open Positions, N = 85



Source: 2024 WET Provider Survey

In a budget-restrictive environment, employee retention is a high priority for the ACBHD's leadership. Survey respondents did not report significant challenges with staff retention, as shown in Figure 2.

Figure 2. Provider-Reported Effectiveness of Staff Retention, N = 85



Source: 2024 WET Provider Survey

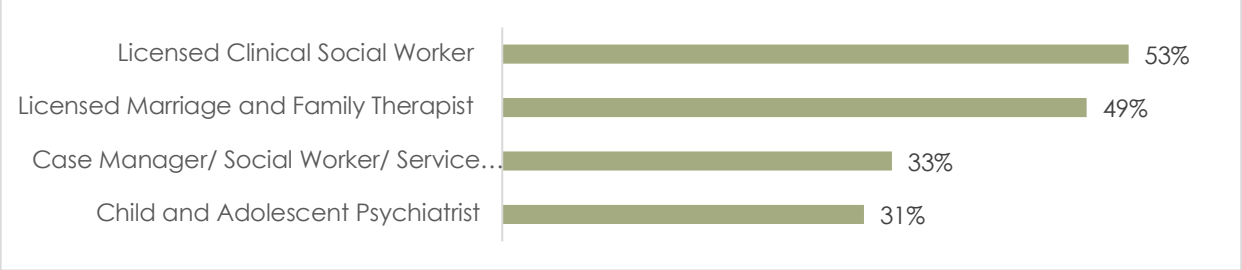
Providers who completed the survey noted the biggest challenges in recruiting and hiring. As seen in Figures 3 and 4, providers reported that licensed clinical roles were the most difficult positions to recruit and hire for.

Figure 3. Percentage of Respondents Reporting Positions Most Challenging to Recruit For, N = 85



Source: 2024 WET Provider Survey

Figure 4. Percentage of Respondents Reporting Positions Most Challenging to Hire For, N = 85



Source: 2024 WET Provider Survey

Moreover, during the CBO provider webinar, the small group conversation among SUD provider, and in the provider survey, providers described the challenges in recruiting and retaining BIPOC clinicians, citing issues with noncompetitive salaries and benefits.

> *"The lack of BIPOC clinicians is a significant issue, and we struggle to recruit and retain these essential staff members."*

Finding 2: ***There is a shortage in bilingual and racially diverse staff, especially clinicians.*** Providers spoke to the critical need for enhanced linguistic diversity and cultural competence within the workforce. Feedback from the CBO provider webinar, the provider survey, and the small group conversation among SUD providers surfaced a significant shortage of staff who can effectively serve

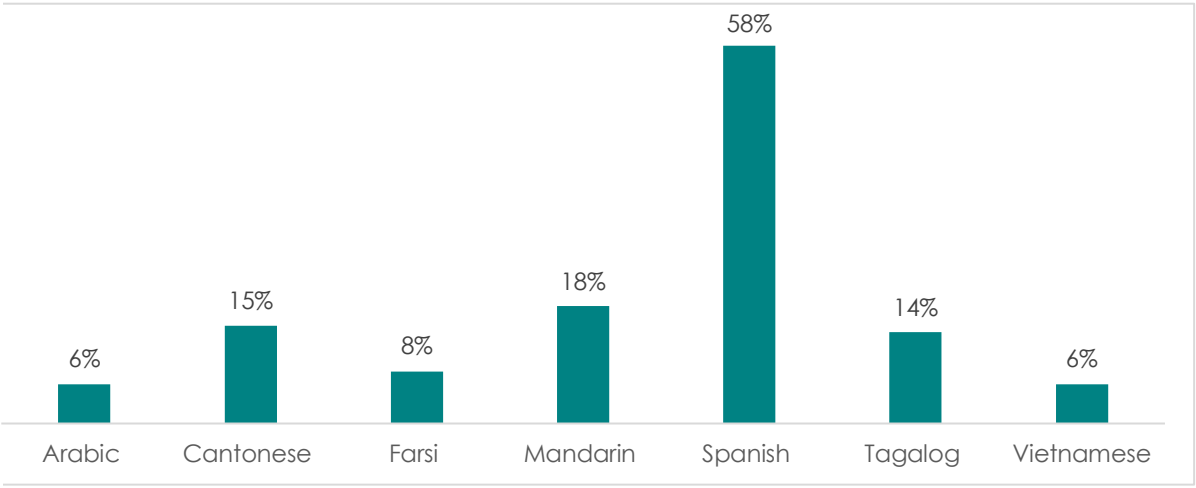
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specific community groups, such as the growing Middle Eastern population, and underscored the need for increased language capacity, particularly in Asian languages.

> *"Not enough bilingual/bicultural mental health professionals to serve diverse underserved/unserved immigrant and refugee communities."*

Notably, over half of the survey respondents reported using languages other than English with their clients, with Spanish being the most common (58%), as seen in Figure 5. Respondents were able to select more than one language option, including "other." Providers reported speaking "other," including an Alaska Native Language, French, Ki'che', Italian, Russian, Khmer, Tibetan, Nepali, Rwandan, Tigrinya, Korean, Japanese, and Punjabi.

Figure 5. Percentage of Providers Reporting Speaking Languages with Clients Other than English, N = 85



Source: 2024 WET Provider Survey

SUD providers further emphasized the impact of limited linguistic capacity on their ability to provide ethical and effective care. Providers noted that often the evidence-based models they are required to use do not have documentation available in many languages other than English. Providers stated that when they do translate documents, it is often a long and expensive process.

> *"It makes me feel really uncomfortable signing clients up for things that they don't understand."*

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Finding 3: ***Providers who participated in the needs assessment reported experiencing challenges in meeting the complex health and social needs of their clients, which can contribute to burnout.***

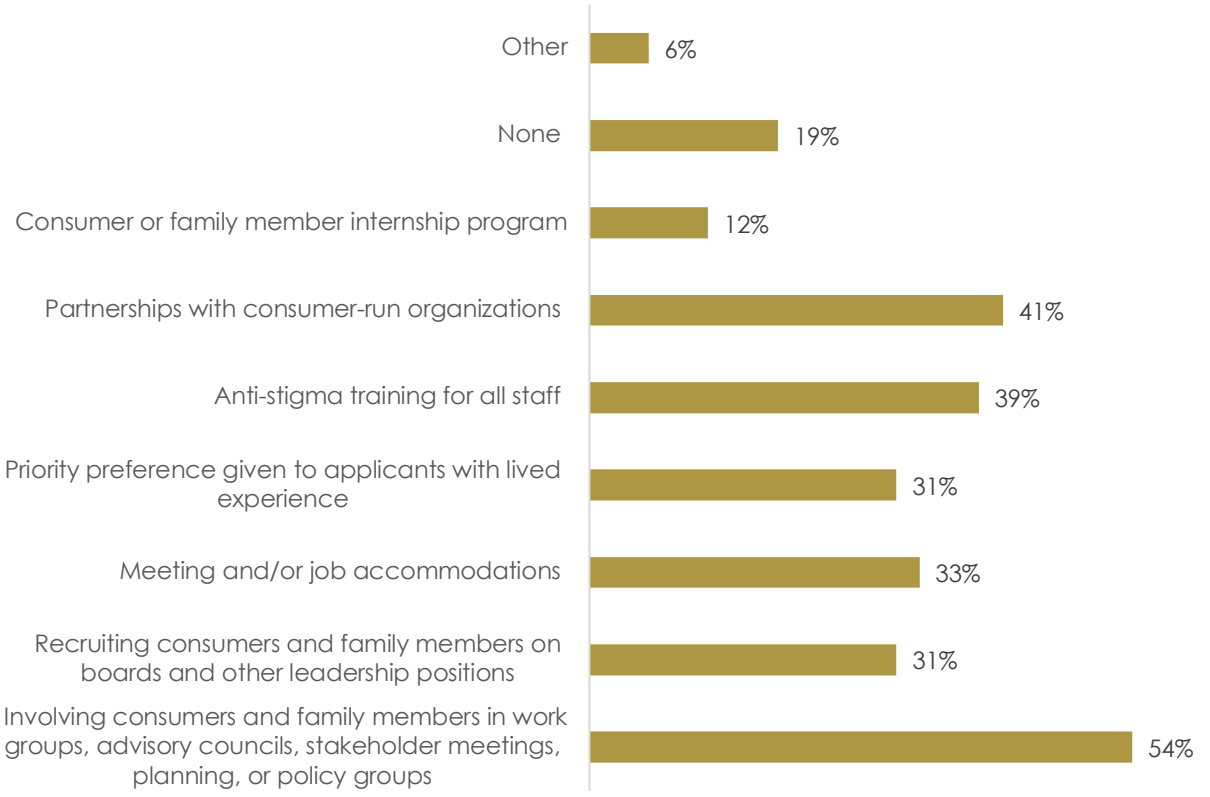
Some providers explained that a heavy workload and an inability to meet the complex and diverse needs of their client population lead to burnout and compromise the quality of care. Providers emphasized the complexity of their roles, which span therapy, case management, coordination, and coaching. In the provider survey, they pointed out the difficulties associated with serving populations affected by broader socioeconomic issues, such as poverty, housing, and food insecurity, and the lack of holistic services to meet these needs. Respondents highlighted the complex needs their clients are facing and the need for comprehensive wraparound services provided by a range of partners to address these needs. They spoke to gaps in the continuum of care, citing the need for dedicated translation/interpretation services for English-speaking clinicians and culturally and linguistically responsive substance use treatment. SUD providers noted that many clients on their caseloads were often living with co-occurring disorders and needed additional support to address their mental health needs.

Finding 4: ***Providers expressed support for the critical role that the family and peer workforce can play in meeting their clients' needs and reported engagement efforts.***

Providers expressed support for the ACBHD's focus on expanding the family and peer workforce. The Office of Peer Support Services and the Office of Family Empowerment are primarily responsible for ACBHD's peer initiatives, though the WET unit provides training for the peer and family workforce. Survey respondents reported that they are actively working to expand their family and peer workforce, with over half of the respondents reporting that they engage peers and families (54%) in work groups and advisory councils. Respondents were able to select more than one option for peer and family engagement. Figure 6 shows that provider organizations are utilizing a variety of methods to deepen their partnership with peers and family members.

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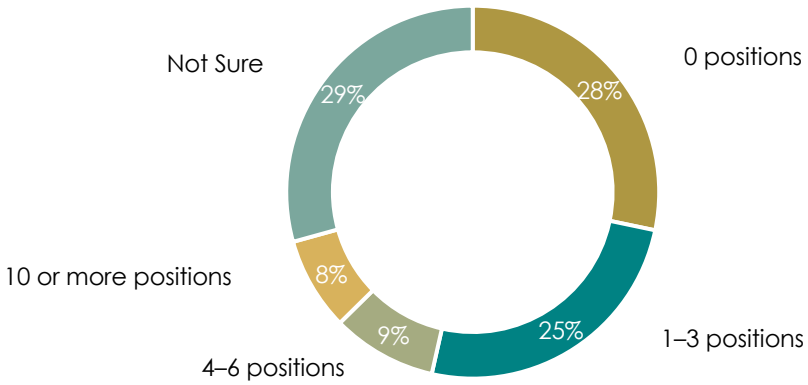
Figure 6. Peer and Family Engagement in Organizations, N = 85



Source: 2024 WET Provider Survey

Organizations are making progress with integrating peers and family members into their paid workforce. Overall, about 42% of providers reported that their organization had at least one designated peer or family-member position, as seen in Figure 7.

Figure 7. Provider-Reported Number of Designated Family or Peer Positions at Organization, N = 85

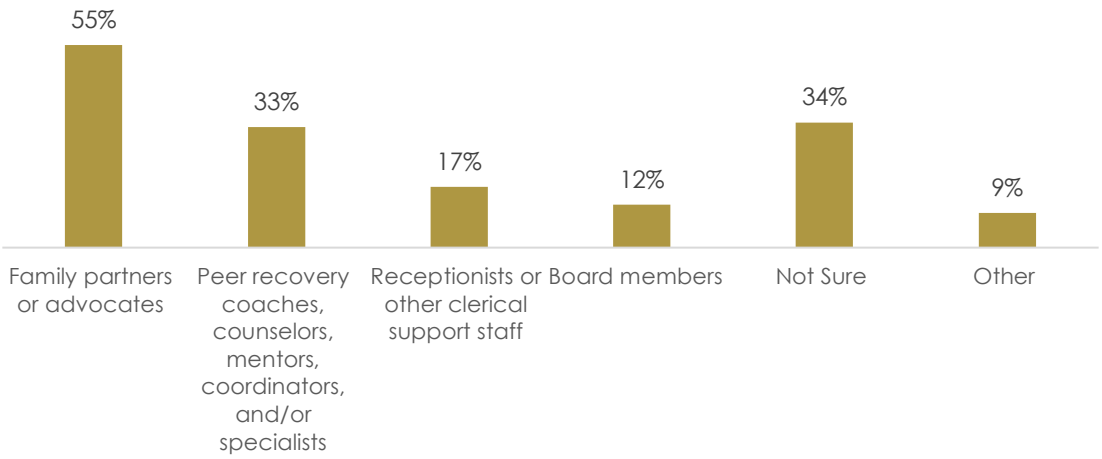


Source: 2024 WET Provider Survey

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Peers and family members working at provider organizations most commonly serve as family partners, advocates, peer recovery coaches, counselors, mentors, coordinators, and/or specialists, as shown in Figure 8. About 9% of survey respondents reported peers serving in other leadership or staff roles, including as program directors, program specialists, managers, and mental health specialists.

Figure 8. Provider-Reported Roles for Peers and Family Members within Organizations, N = 85



Source: 2024 WET Provider Survey

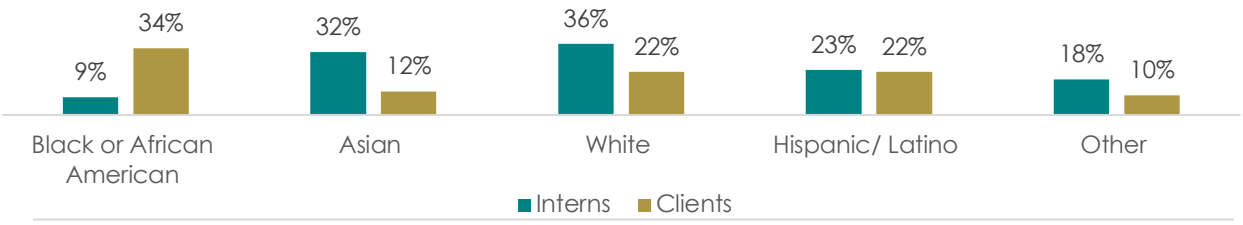
Key Findings: Pipeline Programs and Preparation of a Diverse Workforce

To achieve the ACBHD's vision for a workforce that is sufficient in size, the intern program currently prepares rising behavioral health professionals for future careers in the behavioral healthcare field. The mission of the ACBHD's internship program is to provide training that optimizes student learning, leadership, and overall support and development.

***Finding 1:* Intern diversity does not align with the cultural and linguistic diversity of Alameda County's client population.**

ACBHD interns are not representative of the racial, ethnic, and linguistic backgrounds of the client population. As seen in Figure 9, there is the most incongruence in racial and ethnic diversity among African American / Black clients and interns.

Figure 9. Racial/Ethnic Diversity of ACBHD Interns (N = 22) and Clients (N = 28,108), 2022–2023



Source: ACBHD Workforce Education, Training and Development Internship Program Data, Yellow Fin, 2023; Mental Health Services Demographic-Ethnicity Data, Yellow Fin, FY 2022–2023

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A quantitative analysis of intern demographic data shows gaps in recruiting African American and Latino interns. From 2018 to 2023, ACBHD interns have become less racially and ethnically diverse, as seen in Table 2. While the percentage of Asian interns has doubled since 2018, the percentage of African American and Hispanic/Latino interns has decreased.

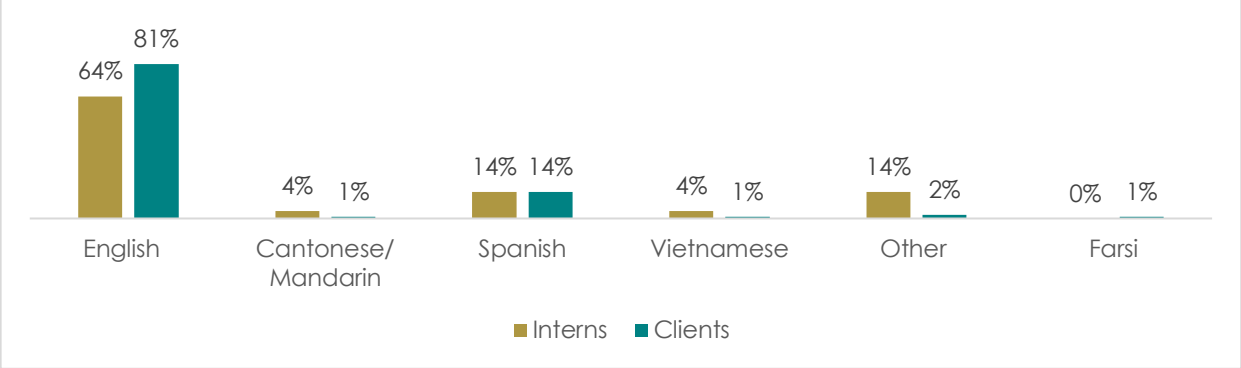
Table 2. Racial/Ethnic Diversity of ACBHD Interns, 2018–2023

Year	N	Black or African American	Asian	White	Hispanic/ Latino	Other
2022–23	22	9%	32%	41%	0%	18%
2021–22	18	22%	11%	28%	28%	11%
2020–21	21	29%	24%	19%	19%	9%
2019–20	31	16%	23%	29%	32%	0%
2018–19	19	21%	16%	26%	37%	0%

Source: ACBHD Workforce Education, Training and Development Internship Program Data, Yellow Fin, 2018–2023

The linguistic capacity of interns mostly reflects languages spoken among the ACBHD's clients, as seen in Figure 10. There is a need for more interns who speak Farsi to meet emerging client language needs.

Figure 10. Languages Spoken by ACBHD Interns (N = 22) and Clients (N = 28,108), 2022–2023[5]



Source: ACBHD Workforce Education, Training and Development Internship Program Data, Yellow Fin, 2023, and Mental Health Services Demographic-Ethnicity Data, Yellow Fin, FY 2022–2023

The linguistic diversity of ACBHD interns has decreased over the last five years, as seen in Table 3. While the percentage of interns speaking Cantonese/Mandarin has increased since 2018, the percentage of interns speaking Vietnamese and other languages has decreased.

5. The bar chart includes only languages that were noted in both intern and client data.

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Table 3. Linguistic Diversity of ACBHD Interns, 2018–2023

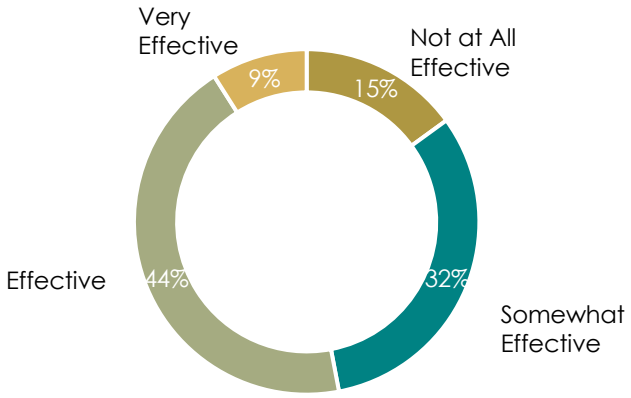
Year	N	English	Cantonese/ Mandarin	Spanish	Vietnamese	Other
2022–23	22	64%	4%	14%	4%	14%
2021–22	18	55%	0%	28%	0%	17%
2020–21	21	52%	0%	24%	0%	19%
2019–20	31	55%	7%	29%	3%	3%
2018–19	19	42%	0%	21%	11%	21%

Source: ACBHD Workforce Education, Training and Development Internship Program Data, Yellow Fin, 2018–2023

***Finding 2:* Supervisors and former interns reported mixed levels of satisfaction and effectiveness with the intern program.**

Almost two-thirds of survey respondents (62%) reported serving as an intern supervisor or host. Less than half of these respondents (47%) would recommend being a supervisor to a colleague, and 18% were unsatisfied with their experience and would not recommend it to others. In addition, 47% of providers reported the program as somewhat effective (32%) or not at all effective (15%) at preparing a diverse workforce, as seen in Figure 11.

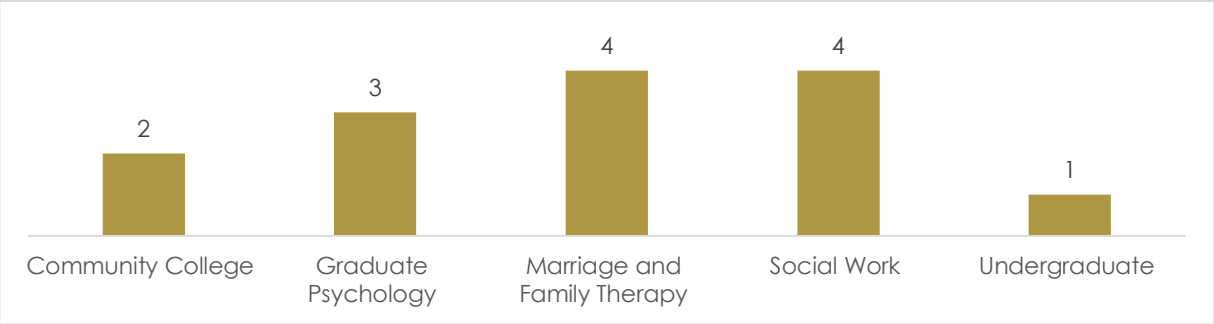
Figure 11. Provider-Reported Effectiveness of WET Pipeline Programs in Preparing a Diverse Workforce, N = 85



Source: 2024 WET Provider Survey

The small number of survey respondents (13) who had experience as an ACBHD intern means that the survey feedback cannot be generalized across ACBHD's workforce. While over half (7) of those who had participated would recommend the pipeline program to other students, almost one-fourth (3) would not recommend it. The majority of providers who responded were graduate-level interns in marriage and family therapy (4) and social work (4), as seen in Figure 12.

Figure 12. Provider-Reported Internship by Student Type, N = 13

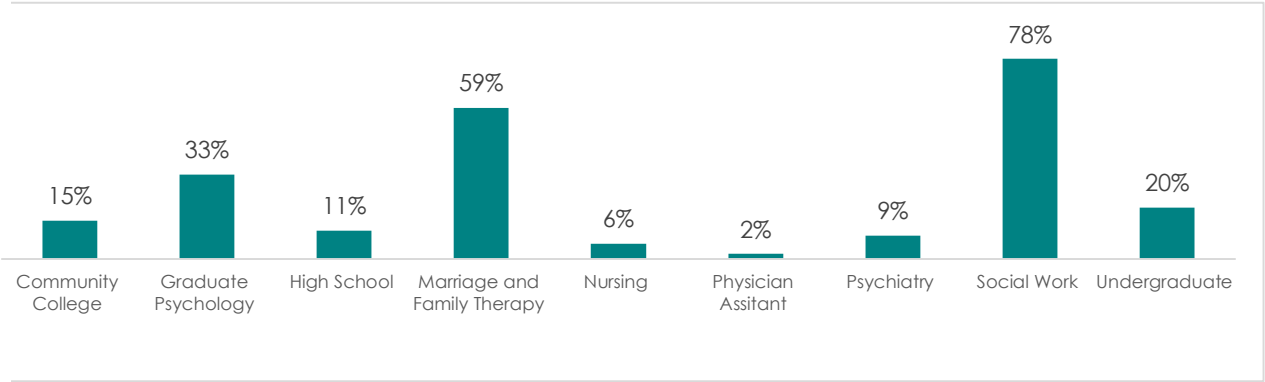


Source: 2024 WET Provider Survey

Finding 3: ***Providers who participated in the survey offered recommendations to strengthen and improve the ACBHD intern programs.***

A majority of survey respondents reported hosting a wide range of student interns, with graduate-level students in marriage and family therapy (59%) and social work (78%) comprising the largest proportion, as shown in Figure 13, which aligns with the ACBHD's need for licensed clinical professionals.

Figure 13. Provider-Reported Supervision by Student Intern Type, N = 53



Source: 2024 WET Provider Survey

Qualitative-survey responses highlighted a need for interns with a range of levels of education, from associate to post-master level, to meet the needs of the communities they serve. Additionally, providers report a need for interns in roles ranging from SUD counselors to marriage and family therapists. They also recommended increasing opportunities for people with lived experience with behavioral health conditions and residents of Alameda County. Providers cited several structural barriers and challenges that make it difficult to find staff who are willing to take on the added responsibility of serving as an intern supervisor. They reported the following recommendations to improve the intern program:

- Adequate compensation and stipends for intern recruitment and retention, especially when attempting to recruit multicultural and multilingual interns
- More time and compensation for clinical supervisors
- Expanded infrastructure and space for hosting interns

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- Additional professional development of interns as they advance in their careers, such as alumni networks and continued mentoring

During the small-group conversation among SUD providers, providers mentioned similar intern needs and noted Merritt College's Community Social Services / Substance Abuse (COSER) program as an effective SUD pipeline. They noted that incoming professionals still had a learning curve with the documentation requirements of their role, including writing case notes and client briefs. SUD providers also cited the need to support incoming COSER graduates with the development of soft skills.

Key Findings: Training and Education Needs

Through trainings to agency staff and licensed clinicians, the WET unit aims to strengthen the capacity of providers to deliver clinical services that can improve the lives of clients and their families. The Training Unit offers training opportunities for the ACBHD's staff, contracted CBO staff, individual providers and other Alameda County agencies. The Training Unit hosts trainings facilitated by contracted trainers and also collaborates with the systems of care and other partners to offer continuing-education sponsorships and technical assistance. Through this collaboration, trainings can be tailored to meet the specific learning needs of staff from different systems of care. In FY 2021–2022, the Training Unit hosted 71 events and trained 2,469 people. The unit provides continuing education for the following licensed professions:

- Clinical Social Worker
- Marriage and Family Therapist
- Professional Clinical Counselor
- Education Psychologist
- Psychologist
- Registered Nurse
- Vocational Nurse
- Addiction Professional
- Medical Doctor

Through the needs assessment, the WET unit was looking to learn about current training gaps and how it could best address providers' emerging skills and knowledge needs.

***Finding 1:* Providers have mixed feedback on current WET unit offerings.**

Most respondents were unfamiliar with the WET trainings, but those providers who participated in WET offerings reported satisfactory experiences. It is possible that survey respondents did not know that the trainings they participated in were organized by the WET unit. Of providers who reported participating in WET education programs, a majority (63%) would recommend the programming to a peer. Similarly, of those who had participated in WET training programs, almost half would recommend it to a colleague (42%), but 29% would not, as seen in Figure 14.

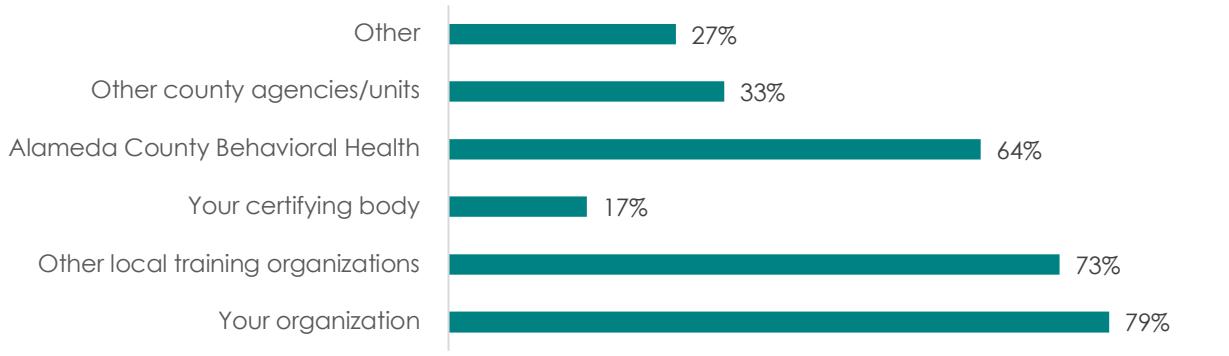
Figure 14. Provider-Reported Likelihood to Recommend WET Education (N = 16) and Training (N = 38) to a Colleague



Source: 2024 WET Provider Survey

Most survey respondents reported accessing training and education opportunities outside of the ACBHD to support their professional development. Over half of the respondents seek trainings internally from their organization (79%) or other local training organizations (73%), as shown in Figure 15. Providers reported accessing training, education, and professional development through national organizations. They sought trainings from the Centers for Disease Control and Prevention; the National Alliance on Mental Illness; statewide agencies, including the California Alliance and Catalyst Center; and online sites.

Figure 15. Provider-Reported Training and Education Resources, N = 85



Source: 2024 WET Provider Survey

Finding 2: ***Providers have an interest in a variety of training formats and delivery and offered recommendations to improve WET trainings.***

Qualitive-survey responses and the small-group conversation among SUD providers, uncovered that providers prefer more interactive and dynamic training options. Providers shared diverse perspectives regarding their preferred training format, which included a mix of in-person sessions to prevent multitasking and enhance engagement, as well as virtual meetings for convenience.

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"Staff like to go to trainings, but it's more time required, and [there's] lots they will have to catch up on. Already feel overwhelmed with day-to-day tasks."

When asked about their training needs in the survey, providers expressed a desire for more robust mechanisms for feedback and evaluation of training programs. They suggested implementing evaluative measures to ensure that trainings are effective, relevant, and skill based. While some providers were unaware that the WET unit offered trainings with certification, others felt that the quality of the training could be improved.

"I would like to work in tandem with you to help develop a more cohesive network of trainings in the county (amongst CBOs and ACBH)."

Other training recommendations offered by survey respondents, SUD providers, and CBO webinar participants are:

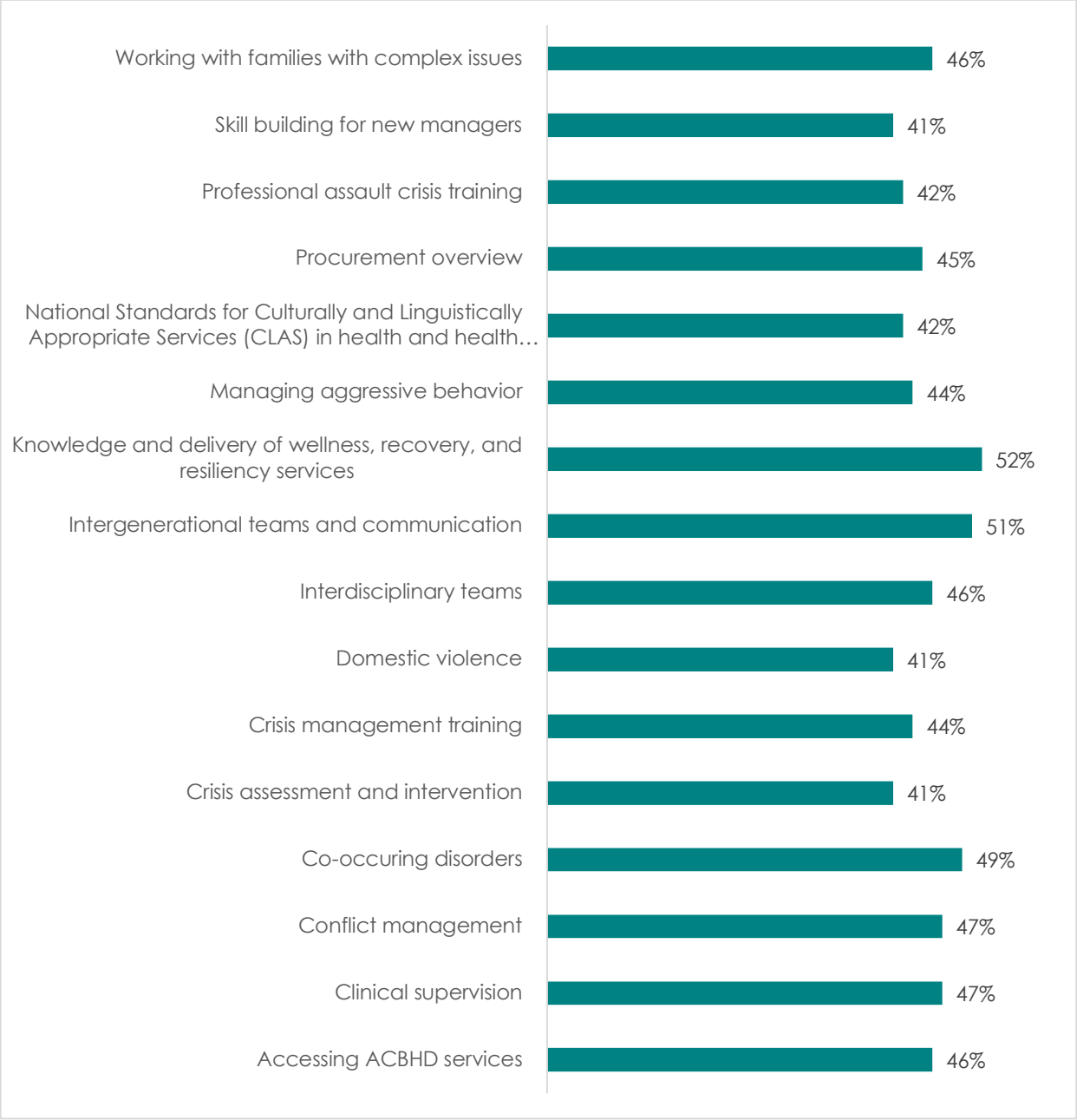
- The need to accommodate various schedules by offering training at different times of the day was also emphasized
- A desire to offer more input to the WET team around sharing resources and codeveloping training programs that meet CEU requirements
- More efficient administrative procedures for accessing and participating in training programs. They noted that bureaucratic hurdles can delay or hinder their ability to attend necessary trainings
- A preference for trainings that integrate real-world scenarios and case studies to practice applying knowledge
- Content offered as a train-the-trainer model to allow attendees to share knowledge and skills with providers across their organization
- A desire for trainings delivered by people with lived experience with behavioral health conditions
- A desire to offer the general public trainings in essential life skills, such as financial literacy, community trauma, and self-advocacy. They noted that these trainings could enhance self-understanding, development, and people's ability to effectively advocate within various systems

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Finding 3: ***Providers reported a strong demand for rigorous trainings that enable them to deliver culturally responsive services to Alameda County's diverse client populations and specifically requested advanced clinical-skills training***

The training topics that providers felt they needed more training support in varied. As seen in Figure 16, providers reported the highest need for additional training in areas related to clients' holistic needs and their own administrative duties.

Figure 16. Percentage of Respondents Reporting Needing More Training Across Topics, N = 85



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Source: WET Provider Survey

Providers reported feeling well trained in areas related to service provision, such as clinical models, documentation, and collaborating with clients. Providers expressed a desire for trainings that increase their skills in implementing evidence-based practices and clinical skills. Some described current trainings as insufficiently advanced to strengthen clinical practices.

> *"A lot of the trainings have good titles, but they're complete fluff. Clinicians are discouraged to take these trainings. I keep hearing 'evidence based,' but I don't see evidence-based trainings."*

During the CBO provider webinar, many providers reported that there is a significant demand within CBOs for high-quality evidence-based training that meets both the staff's clinical needs and professional licensing requirements. Survey respondents also expressed interest in advanced training in specific therapeutic modalities and approaches, especially those that include certification. Overall, a majority of survey respondents (73%) reported that it was very important that trainings offer CEUs. There is also interest among providers in participating in training series or advanced-skills development. Some of the topic areas mentioned in qualitative responses about topics for advanced training include:

- **Family Therapy:** Advanced training in family systems therapy and evidence-based practices for working with families
- **Suicide Prevention:** In-depth training on assessing and managing suicidal ideation and behavior
- **Trauma-Informed Care:** Comprehensive programs on understanding and treating trauma, including complex trauma and PTSD
- **Cognitive Behavioral Therapy (CBT):** Advanced certification in CBT for various mental health conditions
- **Dialectical Behavior Therapy (DBT):** Training and certification in DBT for treating borderline personality disorder and other conditions
- **Substance Use Disorders:** Specialized training in treating co-occurring mental health and substance use disorders, including medication-assisted treatment (MAT)
- **Eating Disorders:** Many providers indicated a need for specialized training on eating disorders, including early identification, treatment modalities, and ongoing support strategies
- **Cultural Competency:** Programs that include cultural humility and practices for working with diverse populations, ensuring that providers can deliver equitable and effective care

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Finding 4: ***Providers feel most prepared to meet the needs of Latino/Hispanic communities but reported a need for training to engage clients across other ethnic and cultural backgrounds***

The majority of survey respondents did not cite the need for additional training to serve specific ethnic populations. Those who did cite a need reported the greatest need for training in order to support Native American / Indigenous People (25%), as shown in Figure 17.

Figure 17. Provider-Reported Need for Training to Meet the Needs of Priority Populations

Target Population	N	%
Native American / Indigenous People	39	25%
Asian American / Pacific Islander	31	19%
Lesbian/Gay/Bisexual/Transgender//Questioning (LGBTQ+)	28	18%
African American / Black	22	14%
Transition-Aged Youth	23	14%
Latino / Hispanic	14	9%
Early-Childhood Mental Health	1	1%
Asian American / Pacific Islander Family Support	1	1%

Source: 2024 WET Provider Survey

During the CBO provider webinar, providers expressed interest in training programs that strengthen their ability to engage clients of diverse cultural backgrounds and respond to the emerging needs of their clients. Similarly, survey respondents also noted the importance of culturally specific and inclusive training programs that address the unique needs of diverse populations, such as LGBTQ communities, immigrant families, Asian and Pacific Islander communities, Middle Eastern populations, African American communities, and children and youth.

> *"The gaps in our team's skills include lack of East Asian–language support for our clients, families, and community and of assessments and evaluations reflecting cultural factors related to the AAPI population."*

Finding 5: ***Providers expressed frustration with certain elements of the bureaucracy of the behavioral health care system and value up-to-date information.***

Providers explained that constant changes within the healthcare systems, especially new regulations and requirements, pose challenges and create barriers to care. Many respondents who were surveyed emphasized the need for timely information to help them stay compliant and effective in their roles. This includes access to training or briefings that cover new policy updates and regulatory changes. Many providers highlighted challenges in understanding and complying with various county-level policies and procedures. They mentioned that frequent changes to these requirements often lead to confusion and inefficiencies in service delivery.

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Conclusion and Recommendations

There are current workforce gaps in bilingual and racially diverse staff across community-based providers. Providers expressed challenges in the recruitment and hiring of staff who reflect the communities the ACBHD serves. Providers also cited clients' needs for holistic supports and recognize the opportunity to leverage the peer and family workforce to meet client needs. Overall, there is a need for a pipeline of professionals who represent diverse cultural, linguistic, and professional-training backgrounds. There is also an opportunity to raise awareness of the ACBHD's intern program among providers. Providers support interns as an effective means to grow the behavioral health workforce and meet emerging workforce gaps. Providers had varied experiences with current WET training offerings. Providers had keen insights about their emerging education needs. They expressed a desire for opportunities to give training feedback and offered suggestions for training topics, formats, and delivery methods.

Given these findings, the resource-restrictive environment, and the WET unit's scope of influence, BRG offers the following recommendations:

1. Sustain marketing efforts to promote WET training and education offerings with community-based providers
2. Continue to offer advanced-skills training in the following topics:
    - Understanding and assessing health conditions
    - Knowledge and delivery of "wellness, recovery, resiliency" services
    - Intergenerational teams and communication
    - Co-occurring disorders
    - Clinical supervision
    - Conflict management
    - Accessing ACBHD services
    - Interdisciplinary teams
    - Working with families with complex issues
    - Domestic violence
3. Routinely gather training feedback from providers and share format and delivery preferences with contracted trainers to integrate them into future offerings
4. Sustain training offerings for certified peer specialists and other peer and family professionals to support the professional development of the peer and family workforce
5. Recruit interns for the following roles to address provider-identified workforce gaps:
    - Licensed clinical social worker
    - Licensed marriage and family therapist
    - Case manager, social worker, and service coordinator
    - Child and adolescent psychiatrist
6. Sustain and develop new strategies to increase the applicant pool of interns so that they better reflect the cultural, linguistic, and ethnic diversity of clients, including the following:
    - Continue to collect intern demographic data
    - Offer a diversity stipend similar to peers (i.e., Multicultural Student Stipend Program)
    - Partner with minority-serving institutions for intern recruitment
    - Solicit ideas from other departments about how to give preference to interns who match the cultural, linguistic, and ethnic diversity of clients
7. Share workforce-capacity findings with human resources and systems of care across the ACBHD to adapt hiring and recruiting strategies to address identified needs

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APPENDICES

APPENDIX A. WET PROVIDER SURVEY

INTRODUCTION

As valued stakeholders to Alameda County Behavioral Health (ACBH), the Workforce, Education and Training (WET) team wants to hear from community-based providers and organizations across ACBH systems of care. Please take about 20 minutes to complete this survey. The WET team wants to hear from you about:

- Your training and education needs
- Your perspective on the diversity of the workforce
- The effectiveness of pipeline programs to build the future workforce

The WET team is currently conducting a needs assessment in partnership with an independent research firm, Bright Research Group. The WET team will use survey results to inform their workforce, education and training programming. Results will not be used to assess your organization nor affect future contracting with your organization.

Answers are Confidential

We want your honest feedback and there will be no consequence for your honesty. Although there are questions that ask you to share information about yourself and your organization, your answers will be kept confidential. If there's a question you do not want to answer, you can skip it.

TRAINING AND EDUCATION NEEDS

1. How important is it to you that trainings offer continuing education credits?

☐ Very important
☐ Important
☐ Somewhat important
☐ Not important at all

2. Where do go to meet your training and education needs?

☐ Your organization
☐ Other local training organizations
☐ Your certifying body
☐ Alameda County Behavioral Health
☐ Other county agencies/units
☐ Other_____

3. What feedback do you have for the WET team about your training needs? You can provide feedback on training topics, content, format, certification, availability, etc. [Open-ended/Short text]

_____

group home for undocumented Latino community experiencing MH crisis. And final suggestion to hire a position and develop a comprehensive master directory that gets updated with different resources like hospitalization, housing, treatment etc.

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4. How would you like to collaborate with the WET team? [Open-ended/Short text]

_____

5. What are the gap(s) in your or your team's skills or competencies? [Open-ended/Short text]

_____

   a. How can the WET team support you to address the gap(s)?

   _____

FAMILIARITY WITH WET AND EXPERIENCE ACCESSING PIPELINE NEEDS

6. Which WET unit program have you participated in? (Check all that apply)

☐ Training Programs
   1. [Skip logic based on selection]
      How likely are you to recommend a WET training program to a peer or colleague?
      0 1 2 3 4 5 6 7 8 9 10
      Not Likely Very Likely

☐ Education Programs
   a. [[Skip logic based on selection]
      How likely are you to recommend a WET education program to a peer or colleague?
      0 1 2 3 4 5 6 7 8 9 10
      Not Likely Very Likely

☐ Pipeline Programs (Programs that are specifically designed to develop our future workforce capacities, including internships, fellowships, and conferences for high school students that promote skill building and exposure to the various behavioral health-oriented careers.)
   1. [Skip logic based on selection]
      How likely are you to recommend a WET training program to a peer or colleague?
      0 1 2 3 4 5 6 7 8 9 10
      Not Likely Very Likely

☐ None of the above

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7. What are your training needs in the following areas? Select those that apply.

Training Area	*I could use more support to apply skills in this topic in my role*	*I could use more training in this topic*	*I feel well trained in this topic*
Advanced assessment, differential diagnosis and treatment planning			
Basic Cognitive Behavioral Therapy (CBT)			
Clinical Supervision			
Co-occurring disorders			
Compassion Fatigue			
Crisis Assessment and intervention (Danger to self, danger to others, grave disability)			
Cultural humility and responsiveness			
Documentation			
Domestic Violence			
Knowledge and delivery of "wellness, recovery, resiliency" services			
Managing aggressive behavior			
Motivational Interviewing			
Post-traumatic stress disorder			
Resource sharing between consumers and providers			
Trauma Assessment and Interventions			
Understanding and assessing health conditions			
Wellness Recovery Action Planning (WRAP)			
Working collaboratively with clients and families			
Working with families with complex issues			
Other_____			

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8. Were you a student intern with an ACBH contracted provider or system of care? Y/N

    1. [Skip logic if Y to #7] What type of student intern were you? (Check all that apply)
        - ☐ Community College
        - ☐ Graduate Psychology
        - ☐ High School
        - ☐ Marriage and Family Therapy
        - ☐ Nursing
        - ☐ Physician Assistant
        - ☐ Psychiatry
        - ☐ Social Work
        - ☐ Undergraduate
        - ☐ Youth and Young Adults not enrolled in school

    2. How likely are you to recommend this pipeline program to other students?

        0 1 2 3 4 5 6 7 8 9 10

        Not Likely Very Likely

9. Have you served as supervisor or host for student intern[s] at your organization? Y/N

    a. [Skip logic if Y to #8] What type of student intern[s] have you hosted? (Check all that apply)
        - ☐ Community College
        - ☐ Graduate Psychology
        - ☐ High School
        - ☐ Marriage and Family Therapy
        - ☐ Nursing
        - ☐ Physician Assistant
        - ☐ Psychiatry
        - ☐ Social Work
        - ☐ Undergraduate
        - ☐ Youth and Young Adults not enrolled in school

    b. How likely are you to recommend hosting a student intern to a colleague?

        0 1 2 3 4 5 6 7 8 9 10

        Not Likely Very Likely

10. In your opinion, how effective are the WET pipeline programs (programs that are specifically designed to develop our future workforce capacities, including internships, fellowships, and conferences for high school students that promote skill building and exposure to the various behavioral health-oriented careers) at preparing a diverse workforce?

- ☐ Very effective
- ☐ Effective
- ☐ Somewhat effective
- ☐ Not effective at all

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11. What additional feedback do you have on how well the pipeline programs (programs that are specifically designed to develop our future workforce capacities, including internships, fellowships, and conferences for high school students that promote skill building and exposure to the various behavioral health-oriented careers) prepare a diverse workforce? [Open-ended/Short text]

_____

12. What level of internships are needed to address the needs of the communities you serve? [Open-ended/Short text]

_____

13. What infrastructure/staffing is needed to manage the interns at your organization effectively? [Open-ended/Short text]

_____

PERSPECTIVE ON WORKFORCE SHORTAGES, CULTURAL COMPETNCE NEEDS AND FAMILY AND PEER WORKFORCE

14. When it comes to hiring in your organization, how difficult is it to fill open positions?

- ☐ Very difficult
- ☐ Difficult
- ☐ Somewhat difficult
- ☐ Not difficult at all

15. How well is your organization retaining staff?

- ☐ Very well
- ☐ Well
- ☐ Somewhat well
- ☐ Not well at all

16. How well is your organization recruiting staff that reflect the client population you serve?

- ☐ Very well
- ☐ Well
- ☐ Somewhat well
- ☐ Not well at all

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17. Which three roles are the most challenging to hire, retain and recruit diverse staff for? (Select first, second, third for only three roles)

Position/ Role	*Most Challenging to Hire*	*Most Challenging to Retain*	*Most Challenging to Recruit Diverse Staff*	*N/A*
Case Manager/ Social Worker/ Service Coordinator				
Certified Peer Specialist				
Child and Adolescent Psychiatrist				
Designated Consumer/ Family Member Personnel				
Employment Services Staff				
Executive and Management Staff				
General Psychiatrist				
Housing Services Staff				
Licensed Clinical Social Worker				
Licensed Marriage and Family Therapist				
Mental Health Rehabilitation Counselor				
Psychiatric Mental Health Nurse Practitioner				
Substance Abuse Counselor				
Other_____				

18. How well prepared do you feel to meet the needs of the following target populations?

Target Population	*Need more training*	*Somewhat Prepared*	*Well Prepared*	*N/A*
African American/Black				
Asian American/Pacific Islander				
Latinx/Hispanic				
Lesbian/Gay/ Bisexual/Transgender /Questioning (LGBTQ+) issues				
Native American/Indigenous People				
TAY- Transition Aged Youth				
Other: _____				

19. What language(s) other than English do you speak with clients?

- ☐ Arabic
- ☐ Cantonese
- ☐ Farsi
- ☐ Mandarin
- ☐ Spanish

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- ☐ Tagalog
- ☐ Vietnamese
- ☐ Other: _____

20. What are the gap(s) in services for the communities you serve? [Open-ended/Short text]

_____

a. How can the WET team support you to address the gap(s)?

_____

21. Which strategies does your organization use to engage and include peers and family members in service provision and/or practice and policy development?

- ☐ Involving consumers and family members in workgroups, advisory councils, stakeholder meetings, planning or policy groups
- ☐ Recruiting consumers and family members on boards and other leadership positions
- ☐ Meeting and/or job accommodations
- ☐ Priority preference given to applicants with lived experience
- ☐ Anti-stigma training for all staff
- ☐ Partnerships with consumer-run organizations
- ☐ Consumer or family member internship program
- ☐ None
- ☐ Other: _____

22. Does your organization hire certified peer specialists?

- ☐ Yes
- ☐ No
- ☐ Not Sure

23. How many designated peer or family member positions are there at your organization?

- ☐ 0
- ☐ 1-3
- ☐ 4-6
- ☐ 7-9
- ☐ 10 or more

24. What roles do peers and family members have within your organization?

- ☐ Family partners or advocates
- ☐ Peer recovery coaches, counselors, mentors, coordinators, and/or specialists
- ☐ Receptionists or other clerical support staff
- ☐ Board members
- ☐ Other_____

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25. How interested are you in sharing information or developing public available trainings (for peers, family members, non-clinical staff and the general public) in the following areas? Select those that apply

	Not At All Interested	*Somewhat Interested*	*Interested*	*Very Interested*
Access to mental health services				
Family and/or consumer support				
Stress management				
5150/5585 training				
Other:				

DEMOGRAPHICS

26. Please select the setting(s) that best represent your workplace. Select all that apply

- ☐ Community Based Organizations
- ☐ Community Mental Health/ Behavioral Health Agencies
- ☐ Hospital
- ☐ Involuntary Treatment/Substance Use Disorder
- ☐ Peer Services
- ☐ School
- ☐ Social Services Agency
- ☐ State& Regional Agency
- ☐ Substance Use/ Outpatient Setting
- ☐ Withdrawal Management

27. What is the size of your organization?

- ☐ Under 25 employees
- ☐ 25-50 employees
- ☐ 51-100 employees
- ☐ 101-200 employees
- ☐ More than 200 employees

28. Which system of care does your organization work in? Select all that apply

- ☐ Acute & Crisis Services
- ☐ Adult & Older Adult Services
- ☐ Child & Youth Services
- ☐ Forensic Services
- ☐ Integrated Primary Care Services
- ☐ Psychiatry and Nursing Services
- ☐ Substance Use

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29. How long have you been at your organization?

- ☐ Less than one year
- ☐ 1-3 years
- ☐ 4-6 years
- ☐ 6-10
- ☐ Over 10 years

30. What is your highest level of education completed?

- ☐ High school degree or GED equivalent
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctorate
- ☐ Other: _____

31. What is your current role?

- ☐ Case Manager/ Social Worker/ Service Coordinator
- ☐ Child and Adolescent Psychiatrist
- ☐ Designated Consumer/ Family Member Personnel
- ☐ Employment Services Staff
- ☐ Executive and Management Staff
- ☐ General Psychiatrist
- ☐ Housing Services Staff
- ☐ Licensed Clinical Social Worker
- ☐ Licensed Marriage and Family Therapist
- ☐ Mental Health Rehabilitation Counselor
- ☐ Psychiatric Mental Health Nurse Practitioner
- ☐ Substance Abuse Counselor
- ☐ Other_____

32. How long have you been in your current position?

- ☐ Less than one year
- ☐ 1-3 years
- ☐ 4-6 years
- ☐ Over 6 years

These questions are optional. Your answers are confidential. If you want to skip a question, just select prefer not to say.

33. What is your racial/ethnic identity (Select all that apply):

- ☐ American Indian or Alaskan Native
- ☐ Black/African American
- ☐ East Asian
- ☐ Latino/a/e
- ☐ Middle Eastern or North African

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- ☐ Native Hawaiian or Pacific Islander
- ☐ South Asian
- ☐ Southeast Asian
- ☐ White
- ☐ Other_____
- ☐ Prefer not to say

34. Please select the language(s) you speak (Select all that apply):

- ☐ Arabic
- ☐ Chinese
- ☐ Farsi
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Other: _____
- ☐ Prefer not to say

35. What is your gender identity?

- ☐ Female
- ☐ Male
- ☐ Gender non-binary
- ☐ Genderqueer
- ☐ Trans Female
- ☐ Trans Male
- ☐ Another gender identity: _____
- ☐ Prefer not to say

36. Do you have a disability?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

37. Which of the following lived experiences have you had? (Select all that apply)

- ☐ Living with mental health challenges
- ☐ Having a friend/family member living with mental health challenges
- ☐ Living with a substance use disorder
- ☐ Having a friend/family member living with a substance use disorder
- ☐ Experiencing a significant traumatic event
- ☐ Having a friend/family experience a significant traumatic event
- ☐ Living in the foster care system
- ☐ Having a friend/family member living in the foster care system
- ☐ None of the above
- ☐ Other:_____
- ☐ Prefer not to say

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APPENDIX B. DEMOGRAPHICS OF WET PROVIDER SURVEY RESPONDENTS

Race/Ethnicity		
American Indian or Alaskan Native	2	3%
Black / African American	15	19%
East Asian	6	8%
Latino/Hispanic	15	19%
Middle Eastern or North African	1	1%
Native Hawaiian or Pacific Islander	2	3%
South Asian	3	4%
Southeast Asian	2	3%
White	33	41%
Other	4	5%
Language Spoken		
Cantonese	1	1%
English	54	74%
Farsi	1	1%
Mandarin	2	3%
Spanish	15	21%
Tagalog	2	3%
Other	12	16%
Educational Level		
High School Degree / GED	3	4%
Some College	4	5%
Associate Degree	14	17%
Bachelor's Degree	50	59%
Master's Degree	12	14%
Doctorate	2	2%
Gender Identity		
Female	66	83%
Male	8	10%
Gender Non-binary	1	1%
Gender Queer	1	1%

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Appendix C. Professional Tenure of WET Provider Survey Respondents

Organizational Tenure		
Less than 1 year	7	8%
1–3 years	19	22%
4–6 years	14	17%
6–10 years	16	19%
Over 10 years	29	34%
Current-Position Tenure		
Less than 1 year	13	15%
1–3 years	30	35%
4–6 years	16	19%
Over 6 years	26	31%

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Alameda County Supportive Housing Community Land Alliance

Year Two Evaluation Report

November 2024

Prepared for

Alameda County Health

Alameda County Health
Housing and Homelessness Services

PUBLIC CONSULTING GROUP

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Executive Summary

The demand for affordable housing far exceeds the supply of available units in Alameda County and throughout the Bay Area. In addition to an inadequate supply of housing inventory, the rising cost of homes and rental rates has contributed to evictions, displacement, and homelessness. Households living on fixed incomes such as seniors, individuals with disabilities, and those with severe mental illness (SMI), encounter the greatest challenges in sustaining housing in this environment. According to projected 2024 Point-in-Time (PIT) Count data, 9,450 people were estimated to be experiencing homelessness on a given night in January 2024, which is an 18 percent increase from the count in 2019.

Alameda County is dedicated to creating a stable housing system that better supports individuals with SMI. In 2019, Alameda County Health (formerly Alameda County Health Care Services Agency) was awarded a Mental Health Services Act (MHSA) Innovation grant, to utilize a community land trust (CLT) model paired with a supportive housing model as a pathway for permanent and sustainable affordability and increased community control to address the housing crisis for individuals with SMI. The Supportive Housing Community Land Alliance (SHCLA) was contracted to lead the implementation of this innovative approach, overseen by Alameda County Health, Housing and Homelessness Services (H&H).

SHCLA had four **Learning Goals**:

1. Can Alameda County, within two years of using the Community Land Trust (CLT) model, create an equitable representation on a well-run/effective Board of Directors that includes one-third (1/3) consumers, one-third (1/3) family members, and one-third (1/3) community housing experts?

2. Can a CLT model, targeting the SMI population, facilitate a successful financing model that results in adequate resources to sustain operation of a community land trust to provide permanent supportive housing for individuals with an SMI?

3. Can the use of a CLT model for supportive, affordable housing targeted to the SMI population have an impact on reducing Board and Care closure rates in the County?

4. Can the CLT model provide an opportunity to build personal wealth balanced with community wealth using the private sector for public good?

Public Consulting Group LLC (PCG) was contracted to conduct an independent external evaluation of SHCLA. PCG conducted a process and outcome evaluation, utilizing a mixed methods strategy drawing from multiple qualitative and quantitative sources. Key evaluation questions were derived from the program's implementation goals and outlined in the theory of change and logic model to guide the evaluation. This final evaluation report primarily focuses on findings from Year Two (January 1, 2024 – September 30, 2024), including achievements, challenges, and lessons learned from the last two years related to SHCLA's implementation, capacity building, impact, and sustainability. Results

from the evaluation are important to identify opportunities SHCLA and the County can consider to ensure continued implementation and sustainability of the model.

Key Findings

Throughout Years One and Two of implementation, SHCLA had many achievements, challenges, and lessons learned, which are highlighted throughout the evaluation findings. Key findings from the Year Two evaluation are described below.

Key Findings	
Achievements	• SHCLA is nearly fully staffed, with just one position remaining to be filled to complete the team. Complete staffing will ultimately allow the organization to operate and engage with the community that is most responsive to their needs. • Noted in interviews, the Advisory Committee members are excellent networkers and have introduced the organization to key contacts, including assembly members. • Collectively, the Board of Directors brings together combined experience aligned with the proposed composition of one-third public representatives, one-third community experts, and one-third with lived experience, family members, or future residents. • Significant efforts have been invested in the development of the organization's infrastructure. • SHCLA has signed letters of intent (LOIs) for the Family Partnership and licensed Board and Care model and is very close to acquisition of two different properties. • The visibility of the organization has increased. SHCLA is recognized by important County players such as POCC, HCD, FASMI, EBSHC, and the Mental Health Advisory Board. • SHCLA received letters of support from several City Council members. • The Director of H&H recently presented in Washington D.C. and used SHCLA's project as a model. • Interviews with HSP Board and Care Operators indicated that SHCLA has had a positive impact on these operators, specifically through provision of technical assistance, financial support, and listening to the needs of operators. • SHCLA has secured memorandums of understanding (MOU)s with multiple HSP Board and Care Operators. • SHCLA created a Sustainability Plan and a Fund Development Strategy to ensure operations beyond 2024.

Key Findings	
Challenges	• It has been difficult for SHCLA to meet program implementation expectations without funding for initial acquisitions as expected in the original proposal to the state. • Various funding sources require an organization to have at least three years of experience with audited financials and three projects that are similar in size or community served. As a result, SHCLA has been ineligible to receive those specific funds. • There have been challenges securing product-market fit for for-profit operators, less familiar with the community land trust model. • Significant reliance on a County contract presents challenges with the timing of reimbursements and financial stability. • There have been challenges modifying the budget to serve the needs of the project goals under an ambitious timeline.
Lessons Learned	• Acquiring property for a start-up organization can be very challenging without dedicated funding for initial purchases or adequate staff to acquire properties. Securing acquisition or operating subsidy funds prior to program implementation can help to accelerate the implementation process and support the achievement of future program goals. Replacing Property Management and Workforce Development positions with real estate staff dramatically increased SHCLA's ability to deliver within the project's ambitious timelines. • The CLT model is complex and can be difficult to understand due to its unique structure, which separates land ownership from homeownership. Its legal, financial, and governance structures require a deep understanding of how community control and long-term affordability are maintained, making it challenging for those unfamiliar with these concepts. • SHCLA and the County can leverage past experiences and learning, such as the challenges faced with property acquisition and grant implementation, to refine strategies and improve future outcomes.

Opportunities

Based on process and outcome evaluation findings, the following opportunities are presented to consider as SHCLA continues implementation in 2024 and beyond.

- Continue to gain letters of support for funding from organizations and County officials.
- Strengthen a support system for Board and Care operators to facilitate the sharing of challenges, resources, and best practices.
- Explore upcoming funding opportunities such as the Bridge Housing and Behavioral Health (BHBH) Program, the Community Assistance, Recovery, and Empowerment (CARE) Court program, and Proposition 1, Behavioral Health Services Program and Bond Measure.
- Increase the number of Board of Director members with lived or living experience and connections to philanthropy.
- Maintain a strong relationship with the County and secure champions within the County who can advocate for SHCLA's mission and budget.
- Continue community outreach and education, especially with HSP Board and Care operators.
- Continue to present and explain the benefits of the CLT models and SHCLA's models.
- Explore opportunities to partner with Social Services as the organization looks to strengthen relationships with service providers.
- Continue to participate in MHSA Stakeholder meetings.
- Continue to highlight and celebrate the organization's achievements to build morale and demonstrate progress to partners.

Background

The demand for affordable housing far exceeds the supply of available units in Alameda County and throughout the Bay Area. In addition to an inadequate supply of housing inventory, the rising cost of homes and rental rates has contributed to evictions, displacement, and homelessness. Households living on fixed incomes such as seniors, individuals with disabilities, and those with serious mental illness (SMI), encounter the greatest challenges in sustaining housing in this environment.

Social determinants of health refer to the conditions in environments where individuals are born, live, work, play, worship, and age, that affect a broad spectrum of health, functioning, and quality-of-life outcomes and risks. According to the U.S. Department of Health and Human Services, safe and stable housing is a social determinant of health and can have a major impact on mental and physical health.[1] Without a safe and affordable place to live, it is almost impossible to achieve good health or to achieve one's full potential. Individuals with SMI, who also experience housing insecurity and homelessness, are at a higher risk for immediate, life-threatening physical illness and often live in dangerous environments.[2]

The U.S. Department of Housing and Urban Development (HUD) mandates that communities receiving federal funding to support homeless services conduct a Point-in-Time (PIT) Count of individuals, youth, and families experiencing homelessness to gather data on demographics and other characteristics every two years.[3] According to the 2022 PIT Count Report, Alameda County uses PIT Count data for a range of purposes including fundraising, system scaling, planning, funding allocations, and expanding housing and services to address needs and make improvements. In February 2022, the count revealed a total of 9,747 individuals experiencing homelessness, an increase of 1,725 individuals since 2019. Additionally, 40 percent of PIT Count participants reported having at least one disabling condition such as psychiatric or emotional conditions, PTSD, chronic health condition, physical disability, substance use challenges, traumatic brain injury, or HIV/AIDS related illness. The PIT Count also found that marginalized groups, such as African Americans, multi-racial, and Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) individuals, are disproportionately represented in the homeless population, facing a significantly higher likelihood of homelessness compared to the general population.[4]

According to projected 2024 PIT Count data, 9,450 people were estimated to be experiencing homelessness on a given night in January 2024, which is an 18 percent

[1] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2024). Retrieved from Social Determinants of Health.
[2] National Alliance to End Homelessness. (2024). Health and Homelessness. Retrieved from Health and Homelessness.
[3] Alameda County Health, Housing and Homelessness Services. (2024). Point in Time Count. Retrieved from Point in Time Count.
[4] Applied Survey Research. (2022). 2022 Alameda County Homeless Count and Survey Comprehensive Report. Retrieved from 2022 Alameda County Homeless Count and Survey Comprehensive Report.

increase from the count in 2019. Approximately two-thirds (67%) of those individuals were estimated to be living unsheltered, while the remaining third were sheltered. There were also 2,867 people estimated to be experiencing chronic homelessness on a single night in January 2024 in Alameda County, which is a 28 percent increase from the 2019 count.[5][6]

Alameda County has undertaken significant efforts to address homelessness and housing insecurity among its residents, employing a community-based, equity driven approach, as detailed in the Home Together 2026 Community Plan. In 2019, ACH established the Office of Homelessness and Care Coordination (OHCC) to implement various programs and initiatives to "ensure the availability of diverse and affordable housing for all residents with the collective goal to eliminate homelessness in Alameda County."[7] The same year, ACH put forth and was awarded a Mental Health Services Act (MHSA) Innovation grant, to utilize a community land trust (CLT) model paired with a supportive housing model as a pathway for permanent and sustainable affordability and increased community control to address the housing crisis for individuals with SMI. The Supportive Housing Community Land Alliance (SHCLA) was contracted to lead the implementation of this innovative approach.

The County is currently experiencing a homelessness crisis, and on September 19th, 2023, the Alameda County Board of Supervisors officially declared a State of Emergency related to Homelessness in Alameda County to address the critical situation.[8] This emergency declaration could provide access to additional resources and tools to enable a more rapid and effective response to the crisis. Tools could include expedited hiring to address homelessness and behavioral health needs, more efficient allocation of funds, accelerated housing development, expanded services, and the ability to request additional resources from the State and Federal governments.

In March 2024, ACH launched a new brand identity that reflects its commitment to providing equitable access to health care resources and services for all. With this rebranding, the agency adopted the new name Alameda County Health. During this transition, OHCC was renamed Housing and Homelessness Services (H&H).[9] H&H is dedicated to creating a stable housing system that better supports individuals with SMI, demonstrated through SHCLA.

[5] Simtech Solutions. (2024) Alameda County Point-in-Time Count Results Summary. Retrieved from Alameda County Point-in-Time Count Results Summary.
[6] Applied Survey Research. (2019). Alameda County Homeless County and Survey Comprehensive Report 2019. Retrieved from Alameda County Homeless Count and Survey 2019.
[7] Alameda County. (2021). Home Together 2026 Community Plan. Retrieved from Home Together 2026 Report.
[8] Alameda County Board of Supervisors. (2023). Adopt a Countywide State of Emergency on Homelessness. Retrieved from Adopt a Countywide State of Emergency on Homelessness .
[9] Alameda County Health. (2024). Welcome to AC Health. Retrieved from Welcome to AC Health.

Community Land Trust Model

CLTs are nonprofit organizations specifically designed to uphold the long-term availability of land for affordable housing, catering primarily to families with lower incomes. Governed by a Board of Directors with representation from the community, the CLT model is reinforced by the concept that residents, as part of the land trust, share a common interest in the organization that owns the land they inhabit. This model facilitates a sustained balance, ensuring residents maintain a degree of control over the organization while striving for long-term sustainable community outcomes. The CLT operationalizes its mission through several key strategies:[10]

- Retains ownership of the land and provides a long-term lease, generally a ground lease, of the structure(s) to homebuyers.
- Maintains an interest in maintenance of the structures and/or land while the tenant/co-owner makes improvements to the property.
- Retains a long-term option to repurchase the home at an agreed-upon formula-driven price, giving the homeowner partial equity with the remaining equity staying with the community land trust.
- Resells/rents the structure at a below-market rate; in either scenario, the land is retained in perpetuity within the trust.

A key goal of CLTs is to preserve housing affordability, ensuring that households with lower incomes can maintain access to safe and reasonably priced residences, even as neighborhood housing costs rise. Beyond affordability, CLT models offer broader support to residents and the community. CLT homeowners exhibit lower rates of delinquency and foreclosure compared to those engaging with the traditional housing market. This is attributed to the CLT's proactive assistance for homeowners facing mortgage challenges and its inherent ability to add community value irrespective of the housing market's rapid cost increases. CLTs also organize residents at each home, providing opportunities for resident empowerment through shared governance. Furthermore, CLTs prioritize community voices in decision-making and land use, fostering a more inclusive and participatory approach.[11]

Crucially, CLTs contribute to advancing racial equity in homeownership by increasing opportunities for minorities to engage in first-time homeownership.[12] This multifaceted approach aligns with the overarching mission of CLTs, transcending the conventional housing paradigm to create sustainable, affordable, and equitable communities. This model also fosters the opportunity for individuals with lower incomes to build wealth

[10] Supportive Housing Community Land Alliance Innovative Project Plan Description. (2019).
[11] Grounded Solutions Network. (2024). Foreclosure Crisis. Retrieved from Foreclosure Crisis.
[12] Shelterforce. (2021). Understanding Community Land Trusts. Retrieved from Understanding Community Land Trusts.

through equity of home ownership which in turn ensures residents are not displaced due to gentrification or land speculation.

While there are many strengths related to CLTs, it is important to note that CLTs often depend on external grant funding for land acquisition, housing development, and operations. Without public capital, it can be difficult for land trusts to fulfill their mission, carry out intended activities, and ensure long-term sustainability.

SHCLA Overview and Goals

Recognizing the significant need to address community challenges related to homelessness and SMI, the County identified the CLT model as an innovative solution. SHCLA was established with broad community support and the active involvement of families who advocated for its creation. ACH collaborated closely with the community and leaders in the housing, development, and healthcare sectors to support the model. Although the CLT model has not previously been developed to house individuals with SMI, its success could position it as a future best practice, potentially serving as a model for other counties to adapt. The MHSA Innovations grant was the primary source of funding for SHCLA operations from 2019 through 2024.

Following the initial plan set forth in the Alameda County MHSA Innovation Grant, SHCLA applies the CLT model by bringing permanent affordability and community control to help ease the housing crisis for SMI consumers whose income is 200 percent below the federal poverty level. The organization aims to acquire land and ultimately maintain ownership of what it acquires permanently, in turn, developing long-term, renewable leases with residents. To achieve this lofty aim within the five-year time frame of the innovation funding, SHCLA was charged with establishing itself as a as a nonprofit [501(c)(3)], creating initial infrastructure, staffing, establishing agreements between community partners, developing policies and procedures, and acquiring properties and residents.

SHCLA is governed by of a Board of Directors to be comprised of nine to 12 individuals, with one-third representing consumers and family members, one-third representing the public sector, and one-third representing community partners with specific areas of expertise and a commitment to expanding and improving supportive housing. This was created to balance the interest of individual land trust homeowners with the interests of the community.



SHCLA was designed to:

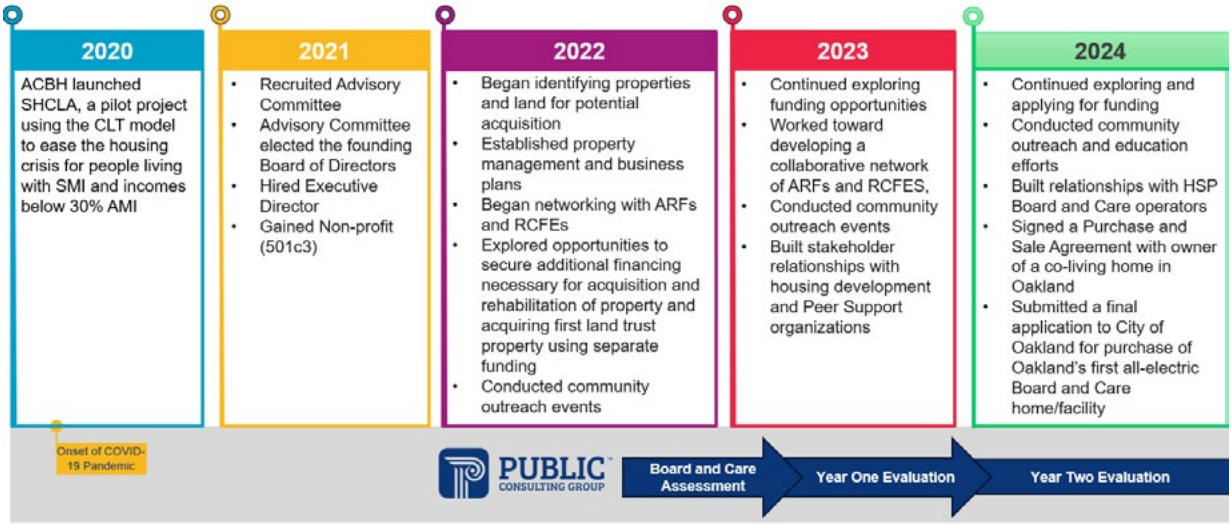
- Create and steward permanently affordable housing through the community land trust model by maintaining ownership of the land;
- Ensure that the homes on this land will provide safe, secure, and supportive housing for residents whose income is 30 percent or less of the Alameda County Area Median Income (AMI); and

- Provide residents with stable and affordable housing that is integrated with compassionate and caring supportive services to ultimately provide opportunities for individuals with SMI to have affordable home ownership while building personal and community equity.

Figure 1 illustrates SHCLA's operations timeline from 2019 to 2024. Despite being launched during the onset of the COVID-19 pandemic, SHCLA made substantial progress while operating virtually for the first two years. In 2024, key activities included continued efforts to explore and apply for funding, community outreach and education, building relationships with HSP Board and Care operators, signing a Purchase and Sale Agreement with the owner of a co-living home in Oakland, signing a Letter of Intent to purchase a 9-unit home in Oakland, and submission of a final application to the City of Oakland for the purchase of Oakland's first all-electric Board and Care home with solar and other environmentally sustainable features.

Public Consulting Group LLC (PCG) was contracted to conduct a Baseline Board and Care Assessment (October 1, 2022 - June 30, 2023) and independent external evaluation of the SHCLA. The Year One Evaluation comprised January 1, 2023, through December 31, 2023, while the Year Two evaluation was conducted from January 1, 2024, through September 30, 2024.

FIGURE 1. TIMELINE



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Report Purpose and Structure

This final evaluation report primarily focuses on findings from Year Two (January 1, 2024 – September 30, 2024), including achievements, challenges, and lessons learned from the last two years related to SHCLA's implementation, capacity building, impact, and sustainability. Results from the evaluation are important to identify opportunities SHCLA and the County can consider to ensure continued implementation and sustainability of the model. The report is comprised of the following sections:

- Evaluation Methodology;
- Implementation;
- Capacity Building;
- Outcomes;
- Summary; and
- Opportunities.

Evaluation Methodology

PCG conducted a process and outcome evaluation utilizing a mixed methods strategy drawing from multiple qualitative and quantitative sources. Key evaluation questions were derived from the program's implementation goals. Additionally, they were outlined in the theory of change and logic model to guide the evaluation. Results from the evaluation are important to identify what opportunities SHCLA and the County can consider to ensure continued implementation and sustainability of the organization. Results Based Accountability (RBA) is also employed to center the intended results and measures needed to achieve them (How much did we do? How well did we do it? Is anyone better off?).[13]

To enhance the evaluation, PCG utilized an Action Research Model[14] which requires the evaluator to be actively engaged in the project implementation process by providing technical assistance and guidance on an ongoing basis. As the evaluator, PCG attended ongoing SHCLA project meetings and provided regular feedback to ensure continuous quality improvement.

The overarching evaluation questions were:[15]

1. Can Alameda County, within two years of using the Community Land Trust (CLT) model, create an equitable representation on a well-run/effective Board of Directors that includes one-third (1/3) consumers, one-third (1/3) family members, and one-third (1/3) community housing experts?
2. Can a community land trust model, targeting the SMI population, facilitate a successful, financing model that results in adequate resources to sustain operation of a community land trust?
3. Can the use of a CLT model for supportive, affordable housing targeted to the SMI population have an impact on reducing Board and Care closure rates in Alameda County?
4. Can the use of a CLT model for supportive affordable housing targeted to the SMI population have a positive impact on HSP Board and Care operators in Alameda County?
5. How effectively has SHCLA communicated its role and impact within Alameda County?
6. Can the CLT model provide an opportunity to build personal wealth balanced with community wealth using the private sector for public good?
7. What is the long-term sustainability and growth potential of SHCLA?

[15] Due to the status of SHCLA implementation during the Year Two evaluation, questions three and six were unable to be answered. Questions four, five, and seven were added to the Year Two evaluation to further assess SHCLA implementation.

Process Evaluation

A critical component when implementing a new initiative, especially one which has merit for replication across other counties or states, is to understand how the program was implemented. Both the process used and the degree to which the program is implemented as originally intended (fidelity to the model) are important factors to consider. Results of the process evaluation also serve to inform the outcome evaluation. For example, if the program is not implemented as intended, the divergence from fidelity may be why outcomes are not achieved as expected. The process evaluation aims to provide insight and documentation of the second year of SHLCA implementation. The process evaluation questions examined in Year Two are included in Table 1.

TABLE 1. PROCESS EVALUATION QUESTIONS FOR YEAR 2

1. How were members of the Board recruited, and has the composition goal been achieved?
2. Are members satisfied with the governance, discussions, decisions, and bylaws?
3. Has an Executive Director been appointed, and other staff positions filled?
4. Has the CLA secured approval for incorporation as a non-profit 501(c)(3) entity?
5. Which models have proved effective for CLT sustainability?
6. What public and private investments have been leveraged/secured?
7. Has the organization developed supportive housing property management skills, master leasing capacity, housing partnership, and the subsidy management expertise?
8. Has sustainability been achieved?
9. Which strategies have been most/least impactful to raise awareness of SHCLA's presence within the community?
10. How successful has the community land trust been in establishing and nurturing partnerships with key stakeholders (*e.g., community stakeholders, including residents, local organizations, and advocacy groups, government agencies, housing authorities, financial institutions, and nonprofit organizations*) to leverage resources and support its mission of providing affordable housing)?

Outcome Evaluation

The outcome evaluation focuses on the broader effects directly impacting individuals served through SHCLA by examining if the CLT model provides an opportunity to build personal wealth balanced with community wealth using the private sector for the public good. Due to the current stage of SHCLA implementation at the time of the Year Two evaluation, PCG was unable to fully address the initial outcome evaluation questions. Table 2 highlights the outcome questions PCG originally sought to answer as part of the

SHCLA Year Two evaluation. PCG collaborated with ACH and SHCLA to re-focus the outcome evaluation on the long-term sustainability and growth potential of the organization.

TABLE 2. OUTCOME EVALUATION QUESTIONS

1. What investments from family members have been made in specific land trust projects?
2. Have clients and families purchased units?
3. Have outcomes improved for housed clients?

Data Collection and Analysis

Using a mixed-methods evaluation strategy involving both quantitative and qualitative data sources, PCG worked with ACH to develop data collection instruments and collect data from key partners for the Years One and Two evaluations.

In PCG's initial evaluation plan, quantitative data sources for the Year Two Evaluation included SHCLA records to assess residents' income, number of months in SHCLA housing, and percentage of units purchased by clients and families. PCG also intended to review case manager data to evaluate residents' health insurance and usage of acute mental health services. Given the status of SHCLA implementation at the time of the Year Two evaluation, PCG was unable to analyze these quantitative data sources.

Qualitative data elements in Year Two consisted of seven interviews with key partners and experts, including the Project Management Team, Board of Directors, ACH and H&H staff, Housing and Community Development staff, and East Bay Supportive Housing Collaborative staff. Additionally, PCG conducted a group interview with nine HSP Board and Care operators, in addition to the HSP Team Lead and two HSP liaisons (Appendix A). Interviews were conducted in June through July 2024 via Microsoft Teams. The group interview with SHCLA's Board of Directors was conducted in-person.

PCG also conducted a document review to further assess SHCLA's progress towards implementation. The following documents were reviewed and analyzed by the evaluation team:

- Project Team Meeting Notes
- SHCLA Micro Grant Award Letters
- SHCLA's Sustainability Plan
- SHCLA's Program and Funding Strategy
- SHCLA's Project Narratives
- SHCLA's Social Media Sites including LinkedIn and YouTube

Limitations

There are several limitations to note, primarily related to SHCLA's program implementation status and the engagement of partners, that impacted data collected.

In PCG's proposed evaluation plan, interviews were intended to be conducted with clients to measure satisfaction with the CLT and members of the organization, as well as to measure perceived benefits and challenges with housing under the CLT. Additionally, documentation was intended to be reviewed to analyze client income and health insurance, usage of acute mental health services, number of months in SHCLA housing, and percentage of units purchases by clients and/or families. PCG was unable to conduct these interviews or review these documents due to the current stage of SHCLA implementation at the time of the Year Two evaluation

PCG was unable to include SHCLA's Quarterly Reports from January-September 2024 within the timeframe of Year Two data collection (January 1, 2024-August 31, 2024). However, the quarterly reports can be found in Appendix B. Furthermore, due to small sample sizes, reliable reporting on the significance of the findings is limited to the perspectives of those included in the data. Although greater participation among Board and Care operators was anticipated, PCG understands that limited engagement with this group is likely influenced by the high demands of caring for individuals with SMI, shrinking staff support, rising operational costs, and uncertainty about the long-term sustainability of their facilities.

Implementation

Innovation funding was intended to be used across five years to create and fully develop SHCLA based on a CLT and supportive housing model. The initial two years of implementation were designed to establish the initial infrastructure and staffing, secure agreements with community partners, and develop policies and procedures. During the five-year initial funding cycle, ACH anticipated completing at least two new supportive housing projects through SHCLA. This section discusses the evaluation findings across SHCLA start-up to implementation, organizational capacity to meet its mission and goals, and progress on acquisition.

Start-Up to Implementation

Over the past two years, SHCLA has had many accomplishments and lessons learned, particularly related to operations. Key short-term outcomes discussed in this section are the incorporation of the SHCLA as a non-profit 501C(3), development of policies and procedures, and formation of a diverse Board of Directors and organization staffing structure which allows for equitable participation by SMI consumers and family members.

Establish Non-Profit (501c3) Operational Infrastructure

One of SHCLA's greatest initial achievements was receiving non-profit (501c3) status, submitting the 1023 application, and getting approval from the Internal Revenue Service (IRS) in 2021. The Board of Directors dedicated considerable time to completing the application, and it took almost one year to receive a response from the IRS. SHCLA received this status just in time to continue its operations, achieving one of its short-term outcomes.

Administrative Operations, Policies and Procedures

SHCLA has established essential operational components such as a financial infrastructure, including a bank account, payroll processing, as well as health benefits for staff. To facilitate the onboarding processes, the organization developed an onboarding guide, personnel handbook, and training plan for prospective new hires. SHCLA partnered with an accounting firm to handle bookkeeping and accounting services. The scope of their services included establishing SHCLA's chart of accounts, generating invoices, processing payroll, and providing financial statements.

The Executive Director and Board of Directors review the Standards of Excellence checklist as an ongoing risk management and performance tracking tool. This tool helps SHCLA adhere to best practices concerning its Board, mission, governance, financial management, development and fundraising, volunteer management, safety, project protocol, community impact, hiring, training, record retention, IT, collaboration, marketing, and communications.

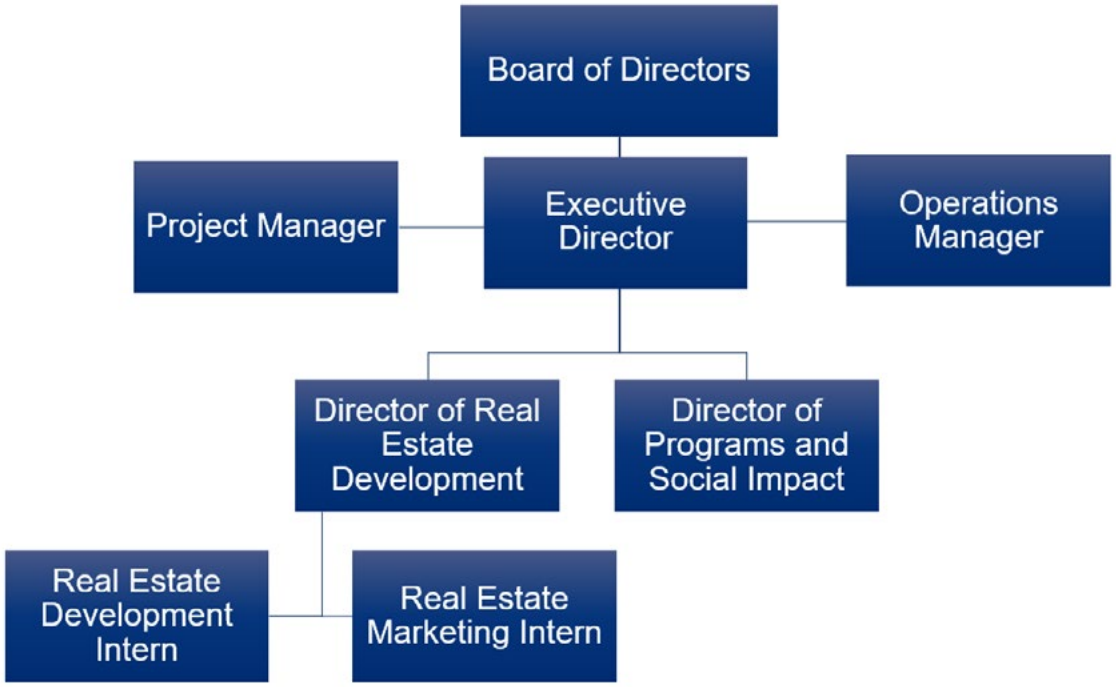
SHCLA's Innovative Project Plan Description included that the organization would "develop master leasing and housing subsidy management policies and procedures, hire and train key staff to operationalize property and subsidy management plans, and begin transition of property and subsidy management approach from existing entities to

SHCLA". According to SHCLA staff, the organization developed a plan for subsidy management, which was subsequently shared with the County. Ultimately, it was determined that the County would assume responsibility for subsidy management, allowing SHCLA to concentrate primarily on property acquisition.

Staffing

The vision and direction of SHCLA are shaped through a collaborative effort involving SHCLA staff, a Board of Directors, and an Advisory Committee. Figure 2 presents the current SHCLA staffing structure.

FIGURE 2. SHCLA STAFFING[16]



Despite delays in contract execution that postponed initial staffing, the organization hired an Executive Director in November 2021 who has successfully led the organization for nearly three years to date. The Executive Director's primary responsibility is to provide oversight of SHCLA, consultants, and staff, as well as the Board of Directors, and the organization's two housing models. SHCLA also hired a Project Manager in July of 2024 who is responsible for overseeing the implementation of the project, developing agency and community support and linkages, and ensuring the project achieves its intended objectives.

Over the past year, there have been modifications to SHCLA's staffing framework. The initial SHCLA staffing plan proposal included an Administrative Assistant responsible for

[16] Supportive Housing Community Land Alliance. (2024) About. Retrieved from About SHCLA.

providing support to the Executive Director and other staff, assisting in daily office needs, and managing the agency's general administrative activities. Considering implementation status, SHCLA identified several alternative positions, including an Operations Manager, to be better suited for their current needs. The organization received approval from the County in 2024 to update staffing roles. The role of the Operations Manager includes various administrative duties, office manager duties, and outreach and communication responsibilities. The position was filled in the Spring of 2024.

The initial SHCLA staffing proposal also included a Director of Property Management responsible for integrating supportive housing property management and policies, existing best practices, and the unique requirements created by mixed funding sources. This position was replaced with a Director of Real Estate Development responsible for leading real estate acquisitions and building out the real estate development department. The position was staffed in 2024.

In addition to the previous positions described, SHCLA's initial staffing proposal included a Director of Workforce Development and Training responsible for ensuring that staff involved with specific housing projects have the support and tools necessary to maximize the success of housing projects. This position was replaced with a Director of Programs and Social Impact responsible for tracking and sharing the organization's impact goals and measures. This position was staffed in 2024.

SHCLA's current staffing structure also includes a Real Estate Development Intern responsible for researching and assisting in the identification of future development sites, and a Real Estate Marketing Intern responsible for developing content for social media and website distribution. In 2024, SHCLA hired a Real Estate Development Intern from Carnegie Mellon University, who played a pivotal role in advancing the organization's housing projects with a focus on due diligence and feasibility. His efforts supported SHCLA in assessing potential properties and operators, ensuring they align with their programs and regulations.[17] The organization additionally hired a Real Estate Marketing Intern from University of San Francisco who works directly under the Operations Manager.

SHCLA uses multiple platforms including LinkedIn and Indeed to recruit potential staff members and works with a Human Resources Consultant to screen candidates and conduct initial interviews. The organization's Advisory Committee and Board of Directors often participate in the following interview rounds. The organization is nearly fully staffed, with just one position remaining to be filled to complete the team. Complete staffing will ultimately allow SHCLA to engage in a way with the community that is most responsive to their needs.

[17] LinkedIn. (2024). Supportive Housing Community Land Alliance Posts. Retrieved from Supportive Housing Community Land Alliance Posts.

Advisory Committee

In 2021, SHCLA recruited an Advisory Committee, which is comprised of a diverse membership including peers and family members, public sector representatives, and community partners. There are multiple members of the Advisory Committee with living and lived experience who represent various areas of expertise, such as members from Peers Organizing Community Change (POCC), the California Housing Finance Agency, and real estate agents. The Advisory Committee provides expertise, perspective, and resources, along with offering feedback and recommendations to the Board of Directors.[18] This group meets monthly to provide feedback on items and documents related to operations.

One of the early key accomplishments of the Advisory Committee was electing the founding Board of Directors. Five Board members were initially elected; however, two of those individuals are no longer members, due to varying reasons. The current Board of Directors is comprised of six members. During interviews, the Board of Directors members indicated that the Advisory Committee members are excellent networkers and have introduced the organization to key contacts, including assembly members. Board members also highlighted the Advisory Committee's strong presence at last year's in-person "Out of the Shadows" panel discussion at SHCLA's second-anniversary community event at the Oakland Museum of California.

Board of Directors

A key objective and short-term outcome of SHCLA is the establishment of a Board of Directors, comprised of nine to 12 individuals, represented by one-third public representatives, one-third community experts, and one-third with lived experience, family members, or future residents.

Collectively, the group brings together combined experience aligned with the proposed composition. Among the current six members, three qualify as community experts, and two members have experience connected to public representation. Board members have a variety of backgrounds in homelessness advocacy, housing security, transportation/mobility, construction, philanthropy and policymaking. During the Board of Directors group interview, multiple members shared that they have family members with SMI, while others mentioned current and past work supporting individuals with SMI. Additionally, multiple members indicated experience supporting individuals with housing insecurities, highlighting the benefits of stable housing and the positive impact it can have on individuals with SMI.

Figure 3 showcases the strengths, weaknesses, opportunities, and threats highlighted by the Board in the Board of Directors for Year Two.

[18] Supportive Housing Community Land Alliance. (2024). Get Involved. Retrieved from SHCLA Get Involved.

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FIGURE 3. SHCLA'S STRENGTHS, WEAKNESSES, OPPORTUNITIES, AND THREATS

Strengths	Weaknesses	Opportunities	Threats
• Significant efforts have been invested in the development of the organization's infrastructure. • The Board demonstrates a strong commitment and dedication, even while balancing demanding careers and initial capacity challenges. • The process of property acquisition has offered valuable learning experiences. • SHCLA has strong partnerships with other CLTs, local government, and community organizations.	• There have been challenges securing product-market fit for for-profit operators, less familiar with the community land trust model. • There were past challenges with Board capacity and the loss of key members. • Significant reliance on a County contract presents challenges with the timing of reimbursements and financial stability. • There have been challenges modifying the budget to serve the needs of the project goals under an ambitious timeline.	• Potential to expand the Board to 10-12 members, increasing capacity and support • Maintaining a strong relationship with the County and securing champions within the County who can advocate for SHCLA's mission and budget • Development of a marketing budget and strategy to better communicate SHCLA's mission and achievements • Leveraging learning experiences from past challenges to refine strategies and improve future outcomes	• Current economic conditions and real estate marketing challenges, such as high interest rates, can impact property acquisition efforts. • The complexity of the CLT model and the challenges in communicating its purpose and benefits to stakeholders and the broader community

Board member recruitment continues to be a priority. The process for recruitment begins with the submission of an initial interest form, which is reviewed by the Executive Director. This is followed by a conversation either in person or via Zoom. Candidates are subsequently invited to meet the Advisory Committee for additional input. Afterward, potential Board members are invited to attend and observe a Board meeting, providing an opportunity to meet the Board and gain insight into its proceedings. Finally, the Board votes on the candidate's membership. By the end of 2024, SHCLA plans to have between 10 and 12 Board members. As Alameda County employees are ineligible to serve as Board members, SHCLA is actively seeking to recruit other public representatives to serve on the Board. SHCLA staff also indicated that there is an opportunity to recruit additional Board members with deeper connections to philanthropy and Board members from the southern part of the County.

SHCLA's Executive Director has worked closely with the Board of Directors to set the strategic vision for the organization. The Board convenes monthly, with occasional ad hoc meetings as needed. The organization provides a Board report, which includes a financial presentation and a forward-looking analysis of key trends and upcoming developments. Additionally, the meetings offer updates on the organization's collaboration with the County and other project updates. Interviews with Board members indicate that they are satisfied with SHCLA's governance, bylaws, and decision-making processes, and they express interest in seeing the project continue beyond 2024.

SHCLA Housing Models

SHCLA was designed to create two types of housing along the continuum to support individuals with mental health challenges — the Licensed Board and Care Model and the Family Partnership Model (Figure 2). Both models are designed to provide permanently affordable community-controlled assets governed by a diverse Board of Directors, as described earlier.

FIGURE 4. SHCLA'S HOUSING MODELS[19]



The first housing model that SHCLA plans to develop is the **Family Partnership,** in which parents of adult children with SMI can purchase a home or unit for their child to provide them with support and stability.

Components of the Family Partnership Model include:[20]

- Families receive a lifetime lease, and SHCLA owns the land and improvement.
- Families establish special needs trusts, CalAble accounts, and work with an attorney and financial advisor/estate planner to ensure adequate assets are available for the long-term needs of their adult children.
- Family groups work with an attorney to establish a retained life estate.

[19] YouTube. (2024). Supportive Housing Community Land Alliance x National Alliance on Mental Illness. Retrieved from SHCLA x NAMI.
[20] YouTube. (2024). Supportive Housing Community Land Alliance x National Alliance on Mental Illness. Retrieved from SHCLA x NAMI.

- SHCLA stewards homeownership through homeowner education on budgeting, holding a mortgage, home repair, and maintenance.
- SHCLA provides resident and family representation via Resident Councils and Board seats.
- The property is provided to another family with SMI lived experience at an affordable price.

SHCLA's role in the Family Partnership as owners of the land and improvements also includes working with the families to secure supportive partnerships, such as executing memorandum of understandings (MOUs) with organizations that provide supportive services. Additionally, SHCLA will coordinate property management, such as maintenance and property upkeep.

Biophilic design is also important as SHCLA considers recovery and connection to the living world. This design concept focuses on the use of direct nature to increase connection to the natural environment. In designing the interior spaces of the property, SHCLA intends to include plants and greenery to help alleviate symptoms of SMI and provide opportunities for engagement with activities related to planting and growing.

The second model that SHCLA plans to establish is a **Licensed Adult Residential Facility**, in which the organization master leases the home to an operator for a 10-year term, with an owner right to renew for five additional years. SHCLA can preserve the home by purchasing the property if the operator chooses to retire or close their home. This model was created as a solution to the significant number of Board and Care home closures over the past three years. Therefore, it is important for the organization to provide technical assistance, support, and opportunities for operators to succeed.



Through this model, SHCLA intends to offer asset management services including property management oversight, lease reviews, and contractor selection for capital projects. SHCLA will also provide social impact oversight to include metric performance oversight of the operator, staff, and any outside staff vendors to comply with MHSA grant funding. SHCLA has been working closely with a licensed Board and Care Operator to bring this project to life.

The target population for the first acquisition under the Licensed Board and Care Model is Transition Age Youth (TAY), who are non-minor dependents under extended Foster Care, as designed under AB 12 and extended Foster Care due to their care needs as individuals who have experienced significant trauma, transitions from facilities, and ultimate homelessness. Additionally, 100 percent of the target population will be living

with SMI. The proposed project will house TAY who are 100 percent unhoused at the time of services engagement with Bay Area Community Services (BACS) and their full Full-Service Partnership-wrap around services program. Future acquisitions under this model will serve seniors and will likely be in the southern part of the county.

Organizational Capacity to Meet Mission and Goals

SHCLA's mission is to ease the housing crisis for people with serious mental health challenges in Alameda County. The organization plans to carry out its mission by creating and stewarding permanently affordable housing. Ultimately, the homes within the land trust aim to provide safe, secure, and supportive housing for residents whose income is 30 percent or less than the Alameda County AMI. [21]

SHCLA has several internal programs intended to facilitate their mission. These programs include Property Acquisition, Supportive Services, Micro Grants, and a Services Collaborative. Descriptions of each program are provided in Figure 4.[22]

FIGURE 5. SHCLA INTERNAL PROGRAMS

Property Acquisition	Acquiring and rehabilitating properties in high-opportunity/moderately resourced/transit-oriented neighborhoods with public or private funds
Supportive Services	SHCLA contracts with quality service partners and Board and Care operators to provide supportive services; SHCLA provides quality standards; families participate in Resident Councils
Micro Grants	Quality of life improvements for Board and Care homes
Services Collaborative	Collective Impact approach to services including health centers, peer support organizations, art therapists, city and county staff, and development partners

SHCLA's strategy to meet its mission and goals includes the following concepts:[23]

- Leveraging public and private investments in a single property;
- Acquiring and rehabilitating properties vs. new development in early years of operation;

[21] Supportive Housing Community Land Alliance. (2024). Our Mission. Retrieved from SHCLA's Mission.
[22] YouTube. (2024). Supportive Housing Community Land Alliance x National Alliance on Mental Illness. Retrieved from SHCLA x NAMI.
[23] YouTube. (2024). Supportive Housing Community Land Alliance x National Alliance on Mental Illness. Retrieved from SHCLA x NAMI.

- Clustering developments in neighborhoods for efficient and effective provision of property management and services;
- Property and neighborhood beautification using biophilic design and art at site and neighboring homes;
- Providing services that are rich in community activities and participation, peer navigation, and family involvement;
- Highlighting community as a mental health intervention; and
- Providing "integrated settings" through engaging neighborhood groups and activities in the community.

SHCLA's model emphasizes on-site services and strong community integration, prioritizing trauma-informed, culturally responsive, compassionate, collaborative, and peer-centered care. Recognizing the importance of fostering meaningful connections to combat isolation through social support, SHCLA ensures families benefit from a comprehensive range of services. These include site locations that are conducive to recovery and advocacy for families and the system of care established to meet family needs. Additionally, families will have access to financial assistance, including accounting and legal support, supportive services, grant writing, and fundraisers as well as peer support tailored to both parents and residents.[24]

As residents progress through programming, SHCLA would ultimately like to measure progress toward well-being goals. In addition to measuring the number of days that residents remain permanently housed, SHCLA plans to use the Milestone of Recovery Scale (MORS), a measurement tool that tracks recovery for residents with mental health needs. The MORS tool assesses a client's level of risk, level of engagement with the mental health service system, and level of skills and supports.[25]

Funding Operations

The total budget for SHCLA's project exceeds $6M, accounting for personnel costs, operating costs, equipment and technology, and consultant costs. SHCLA's Innovative Project Plan Description outlined that MHSA Innovation funds were not permitted to be utilized for the purchase of land or rehabilitation and/or construction of new housing, as innovation funds cannot be allocated under CCR§ 3910.010(b)(1).[26] In the Project Plan Description, submitted in July 2019, the County initially identified Capital Facilities and Technological Needs (CFTN) funding to purchase initial property for the project, once SHCLA was operational.[27] However, this funding did not materialize for SHCLA.

[24] YouTube. (2024). Supportive Housing Community Land Alliance x National Alliance on Mental Illness. Retrieved from SHCLA x NAMI.
[25] Alameda County Behavioral Health Services. (n.d.). Milestones of Recovery Scale (MORS) Retrieved from Milestones of Recovery Scale (MORS).
[26] Cornell Law School, Legal Information Institute. (2015). Cal. Code Regs. Tit. 9, § 3910.010 - Time-Limited Pilot Project. Retrieved from Cal. Code Regs. Tit. 9, § 3910.010 - Time-Limited Pilot Project.
[27] Supportive Housing Community Alliance Innovative Project Plan Description

Despite the absence of CFTN funding, the County has worked with SHCLA to identify alternative funding sources for acquisition, while SHCLA has diligently pursued funding opportunities for acquisition and operations by submitting applications to local and state sources. To date, SHCLA has secured two grants to support operations of the organization, a Local Initiative Support Commission (LISC) grant to build a Resident Council for SHCLA's Family Partnership Model, and a Catholic Campaign for Human Development grant. Rather than focusing significant time on obtaining grants for operating, SHCLA has been working with the assistance of an outside grant writer to concentrate its efforts on securing capital for projects and an additional contract with the County to continue implementation efforts. It should be noted that various funding sources require an organization to have at least three years of experience with audited financials and three projects that are similar in size or community served. As a result, SHCLA has been ineligible to receive those specific funds.

Acquisition

SHCLA expects to secure two properties by December 15, 2024. The current property of interest for the Family Partnership Model is located in Oakland, California. SHCLA plans to acquire this nine-unit home with rental units to establish affordable, independent living apartments, complemented by supportive services, for adult children with SMI who receive financial support from their parents. The home will offer a family-supported independent living environment with a variety of unit types, and it will house residents from diverse backgrounds including skills, experiences, geographies, and ages.[28]

Recently, SHCLA obtained a $50,000 grant to establish a family-led Resident Council, offering an opportunity for families to provide peer support. This council will enable families to share and receive information and education on various systems and strategies for connectedness, while also helping parents develop positive approaches and methods for addressing individual and family self-care needs. In addition to emotional support, the Resident Council will allow for concrete support, such as coordinating care or transportation. A key deliverable of this initiative will be the development of a toolkit for families across the country describing how to create and govern a Resident Council with family participation. SHCLA is currently building out a waitlist for families interested in family-supported housing.

The current property of interest for the Licensed Board and Care Model contains 24 beds and is also West Oakland's first all-electric building with rooftop solar panels. The property will offer more than ten supportive services, including specialized care for Substance Abuse Disorder. This housing model emphasizes resident quality of life and engagement opportunities, and the current property of interest has a community roof deck to offer enhanced community activities. Additionally, the property is located in proximity to the West Oakland Bart Station, a community garden, church, and grocery store for residents. Ultimately, SHCLA hopes that 90 percent of residents will experience improved mental

[28] SHCLA's Project Narrative for *AVEC*

health, reduction of symptoms, and psychiatric hospitalization through coordinated behavioral healthcare and medication management.[29]

SHCLA has signed letters of intent (LOIs) for both housing models and is very close to acquisition of the two properties of interest.

California State Initiatives and Funding Opportunities

Alameda County was recently awarded various funding opportunities aimed at supporting individuals experiencing homelessness with highly complex behavioral health needs. SHCLA is actively monitoring these sources as potential opportunities to carry out its mission and goals. In August 2024, Alameda County Health (ACH) announced the receipt of an additional $14M through the Bridge Housing and Behavioral Health (BHBH) Program. This latest grant of $14,040,909, when combined with the Round One award of $46,782,359, brings the total BHBH funding for the county to nearly $61M. The time-sensitive nature of this block grant emphasizes the urgency of the County's efforts to address the diverse needs of its unhoused population. BHBH funding is expected to become available in the Fall through December 2024, and all funding must be utilized by June 2027. Alameda County Health's Behavioral Health Department and Alameda County Health Housing and Homelessness Services program plan to work collaboratively to prioritize this investment toward three key areas:[30]

- Expanding interim housing capacity with intensive, on-site services to quickly place individuals with high mental health needs;
- Strengthening homelessness prevention efforts for unstably housed individuals by bolstering family and natural support systems; and
- Identifying and supporting individuals exiting the criminal justice system to prevent homelessness during critical transition periods.

The Community Assistance, Recovery, and Empowerment (CARE) Court program, Mandated by the state, CARE Court is another opportunity designed to offer comprehensive treatment and support for individuals who are homeless and struggling with SMI, substance abuse, and trauma. The funded is intended to support the following key initiatives:[31]

- Expansion of Forensic Access Points to improve access to the Coordinated Entry system for justice involved individuals;
- Homelessness Prevention strategies targeting complex populations, including CARE Court participants and individuals transitioning out of jail;

[29] SHCLA's Project Narrative for *The Union*
[30] Alameda County Health. (2024). Bridge Housing Award Press Release. Retrieved from Bridge Housing Award Press Release.
[31] Alameda County Health. (2024). Bridge Housing Award Press Release. Retrieved from Bridge Housing Award Press Release.

- Rehabilitation of existing interim housing to avoid closures due to deferred maintenance; and
- Enhanced outreach, engagement, and housing navigation services.

Another upcoming funding opportunity is Proposition One, which authorizes over $6B in bonds to build more facilities for mental health care and substance use treatment and more housing for individuals with mental health and substance use challenges. Of these funds, $2B will be allocated to local governments to be used for individuals who are experiencing homelessness or at risk of becoming homeless and have mental health, drug, or alcohol challenges.[32] In July 2024, Governor Gavin Newsom announced the release of up to $3.3B of Proposition 1 funding through the Behavioral Health Continuum Infrastructure Program (BCHIP) grant to expand the behavioral health continuum and provide appropriate care to individuals with mental health challenges and substance use disorders. Round One of BCHIP applications are due on December 13, 2024, and are expected to be awarded by early 2025. A second round of funds will be administered in 2025 to support additional behavioral health facilities.[33] It should be noted that Alameda County is still awaiting guidelines from the state regarding these funding sources.

[32] The California Legislature's Nonpartisan Fiscal and Policy Advisory, Legislative Analyst's Office. (2024). Proposition 1. Retrieved from Proposition 1.
[33] Governor Gavin Newsom. (2024). Governor Newsom Announces up to $3.3 Billion of Prop 1 Funding for Treatment of Seriously Ill and Homeless. Retrieved from Prop 1 Funding.

Capacity Building

During Year Two, several steps have been taken to build capacity and help strengthen the ability of SHCLA to effectively deliver on its mission both now and in the future. While financing for property acquisitions remains a challenge, SHCLA continues to pursue opportunities to foster potential partnerships advantageous to both acquisition models.

SHCLA engages and promotes interagency and community collaboration among a wide range of partners (County Agencies and Offices, housing, real estate legal and financial experts, consumer/client representatives, family member representatives, and existing nonprofit affordable housing developers), developing informal and formal agreements. These partnerships help aid SHCLA in the establishment of a CTL focusing on supportive housing that incorporates unique aspects to address local conditions.

Community Engagement

SHCLA hosted several events this past year to promote community awareness and engagement, including an event at the end of Year One to discuss partner feedback that included the SHCLA Board Advisory Committee, Board and Care operators and Alameda County staff. The Executive Director has also attended community events throughout the year and conducted formal presentations at multiple partner meetings and events, including the Mental Health Advisory Board, Care First, Jails Last taskforce and East Bay NAMI.

In May 2024, SHCLA hosted a *Housing as Healthcare* event for Affordable Housing Month in partnership with East Bay Housing Organizations (EBHO). This event provided an in-person community and partner engagement opportunity to learn more about the impact of Board and Care homes and permanent supportive housing in supporting Alameda County residents with SMI. The event was held at SHCLA's co-working space in Oakland and offered an opportunity for community members to meet SHCLA staff members and learn about the local housing continuum.[34]

One-page handouts on topics ranging from the CLT model to collaborating with advocates for change to the need to expand and preserve Board and Care homes were developed and shared with the community through various avenues, including through the Cultural Responsiveness Committee and their list serve. These informative handouts increased awareness of the SHCLA and its needs in a broader segment of the community.

Additional efforts to engage the broader community and raise awareness of SHCLA's mission include a Happy Hour at a local bookstore in Oakland to educate and support

[34] LinkedIn. (2024). Supportive Housing Community Land Alliance Posts. Retrieved from Supportive Housing Community Land Alliance Posts.

potential community partnerships. This event provided an opportunity for community members to learn more about SHCLA's work, network with peers, and explore how to get involved with the organization. The initial event was a success with over 30 attendees. According to partner interviews, the organization has found that in-person gatherings are the most effective for raising awareness, as they facilitate robust discussions with community members. Additionally, SHCLA provides food at these engagement events to further build community relationships.

In August 2024, SHCLA's Executive Director also presented at multiple events including a presentation with POCC on Engaging Equitably and a virtual Housing and Mental Health Discussion with East Bay NAMI to discuss the overarching goals of SHCLA, community need, the Family Partnership Model, and SHCLA's solution and impact on the community.

There has also been an emphasis on increasing social media engagement to increase public awareness of SHCLA and its mission, and the number of followers on LinkedIn has exceeded 750 in the last year.[35] SHCLA utilizes its social media platforms to highlight engagement opportunities, as well as news related to the local mental and behavioral health and supportive housing funding opportunities. Establishment of the Real Estate Marketing Intern position also enables the organization to develop a broader base of supporters that have an interest or connection to mental health, by advocating for Board and Care homes and individuals with SMI in a visually appealing way.

Local political candidates have also contacted SHCLA, and there is discussion of creating a forum for candidates to speak and show alignment for community supportive housing. Recently, the Executive Director presented at the California Association of Mental Health Peer-Run Organizations (CAMHPRO) to share about equitable engagement efforts and work with POCC. Great progress in creating community connections through equitable engagement has been made during Year Two.

Ultimately, SHCLA aims to enhance its visibility by maintaining presence at regional, city, and state-level events. Participation in these regular meetings not only enables SHCLA staff to stay informed about developments in the behavioral health, housing, and healthcare sectors, but also ensures the organization's active involvement and recognition as a key partner in these areas.

Partnership Development

SHCLA has focused activities on creating partnerships during the second year to ensure success and sustainability moving forward. Key Partners include the Couty and other

[35] LinkedIn. Supportive Housing Community Land Alliance Home. Retrieved from SHCLA Home.

government agencies, licensed Board and Care Operators, and other service providers. Major shifts at the state level seem to align with the production of licensed Board and Cares, and future goals for SHCLA include producing additional types of housing across the behavioral health continuum such as respite and crisis residential facilities to better support the success of licensed Board and Care residents with SMI. Innovative, equitable partnerships at the local, regional and state levels, and community buy-in, are key to expanding the behavioral health housing continuum in Alameda County.



County

SHCLA works in close collaboration with ACH Health and H&H. ACH provides funding to the organization in terms of operating support. H&H provides oversight of the project and funding through state MHSA Innovation funding. The Housing Development and Capacity Coordinator meets with SHCLA's Executive Director monthly and is available for technical assistance. According to leadership at H&H, the County is in favor of SHCLA's mission and sustaining the organization.

SHCLA has also actively worked to establish a partnership with Alameda County Housing and Community Development (HCD) Department, which allocates state, local, and federal funds to projects and programs aimed at addressing housing affordability, improving community infrastructure, and preventing displacement. HCD receives HUD Continuum of Care funding and plays a lead role in the development of housing and programs serving low- and moderate-income households, homeless, and disabled populations. Additionally, HCD serves as the grant recipient for the Community Development Block Grant (CDBG) program, which provides local governments with resources to implement services and programs that support individuals and neighborhoods with low incomes and address the needs of community development.[36] SHCLA has met with the Housing Director at HCD several times over the past two years to share information about the organization's mission and goals. This year, topics included upcoming funding sources related to housing and homelessness and mental health.

Other partners and supporters within Alameda County include POCC and Families Advocating for the Seriously Mentally Ill (FASMI). Along with SHCLA, these organizations recognize the importance of having families and individuals with lived experience help inform their work.

[36] Alameda County Housing and Community Development Department. (2024). Housing and Community Development Department. Retrieved from Housing & Community Development Department .

SHCLA connected with the Care First, Jails Last taskforce to discuss future organizational needs. As a result of SHCLA's presentation, the taskforce's recommendations to the Board of Supervisors included SHCLA receiving capital for acquisitions to replace the CFTN funding. The Executive Director gave a similar presentation to the Mental Health Advisory Board, which also makes recommendations to the Board of Supervisors.

Discussions with the San Francisco Foundation provided the opportunity for introduction to its investment team and sharing SHCLA's Case for Support that outlines the community benefits of donor support, opening the door to potential resource opportunities. Leadership also participated in a workshop presentation of a licensed Board and Care stretch project before a panel that included the Deputy Director of HCD and the CEO of United Way San Francisco. This event was an opportunity to raise awareness of the model, receive feedback from community partners, and cultivate influential partnerships for sustainability.

HSP Board and Care Operators

The Housing Support Program (HSP) has provided funding and support for the non-clinical care of individuals with SMI living in licensed Board and Care homes since 1987. HSP is a critical component of the housing continuum, also supporting ACH in meeting residents' goals related to treatment plans and serving population not reached by HCD and other partners and programs. Over the past two years, SHCLA has worked hard to build relationships with HSP operators. As mentioned previously, SHCLA is working collaboratively with one of the current HSP operators to partner on the 24-bed facility in West Oakland.

One of SHCLA's focuses of 2024 was launching a Services Collaborative, in which HSP Operators will be offered training to build the capacity their facilities to sustain their businesses while driving quality by linking partner facilities with small business resources and customized training by subject matter experts in the health, mental health, homelessness, and aging systems of care.[37] The SHCLA Director of Programs and Social Impact will oversee the development of the SHCLA Services Collaborative, leading training, technical assistance, and capacity building for HSP providers. Activities of the Services Collaborative include:

- Formally assessing the needs of the Services Collaborative to inform delivery and evaluation of services
- Additional trainings and workshops as needed for more breadth and depth
- Coordination of technical assistance and support for government resources
- Quality improvement activities in a peer learning environment
- Outcomes measurement (participation, testimony, financial benefits)

[37] SHCLA's Program and Funding Strategy V 3.0

Engagement with Board and Care Operators has opened doors for potential collaborative partnerships and discussions on expanding the types of housing options across the behavioral health continuum. Cultivating these relationships has brought about new opportunities to partner with Board and Care operators to explore innovative ways to utilize the model in the behavioral health housing continuum.

Service Providers

SHCLA leadership makes ongoing efforts to speak with service providers across Alameda County to learn about their needs and explore ways that the organization can adapt to best support and collaborate with providers. As previously mentioned, SHCLA has hired both a Real Estate Development Intern and a Real Estate Marketing Intern to assist in maintaining these relationships and identifying and building new ones with an eye toward future collaboration and innovative oversight options. SHCLA has continued to build relationships with various service providers including Bay Area Community Service Providers (BACS), Fred Finch Youth and Family Services, Felton Institute, Roots Community Health Center, and Baywell Health (formally West Oakland Health Center). SHCLA has conducted meetings with these providers to build the partnerships that are necessary for SHCLA to be successful.

Ultimately, these partnerships offer SHCLA the opportunity to share information about the project, learn about future initiatives or planned activities, identify areas of alignment, explore opportunities for future collaboration, and create a memorandum of understanding.

Summary

Over the past several years, SHCLA successfully recruited a Board of Directors that closely aligns with its intended composition goals. Additionally, an Executive Director was appointed, and the organization is nearly fully staffed. Overall, Board members have reported satisfaction with the governance structure, discussions, decisions, and bylaws established. SHCLA also achieved approval for incorporation as a non-profit 501(c)(3) entity. The organization has worked hard to apply for funding for initial acquisition and operations. SHCLA has two housing models designed to support individuals with SMI, and the organization is very close to securing its first two properties. Once these acquisitions are finalized, the organization will be in a stronger position to assess its long-term sustainability.

SHCLA has been successful in establishing and nurturing partnerships with the County and local organizations, HSP Board and Care Operators, and other service providers. In-person engagement events and increased usage of social media have been impactful in increasing the organization's visibility and opportunities for future collaboration.

Outcomes

SHCLA's Innovative Project Plan Description describes that long-term success will include, but is not limited to:

- Effect on Board and Care closures, and
- The financial model is sustainable with funds being directed towards the development of new units.

Although SHCLA has yet to secure acquisitions for its proposed housing models, the organization has had a clear impact on HSP Board and Care operators in Alameda County. Additionally, SHCLA is on a path to future growth and sustainability.

Impact on Board and Care Operators

Interviews with HSP Board and Care Operators indicated that SHCLA has had a positive impact. Over the past year, SHCLA has facilitated technical assistance with the County to HSP Board and Care Operators regarding the Community Care Expansion (CCE) Program, which provides funding for acquisition, construction, and rehabilitation projects to preserve and expand adult and senior care facilities that serve Supplemental Security Income/State Supplementary Payment (SSI/SSP) and Cash Assistance Program for Immigrants (CAPI) applicants and recipients, who are experiencing or at risk of homelessness.[38] More recently, SHCLA has been asked by the County to provide support to Board and Care Operators who have lost commercial liability insurance.

Additionally, SHCLA has provided financial support to HSP Board and Care Operators to improve resident's quality of life, facility quality, and sustainability. In January 2025, SHCLA launched its inaugural $5K Micro-Grant program, awarding funds to 11 Alameda County-based HSP operators of licensed Board and Care homes totaling $55K. SHCLA established and funded the micro-grant, which was designed to bring licensed facilities "out of the shadows" by addressing deferred maintenance and supporting other quality-of-life improvements for residents at HSP sites.[39] Nearly all the HSP Operator interviewees reported that the microgrant had a positive impact on their home, noting that the funds were mostly used for building maintenance. Interviewees expressed their gratitude towards SHCLA for providing financial support during a time of great need. It should be noted that the Micro-Grant program was not included within the scope or budget of the MHSA Innovation grant and the County's contract with SHCLA.

In addition to providing technical assistance and financial support, SHCLA has been instrumental in listening to the needs of operators and serving as a key source of support. SHCLA envisions potential partnerships with HSP Operators to acquire properties and master lease them to these operators. This approach would allow smaller operators, managing six beds or less, to expand their capacity to 15 beds or more, thereby enhancing their financial sustainability and ability to serve more clients. Data suggest that 70% of closures are facilities with 6 or less beds. PCG's evaluation in the first year noted that there was mistrust amongst Board and Care operators. SHCLA has worked hard to

[38] California Department of Social Services. (2024). Community Care Expansion Program. Retrieved from Community Care Expansion Program.
[39] LinkedIn. (2024) Supportive Housing Community Land Alliance Posts. Retrieved from Supportive Housing Community Land Alliance Posts.

build trust with the operators and follow through with micro-grants and technical assistance.

HSP Board and Care Operator interviewees reported that SHCLA leadership has attended multiple HSP meetings and visited their facilities to introduce the program and establish potential partnerships. However, operators indicated that the program is very difficult to comprehend, and they are still trying to understand what SHCLA can offer them. One operator reported that, while they understand the program's potential, they are unclear how those goals will be achieved. Additionally, several operators reported a more immediate need for assistance but acknowledged that it takes time for start-up organizations to become fully operational. Interviewees indicated a desire to further connect with SHCLA leadership to learn more. According to HSP liaison interviewees, going out and meeting owners at their homes has been successful in building relationships with HSP Operators and understanding nuances of what support is available. There is an opportunity for SHCLA to continue in-person visits to further clarify SHCLA's mission, what the organization can offer operators, and how they can work together in partnership. Even with these challenges, two operators currently funded by the county, have agreed to partner with SHCLA on projects serving SMI residents.

Sustainability and Growth

SHCLA's bold vision is to provide environmentally sustainable housing in high-opportunity neighborhoods for individuals with SMI in Alameda County. By leveraging MHSA Innovation funds as initial "seed" funding to establish the land trust, the organization envisions a sustainable entity with equitable stakeholder representation. In the long term, SHCLA aims to use non-MHSA Innovation funds to develop supportive housing units, ensuring continued growth and impact. While SHCLA's contract with the County is set to expire on December 15, 2024, the organization hopes to continue its operations in 2025 and beyond.

Sustainability Planning

SHCLA developed a comprehensive Sustainability Plan that represents a holistic approach to long-term organizational resilience as they continue to expand and diversify a community of resource allies.

SHCLA's Sustainability Plan works to achieve sustainability across four pillars, as described in Figure 6.

FIGURE 6. SHCLA'S FOUR PILLARS FOR SUSTAINABILITY[40]

Purpose	Easing the housing crisis for people living with serious mental health challenges in Alameda County
People	Equitably centering the diverse community that constitutes the SHCLA

[40] SHCLA's Sustainability Plan Draft 06/07/22

Profit	Achieving long-term sustainability through diverse sources of revenue
Planet	A regenerative environment that supports health, wellbeing, and equitable access

To further ensure sustainability and mitigate risk, SHCLA created an Executive Director Succession Plan and an Emergency Preparedness and Business Continuity Plan. These plans will help to ensure that the organization may continue through challenging times.

Growth Potential

SHCLA's approach to funding outlines a clear path for the organization's ongoing resource development and offers partners a roadmap to creating a significant impact through housing development and enhanced service quality for unhoused and vulnerable populations. The organization created a Fund Development Strategy which contains goals and benchmarks for 2024 and beyond. Near-term, mid-term, and long-term strategies are outlined in Figure 7.

FIGURE 7. SHCLA'S FUND DEVELOPMENT STRATEGIES[41]

Near-Term Strategies

- Apply for grants to fund operating expenses and core program activities, including the Services Collaborative, and double the number of micro grant-program grantees.
- Partner with local foundations to engage high-net-worth individual donors in supporting program-related goals by establishing and managing Donor Advised Funds (DAFs)
- Partner with at least one local foundation to explore, establish, and secure program-related investments to support development activities in 2024.

Mid-Term Strategies

- Cultivate relationships with private funders at the regional and state level as a priority before approaching national-level private funders.
- Host a "friend-raiser" event to showcase the program and highlight the activities of the Services Collaborative.
- Expand grant funding in support of operations, development, and research for the Community Care Model.
- Seek corporate sponsorship opportunities to provide resources that fund sustainable amenities, community art projects, resident amenities, and resiliency housing.

Long-Term Strategies

- Establish banking relationships with multiple banks over time to optimize the return on financial products in a competitive market, and to maximize the potential for charitable contributions.
- Engage relationships with major employers and industry-leading companies across the County through its existing interface and affiliation with local member organizations.
- Continue to develop its program and service delivery offerings, which will enhance the success rate from its efforts to develop private funding opportunities in the future.

By the end of 2024, SHCLA aims to:

- Acquire a 15+ bed licensed Board and Care home;
- Acquire a 9-unit Family Partnership home;

[41] SHCLA's Program and Fund Development Strategy v 3.0

- Raise $5M in public capital, while also leveraging $1M in SHCLA capital; and
- Preserve or create 30+ beds in Alameda County.

Looking beyond 2024, SHCLA aims to explore how the organization can contribute to developing housing solutions across the behavioral health continuum. While the two current models provide a strong foundation, SHCLA recognizes that residents may transition between different care settings. As the organization considers creating permanent homes where residents can remain indefinitely, it acknowledges that those requiring higher levels of care may need alternative housing arrangements. This is a key focus for SHCLA in 2025 and beyond, particularly in light of upcoming state initiatives such as CARE Court, BHBH Program, and Proposition One. The overarching goal is to ensure that residents in either model can move across the continuum of care with ease and support of SHCLA.

Summary

The Year Two Evaluation Report presents the evaluation findings for the second year of the program (January 1, 2024, to September 30, 2024). Key findings are described below.

Key Findings	
Achievements	• SHCLA is nearly fully staffed, with just one position remaining to be filled to complete the team. Complete staffing will ultimately allow the organization to operate and engage with the community that is most responsive to their needs. • Noted in interviews, the Advisory Committee members are excellent networkers and have introduced the organization to key contacts, including assembly members. • Collectively, the Board of Directors brings together combined experience aligned with the proposed composition of one-third public representatives, one-third community experts, and one-third with lived experience, family members, or future residents. • Significant efforts have been invested in the development of the organization's infrastructure. • SHCLA has signed letters of intent (LOIs) for the Family Partnership and licensed Board and Care model and is very close to acquisition of two different properties. • The visibility of the organization has increased. SHCLA is recognized by important County players such as POCC, HCD, FASMI, EBSHC, and the Mental Health Advisory Board. • SHCLA received letters of support from several City Council members. • The Director of H&H recently presented in Washington D.C. and used SHCLA's project as a model. • Interviews with HSP Board and Care Operators indicated that SHCLA has had a positive impact on these operators, specifically through provision of technical assistance, financial support, and listening to the needs of operators. • SHCLA has secured memorandums of understanding (MOU)s with multiple HSP Board and Care Operators. • SHCLA created a Sustainability Plan and a Fund Development Strategy to ensure operations beyond 2024.

Key Findings	
Challenges	• It has been difficult for SHCLA to meet program implementation expectations without funding for initial acquisitions as expected in the original proposal to the state. • Various funding sources require an organization to have at least three years of experience with audited financials and three projects that are similar in size or community served. As a result, SHCLA has been ineligible to receive those specific funds. • There have been challenges securing product-market fit for for-profit operators, less familiar with the community land trust model. • Significant reliance on a County contract presents challenges with the timing of reimbursements and financial stability. • There have been challenges modifying the budget to serve the needs of the project goals under an ambitious timeline.
Lessons Learned	• Acquiring property for a start-up organization can be very challenging without dedicated funding for initial purchases or adequate staff to acquire properties. Securing acquisition or operating subsidy funds prior to program implementation can help to accelerate the implementation process and support the achievement of future program goals. Replacing Property Management and Workforce Development positions with real estate staff dramatically increased SHCLA's ability to deliver within the project's ambitious timelines. • The CLT model is complex and can be difficult to understand due to its unique structure, which separates land ownership from homeownership. Its legal, financial, and governance structures require a deep understanding of how community control and long-term affordability are maintained, making it challenging for those unfamiliar with these concepts. • SHCLA and the County can leverage past experiences and learning, such as the challenges faced with property acquisition and grant implementation, to refine strategies and improve future outcomes.

Opportunities

Based on process and outcome evaluation findings, the following opportunities are presented to consider as SHCLA continues implementation in 2024 and beyond.

- Continue to gain letters of support for funding from organizations and County officials.
- Strengthen a support system for Board and Care operators to facilitate the sharing of challenges, resources, and best practices.
- Explore upcoming funding opportunities such as the Bridge Housing and Behavioral Health (BHBH) Program, the Community Assistance, Recovery, and Empowerment (CARE) Court program, and Proposition 1, Behavioral Health Services Program and Bond Measure.
- Increase the number of Board of Director members with lived or living experience and connections to philanthropy.
- Maintain a strong relationship with the County and secure champions within the County who can advocate for SHCLA's mission and budget.
- Continue community outreach and education, especially with HSP Board and Care operators.
- Continue to present and explain the benefits of the CLT models and SHCLA's models.
- Explore opportunities to partner with Social Services as the organization looks to strengthen relationships with service providers.
- Continue to participate in MHSA Stakeholder meetings.
- Continue to highlight and celebrate the organization's achievements to build morale and demonstrate progress to partners.

Appendix A. Key Informant Interview Data Collected

Stakeholder Group	Description	Number of Participants
Program Management Team Interviews	Interviews were conducted with several members of the Project Management Team. These interviews were aimed at understanding the successes and challenges encountered in implementing SHCLA in the first two years, as well as sustainability of SHCLA.	2
Alameda County Health, Housing and Homelessness Services Interview	An interview was conducted with a Housing and Homelessness Services staff person. This interview was aimed at understanding the knowledge and interactions with SHCLA.	1
Alameda County Health, Behavioral Health Department	An interview was conducted with a Behavioral Health Department staff person. This interview was aimed at understanding the knowledge and interactions with SHCLA.	1
Housing and Community Development Interview	An interview was conducted with a Housing and Community Development staff person. This interview was aimed at understanding the knowledge and interactions with SHCLA.	1
East Bay Supportive Housing Collaborative	An interview was conducted with an East Bay Supportive Housing Collaborative staff person. This interview was aimed at understanding the knowledge and interactions with SHCLA.	1
Board of Directors Interview	This group interview was aimed at understanding the operations, successes and challenges of SHCLA's Board of Directors and implementing the SHCLA in the first two years, as well as sustainability of SHCLA.	6
HSP Team and Board and Care Operators Group Interview	Interviews were conducted with current clients being served by the SHCLA with the aim to measure satisfaction with the CLT and members of the organization; perceived benefits and challenges with housing under the CLT.	12

Appendix B. SHCLA Quarterly Reports

shcla
Supportive Housing
Community Land Alliance

Q1 2024 Report to Housing and Homelessness

Reporting Period: 1/1/2024 – 3/31/2024

April 15, 2024

Reports shall include, but not be limited to:

- Progress overview – accomplishments, challenges, and milestones;
- Quality Management – regarding community outreach and marketing to stakeholders, consumers, family members, and the public; describing processes to maintain timely achievement of project components including Project Management Team, Board of Directors, acquiring legal counsel, develop CLT entity infrastructure, and primary CLT staffing;
- Any challenges to staffing and recruitment, e.g. Board Members, etc;
- Issues to be aware of, e.g, new regulations or denials of any legal document submission and;
- How any deviations from the planned deliverables and/or project timeline is being addressed
- Summary of data, evaluation data, outcomes

Continue to develop a sustainability plan for SHCLA

A. Short term: SHCLA continues to refine its financial models for the acquisition of board and care homes and independent living homes in our family partnership model. SHCLA expects to generate moderate developer fees for each project as part of its sustainability planning. County MHSA Innovations funds to be used as match for such projects as long as funds are not used for the acquisition of the property.

B. Longer term: SHCLA plans to engage in strategic planning in Q4. This may include an expanded scope of housing along the continuum of housing: behavioral health facilities that meet the requirements of major state initiatives including Care Court, Behavioral Health Bridge Housing, and Prop 1.

a. SHCLA working to better understand how board and care homes will access CalAim funding and/or connect with Coordinated Entry to receive Continuum of Care Funding (ex. Insight Housing's Russell Street Residence).

C. End of Year Fundraising.
   a. End of Year Fundraising planned in Q4 following grant writing efforts throughout the year. SHCLA plans to have proof of concept at this time which will allow philanthropy and major donor support.
   b. SHCLA's Program and Fund Development Plan (attached) includes an outline of expected fundraising targets in 2024 and 2025. A significant amount of SHCLA's funding will continue to be derived from Alameda County in 2024 and progressively increase support of philanthropic and major donors.

D. Media: SHCLA continues to make improvements to its social media presence. Digital Marketing Intern to support administrative staff with newsletter and social media engagement.

II. Work with Public Consulting Group (PCG) to support the delivery of their evaluation services for SHCLA

A. SHCLA executive director met with PCG on January 30, February 21, and March 18. Meetings topics included updates on both project types (licensed board and care and family partnership). Staff shared with PCG the challenge new affordable housing developers face regarding the experience requirements of many sources of funding. For example, some funding sources do not allow staff or consultant experience to meet the developer experience requirements that often require at least 3 years and 2-3 projects of similar size/scope.

III. Facilitate monthly Project Management (PMT) meetings with designated OHCC Contract Manager

A. During the reporting period, SHCLA met regularly with H&H representative Amy Faulstich, Housing Development and Capacity Coordinator on February 5 and March 4. Meeting topics included project updates, the PCG evaluation, the County contract, and funding opportunities.

IV. Secure and establish a workspace for the organization

A. SHCLA continues to work out of Port Labs in downtown Oakland. As staff grows, SHCLA has space to add desks with low-overhead.

V. Establish nonprofit operational infrastructure

A. SHCLA selected Linquist von Husen as its accounting firm and moved HRMIS systems from Zenefits to Gusto.

B. Staff continue to recruit board members and have several candidates in consideration. The goal is to add between 6 and 9 members by year's end.

VI. Hire key leadership positions and other staff positions

A. Staff has been in discussion with H&H staff about its intention to hire real estate development staff to accommodate efficient acquisitions as part of the project's main objective. Proposal to amend the Property Management and Workforce Development and Training Director positions to a Director of Real Estate Development and Director of Programs and Social Impact. A budget modification would also add a Project Manager to provide day-to-day support of real estate acquisitions.

VII. Develop a workforce development and training plan

A. A workforce development and training draft has been developed. Staff working with potential partners to better align the plan with actual services available across the county.

VIII. *Next steps*

A. Refine Feasibility of potential projects and partnerships
B. Secure funding for Vernon family partnership and board and care acquisition
C. Work with ACBH, OHCC, HCD, and SSA to align on sustainability plan outcomes and goals



Q2 Report to Office of Homeless Care and Coordination

Reporting Period: 4/1/2023 – 6/30/2023

July 15, 2023

Reports shall include, but not be limited to:

- Progress overview – accomplishments, challenges, and milestones;
- Quality Management – regarding community outreach and marketing to stakeholders, consumers, family members, and the public; describing processes to maintain timely achievement of project components including Project Management Team, Board of Directors, acquiring legal counsel, develop CLT entity infrastructure, and primary CLT staffing;
- Any challenges to staffing and recruitment, e.g. Board Members, etc;
- Issues to be aware of, e.g, new regulations or denials of any legal document submission and;
- How any deviations from the planned deliverables and/or project timeline is being addressed
- Summary of data, evaluation data, outcomes

I. Continue to develop a sustainability plan for SHCLA

A. Short term: SHCLA continues to refine its proformas as it engages in due diligence for the Vernon Street Acquisition and receives estimates from third party consultants. This includes vendors for appraisals, environmental reviews, physical needs assessments, real estate development consultants, asset management, and others. Staff has no certainty that any additional funding will be available to support SHCLA's operations beyond the current MHSA grant. This means that SHCLA must create financial sustainability through real estate development activities (developer fees, asset management fees, etc).

B. Longer term:

a. Insuring SHCLA has enough real estate development staff to take on projects of a size and scale that will generate sufficient revenue to support SHCLA operations (estimated to be roughly $2.5M per year).
b. SHCLA in discussions about expanded scope of property types to include other facilities along the behavioral health continuum. One of the challenges the County faces is sufficient housing above and below board and care homes along the housing continuum. SHCLA has reviewed organizational models such as Progress Foundation in San Francisco as one viable option. A visual of the housing continuum is presented below for visual reference.

SETTING	FORENSIC/ CORRECTIONS	TREATMENT BEDS		TREATMENT BEDS/ HOUSING	HOUSING	
		ACUTE	SUBACUTE	COMMUNITY AND RESIDENTIAL TREATMENT	INTERIM	HOUSING WITH SUPPORTS
Description	Most restrictive locked setting, offering varying levels of service	Highly structured institutional setting aimed at stabilizing acute conditions, with 24/7 staffing	Secured and structured setting aimed at rehabilitation, with 24/7 staffing	Intensive services in a residential setting focused on stability; a step-down from higher level of care	Supportive and temporary housing with a range of services and supports; typically transitional	Long-term, low-structure setting with a range of services and supports for stable individuals
Examples	▸ Jail ▸ Prison ▸ Juvenile detention facility ▸ Other correctional facilities	▸ Acute psychiatric hospital ▸ General acute care hospital ▸ State psychiatric hospital ▸ Psychiatric health facility ▸ Psychiatric residential treatment facility	▸ Mental health rehabilitation center ▸ Skilled nursing facility—special treatment program ▸ State psychiatric hospital ▸ Community treatment facility	▸ Adult Residential Care Facility and Residential Care Facility for the Elderly (ARF/RCFE) (board and care) ▸ Short-term residential therapeutic program ▸ Congregate care facility ▸ Social rehab facility ▸ Crisis residential program ▸ Peer supported housing ▸ Peer respite	▸ ARF/RCFE ▸ Emergency and interim shelter ▸ Recuperative care ▸ Short-term posthospitalization ▸ Tiny home ▸ Hotel/motel ▸ Modular home ▸ Recommissioned property ▸ Other types of housing as developed locally	▸ ARF/RCFE ▸ Permanent supportive housing ▸ Public subsidized housing ▸ Scattered site ▸ Master lease ▸ Single-room occupancy ▸ Boarding home ▸ Other types of housing as developed locally

C. Partnership Development:
   a. Staff met with a number of service providers across the county to learn more about their real estate development needs and service offerings. During the reporting period, staff met with Roots, Fred Finch, BACS, Felton Institute. SHCLA Executive Director was invited to join All Home's Regional Impact Council to discuss a coordinated strategy for the homeless response system.

D. Outreach: Staff attended the Peers Organizing for Community Change (POCC) June Gathering to build relationships with service providers and share SHCLA's project with community advocates with lived experience.

II. Work with Public Consulting Group (PCG) to support the delivery of their evaluation services for SHCLA

A. SHCLA executive director met with PCG on April 24, May 15, and June 26. Conversations included project updates, outreach, and fundraising.

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Appendices

III. *Facilitate monthly Project Management (PMT) meetings with designated OHCC Contract Manager*

A. During the reporting period, SHCLA met regularly with H&H representative Amy Faulstich, Housing Development and Capacity Coordinator on April 3, May 6, June 3 Meeting topics included project updates, the PCG evaluation, the County contract and progress towards major deliverables.

IV. *Secure and establish a workspace for the organization*

A. SHCLA continues to access co-working space at Port Labs in downtown Oakland. Additional desks were added for staff during the reporting period. The workspace is also conducive to larger gatherings with the broader community. Future events will include 50+ guests in the office space.

V. *Establish nonprofit operational infrastructure*

A. SHCLA continues to recruit board members. In addition to recent board member, S. Novick, formerly of the Kaiser Foundation, SHCLA is recruiting members with lived experience and community experts. SHCLA expects to retain two to three new board members in the next quarter, and another four members in Q4 of the year.

VI. *Hire key leadership positions and other staff positions*

A. SHCLA hired a Director of Real Estate Development and Director of Programs and Social Impact with approval of the budget modification. Both roles will support with acquisitions and program design in their respective areas. The Director of Real Estate Development formerly served as staff at LISC Strategic Investments, Goldman Sachs, and the Greenville Housing Fund. The Director of Programs comes from Center for Employment Opportunities, where she served as a Director serving formerly incarcerated youth in workforce development programs.

VII. *Develop a workforce development and training plan*

A. Director of Programs and Social Impact is reviewing the workforce development and training plan given extensive experience in the space. The plan includes resources for staff training and the role SHCLA will play as possible convenors of a services collaborative of board and care operators.

VIII. *Next steps*

A. Refine Feasibility of potential projects and partnerships
B. Secure funding for Vernon family partnership and board and care acquisition
C. Work with ACBH, OHCC, HCD, and SSA to align on sustainability plan outcomes and goals



Q3 2024 Report to Housing and Homelessness

Reporting Period: 7/1/2024 – 9/30/2024 October 15, 2024

Reports shall include, but not be limited to:

- Progress overview – accomplishments, challenges, and milestones;
- Quality Management – regarding community outreach and marketing to stakeholders, consumers, family members, and the public; describing processes to maintain timely achievement of project components including Project Management Team, Board of Directors, acquiring legal counsel, develop CLT entity infrastructure, and primary CLT staffing;
- Any challenges to staffing and recruitment, e.g. Board Members, etc;
- Issues to be aware of, e.g, new regulations or denials of any legal document submission and;
- How any deviations from the planned deliverables and/or project timeline is being addressed
- Summary of data, evaluation data, outcomes

I. Secure separate financing necessary for acquisition and/or rehabilitation of property

A. Short term: SHCLA submitted an initial application to the City of Oakland for the acquisition of a 24-bed licensed board and care facility serving Transition Aged Youth (TAY). The funding would provide roughly $4M in acquisition funding and the County of Alameda MHSA Innovations grant will serve as a match for the city funds, with the understanding that MHSA funding cannot be used for acquisition. SHCLA is also in discussion with CDFIs including LISC and the Partnership for the Bay's Future Fund regarding our family partnership model.

B. Longer term: SHCLA continues to better understand the challenges service providers and behavioral health facilities face when seeking funding to preserve and protect housing along the behavioral health continuum. As county-funded nonprofit service providers move to create real estate development departments of their own, partnering with SHCLA will take considerable work to ensure product-market-fit. This means that SHCLA's long-term strategy should include potential partnerships with organizations that do not need or want to grow their capacity to take on development projects themselves. At this time, it appears as though SHCLA can provide the greatest value to providers of behavioral health facilities, not affordable housing eligible for tax credits. These facilities include partnerships to preserve and produce projects with Federally Qualified Health Centers, psychiatric residential treatment facilities, board and care homes, and social rehab facilities.

C. End of Year Fundraising
    a. SHCLA is developing a "Case for Support" for philanthropic and major donor outreach. Staff have refined the copy and plans to work with a designer to complete the visual elements for outreach efforts.
    b. Staff met with program officers at San Francisco Foundation, and the Funders Together Network (a meeting of United Ways across the nation). Goal is to increase SHCLA presence and meet with major donors and program officers. SHCLA board members and advisory committee members are engaged in outreach efforts and review of SHCLA collateral given their experience in the space.

II. **Acquire first land trust property using separate funding because Innovation**

funds cannot be used under CCR§ 3910.010(b)(1)

A. SHCLA staff are awaiting a response from the City of Oakland regarding its R2H2 application. The funding would provide $3.8M towards the acquisition of a property. Given the City of Oakland's prioritization of Transition Age Youth (TAY) populations, we believe the project has a high likelihood of receiving an award. Staff met with County Social Services staff regarding the potential of a commitment to the project. Staff will continue to work with County staff on required underwriting requirements of the City of Oakland.

III. **Secure separate financing necessary for acquisition and/or rehabilitation of second property**

A. Staff met with a number of institutions regarding the acquisition of properties. Most notable was the Housing Accelerator Fund's team who indicated both models would likely qualify for lending under various funding sources they would administer.

IV. **Acquire second land trust property using separate funding**

A. Staff continue to meet with families to move towards a formal commitment of family contributions towards the project. At present, this includes a roughly $125K initial contribution and monthly contribution of roughly $2K per month. The structure of the family contribution will likely be a lifetime lease to ensure SHCLA takes on the responsibilities of ownership while the adult children receive lifetime care and support provided by a part-time Resident Assistant.

V. **Completion of final evaluation report on land trust model; dissemination of findings to key stakeholders**

A. Staff continue to meet with community stakeholders in order to share project updates and is preparing advisory committee members to disseminate updates and key findings in early December.

VI. **Develop budgets for residential care facilities (ARF) and single-family home purchases through separate funding**

A. Proformas for both models are well grounded following extensive work with operators of both models. We've reviewed service plans and Plans of Operations submitted to the state, met with a service providers thathas agreed to provide property management and supportive services, and secured proposals from vendors.

VII. **Complete program manuals for property management and supportive services**

A. Program Manuals for Property Management and Supportive Services are complete and will be submitted to the County in Q4. Staff reviewed seminal reports by Corporation for Supportive Housing and SAMHSA to guide our manuals and ensure fidelity to best practices.

VIII. **Develop strategic partnerships to acquire properties with nonprofits that are buying property, serving clients with SMI and delivering supportive services**

A. Staff continue to meet with potential partners. Most significant is our planned partnership with Gentle Heart Care Services, a 2023 Microgrant recipient. The operator currently serves non-minor dependent residents and is an HSP Provider with a stellar track record.

IX. ***Next steps***

A. Secure family commitment for acquisition of Vernon Street
B. Recruit board members
C. Prepare for End of Year Campaign for Q4 Launch

Final Report for 1x MHSA Enhancement Capacity Funds, First Round, FY23/24

Background

In 2022, ACBHD began discussions on how to invest in contracted community-based organizations (CBOs) to rebuild or enhance their capacity. These discussions began for several reasons. Most notably, the effect the COVID-19 pandemic had on the ability of CBOs to provide services, and the mental health effect it had on CBO staff and leadership. To counter these issues and provide support to the CBO community ACBHD developed a one-time capacity grant/investment opportunity that was, effective July 1, 2023, through June 30, 2024.

There are two well knowns in behavioral health care as a provider:

1. CBOs tend to not upgrade their own infrastructure due to the nature of the business: funding and donations only go so far. Sacrifices are made for client care; and
2. Non-profit staff salaries generally have a difficult time providing competitive salaries and benefits compensation compared to private companies along with the fact that the nature of the work is a notoriously difficult job with stress and burnout.

A third aspect was identified which compounded the above two points even further: updating technological infrastructure to align with county utilized technology (i.e. county billing system, aka SmartCare) to comply with recent legislation California Advancing and Innovating Medi-Cal (Cal AIM).

Two funding resources were identified to accommodate for mental health providers and SUD providers: MHSA (Mental Health Services Act) and 2011 Realignment funds respectively (2011 Realignment funds were used because the funding has more flexibility).

The following qualification criteria for applicants was included because these enhancement funds were to be used to bolster CBO's capacity and abilities which in turn will be directly impactful for the county's community clients. The qualification criteria for the applicant were:

1. Be a CBO which currently provided ACBHD-contracted services to ACBHD clients under a Maser or FSP Contract in FY 2022-23; and
2. Have a continuing contracted program with ACBHD under ACBHD under a Master or FSP Contract carrying forward into FY 2023-24.

The county additionally identified specific categories for CBO applicants. These areas were recognized as areas of struggle for many CBOs especially due to negative effects of the pandemic

that were coming to light. To add to these struggles are several legislative initiatives that require technological upgrades to CBO's systems.

The categories were:

1. Initiatives to support the launch and sustainability of Cal AIM[1]:
   i. Additional technology equipment and infrastructure;
   ii. Enhanced staff training; and
   iii. Other activities to strengthen organizational capacity to implement Cal AIM, including but not limited to data exchange and interoperability, payment reform, and/or policy changes.

2. Staffing capacity investments, such as enhanced staff recruitment, onboarding, and retention activities, including but not limited to signing and one-time retention bonuses.

3. COVID-19 accommodations, including but not limited to personal protective equipment (PPE). Any site improvements, COVID related or not, should be applied for under Category 4 below.

4. Renovations/repairs or facility improvements, If applying for funds in this category, Applicant must include estimate provided by a contractor and information regarding timeline including permitting process, etc. Receipt of funds in this category will require acknowledgement by awarded Contractor that awarded Contractor is responsible for the quality assurance and completion of all improvements/renovations implemented with One-Time Enhancement Funds.

5. Vehicles for program services. Replacement or new vehicles. Applicant must demonstrate that all ongoing operational costs will be covered. Contract adjustments for ongoing costs related to purchases of vehicles made with One-Time Enhancement Funds will not be included during the annual contract renewal process.

MHSA Component	Total	Percent
CFTN	$1,220,997.00	24%
CSS	$651,139.00	13%
PEI	$0.00	
WET	$3,163,814.00	63%
SUD	$795,150.00	
TOTAL	**$5,831,100.00**	
Only MHSA TOTAL	**$5,035,950**	**100%**

The MHSA components that applied to these categories were Capital Facilities and Technological Needs; Workforce, Education, and Training; and Community Services and Support. Applicants could apply for up to $88,350. The MHSA funding committed totaled $10 million. The amount spent totaled: $5,035,950. CBOs that provided Substance Use Disorder (SUD) services that applied for the RFPQ were awarded funding from 2011 Realignment funding. This totaled $795,150.

[1] Medi-Cal Transformation

Expenditure Totals

It is apparent which categories were most in demand. Overall, MHSA component percentages were overwhelmingly #1, #2, and #4. It is not surprising that these three categories were chosen most often because, as mentioned above, CBOs tend to have staffing struggles, and since they do not invest extensively in infrastructure, upgrading their technological needs to meet legislative requirements could be a challenge.

Impact per Category

Category #1: Initiatives to support the launch and sustainability of Cal AIM

Cal AIM is a multiyear plan to transform California's Medi-Cal program and to make it integrate more seamlessly with other social services. The goal of Cal AIM is to improve outcomes for Californians covered Medi-Cal, especially those with the most complex needs.

Preparation for Cal AIM has many providers rebuilding their technology infrastructure because they have not had the funding or opportunity to do appropriate upgrades in the past. From an operation perspective, meeting requirements for Cal AIM changes around billing and documentation meant that an investment into technology needs were going to be a high priority.

This funding allowed providers to hire health contractors and purchase IT products and supplies needed to implement the launch of new electronic health records (EHR) and allowed the provider to more easily adhere to Cal AIM guidelines. These improvements further allowed operations and quality assurance staffers to focus on the operational and quality assurance aspects of implementing Cal AIM and has permitted an increase in internet and operational security at a systems level.

Furthermore, under this category, staffers were able to attend monthly DHCS Cal AIM Learning Collaboratives; Cal AIM Best Practices webinar and CAMHPRO Medical Billing Forum among other training and webinars. Being able to attend and not worry about costs for travel or overtime costs had providers feeling supported. The increased efficiency of new technology is already lowering workplace stress on an already taxed staff through its built-in documentation templates and billing processes.

Comments from provider final reports:

- New EHR brings better support for billing process.
- Outcome to improve fidelity with which client services are accounted for during billing process.
- Improve easier audits with “swap shots” to see side by side key changes.
- Bolstered defenses against ransomware attacks and prevent unauthorized access to client’s confidential information; and

- Bring EHR systems (one of which had been in operation since 2009) up to date for HIPAA.

A great example of **Activities to strengthen organizational capacity to implement Cal AIM, including but not limited to data exchange and interoperability, payment reform, and/or policy changes**:

…we contracted with a Licensed Clinical Social Worker (LCSW) and Psychiatric Nurse Practitioner (Psych NP). The LCSW conducted assessments and case management, ensuring thorough documentation, and generating valuable data for treatment and policy adjustments. The Psych NP managed medical records, prescriptions, and care coordination, facilitating seamless data exchange, and improving patient outcomes. Both professionals provided services, with the LCSW focusing on behavioral health and the Psych NP covering a broad range, including medication management, supporting payment reform, and offering a cost-effective alternative to psychiatrists.

Category #2: Staffing capacity investments

Of all the categories listed, this was the largest accessed by providers. As mentioned, non-profit behavioral health workers tend to have lower pay than private health workers. These workers also have high stress levels and burnout.

Funds were used extensively in this category to give staff bonuses; sign-on bonuses for new staffer and staff appreciation events to maintain a healthy and productive staff. Team building activities enhanced collective ability to manager conflict, engage in difficult conversations, and navigate change. Staff retention bonuses led to improved employee retention and satisfaction with all key positions retained throughout the fiscal year. Many staffers shared that the bonuses made them feel seen and valued. Being able to have this funding available to providers not only acknowledged staffers hard work and dedication. It also reinforced the provider's commitment to the ongoing professional development and well-being of their staff.

One provider's retention bonus had a much-desired impact. In FY 22-23, the agency's turnover rate was 29.8%. In FY 23-24 the turnover rate was reduced to 23.9% which is below the industry average of approximately 30%. These bonuses have not only boosted staff morale. They have also played a pivotal role in ensuring continuity and quality in provider programs and services.

Many providers purchased new computers replacing outdated onsite devices. One provider could finally update their Microsoft which had not been updated since 2012. Another, due to their purchase, could finally end their "bring your own device" policy.

From CBO final reports: *"Many mental health clinicians are invested in community based mental health but often get concerned about their own financial circumstances and face a dilemma of choosing non-profit organizations due to educational debt and low compensation. We are glad*

that we were able to offer these programs to help them feel less financial stress and pursue their passion in community-based mental health services."

"I want to extend my deepest gratitude to whomever was involved in making this retention bonus happen. You may have an idea how great it feels to have admin support us like this, but I am certain you could quadruple that idea and still not know exactly how much. Please pass this on to whomever was involved, including ACBHCS."

"I thank the leadership of ACBHD for using this funding opportunity in creative ways. With it, you gave us the ability to invest in our systems and more fully appreciate our hard- working staff. With a stable workforce we can support more children and families throughout Alameda County."

Category #3: COVID-19 accommodations

Although covid-19 was no longer considered a public health emergency in FY 23-24, it continues to be prevalent much like colds and flu. Providers continue to be diligent to ensure their facilities are safe, healthy, and free of Covid.

Providers who received funds from this category used it for:

- Purchasing Covid antigen test used upon client admissions;
- Enhanced cleaning protocol with purchases of personal protective equipment; furnishings that could be properly and regularly cleaned and disinfected, larger capacity air purifiers, automatic soap and hand sanitizer dispensers, masks and cleaning supplies; and
- Written materials pertaining to covid-19 were translated.

Category #4: Renovations/repairs or facility improvements.

This category was the second most used of all the categories. Again, as mentioned, investing into renovations and facility improvements are generally not highest priority because it is sacrificed for client care.

Improvements to provider locations were broad and varied. There were floor replacements and carpet removals which provided cleaner spaces for clients. New workstations with sit/stand capabilities and ergonomic measures; new network cabling, with updated Wi-Fi and fax which brought efficiency for the staff; additional client service room; noise machines for privacy along with soundproofing panels for front desk renovation to name a few items of facility improvements.

Windows were replaced in several providers location. Larger improvements include two providers installing new HVAC systems. Both providers have never had air-conditioner that worked efficiently. Due to these funds, they now have air conditioning, better heating which has brought

staff and client comfort. Enhanced client comfort and improving the building's environment has increased trust and eased environmental stressors on clients.

These improvements revitalized offices with new furniture and equipment needed to make workspaces more accessible and efficient for staff. A more welcome and open work environment has decreased staffer stress and increased comfort for clients.

Other highlights from final reports include:

- Remodel of a staff breakroom that was an eyesore and removal of a carpet brought the provider into site compliance of cleanliness;
- Waiting room chair for people with mobility problems; and
- Purchase lockable totes for all laptop computers to practice HIPAA compliance measures;

Category #5: Vehicles for program services

This category had only a handful of CBOs access it. Although small in usage, the impact was immediate for these providers. One provider had replaced a 16-year-old vehicle that they had not been able to obtain funding to replace. The vehicle purchases fostered a stronger source of community and support among the CBO beneficiaries.

One provider serving older adults gave a thorough impact narrative. In the first 6 months after purchasing the vehicle, the provider's ability for safe transportation was immediate. The new vehicle they purchased:

- Ensured that at least 75% of the participants receiving transportation services make appointments on time.
- 95% effectiveness in making on-time appointments to SSA and for medical appointments.
- 80% of referred older adults received transportation services when needed.

The vehicles have enabled the following:

- Relocation services and the ability to move them safely and effectively.
- Access to Community Resources East Bay Law, Legal Assistance for Seniors, Utility Companies, and Citizenship support.
- Disability friendly and provides accessibility.

Conclusion

As the county was coming out of the COVID-19 pandemic, it was clear that providers were struggling with retaining staff, morale, and updating infrastructure to be compliant with new legislation. These enhancements have been used in many positive ways to build capacity in the county's ability to provide behavioral health care via its contracted providers.

With these enhancements, much needed recruitment support for outreach and engagement efforts to recruit and hire clinically trained staff was achieved. These funds supported trainings for staff, new workstations, laptops, and retention bonuses which all bolstered morale.

Renovations to buildings have increased comforts of heating and cooling; increased health and safety compliance in cleanliness; better welcoming environments for clients and staff; and telemedicine visits have been improved due to upgrades in provider technology.

These enhancement funds provided by the county and their impact can be summed up by a provider serving children and youth:

"…On behalf of…Board of Directors, staff, and participants, I would like to thank you for the allocation of One-Time Enhancement Funds to our organization during FY23-24. The funds made an impact in helping us to recruit and retain staff as well as make some facility improvements. Without those resources, we could not have done those things…Thank you again for your contribution to our organization and our community."

Name	Do you have any public comments on the MHSA FY25/26 Annual Plan Update?	Response	Date
Anonymous Alameda County Resident	Pge 543- African American Wellness Hub Complex - The plan doesn't state any specific goals or next steps in developing the Complex or when it is expected to be completed. I would like to see more specific information about this.	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care. Alameda County MHSA will work to ensure that we fund programs that are equitable and address the various needs of our different populations. Alameda County has hosted multiple listening sessions to gather community feedback on the programming, design, and community requests on the African American Wellness Hub.	5/16/2025

Carla Gilbert Keener	As highlighted during the recent listening session with members of the Board of Directors of HHREC, collaboration across agencies is essential. But collaboration alone is not enough—it must be coordinated, strategic, and grounded in the lived experiences of the communities we aim to serve. One of the most powerful tools for community healing is culturally rooted, intergenerational programming. In Black communities, healing is deeply tied to family, tradition, and legacy. Programs that bring together youth, adults, elders, and faith leaders foster connection, belonging, and a shared responsibility for wellbeing. These spaces not only offer support, but also rebuild trust—particularly where systems have historically caused harm. Respect for women and elders must be central in these efforts. Women are often the pillars of caregiving and emotional support in our communities, and elders are the carriers of wisdom, resilience, and history. Honoring their voices in the development and delivery of mental health services enhances the strength and authenticity of our programs. We also cannot underestimate the importance of involving the faith community and drawing on practices of ancestral healing. These are long-standing sources of strength, hope, and restoration in Black culture. When behavioral health approaches integrate spiritual, cultural, and ancestral elements, they resonate more deeply and help people move toward true healing—not just treatment. Accessibility remains a core issue. Services must be mobile-friendly, offer various modes of communication, and include scheduling support to meet people where they are—both literally and figuratively. Workforce development must center cultural and linguistic competence, and we need a pipeline that diversifies the behavioral health workforce to reflect the communities served. Finally, support for vulnerable populations—especially justice-involved individuals and victims of violence—must be prioritized. Community-based violence prevention, reentry support, and early intervention programs are critical, particularly for youth at risk of entering or returning to the justice system. All of this requires more than acknowledgement—it requires action and sustained investment. Alameda County must allocate the funding necessary to support programs that are culturally responsive, intergenerational, community-led, and rooted in healing. Thank you for your time and for centering equity and justice in the County's behavioral health strategy.	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care. Alameda County MHSA strives to fund programs that address the needs of different populations. We welcome your feedback in ensuring our programs address equity and sustainability. Alameda County will continue to fund equitable programs which you can read on our website: https://acmhsa.org/reports-data/#mhsa-plans	4/25/2025

Anonymous Alameda County Resident	The plan is not clear with how the county will address the needs of the transgender community.	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care. Alameda County MHSA will work to ensure that we fund programs that are equitable and address the various needs of our different populations.	5/16/2025
Anonymous Alameda County Resident	Page 318 - Youth Outreach and Engagement: My concern is that often African American Males are not identified early on and or do not seek support until they are well over 25. I would like to see support for African American males in their late 20's for young adult services.	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care. Alameda County MHSA will work to ensure that we fund programs that are equitable and address the various needs of our different populations.	5/16/2025
Anonymous Alameda County Resident	The plan is not clear with how the county will address the needs of the transgender community.	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care. Alameda County MHSA will work to ensure that we fund programs that are equitable and address the various needs of our different populations.	5/16/2025
Anonymous Alameda County Resident	Page 318- Older Adults PEI Strategies - I like the focus on older adults but would like for the county to recognize the difference in needs for older adults 59-79 and those 80 and older. People are aging differently now because of nutrition and the emphasis on senior health.	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care. Alameda County MHSA will work to ensure that we fund programs that are equitable and address the various needs of our different populations.	5/16/2025

Anonymous Alameda County Resident	There is value in community support. It fosters a culture of support and understanding. The more programs we have available to younger audiences, the better. Would love to see greater initiatives in K-12 spaces.	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care. Alameda County MHSA will work to ensure that we fund programs that are equitable and address the various needs of our different populations.	5/15/2025
Anonymous Alameda County Resident	As a family member seeking mental health services in Alameda County, I appreciate the comprehensive approach outlined in the FY 2025–2026 MHSA Plan Update. The plan's emphasis on community collaboration, cultural competence, and family-driven services resonates deeply, especially given the diverse needs of our community. Initiatives like the Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) programs demonstrate a commitment to early access and holistic care, which are crucial for families navigating mental health challenges. However, I would like to see more detailed information on how families can actively participate in program planning and evaluation processes, ensuring that our voices contribute to shaping services that directly impact our loved ones. Additionally, clearer communication regarding available resources and support mechanisms for families would enhance our ability to engage effectively with the system. Furthermore, I am curious about how the county plans to incorporate non-Western medical care into its mental health services. Specifically: Integration of Traditional Practices: Will the plan include provisions for integrating traditional healing practices, such as acupuncture, herbal medicine, or spiritual counseling, which are significant in many cultures represented in Alameda County? Cultural Competency Training: Are there initiatives to train mental health professionals in understanding and respecting non-Western approaches to mental health, ensuring culturally sensitive care? Collaborations with Traditional Healers: Does the county intend to	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care. Alameda County MHSA will work to ensure that we fund programs that are equitable and address the various needs of our different populations.	5/13/2025

	collaborate with traditional healers or community leaders who provide non-Western mental health support, to bridge gaps between different care models? Accessibility and Funding: Will there be funding or resources allocated to make non-Western mental health services accessible to those who prefer or rely on these methods? Understanding how these aspects are addressed would provide a more inclusive and effective mental health care system that respects and integrates the diverse cultural practices of Alameda County's residents. I encourage the county to consider these questions and provide clarity on how non-Western medical care will be incorporated into the mental health services framework. This inclusion would not only honor the cultural diversity of our community but also enhance the effectiveness of mental health interventions by aligning them with individuals' cultural beliefs and practices.		
K.	I'm especially excited to see the number of inclusive measures taken. The county's asking for community input is encouraging.	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care.	5/15/2025
Anonymous Alameda County Resident	The work everyone is doing is great! Please consider housing programs within religious organizations. Many are only willing to receive help that is promoted by their local church.	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care. For additional housing information please see ACH Housing and Homelessness Division: https://homelessness.acgov.org/index.page	5/15/2025

Anonymous Alameda County Resident	I know so many people who are still hesitant to connect with services, but they've been great for me! We really need more opportunities in the community, somewhere visible, where people can discover the offerings.	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care.	5/15/2025
Anonymous Alameda County Resident	yes	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care.	5/14/2025
Gene	Alameda County's commitment to addressing substance use and mental health conditions is a powerful step forward and is making a positive impact on countless lives. I look forward to seeing how the County can expand its services and make them more accessible to seniors and those who lack access to resources.	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care.	5/13/2025
Anonymous Alameda County Resident	Kudos to Alameda County for recognizing the importance of mental health and substance use recovery. It's a testament to the county's dedication to creating a supportive environment for all its residents.	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care.	5/13/2025
Maya	Well done	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care.	4/25/2025
CC Win	Ok I like Karen Tribble, and Everything that's Stated her and if I see or go to any of these places for Services/Referral/MTGs,Services and somethings not right and it's affecting Me or My Family I Address it immediately. I do the Yearly Survey as Well.Very Greatful to Everyone Involved.	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care.	4/24/2025

Kaye Mraz	Yes	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care.	4/23/2025
Gavin O'Neill	Please keep helping mental health services in the collaborative courts	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care.	4/23/2025
Rose	More CBO's that support housing for youth and Veterans. More homes available	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care. For additional housing information please see ACH Housing and Homelessness Division: https://homelessness.acgov.org/index.page	5/9/2025
Anonymous Alameda County Resident	I would like to see the plan develop more strategies to involve more Peer Specialist in the WET program	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care.	5/16/2025

Anonymous Alameda County Resident	As a community organizer deeply invested in equitable mental health access, I commend Alameda County's MHSA FY 2025–26 Plan for its commitment to community collaboration and cultural responsiveness. However, I urge the County to ensure that the plan includes a comprehensive narrative analysis of the mental health needs of unserved, underserved, and inappropriately served populations, as well as detailed demographic data by age, gender, race/ethnicity, and primary language. Additionally, I recommend that the County establish formal Full Service Partnership (FSP) agreements with each client served under the FSP Service Category, as required by regulations. By addressing these areas, the plan can more effectively promote wellness, recovery, and resiliency across all communities in Alameda County.	Thank you for the public comment, we will make sure to publicize and share with the various ACBHD Systems of Care. Alameda County MHSA will work to ensure that we fund programs that are equitable and address the various needs of our different populations. Thank you for your recommendations.	5/8/2025

APPENDIX J: J-1: Community Services and Supports: Clients Served by Age Group

Program Number	Name of Program	Funding Category	Age/Population Served	TOTAL Number of Clients Served	Budget	Cost per Client
OESD 4A	City of Fremont - Mobile Teams	CSS - OESD	Adults, Older Adults	271	$1,173,998	$4,332.10
OESD 5A	Alameda County Behavioral Health Crisis	CSS - OESD	Youth Transitional Age Youth, Adults, Older	2,900	$15,271,563	$5,266.06
OESD 7	Behavioral Health Court (BHC)	CSS - OESD	Adults	50	$515,321	$10,306.42
OESD 7	Court Advocacy Project (CAP)	CSS - OESD	Adults	70	$290,280	$4,146.86
OESD 7***	Alameda County Collaborative Courts	CSS - OESD	Adults	284	$290,280	$1,022.11
OESD 8***	Alameda County Behavioral Health – Guidance Clinic	CSS - OESD	Youth	348	$192,745	$ 553.86
OESD 9	Seneca Family of Agencies – MST	CSS - OESD	Youth	36	$1,035,030	$28,750.83
OESD 11	BACS Amber House – CSU / CRU	CSS - OESD	Adults CSU, Adults CRT	871	$5,382,469 (CSU) $2,540,813 (CRT)	$6,179.64 (CSU) $2,917.12 (CRU)
OESD 11	Telecare Crisis Stabilization Unit	CSS - OESD	Youth	618	$5,762,755	$9,324.85
OESD 14	Multi-Lingual Counseling Center – Staffing to Asian Population	CSS - OESD	Youth Transitional Age Youth, Adults	110	$175,750	$1,597.73
OESD 14	Asian Health Services - Language ACCESS	CSS - OESD	Adults	1807	$1,741,027	$ 963.49
OESD 15	La Familia Counseling Center – ACCESS Staffing to Latinx Population	CSS - OESD	Adults	65	$975,499	$15,007.68
OESD 17	A&A Health Services – Residential Treatment	CSS - OESD	Adults	-	$1,004,440	No Data
OESD 17	Ever Well Health Systems – Residential Support Services	CSS - OESD	Adults	-	$1,052,795	No Data
OESD 18	Wellness Centers (Fremont) / So. Co. Wellness	CSS - OESD	Adults	2,774	$687,955	$248.00
OESD 18	Wellness Centers (HEDCO)	CSS - OESD	Adults	3,910	$833,766	$ 213.24
OESD 18	Wellness Centers (Townhouse)	CSS - OESD	Transitional Age Youth, Adults	6,672	$1,113,609	$ 166.91

Program Number	Name of Program	Funding Category	Age/Population Served	TOTAL Number of Clients Served	Budget	Cost per Client
OESD 18	Wellness Centers (Valley)	CSS - OESD	Adults	20	$631,188	$31,559.40
OESD 18	Bonita House – Berkeley	CSS - OESD	Adults	246	$466,397	$1,895.92
OESD 18	Bonita House – Casa Ubuntu / East Oakland Wellness Center	CSS - OESD	Adults	20	$939,041	$46,952.05
OESD 18	NAMI MHAAC – Chinese Community	CSS - OESD	Adults	-	$20,000	No Data
OESD 18	NAMI MHAAC – East Bay	CSS - OESD	Adults	-	$20,000	No Data
OESD 18	NAMI MHAAC – Tri-Valley	CSS - OESD	Adults	-	$20,000	No Data
OESD 18	ACNMHC – Peer Wellness Collective	CSS - OESD	Adults	-	$1,209,035	Data not provided
OESD 19	Hiawatha Harris	CSS - OESD	Adults	2,780	$3,097,086	$1,114.06
OESD 19	STEPS – Telecare	CSS - OESD	Adults	67	$753,353	$11,244.07
OESD 20	Bonita House – Individual Placements Services (IPS)	CSS - OESD	Adults	21	$2,290,221	$109,058.14
OESD 20	Center for Independent Living (CIL)	CSS - OESD	Adults	9	$122,941	$13,660.11
OESD 23	REFUGE	CSS - OESD	Transitional Age Youth	25	$1,734,121	$69,364.84
OESD 24	Schreiber Center	CSS - OESD	Adults, Older Adults	48	$423,999	$8,833.31
OESD 25	Primary Care Integration – TRUST Clinic	CSS - OESD	Adults	1,623	$3,176,761	$1,957.34
OESD 25	Alameda Health Consortium (AHC) – IBHCS (Pediatric Care Coordination Pilot)	CSS - OESD	Youth	4,747	$ 2,198,971	$ 463.23
OESD 25	Alameda Health System (AHS) – IBHCS (Care Coordination)	CSS - OESD	Adults	793	$161,363	$ 203.48
OESD 25	Axis Community Health – Behavior Health Primary Care Integration Project	CSS - OESD	Adults	804	$97,020	$ 120.67

Program Number	Name of Program	Funding Category	Age/Population Served	TOTAL Number of Clients Served	Budget	Cost per Client
OESD 25 ***	Axis Community Health –Primary Care Integration Project (MH Urgent Care)	CSS - OESD	Adults	1,062	$675,000	$ 635.59
OESD 25 BH	Primary Care Integration–Care Coordination Bay Area Community Health (BACH)	CSS - OESD	Adults	3,843	$503,778	$ 131.09
OESD 25 BH	Fremont PATH/Bay Area Community Health	CSS - OESD	Adults	76	$141,908	$1,867.21
OESD 25 BH	Primary Care Integration – Native American Health Center	CSS - OESD	Adults	182	$97,020	$ 533.08
OESD 25 BH	Primary Care Integration – La Familia (Early Childhood Integration)	CSS - OESD	Youth	20	$101,187	$5,059.35
OESD 25 BH	Primary Care Integration Eastmont– Oakland-PATH (OACSC)	CSS - OESD	Adults	303	$127,227	$ 419.89
OESD 25 BH	Primary Care Integration Eden – Oakland-PATH	CSS - OESD	Adults	124	$187,357	$1,510.94
OESD 25 BH	Primary Care Integration – La Clinica de la Raza	CSS - OESD	Adults	336	$193,738	$ 576.60
OESD 25 BH	Primary Care Integration – Tiburcio Vasquez Health	CSS - OESD	Adults	4,873	$161,363	$ 33.11
OESD 25 BH	Primary Care Integration – West Oakland Health Center	CSS - OESD	Adults	750	$97,020	$ 129.36
OESD 26A	Hiawatha Harris – Pathways	CSS - OESD	Adults	875	$381,647	$ 436.17
OESD 26B	ROOTS – AfiyaCare	CSS - OESD	Adults	52	$425,940	$8,191.15
OESD 27	Adobe Services (IHOT)	CSS - OESD	Adults	78	$655,264	$8,400.82
OESD 27	Bonita House (IHOT)	CSS - OESD	Adults	129	$655,264	$5,079.57
OESD 27	La Familia (IHOT)	CSS - OESD	Adults	76	$655,264	$8,621.89
OESD 27	STARS (IHOT)	CSS - OESD	Adults	47	$567,627	$12,077.17
OESD 27	Telecare – AdROC	CSS - OESD	Adults	172	$877,598	$5,102.31

Program Number	Name of Program	Funding Category	Age/Population Served	TOTAL Number of Clients Served	Budget	Cost per Client
OESD 27	Telecare – TAYROC	CSS - OESD	Transitional Age Youth	101	$129,326	$1,280.46
OESD 28	BACS – SAGE	CSS - OESD	Adults,	247	$2,968,615	$12,018.68
OESD 30	La Familia – Sally Place Peer Respite	CSS - OESD	Adults	115	$1,204,953	$10,477.85
OESD 31	Felton Institute – Early Psychosis Program	CSS - OESD	Transitional Age Youth	60	$1,528,122	$25,468.70
OESD 32	Crisis Support Services – Suicide Prevention Crisis Line	CSS - OESD	All ages, data not disaggregated*	38,228	$867,000	$ 22.68
OESD 32	Crisis Support Services – Zero Suicide Program	CSS - OESD	Adults	859	$208,165	$ 242.33
OESD 33	Felton Institute – Deaf Community Counseling (Adult & Child)	CSS - OESD	Adults	44	$328,153	$7,458.02
OESD 34	School-Based Behavior Health – Alameda Family Services	CSS - OESD	Youth	1662	$145,441	$ 87.51
OESD 34	EBAC (East Bay Agency for Children) – *program closed*	CSS - OESD	Youth			
OESD 34	Fred Finch Youth & Family Svc. – *program inoperable, reinstated in FY24/25*	CSS - OESD	Youth		$40,450	
OESD 34	Lincoln Child Center – *program closed*	CSS - OESD	Youth			
OESD 34	School-Based Behavior Health – Seneca ASCEND	CSS - OESD	Youth	430	$85,685	$ 199.27
OESD 34	School-Based Behavior Health – STARS	CSS - OESD	Youth	209	$96,474	$ 461.60
OESD 35	East Bay Agency for Children (EBAC) – Fremont	CSS - OESD	Adults	902	$91,974	$ 101.97
OESD 35	MHAAC – Family Education and Resource Center (FERC)	CSS - OESD	Adults	1,268	$2,418,471	$1,907.31
OESD 36	CalMHSA Presumptive Transfer	CSS - OESD	Youth	95	$762,973	$8,031.29
OESD 37	Bay Area Community Services (BACS) – Reentry Treatment Teams (RTT)	CSS - OESD	Adults	179	$2,427,097	$13,559.20

Program Number	Name of Program	Funding Category	Age/Population Served	TOTAL Number of Clients Served	Budget	Cost per Client
OESD 37	La Familia Counseling Center – Re-entry Treatment Teams (RTT)	CSS - OESD	Adults	33	$491,281	$14,887.30
OESD 38	Bay Area Legal Aid	CSS - OESD	Adults	302	$666,409	$2,206.65
OESD 38	Alameda County Homeless Action Center (HAC)	CSS - OESD	Adults	540	$932,817	$1,727.44

*For OESD 32 Crisis Line, age is not aggregated due to the primary focus for crisis support and de-escalation.

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: ALAMEDA

☐ Three-Year Program and Expenditure Plan
X Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Karyn Tribble, ACBHD Director	Name: Melissa Wilk
Telephone Number: (510) 567-8100	Telephone Number: (510) 272-6565
E-mail: Karyn.Tribble@acgov.org	E-mail: melissa.wilk@acgov.org
Local Mental Health Mailing Address: 2000 EMBARCADERO COVE, SUITE 400 OAKLAND, CA 94606	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

KARYN TRIBBLE, ACBHD DIRECTOR
Local Mental Health Director (PRINT)

Signed by: BA167CA0C0D444A...
Signature

8/29/2025
Date

I hereby certify that for the fiscal year ended June 30, 2025, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated December 20, 2024 for the fiscal year ended June 30, 2024. I further certify that for the fiscal year ended June 30, 2025, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

MELISSA WILK, AUDITOR-CONTROLLER
County Auditor Controller / City Financial Officer (PRINT)

DocuSigned by: Melissa Wilk 24917D890CE3433...
Signature

9/15/2025
Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)

ALAMEDA COUNTY BOARD OF SUPERVISORS
MINUTE ORDER

The following action was taken by the Alameda County Board of Supervisors on 10/07/2025

Approved as Recommended ☑ **Other** ☐

Unanimous ☐ **Tam:** ☐ **Haubert:** ☐ **Miley:** ☐ **Márquez:** ☐ **Fortunato Bas:** ☐ - **5**
Vote Key: N=No; A=Abstain; X=Excused

Documents accompanying this matter:

Documents to be signed by Agency/Purchasing Agent:

File No. _____
Item No. 8

Copies sent to:

Brenda.ng@acgov.org; Jill.Louie@acgov.org; Tracy.Hazelton@acgov.org

Special Notes:

I certify that the foregoing is a correct copy of a Minute Order adopted by the Board of Supervisors, Alameda County, State of California.

ATTEST:
Clerk of the Board
Board of Supervisors

By: Nancy French
Deputy



Aneeka Chaudhry
Interim Director

AGENDA _____ October 7, 2025

September 9, 2025

The Honorable Board of Supervisors
County of Alameda
1221 Oak Street
Oakland, CA 94612

SUBJECT: ADOPT THE FISCAL YEAR 2025-26 MENTAL HEALTH SERVICES ACT ANNUAL PLAN UPDATE FOR ALAMEDA COUNTY BEHAVIORAL HEALTH DEPARTMENT

Dear Board Members:

RECOMMENDATION:

Adopt the Mental Health Services Act Annual Plan Update for Fiscal Year 2025-26, which has been certified by the Alameda County Behavioral Health Department Director and the Auditor Controller to meet specified requirements in accordance with the California Welfare & Institutions Code Section 5847.

DISCUSSION/SUMMARY:

Alameda County Behavioral Health Department (ACBHD) is requesting your Board to adopt the Fiscal Year (FY) 2025-26 Mental Health Services Act Annual Plan Update (MHSA Plan). Following your approval, ACBHD will submit the MHSA Plan to the Mental Health Services Oversight & Accountability Commission (MHSOAC) within 30 days after the Board of Supervisors' adoption.

The MHSA Plan must be certified by the designated Mental Health Director and the Auditor Controller of Alameda County to meet specified Mental Health Services Act (MHSA) requirements in accordance with the California Welfare & Institutions Code Section 5847. These requirements include attesting that ACBHD has complied with fiscal accountability requirements as directed by the California Department of Health Care Services (DHCS); ensured expenditures are consistent with the MHSA requirements; and prepared and circulated a draft plan for review and comment for 45 days to representatives of stakeholder interests or interested parties. The FY 2025-26 MHSA Plan meets those requirements and provides an overview of the various MHSA funded programs being implemented in the County as well as a fiscal overview of MHSA funds received.

On June 27, 2012, Assembly Bill 1467 chaptered into law requires each county mental health program to prepare and submit a Board-adopted three-year program and expenditure plan, and annual plan updates to the MHSOAC. On December 19, 2023 (Item No. 3), your Board approved the adoption of the MHSA Three-Year Program and Expenditure Plan (MHSA Three -year Plan) for FY 2023-24 through 2025-26. On January 4, 2024, ACBHD submitted the MHSA Three -year Plan to MHSOAC. On April 1, 2025, ACBHD posted the FY 2025-26 Annual Plan Update, which is the third year of the MHSA Three-year Plan on its website for a 45-day public comment period. The Mental Health Advisory Board hosted a public hearing on May 19, 2025, at which time ACBHD addressed public

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questions and concerns. ACBHD presented the MHSA Plan to the Alameda County Board of Supervisors Health Committee at its public meeting on June 9, 2025, and the Health Committee recommended the MHSA Plan go to your Board for adoption.

The MHSA Plan continues with the implementation of over 221 ongoing and short-term programs and projects in treatment, prevention, workforce development, innovation, capital facilities and technology needs. The main changes from the previous years include:

I. COMMUNITY SERVICES AND SUPPORTS (CSS)

Full-Service Partnerships (FSP)
- Continued analysis of Case Management Models for alignment with Proposition 1 required FSP Intensive Case Management services

II. INNOVATION (INN)
- Implementation Status of two Forensic Focused INN Programs
- Implementation Status of Final INN Project: Psychiatric Advance Directives (PADs Phase II)

III. WORKFORCE EDUCATION DEVELOPMENT AND TRAINING (WET) AND CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

a) WET Program
- Completion of the MHSA required Capacity Assessment

b) CFTN Projects
- African American Wellness Hub Update
- Electronic Health Record System Update

IV. MHSA COMMUNITY INVESTMENT OPPORTUNITY: SECOND ROUND

On July 1, 2026, ACBHD will transition from the MHSA, as regulated under Proposition 63, to the Behavioral Health Services Act, as regulated under Proposition 1. This shift will bring about significant changes within the ACBHD portfolio of programs and services, including the expansion of Full-Service Partnership programs, the incorporation of substance use disorder services, the elevation of housing services, the creation of an early intervention specialty mental health service model, and the realignment of prevention programming from the County to the State.

Your Board's approval of this recommendation will enable the MHSA programs to continue in this final year of the MHSA Three-year Plan and maintain compliance with DHCS and the MHSOAC.

FINANCING:

Appropriations outlined in the Plan Update are offset by MHSA revenue already included in the ACBHD Fiscal Year 2025-26 Approved Budget. There will be no increase in net County cost as a result of your approval.

VISION 2036 GOAL:

The MHSA Plan Update meets the 10X goal pathway of **Health for All** in support of our shared visions of a **Thriving & Resilient Population.**

Sincerely,

DocuSigned by:
Aneeka Chaudhry
E20638BBECB64AD...
Aneeka Chaudhry, Interim Director
Alameda County Health

For questions or additional information regarding this report, please contact the report developer:

Noah Gallo

Senior Planner, Mental Health Services Act

MHSA@acgov.org