09

Office of the City Manager

CONSENT CALENDAR
July 23, 2019

To: Honorable Mayor and Members of the City Council

From: Dee Williams-Ridley, City Manager

Submitted by: Kelly Wallace, Interim Director, Health, Housing & Community Services

Subject: Mental Health Services Act (MHSA) Fiscal Year 2019-2020 (FY20) Annual Update

RECOMMENDATION

Adopt a Resolution approving the Mental Health Services Act (MHSA) Fiscal Year 2019-2020 (FY20) Annual Update, which provides information on current and proposed uses of funds on mental health programming, and forwarding the MHSA FY20 Annual Update to appropriate state officials.

FISCAL IMPACTS OF RECOMMENDATION

Approval of the FY20 Annual Update enables funding for MHSA programs and services. The City of Berkeley receives funding from MHSA revenues on a monthly basis from the State of California. The total MHSA funding amount the City will receive in a given year is unknown until the end of the year, therefore MHSA plans and Annual Updates must approximate revenues and expenditures in a given year. The FY20 Annual Update includes the following estimated revenue and expenditures in each MHSA component and the local Prudent Reserve amount, as reported in this MHSA Annual Update:

MHSA Funding Component	Estimated Fund Balances (By 6/30/19)	Estimated New Funding (For FY20)	Transfer from Prudent Reserve (In FY20)	Estimated Expenditures (In FY20)
Community Services & Supports	$6,777,484	$4,797,986	$320,323	$7,015,404
Prevention & Early Intervention	$1,801,362	$1,349,684	$47,864	$1,690,045
Innovations	$1,347,715	$315,656	$0	$954,800
Workforce, Education & Training	$5,000	$0	$0	$5,000
Capital Facilities & Technological Needs	$2,500,000	$0	$0	$2,500,000
TOTALS	$12,431,561	$6,463,326	$368,187	$12,165,249

Due to staff changes in the past, careful efforts not to over allocate funds until needs were clear, and funding allocations in prior years differing from what was projected, the City of Berkeley has acquired a significant amount of unspent MHSA funds. Through the addition of new staffing and/or programming in previous MHSA Annual Updates and this

FY20 Annual Update, a significant portion of unspent funds will be utilized during the plan timeframe.

CURRENT SITUATION AND ITS EFFECTS

The MHSA FY20 Annual Update is the local plan, informed by area stakeholders, that provides an update to the previously approved MHSA FY17/18 -19/20 Three Year Program and Expenditure Plan, details current mental health programs and services, and proposes areas of new programming and/or increased staffing and includes the state required MHSA FY15/16 – 17/18 Three Year Prevention & Early Intervention Evaluation Report and the FY18 Annual Innovations Evaluation Report. Per state legislation, MHSA Plans and Annual Updates must include a community program planning process with the involvement of area stakeholders, writing a draft plan, initiating a 30-day public review, and conducting a public hearing at a Mental Health Commission meeting.

Development of the City of Berkeley MHSA FY20 Annual Update included a Community Planning process to obtain input at numerous community meetings, public events and through the Berkeley Considers Forum; producing a draft plan; incorporating feedback from the planning process; a 30-Day Public Review from May 29 through June 27, and a Public Hearing on the evening of June 27 before the Mental Health Commission. Comments and input received during the 30-day Public Review and/or at the Public Hearing focused on:

- Increasing access to services for individuals who have physical disabilities, as well as vision and other co-disabilities.
- Ensuring that any program staff who are working with Trauma Informed Care models (and program staff in general) are provided with supports around Compassion Fatigue.
- Including funding for Senior Centers that can be flexibly used for housing issues, and other problems seniors are facing.
- Collaborating with the Wright Institute.
- Creating an RFP that provides additional services and supports for the LGBTQI population.

Written Public Comments received either during the 30-Day Public Review or that were distributed (and heard) at the Public Hearing are included in Exhibit A, MHSA FY2019-2020 Annual Update, Appendix E. Some of the various written comments received focused on increasing services and supports in Albany; and adopting a systems integrated framework and approach to utilize with Results Based Accountability for evaluating programs. All comments received during the 30 Day Public Review and the Public Hearing will be utilized to inform this and/or future MHSA Plans and Updates.

After the close of the Public Hearing the Mental Health Commission made the following motion:

M/S/C (Castro, Fine) Motion to approve the plan (MHSA FY20 Annual Update) and

move it to City Council.
Ayes: Castro, cheema, Fine, Kealoha-Blake; Noes: Heda; Abstentions: None; Absent: Davila.

ENVIRONMENTAL SUSTAINABILITY
There are no identifiable environmental effects or opportunities associated with the subject of this project.

BACKGROUND
California voters adopted the Mental Health Services Act (Proposition 63) on November 2, 2004. The Act places a 1% tax on every dollar of personal income over $1 million. MHSA revenues are allocated to mental health jurisdictions across the state to transform the mental health system into one that is consumer and family driven, culturally competent, wellness and recovery oriented, collaborative with community partners, and inclusive of integrated services. MHSA includes the following five funding components:

- Community Services & Supports: Primarily for treatment services and supports for Severely Mentally Ill Adults and Seriously Emotionally Disturbed Children.
- Prevention & Early Intervention: For strategies to prevent mental illnesses from becoming severe and disabling.
- Workforce, Education & Training: Primarily for strategies to identify and remedy mental health occupational shortages, promote cultural competency, and promote the employment of mental health consumers and family members.
- Capital Facilities and Technological Needs: For capital projects on owned buildings and on mental health technology projects.
- Innovations: For short-term pilot projects designed to increase new learning in the mental health field.

MHSA also provides funding for local housing development; collaborative programs for suicide prevention, school mental health, programs that combat stigma and discrimination; and training and technical assistance in the areas of cultural competency and prevention/early intervention. Three of the funding components are allocated annually and may be spent over a three-year timeframe. These are Community Services & Supports, Prevention & Early Intervention, and Innovations. Workforce, Education & Training and Capital Facilities and Technological Needs funds were awarded with expenditure timeframes of 10 years each, and must be utilized by the end of FY18.

The City of Berkeley Mental Health (BMH) currently has an approved MHSA FY2018 through 2020 Three Year Program and Expenditure plan in place to utilize funds in each MHSA component area. This FY20 Annual Update is required by the state to provide an update to the previously approved Three Year Program and Expenditure Plan which runs through June 30, 2020. Since the inception of MHSA, funds have been utilized to transform the mental health service delivery system to better meet the needs of

underserved and inappropriately served communities, among others. This initiative has also provided the opportunity for BMH to further develop and expand the system of care by adding new programs within the division and utilizing non-profit providers in the planning and delivery of comprehensive mental health services.

Prior to July 2012, draft MHSA plans had to be approved by the State Department of Mental Health (DMH) after the community review process had been completed. The passage of AB 1467 in July 2012 requires the local governing board, Berkeley City Council, to approve MHSA plans and plan updates before submitting them to the State. An exception is Innovations plan updates, which must be approved by City Council as well as the State Mental Health Oversight and Accountability Commission (MHSOAC) when requesting funds for new Innovations programs.

Past Council Action

Since the inception of the MHSA program, Council has taken multiple actions including authorization of the following:

- March 7, 2006, $1.1 million MHSA Community Services and Supports funds for three years through FY2008;
- July 25, 2006, $2,510,238 MHSA Community Services and Supports funding ;
- May 6, 2008, $5,523,662 MHSA Community Services & Supports, and Housing funds;
- March 20, 2012, $429,600 MHSA Innovations funds, and to implement the Innovations Plan;
- September 11, 2012, approval of the MHSA Prevention & Early Intervention (PEI) Statewide Project Plan Update and execution of a Memorandum of Understanding (MOU) between the City and Alameda County Behavioral Health Care Services, to formalize the working relationship around PEI Statewide projects and funding through June 30, 2014.
- May 7, 2013, approval of the MHSA Fiscal Years 2012 and 2013 Annual Update for mental health services and supports through June 30, 2014
- January 21, 2014, approval of the Innovations Plan Update, and to increase the contract amounts on projects funded through June 30, 2014.
- June 24, 2014, approval of the MHSA Fiscal Years 2013 and 2014 Annual Update for mental health services and supports through June 30, 2015.
- January 27, 2015, approval of the Innovations Plan Amendment, to utilize $44,500 to hire up to two consultants who will conduct the State required evaluation and community program planning for this MHSA component.
- May 26, 2015, approval of the MHSA Fiscal Years 2015 through 2017 Three Year Program and Expenditure Plan for mental health services and supports through June 30, 2016.
- April 26, 2016, approval of the MHSA Innovation Plan Update to implement a Trauma Informed Care Project for Educators through June 30, 2018.
- June 28, 2016, approval of the MHSA Fiscal Years 2015 and 2016 Annual Update for mental health services and supports through June 30, 2017.

- January 24, 2017, approval of the MHSA Fiscal Years 2016 and 2017 Annual Update for mental health services and supports through June 30, 2017.
- July 25 2017, approval of the MHSA Fiscal Years 2017/2018 – 2019/2020 Three Year Program and Expenditure Plan for mental health services and supports through June 30, 2018.
- October 30 2018, approval of the MHSA Innovations Trauma Informed Care Plan Update through June 30, 2021.
- October 30, 2018, approval of the MHSA Fiscal Years 2018 and 2019 Annual Update for mental health services and supports through June 30, 2019.

Council has also previously approved MHSA funding for local housing development projects and for contracts with community-based agencies to implement mental health services and supports; housing and vocational services, and translation services.

RATIONALE FOR RECOMMENDATION

State legislation requires mental health jurisdictions to create MHSA Three Year Plans and to provide updates on MHSA plans on an annual basis. The legislation also requires local approval on MHSA Plans and plan updates. Approval of the MHSA FY20 Annual Update will fulfill state requirements.

ALTERNATIVE ACTIONS CONSIDERED

As obtaining approval on MHSA plans and plan updates by the local governing body is a state requirement, no other alternative action was considered.

CONTACT PERSON

Karen Klatt, Community Services Specialist III, HH&CS, 981-7644

Attachments:

1. Resolution
   Exhibit A: MHSA FY2019-2020 Annual Update

RESOLUTION NO. ##,###-N.S.

MENTAL HEALTH SERVICES ACT (MHSA)
FISCAL YEAR 2019 – 2020 (FY20) ANNUAL UPDATE

WHEREAS, Mental Health Services Act (MHSA) funds are allocated to mental health jurisdictions across the state for the purposes of transforming the mental health system into one that is consumer and family driven, culturally competent, wellness and recovery oriented, includes community collaboration, and implements integrated services; and

WHEREAS, MHSA includes five funding components: Community Services & Supports; Prevention & Early Intervention; Innovations; Workforce, Education & Training; and Capital Facilities and Technological Needs; and

WHEREAS, the City's Department of Health, Housing & Community Services, Mental Health Division, receives MHSA Community Services & Supports, Prevention & Early Intervention, and Innovations funds on an annual basis, and received one-time distributions of MHSA Workforce, Education & Training and Capital Facilities and Technological Needs funds; and

WHEREAS, in order to utilize funding for programs and services, the Mental Health Division must have a locally approved Plan, Annual Update, or Three Year Program and Expenditure Plan in place for the funding timeframe; and

WHEREAS, on May 7, 2013 by Resolution No. 66,107-N.S., the City Council authorized the City Manager to approve the MHSA Fiscal Years 2012 and 2013 Annual Update; and

WHEREAS, on June 24, 2014 by Resolution No. 66,668-N.S., the City Council authorized the City Manager to approve the MHSA Fiscal Years 2013 and 2014 Annual Update; and

WHEREAS, on May 26, 2015 by Resolution No. 67,026-N.S., the City Council authorized the City Manager to approve the MHSA Fiscal Years 2015 through 2017 Three Year Program and Expenditure Plan; and

WHEREAS, on June 28, 2016 by Resolution No. 67,552-N.S., the City Council authorized the City Manager to approve the MHSA Fiscal Years 2015 through 2016 Annual Update; and

WHEREAS, on January 24, 2017 by Resolution No. 67,799-N.S., the City Council authorized the City Manager to approve the MHSA Fiscal Years 2016 through 2017 Annual Update; and

WHEREAS, on July 25, 2017 by Resolution No. 68,109-N.S., the City Council authorized the City Manager to approve the MHSA Fiscal Years 2017/18 - 2019/20 Three Year Program and Expenditure Plan; and

WHEREAS, on October 30, 2018 by Resolution No. 68,639-N.S., the City Council authorized the City Manager to approve the MHSA Fiscal Years 2018 through 2019 Annual Update; and

WHEREAS, City Council has previously approved MHSA funding for local housing development projects and for contracts with community-based agencies to implement: mental health services and supports; housing and vocational services, and translation services; and

WHEREAS, in order to comply with state requirements the MHSA FY20 Annual Update must be approved by City Council.

NOW THEREFORE, BE IT RESOLVED by the Council of the City of Berkeley that the MHSA FY20 Annual Update that, incorporated herein as Exhibit A, is hereby approved.

BE IT FURTHER RESOLVED that the City Manager is authorized to forward the FY20 Annual Update to appropriate state officials.

Exhibit A: MHSA FY2019/20 Annual Update

Exhibit A

City of Berkeley Mental Health Mental Health Services Act (MHSA)

FY2019-2020 Annual Update

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BACKGROUND AND OVERVIEW

California voters passed Proposition 63, the Mental Health Services Act (MHSA), in November 2004, to expand and transform the public mental health system. This legislation places a 1% tax on personal incomes above $1 million dollars. Funds are deposited into the MHSA State Treasury Fund and allocations per each mental health jurisdiction are determined based on the total population in a given area.

Through the following five funding components, the MHSA was designed to create the capacity for a broad continuum of prevention, early intervention and treatment services along with the necessary infrastructure, technology, and training elements to support effective mental health system transformation:

- Community Services & Supports (CSS): Primarily provides treatment services and supports for Severely Mentally Ill Adults and Seriously Emotionally Disturbed Children.
- Prevention & Early Intervention (PEI): For strategies to recognize early signs of mental illness and to improve early access to services and programs, including the reduction of stigma and discrimination and for strategies to prevent mental illness from becoming severe and disabling.
- Innovations (INN): For short-term pilot projects designed to increase new learning in the mental health field.
- Workforce, Education & Training (WET): Primarily for strategies to identify and remedy mental health occupational shortages, promote cultural competency and the employment of mental health consumers and family members in the workplace.
- Capital Facilities and Technological Needs (CFTN): For capital projects on owned buildings and on mental health technology projects.

Among other things, the MHSA provides enhanced services and supports for Seriously Emotionally Disturbed children and Transition Age Youth (TAY), adults, and older adults suffering from Severe Mental Illness through a “no wrong door” approach and aims to move public mental health service delivery from a “disease oriented” system to one that is culturally responsive, consumer informed, and wellness recovery oriented. This is accomplished through implementing programs that focus on the following major components:

- Wellness, recovery and resilience;
- Cultural competency;
- Consumer/family driven services;
- Consumer/family member integration in the mental health system; and
- Community collaboration.

The MHSA also strives to improve and increase services and supports for individuals and families from cultural and ethnic populations that are traditionally unserved and underserved in the mental health system. In Berkeley and Albany these have included: Asian Pacific Islanders (API);

Latinos; Lesbian, Gay, Bi-Sexual, Transgender, Queer/Questioning, Inter-Sexed (LGBTQI); Senior Citizens; and Transition Age Youth (TAY). African Americans have been an additional population of focus as data indicates they are overrepresented in the mental health system and hence "inappropriately served", which could be due to being provided services that are not culturally responsive and/or appropriate.

In order to access MHSA funds, a stakeholder informed plan outlining how funds will be utilized must be developed and locally approved. Development of a MHSA Plan includes: community program planning with the involvement of area stakeholders, writing a draft plan, initiating a 30-day public review, conducting a public hearing at the Mental Health Commission meeting, and obtaining approval on the plan from City Council. The Community Services & Supports, Prevention & Early Intervention, and Innovation funding components are the only re-occurring monies that are allocated annually and may be spent over a three-year time period. Workforce, Education & Training and Capital Facilities and Technological Needs funds had initial expenditure time periods of 10 years each, and had to be utilized by the end of Fiscal Year 2018 (FY18).

The MHSA legislation requires mental health jurisdictions to provide updates on MHSA Plans on an annual basis and an integrated Program and Expenditure Plan must also be developed every three years. Currently, the City of Berkeley Mental Health (BMH) Division has an approved MHSA FY2017/18 - 2019/20 Three Year Program and Expenditure Plan (Three Year Plan) in place which covers each funding component. Since 2006, as a result of the City's approved MHSA plans, a number of new services and supports have been implemented to address the various needs of the residents of Berkeley and Albany including the following:

- Intensive services for Children, TAY, Adults and Older Adults;
- Multi-Cultural Outreach engagement, trainings, projects and events;
- Mental health services and supports for homeless TAY;
- Wellness Recovery services and activities;
- Family Advocacy, Housing services and supports, and Benefits Advocacy;
- Trauma services and short term projects to increase service access and/or improve mental health outcomes for unserved, underserved and inappropriately served populations;
- Increased mental health prevention, and intervention services for children and youth in area schools and communities;
- Augmented Homeless Outreach and treatment services;
- A Transitional Outreach Team; and a
- Mental Health Consumer, Peer Leadership Program.

Additionally, an outcome of the implementation of the MHSA is that mental health consumers, family members and other stakeholders now regularly serve on several of BMH internal decision making committees. These individuals share their "lived experience" and provide valuable input which has become an integral component that informs the Division on the implementation of MHSA services and supports. Even prior to the passage of Proposition 63, BMH convened (and

has since maintained) an MHSA Advisory Committee which serves in an advisory capacity on MHSA programs and is comprised of mental health consumers, family members, and individuals from unserved, underserved and inappropriately served populations, among other community stakeholders.

This City of Berkeley MHSA FY2019/20 (FY20) Annual Update is a stakeholder informed plan that provides an update to the previously approved Three Year Plan. The Annual Update summarizes proposed program changes and additions, includes descriptions of currently funded MHSA services, and provides a reporting on FY2017/18 (FY18) program data.

MESSAGE FROM THE MENTAL HEALTH MANAGER

Access to care is the central focus of the City of Berkeley's MHSA 2019/20 Plan. MHSA funded services have significantly increased the size and variety of providers that provide mental health care. This plan builds on past MHSA plans and includes new or continued funding for a wide array of programs that are focused on increasing access to care -- funding a Wellness Center that will open this Fall, expanding the Mobile Crisis Team, creating a Transitional Outreach Team that follows up on individuals who enter crisis, leveraging other funding to reconstruct the main Adult Clinic, funding new case management for transitional aged youth with community based providers, increasing services available while stabilizing Russell Street Board and Care, creating new supported housing at McKinley Street, and expanding and making permanent the Homeless Outreach and Treatment Team. All of these existing and proposed programs and projects help expand the options for engaging and connecting to individuals and families in Berkeley and Albany who would benefit from mental health treatment.

While these expansions to the Mental Health Division and the community based providers serving individuals in Berkeley and Albany are welcome and vital, our community continues to struggle to meet the needs of those who are unconnected to care – especially individuals who are homeless. Far too many people continue to struggle and suffer, and engaging and meeting the needs of these individuals will require continued efforts and innovative thinking, as well an increasing partnership between the community and mental health care providers. Along this line, this MHSA Plan includes funding for the possible development of a primary care site that will be focused on providing integrated care for individuals who are homeless and/or have behavioral health care issues.

The system of care is focused on providing services that are welcoming, culturally appropriate, and recovery oriented. Both the Mental Health Division and community providers are increasingly able to measure their impact through Results Based Accountability and to the information gathered from outcome measures to improve care. Through Mental Health First Aid Training and strategic partnerships with the Berkeley Unified School District, this Mental Health Division is focused on partnering with the larger community to support the development of a web of partnerships that all support individuals in Berkeley and Albany being able to connect to the care they deserve.

The mental health division presents the City of Berkeley's MHSA 19/20 with gratitude for all the hard work that went into the programs it describes. Our community partners, consumers, Mental Health Commission, and City staff all deserve appreciation for their efforts, input, and partnership.

DEMOGRAPHICS*

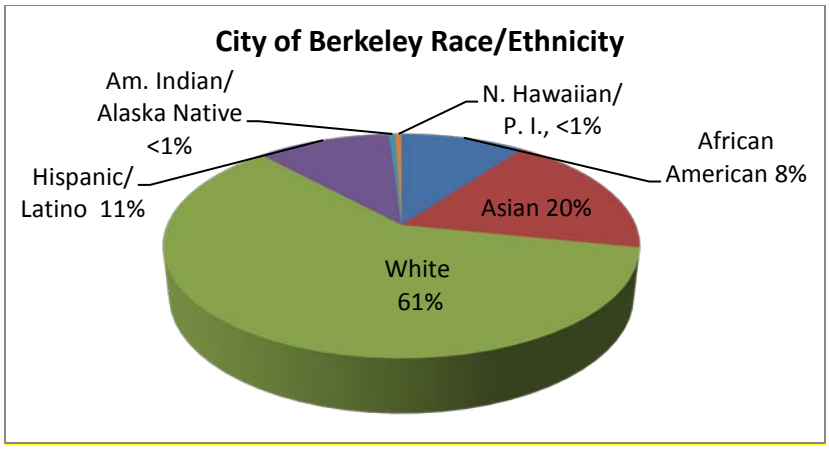
*United States Census American Fact Finder: https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

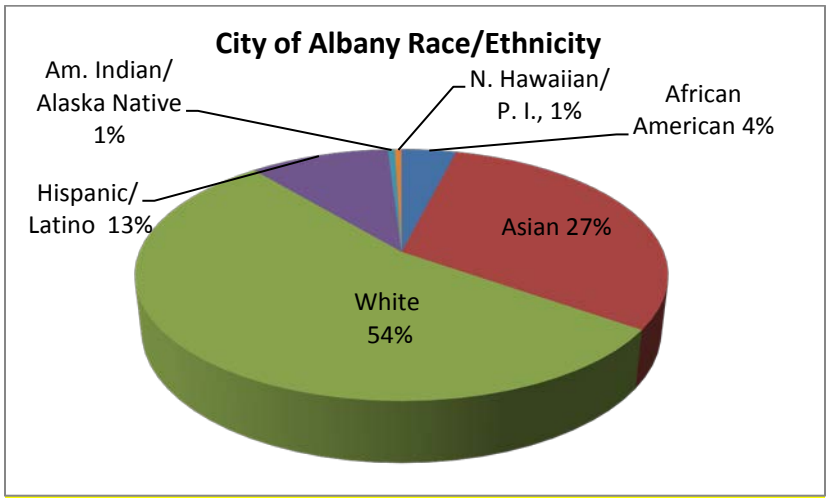
Description

Situated in the heart of the San Francisco Bay area, and home to the University of California, Berkeley is an urban city, located in northern Alameda County. Adjacent to Berkeley and bordering Contra Costa County is the small suburban city of Albany. With a combined land mass of around 12.2 miles and a total population of 142,467 the cities of Berkeley and Albany are densely populated and larger than 23 of California's small counties.

Race/Ethnicity

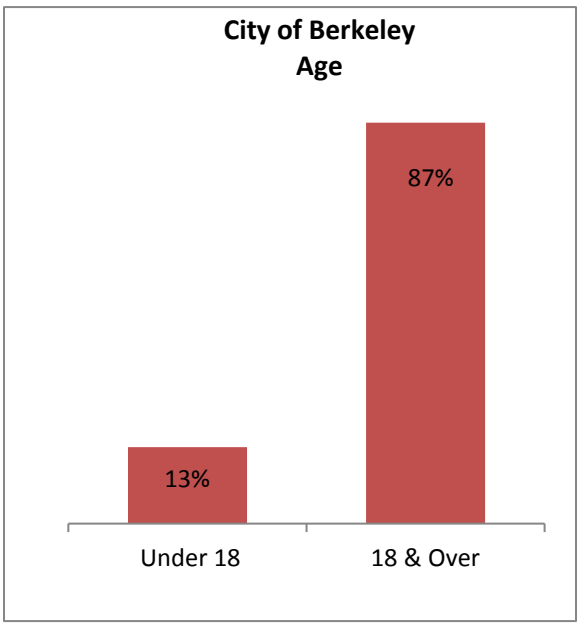
Berkeley and Albany are diverse communities with changing demographics. In each city the African American population has decreased in recent years while the Latino and Asian populations have both increased. Both cities have large student populations, including Albany Village, providing housing for many of University of California's foreign students and their families. Threshold languages include English, Spanish, Farsi, Cantonese, and Vietnamese, and approximately 28% of Berkeley and 41% of Albany residents speak a language other than English at home. Each city is comprised of the following racial and ethnic demographics: White; African American; Asian; Hispanic/Latino; American Indian/Alaska Native; and Native Hawaiian/Pacific Islander (P.I.). Demographics per city are outlined below:

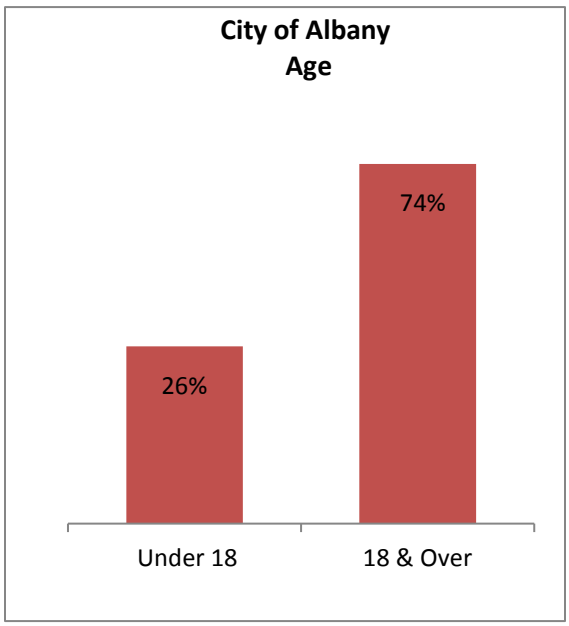




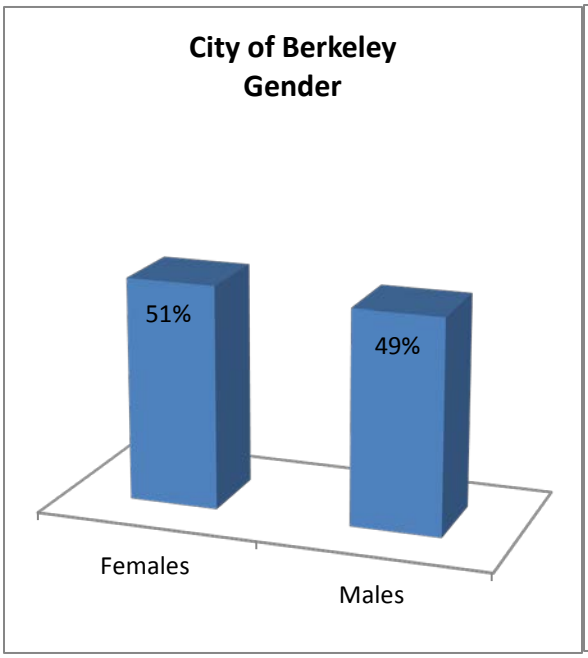
Age/Gender

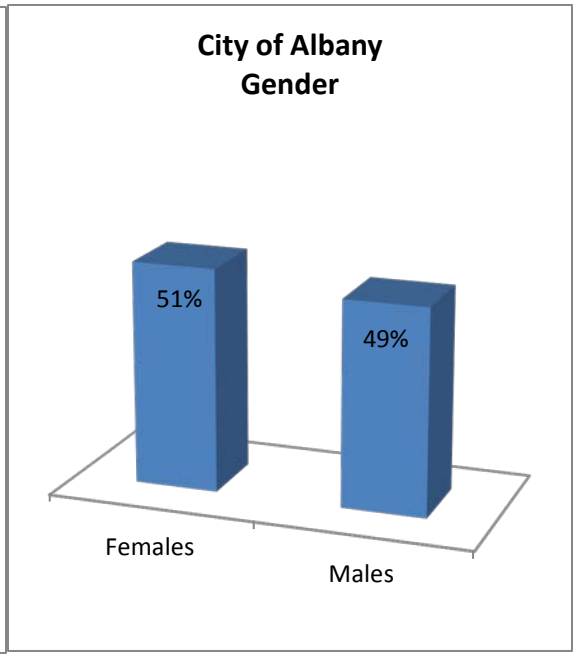
As depicted in the tables below, a large percentage of individuals in Berkeley and Albany are over the age of 18 and per population, Albany has twice as many individuals under the age of 18 as the City of Berkeley:





Gender demographics are very similar in both cities as shown below:





Lesbian, Gay, Bisexual, Transgender, Queer (LBGTQ) Population

Based on a Gallop Survey of interviews conducted during the timeframe of 2012-2014, the San Francisco bay area has the highest LGBTQ population (6.2%) of any of the top 50 United States metropolitan areas. Additionally according to Williams Institute, in a survey of Cities with 50+ same-sex couples (ranked by same-sex couples per 1,000 households) conducted in 2010, the City of Berkeley ranked number 13 in the State of California and number 48 among 1,415 United States cities. The City of Berkeley had 2.1% same-sex households according to the 2010 United States Census and the City of Albany had 1.7% same-sex households.

Income/Housing

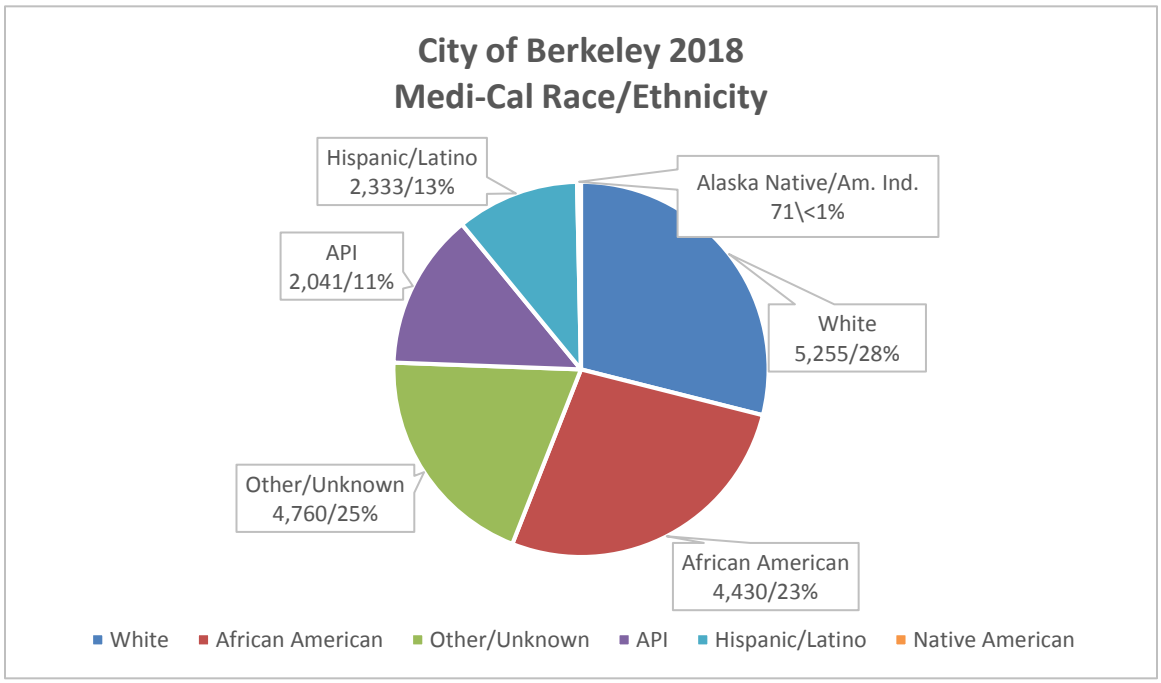
With some of the highest housing costs in the Bay Area, the Berkeley median household income is $75,709, and Albany is $87,694. Nearly 20% of Berkeley and 11% of Albany residents live below the poverty line and approximately 42% of Berkeley and 35% Albany children qualify for free and reduced lunches. While 43% of Berkeley and 48% of Albany residents own their own homes, there are many homeless individuals including women, TAY, and Older Adults. In Berkeley, approximately 46% of the homeless population meets the federal definition for chronic homelessness (adults unaccompanied by children, who have at least one disability and have been homeless for over a year or four or more times in the last year). This is a disproportionately high percentage compared to other municipalities, and a sub-group with higher rates of both mental illness and substance abuse.

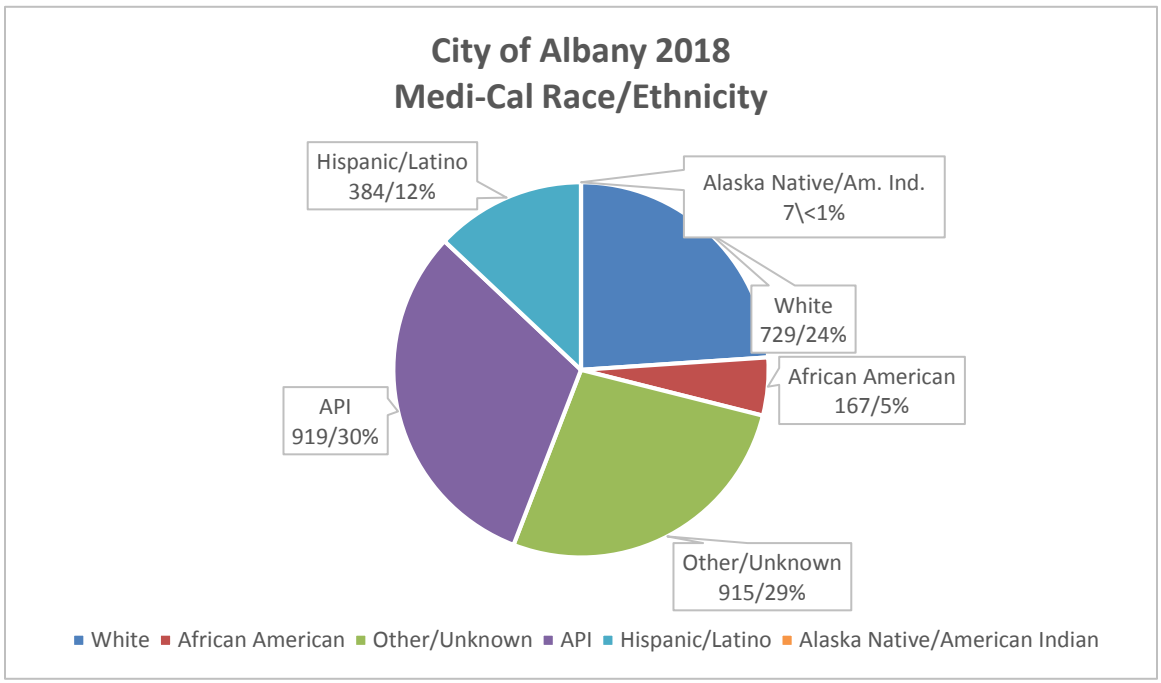
Education

Berkeley and Albany have a highly educated population: 97% of individuals aged 25 or older are high school graduates; and approximately 72% possess a bachelor's degree or higher.

System Organization

Berkeley Mental Health (BMH), one of two city-based public mental health programs in the state, provides services for residents of Berkeley and Albany. It is a Division of the City of Berkeley Health, Housing & Community Services (HHCS) Department. Services are provided at multiple clinic sites and in the field. BMH has several units providing services: Access; Family, Youth & Children; and Adult Services. Services include: assessment, assertive community treatment, individual and group therapy, case management and crisis intervention. In addition to offering homeless outreach and support, some services are provided through a variety of community-based agencies and at school sites. As part of the Access unit, a Mobile Crisis response Team operates seven days a week. The majority of mental health services provided by BMH are aimed towards the Medi-Cal and uninsured population; as such it is important to note the ways in which the Medi-Cal population demographics differ from the overall demographics in Berkeley and Albany. Using data available from Alameda County, the Medi-Cal population in Berkeley in 2018 was as follows:


City of Berkeley 2018
Medi-Cal Race/Ethnicity
Hispanic/Latino
2,333/13%
Alaska Native/Am. Ind.
71\<1%
API
2,041/11%
White
5,255/28%
Other/Unknown
4,760/25%
African American
4,430/23%
White
African American
Other/Unknown
API
Hispanic/Latino
Native American


City of Albany 2018
Medi-Cal Race/Ethnicity
Hispanic/Latino
384/12%
Alaska Native/Am. Ind.
7\<1%
White
729/24%
African American
167/5%
API
919/30%
Other/Unknown
915/29%
White
African American
Other/Unknown
API
Hispanic/Latino
Alaska Native/American Indian

Community Program Planning (CPP)

Community Program Planning (CPP) for the City of Berkeley's MHSA FY2019/20 (FY20) Annual Update was conducted over a one month period to enable opportunities for input from MHSA Advisory Committee members, consumers, family members, representatives from community-based organizations, individuals from unserved, underserved and inappropriately served populations, BMH Staff, City Commissioners, and other MHSA Stakeholders. During this process, one MHSA Advisory Committee meeting and four Community Input meetings were held.

As with previous MHSA Plans and Annual Updates, the methodology utilized for conducting CPP for the MHSA FY20 Annual Update was implemented to enable a collaborative process to occur between Berkeley Mental Health (BMH) staff, MHSA Advisory Committee members and other MHSA stakeholders. Development of the MHSA FY20 Annual Update began with an internal examination of existing programs, unaddressed needs, and available funding which included a review of input received during the preparation of previous MHSA planning processes. Following an internal review, proposed ideas and potential programs were vetted through the MHSA Advisory Committee prior to engaging other stakeholders.

Proposed additions that were considered in this process included:

- Turn the Homeless Outreach and Treatment Team (HOTT) pilot project into a permanent Full Services Partnership program;
- Add a BMH Social Services Specialist position, to increase the Division's capacity to serve individuals with substance use disorders;
- Add a BMH Assistant Management Analyst position, to support Division logistics and program outcomes;
- Implement "Hearing Voices Support Groups" for youth and family members;
- Provide funding for Russell Street Board and Care Subsidies;
- Provide funding to the Health, Housing & Community Services (HHCS), Aging Division, to implement counseling services at Senior Centers;
- Fund a planning process for an integrated primary care site in Berkeley for homeless and severely mentally ill populations;
- Provide funding for the "Berkeley Unified School District (BUSD) "African American Success Project";
- Re-issue Requests for Proposals for services that have been under contract with the same contractor for five years or more.

Input received during Community and Staff meetings largely supported the proposed additions. Some additional comments received were as follows:

- Include consumer and family member input on drafting the job duties of the proposed Social Service Specialist position;
- Ensure that the individual hired for the proposed Assistant Management Analyst position will be culturally competent;
- Provide more continuity between the Hub and HOTT. Services in HOTT should be provided after 5:00pm, and there should be a staff on HOTT who be available to answer phone calls.

Additional comments received during community and staff meetings that was not specific to the proposed additions were as follows:

- Implement Peer Respite Housing in Berkeley;
- Peer leadership has been dishonored at BMH and the Division should find a way to support peers by providing funding for peer led programs such as an Expressive Arts program;
- MHSA funds could be utilized to support programs that prepare youth for the workforce;
- MHSA should provide funding for the African American Holistic Health Center;
- Fund a research project on what the impact of institutional racism has on the mental health of African Americans;
- Mental health programs should ensure they are culturally competent in the services they provide, including curriculums, hiring and firing and staff throughout all levels of the programs should reflect the populations served;
- Funds should be spent on a mobile shower bus;
- Assess and address how African Americans mental health, including increased stress caused by the trauma of racism and discrimination intersects with health disparities such as elevated blood pressure, low birth weight, infant mortality, etc;
- Interested in the interaction with the community and why there aren't more people at Community Input Meetings. The Mental Health Division seems to be off to the side. There should be constant messaging on a regular basis through the radio and other media of mental health issues and area programs and services and face-to-face communications with different points of contact such as the homeless population. We need to normalize talking about Mental Health.

The last comment around a lack of participation of community members at MHSA Community Planning process meetings is something that is not specific to Berkeley as other counties struggle with the same issue. In an effort to increase community input on this FY20 Annual Update through implementing additional ways that the community could inform the MHSA process, a handout (located on the following page) was created and available to the community at three area events in May. Copies of the handout were available on a resource table at each event. Community members who were interested in providing input could either do so on a copy of the handout at the event, or submit the document by fax, mail or email. Questions on the handout included the following:

1.) What do you feel are the most pressing unmet Mental Health needs in the City of Berkeley?

2.) Do you have ideas you would like to share on best ways to address these needs?

3.) Is there anything else you would like to share regarding Mental Health services and needs in the City of Berkeley?

The handout also provided the opportunity for individuals who are interested in receiving current and future information on MHSA Plans, funding, and services to leave their contact information.

These same three questions were also put on the Berkeley Considers Forum for a two week period. Berkeley Considers is an online forum for civic engagement. It is run by OpenGov a non-partisan company whose mission is to broaden civic engagement and build public trust in government. As with any public comment process, participation in Berkeley Considers is voluntary.

WOULD YOU LIKE TO BE A PART OF INFORMING
CITY OF BERKELEY MENTAL HEALTH DIVISION
MENTAL HEALTH SERVICES ACT (MHSA) ANNUAL PLANS AND UPDATES?

As part of planning for current and future Mental Health Services Act (MHSA) Annual Plans and Updates, Berkeley Mental Health would like your opinion on the following:

1.) What do you feel are the most pressing unmet Mental Health needs in the City of Berkeley?

2.) Do you have ideas you would like to share on best ways to address these needs?

3.) Is there anything else you would like to share regarding Mental Health services and needs in the City of Berkeley?

Would you like to receive information on the City of Berkeley, Mental Health Division, MHSA Plans and Updates? If so please leave your contact information (name, email and/or mailing address) below:

If you would like to take this home and fill it out, you can mail or fax it to:
Karen Klatt, MHSA Coordinator
City of Berkeley
3282 Adeline Street
Berkeley, CA 94611
(510) 596-9299

You could also send an email answering the questions to: KKlatt@cityofberkeley.info

In all a total of 41 individuals provided input on the three Mental Health Needs questions either through the Berkeley Considers forum or at community events. The top 5 recurring responses on the first two questions are outlined below:

Responses on most pressing unmet Mental Health needs in the City of Berkeley
• Need for more (health, mental health and housing) services for homeless individuals who are living with mental health or co-occurring disorders; • There is not a 24 hour Mobile Crisis service in Berkeley; • Services for children and families who are underinsured; • Need mental health services for Senior Citizens; • More mental health services and supports in the schools for adolescents.
Responses regarding ideas on best ways to address unmet needs
• Early intervention programs to ensure individuals have their basic needs met, such as housing, food, bathing; • Drop-In Centers with 24 hour help; • Implement a 24 hour rapid response program to deal with individuals suffering from Mental Health Crises; • Do a better job of informing residents of the services that already exist and how to access them; • Collaborate with city and county partner programs to address unmet needs.

Some of the responses to the third question included the following:

Responses on anything else regarding Mental Health services and needs in the City of Berkeley
• Provide counseling where the homeless are camped; • Implement in-home peer counseling for seniors living with a mental illness; • Provide group therapy by psychiatrists or therapists accompanied by former patients who have been helped by their own participation in group therapy; • Provide better and more frequent access to psychiatrists and psychologists for individual sessions; • Implement services for the many people who are suffering quietly, but don't feel their lives are terrible enough to get help.

Utilizing the Berkeley Forum and outreach at area events proved to be valuable community planning process activities for increasing additional input on the FY20 Annual Update. One of the many learnings of the input received is that some community members are not aware of many of the services that BMH provides or how to access those services. The Division will use this input to strategize on better ways to inform the community of BMH Services. All input received through this process and the community input meetings will be utilized to inform current and proposed mental health programs through this FY20 Annual Update and/or future MHSA Plans and Updates.

A 30-Day Public Review was held from Wednesday, May 29 through Thursday, June 27 to invite input on this MHSA FY20 Annual Update. A copy of the Plan was posted on the BMH MHSA website was available for reviewing in hard copy format at the downtown Public Library at 2090 Kittredge Street. An announcement of the 30-Day Public Review was mailed and/or emailed to community stakeholders. The Public Hearing for this Annual Update was held at 7:00pm on June 27 at the Mental Health Commission meeting at 1947 Center Street in Berkeley. Comments and input received during the 30-Day Public Review or the Public Hearing were as follows:

- Increase access to services for individuals who have physical disabilities, as well as vision and other co-disabilities.
- Ensure any program staff who are working with Trauma Informed Care models (and program staff in general) are provided with supports around Compassion Fatigue.
- Include funding for Senior Centers that can be flexibly used for housing issues, and other problems seniors are facing.
- Collaborate with the Wright Institute.
- Create an RFP that provides additional services and supports for the LGBTQI population.

Written Public Comments received either during the 30-Day Public Review or that were distributed (and heard) at the Public Hearing are included in Appendix C. Some of the various written comments received focused on increasing services and supports in Albany; and adopting a systems integrated framework and approach to utilize with Results Based Accountability for evaluating programs. All comments received during the 30 Day Public Review and the Public Hearing will be utilized to inform this and/or future MHSA Plans and Updates.

After the close of the Public Hearing the Mental Health Commission made the following motion:

M/S/C (Castro, Fine) Motion to approve the plan (MHSA FY20 Annual Update) and move it to City Council
Ayes: Castro, cheema, Fine, Kealoha-Blake; Noes: Heda; Abstentions: None; Absent: Davila.

MHSA FISCAL YEAR (FY) 2019/20

ANNUAL UPDATE

This City of Berkeley MHSA FY2019/20 (FY20) Annual Update is a stakeholder informed plan that provides an update to the MHSA 2017/18 – 2019/20 Three Year Program and Expenditure Plan (Three Year Plan). The Annual Update summarizes proposed program changes and additions, includes descriptions of currently funded MHSA services that are proposed to be continued in FY20, and a reporting on FY18 program data. Information on the status of local Prudent Reserve MHSA funds is also provided. Additionally, per new state regulations, this Annual Update includes the Three Year Prevention and Early Intervention (PEI) Evaluation Report (Appendix A) and the Annual Innovations (INN) Evaluation Report (Appendix B).

While some MHSA programs have collected outcome and client self-report measures, the majority of the data currently being collected is more process related. However, as previously reported in the MHSA FY2017/18 – 2019/20 Three Year Program and Expenditure Plan (Three Year Plan), there are a few initiatives that are currently underway to evaluate the outcomes of several MHSA programs including the following:

- Impact Berkeley: In FY18, the City of Berkeley introduced a new initiative in the Health Housing and Community Services (HHCS) Department called "Impact Berkeley". Central to this effort is using a highly regarded framework called Results Based Accountability (RBA) to account for the work of the Department. RBA provides a new way of understanding the quality and impact of services provided by collecting data that answer three basic questions:
  1. How much did you do?
  2. How well did you do it?
  3. Is anyone better off?

  RBA has been incorporated into selected programs within the Department. In FY18, this included community agency programs funded through the MHSA Prevention & Early Intervention (PEI) Community Education & Supports program. Through this initiative the Department worked with each contractor to envision, clarify and develop measures on the outcomes and results each program is seeking to achieve, and used a rigorous framework to begin measuring and enhancing progress towards these results. Page 42 of this FY20 Annual Update provides an aggregated summary of some of the results of this initiative. The full report on the Impact Berkeley PEI program results can be accessed on the MHSA website: MHSA Plans and Updates - City of Berkeley, CA
- Homeless Outreach & Treatment Team: This pilot project supports homeless mentally ill individuals in Berkeley/Albany engaging them in mental health services. A local consultant, Resource Development Associates, was hired to measure the outcomes and effectiveness of this pilot project. In early FY19, the first Evaluation Report was released. Some of the many results of this evaluation can be reviewed in the CSS and PEI Sections of this FY20 Annual Update. The City of Berkeley Homeless Outreach and Treatment Team (HOTT) Evaluation can be reviewed on the MHSA Website: https://www.cityofberkeley.info/uploadedFiles/Health_Human_Services/Level_3_-_Mental_Health/Berkeley-HOTT_Evaluation-Report.final.pdf

- PEI Data Outcomes: Per MHSA PEI regulations, all PEI funded programs have to collect additional state identified outcome measures (specific to the category of services provided) as well as detailed demographic information. The first report that included data specific to the new PEI requirements, "City of Berkeley Mental Health Services Act (MHSA) Fiscal Year 2017 Prevention & Early Intervention Evaluation Report" is located on the City of Berkeley Mental Health Division MHSA Website. Beginning in FY19, PEI Evaluations are required to be included in each MHSA Annual Update or Three Year Plan. See Appendix A for the Fiscal Year's 2015/2016 – 2017/2018 Three Year Prevention & Early Intervention Evaluation Report.

- INN Data Outcomes: Per MHSA INN regulations, all INN funded programs have to collect additional state identified outcome measures and detailed demographic information. The first report that included data specific to the new INN requirements, "City of Berkeley Mental Health Services Act (MHSA) Fiscal Year 2017 Innovations Evaluation Report" , is located on the City of Berkeley Mental Health Division MHSA Website. See Appendix B for the Fiscal Year 2018 Annual Innovations Evaluation Report.

- Results Based Accountability Evaluation for all BMH Programs: Through the approved FY19 Annual Update the Division will be executing a Request for Proposal (RFP) process to hire a consultant who will implement a Results Based Accountability Evaluation for all programs across the Mental Health Division.

Future MHSA Plans and Updates will continue to include reporting on the progress of these initiatives.

PROPOSED NEW FUNDING ADDITIONS

Proposed staffing and services to be added through the MHSA FY20 Annual Update, are outlined below:

- **Homeless Outreach and Treatment Team**

The Homeless Outreach and Treatment Team (HOTT) is a pilot project that was funded through both CSS and PEI components. The primary goal of this program is to engage and provide access and linkage to services that promote health, mental health and self-sufficiency for individuals who have significant mental health and related disorders, and are currently living on the streets of Berkeley and Albany. The key components of the program include the following evidence and experienced based practices:

- Persistent and consistent outreach;
- Supportive case management;
- Linkage to care;
- Treatment.

The program has dedicated flexible funds for short-term housing vouchers, to assist clients with short term housing for emergency stabilization and respite. In FY18 an initial evaluation, by Resource Development Associates, was conducted. The initial report showed many positive findings including the following:

- The program provided 1,506 outreach contacts to 319 homeless individuals since inception
- HOTT is serving as an important resource for the local community and homeless service continuum
- A total of 992 referrals to area resources were made in 2018

- The program has been very effective in persistent and consistent outreach, especially for chronically homeless individuals with a history of refusing services
- HOTT meets people where they are, in parks, encampments, motels
- The program has successfully connected homeless individuals to critical resources and service linkages

The City of Berkeley Homeless Outreach and Treatment Team (HOTT) Evaluation can be reviewed on the MHSA Website:

https://www.cityofberkeley.info/uploadedFiles/Health_Human_Services/Level_3_-_Mental_Health/Berkeley-HOTT_Evaluation-Report.final.pdf

While the program has shown valuable outcomes, BMH has encountered difficulties in securing consistent staffing due to the nature of HOTT being a pilot project. In addition, the HOTT participants who have needed ongoing services have had some difficulty transitioning to other treatment teams, and these individuals need intensive ongoing services. As a result of the impact the HOTT program is having in the community, and in an effort to strengthen and provide sustainability of the services, the Division is proposing to make the HOTT program a permanent Full Services Partnership (FSP) program through this FY20 Annual Update. The proposed new FSP will utilize the Assertive Community Treatment service model, where services are provided by a team.

The proposed team staffing will be comprised of the following:

- 1 Program Manager, Health Services Program Specialist or Mental Health Clinical Supervisor (same as HOTT pilot);
- 2 Behavioral Health Clinician II positions and 2 Social Services Specialist positions will provide clinical case management services (increase from 2 Social Services Specialists in HOTT pilot);
- 1 Registered Nurse and a .25 FTE Psychiatrist will provide medication services (increase from 0 RN's and Psychiatrists in HOTT pilot);
- 1 Social Services Specialist (funded through General Funds) for homeless outreach (same as in HOTT pilot).

The proposed funding for this FSP, $366,942, will be provided through CSS System Development funds, to support current and new staffing. Due to the need for additional homeless outreach, the mental health division is hopeful that through general funds additional staffing can be added in for additional homeless outreach.

- **Increase Substance Use Disorder Staffing and Supports**

Community Input during this and previous MHSA plans and Updates has continually echoed a need for increased supports for individuals with substance use disorders. A large portion of individuals who currently receive services at BMH are also suffering from co-occurring disorders, having both mental health issues and substance use disorders. In an effort to increase the capacity to serve individuals with substance use disorders the Division is proposing to utilize $135,613.65 of CSS System Development funds to add a Social Services Specialist who would work directly with individuals to assist them in obtaining the resources and supports they need.

- **Increase Administrative Staffing**

BMH has grown tremendously within the past several years, increasing direct service staff and services. Additionally, Division staff are currently operating out of four different locations while the Adult Clinic is being renovated, and staff will continue to operate out of three sites once the renovation has been completed. BMH has also recently undergone a reorganization and an Assistant Mental Health Manager was hired to, among other duties, oversee the various Division facilities, and program outcomes. To provide support to this position, BMH is proposing to utilize $135,095.60 of CSS System Development funds to add an Assistant Management Analyst who will work closely with the Assistant Mental Health Manager on Division logistics and the implementation of outcome measures to evaluate BMH programs and services.

- **Add Hearing Voices Support Groups for Youth and for Family Members**

Through a previously approved MHSA Plan, BMH has funded the Bay Area Hearing Voices Network to provide a free, weekly, drop-in support group in Berkeley for adults who experience voices, visions, special messages, unusual beliefs or extreme states of consciousness. The support group is co-facilitated by trained group leaders both of whom have lived experience in the mental health system. Through this FY20 Annual Update, BMH is proposing to continue to provide services to adults and to add two additional Hearing Voices Support Groups, one for youth (aged 16-25) and one for family members.

Youth and young adults in the mental health system who hear voices, see visions or experience alternative realities are at high risk of multiple adverse outcomes and costs to the City, including homelessness, unemployment and high crisis services use. Voices, visions, and alternative realities, experiences conventionally described as psychosis within the traditional mental health system, are among the most stigmatized aspects of mental health. Rates of discrimination and social exclusion of youth with psychosis are notoriously high, leading to social isolation, and disengagement from systems of care. The purpose of a Hearing Voices Support Group for youth will be to support young people who hear, see or sense things others don't, by providing better information, advice, and support for participants. In the support group setting individuals will be able to discuss and explore their experiences and meet other youth with similar experiences.

Additionally, according to input received from family members, a Hearing Voices Family Support Group for family members will help improve relationships, and will provide supports on better ways to communicate and respond about their own experiences which often include fears, anxieties, and confusions about what their loved ones are going through. In an effort to support youth and family members, BMH is proposing to utilize a total of $34,736 of CSS System Development funds in FY20 to continue providing Hearing Voices Support Groups to adults and to implement separate support groups for Youth and Family Members.

- **Provide funding subsidies for Russell Street Board and Care**

The Russell Street Board and Care, located in Berkeley, provides housing and services for seventeen individuals. Through this FY20 Annual Update the Mental Health Division is proposing to utilize CSS System Development funds to support these Board and Care units with a supplemental subsidy of up to $1,750 per month per individual. This will support the Board and Care in providing Wellness and Recovery services in addition to legally required services. This

unit subsidy will replace all previous subsidies provided to the Russell Street Board and Care from the Division.

- **Add Counseling Services at Senior Centers**

Seniors who only have medicare insurance currently have great difficulty accessing mental health services, despite consistent input on the need for mental health services for this population. In an effort to increase mental health services and supports for senior citizens, the division is proposing to provide the Aging Services Division of HHCS, with $150,000 of CSS System Development funds to implement counseling services at Senior Center sites.

- **Implement a Planning Process for an Integrated Primary Care Site**

Consistent input received over various MHSA planning processes has included a need for integrated primary and behavioral health care sites for individuals who are homeless and severely mentally ill. One such site that exists in Alameda County is the "Trust Health Center", which is operated out of LifeLong Medical Care. The Trust Health Center addresses physical, mental, and social well-being in one location. Partner organizations assist clients in finding and maintaining stable homes and in establishing strong social supports. Through this FY20 Annual Update, the Division is proposing to allocate $100,000 CSS System Development funds for a planning process to assess the feasibility of implementing an Integrated Primary Care Site in Berkeley.

- **Expand the African American Success Project**

The African American Success Project (AASP) was first implemented in FY19 in four Berkeley Unified School District Schools (King, Longfellow, Willard and Berkeley High School). Closely aligned with the work of Berkeley's 2020 Vision, the AASP works with African American youth and their families to actively engage students in the classroom and school life while creating a pathway for their long-term success. The project implements a three-pronged approach that includes case management and mentorship (which are individualized and tailored to meet each student's needs), community building, and family engagement. Through this approach a case manager engages and works with each student on school success planning. This work includes establishing student check-ins, family connections, teacher and staff collaborations, advocacy, and community building sessions. The project supports students who have disproportionately faced barriers in Berkeley public schools to promote an individual's learning, mental, and socio-emotional well-being.

During the first year the project team worked with 84 students and their families while assessing the effectiveness of the project and identifying ways to strengthen the service model. One key finding was that the project could only have limited impact when staff were spread across four school sites. Going into the next school year, the project will only be implemented at Longfellow. A second key learning was that services could be strengthened if they were integrated into the school day through a class that African American students could elect to take that would provide a safe space to focus on ongoing social and emotional development, skill-building, habits and mindsets that enable self-regulation, interpersonal skills, and perseverance and resilience. The class would be facilitated by a Counselor/Instructor who would follow-up with students in one-on-one counseling sessions on issues of concern that are raised in class and would provide referrals to mental health services and supports as needed.

Through this FY20 Annual Update in order to support the implementation of this additional component, the Division is proposing to allocate $150,000 of Prevention & Early Intervention funds to this project. This MHSA funding contribution will be contingent on Berkeley Unified School District securing funds for staffing that are identified in the proposed project budget, as coming from non-MHSA funds.

- **Re-Issue Requests for Proposals**

To ensure fair contracting practices, the Division will be executing a new Request for Proposal (RFP) process for contracts that have been in place for five or more years. The Division is proposing that all MHSA funded contracts that have been in place for five years or more will be renewed through June 30, 2020. During FY20, new RFP's will be executed for these services and the chosen vendor will begin providing services on 7/1/20.

PROGRAM DESCRIPTIONS AND FY18 DATA BY FUNDING COMPONENT

Outlined in this section per each funding component are descriptions of current City of Berkeley MHSA services along with FY18 program data. Across all MHSA funded programs, in FY18, a total of 6,227 individuals participated in some level of services and supports. Additionally, a total of 762 individuals attended BMH Diversity and Multi-cultural trainings aimed at transforming the system of care, and 1,615 individuals attended BMH Diversity and Multicultural events. Some of the FY18 MHSA funded program highlights include: a reduction in psychiatric inpatient hospital and/or incarceration days for severely mentally ill clients; a decrease in the number of days severely mentally ill clients spent homeless; step down to a lower level of care for some clients; services and supports for homeless or marginally housed TAY who are suffering from mental illness; services and supports for family members; consumer driven wellness recovery activities; Housing, and Benefits Advocacy services and supports for clients; augmented prevention and intervention services for children and youth in the schools and community; increased outreach, and support services for homeless TAY, Adults and Older Adults and individuals in underserved and inappropriately served cultural and ethnic populations.

COMMUNITY SERVICES & SUPPORTS (CSS)

Following a year-long community planning and plan development process, the initial City of Berkeley CSS Plan was approved by the California Department of Mental Health (DMH) in September 2006. Updates to the original plan were subsequently approved in September 2008, October 2009, April 2011, May 2013, May 2014, May 2015, June 2016, January 2017, July 2017 and October 2018. From the original CSS Plan and/or through subsequent plan updates, the City of Berkeley has provided the following services:

- Wrap-around Services for Children and their families;
- TAY, Adult and Older Adult Intensive Treatment Services;
- Multi-cultural Outreach & Engagement;
- TAY Support Services;

- Consumer Advocacy;
- Wellness and Recovery Services;
- Family Advocacy;
- Housing Services and Supports;
- Benefits Advocacy; and
- Transitional Outreach Services.

Descriptions for each CSS funded program FY18 data are outlined below:

FULL SERVICE PARTNERSHIPS (FSP)

Children's Intensive Support Services Full Service Partnership

The Children's Intensive Support Services Full Service Partnership (FSP) is for children ages 0-18 and their families. The program is for children and their families who would benefit from, and are interested in participating in a program designed to address the total needs of a family whose child (and possibly other family members) is experiencing significant emotional, psychological or behavioral problems that are interfering with their wellbeing.

Priority populations include children who:

- have substantial impairment in self-care, school functioning, family relationships, the ability to function in the community, and are at risk of or have already been removed from the home and have a mental health disorder and/or impairments that have presented for more than six months or are likely to continue for more than one year without treatment;
  OR
- display psychotic features, or a history of hospitalization due to Danger to Self, Danger to Others, Grave Disability or a recent attempt within the last six months from the date of referral.

The Children's FSP program utilizes wraparound as the treatment model. Wraparound differs from many service delivery strategies, in that it provides a comprehensive, holistic, youth and family-driven way of responding when children or youth experience serious mental health or behavioral health challenges. The model puts the child or youth and family at the center. With the help of the FSP team, the family and young person take the lead in deciding their vision and goals. Team member's work together to put the goals into an action plan, monitor how well it is working, and make changes to it as needed.

In FY18, a total of 22 children/youth and their families were served through this program. Demographics on those served were as follows:

CLIENT DEMOGRAPHICS N=22		
Client Gender	*Number Served*	*% of total*
Male	15	68%
Female	7	32%

Race/Ethnicity		
Client Race/Ethnicity	*Number Served*	*% of total*
African American	15	68%
Asian Pacific Islander	0	0%
Caucasian	5	22%
Latinx	1	5%
Mixed Race	1	5%

The average length of treatment was seven months. The shortest length of treatment was two months (three families moved out of the service area after two months of engagement) and the longest was over a year (three individuals and their families were still part of the program following the reporting timeframe). Of the 22 individuals and their families that were enrolled the outcomes were as follows: Twelve clients received Special Educational Services due to a specific learning disability; six individuals graduated to a lower level of care; six clients and families moved out of the service area due to the high cost of living in the Bay Area; three clients were placed in residential care by juvenile justice and CPS systems; three clients were still in the program following the reporting timeframe; two were transferred to the BMH Transition Age Youth (TAY), Adult and Older Adult FSP program; and two individuals and their and families disengaged.

Transition Age Youth (TAY), Adult and Older Adult Full Service Partnership

This program provides intensive support services to TAY, Adults and Older Adults with severe mental illness using an Assertive Community Treatment approach. The program focuses on serving individuals who are have had difficulty with obtaining or maintaining housing; frequent and/or lengthy psychiatric hospitalizations; and/or frequent or lengthy incarcerations. Priority populations also include individuals from un-served, underserved and inappropriately served cultural communities.

The team utilizes an Assertive Community Treatment approach which maintains a low staff-to-client ratio (12:1) that allows for frequent and intensive support services. Clients are provided assistance with finding appropriate housing and in some cases may qualify for temporary financial assistance. A full range of mental health services are provided by a team comprised of 1 Clinical Supervisor, 4 Licensed Behavioral Health Clinicians, 1 Social Services Specialist, 1 Registered nurse and a ½ time psychiatrist. The primary goals of the program are to engage clients in their treatment and to reduce days spent homeless, hospitalized and/or incarcerated. Goals also include increasing, employment and educational readiness; self-sufficiency; and wellness and recovery. The program serves up to 60 clients at a time.

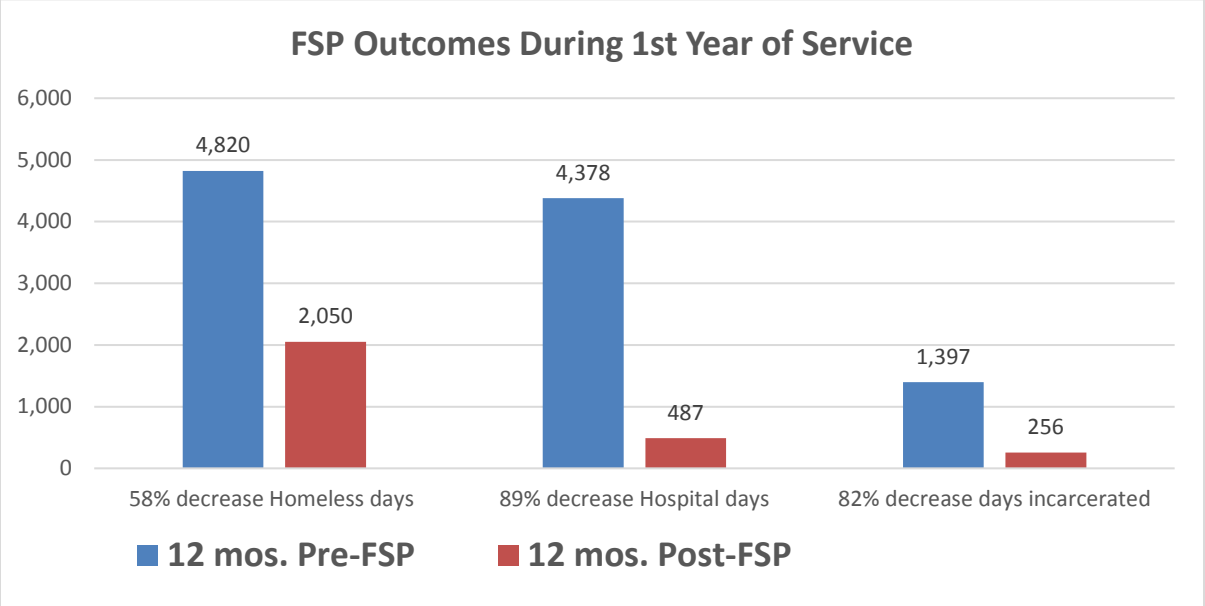
In FY18 a total of 59 Transitional Age youth (TAY), Adults, and Older Adults were served through this program. Demographics on those served include the following:

CLIENT DEMOGRAPHICS N=59		
Client Gender	*Number Served*	*% of total*
Male	38	64%
Female	21	36%

Race/Ethnicity		
Client Race/Ethnicity	*Number Served*	*% of total*
African American	33	56%
Asian Pacific Islander	5	8%
Caucasian	17	29%
Latino	4	7%
Age Category		
Client Age Category	*Number Served*	*% of total*
Transition Age Youth	5	8%
Adult	50	80%
Older Adult	9	12%

TAY, Adult and Older Adult client outcomes included the following: 13 partners were dis-enrolled from the program during FY18: Two partners met treatment goals and graduated to lower levels of care, four partners made the decision to discontinue treatment, one partner moved out of the county, two partners were unable to be located, two partners were discharged due to serving jail sentences and two partners were discharged due to being institutionalized. Three new partners were enrolled into the program over the course of the fiscal year.

There were 59 FSP program participants in FY18, all participants completed a full year of services in the program and are included in the program outcome report data. There were positive outcomes with regard to reductions in days spent homeless, in hospital settings and/or incarcerated. There was a **58% reduction in days spent homeless**. Partners spent 4,820 days homeless (on the street, couch surfing and in shelters) the year before program enrollment and 2,050 days homeless during the first year of program participation. There was an **89% reduction in days spent in psychiatric hospital settings** (Psychiatric Emergency, acute inpatient, IMDs, MHRCs and state psychiatric hospitals) during the first year of program participation. Partners spent 4,378 days in psychiatric hospital settings the year before program enrollment and 487 days in these settings during the first year of program participation. There was an **82% reduction of days spent incarcerated** during the first year of program participation. Partners spent 1,397 days incarcerated (jail and prison) the year prior to program enrollment as compared with 256 days incarcerated during the first year of program participation.



Program challenges included: Finding safe and affordable housing in the bay area as it has become increasingly difficult as housing prices continue to rise and are among the most expensive in the country. Also, Licensed Board & Cares that provide clients 24/7 support and monitor medication adherence have been closing down. Single Room Occupancy Hotels have been raising their monthly rates such that clients are not able to afford staying there without housing subsidies. The program has also struggled with how to better serve individuals with severe substance abuse problems who are unwilling to address or sometimes even acknowledge that they have substance abuse issues. Going forward the Team will continue to develop staff expertise in treating substance abuse disorders by providing ongoing training in Motivational Interviewing.

MULTI-CULTURAL OUTREACH AND ENGAGEMENT

Diversity & Multicultural Services

The Diversity & Multicultural Coordinator (DMC) provides leadership in identifying, developing, implementing, monitoring, and evaluating services and strategies that lead to continuous cultural, ethnic, and linguistic improvements within the organization's system of care, with a special emphasis on unserved, underserved, inappropriately served, and emerging populations. The DMC also collaborates with the state, regional counties, other city divisions, local agencies, and community groups in order to address mental health inequities and disparities for targeted populations and communities, and the community-at-large in the cities of Berkeley and Albany.

The Diversity & Multicultural Coordinator accomplishes these goals by:

- Providing cultural competency training to all behavioral health, community partners, and all stakeholders in the cities of Berkeley, Albany and other geographic locations in the region as a collaborative partner
- Performing outreach and engagement to unserved, underserved, inappropriately served and emerging communities and populations

- Developing long and short term goals and objectives to promote cultural/ethnic and linguistic competency within our system of care
- Developing an annual training plan and budget
- Chairing the agency's Diversity and Multicultural Committee
- Attending continuous trainings in the areas of cultural competency
- Monitoring Interpreter and Translation Services for the agency
- Collaborating with State, Regional, County, and local groups and organizations and
- Developing and updating BMH's Cultural Competency Plan as needed.

Participants involved in Berkeley Mental Health's trainings, committees, groups, cultural/ethnic community events and activities are city staff, service providers, consumers/clients, family members, and residents from diverse groups and populations. There is a focus on improving services for unserved, underserved, inappropriately served, and emerging populations and communities throughout the cities of Berkeley and Albany, and other areas within the region.

From August through December in FY18 the Diversity & Multicultural Coordinator position was unoccupied. Program services, events and activities conducted in FY18, are summarized below:

Diversity & Multicultural Trainings:
BMH's Annual Black History Month Conference 2018 – *Healing Our Families and Strengthening Our Roots in the Community* – February 20, 2018 – (Approximately 110 individuals attended this event.) – Attendees included staff, residents, consumers, family members, students, and service providers.

Alameda County Behavioral Health Care Services (BHCS) Annual Black History Month Conference – *Finding Black Psychology-Toward a New Mental Health Paradigm* – February 28, 2018 – (Approximately 250 individuals attended this event) - Attendees included staff, consumers, family members, community partners, students, and residents. This training was a collaboration with BHCS and the African American Steering Committee for Health and Wellness.

Women's Conference – *The Power of Feminine Energy: Supporting Women and Girls from All Walks of Life* – March 29, 2018 – (Approximately 60 individuals attended this event.) – Attendees included staff, residents, consumers, family members, and service providers.

Latino Conference – *Cultural Values, Unity & Respect: Creating Safe Spaces* – May 23, 2018 – (Approximately 125 individuals attended this event) - Attendees included staff, consumers, family members, community partners, students, and residents. This training was a collaboration with the Public Health Division, Berkeley Unified School District (BUSD), and community partners.

LGBTQ PRIDE Conference –Clutching Our Pearls: LGBTQQI2-S Youth Shaping the Future – June 7, 2018 – (Approximately 90 individuals attended this training) - Attendees included staff, consumers, family members, service providers, students, and residents. This training was a collaboration with BHCS and community partners.

Cultural/Ethnic and Community Events:
BMH Annual Black History Month event – February 7, 2018 (Approximately 60 individuals attended this event) - Attendees included staff, consumers, family members, community partners, and residents.

Lunar New Year Event – February 23, 2018 (Approximately 25 individuals attended this event) - Attendees included staff, consumers, family members, youth, community partners, and residents.

BAHIA, Inc., Health Fair – April 28, 2018 – (Approximately 150 individuals attended this event.) Attendees included residents, consumers, family members, youth, and service providers.

May Is Mental Health Month Event – May 16, 2018 – (Approximately 80 individuals attended this event) - Attendees included staff, consumers, family members, students, community partners, and residents.

Gay Prom – Sponsorship for Horizon Services, Eden Project – June 2, 2018 – (Approximately 300 individuals attended this event) - Attendees included students, staff, consumers, family members, community partners, and residents.

City of Berkeley Juneteenth Festival – June 17, 2018 – (Approximately 1000 plus individuals attended this event) - Attendees included a diverse group of residents and stakeholders from throughout the region.

Committees/Groups:
- BMH Diversity & Multicultural Committee, Chair
- BMH Staff Training Committee, Chair
- Alameda County BHCS PRIDE Committee Member
- Alameda County BHCS Cultural Responsiveness Committee Member
- Statewide Spirituality Liaison, Spirituality Initiative Committee Member
- Berkeley High School (BHS) Community Resource Committee
- State and County Ethnic Services Managers/Cultural Competency Coordinators, Committee Member
- Alameda County BHCS African American Steering Committee for Health and Wellness, Committee Member
- BMH Health Equity Committee – Co-Chair
- African American Holistic Resource Center, Community Leadership Committee, Co-Chair
- City of Albany – Diversity and Inclusion Ad Hoc Committee

Outreach and Engagement:
- Berkeley Drop-In – Homeless Population
- McGee Baptist Church – African Americans
- ROOTS – Re-entry population
- Village Connect, Inc., African American & Latino populations
- Eden Project – LGBTQI2-S – TAY
- Pacific Center – LGBTQI2-S
- BAHIA, Inc. – Latino population

- Healthy Black Families – African American Women & Children
- City of Albany – Seniors, youth, staff and residents
- Berkeley Unified School District – Staff, Students, and Families
- Albany Unified School District – Staff, Students, and Families

Transition Age Youth (TAY) Support Services

Implemented through Covenant House, the Transition Age Youth (TAY) Support Services program provides outreach, services, supports, and/or referrals to TAY with serious mental health issues who are homeless or marginally housed and not currently receiving services. Priority is given to youth coming out of foster care and/or the juvenile justice system and particular outreach strategies are utilized to engage youth from various ethnic communities, including Asian and Latino populations, among others. Program services include: culturally appropriate outreach and engagement; peer counseling and support; assessment; individual and group therapy; family education; case management, coaching, ancillary program referrals and linkages. Also provided are services in housing attainment and retention, financial management, employment, schooling, and community involvement. Services are designed to be culturally relevant, tailored to each individual's needs, and delivered in multiple, flexible environments. The main goals of the program are to increase outreach, treatment services, and supports for mentally ill TAY in need, and to promote self-sufficiency, resiliency and wellness. This program serves 15-20 youth at a time.

In FY18, a total of 174 TAY between the ages of 18-24 were served. Demographics on TAY served were as follows:

CLIENT DEMOGRAPHICS N=174		
Client Gender	*Number Served*	*% of Total*
Unknown	174	100%
Race/Ethnicity		
Client Race/Ethnicity	*Number Served*	*% of Total*
African American	85	49%
Asian Pacific Islander	4	2%
Caucasian	24	14%
Latino	19	11%
Native Hawaiian or Alaska Native	2	1%
Bi-racial/Multi-racial	10	6%
Other	23	13%
Unknown	7	4%

During FY18, in addition to mental health services and supports a large portion of youth participants were provided with Substance Use Disorder services and housing assistance. Additionally, support groups on various mental health topics were a popular addition to the project services.

SYSTEM DEVELOPMENT

System Development includes Wellness Recovery Support Services that are intended to expand collaboration with stakeholders, promote the values of wellness, recovery and resilience, and move the Division towards a more consumer and family member driven system. Services are comprised of the following main components: Wellness/Recovery System Integration; Family Advocacy Services; Employment/Educational services. Some of the additional services to support clients include Housing Services and Supports, Benefits Advocacy, and Transitional Outreach services among others. Together, each ensures that consumers and family members are informed of, and able to be involved in, opportunities to provide input and direction in the service delivery system and/or to participate in recovery-oriented or other supportive services of their choosing. Strategies designed to reach program goals include: developing policies that facilitate the Division in becoming more Wellness & Recovery oriented and consumer/family member driven; outreach to, and inclusion of, consumers and family members on Division committees; provision of family support & education; supported employment and vocational services; wellness activities; peer supportive services; client advocacy; housing supportive services; and benefits advocacy.

Wellness Recovery System Integration

The BMH Wellness Recovery Team works with staff, stakeholders, community members and clients to advance the goals of Wellness and Recovery on a system wide level. In order to accomplish these goals, some of the various tasks include: recruiting consumers for Division committees; convening committees around Wellness Recovery system initiatives; oversight/administration of peer stipends; convening and conducting meetings for a “Pool of Consumer Champions (POCC)”; working with staff to develop various Wellness and Recovery related policy and procedures; and oversight of the Division’s “Wellness Recovery Activities”. The Consumer Liaison is also a resource person around “Mental Health Advance Directives” for consumers desiring to express their treatment preferences in advance of a crisis; and is a participant on a number of local MHSA initiatives. In FY18, these individual and system-level initiatives impacted approximately 406 clients.

In FY18 some of the various activities of the Wellness Recovery Team that were conducted under the direction of the Consumer Liaison included:

Berkeley Pool of Consumer Champions (POCC)

During FY18, 11 meetings were held which included: Giving suggestions for the update to the Berkeley Resource Guide; sponsoring a South Berkeley Art Walk; presenting about their work at the Alameda County POCC Steering Committee; learning a Solstice Song in English and Spanish and singing it at the Alameda County POCC Holiday party; and writing a letter of support for an Expressive Arts therapy project through Tamalpa Institute. The last project became peer led Expressive Arts field trips. The POCC also received an MHSA update on the Innovations Technology Suite Project, updated the POCC Action Plan, had a presentation on Roberts’ Rules and gave input into the new Wellness Center. An average of 4-5 individuals attended each meeting for a total of 15 unduplicated individuals attending over the course of the year.

Wellness Recovery Activities

Designed with, and building on the talents of consumers, the BMH Wellness Recovery activities included workshops, trainings and ongoing health groups. Light refreshments were served at each activity. In FY18, a total of 26 unduplicated consumers attended this program. Peer led activities included:

- Facilitated Discussions - Topics included: Ways to Reduce Stress; Healing Properties of Ginger Tea; Our Values; Watching and Discussing the Video MindGame; Plans for Summer; What to do When You Are Down; Progress On Your Goals; Things to do to Stay Well.
- Creative Writing - Topics included: Writing a story about a picture; Highs and Lows of Recovery; Description of yourself- Your Wishes and Dreams; Gratitude list; Three Truths and a Lie; What Helps and What Doesn't; Goal Setting; Your Recovery Journey; Recovery Essay; Letters to our Younger Selves; Things You Like About Yourself; What to do When Someone is Rude; The Ups and Downs of the Past Week; Your Most Memorable Walk.
- Creating – Mandalas; Greeting Cards; "Wreck This Paper Art"; Butterflies for "Day of the Dead' Altar; Using Dots to Create Art; Choices You Regret and What to do About it; Valentine Cards; Cards to our Future Selves.
- Exercise – Yoga; Stretching; Chi Gung; Walking.
- Games - Wellness Tools Hangman; Moods; Creating a Dinner for Under $30 from Ads; Recovery Hangman; Stress Reduction Hangman; Life Stories; Jenga!
- Drawing – Including: Drawing a Gate, a Church, the London Bridge, a summer day; Coloring mandalas; Outlining objects to Create a Composition; Using Lines; Shared Drawing; Creating Art with Stray Lines; Scribble Drawing.
- Other – Drumming; Meditation; Choosing Your Goals; Calligraphy Writing; Guided Visualization; Plant Identification; Collage; Creating an Altar for the Day of the Dead Exhibit at the Oakland Museum.

Field Trips

In FY18 a total of 17 field trips were offered with 70 persons participating. Peer led field trips in nature incorporating expressive arts entitled "Journeys in Nature" included trips to: Tilden Botanical Garden, Berkeley Marina, Tilden Park, Berkeley Rose Garden, Live Oak Park, Indian Rock and John Hinckle Park, Jewel Lake, Aquatic Park and the Vivarium and Lake Anza. Additional trips included the: San Francisco Museum Of Modern Art; South Berkeley Art Walk, Berkeley Art Museum; a trip to 4th Street in Berkeley to see the Holiday lights and the local Open Art studios; Lake Merritt Bird Sanctuary, Berkeley Animal Shelter, and a Tour of Berkeley Main Library.

Card Party Groups

In FY18 a total of 32 Card Party groups were offered to inspire consumers to create inspirational cards for individuals in psychiatric hospitals. This program is modeled after the Do-Send-A-Card program created by the San Francisco Mental Health Association. BMH Wellness Recovery staff partnered with the Alameda Network of Mental Health Clients' Reach Out Program to distribute the cards that were created from the Card Party groups when they visit the hospitals throughout the County. Patients can choose the card they want to receive. Through this program over 120 cards, were sent to the Reach Out Program.

Mood Groups
Through the BestNow! interns a weekly support group focusing on moods was added. With the aid of interns 15 sessions were offered with a total of 41 visits.

Phone Support
Through the BestNow! interns, phone support to consumers was added. BMH Wellness Recovery staff helped develop the purpose of the calls and provided training on phone counseling to the interns. A total of 16 individuals were referred or expressed interest in receiving a weekly phone call from an intern. Of those, 12 people received a total of 66 supervised phone sessions. When the internship was nearing its end, cards were sent to everyone expressing well wishes.

Mental Health Advance Directives
This consultation is offered monthly on a drop-in basis. As a result of these meetings, recommendations were made to the existing Mental Health Advance Directive policy and procedure.

The Wellness Recovery Team also conducted or participated in the following activities during the reporting timeframe: Developed a monthly color calendar of activities that was sent to approximately 150 individuals via mail and another 130 individuals via email; created an introductory letter about the Wellness Recovery Team to be given to consumers; worked on the development of a Mission Statement for the Wellness Recovery Team: participated in the planning and implementation of the Spring 2018 CASRA conference and the May is Mental Health Month event in Berkeley; co-facilitated 4 Adult Mental Health First Aid trainings and 3 Youth Mental Health First Aid trainings; participated in the Creative Wellness Center Task Force which is planning to develop a Creative Wellness Center; conducted Consumer Perception surveying in November and May during the State survey period, including recruiting, training and supervising surveyors as well as submitting completed surveys to the state; began working with ACBHCS Staff on the 50 year History of the Consumer Movement in Alameda County; administered the Consumer and Family Member Stipend Program and continued work on updating the Stipend Policy; Supervised and trained 2 BestNow! Interns and through them added the weekly Mood Group and individual Phone Support; brought consumers to the POCC BBQ; provided in-service training to interns on Psychopharmacology and Harm Reduction; provided training on Shared Decision Making to 50 staff of Conard House; and attended the following conferences - 2017 Alternatives Conference, 2018 CASRA Conference, and the POCC Annual Conference.

Hearing Voices Support Group
The Hearing Voices Support Group is offered through a contract with the Bay Area Hearing Voices Network. The weekly free drop-in Support Group is for adults who experience voices, visions, special messages, unusual beliefs or extreme states of consciousness. Support groups are co-facilitated by trained group leaders both with lived experience in the mental health system.

In FY18, weekly groups were offered with an average attendance of 10-12 individuals. Several family members have reported that they are pleased that their loved one is engaged and doing well as a result of this group.

Family Support Services

The Family Service Specialist works with Family Members, staff, community-based organizations etc. to improve services and supports for BMH clients and their family members on a system-wide level. Services provide both individual family services and supports, and system–wide change initiatives. This family/caregiver-centered program serving Berkeley and Albany provides information, education, advocacy and support for family/caregivers of children, adolescents, TAY, adults and older adults with serious emotional disturbance or severe mental illness. Services are provided in a culturally responsive manner providing outreach to people of various ethnicities and language groups.

The Family Services Specialist serves as a point of contact for family members who are currently accessing or attempting to access services and/or who have questions and concerns about the mental health system, providing them with supports, and as needed, referrals to additional community resources. Outreach is provided to families through existing BMH family support groups, NAMI of the East Bay, community clinics and the Alameda County Family Education Resource Center (FERC). Additionally, the Family Services Specialist coordinates forums for family members to share their experiences with the system; recruits family members to serve on BMH committees; supports family members through a "Warm line"; conducts a Family Support Group; and creates training opportunities to educate mental health staff on how to effectively work with families. The combination of individual services and system-level initiatives impact approximately 406 clients and their family members a year.

The Family Services Specialist position was vacant until February 2018. Once hired, under the direction of the Family Services Specialist, the following individual or group services and supports were conducted through this program:

Warm Line Phone Support: A Warm Phone Line provided a sympathetic resource for family members needing information, referrals, supports, and assistance in navigating the complex mental health system. Through the Warm Line, the Family Services Specialist helped families find services and resources as needed.

Family Support Group: An English speaking Family Support group was offered to parents, children, siblings, spouses, significant others or caregivers. The group met twice a month for two hours.

Individual Support: The Family Services Specialist met with families as needed, to provide personal support to help them prioritize their needs, connect them with appropriate resources and supports, assist them in navigating the Mental Health system and to provide coping skills for dealing with the high level of stress that can ensue from the impact of mental illness in the family.

In FY18 a total of 26 family members were served. The total number served reflects the fact that the position was vacant and wasn't filled until late February 2018. Demographics on individuals served are outlined below:

CLIENT DEMOGRAPHICS N=26		
Client Gender	*Number Served*	*Percent of Total Number Served*
Male	22	85%
Female	4	15%
Race/Ethnicity		
Client Race/Ethnicity	*Number Served*	*Percent of Total Number Served*
African American	3	11.5%
Asian Pacific Islander	3	11.5%
Caucasian	13	50%
Hispanic/Latino	1	4%
Declined to Answer/Unknown	6	23%
Age Category		
Client Age in Years	*Number Served*	*Percent of Total Number Served*
26-55 years	4	15%
56+ years	9	35%
Declined to Answer/Unknown	13	50%

Employment Services

Previously, a BMH Employment Specialist provided services to support consumers in job readiness and accessing employment opportunities. It was envisioned that these services would at a minimum, create and nurture supported vocational, educational and volunteer "try-out" opportunities in the community; build employment and educational readiness; and increase the numbers of consumers who are gainfully employed and/or engaging in other meaningful activities such as school or volunteer work. Different strategies were implemented along the way including utilizing the Dartmouth model of supported employment. The Dartmouth model helps to promote wellness and recovery by enabling clients to work alongside other non-mentally ill workers in a competitive environment in their community. In this model, employment supports were provided to clients from multiple sources including the following: Employment Specialist; Case Manager; Psychiatrist; and any involved Family Members. The Employment Specialist also: provided supports to clients who were interested in starting their own business by guiding them through the necessary steps of getting a license, advertising, etc.; assisted clients who weren't quite ready to obtain employment, in becoming involved in volunteer opportunities; connected clients with the Department of Rehabilitation for computer skills training; worked with staff to ensure clients were adhering to their medication regimen; and supported clients in filling out job applications and or practicing their interview skills.

Although various strategies were implemented over the years, client participation and employment outcomes remained low through FY12, followed in FY13, with an unexpected vacancy in the Employment Specialist position. Low client outcomes coupled with a vacancy in the position prompted BMH to evaluate current best practices for mental health client employment. Additionally, input received during various MHSA Community Program Planning processes, provided recommendations on strategies to better support clients in reaching their employment goals, such as: assisting clients on interviews and on what to share with an employer regarding reasonable accommodations; providing mentoring and job shadowing; implementing technology training for clients; having services be integrated and supported, and implementing evidence based practices.

A new Employment Specialist position was proposed through the previously approved Three Year Plan. It was envisioned that once hired, the Employment Specialist would be focused on utilizing an evidenced based model for supporting individuals with serious mental illness in obtaining and retaining competitive employment. The hiring process for this position has not occurred yet, as the City of Berkeley has been evaluating whether the best use of funds would be to hire the full-time position, or to contract the services out to a local organization that focuses on employment services and supports for mental health consumers. As a decision on the best approach had not been finalized yet, in the previously approved MHSA FY19 Annual Update, the Division requested to have flexibility on how to best utilize funds allocated for the Employment Services Specialist position.

Housing Services and Supports

Previously a Housing Specialist worked with clients and staff throughout the Division to provide Housing Resources, with the aim of increasing housing opportunities for clients and increasing housing retention. In FY13 the Housing Specialist Position became vacant. Up until early FY18, although clients continued to receive housing support from case managers and/or through Shelter Plus Care personnel, there was not a dedicated staff member in place to focus solely on this aspect of the work. The vacancy in the Housing Specialist position allowed BMH to re-assess where staff expertise would be most beneficial in supporting mental health clients with their housing needs. Additionally, input received during the FY14 and previous MHSA Community Program Planning processes included concerns around the lack of affordable housing in Berkeley and echoed the need for additional supports to assist clients in maintaining their housing.

In FY17, BMH began interviewing for the Housing Specialist position and the position was filled in early FY18. The current Housing Specialist has been involved in: providing housing resource services for clients; working with landlords to increase housing opportunities; collaborating with case management staff, landlords, and Board & Care Managers to provide additional supports for clients who are already housed; and working in tandem with the City of Berkeley HHCS Department Hub (which serves as a single entry point into emergency shelter and transitional housing, where clients are triaged based on their housing and service needs).

Benefits Advocacy Services

Through this project a community-based organization, the Homeless Action Center (HAC), assists clients in obtaining public benefits. Services are provided for approximately 10 BMH clients a year. In FY18, 19 clients were served through this agency. Demographics on those served were as follows:

CLIENT DEMOGRAPHICS N=19		
Client Gender	*Number Served*	*Percent of Total Number Served*
Male	11	58%
Female	8	42%

Race/Ethnicity		
Client Race/Ethnicity	*Number Served*	*Percent of Total Number Served*
African American	9	47%
Caucasian	7	37%
Mixed	1	5%
Other	2	11%
Age Category		
Client Age in Years	*Number Served*	*Percent of Total Number Served*
18-24 years	3	16%
25-44 years	6	32%
45-54 years	5	26%
55-61 years	4	21%
62 & over	1	5%

Flexible Funds for Level One Clients

A contract with the community-based organization, Berkeley Food & Housing Project, enables flexible funds to be used with clients across the system for supports such as housing, clothing assistance, food, transportation, etc. This use of flexible funds aids individuals in achieving better stability in areas where they are less capable of addressing their daily living needs.

Mobile Crisis Team (MCT) Expansion

Through the previously approved MHSA FY14/15 - 16/17 Three Year Program and Expenditure Plan, and as a result of staff and community input on increasing and improving services for those experiencing a mental health crisis, the following additions to BMH have been or are in the process of being implemented through CSS System Development funds:

- New staff were added to expand Mobile Crisis Team (MCT) capacity, allowing two teams to respond separately to crises between 11:30am and 5:00pm. Based on a safety review of the program, staff work as a pair after 5:00pm.
- BMH Staff has continued to conduct multiple Mental Health First Aid Trainings to teach community members how to assist individuals who are in crisis or are showing signs and symptoms of a mental illness.
- A Consumer/Family Member Satisfaction Survey for Crisis services was developed and implemented by BMH Staff.

Transitional Outreach Team (TOT)

This program was added thru the previously approved FY16 MHSA Annual Update to support Crisis Services, through interventions that address issues individuals experience either immediately prior to, or following a mental health crisis. This team, follows up with individuals and families that have had a recent crisis. The goal of the team is brief outreach engagement that will help that individual and/or family get connected to the resources they need so that they are able to move towards recovery.

In FY18, 224 individuals were served through this project. Demographics on those served were as follows:

CLIENT DEMOGRAPHICS N=224		
Client Gender	*Number Served*	*Percent of Total Number Served*
Male	114	51%
Female	110	49%
Race/Ethnicity		
Client Race/Ethnicity	*Number Served*	*Percent of Total Number Served*
African American	52	23%
Caucasian	97	43%
Latino/Hispanic	11	5%
Asian	9	4%
Mixed	1	1%
Other	54	24%
Age Category		
Client Age in Years	*Number Served*	*Percent of Total Number Served*
0-15	15	6%
16-25	42	19%
26-59	101	45%
60+	29	13%
Unknown	37	17%

Outcomes of the program during the reporting timeframe included:

- Successfully conducted follow up to those who have had contact with Mobile Crisis by phone and/or in person.
- Connected many individuals and families to needed mental health care, housing, literacy services, family services, emergency medications.
- Offered intensive short term support to individuals and families who experienced a mental health crisis, including referrals, linkage, psychoeducation, and active support in connecting with needed service in Berkeley or elsewhere in the Alameda County system of care.
- Provided in person outreach and engagement to individuals in inpatient settings who needed assistance connecting to treatment and were unlikely to make it to the clinic for an intake. Settings included John George Psychiatric Facility, Villa Fairmont, Herrick Hospital, Woodrow House, and other sites. TOT staff worked with facility staff in addition to mental health consumers.
- Provided in person outreach and engagement to individuals receiving homeless services and staff at homeless service provider agencies, including MASC, BOSS, BFHP, and others. Also conducted in person outreach at homeless encampments throughout the City.
- Coordinated with other programs within the City's Mental Health Division, including the Crisis/Assessment/Triage (CAT) On Duty staff, field based services such as Mobile Crisis (MCT) and the Homeless Outreach and Treatment Team (HOTT), and with the case management teams at the Adult and Children's clinics.
- Hired a second staff member for the program, increasing capacity in all of the above areas.

Successes:

- Provided numerous individuals and families with follow up services. This capacity did not exist before this program was implemented, and is much needed.
- Positive feedback from service recipients.
- Provided culturally responsive services to Spanish speaking individuals and families to help them navigate the mental health system.

- Connected reluctant, difficult to engage individuals with care at Berkeley Mental Health through persistent outreach and engagement at inpatient facilities and in the community.

Challenges:
- Facility and system issues affecting the BMH Adult Services Program as a whole continue to affect consistency.
- Difficulty in hiring the second staff has delayed the full implementation of the program. (Second staff came on board 9/20/18.)

Sub-Representative Payee Program

In the previously approved MHSA FY2014/15 – 2016/17 Three Year Program and Expenditure Plan the Division proposed to use a portion of CSS System Development funds to outsource Sub-Representative Payee services, as the practice for many years at the BMH Adult Clinic was for clinicians to act as representative payees, managing client's money. While on some levels this practice improved clients' attendance at regular appointments, it also presented an array of other challenges around the dual role of clinician/money manager.

In FY19, Sub-Representative Payee services was contracted out to Building Opportunities for Self Sufficiency (BOSS) who were chosen through a competitive Request For Proposal (RFP) process.

Wellness Recovery Center

Per previously approved MHSA Plans the City of Berkeley has allotted $450,000 of CSS System Development funds annually to pool with Alameda County BHCS monies to fund a local Wellness Recovery Center. In FY16, a Memorandum of Agreement (MOU) with Alameda County BHCS was finalized.

Alameda County BHCS executed an RFP process and Bonita House was the chosen community-based organization who will be implementing the Wellness Center. Bonita House identified a site on University Avenue where the Wellness Center will ultimately be located and construction has begun.

BMH Peer and Family Member Positions

Since the first MHSA Plan, BMH has included positions for peers and family members with lived experience to be added to various programs throughout the Division. The BMH Division utilizes existing City job classifications to create an employment track for peer or family member providers. The entry level position is Community Health Worker, the mid-level is Assistant Mental Health Clinician, and the top-level is Social Services Specialist. All of these classifications are used broadly for differing purposes throughout the City. For the specific positions where the MHSA Plan envisioned utilizing peer or family providers, BMH has had success in establishing employment lists where there are applicants who describe themselves as peer providers or family member providers. In early August 2018, a Peer Specialist was hired to support the Wellness Recovery services work. It is anticipated that BMH will continue to increase the number of peer and family member providers in the future.

Homeless Outreach and Treatment Team (HOTT)

The Homeless Outreach and Treatment Team (HOTT) program was established out of an effort to address the current homeless crisis, and as a result of input received through various MHSA community program planning processes. Utilizing a portion of PEI and CSS funds, blended with realignment and general funds HOTT is a three year pilot program to move homeless mentally ill individuals in Berkeley/Albany into permanent housing and to connect them into the web of services and supports that currently exist within the system of care. Key program components include the following: Persistent and Consistent Outreach; Supportive Case Management; Linkage to Care; and Treatment.

A local consultant, Resource Development Associates, was hired to conduct a dedicated independent evaluation to assess the program accomplishments and to ascertain whether HOTT should continue past the initial funding period. The initial report on FY18 showed many positive findings including the following:

- HOTT is serving as an important resource for the local community and homeless service continuum
- The program has been very effective in persistent and consistent outreach, especially for chronically homeless individuals with a history of refusing services
- HOTT meets people where they are, in parks, encampments, motels
- The program has successfully connected homeless individuals to critical resources and service linkages

The full Evaluation Report can be accessed on the MHSA Website:

https://www.cityofberkeley.info/uploadedFiles/Health_Human_Services/Level_3_-_Mental_Health/Berkeley-HOTT_Evaluation-Report.final.pdf

In FY18 through the first quarter of FY19, 289 individuals were served through this program. As this program is funded in both the CSS and PEI MHSA components, demographics on individuals served through this program are outlined in the PEI section of this FY20 Annual Update.

Case Management for Youth and Transition Age Youth

In response to a continued high need for additional services and supports for youth and TAY who are suffering from mental health issues and may be homeless or marginally housed, BMH allocated $100,000 of CSS System Development funds in FY19 to increase case management services for this population. Use of funding for these services was previously approved in the FY16 MHSA Annual Update. Services are currently provided by Youth Spirit Artworks who were chosen through a competitive RFP process.

AlbanyCares (formerly Albany Community Resource Center)

In the previously approved Three Year Plan the City of Berkeley allocated $32,000 of MHSA CSS System Development funds to support the City of Albany Community Resource Center. The Albany Community Resource Center was initially a short-term pilot project that offered residents a one-stop venue to learn about and receive referrals and resources to assist with a range of social and economic needs. The Community Resource Center was staffed by a half-time Community Resource Center Director.

In early 2018, due to a loss of staffing the Albany Community Resource Center closed prematurely. During the time the Resource Center was in operation, 54 individuals (30 females, and 24 males) between the ages of 8-87 years old were served. The demographics of individuals served were as follows: 9% African American; 7% Asian; 7% Latino; 33% Caucasian; 2% Mixed; 42% Unknown. The top concerns of those served included housing or homelessness, mental health issues, and medical and/or dental needs. The provision of referrals and assistance for Albany residents were able to continue on an interim basis at the Albany Senior Center by Resource Center volunteers.

In March 2018, the Albany City Council authorized the development of a "Human Services Resource Linkage Program" or "AlbanyCares" which would continue the work of the Albany Community Resource Center and would include a full-time Human Services Resource Coordinator. To continue to provide support to this program BMH increased the MHSA annual funding allocation to $50,000, through the approved FY19 Annual Update.

Additional Services for Asian Pacific Islanders

The Asian Pacific Islander population is significantly underserved in the mental health system. In an effort to better meet the needs of this underserved population, BMH proposed through the previously approved MHSA FY19 Annual Update to utilize $100,000 of unallocated CSS System Development funds to contract with a local community-based organization or to partner with ACBHCS to increase funding for a contractor selected for similar purposes. The contractor will provide access to additional services and supports for this population, and if BMH directly contracts with an organization the contractor will be chosen through a competitive Request for Proposal (RFP) process.

Evaluation Consultant

Feedback received over the past couple of years regarding program outcomes has largely focused on implementing evaluative measures that help BMH, MHSA Stakeholders and community members more fully understand and determine how well programs are meeting participant and community needs. Integral to this type of outcome measure is to engage the voice of the program participant around the services they received. Despite best intentions of staff there is simply not the time or expertise to effectively accomplish this and the specialized skills of a consultant will ensure the most successful outcome.

In response to this input, BMH proposed through the previously approved MHSA FY19 Annual Update to allocate $100,000 of CSS System Development funds for a Consultant who will conduct an evaluation on all BMH programs across the system utilizing the "Results Based Accountability" (RBA) framework. The RBA framework will measure how much was done, how well it was done, and whether individuals are better off as a result of the services they received. The Consultant will be chosen through a competitive RFP process. In FY20, the consultant will be hired and the RBA evaluation framework will be implemented across the system.

PREVENTION & EARLY INTERVENTION (PEI)

The original City of Berkeley Prevention & Early Intervention (PEI) Plan was approved by DMH in April 2009. Subsequent Plan Updates were approved in October 2010, April 2011, May 2013, May 2014, May 2015, June 2016, January 2017, July 2017 and October 2018. From the original approved PEI Plan and/or through Plan Updates, the City of Berkeley has provided the following services through this funding component:

- An early identification, assessment, treatment and referral program for children (0-5 years old) and their families;
- Prevention and short-term intervention services in the Berkeley school system;
- Trauma support services for youth, adults and older adults in unserved, underserved and inappropriately served populations;
- An anti-stigma support program for mental health consumers and family members;
- Intervention services for at-risk children; and
- Increased homeless outreach services for TAY, adults, and older adults.

PEI Reporting Requirements

Per MHSA PEI regulations, all PEI funded programs have to collect additional state identified outcome measures (specific to the category of services provided) as well as detailed demographic information. The first report that included data specific to the new PEI requirements, "City of Berkeley Mental Health Services Act (MHSA) Fiscal Year 2017 Prevention & Early Intervention Evaluation Report" is located on the City of Berkeley Mental Health Division MHSA website. Beginning in FY19, PEI Evaluations are required to be included in each MHSA Annual Update or Three Year Plan. See Appendix A for the Fiscal Years 2015/2016 – 2017/2018 Three Year Prevention & Early Intervention Evaluation.

Impact Berkeley

In FY18, the City of Berkeley introduced a new initiative in the HHCS Department called "Impact Berkeley". Central to this effort is using a highly regarded framework called Results Based Accountability (RBA) to account for the work of the Department. RBA provides a new way of understanding the quality and impact of services provided by collecting data that answer three basic questions:

- How much did you do?
- How well did you do it?
- Is anyone better off?

RBA has been incorporated into selected programs within the Department. In FY18, this included community agency programs funded through the MHSA Prevention & Early Intervention Community Education & Supports program. Through this initiative the Department worked with each contractor to envision, clarify and develop measures on the outcomes and results each program is seeking to

achieve, and used a rigorous framework to begin measuring and enhancing progress towards these results. Page 42 of this FY20 Annual Update provides an aggregated summary of some of the results of this initiative. The full report on the Impact Berkeley PEI program results can be accessed on the MHSA Website: MHSA Plans and Updates - City of Berkeley, CA

Descriptions of PEI funded programs, and FY18 program data are outlined below:

Behavioral-Emotional Assessment, Screening, Treatment, and Referral (BE A STAR)

The Be A Star program is a collaboration with the City of Berkeley's Public Health Department providing a coordinated system in Berkeley and Albany that identifies children birth to age five and their parents, who are at risk of childhood development challenges including developmental, social, emotional, and/or behavioral concerns. The program specifically targets low income families, including those with teen parents, who are homeless, substance abusing, or in danger of foster care. Services include triage, assessment, treatment and referrals to appropriate community-based or specialist services as needed. Children and families are accessed through targeted efforts at the following: Black Infant Health; Vera Casey Teenage Parenting programs; Child Health and Disability Prevention programs, Pediatric providers, and through state-subsidized Early Childhood Development Centers. The goals of the program are to identify, screen and assess families early, and connect them with services and supports as needed. The program uses the "Ages and Stages Questionnaires" (ASQ) screening tool to assess children in need. The ASQ consists of a series of 20 questionnaires that correspond to age intervals from birth to 6 years designed to help parents check their child's development. Each questionnaire contains simple questions for parents to answer that reflect developmental milestones for each age group. Answers are scored and help to determine whether the child's development is on schedule or whether the child should be referred for a developmental checkup with a professional. Over 400 children are assessed each year.

PEI Goals: The goal of this program is to bring about mental health, including the reduction of school failure and the removal of children from their homes.

In FY18, 345 children were reached through this program at Berkeley Unified School District (BUSD. A total of 49 of the children reached were already receiving services through an Independent Education Plan (IEP). A total of 280 ASQ's were returned and scored. Through these screenings, 36 children scored in the "Of Concern" range. Outlined below is a breakdown of the BUSD Preschool ASQ screening results of children in the "of concern" range:

BUSD Preschool	Number Screened	Screening Results "Of Concern"	% Scored of Concern
Franklin	171	15	9%
King	74	12	16%
Hopkins	72	7	10%

As a result of the BUSD ASQ screenings, 148 referrals were made to the following services: 28 to Mental Health services; 26 to BUSD Special Education; 38 Speech Services; 56 to BUSD "Response To Intervention (RTI)" services.

Demographics on children who received outreach and/or screenings at BUSD were as follows:

PARTICIPANT DEMOGRAPHICS N=345	
Age Groups	
0-15 (Children/Youth)	100%
Race	
Black or African American	23%
Asian	15%
White	4%
Other	30%
More than one race	12%
Declined to Answer (or Unknown)	16%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American/Chicano	24%
Ethnicity: Non-Hispanic or Non-Latino	
Declined to Answer (or Unknown)	6%
Primary Language Used	
Declined to Answer (or Unknown)	100%
Sexual Orientation	
Declined to answer (or Unknown)	100%
Disability	
Declined to answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Gender Assigned at Birth	
Declined to answer (or Unknown)	100%
Current Gender Identity	
Declined to answer (or Unknown)	100%

A total of 992 additional ASQ's were administered at Berkeley Pediatric Sites. Outcome demographic data is not available on Berkeley Pediatric site screenings.

Supportive Schools Program

Through this program leveraged MHSA PEI funds provide resources to support mental health prevention and intervention services in the Berkeley Elementary schools. Services include: outreach; mental health programming; classroom, group, and one-on-one psycho-social education and support; and consultation with parents and/or teachers.

In FY18, approximately 830 youth participated in individual or group therapy services. Demographic data on individuals served through this program included:

PARTICIPANT DEMOGRAPHICS N=830	
Age Group	
0-15 (Children/Youth)	100%
Race	
American Indian or Alaska Native	4%
Asian	5%
Black or African American	23%
Native Hawaiian/Pacific Islander	<1%
White	37%
Other	1%
More than one race	14%
Declined to Answer (or Unknown)	15%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American/Chicano	1%
Ethnicity: Non-Hispanic or Non-Latino	
More than one ethnicity	8%
Declined to answer (or Unknown)	92%
Primary Language Used	
English	7%
Declined to Answer (or Unknown)	93%
Sexual Orientation	
Declined to answer (or Unknown)	100%

Disability	
Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)	3%
Declined to answer (or Unknown)	97%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	47%
Female	38%
Declined to answer (or Unknown)	15%
Current Gender Identity	
Male	46%
Female	39%
Questioning or unsure of gender identity	Unknown
Declined to answer (or Unknown)	15%

Community Education & Supports

The Community Education & Supports program implements culturally-responsive psycho-educational trauma support services for individuals (18 and above) in various cultural, ethnic and age specific populations that are unserved, underserved and inappropriately served in Berkeley and Albany including: African Americans; Asian Pacific Islanders; Latinos; LGBTQI; TAY; and Senior Citizens. All services are conducted through area community-based organizations. In FY18 each of the Community Education & Supports contractors participated in the HHCS Results-Based Accountability (RBA) Evaluation. In this first year of RBA implementation results were presented in an aggregated format aggregated across all programs as follows.

How Much Did We Do?	How Well Did We Do It?	Is Anyone Better Off?
• 585 Support Groups/Workshops • 1,885 Support Group/Workshop Contacts • 129 Outreach Activities • 1,438 Outreach Contacts • 413 Referrals	• Participants attended 6 support groups or workshop sessions on average over year • More than 9 out of 10 survey respondents were satisfied with services • Referrals by type: 108 Mental Health 97 Social Services 82 Other 74 Physical Health 52 Housing	• 85% Survey respondents reported having increased feeling of social support and connection • 23% Improvement in truancy rate for participating Albany students • Survey respondents reported positive mental health changes

For additional details, definitions of terms, technical notes on how the performance measures were calculated, access information on how various data variables were quantified and for full reporting on other data elements, access the full report on the Impact Berkeley PEI program results on the MHSA website: MHSA Plans and Updates - City of Berkeley, CA

Descriptions for each project within this program are outlined below:

Albany Trauma Project

Implemented through Albany Unified School District this project provides trauma support services to Latinos, Asian Pacific Islanders and African American TAY, and Adults. Through various supports the project: provides helpful information and coping strategies around the effects of trauma; offers interventions to keep at-risk individuals and families from developing serious mental health symptoms and behaviors; provides a forum for clinicians to monitor trauma-exposed individuals and families who may need more intensive mental health services; and creates a venue to explore trauma and stress management through symbols of healing, artwork, and alternative coping strategies. Services include: Youth Support Groups and Adult one-on-one support. Additional one time cultural activities to promote healing through reflection groups and art projects are also conducted throughout the year. This project annually serves approximately 30-40 youth and 25-45 adults.

Descriptions of services provided and numbers served through this project are outlined below:

Youth Support Groups: The use of Support Groups or Group Therapy are considered to be a highly effective and preferred intervention for adolescents who tend to be more likely to accept feedback from their peers than from adults. Through this project, separate weekly therapeutic support groups are provided at Albany High School and MacGregor High School for Asian Pacific Islander, Latino, and African American youth. Groups meet for 1-2 hours a week throughout the school year and are focused on helping participants process various traumatic events through the development of trust, close connections to each other, and creating a safe space for the expression and understanding of feelings.

PEI Goals: The goal of this program is to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the reduction of school failure or drop out.

In FY18, a total of 39 students participated in three separate Support Groups with a total of 455 group sessions. An additional 77 individual sessions were held among group participants. Throughout the year there were 2 Child Protective Services (CPS) report made and four suicide assessments were conducted.

Thirty-two students completed a questionnaire that was administered on the 3rd week of group. Questionnaire Results are outlined below:

QUESTIONNAIRE RESULTS N = 32	
QUESTIONS	**PARTICIPANT RESPONSES**
Have you lost someone close to you?	Yes – 60% No – 40%
Have you witnessed violence in your family?	Yes – 71% No – 29%
Have you witnessed violence in your home?	Yes – 40% No – 60%
Have you been a victim of violence or abuse?	Yes – 32% No – 68%
If yes, have you spoken to anyone about this?	Yes – 60% No – 30% Didn't Answer – 10%
Do you feel that you've had the support in your life to cope effectively with the painful things you've experienced?	Almost Never – 6% Sometimes – 31% Often – 21% Usually – 18% Almost Always – 21% Didn't Answer – 3%
Do you use healthy ways to cope with stress in your life?	Almost Never – 6% Sometimes – 21% Often – 25% Usually – 31% Almost Always – 15% Didn't Answer – 2%
Do you use drugs or alcohol to help cope with your feelings, i.e. relax, calm down, quiet your mind, reduce anger, etc.?	Almost Never – 43% Sometimes – 25% Often – 6% Usually – 15% Almost Always – 9% Didn't Answer – 2%
Are there adults at your school who you can talk openly to about personal issues?	Yes – 69% No – 31%

Twenty-two students completed a questionnaire that was administered on the second to the last Support Group meeting. Results are outlined below:

QUESTIONNAIRE RESULTS N = 22	
QUESTIONS or STATEMENTS	**PARTICIPANT RESPONSES**
I felt welcomed into group.	Almost Never – 0% Sometimes – 0% Often – 4% Usually – 19% Almost Always – 75% Didn't Answer – 2%
I felt the group was a place I could express my feelings.	Almost Never – 0% Sometimes – 9% Often – 4% Usually – 22%

	Almost Always – 63% Didn't Answer – 2%
I felt supported by other group members.	Almost Never – 0% Sometimes – 0% Often – 9% Usually – 18% Almost Always – 72% Didn't Answer – 1%
Have you spoken to someone about the painful things you've experienced?	Almost Never - 4% Sometimes – 14% Often – 14% Usually – 47% Almost Always – 19% Didn't Answer – 2%
Do you feel that you have support in your life to deal with painful things you've experienced?	Almost Never – 0% Sometimes – 18% Often – 18% Usually – 27% Almost Always – 36% Didn't Answer – 1%
Do you use healthy ways to cope with the stress in your life?	Almost Never – 0% Sometimes – 21% Often – 31% Usually – 28% Almost Always – 18% Didn't Answer – 2%
Do you use drugs or alcohol to help cope with your feelings, i.e. relax, calm down, quiet your mind, reduce anger, etc.?	Almost Never – 59% Sometimes – 13% Often – 4% Usually –18% Almost Always – 4% Didn't Answer – 2%
Are there adults at your school who you can talk openly to about personal issues?	Yes – 68% No – 22% Sometimes – 9% Didn't Answer – 1%
Would you recommend this group to a friend?	Yes – 90% No – 0% Maybe – 10%

According to the pre-group questionnaire a vast majority of Group members had experienced significant trauma. Other traumas students had experienced which were discussed during Support Groups sessions had to do with racism, immigration, loss of a parent, mental illness of a parent or sibling, parental alcoholism/addiction, adoption, significant early loss, divorce, extreme physical illness of a parent, poverty, rejection by parents, and living in highly chaotic and conflicted families.

Results suggest that without exception group members reported positive experiences in the support groups. All students who completed the post-group questionnaire responded that they felt welcomed into the group, and felt supported by other group members and selected either "Often, Usually, or Almost Always" as their responses. All students except for 2 (who responded "maybe")

responded “yes” to the question: “I would recommend this group to a friend.” In addition, students’ responses in the “Dear Group Letter” indicated a highly positive experience in the groups.

In comparing the pre and post-group questionnaire results there was an increase in the following: students felt more supported in their lives, used healthy coping strategies more often, decreased their use of alcohol and drug use as a way to manage their feelings, and attended school with more frequency.

Adult Support Groups: Previously this project implemented outreach and engagement activities and support groups to Latino immigrant adults dealing with trauma issues, who live and work the backstretch of Golden Gate Field’s race track as groomers, exercise jockeys, and caretakers of the horses. Over the course of this reporting timeframe this project has migrated to more of a one-on-one engagement and support project with occasional drumming and other cultural and strength building group activities.

PEI Goals: The goal of this project is to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the prevention of suicide.

In FY18, approximately 35 unduplicated individuals participated in either one-on-one engagement or community group events. All participants had a myriad of basic living and mental health needs and many were isolated and illiterate.

This project has continued to be a key source of reaching a community that otherwise would not have resources. It is structured to take into account the barriers those living and working on the backstretch experience in accessing services, including complicated work hours, difficulty getting transportation, as well as their levels of acculturation, language and experience. Self-report from multiple participants’ overtime, has indicated that having mental health resources come into the backstretch has been a strong support for them.

In FY18, there were a total of 73 unduplicated individuals were served through the Albany Trauma Project. Demographics on individuals served were as follows:

PARTICIPANT DEMOGRAPHICS N=73	
Age Group	
16-25	62%
26-59	29%
60+	9%
Race	
Asian	22%
Black or African American	12%
Native Hawaiian or other Pacific Islander	3%
White	15%
Other	48%

Ethnicity: Hispanic or Latino	
Central American	4%
Mexican/Mexican-American/Chicano	59%
South American	1%
Ethnicity: Non-Hispanic or Non-Latino	
African	12%
Asian Indian/South Asian	3%
Chinese	16%
Filipino	1%
Japanese	4%
Primary Language Used	
English	26%
Spanish	60%
Mandarin	7%
Other	7%
Sexual Orientation	
Gay or Lesbian	1%
Heterosexual or Straight	90%
Bisexual	4%
Questioning or Unsure	2%
Declined to Answer (or Unknown)	3%
Disability	
No Disability	52%
Difficulty Hearing or Having Speech Understood	4%
Physical/Mobility Disability	8%
Chronic Health Condition	5%
Declined to Answer (or Unknown)	31%
Veteran Status	
No	100%

Gender: Assigned sex at birth	
Male	62%
Female	38%
Current Gender Identity	
Male	62%
Female	38%

Living Well Project

Implemented through Center for Independent Living, this project provides services for Senior Citizens (aged 50 and over) who are coping with trauma and/or mental health issues associated with acquired disabilities. Senior Citizens with acquired disabilities are one of the most difficult groups to reach with disability services. It is similarly difficult to intervene with this group's developing mental health issues related to aging and the traumatic impact of acquiring one or more disabilities (such as loss of mobility, vision, hearing, et al). The core of the project is a wellness workshop series entitled "Living Well with a Disability". Through a combination of education, goal setting, group and peer counseling, the workshop series is designed to promote positive attitudinal shifts in a population who, despite the tremendous need for care, are often typically not responsive to mental health intervention. The workshop series includes a 10 week, one to two hour class conducted by Peer Facilitators, and an optional 30 minute counseling session. Counseling sessions are designed to monitor curriculum impact and continually assess individual goals and resource needs. This project serves up to 150 Older Adults a year.

PEI Goals: The goal of this program is to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the prevention of suicide.

In FY18, eight workshop cycles were conducted, five of the workshops were the "Living Well" series and three were "Continuing to Live Well" series, as it has been found that seniors with significant long-term goals want and need more than one workshop cycle to reach and maintain their goals. Each Living Well Workshop Series included the following sessions: Orientation; Goal Setting; Problem Solving; Healthy Reactions; Beating the Blues (Depression and Moods); Healthy Communication; Seeking Information; Physical Activity; Eating Well (Nutrition); Advocacy (Self and Systems Change); and Maintenance. Topics of Grief and Loss, Depression, Retirement, and Senior Invisibility were also incorporated into the program. This program also hosted outreach and informational events. In all approximately 81 Senior Citizens participated in some aspect of this program with 59 participating in the Living Well Workshops. Demographics of Workshop participants are outlined below:

PARTICIPANT DEMOGRAPHICS N=59	
Age Groups	
26-59 (Adult)	5%
Ages 60+ (Older Adult)	93%
Declined to Answer (or Unknown)	2%
Race	
Asian	3%
Black or African American	50%
Native Hawaiian or Other Pacific Islander	1%
White	20%
Other	13%
More than one race	3%
Declined to Answer (or Unknown)	10%
Ethnicity: Hispanic or Latino	
Caribbean	3%
Central American	2%
South American	2%
Other	18%
Declined to Answer (or Unknown)	75%
Ethnicity: Non-Hispanic or Non-Latino	
African	7%
Chinese	3%
European	5%
More than one Ethnicity	2%
Other	10%
Declined to Answer (or Unknown)	73%
Primary Language Used	
English	98%
Spanish	2%

Sexual Orientation	
Gay or Lesbian	2%
Heterosexual or Straight	66%
Questioning or Unsure	2%
Declined to Answer (or Unknown)	30%
Disability	
Difficulty seeing	11%
Difficulty hearing or Having Speech Understood	7%
Mental (not mental health)	17%
Physical/mobility disability	26%
Chronic health condition	17%
No Disability	17%
Declined to Answer (or Unknown)	5%
Veteran Status	
Yes	3%
No	80%
Declined to Answer (or Unknown)	17%
Gender: Assigned sex at birth	
Male	22%
Female	47%
Declined to Answer (or Unknown)	31%
Current Gender Identity	
Male	19%
Female	37%
Transgender	44%

Harnessing Hope Project

Implemented through GOALS for Women this project provides community-based, culturally competent, outreach and support services for African Americans residing in the South and West Berkeley neighborhoods who have experienced traumatic life events including racism and socioeconomic oppression and have unmet mental health support needs. The primary goals of

the project are to normalize stress responses and empower families through psycho-education, consciousness raising, strength-based coping skills, and supportive services through the following: Outreach and engagement; screening and assessment; psycho-education; family education; support groups such as “Kitchen Table Talk groups (non-stigmatizing, culturally responsive, peer centered groups) and “Just Like Sunday Dinners” (a space for African Americans from all generations to come together to gain supports from one another); workshops and classes; mental health referrals and community linkages; peer counseling and support. A key component of this project is to train and mentor community leaders to become Peer Facilitators of Kitchen Table Talk groups. This project serves approximately 50-130 individuals a year.

PEI Goals: The goal of this program is to address and promote recovery and related functional outcomes for a mental illness early in its emergence including the prevention of suicide.

In FY18, the following activities were conducted through this project:

Outreach and Engagement: Outreach and engagement activities were conducted to approximately 107 women at various City locations, agencies and events to increase knowledge and the recognition of early signs of mental illness and to inform residents of project services.

Peer Facilitator Training: Peer Facilitator Trainings were held to increase knowledge and skills around how to facilitate peer support groups through an African American cultural lens. Five individuals participated in the Peer Facilitator Trainings. Some participants went on to facilitate Kitchen Table Talk Support Groups, and were supported through mentoring sessions that were held to provide facilitators with support and skills around how to handle difficult group topics and issues.

Kitchen Table Talk Support Groups: These support groups were designed to increase information and supports around current and historical trauma and to teach participants healthy coping skills. Approximately 54 African American women ranging in ages from 18-60, and youth ranging in ages from 12-16 participated in Kitchen Table Talk Support Groups, many of whom were also assessed and received individual and/or family psycho-educational support services, or were referred to additional community resources as needed. Group participants learned from each other and demonstrated their cultural strengths and resilience around effective ways to manage stress.

In FY18, 54 individuals were served through this project. Demographics on individuals served through this project were as follows:

PARTICIPANT DEMOGRAPHICS N=54	
Age Groups	
0-15 (Children/Youth)	8%
16-25 (Transition Age Youth)	5%
26-59 (Adult)	67%
Ages 60+ (Older Adult)	12%

Declined to Answer (or Unknown)	8%
Race	
Black or African American	87%
Asian	2%
White	8%
More than one Race	3%
Ethnicity: Hispanic or Latino	
Declined to Answer (or Unknown)	0%
Ethnicity: Non-Hispanic or Non-Latino	
African	1%
Declined to Answer (or Unknown)	99%
Primary Language Used	
English	100%
Sexual Orientation	
Heterosexual or Straight	91%
Questioning or Unsure	2%
Declined to Answer (or Unknown)	7%
Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
Yes	12%
No	81%
Declined to Answer (or Unknown)	7%
Gender: Assigned sex at birth	
Declined to Answer	100%
Current Gender Identity	
Male	25%
Female	71%
Other	4%

Trauma Support Project for LGBTQI Population

Implemented through the Pacific Center for Human Growth, this project provides outreach, engagement and support group services for individuals (18 and above) in the LGBTQI community who are suffering from the impact of oppression, trauma and other life stressors. Particular emphasis is on outreaching and providing supportive services to identified underserved populations within the local LGBTQI community. Approximately 12-15 weekly or bi-weekly support groups are held throughout the year targeting various populations and needs within the LBGTQI community. Support groups are led by Peer Facilitator community volunteers who are trained in Group Facilitation/Conflict Resolution and who have opportunities to participate in additional Skill Building workshops in order to share methods used to address group challenges and to learn new facilitator techniques. This project serves approximately 250 individuals a year.

PEI Goals: The goal of this program is to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the prevention of suicide.

In FY18, outreach to over 1000 community members was conducted at various locations including Street Fairs, Community Agencies, and area events. During the reporting timeframe, a total of 15 new Peer Facilitators were trained. Fourteen Peer Facilitators attended Skill Building Consultation Trainings that were conducted on a monthly basis by the Program Manager. Eighteen ongoing peer support groups were held on a weekly or bi-weekly basis including the following: Butch-Stud; Female to Male; Women Coming Out; Middle-Aged Men; Married/Formerly Married Gay/Bisexual Men; Young Men; Queer Femmes; Transgender Support Group; Lesbians/Women of Color; Partners of Trans and Gender-Varient; Middle Eastern Women's Group; Senior Gay Men's Group; Bi-sexual Women; Aging Lesbians; Gender Varient Group; Island Pride, Outstanding Seniors, TAG - Transitional Age Group, and QPAD – for Queer Men in their 20's and 30's.

In FY18, a total of 164 individuals participated in support groups throughout the year. Fifteen support group participants were referred to individual Mental Health Services. Demographics on individuals served through this program included the following:

PARTICIPANT DEMOGRAPHICS N=164	
Age Groups	
16-25 (Transition Age Youth)	34%
26-59 (Adult)	56%
Ages 60+ (Older Adult)	10%

Race	
American Indian or Alaska Native	3%
Asian	6%
Black or African American	5%
Native Hawaiian or Other Pacific Islander	3%
White	63%
More than one race	10%
Declined to Answer (or Unknown)	10%
Ethnicity: Hispanic or Latino	
Central American	5%
Mexican/Mexican-American/Chicano	47%
Puerto Rican	5%
South American	10%
Decline to Answer (or Unknown)	33%
Ethnicity: Non-Hispanic or Non-Latino	
African	4%
Asian Indian/South Asian	2%
Chinese	3%
Eastern European	12%
European	58%
Filipino	1%
Japanese	1%
Korean	2%
Middle Eastern	5%
More than one Ethnicity	3%
Other	6%
Decline to Answer (or Unknown)	3%
Primary Language Used	
English	98%
Declined to Answer (or Unknown)	2%

Sexual Orientation	
Gay or Lesbian	33%
Heterosexual or Straight	2%
Bisexual	24%
Questioning or Unsure	4%
Queer	31%
Other	4%
Declined to Answer (or Unknown)	2%
Disability	
Other Disability	23%
No Disability	77%
Veteran Status	
Yes	9%
No	91%
Gender: Assigned sex at birth	
Male	31%
Female	67%
Declined to Answer (or Unknown)	2%
Current Gender Identity	
Male	22%
Female	38%
Transgender	9%
Genderqueer	21%
Questioning or Unsure	4%
Other	6%

Transition Age Youth Trauma Support Project

Implemented through Covenant House, this project provides supportive services for Transition Age Youth (TAY) who are suffering from the impact of trauma and/or other life stressors and are homeless, marginally housed, or housed but in need of supports. The project serves a wide range of youth from various cultural and ethnic backgrounds who share the common goal of living lives less impacted by trauma and more impacted by wellness. The project consists of the following four components: One-on-one sessions that assess individuals needs around trauma supports and support group readiness; psycho-educational support groups; youth social outings that provide TAY with exposure to healthy settings designed to enhance life skills and choices; and youth celebratory events that are held monthly to convene youth around a positive occasion to acknowledge the various small and large accomplishments of TAY participants, and build trust and community. Approximately 30-35 TAY receive services through this project a year.

PEI Goals: The goal of this program is to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the prevention of suicide.

In FY18, 22 TAY participated in one-on-one sessions, case management, support groups, and/or group outings and celebrations. Demographics on youth served were as follows:

CLIENT DEMOGRAPHICS N=22	
Age Group	
16-25 (Transition Age Youth)	100%
Race	
American Indian or Alaska Native	4%
Black or African American	32%
White	23%
Other	18%
More than one Race	23%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American	84%
Puerto Rican	8%
South American	8%
Ethnicity: Non-Hispanic or Non-Latino	
Declined to Answer (or Unknown)	100%
Primary Language Used	
English	64%
Spanish	36%

Sexual Orientation	
Gay or Lesbian	18%
Heterosexual or Straight	50%
Bisexual	27%
Questioning or Unsure	5%
Disability	
Difficulty Seeing	27%
Mental (not mental health)	37%
Physical/Mobility Disability	9%
Chronic Health Condition	27%
Veteran Status	
Yes	2%
No	98%
Gender: Assigned sex at birth	
Male	77%
Female	23%
Current Gender Identity	
Male	60%
Female	19%
Transgender	13%
Genderqueer	4%
Questioning or Unsure	4%

Social Inclusion Program

The Social Inclusion program was created to combat stigma, attitudes and discrimination around individuals with mental health issues. Through this program, a "Telling Your Story" group provides mental health consumers with opportunities to be trained, compensated and empowered to share their stories of healing in a supportive peer environment. When they feel ready, consumers can elect to be community presenters, sharing their inspirational stories at pre-arranged local public venues to dispel myths and educate others. This program serves approximately 5-10 individuals a year.

PEI Goals: To reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families. To create changes in attitude, knowledge and/or behaviors related to seeking mental health services or related to mental illness.

In FY18, the "Telling Your Story" group met 22 times with 16 unduplicated individuals attending for a total of 169 visits. Groups averaged 7-8 attendees. Program participants spent time discussing and practicing what makes a good story. One panel presentation to Berkeley Mental Health interns, which was well received.

In FY18 this program began collecting outcomes data. Measures were based on the assumption that individuals participating in "Telling Your Story" were finding meaning, transforming their lived experience and enhancing their recovery. The Recovery Assessment Scale (RAS) was used. After three measurements, it appeared that results were more impacted by what happened that day in the person's life than in the "Telling Your Story" group. Staff then assessed whether developing RBA measures would be a better way to assess the program.

The "Telling Your Story" group brainstormed and discussed criteria on what makes a good story. The list of criteria that was generated was re-visited at many meetings and each criteria was discussed by the group. The group then practiced giving feedback to each person based on the criteria. A survey that included the criteria, with emphasis on participants understanding and awareness of turning points in their stories was then developed. The survey was then administered towards the end of the fiscal year and the results were tallied. The results indicated that the highest rated question pertained to participants' confidence in telling a story that would change negative perceptions of mental illness. The results also guided the group to work on effectively using pauses and timing in telling a story.

Demographics on group participants are outlined below:

CLIENT DEMOGRAPHICS N=16	
Age Group	
26-59 (Adult)	37%
Ages 60+ (Older Adult)	37%
Declined to Answer (or Unknown)	26%

Race	
Asian	8%
Black or African American	50%
White	34%
Other	8%
Ethnicity: Hispanic or Latino	
Puerto Rican	8%
Declined to Answer (or Unknown)	92%
Ethnicity: Non-Hispanic or Non-Latino	
Declined to Answer (or Unknown)	100%
Primary Language Used	
English	75%
Declined to Answer (or Unknown)	25%
Sexual Orientation	
Gay or Lesbian	7%
Heterosexual or Straight	58%
Bisexual	14%
Queer	7%
Declined to Answer (or Unknown)	14%
Disability	
Difficulty Seeing	12%
Difficulty Hearing, or Having Speech Understood	16%
Mental (not mental health)	20%
Physical/Mobility Disability	12%
Chronic health condition	24%
Other Disability	4%
No Disability	8%
Declined to Answer (or Unknown)	4%

Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	33%
Female	58%
Declined to Answer (or Unknown)	9%
Current Gender Identity	
Male	33%
Female	58%
Declined to Answer (or Unknown)	9%

High School Youth Prevention Program

This program operates in conjunction with other health related services offered at Berkeley High School (BHS) and Berkeley Technology Academy (BTA) to provide young people with the information and individual support they need to make positive and healthy decisions in their lives. The program includes: outreach activities designed to provide students with basic information around the risks of certain behaviors, and ways to protect themselves and make positive and safer decisions; classroom presentations to enable students to receive more in-depth information around a variety of health topics and available resources, and provide the opportunity for students to do a personal assessment of risk and current lifestyle choices; drop-in crisis and counseling services; individual appointments to identify young people who may need more intensive intervention; and short-term treatment. The individual appointments, held at the school-based health center, provide young people with the opportunity to hold very in-depth discussions around the choices they are making and the risks that are involved in their choices. They receive guidance about changes they can make to reduce or eliminate their risks, and are given the opportunity to identify barriers that might exist for them that prevent them from making healthier choices. In addition, they complete a 40 question, in-depth HEADSSS (Home, Education, Activities, Drugs/Alcohol, Sexuality, Safety, and Suicidality) assessment. Based on the outcome of the individual appointment and/or assessment, a young person may be referred to either a medical or mental health professional for follow-up care and intervention and/or treatment. Approximately 2600 Berkeley High School Students and 100 B-Tech students receive some level of services through this program each year.

This program was implemented in FY13 and has become a successful partnership between BUSD and the Public Health and Mental Health Divisions of Berkeley's HHCS Department. As the program has developed, the staffing structure for the program has increased and evolved to better meet the needs of the participants of both BHS and B-Tech. Additionally, BMH has been involved in implementing and assessing the Cognitive, Behavioral, and Intervention for Trauma in Schools (CBITS) as a model of care at these locations. The need for additional supports and resources for this program will continue to be accessed and adjusted accordingly.

PEI Goals: The goal of this program is to bring about mental health, including the reduction of school failure or dropout.

In FY18, approximately 1,260 students received services through this project, and 264 students received ongoing mental health services for a total of 738 visits. Demographics on the total number served were as follows:

PARTICIPANT DEMOGRAPHICS N=1,260	
Age Groups	
0-15 (Children/Adult)	6%
16-25 (Transition Age Youth)	13%
Declined to Answer (or Unknown)	81%
Race	
Asian	4%
Black or African American	23%
White	30%
Other	22%
More than one Race	17%
Declined to Answer (or Unknown)	4%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American/Chicano	18%
Ethnicity: Non-Hispanic or Non-Latino	
Declined to Answer (or Unknown)	80%
Primary Language	
Declined to Answer (or Unknown)	100%
Sexual Orientation	
Declined to Answer (or Unknown)	100%

Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	36%
Female	63%
Declined to Answer (or Unknown)	1%
Current Gender Identity	
Male	36%
Female	63%
Declined to Answer (or Unknown)	1%

Demographics on the 264 students receiving ongoing counseling services were as follows:

PARTICIPANT DEMOGRAPHICS N= 252	
Age Groups	
0-15 (Children/Adult)	27%
16-25 (Transition Age Youth)	73%
Race	
Asian	5%
Black or African American	28%
White	25%
Other	18%
More than one Race	18%
Declined to Answer (or Unknown)	6%
Ethnicity: Hispanic or Latino	
Declined to Answer (or Unknown)	18%
Ethnicity: Non-Hispanic or Non-Latino	
Declined to Answer (or Unknown)	100%
Primary Language	
Declined to Answer (or Unknown)	100%
Sexual Orientation	
Declined to Answer (or Unknown)	100%

Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	34%
Female	64%
Declined to Answer (or Unknown)	2%
Current Gender Identity	
Male	34%
Female	64%
Declined to Answer (or Unknown)	2%

Community-Based Child & Youth Risk Prevention Program

This program targets children and youth from un-served, underserved, and inappropriately served populations who are impacted by multiple risk factors including trauma, family or community violence, familial distress, and/or family substance abuse, (among other issues). The program is primarily community-based with some supports also provided in a few area schools. A range of psycho-educational activities provide information and supports for those in need. Services also include assessment, brief treatment, case management, and referrals to long term providers and other resources as needed. The main goals are to reduce risk factors or other stressors, and promote positive cognitive, social, and emotional well-being. This program serves approximately 50 Children & Youth a year.

PEI Goals: The goal of this program is to bring about mental health including the reduction of school failure and the removal of children from their homes.

In FY18, a total of 67 children (aged 0-5) were served through this program. Demographics on those served were as follows:

PARTICIPANT DEMOGRAPHICS N=67	
Age Groups	
0-15 (Children/Adult)	100%
Race	
Asian	9%
Black or African American	48%
White	13%
Other	28%

More than one Race	2%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American/Chicano	7%
Ethnicity: Non-Hispanic or Non-Latino	
Declined to Answer (or Unknown)	93%
Primary Language	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Gender: Assigned sex at birth	
Male	60%
Female	40%
Current Gender Identity	
Male	60%
Female	40%

Homeless Outreach and Treatment Team (HOTT)

The Homeless Outreach and Treatment Team (HOTT) program was established out of an effort to address the current homeless crisis, and as a result of input received through various MHSA community program planning processes. Utilizing a portion of PEI and CSS funds, blended with realignment and general funds HOTT is a three year pilot program to move homeless mentally ill individuals in Berkeley/Albany into permanent housing and to connect them into the web of services and supports that currently exist within the system of care. Key program components include the following: Persistent and Consistent Outreach; Supportive Case Management; Linkage to Care; and Treatment.

PEI Goals: The goal of this program is to connect individuals who have severe mental illnesses as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to, care provided by county mental health programs.

A local consultant, Resource Development Associates, was hired to conduct a dedicated independent evaluation to assess the program accomplishments and to ascertain whether HOTT should continue past the initial funding period. The initial report on FY18 showed many positive findings including the following:

- HOTT is serving as an important resource for the local community and homeless service continuum.
- The program has been very effective in persistent and consistent outreach, especially for chronically homeless individuals with a history of refusing services.
- HOTT meets people where they are, in parks, encampments, motels.

- The program has successfully connected homeless individuals to critical resources and service linkages.

The City of Berkeley Homeless Outreach and Treatment Team (HOTT) Evaluation can be reviewed on the MHSA website:

https://www.cityofberkeley.info/uploadedFiles/Health_Human_Services/Level_3_-_Mental_Health/Berkeley-HOTT_Evaluation-Report.final.pdf

In FY18 through the first quarter of FY19, 289 individuals were served through this program. The HOTT Evaluation reported on numbers from January 2018 through October 2018 and staff provided data collected from July – December 2017. Demographics on individuals that received services through this program were as follows:

PARTICIPANT DEMOGRAPHICS N= 289	
Age Groups	
16-25 (Transition Age Youth)	<1%
26-59 (Adult)	6%
Ages 60+ (Older Adult)	1%
Declined to Answer (or Unknown)	92%
Race	
Asian	1%
Black or African American	33%
White	35%
Other	10%
Declined to Answer (or Unknown)	21%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American/Chicano	9%
Ethnicity: Non-Hispanic or Non-Latino	
Non-Hispanic or Non-Latino	65%
Declined to Answer (or Unknown)	26%
Primary Language Used	
English	65%
Other	3%
Declined to Answer (or Unknown)	32%
Sexual Orientation	
Declined to Answer (or Unknown)	100%

Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
Declined to Answer (or Unknown)	100%
Gender: Assigned sex at birth	
Declined to Answer (or Unknown)	100%
Current Gender Identity	
Male	7%
Female	8%
Declined to Answer (or Unknown)	85%

The HOTT program made 921 referrals in 2018 for homeless individuals to many critical services and resources, including 92 referrals to mental health services.

Dynamic Mindfulness Program (DMind)

Through the previously approved MHSA FY19 Annual Update BMH allocated $95,000 of unspent PEI funds to support the Berkeley Unified School District (BUSD) Dynamic Mindfulness (DMind) Program. DMind is an evidence-based trauma-informed program that will be implemented in each of the BUSD middle and high schools. Validated by independent researchers as a transformative program for teaching children and youth, skills for optimal stress resilience and healing from trauma, the DMind program integrates mindful action, breathing, and centering into an intervention that can be implemented in the classroom in 5-15 minute sessions, 3 to 5 times a week. This program has proven to be successful with vulnerable students who are exhibiting signs of trauma/PTSD from Adverse Childhood Experiences (ACEs), and/or disengagement from school, chronic absences, and significant behavioral challenges, including emotion regulation, impulse control, and anger management. DMind also enables teacher well-being, which has been shown to enhance student learning. The program components will include in-class and after-school DMind sessions for students, student peer leadership development, training and coaching of school staff, and program evaluation.

Mental Health Peer Education Program

Through the previously approved MHSA FY19 Annual Update BMH allocated $92,778 of unspent PEI funds to support the BUSD Mental Health Peer Education Program. This is a new program in BUSD that implements a mental health curriculum for 9th graders and an internship program for a cohort of high school students in an effort to increase student awareness of common mental health difficulties, resources, and healthy coping and intervention skills. Through this program students are trained by a licensed BUSD clinician to conduct class presentations covering common mental health disorders, on and off campus resources, as well as basic coping and intervention skills.

California Mental Health Services Authority (CalMHSA) PEI Statewide Projects

In 2009, California's counties formed the California Mental Health Services Authority (CalMHSA) as a Joint Powers Authority to implement PEI statewide program initiatives. With an approved combined funding level of $40 million per year for four years during the timeframe of 2011 through 2015, CalMHSA implemented statewide initiatives in the following areas: Suicide Prevention, Stigma and Discrimination Reduction, and Student Mental Health. Following 2015, funding for PEI Statewide projects was generated through pooled contributions from individual counties. Contributing counties are members of a CalMHSA board that provides direction into the types of initiatives that are implemented. In order to continue to sustain programming, CalMHSA previously asked counties to allocate 4% of their annual local PEI allocation each year from FY2018 – FY2020 to these statewide initiatives. In the City of Berkeley, this currently amounts to approximately $53,987 a year.

Through the previously approved Three Year Plan the City of Berkeley allocated PEI funds for one year towards this statewide initiative, and for the remaining two years, elected to assess on an annual basis whether or not to continue to allocate funds to this initiative. In FY18, through this initiative resources on Suicide Prevention, Student Mental Health and Stigma and Discrimination reached an excess amount of 1,423 individuals. Additionally an excess of 1,276 pamphlets and resources on Suicide Prevention, Student Mental Health and Stigma and Discrimination were distributed in local schools and the community. BMH also participated in the CalMHSA "Each Mind Matters" campaign and distributed materials and giveaways at the local "May is Mental Health Month" event. As with last year, in FY20, BMH is proposing to allocate 4% of PEI Funds (approximately $53,987) to CalMHSA to access and participate in the PEI Statewide Program initiative.

INNOVATIONS (INN)

The City of Berkeley's initial INN Plan was approved in February 2012. Subsequent updates to the initial plan were approved in May 2013, January 2014, June 2014 and January 2015. Per the initial INN Plan and/or through Plan Updates the following seven pilot projects were implemented from June 2012 – June 2015 through this funding component:

- A Community Empowerment project for African Americans;
- Services and supports for Ex-offenders re-entering the community, Veterans returning home from being deployed or at war, and their families;
- Cultural Wellness strategies for Asian Pacific Islanders;
- A Holistic Health care project for TAY;
- Technology Support Groups for senior citizens;
- Nutrition, Healthy Meal Preparation, and Exercise classes for Board and Care residents;
- Mental Health services and supports for LGBTQI located in community agencies.

In May 2016, the second MHSA INN Plan was approved. This plan implemented a Trauma Informed Care for Educators project in BUSD. This project was extended in FY18 and in FY19

proposed changes to the population and funding amount of the original TIC Plan were vetted through community program planning, and an update to the TIC Plan underwent a 30 Day Public Review and Public Hearing process. The TIC Plan Update was approved through City Council in October 2018 and by the MHSOAC in December 2018.

Additionally, in September 2018, following a four month community planning process and approval from City Council, the City of Berkeley Technology Suite Project was approved by the MHSOAC. This project allocates a total of $462,916 to join a Statewide Collaborative with other California counties to pilot a Mental Health Technology Project that will make various technology-based mental health services and supports available locally in Berkeley and Albany.

INN Reporting Requirements

Per MHSA INN regulations, all INN funded programs have to collect additional state identified outcome measures and detailed demographic information. The first report that included data specific to the new INN requirements, "City of Berkeley Mental Health Services Act (MHSA) Fiscal Year 2017 Innovations Evaluation Report" , is located on the City of Berkeley Mental Health Division MHSA Website. See Appendix B for the Fiscal Year 2018 Annual Innovation Evaluation Report. The next round of Innovation programs to be funded will also have provisions for evaluation to be an integral part of the project.

A description of the currently funded INN programs and project updates are outlined below:

Trauma Informed Care Project

In May 2016, following a three month community planning process the City of Berkeley received approval from the Mental Health Oversight and Accountability Commission (MHSOAC) to implement a Trauma Informed Care (TIC) for Educators project into several Berkeley Unified School District (BUSD) schools to assess whether educators who are trained to become aware of their own trauma and trauma triggers (and how to address them), are better equipped to recognize and make appropriate decisions on how to help students who are exhibiting trauma symptoms, and assist them in accessing the mental health services and supports they may need.

The project was implemented through the 20/20 Vision Program which is operated out of the City of Berkeley, City Manager's Office. After a year of the TIC Project being executed, there were two vacancies in the 20/20 Vision Program which impacted the ability to continue the implementation of the TIC Project. The project was only able to be implemented for one year in FY17 and during that timeframe an evaluation was conducted by Hatchuel Tabernik & Associates on the project outcomes. The report is part of the larger "City of Berkeley Mental Health Services Act (MHSA) Fiscal Year 2017 Innovations Evaluation Report" referenced above.

Outlined below is demographic data and program outcomes from that report.

In FY17, 93 individuals participated in TIC Trainings. Demographic data that was collected during this timeframe was as follows:

PARTICIPANT DEMOGRAPHICS N=93	
Age Groups	
26-59 (Adult)	100%
Race	
Asian/Pacific Islander	8.5%
Black or African American	10%
White	60%
Other	4.3%
More than one Race	5.7%
Ethnicity	
Hispanic or Latino	11.4%
Gender	
Male	22.9%
Female	77.1%

Pre and Post Survey results demonstrated that participants had an increased sense of efficacy with trauma-induced behavior and mental health concerns among their students. As a result of the program, educators felt less challenged by behavior issues in their classroom, increased their knowledge around students' barriers to accessing services and how to handle and approach students' behavior issues, and felt more comfortable working with parents, especially around recommending that their child seek counseling.

While the data indicated that it was too early to determine the student impact of the program, baseline FY16 data on the number of students identified for "Response to Intervention"- RTI (a multi-tier approach to the early identification and support of students with learning and behavior needs, as a proxy for early disciplinary issues) and Mental Health follow-up, was collected and compared with the reporting timeframe. Fifty students were referred to RTI, which was an increase from the 14 students in FY16, who were referred to the services. The number of students identified for Mental Health follow-up, remained the same, at 5 students each year. Although an evaluation was conducted, with only one year of project implementation there was not enough time to adequately evaluate the learning objectives.

In FY18, due to staffing vacancies this project was not able to continue to be implemented. When staffing vacancies were filled in mid FY18, meetings were held with several BUSD principals who indicated that although their schools received a lot of positive benefits out of the TIC project, additional training requirements within the school system had been added for teachers and administrators that needed to be fulfilled over the next couple of years. As a result, the TIC Project would not be able to be prioritized within the school system at that time. In light of the changes in the school system, staff conducted outreach and found that four area Head Start Centers were interested in executing the same TIC Project for their early childhood educators and staff, to impact the children and families who are served at the centers.

As such, proposed changes to the population and funding amount of the original TIC Plan were vetted through community program planning, and an update to the TIC Plan underwent a 30 Day Public Review and Public Hearing process. The TIC Plan Update was approved through City Council in October 2018 and by the MHSOAC in December 2018. The proposed new funding amount for the remainder of the modified TIC project will be $340,000. The modified project implements TIC Training for Educators and interested parents in four local Head Start sites.

Technology Suite Project

In September 2018, following a four month community planning process and approval from City Council, the City of Berkeley Technology Suite Project was approved by the MHSOAC. This project allocates a total of $462,916 to join a Statewide Collaborative with other California counties to pilot a Mental Health Technology Project that will make various technology-based mental health services and supports available locally in Berkeley and Albany. The proposed INN project will seek to learn whether the Technology Suite Project will increase access to mental health services and supports; and whether it will increase the quality of mental health services, including leading to better outcomes.

Since plan approval the City of Berkeley has been working both internally and with the State collaborative on various aspects of this project to prepare for city wide implementation. It is envisioned that the technology suite apps will be locally available by September 2019.

Future MHSA INN Projects

In FY20, BMH will begin the community planning process for the next round of INN funded Projects. As reported in the approved FY19 Annual Update the funding amount for this round of MHSA INN Projects will be approximately $400,000, which depending on the planning process, may be awarded to one or more projects.

WORKFORCE, EDUCATION & TRAINING (WET)

The City of Berkeley WET Plan was approved in July 2010 by DMH for a total amount of $656,900 to be utilized on local programs through FY18. A subsequent update was approved in May 2013. Specific programs in the approved WET Plan include:

- Peer Leadership Coordination;
- Staff Development and MHSA Training;
- High School Career Pathways Program;
- Graduate Level Training Stipend Program;
- Peer Leader Stipend Program.

Descriptions for each WET funded program along with a report on program activities, is outlined below:

Peer Leadership Coordination

The Peer Leadership program trained mental health consumers to be providers of mental health services, and to provide leadership within the mental health consumer community. Per the approved WET plan, the Peer Leader Coordinator provided and coordinated training for consumers, including those from culturally and linguistically diverse communities to increase the necessary skills that would enable participants to secure consumer positions in the mental health system as they became available; and to participate on BMH committees and Boards. In this capacity, the Peer Leader Coordinator, in partnership with the Alameda County Network of Mental Health Clients' BESTNow! program, developed a Facilitation Training to train peers as co-facilitators of support and self-help groups. There is a great need for self-help and support groups in the mental health system and consumers hired as peer specialists often are required to co-facilitate groups as part of their job duties. After completing the 12-week classroom course, participants gave a small presentation about their group to BMH Staff. Participants received stipends through BESTNow! for co-facilitating and providing outreach for their group for six months. This enabled Peer led activities and groups to be offered and increased attendance at the existing Wellness Recovery Activities group.
Through this program the Peer Leader Coordinator researched local organizations in the Bay Area that could offer training and stipends for the Peer Leadership program. As staff on all BMH treatment teams identified the need for support groups for their clients, and group facilitation as an important Peer Specialist skill, a contract was developed with the Alameda County Network of Mental Health Clients BESTNOW! Program to offer Facilitation Training in Berkeley for up to 10 consumers. The training included 12 weeks of classroom instruction in support group facilitation and an internship co-facilitating a support group. Two new peer led groups were implemented during this timeframe: "Dancing Voices", which offered a variety of creative activities such as dance, poetry, and visual arts to explore identity and wellness; and "Getting on Track", which was geared towards elders and offered activities and education related to healthy living. Other attendees were able to facilitate existing BMH wellness recovery groups and activities.

Some of the challenges of this project included establishing the groups and ensuring they were well-attended. Another challenge was that participants had contrasting expectations for the training. Some expected to become employed through this project, while others were looking to enhance their own wellness and skill sets. Some participants felt that the training should have included longer term paid placement opportunities outside the one group of which a stipend was offered. This at times impacted class agendas and trainers worked to address the various concerns. In order to avoid this type of conflict in any future program, it's important to ensure the goals and limitations of the project are clearly communicated.

Overall, this project was very successful in training participants and offering peer-led groups. The trainers witnessed significant personal development and growth among participants and a number of them gained confidence and sought out paid work. Others became increasingly comfortable in their developing facilitation skills and showed increased engagement in class. The positive changes in the participants highlighted the value of peer-led and peer-focused trainings.

Staff Development and MHSA Training

This WET component implements training for BMH staff and those from affiliated community agencies in an effort to transform the system of care. A BMH Staff Training Coordinator prepares, facilitates, presents, monitors, evaluates and documents training activities for BMH's system of care. The Training Coordinator also collaborates with staff from state, counties, local agencies and community groups in order to enhance staff development of employees in the cities of Berkeley and Albany and other areas in the region.

The Training Coordinator accomplishes these goals by:

- Providing staff training in the area of behavioral health to all stakeholders in the cities of Berkeley, Albany and other geographic locations in the region as a collaborative partner;
- Developing long and short term goals and objectives to promote staff development and competencies within our system of care;
- Developing an annual budget;
- Chairing the agency's Staff Training Committee;
- Attending continuous trainings in the areas of behavioral health services and other trainings as needed;
- Collaborating with State, Regional, County, and local groups and organizations; and
- Developing a two-year staff training work plan.

From August through December of FY18 the Training Coordinator position was unoccupied. In FY18, the Training Coordinator implemented the following trainings through this component: ADA: Disability rights and Reasonable Accommodations – January 23, 2018 – (56 individuals attended this training.) Attendees included staff.

Law and Ethics for Mental Health, Behavioral Health and Health Care Providers – March 23, 2018 – (37 individuals attended this training.) Attendees included staff and service providers.

Strengths-Based Workshop – April 11, 2018 – (10 individuals attended this training.) Attendees included staff.

Law Enforcement & HIPAA – May 14, 2018 – (24 individuals attended this training.) Attendees included staff.

High School Career Pathways Program

Through this program BUSD implemented a curriculum and mentoring program for youth designed to provide opportunities that support student's interest in pursuing a career in the mental health field. This project was implemented in FY15. During this timeframe, BMH FYC, provided internships to two Berkeley High School students. In FY18 there was a vacancy in the school personnel who had oversight of this program, therefore there were not any student internships in that reporting timeframe and the project was not continued.

Graduate Level Training Stipend Program

Per the original WET Plan, this program offered stipends to Psychologists, Social Workers, Marriage and Family Therapists and other counseling trainees and interns who have cultural and linguistic capabilities. Guidelines were developed and a system was implemented to recruit

and provide incentives to those meeting criteria, thereby allowing BMH to attract a more culturally and linguistically diverse pool of graduate level trainees and interns. This program was first implemented in 2016 and in FY18 this program offered stipends to all counseling trainees and interns at BMH. In FY20, through the approved City of Berkeley MHSA Reversion Expenditure Plan, the remaining WET funds will be expended on this program.

Peer Leader Stipend Program

Under the direction of the Peer Leader Coordinator, this program provided opportunities for peer leaders to take active roles on Division committees, and/or serve in direct service positions in the clinics. As part of participating in various leadership or peer positions, consumers and family members were offered stipends. These opportunities helped to prepare consumers and their family members for roles within the public mental health system. BESTNow! also offered stipends to individuals who participated in the internship program offered in partnership with BMH through the Peer Leadership Coordination program.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

The original City of Berkeley CFTN Plan was approved by DMH in April 2011, with updates to the plan in May 2015, June 2016, and January 2017. Through previously approved MHSA Plans and/or Annual Updates, BMH has allocated a total of $3,773,811 towards the renovation of the Adult Mental Health Clinic.

The Adult Clinic serves Berkeley's most at-risk and fragile population through crisis intervention, case management, individual/or group therapy, and psychiatric medication support. FSP/Intensive Case Management Teams, Clinical services, Mobile Crisis, and Homeless Outreach. In its current condition, use of the Adult Clinic space is inefficient and inadequately aligned with MHSA goals, including that of creating welcoming spaces for client and family centered wellness and recovery programs and services. In addition to electrical, HVAC and other environmental upgrades, it was originally envisioned that CFTN funds would be used to re-configure shared work spaces to increase safety; improve clinical, wellness/recovery, support services, and administrative functions; and support the implementation of electronic health records and other emerging technologies. In FY18, renovation on the Adult Clinic was in the design and pre-construction phase. In FY19 construction on the Adult Clinic began.

FY18 AVERAGE COST PER CLIENT

COMMUNITY SERVICES & SUPPORTS			
Program Name	**Approx. # of Clients**	**Cost**	**Average Cost Per Client**
Children's Intensive Support Services FSP	22	$345,016	$15,683
TAY, Adult & Older Adult FSP	59	$1,692,695	$28,689
TAY Support Services	174	$122,856	$706
Wellness Recovery System Integration (includes: Homeless Outreach and Treatment Team; Wellness Recovery Services; Family Support Services; Employment/Educational Services; Housing Services and Supports, Crisis Services)	406	$1,242,987	$3,062
Benefits Advocacy	19	$20,000	$1,053
PREVENTION & EARLY INTERVENTION			
BE A STAR	345	$101,689	$295
Supportive Schools Program	830	$55,000	$66
Albany Trauma Project	148	$53,040	$358
Living Well Project	59	$32,046	$543
Harnessing Hope Project	54	$32,046	$593
LGBTQI Trauma Project	164	$32,046	$195
TAY Trauma Project	22	$32,046	$1,456
High School Youth Prevention Program	1,260	$411,840	$327
Social Inclusion Program	16	$6,035	$85
Homeless Outreach and Treatment Team	289	$142,617	$493
Child And Youth at Risk Project	67	$9,311	$139
INNOVATION			
Trauma Informed Care Project	93	$32,773	$352

PRUDENT RESERVE FUNDS

Per MHSA legislation mental health jurisdictions are required to maintain a local Prudent Reserve to be able to fund the most crucially CSS support services in the event there is a year where there is a downturn in the amount of MHSA funds received at the state and locally allocated. Beginning this year, new state regulations require a report out on the level of local Prudent Reserves by the end of the fiscal year. Mental health jurisdictions must show that the amount of the Prudent Reserve is not higher than 33% of a total of the past five years of MHSA funding distributions and must submit the "Mental Health Services Act Prudent Reserve Assessment/Reassessment" form attesting to the amount in the Prudent Reserve fund. The current amount of the City of Berkeley MHSA Prudent Reserve is $1,605,816. Based on the new state regulations on how to calculate the allowable amount in the Prudent Reserve, the amount the City of Berkeley should have in the Prudent Reserve is $1,237,629.31, (a difference of $368,186.69). In FY20 the City of Berkeley will transfer $320,323 from the Prudent Reserve to the CSS funding component, and $47,864 into the PEI funding component – these transfers will bring the City of Berkeley into compliance with the new state regulations regarding the Prudent Reserve. The current funding amount and the signed "Mental Health Services Act Prudent Reserve Assessment/Reassessment" form will be submitted to the state by 6/30/19.

State of California
Health and Human Services Agency

Department of Health Care Services

MENTAL HEALTH SERVICES ACT
PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City: City of Berkeley

Fiscal Year: FY2018/19

Local Mental Health Director

Name: Steve Grolnic-McClurg

Telephone: (510) 981-5249

Email: SGrolnic-McClurg@cityofberkeley.info

I hereby certify[1] under penalty of perjury, under the laws of the State of California, that the Prudent Reserve assessment/reassessment is accurate to the best of my knowledge and was completed in accordance with California Code of Regulations, Title 9, section 3420.20 (b).

Steven Grolnic-McClurg — 6/21/19

Local Mental Health Director (PRINT NAME) | Signature | Date

[1]Welfare and Institutions Code section 5892 (b)(2) DHCS 1819 (02/19)

PROGRAM BUDGETS

FY 2019/20 Mental Health Services Act Annual Update
Funding Summary

County: City of Berkeley

Date: 5/29/19

	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 FY2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	6,777,484	1,801,362	1,347,715	5,000	2,500,000	
2. Estimated New FY2019/20 Funding	4,797,986	1,349,684	315,656			
3. Transfer in FY 2019/20[a/]						
4. Transfer Local Prudent Reserve in FY 2019/20	320,323	47,864				
5. Estimated Available Funding for FY 2019/20	11,895,793	3,198,910	1,663,371	5,000	2,500,000	
B. Estimated FY19/20 Expenditures	7,015,404	1,690,045	954,800	5,000	2,500,000	
G. Estimated FY19/20 Fund Balance	4,880,389	1,508,865	708,571	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Unspent Local Prudent Reserve on June 30, 2019	1,605,816
2. Contributions to the Local Prudent Reserve in FY2019/20	0
3. Transfers from the Local Prudent Reserve in FY2019/ FY19/20	360,883
4. Estimated Local Prudent Reserve balance on June 30 e 30, 2020	1,244,933

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 2019/20 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: City of Berkeley Date: 5/29/19

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. TAY, Adult & Older Adult FSP	2,114,328	2,114,328				
2. Children's FSP	601,198	601,198				
3. Homeless FSP and Outreach Team	633,761	633,761				
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Multicultural Outreach & Engagement	311,520	311,520				
2. System Development, Wellness & Recovery	2,297,251	2,297,251				
3. Homeless Outreach & Treatment Team (HOTT)	465,633	165,996		89,874		209,763
4. Fitness to Independence	74,251	74,251				
5. Crisis Services	107,128	107,128				
6.						
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	709,971	709,971				
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	7,315,041	7,015,404	0	89,874	0	209,763
FSP Programs as Percent of Total	47.7%					

FY 2019/20 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: City of Berkeley Date: 5/29/19

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Homeless Outreach (HOTT)	116,408	23,906		29,102		63,400
2. Community Based Children & Youth Risk	22,661	22,661				
3. High School Prevention Program	106,412	106,412				
4. Social Inclusion	9,000	9,000				
5. African American Success Project	37,500	37,500				
6. CAL MHSA	40,490	40,490				
7. Dynamic Mindfullness	71,250	71,250				
8. Mental Health Peer Education Program (MEET)	77,900	77,900				
9.	0	0				
10.	0	0				
PEI Programs - Early Intervention						
11. BE A STAR	162,260	162,260				
12. Community Education & Supports	192,376	192,376				
13. High School Prevention Program	319,235	319,235				
14. Homeless Outreach (HOTT)	349,225	71,719		87,306		190,200
15. Community Based Children & Youth Risk	67,982	67,982				
16. African American Success Project	112,500	112,500				
17. CAL MHSA	13,497	13,497				
18. Dynamic Mindfullness	23,750	23,750				
19. Mental Health Peer Education Program (MEET)	25,966	25,966				
20. Supportive Schools Project	55,000	55,000				
PEI Administration	256,641	256,641				
PEI Assigned Funds						
Total PEI Program Estimated Expenditures	2,060,053	1,690,045	0	116,408	0	253,600

FY 2019/20 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: City of Berkeley Date: 5/29/19

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Trauma Informed Care Project	200,000	200,000				
2. Techonology Suite Project	334,800	334,800				
3. New INN Programs	400,000	400,000				
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	20,000	20,000				
Total INN Program Estimated Expenditures	954,800	954,800	0	0	0	0

FY 2019/20 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: City of Berkeley Date: 5/29/19

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1.	5,000	5,000				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	5,000	5,000	0	0	0	0

FY 2019/20 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: City of Berkeley Date: 5/29/19

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Adult Clinic Renovation (2640 MLK)	2,500,000	2,500,000				
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
CFTN Programs - Technological Needs Projects						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
CFTN Administration						
Total CFTN Program Estimated Expenditures	2,500,000	2,500,000				

APPENDIX A

Fiscal Year's 2015/2016 – 2017/2018 Prevention & Early Intervention Three Year Evaluation Report

City of Berkeley
Mental Health Services Act (MHSA)

Fiscal Year's 2015/16 – 2017/2018 Prevention & Early Intervention Three Year Evaluation Report

WELLNESS • RECOVERY • RESILIENCE

INTRODUCTION

Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funds are used to prevent mental illnesses from becoming severe and disabling. Programs funded under the MHSA PEI component are focused on individuals across the life span and should emphasize improving timely access to services for underserved populations. Programs shall also include the following components:

- Outreach to increase knowledge and recognition of the early signs of mental health challenges or potentially severe and disabling mental illnesses.
- Reduction in stigma associated with either having or being diagnosed with a mental illness or seeking mental health services.
- Reduction in discrimination against people with mental health challenges or mental illness.
- Access and linkages to necessary medical care for those in need of additional services.
- Emphasis on strategies to reduce the following negative outcomes that may result from untreated mental health challenges and mental illness: Suicide; Incarcerations; School failure or dropout; Unemployment; Prolonged suffering; Homelessness; Removal of children from their homes.

Per Mental Health Services Act (MHSA) State requirements, beginning December 2017, Mental Health jurisdictions are to submit a Prevention and Early Intervention (PEI) Evaluation Report to the Mental Health Services Oversight and Accountability Commission (MHSOAC) on an annual basis. The first PEI Annual Report provided a report on Fiscal Year 2017 (FY17) Data. Additionally, beginning December 2018, a Three Year PEI Evaluation Report is due to the MHSOAC every three years. The City of Berkeley requested and was granted a one-month extension to complete the FY17 PEI Evaluation Report. The report is posted on the City of Berkeley Mental Health Division website: https://www.cityofberkeley.info/uploadedFiles/Health_Human_Services/Level_3_-_Mental_Health/City%20of%20Berkeley%20FY17%20PEI%20Evaluation%20Report(2).pdf

New PEI Regulations released in 2018 now require mental health jurisdictions to submit either a Three Year Evaluation Report or an Annual Evaluation Report to the State by June 30th of each fiscal year. The PEI Evaluation Report should be included with the MHSA Annual Update or Three Year Program and Expenditure Plan and undergo a 30 Day Public Comment period and approval from the local governing board. In FY19, the Fiscal Years 2015/2016 – 2017/2018 Three Year Prevention & Early Intervention Evaluation Report (Three Year PEI Evaluation Report) that covers data from FY16/17 – FY17/18 is due.

This Three Year PEI Evaluation Report provides descriptions of currently funded MHSA services, and reports on FY16/17 and FY17/18 program and demographic data to the extent possible. Although this is a three year evaluation spanning the FY15/16 – FY17/18 timeframe, per state regulations data from FY15/16 is not required in this Three Year PEI Evaluation Report as new PEI requirements were not implemented in that fiscal year.

As with the first PEI Evaluation Report the main obstacles in collecting data for this Three Year PEI Evaluation Report continue be limited staffing and resources both within the City and at Contractor sites to implement and oversee all the necessary data collection requirements. While, it may be a multi-year process before the City of Berkeley will be able to present a complete data set for each PEI Program on an Annual basis, ongoing efforts will continue towards accomplishing this goal.

Impact Berkeley Initiative

Impact Berkeley: In FY18, the City of Berkeley introduced a new initiative in the Health Housing and Community Services (HHCS) Department called "Impact Berkeley". Central to this effort is using a highly regarded framework called Results Based Accountability (RBA) to account for the work of the Department. RBA provides a new way of understanding the quality and impact of services provided by collecting data that answer three basic questions:

1. How much did you do?

2. How well did you do it?

3. Is anyone better off?

RBA has been incorporated into selected programs within the Department. In FY18, this included community agency programs funded through the MHSA Prevention & Early Intervention Community Education & Supports program. Through this initiative the Department worked with each contractor to envision, clarify and develop measures on the outcomes and results each program is seeking to achieve, and used a rigorous framework to begin measuring and enhancing progress towards these results. Page 30 of this Three Year Evaluation Report provides an aggregated summary of some of the results of this initiative. The full report on the RBA results can be accessed on the MHSA website: MHSA Plans and Updates - City of Berkeley, CA

BACKGROUND

In 2007, the California Department of Mental Health (DMH) issued State Requirements (through DMH Information Notice 07-17) outlining how Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funds were to be used for local programs. Through these requirements, PEI Programs were to be utilized on the following Key Community Mental Health Needs and Priority Populations:

Key Community Mental Health Needs:

- Disparities in Access to Mental Health Services – Reduce disparities in access to early mental health interventions due to stigma, lack of knowledge about mental health services or lack of suitability (i.e., cultural competency) of traditional mainstream services.
- Psycho-Social Impact of Trauma – Reduce the negative psycho-social impact of trauma on all ages.
- At-Risk Children, Youth and Young Adult Populations – Increase prevention efforts and response to early signs of emotional and behavioral health problems among specific at-risk populations.
- Stigma and Discrimination – Reduce stigma and discrimination affecting individuals with mental illness and mental health problems.
- Suicide Risk – Increase public knowledge of the signs of suicide risk and appropriate actions to prevent suicide.

PEI Priority Populations:

- Underserved Cultural Populations – Projects that address individuals who are unlikely to seek help from any traditional mental health services whether because of stigma, lack of knowledge, or other barriers (such as members of ethnically/racially diverse communities, members of gay, lesbian, bisexual, transgender communities, etc.) and would benefit from PEI programs and interventions.
- Individuals Experiencing Onset of Serious Psychiatric Illness – Individuals identified by providers, including but not limited to primary health care, as presenting signs of mental illness first break, including individuals who are unlikely to seek help from any traditional mental health service.

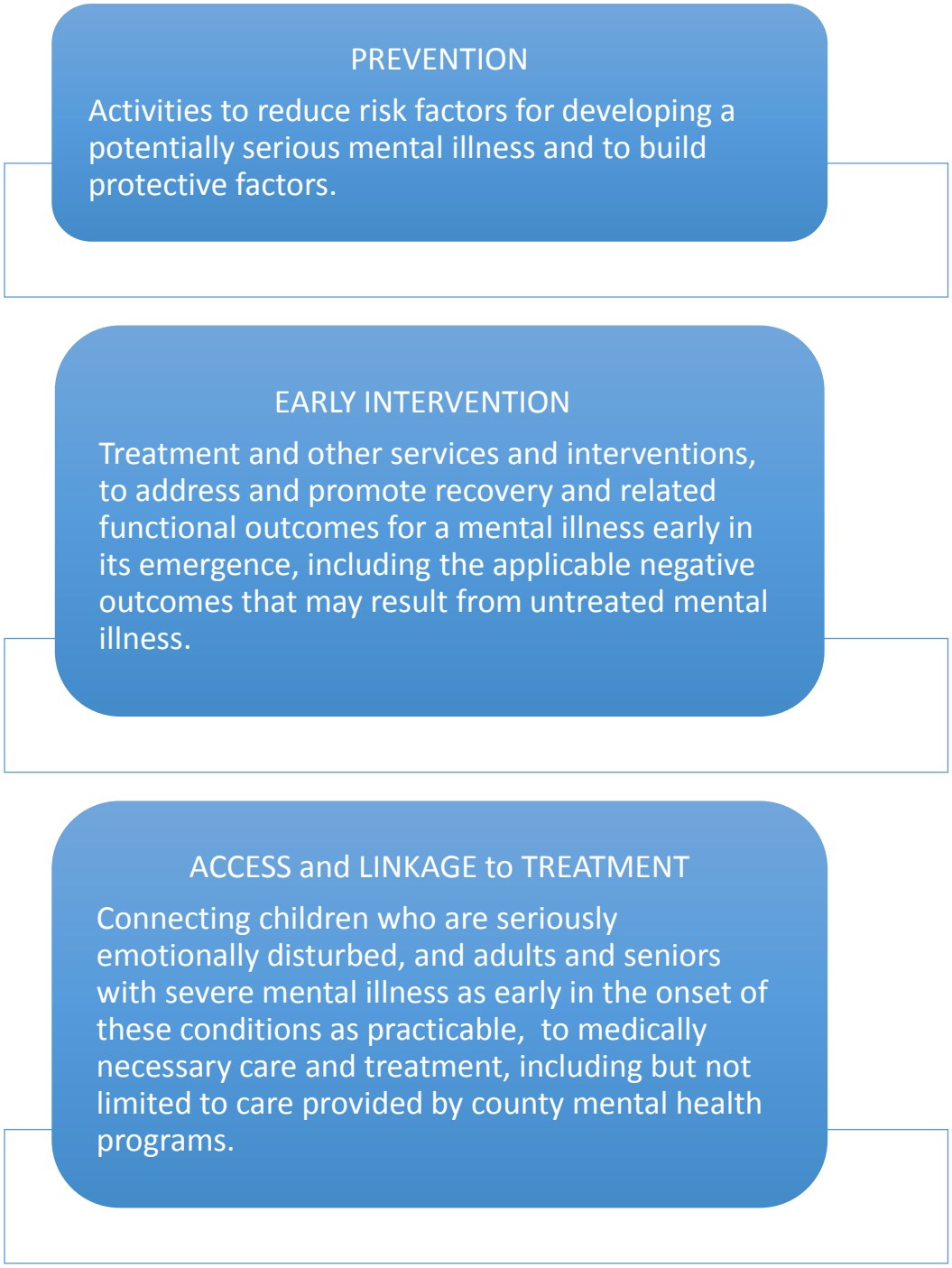
- Children and Youth in Stressed Families – Children and youth placed out-of-home or individuals in families where there is substance abuse or violence, depression or other mental illnesses or lack of caregiving adults (e.g., as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems.
- Trauma-Exposed – Individuals who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including individuals who are unlikely to seek help from any traditional mental health service.
- Children and Youth at Risk for School Failure – Due to unaddressed emotional and behavioral problems.
- Children and Youth at Risk of or Experiencing Juvenile Justice Involvement – Individuals with signs of behavioral/emotional problems who are at risk of or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through MHSA Community services and Supports funded services.

In April 2009, following a nine-month long Community Planning Process, the original City of Berkeley Prevention and Early Intervention plan was approved. Subsequent updates to the original plan were approved in October 2010, April 2011, May 2013, May 2014, June 2016, January 2017, July 2017 and October 2018. Based on the DMH Regulations, through the original PEI Plan (or subsequent updates) programs were created to address Key Community Mental Health Needs and PEI Priority Populations as follows:

PEI Program	Key Community Mental Health Needs	PEI Priority Populations
Behavioral-Emotional Assessment, Screening, Treatment and Referral – (BE A STAR)	➢ At-Risk Children, Youth and Young Adult Populations	• Children and Youth in Stressed Families • Children and Youth at Risk for School Failure • Underserved Cultural Populations
Supportive Schools (originally named "Building Effective Schools Together"-BEST)	➢ At-Risk Children, Youth and Young Adult Populations	• Children and Youth in Stressed Families • Children and Youth at Risk for School Failure • Underserved Cultural Populations
Community Education & Supports	➢ Psycho-social Impact of Trauma ➢ At-Risk Children, Youth and Young Adult Populations	• Trauma Exposed • Underserved Cultural Populations • Children/Youth in Stressed Families • Children and Youth at Risk for School Failure
Social Inclusion	➢ Stigma and Discrimination ➢ Psycho-social Impact of Trauma	• Trauma Exposed • Underserved Cultural Populations
Community Based Child & Youth Risk Prevention Program	➢ At-Risk Children, Youth and Young Adult Populations	• Children and Youth in Stressed Families • Children and Youth at Risk for School Failure

PEI Program	Key Community Mental Health Needs	PEI Priority Populations
		• Underserved Cultural Populations
High School Youth Prevention Project	➢ At-Risk Children, Youth and Young Adult Populations ➢ Disparities in Access to Mental Health services ➢ Psycho-social Impact of Trauma	• Trauma Exposed • Children and Youth in Stressed Families • Children and Youth at Risk for School Failure • Underserved Cultural Populations
Homeless Outreach & Treatment Team (HOTT)	➢ Psycho-social Impact of Trauma ➢ Disparities in Access to Mental Health services ➢ At-Risk Children, Youth and Young Adult Populations	• Underserved Cultural Populations • Trauma Exposed
Mental Health Peer Mentor Program	➢ At-Risk Children, Youth and Young Adult Populations ➢ Disparities in Access to Mental Health services ➢ Psycho-social Impact of Trauma	• Trauma Exposed • Children and Youth in Stressed Families • Children and Youth at Risk for School Failure • Underserved Cultural Populations
Dynamic Mindfulness Program	➢ At-Risk Children, Youth and Young Adult Populations ➢ Disparities in Access to Mental Health services ➢ Psycho-social Impact of Trauma	• Trauma Exposed • Children and Youth in Stressed Families • Children and Youth at Risk for School Failure • Underserved Cultural Populations

On October 6, 2015, updated PEI regulations designed by the Mental Health Services Oversight and Accountability Commission (MHSOAC) became effective. The updated regulations changed the PEI requirements. Per new PEI State Regulations, Mental Health jurisdictions are to utilize PEI funds to implement all of the following programs: Prevention, Early Intervention, Access and Linkage to Treatment, Stigma and Discrimination Reduction, and Outreach for Increasing Recognition of Early Signs of Mental Illness. Jurisdictions may also opt to utilize some PEI funds to implement a Suicide Prevention program. The definitions of each program are outlined below:


PREVENTION
Activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors.
EARLY INTERVENTION
Treatment and other services and interventions, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that may result from untreated mental illness.
ACCESS and LINKAGE to TREATMENT
Connecting children who are seriously emotionally disturbed, and adults and seniors with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs.

STIGMA and DISCRIMINATION REDUCTION

Activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

Engaging, encouraging, educating, and/or training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.

OPTIONAL - SUICIDE PREVENTION

Activities to prevent suicide as a consequence of mental illness.

Within each PEI program the following strategies must also be implemented: Access and Linkage, Improve Timely Access, and Reduce and Circumvent Stigma. The definitions of each strategy are outlined below:

Access and Linkage	Improve Timely Access	Reduce and Circumvent Stigma
• Activities that engage and connect youth, adults, and seniors with severe mental illness, as early in the onset of the condition as practicable, to medically necessary care and treatment.	• Improve timely access to mental health services for underserved populations through accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services	• Reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, or seeking mental health services. Make services accessible, welcoming, and positive.

The new PEI Regulations, also included program and demographic data requirements that are to be reported to the MHSOAC through Annual and Triennial PEI Evaluation Reports. The following pages outline the PEI Program and Demographic reporting requirements:

PEI PROGRAM REQUIREMENTS

PROGRAM TYPE	PROGRAM DEFINITION	PROGRAM AND DATA COLLECTION REQUIREMENTS
Prevention	A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors.	➢ Describe the target population- type of risk(s) and the criteria used for establishing/identifying those at risk ➢ Measure the impact of one or more of the negative outcomes listed in the MHSA (suicide, incarcerations, school failure or dropout, unemployment, homelessness, and removal of children from their homes) ➢ Demonstrate the use of an evidence-based or promising practice or a community or practice-based evidence standard* ➢ Collect all PEI demographic variables
Early Intervention	Treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that may result from untreated mental illness.	➢ Provide services that do not exceed 18 months ➢ Program may include services to parents, caregivers, and other family members of the person with early onset of a mental illness. ➢ Program may be combined with a Prevention program ➢ Measure the impact of one or more of the negative outcomes listed in the MHSA (suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes). ➢ Demonstrate the use of an evidence-based or promising practice or a community or practice-based evidence standard* ➢ Collect all PEI demographic variables
Access and Linkage to Treatment	Connecting children who are seriously emotionally disturbed, and adults and seniors with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs.	➢ Collect # of unduplicated individuals served ➢ Collect # of unduplicated referrals made to a Treatment program (and type of program) ➢ Collect # of individuals who followed through (participated at least once in Treatment) ➢ Measure average time between referral and engagement in services per each individual ➢ Measure duration of untreated mental illness (interval between onset of symptoms and start of treatment)per each individual ➢ Collect all PEI demographic variables
Stigma and Discrimination Reduction	Direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness,	➢ Collect the number of individuals reached by activity (e.g., # who participated in each service or activity)

PROGRAM TYPE	PROGRAM DEFINITION	PROGRAM AND DATA COLLECTION REQUIREMENTS
	having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.	➢ Measure changes in attitude, knowledge, and/or behavioral related to seeking mental health services or related to mental illness ➢ Collect all PEI demographic variables
Outreach for Increasing Recognition of Early Signs of Mental Illness	A process of engaging, encouraging, educating, and/or training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.	➢ May include reaching out to individuals with signs and symptoms of a mental illness, so they can recognize and respond to their own symptoms. ➢ May be a stand-alone program, a strategy within a Prevention program, a strategy within an Early Intervention program, a strategy within another program funded by PEI funds, or a combination thereof. ➢ Unduplicated # of individual potential responders ➢ The types of potential responders engaged in each setting (e.g., nurses, principals, parents, etc.) ➢ The # and kind of settings in which the potential responders were engaged ➢ Measure impact to 1 or more of the negative outcomes listed in the Act (suicide, incarcerations, school failure or dropout, unemployment, homelessness, and removal of children from their homes) ➢ Collect all demographic variables for all unduplicated individual potential responders
OPTIONAL Suicide Prevention	Activities to prevent suicide as a consequence of mental illness.	➢ Collect available #of individuals reached ➢ Collect # of individuals reached be activity (ex. # trained, # who accessed website) ➢ Select and use a validated method to measure changes I attitudes, knowledge and/or behavior regarding suicide related mental illness ➢ Collect all PEI demographic variables for all individuals reached

* Evidence-based practice standard: Activities for which there is scientific evidence consistently showing improved mental health outcomes for the intended population, including, but not limited to, scientific peer-reviewed research using randomized clinical trials.
Promising practice standard: Programs and activities for which there is research showing positive outcomes, but the research does not meet the standards used to establish evidence-based practices and does not have enough research or replication to support generalizable positive public health outcomes.
Community and/or practice-based evidence standard: A set of practices that communities have used and determined to yield positive results by community consensus over time, which may or may not have been measured empirically. Takes a number of factors into consideration, including worldview, historical, and social contexts of a given population or community, which are culturally rooted.

PEI Demographic Reporting Requirements

For the information reported under the various program categories, each program will need to report disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services by:

(A) The following Age groups:

- 0-15 (children/youth)
- 16-25 (transition age youth)
- 26-59 (adult)
- ages 60+ (older adults)
- Number of respondents who declined to answer the question

(B) Race by the following categories:

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or other Pacific Islander
- White
- Other
- More than one race
- Number of respondents who declined to answer the question

(C) Ethnicity by the following categories:

(i) Hispanic or Latino as follows

- Caribbean
- Central American
- Mexican/Mexican-American/Chicano
- Puerto Rican
- South American
- Other
- Number of respondents who declined to answer the question

(ii) Non-Hispanic or Non-Latino as follows

- African
- Asian Indian/South Asian
- Cambodian
- Chinese
- Eastern European
- European
- Filipino
- Japanese
- Korean
- Middle Eastern
- Vietnamese
- Other
- Number of respondents who declined to answer the question
- More than one ethnicity

(D) Primary language used listed by threshold languages for the individual county

- English
- Spanish
- Number of respondents who declined to answer the question

(E) Sexual orientation

- Gay or Lesbian
- Heterosexual or Straight
- Bisexual
- Questioning or unsure of sexual orientation
- Queer
- Another sexual orientation
- Number of respondents who declined to answer the question

(F) Disability, defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness

- If Yes, report the number that apply in each domain of disability(ies)
  - Communication domain separately by each of the following:
    - difficulty seeing,
    - difficulty hearing, or having speech understood)
    - other, please specify
  - Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)
  - Physical/mobility domain
  - Chronic health condition (including but not limited to chronic pain)
  - Other (specify)
- No
- Number of respondents who declined to answer the question

(G) Veteran Status,

- Yes
- No
- Number of respondents who declined to answer the question

(H) Gender

(i) Assigned sex at birth:
(a) Male
(b) Female
(c) Number of respondents who declined to answer the question

(ii) Current gender identity:
(a) Male
(b) Female
(c) Transgender
(d) Genderqueer
(e) Questioning or unsure of gender identity
(f) Another gender identity
(g) Number of respondents who declined to answer the question

Effective July 2018 amended PEI regulations specifed the following:

- For projects/programs serving children or youth younger than 18 years of age, the demographic information collected and reported should only be done so to the extent permissible by privacy laws.
- For projects/programs serving minors younger than 12 years of age, demographic information shall be collected and reported, except for sexual orientation, current gender identity, and veteran status.
- Information that cannot be obtained directly from the minor may be obtained from the minor's parent, legal guardian, or other authorized source.

CITY OF BERKELEY PEI PROGRAMS

Upon the release of the new PEI Regulations, the City of Berkeley programs were reviewed to evaluate whether programs that were already funded would fit into the new required PEI Program definitions. As a result, local PEI funded programs were re-classified from the previous construct, into the following:

STATE REQUIRED PEI PROGRAMS	CITY OF BERKELEY PEI PROGRAMS
Combined Prevention and Early Intervention	• Be A Star • High School Youth Prevention Project • Community Based Child & Youth Risk Prevention Program • Mental Health Peer Education Program* • Dynamic Mindfulness Program*
Early Intervention	• Supportive Schools Program • Community Education & Supports Projects
Access and Linkage to Treatment	• Homeless Outreach & Treatment Team
Stigma and Discrimination Reduction	• Social Inclusion Project
Outreach for Increasing Recognition of Early Signs of Mental Illness	• High School Youth Prevention Project

*This project was added through the MHSA FY19 Annual Update

The City then assessed the current capacity both internal and at Contractor sites that would be necessary to collect and evaluate the new PEI Data and quickly realized there were very limited resources and staffing available. Beginning in FY18, as a measure to provide resources to assist with the collection of data at Contractor sites, additional funds were added to each PEI funded contract.

Additionally, within FY18, the City of Berkeley Health, Housing and Community Services (HHCS) Department began the roll-out of "Impact Berkeley" in various Public Health and Mental Health programs. "Impact Berkeley" is an evaluation that utilizes the methodology of "Results Based Accountability" (RBA), which seeks to answer how many individuals are being served, how well the program is providing services, and whether participants are better off as a result of participating in the program, or receiving services. Through this initiative the Department envisioned, clarified, and developed a common language about the

outcomes and results that each program seeks to achieve, and then began implementing a rigorous framework to measure and enhance programs towards these results. The first part of this roll-out included the PEI Community Education & Supports Program contracted services. In FY18, staff began working with PEI funded Contractors both on establishing measures for "Impact Berkeley" and for PEI program requirements. Results of the first year of the RBA Evaluation are captured in this report and will continue to be reported in future PEI Evaluation Reports.

This Three Year PEI Evaluation Report documents program measures and demographic elements to the extent data was available. While, it may be a multi-year process before the City of Berkeley will be able to present a complete data set for each PEI Program on an Annual basis, ongoing efforts will continue towards accomplishing this goal.

PREVENTION AND EARLY INTERVENTION COMBINED PROGRAMS

Behavioral-Emotional Assessment, Screening, Treatment, and Referral (BE A STAR)

The Be A Star program is a collaboration with the City of Berkeley's Public Health Department providing a coordinated system in Berkeley and Albany that identifies children birth to age five and their parents, who are at risk of childhood development challenges including developmental, social, emotional, and/or behavioral concerns. The program specifically targets low income families, including those with teen parents, who are homeless, substance abusing, or in danger of foster care. Services include triage, assessment, treatment and referrals to appropriate community-based or specialist services as needed. Children and families are accessed through targeted efforts at the following: Black Infant Health; Vera Casey Teenage Parenting programs; Child Health and Disability Prevention programs, Pediatric providers, and through state-subsidized Early Childhood Development Centers. The goals of the program are to identify, screen and assess families early, and connect them with services and supports as needed. The program uses the "Ages and Stages Questionnaires" (ASQ) screening tool to assess children in need. The ASQ consists of a series of 20 questionnaires that correspond to age intervals from birth to 6 years designed to help parents check their child's development. Each questionnaire contains simple questions for parents to answer that reflect developmental milestones for each age group. Answers are scored and help to determine whether the child's development is on schedule or whether the child should be referred for a developmental checkup with a professional. Over 400 children are assessed each year.

PEI Goals: The goal of this program is to bring about mental health, including the reduction of school failure and the removal of children from their homes.

In FY17, a total of 455 children were reached through this program. At Berkeley Unified School District (BUSD) this program reached 370, 3-5 year olds. A total of 59 of the children reached were already receiving services through an Independent Education Plan (IEP). A total of 296 ASQ's were returned and scored. Through these screenings, 45 children scored in the "Of Concern" range. Outlined below is a breakdown of the BUSD Preschool ASQ screening results of children in the "of concern" range:

BUSD Preschool	Number Screened	Screening Results "Of Concern"	% Scored of Concern
Franklin	150	26	17.3%
King	74	12	16.2%
Hopkins	72	7	9.7%

As a result of the BUSD ASQ screenings, 49 referrals were made to the following services:
25 to Mental Health services; 11 to BUSD Special Education; 13 to other area Districts Special Education services.

A total of 85 additional ASQ's were administered by Public Health nurses during home visits. Of the 85 completed ASQ's, 8% scored in the "of concern" range and 27% scored in the "monitoring" range. Children who received scores in the "Of Concern" range were referred to their pediatrician for follow-up and those receiving scores in the "monitor only" range were screened again at a later date (usually between 2-6 months later).

Demographics on all children who received outreach and/or screenings were as follows:

PARTICIPANT DEMOGRAPHICS N=455	
Age Groups	
0-15 (Children/Youth)	100%
Race	
Black or African American	23%
Asian	23%
White	9%
Other	31%
More than one race	6%
Declined to Answer (or Unknown)	8%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American/Chicano	31%
Ethnicity: Non-Hispanic or Non-Latino	
Declined to Answer (or Unknown)	69%
Primary Language Used	
Declined to Answer (or Unknown)	100%
Sexual Orientation	
Declined to answer (or Unknown)	100%
Disability	
Declined to answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Gender Assigned at Birth	
Declined to answer (or Unknown)	100%
Current Gender Identity	
Declined to answer (or Unknown)	100%

In FY18, at Berkeley Unified School District (BUSD) 345 children were reached through this program. A total of 49 of the children reached were already receiving services through an Independent Education Plan (IEP). A total of 280 ASQ's were returned and scored. Through these screenings, 36 children scored in

the "Of Concern" range. Outlined below is a breakdown of the BUSD Preschool ASQ screening results of children in the "of concern" range:

BUSD Preschool	Number Screened	Screening Results "Of Concern"	% Scored of Concern
Franklin	171	15	9%
King	74	12	16%
Hopkins	72	7	10%

As a result of the BUSD ASQ screenings, 148 referrals were made to the following services:
28 to Mental Health services; 26 to BUSD Special Education; 38 Speech Services; 56 to BUSD "Response To Intervention (RTI)" services.

Demographics on children who received outreach and/or screenings at BUSD were as follows:

PARTICIPANT DEMOGRAPHICS N=345	
Age Groups	
0-15 (Children/Youth)	100%
Race	
Black or African American	23%
Asian	15%
White	4%
Other	30%
More than one race	12%
Declined to Answer (or Unknown)	16%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American/Chicano	24%
Ethnicity: Non-Hispanic or Non-Latino	
Declined to Answer (or Unknown)	6%
Primary Language Used	
Declined to Answer (or Unknown)	100%
Disability	
Declined to answer (or Unknown)	100%
Gender: Gender Assigned at Birth	
Declined to answer (or Unknown)	100%

High School Youth Prevention Program

This program operates in conjunction with other health related services offered at Berkeley High School (BHS) and Berkeley Technology Academy (BTA) to provide young people with the information and individual support they need to make positive and healthy decisions in their lives. The program includes: outreach activities designed to provide students with basic information around the risks of certain behaviors, and ways to protect themselves and make positive and safer decisions; classroom presentations to enable students to receive more in-depth information around a variety of health topics and available resources, and provide the opportunity for students to do a personal assessment of risk and current lifestyle choices; drop-in crisis and counseling services; individual appointments to identify young people who may need more intensive intervention; and short-term treatment. The individual appointments, held at the school-based health center, provide young people with the opportunity to hold very in-depth discussions around the choices they are making and the risks that are involved in their choices. They receive guidance about changes they can make to reduce or eliminate their risks, and are given the opportunity to identify barriers that might exist for them that prevent them from making healthier choices. In addition, they complete a 40 question, in-depth HEADSSS (Home, Education, Activities, Drugs/Alcohol, Sexuality, Safety, Suicidality) assessment. Based on the outcome of the individual appointment and/or assessment, a young person may be referred to either a medical or mental health professional for follow-up care and intervention and/or treatment. Approximately 2600 Berkeley High School Students and 100 B-Tech students receive some level of services through this program each year.

This program was implemented in FY13 and has become a successful partnership between BUSD and the Public Health and Mental Health Divisions of Berkeley's HHCS Department. As the program has developed, the staffing structure for the program has increased and evolved to better meet the needs of the participants of both BHS and B-Tech. Additionally, BMH has been involved in implementing and assessing the Cognitive, Behavioral, Intervention for Trauma in Schools (CBITS) as a model of care at these locations. The need for additional supports and resources for this program will continue to be accessed and adjusted accordingly.

PEI Goals: The goal of this program is to bring about mental health, including the reduction of school failure or dropout.

In FY17, approximately 3,652 students received services through this project with 1,215 students receiving mental health services. Demographics on the total number served were as follows:

PARTICIPANT DEMOGRAPHICS N=3,652	
Age Groups	
0-15 (Children/Adult)	22%
16-25 (Transition Age Youth)	78%
Race	
American Indian or Alaska Native	1%
Asian	5%

Black or African American	24%
Native Hawaiian or Pacific Islander	1%
White	29%
Other	2%
More than one Race	18%
Declined to Answer (or Unknown)	1%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American/Chicano	20%
Ethnicity: Non-Hispanic or Non-Latino	
Declined to Answer (or Unknown)	80%
Primary Language	
English	93%
Spanish	7%
Sexual Orientation	
Gay or Lesbian	1%
Heterosexual or Straight	96.3%
Bisexual	2.6%
Declined to Answer (or Unknown)	.1%
Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	21%
Female	77%
Declined to Answer (or Unknown)	2%
Current Gender Identity	
Male	21%
Female	77%
Transgender	>.1%
Declined to Answer (or Unknown)	1.4%

Demographics on the students receiving ongoing counseling services were as follows:

PARTICIPANT DEMOGRAPHICS N=1,215	
Age Groups	
0-15 (Children/Adult)	22%
16-25 (Transition Age Youth)	78%
Race	
Asian	8%
Black or African American	25%
Native Hawaiian or Pacific Islander	3%
White	24%
Other	28%
More than one Race	12%
Ethnicity: Hispanic or Latino	
Central American	6%
Mexican/Mexican-American/Chicano	19%
Declined to Answer (or Unknown)	3%
Ethnicity: Non-Hispanic or Non-Latino	
Declined to Answer (or Unknown)	72%
Primary Language	
English	82%
Spanish	16%
Declined to Answer (or Unknown)	2%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%

Gender: Assigned sex at birth	
Male	34%
Female	64%
Declined to Answer (or Unknown)	2%
Current Gender Identity	
Male	34%
Female	64%
Declined to Answer (or Unknown)	2%

In FY18, approximately 1,260 students received services through this project, and 264 students received ongoing mental health services for a total of 738 visits. Demographics on the total number served were as follows:

PARTICIPANT DEMOGRAPHICS N=1,260	
Age Groups	
0-15 (Children/Adult)	6%
16-25 (Transition Age Youth)	13%
Declined to Answer (or Unknown)	81%
Race	
Asian	4%
Black or African American	23%
White	30%
Other	22%
More than one Race	17%
Declined to Answer (or Unknown)	4%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American/Chicano	18%
Ethnicity: Non-Hispanic or Non-Latino	
Declined to Answer (or Unknown)	80%
Primary Language	
Declined to Answer (or Unknown)	100%

Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	36%
Female	63%
Declined to Answer (or Unknown)	1%
Current Gender Identity	
Male	36%
Female	63%
Declined to Answer (or Unknown)	1%

Demographics on the 264 students receiving ongoing counseling services were as follows:

PARTICIPANT DEMOGRAPHICS N= 264	
Age Groups	
0-15 (Children/Adult)	27%
16-25 (Transition Age Youth)	73%
Race	
Asian	5%
Black or African American	28%
White	25%
Other	18%
More than one Race	18%
Declined to Answer (or Unknown)	6%
Ethnicity: Hispanic or Latino	
Declined to Answer (or Unknown)	18%
Ethnicity: Non-Hispanic or Non-Latino	
Declined to Answer (or Unknown)	100%

Primary Language	
Declined to Answer (or Unknown)	100%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	34%
Female	64%
Declined to Answer (or Unknown)	2%
Current Gender Identity	
Male	34%
Female	64%
Declined to Answer (or Unknown)	2%

Community-Based Child & Youth Risk Prevention Program

This program targets children and youth from un-served, underserved, and inappropriately served populations who are impacted by multiple risk factors including trauma, family or community violence, familial distress, and/or family substance abuse, (among other issues). The program is primarily community-based with some supports also provided in a few area schools. A range of psycho-educational activities provide information and supports for those in need. Services also include assessment, brief treatment, case management, and referrals to long term providers and other resources as needed. The main goals are to reduce risk factors or other stressors, and promote positive cognitive, social, and emotional well-being. This program serves approximately 50 Children & Youth a year.

PEI Goals: The goal of this program is to bring about mental health including the reduction of school failure and the removal of children from their homes.

In FY17, The City of Berkeley was not able to implement this program due to staff turnover and vacancies.

In FY18, a total of 67 children (aged 0-5) were served through this program. Demographics on those served were as follows:

PARTICIPANT DEMOGRAPHICS N=67	
Age Groups	
0-15 (Children/Adult)	100%
Race	
Asian	9%
Black or African American	48%
White	13%
Other	28%
More than one Race	2%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American/Chicano	7%
Ethnicity: Non-Hispanic or Non-Latino	
Declined to Answer (or Unknown)	93%
Primary Language	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Gender: Assigned sex at birth	
Male	60%
Female	40%
Current Gender Identity	
Male	60%
Female	40%

Mental Health Peer Education Program

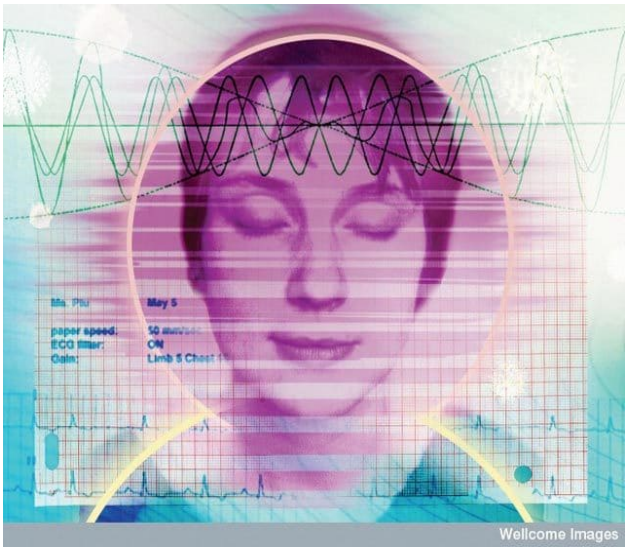
The Mental Health Peer Education Program was added through the MHSA FY19 Annual Update. This program implements a mental health curriculum for 9th graders, and an internship program for a cohort of high school students, in Berkeley Unified School District (BUSD), in an effort to increase student awareness of common mental health difficulties, resources, and healthy coping and intervention skills. Through this program students are trained by a licensed BUSD clinician to conduct class presentations covering common mental health disorders, on and off campus resources, as well as basic coping and intervention skills.

PEI Goals: The goal of this program is to bring about mental health, including the reduction of school failure or dropout.

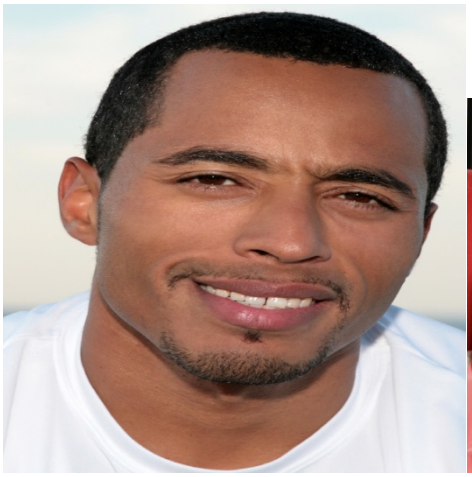
Dynamic Mindfulness Program (DMind)

The Dynamic Mindfulness (DMind) program was added through the MHSA FY19 Annual Update. DMind is an evidence-based trauma-informed program that will be in each of the BUSD middle and high schools. Validated by independent researchers as a transformative program for teaching children and youth, skills for optimal stress resilience and healing from trauma, the DMind program integrates mindful action, breathing, and centering into an intervention that can be implemented in the classroom in 5-15 minute sessions, 3 to 5 times a week. This program has proven to be successful with vulnerable students who are exhibiting signs of trauma/Post Traumatic Stress Disorder (PTSD) from Adverse Childhood Experiences (ACEs), and/or disengagement from school, chronic absences, and significant behavioral challenges, including emotion regulation, impulse control, and anger management. DMind also enables teacher well-being, which has been shown to enhance student learning. The program components include in-class and after-school DMind sessions for students, student peer leadership development, training and coaching of school staff, and program evaluation.

PEI Goals: The goal of this program is to bring about mental health, including the reduction of school failure or dropout.



EARLY INTERVENTION (ONLY) PROGRAMS



Supportive Schools Program

Through this program leveraged MHSA PEI funds provide resources to support mental health prevention and intervention services in the Berkeley Elementary schools. Services include: outreach; mental health programming; classroom, group, and one-on-one psycho-social education and support; and consultation with parents and/or teachers.

PEI Goals: The goal of this program is to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the reduction of school failure and the removal of children from their homes.

In FY17, approximately 1,072 youth participated in individual or group therapy services and 35 parents received consultation services. Demographic data on individuals served through this program included:

PARTICIPANT DEMOGRAPHICS N=1,107	
Age Group	
0-15 (Children/Youth)	97%
26-59 (Adult)	3%
Race	
American Indian or Alaska Native	3%
Asian	5%
Black or African American	22%
Native Hawaiian/Pacific Islander	<1%
White	33%
Other	<1%
More than one race	14%
Declined to Answer (or Unknown)	7%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American/Chicano	15%
Ethnicity: Non-Hispanic or Non-Latino	
African	1%
Asian Indian/South Asian	<1%
European	<1%
Filipino	<1%
Japanese	<1%
Korean	<1%

Middle Eastern	<1%
Vietnamese	<1%
More than one ethnicity	1%
Declined to answer (or Unknown)	80%
Primary Language Used	
English	8%
Spanish	4%
Mandarin	<1%
Declined to Answer (or Unknown)	88%
Sexual Orientation	
Declined to answer (or Unknown)	100%
Disability	
Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)	6%
Declined to answer (or Unknown)	94%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	47%
Female	38%
Declined to answer (or Unknown)	15%
Current Gender Identity	
Male	43%
Female	41%
Questioning or unsure of gender identity	<1%
Declined to answer (or Unknown)	16%

In FY18, approximately 830 youth participated in individual or group therapy services. Demographic data on individuals served through this program included:

PARTICIPANT DEMOGRAPHICS N=830	
Age Group	
0-15 (Children/Youth)	100%
Race	
American Indian or Alaska Native	4%
Asian	5%
Black or African American	23%
Native Hawaiian/Pacific Islander	<1%
White	37%
Other	1%
More than one race	14%
Declined to Answer (or Unknown)	15%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American/Chicano	1%
Ethnicity: Non-Hispanic or Non-Latino	
More than one ethnicity	8%
Declined to answer (or Unknown)	92%
Primary Language Used	
English	7%
Declined to Answer (or Unknown)	93%
Sexual Orientation	
Declined to answer (or Unknown)	100%
Disability	
Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)	3%
Declined to answer (or Unknown)	97%
Veteran Status	
No	100%

Gender: Assigned sex at birth	
Male	47%
Female	38%
Declined to answer (or Unknown)	15%
Current Gender Identity	
Male	46%
Female	39%
Questioning or unsure of gender identity	Unknown
Declined to answer (or Unknown)	15%

Community Education & Supports Program

The Community Education & Supports program implements culturally-responsive psycho-educational trauma support services for individuals (18 and above) in various cultural, ethnic and age specific populations that are unserved, underserved and inappropriately served in Berkeley and Albany including: African Americans; Asian Pacific Islanders; Latinos; LGBTQI; TAY; and Senior Citizens. All services are conducted through area community-based organizations.

In FY18 each of the Community Education & Supports contractors participated in the HHCS Results-Based Accountability (RBA) Evaluation. In this first year of RBA implementation results were presented in an aggregated format aggregated across all programs as follows:

How Much Did We Do?	How Well Did We Do It?	Is Anyone Better Off?
• 585 Support Groups/Workshops • 1,885 Support Group/Workshop Contacts • 129 Outreach Activities • 1,438 Outreach Contacts • 413 Referrals	• Participants attended 6 support groups or workshop sessions on average over year • More than 9 out of 10 survey respondents were satisfied with services • Referrals by type: 108 Mental Health 97 Social Services 82 Other 74 Physical Health 52 Housing	• 85% Survey respondents reported having increased feeling of social support and connection • 23% Improvement in truancy rate for participating Albany students • Survey respondents reported positive mental health changes

For additional detail on how various data variables were quantified and for full reporting on other data elements, access the full MHSA Plans and Updates - City of Berkeley, CA

Descriptions of services provided and numbers served through this project are outlined below:

Albany Trauma Project

Youth Support Groups: The use of Support Groups or Group Therapy are considered to be a highly effective and preferred intervention for adolescents who tend to be more likely to accept feedback from their peers than from adults. Through this project, separate weekly therapeutic support groups are provided at Albany High School and MacGregor High School for Asian Pacific Islander, Latino, and African American youth. Groups meet for 1-2 hours a week throughout the school year and are focused on helping participants process various traumatic events through the development of trust, close connections to each other, and creating a safe space for the expression and understanding of feelings.

PEI Goals: The goal of this program is to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the reduction of school failure or drop out.

In FY17, a total of 21 students participated in three separate Support Groups with a total of 449 group sessions. An additional 54 individual sessions were held among group participants. Throughout the year there was 1 Child Protective Services (CPS) report made and four suicide assessments were conducted.

Twenty-four students completed a questionnaire that was administered on the 3rd week of group. Questionnaire Results are outlined below:

QUESTIONNAIRE RESULTS N = 24	
QUESTIONS	**PARTICIPANT RESPONSES**
Have you lost someone close to you?	Yes – 75% No – 25%
Have you witnessed violence in your family?	Yes – 58% No – 42%
Have you witnessed violence in your home?	Yes – 42% No – 58%
Have you been a victim of violence or abuse?	Yes – 37% No – 63%
If yes, have you spoken to anyone about this?	Yes – 25% No – 12% Didn't answer – 63%
Do you feel that you've had the support in your life to cope effectively with the painful things you've experienced?	Yes - 63% No – 33% Didn't answer – 4%
Are you currently experiencing a lot of stress in your life?	Yes – 83% No – 17%
Do you use drugs or alcohol to help cope with your feelings, i.e. relax, calm down, quiet your mind, reduce anger, etc.?	Yes – 50% No – 50%

QUESTIONNAIRE RESULTS N = 24	
QUESTIONS	**PARTICIPANT RESPONSES**
Are there adults at your school who you can talk openly to about personal issues?	Yes – 50% No – 50%

Twenty-one students completed a questionnaire that was administered on the second to the last Support Group meeting. Results are outlined below:

QUESTIONNAIRE RESULTS N = 21	
QUESTIONS or STATEMENTS	**PARTICIPANT RESPONSES**
I felt welcomed into group.	Yes – 100%
I felt the group was a place I could express my feelings.	Yes – 90% Sometimes – 10%
I felt supported by other group members.	Yes – 95% Most times – 5%
Do you have support in your life to deal with the painful things you've experienced?	Yes - 90% Somewhat – 10%
Are you currently experiencing a lot of stress in your life?	Yes - 48% Kind of – 9% Not as much – 9% In the middle – 5% Not really – 19% No – 10%
Do you use drugs or alcohol to help cope with your feelings, i.e. relax, calm down, quiet your mind, reduce anger, etc.?	Yes – 14% Sometimes – 10% Kind of – 5% No – 71%
In the future, I would seek therapy or group counseling if I felt I needed help.	Yes – 62% Maybe – 33% No – 5%
Are there adults at your school who you can talk openly to about personal issues?	Yes – 90% Kind of – 5% No – 5%

According to the pre-test a vast majority of Group members had experienced significant trauma. Other traumas students had experienced which were discussed during Support Groups sessions had to do with

racism, immigration, loss of a parent, mental illness of a parent or sibling, parental alcoholism/addiction, adoption, significant early loss, divorce, extreme physical illness of a parent, poverty, rejection by parents, and living in highly chaotic and conflicted families. An unusually high number of students did not live with either of their parents which led them to feel further isolated and rejected.

In comparing the results of the questionnaires there was a marked increase in students who felt there was an adult at school they could speak with about personal issues, a significant decrease in students perception of stress in their lives, and a decrease in the number of Group members who indicated they used substances to manage their feelings. This seems to suggest that the Support Group experience helped participants to: engage in healthier coping strategies, and to feel less overwhelmed and more connected to each other and adults at school. Questionnaire results also suggest that Group members had a positive experience. All participants who completed the end of the group questionnaire responded that they felt welcomed into the group. Only two students indicated that they sometimes felt that the Group was a place they could talk about their feelings, all of the other participants indicated they could talk about their feelings in group. Additionally, only one student indicated they sometimes felt supported by their peers, while all other participants indicated that they felt supported by their peers. Lastly, a high percentage of students indicated if they needed help in the future, that they may seek Therapy or Group Counseling services.

Adult Support Groups: This project implements Outreach and engagement activities and support groups to Latino immigrant adults dealing with trauma issues, who live and work the backstretch of Golden Gate Field's race track as groomers; exercise jockeys and caretakers of the horses. Groups meet once a week from 1-2 hours each and utilize strength-based and indigenous activities focused on increasing positive communication and coping skills to support participants through issues of acculturation, immigration, and dislocation.

PEI Goals: The goal of this project is to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the prevention of suicide.

In FY17, 289 individuals participated in either individual or group counseling, case management services, weekly workshop activities, or community group events. All participants had a myriad of basic living and mental health needs and many were isolated and illiterate. In addition to the weekly support groups many participated in special holiday celebrations and activities (such as celebrations of Dia de los muertos and Virgin de Guadalupe) that were offered through this project to build community, and support issues of healing.

This project has continued to be a key source of reaching a community that otherwise would not have resources. It is structured to take into account the barriers those living and working on the backstretch experience in accessing services, including complicated work hours, difficulty getting transportation, as well as their levels of acculturation, language and experience. Self-report from multiple participants' overtime, has indicated that having mental health resources come into the backstretch has been a strong support for them.

In FY17, there were a total of 289 individuals served through the Albany Trauma Project. Demographics on individuals served were as follows:

PARTICIPANT DEMOGRAPHICS N=289	
Age Group	
0-15 (Children/Youth)	3%
16-25 (Transition Age Youth)	11%
26-59 (Adult)	8%
60 and Over (Older Adult)	5%
Declined to Answer (or Unknown)	73%
Race	
Asian	2%
Black or African American	2%
Other	96%
Ethnicity: Hispanic or Latino	
Central American	8%
Mexican/Mexican-American/Chicano	88%
Ethnicity: Non-Hispanic or Non-Latino	
Declined to answer (or Unknown)	4%
Primary Language Used	
English	5%
Spanish	95%
Sexual Orientation	
Heterosexual	93%
Declined to answer (or Unknown)	7%
Disability	
Difficulty Seeing	1%
Physical/mobility domain	1%
Chronic health condition	1%
Declined to answer (or Unknown)	97%
Veteran Status	
No	100%

Gender: Assigned sex at birth	
Male	16%
Female	11%
	73%
Current Gender Identity	
Male	16%
Female	11%
Declined to answer (or Unknown)	73%

In FY18, a total of 38 students participated in three separate Support Groups with a total of 455 group sessions. An additional 77 individual sessions were held among group participants. Throughout the year there were 2 Child Protective Services (CPS) report made and four suicide assessments were conducted.

Thirty-two students completed a questionnaire that was administered on the 3rd week of group. Questionnaire Results are outlined below:

QUESTIONNAIRE RESULTS N = 32	
QUESTIONS	**PARTICIPANT RESPONSES**
Have you lost someone close to you?	Yes – 60% No – 40%
Have you witnessed violence in your family?	Yes – 71% No – 29%
Have you witnessed violence in your home?	Yes – 40% No – 60%
Have you been a victim of violence or abuse?	Yes – 32% No – 68%
If yes, have you spoken to anyone about this?	Yes – 60% No – 30% Didn't Answer – 10%
Do you feel that you've had the support in your life to cope effectively with the painful things you've experienced?	Almost Never – 6% Sometimes – 31% Often – 21% Usually – 18% Almost Always – 21% Didn't Answer – 3%
Do you use healthy ways to cope with stress in your life?	Almost Never – 6% Sometimes – 21% Often – 25% Usually – 31% Almost Always – 15%

	Didn't Answer – 2%
Do you use drugs or alcohol to help cope with your feelings, i.e. relax, calm down, quiet your mind, reduce anger, etc.?	Almost Never – 43% Sometimes – 25% Often – 6% Usually – 15% Almost Always – 9% Didn't Answer – 2%
Are there adults at your school who you can talk openly to about personal issues?	Yes – 69% No – 31%

Twenty-two students completed a questionnaire that was administered on the second to the last Support Group meeting. Results are outlined below:

QUESTIONNAIRE RESULTS N = 22	
QUESTIONS or STATEMENTS	**PARTICIPANT RESPONSES**
I felt welcomed into group.	Almost Never – 0% Sometimes – 0% Often – 4% Usually – 19% Almost Always – 75% Didn't Answer – 2%
I felt the group was a place I could express my feelings.	Almost Never – 0% Sometimes – 9% Often – 4% Usually – 22% Almost Always – 63% Didn't Answer – 2%
I felt supported by other group members.	Almost Never – 0% Sometimes – 0% Often – 9% Usually – 18% Almost Always – 72% Didn't Answer – 1%
Have you spoken to someone about the painful things you've experienced?	Almost Never - 4% Sometimes – 14% Often – 14% Usually – 47% Almost Always – 19% Didn't Answer – 2%
Do you feel that you have support in your life to deal with painful things you've experienced?	Almost Never – 0% Sometimes – 18% Often – 18% Usually – 27% Almost Always – 36%

	Didn't Answer – 1%
Do you use healthy ways to cope with the stress in your life?	Almost Never – 0% Sometimes – 21% Often – 31% Usually – 28% Almost Always – 18% Didn't Answer – 2%
Do you use drugs or alcohol to help cope with your feelings, i.e. relax, calm down, quiet your mind, reduce anger, etc.?	Almost Never – 59% Sometimes – 13% Often – 4% Usually –18% Almost Always – 4% Didn't Answer – 2%
Are there adults at your school who you can talk openly to about personal issues?	Yes – 68% No – 22% Sometimes – 9% Didn't Answer – 1%
Would you recommend this group to a friend?	Yes – 90% No – 0% Maybe – 10%

Results from the pre and post group questionnaires suggest that without exception group members reported positive experience in the support groups. All students who completed the post-group questionnaire responded that they felt welcomed into the group, and felt supported by other group members and selected either "Often, Usually, or Almost Always" as their responses. All students except for 2 (who responded "maybe") responded "yes" to the question: "I would recommend this group to a friend." In addition, students' responses in the "Dear Group Letter" indicated a highly positive experience in the groups.

Per questionnaire results there was an increase in the following: students felt more supported in their lives, used healthy coping strategies more often, decreased their use of alcohol and drug use as a way to manage their feelings, and attended school with more frequency.

Adult Support Groups: Over the course of FY18 this project has migrated to more of a one-on-one engagement and support project with occasional drumming and other cultural and strength building group activities. Approximately 35 unduplicated individuals participated in either one-on-one engagement or community group events.

In FY18, a total of 73 unduplicated individuals were served through the Albany Trauma Project. Demographics on individuals served were as follows:

PARTICIPANT DEMOGRAPHICS N=73	
Age Group	
16-25 (Transition Age Youth)	62%
26-59 (Adults)	29%
60+ (Older Adults)	9%
Race	
Asian	22%
Black or African American	12%
Native Hawaiian or other Pacific Islander	3%
White	15%
Other	48%
Ethnicity: Hispanic or Latino	
Central American	4%
Mexican/Mexican-American/Chicano	59%
South American	1%
Ethnicity: Non-Hispanic or Non-Latino	
African	12%
Asian Indian/South Asian	3%
Chinese	16%
Filipino	1%
Japanese	4%
Primary Language Used	
English	26%
Spanish	60%
Mandarin	7%
Other	7%
Sexual Orientation	
Gay or Lesbian	1%
Heterosexual or Straight	90%
Bisexual	4%

Questioning or Unsure	2%
Declined to Answer (or Unknown)	3%
Disability	
No Disability	52%
Difficulty Hearing or Having Speech Understood	4%
Physical/Mobility Disability	8%
Chronic Health Condition	5%
Declined to Answer (or Unknown)	31%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	62%
Female	38%
Current Gender Identity	
Male	62%
Female	38%

Living Well Project

Implemented through Center for Independent Living, this project provides services for Senior Citizens (aged 50 and over) who are coping with trauma and/or mental health issues associated with acquired disabilities. Senior Citizens with acquired disabilities are one of the most difficult groups to reach with disability services. It is similarly difficult to intervene with this group's developing mental health issues related to aging and the traumatic impact of acquiring one or more disabilities (such as loss of mobility, vision, hearing, et al). The core of the project is a wellness workshop series entitled "Living Well with a Disability". Through a combination of education, goal setting, group and peer counseling, the workshop series is designed to promote positive attitudinal shifts in a population who, despite the tremendous need for care, are often typically not responsive to mental health intervention. The workshop series includes a 10 week, one to two hour class conducted by Peer Facilitators, and an optional 30 minute counseling session. Counseling sessions are designed to monitor curriculum impact and continually assess individual goals and resource needs. This project serves up to 150 Older Adults a year.

PEI Goals: The goal of this program is to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the prevention of suicide.

In FY17, eight workshop cycles were conducted, five of the workshops were the "Living Well" series and three were "Continuing to Live Well" series, as it has been found that seniors with significant long-term goals want and need more than one workshop cycle to reach and maintain their goals. Each Living Well Workshop Series included the following sessions: Orientation; Goal Setting; Problem Solving; Healthy Reactions; Beating the Blues (Depression and Moods); Healthy Communication; Seeking Information; Physical Activity; Eating Well (Nutrition); Advocacy (Self and Systems Change); and Maintenance. Topics of Grief and Loss, Depression, Retirement, and Senior Invisibility were also incorporated into the program. By participant self-report, the Living Well Workshop Series was very helpful, with many reporting that they wanted the workshops to be extended for a longer period of time. This program also hosted outreach and informational events. In all approximately 205 Senior Citizens participated in some aspect of this program with 54 participating in the Living Well Workshops.

Demographics of Workshop participants are outlined below:

PARTICIPANT DEMOGRAPHICS N=54	
Age Groups	
26-59 (Adult)	9%
Ages 60+ (Older Adult)	91%
Race	
American Indian or Alaska Native	2%
Black or African American	63%
White	20%
Other	7%
Declined to Answer (or Unknown)	8%
Ethnicity: Hispanic or Latino	
Caribbean	4%
Central American	2%
Mexican/Mexican-American/Chicano	4%
Puerto Rican	2%
South American	2%
Other	5%
Ethnicity: Non-Hispanic or Non-Latino	
African	4%
Other	19%
Declined to Answer (or Unknown)	58%

Primary Language Used	
English	93%
Spanish	7%
Sexual Orientation	
Heterosexual or Straight	76%
Declined to Answer (or Unknown)	24%
Disability	
Difficulty seeing	7%
Difficulty hearing	9%
Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)	17%
Physical/mobility domain	28%
Chronic health condition	37%
Declined to Answer (or Unknown)	11%
Veteran Status	
Yes	9%
No	89%
Declined to Answer (or Unknown)	2%
Gender: Assigned sex at birth	
Male	20%
Female	76%
Declined to Answer (or Unknown)	4%
Current Gender Identity	
Male	20%
Female	70%
Declined to Answer (or Unknown)	10%

In FY18, eight workshop cycles were conducted, five of the workshops were the "Living Well" series and three were "Continuing to Live Well" series. Each Living Well Workshop Series included the following sessions: Orientation; Goal Setting; Problem Solving; Healthy Reactions; Beating the Blues (Depression and Moods); Healthy Communication; Seeking Information; Physical Activity; Eating Well (Nutrition); Advocacy (Self and Systems Change); and Maintenance. Topics of Grief and Loss, Depression, Retirement,

and Senior Invisibility were also incorporated into the program. As with FY18, in FY19 participants reported the Living Workshop Series to be very helpful with many reporting that they they wanted the workshops to be extended for a longer period of time.

In all approximately 81 Senior Citizens participated in some aspect of this program in FY18 with 59 participating in the Living Well Workshops. Demographics of Workshop participants are outlined below:

PARTICIPANT DEMOGRAPHICS N=59	
Age Groups	
26-59 (Adult)	5%
Ages 60+ (Older Adult)	93%
Declined to Answer (or Unknown)	2%
Race	
Asian	3%
Black or African American	50%
Native Hawaiian or Other Pacific Islander	1%
White	20%
Other	13%
More than one race	3%
Declined to Answer (or Unknown)	10%
Ethnicity: Hispanic or Latino	
Caribbean	3%
Central American	2%
South American	2%
Other	18%
Declined to Answer (or Unknown)	75%
Ethnicity: Non-Hispanic or Non-Latino	
African	7%
Chinese	3%
European	5%
More than one Ethnicity	2%
Other	10%
Declined to Answer (or Unknown)	73%

Primary Language Used	
English	98%
Spanish	2%
Sexual Orientation	
Gay or Lesbian	2%
Heterosexual or Straight	66%
Questioning or Unsure	2%
Declined to Answer (or Unknown)	30%
Disability	
Difficulty seeing	11%
Difficulty hearing or Having Speech Understood	7%
Mental (not mental health)	17%
Physical/mobility disability	26%
Chronic health condition	17%
No Disability	17%
Declined to Answer (or Unknown)	5%
Veteran Status	
Yes	3%
No	80%
Declined to Answer (or Unknown)	17%
Gender: Assigned sex at birth	
Male	22%
Female	47%
Declined to Answer (or Unknown)	31%

Current Gender Identity	
Male	19%
Female	37%
Transgender	44%

Harnessing Hope Project

Implemented through GOALS for Women this project provides community-based, culturally competent, outreach and support services for African Americans residing in the South and West Berkeley neighborhoods who have experienced traumatic life events including racism and socioeconomic oppression and have unmet mental health support needs. The primary goals of the project are to normalize stress responses and empower families through psycho-education, consciousness raising, strength-based coping skills, and supportive services through the following: Outreach and engagement; screening and assessment; psycho-education; family education; support groups such as "Kitchen Table Talk groups (non-stigmatizing, culturally responsive, peer centered groups) and "Just Like Sunday Dinners" (a space for African Americans from all generations to come together to gain supports from one another); workshops and classes; mental health referrals and community linkages; peer counseling and support. A key component of this project is to train and mentor community leaders to become Peer Facilitators of Kitchen Table Talk groups. This project serves approximately 50-130 individuals a year.

PEI Goals: The goal of this program is to address and promote recovery and related functional outcomes for a mental illness early in its emergence including the prevention of suicide.

In FY17, the following activities were conducted through this project:

Outreach and Engagement: Outreach and engagement activities were conducted to approximately 107 women at various City locations, agencies and events to increase knowledge and the recognition of early signs of mental illness and to inform residents of project services.

Kitchen Table Talk Support Groups: These groups were designed to increase information and supports around current and historical trauma and to teach participants healthy coping skills. Approximately 27 African American women ranging in ages from 18-60, and youth ranging in ages from 12-16 participated in Kitchen Table Talk Support Groups. Group participants learned from each other and demonstrated their cultural strengths and resilience around effective ways to manage stress.

Peer Facilitator Training: Peer Facilitator Trainings were held to increase knowledge and skills around how to facilitate peer support groups through an African American cultural lens. Five individuals participated in the Peer Facilitator Trainings. Some participants went on to facilitate Kitchen Table Talk Support Groups, and were supported through mentoring sessions that were held to provide facilitators with support and skills around how to handle difficult group topics and issues.

In FY17, 33 individuals were served through this project. Demographics on individuals served through this project were as follows:

PARTICIPANT DEMOGRAPHICS N=33	
Age Groups	
0-15 (Children/Youth)	24%
16-25 (Transition Age Youth)	3%
26-59 (Adult)	37%
Ages 60+ (Older Adult)	12%
Declined to answer (or Unknown)	24%
Race	
Black or African American	88%
Asian	3%
More than one Race	6%
Declined to answer (or Unknown)	3%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American/Chicano	6%
Ethnicity: Non-Hispanic or Non-Latino	
Vietnamese	3%
East Asian	3%
Declined to Answer (or Unknown)	88%
Primary Language Used	
Declined to Answer (or Unknown)	100%
Sexual Orientation	
Heterosexual or Straight	27%
Declined to Answer (or Unknown)	73%
Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
Declined to Answer (or Unknown)	100%
Gender: Assigned sex at birth	
Male	9%
Female	82%
Declined to Answer	9%

Current Gender Identity	
Male	9%
Female	82%
Declined to Answer (or Unknown)	9%

In FY18 outreach was conducted to 109 individuals and 54 individuals received services through this project. Demographics on individuals served through this project were as follows:

PARTICIPANT DEMOGRAPHICS N=54	
Age Groups	
0-15 (Children/Youth)	8%
16-25 (Transition Age Youth)	5%
26-59 (Adult)	67%
Ages 60+ (Older Adult)	12%
Declined to Answer (or Unknown)	8%
Race	
Black or African American	87%
Asian	2%
White	8%
More than one Race	3%
Ethnicity: Hispanic or Latino	
Declined to Answer (or Unknown)	0%
Ethnicity: Non-Hispanic or Non-Latino	
African	1%
Declined to Answer (or Unknown)	99%
Primary Language Used	
English	100%
Sexual Orientation	
Heterosexual or Straight	91%
Questioning or Unsure	2%
Declined to Answer (or Unknown)	7%
Disability	
Declined to Answer (or Unknown)	100%

Veteran Status	
Yes	12%
No	81%
Declined to Answer (or Unknown)	7%
Gender: Assigned sex at birth	
Declined to Answer	100%
Current Gender Identity	
Male	25%
Female	71%
Other	4%

Trauma Support Project for LGBTQI Population

Implemented through the Pacific Center for Human Growth, this project provides outreach, engagement and support group services for individuals (18 and above) in the LGBTQI community who are suffering from the impact of oppression, trauma and other life stressors. Particular emphasis is on outreaching and providing supportive services to identified underserved populations within the local LGBTQI community. Approximately 12-15 weekly or bi-weekly support groups are held throughout the year targeting various populations and needs within the LBGTQI community. Support groups are led by Peer Facilitator community volunteers who are trained in Group Facilitation/Conflict Resolution and who have opportunities to participate in additional Skill Building workshops in order to share methods used to address group challenges and to learn new facilitator techniques. This project serves approximately 250 individuals a year.

PEI Goals: The goal of this program is to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the prevention of suicide.

In FY17, outreach to over 400 community members was conducted at various locations including Street Fairs, Community Agencies, and area events. During the reporting timeframe, a total of 16 new Peer Facilitators were trained. Fourteen Peer Facilitators attended Skill Building Consultation Trainings that were conducted on a monthly basis by the Program Manager. Seventeen ongoing peer support groups were held on a weekly or bi-weekly basis including the following: Queer Women; Butch-Stud; Female to Male; Women Coming Out; Middle-Aged Men; Married/Formerly Married Gay/Bisexual Men; Young Men; Queer Femmes; Transgender/Transsexual Support Group; Lesbians/Women of Color; Partners of Trans and Gender-Varient; Middle Eastern Women's Group; Senior Men; Bi-sexual Women; Aging Lesbians; Gender Varient Group; and QPAD – for Queer Men in their 20's and 30's.

In FY17, a total of 244 individuals participated in support groups throughout the year. Fourteen support group participants were referred to individual Mental Health Services. Demographics on individuals served through this program included the following:

PARTICIPANT DEMOGRAPHICS N=244	
Age Groups	
16-25 (Transition Age Youth)	28%
26-59 (Adult)	57%
Ages 60+ (Older Adult)	13%
Declined to Answer (or Unknown)	2%
Race	
American Indian or Alaska Native	2%
Asian	10%
Black or African American	8%
White	59%
More than one race	10%
Declined to Answer (or Unknown)	11%
Ethnicity: Hispanic or Latino	
Hispanic	10%
Ethnicity: Non-Hispanic or Non-Latino	
Non-Hispanic	90%
Primary Language Used	
English	84%
Spanish	1%
Declined to state (or Unknown)	15%
Sexual Orientation	
Gay or Lesbian	36%
Heterosexual or Straight	4%
Bisexual	17%
Questioning or unsure of sexual orientation	4%
Queer	26%
Another sexual orientation	6%
Declined to Answer (or Unknown)	7%
Disability	
Disabled	18%
Not disabled	73%

Declined to Answer (or Unknown)	9%
Veteran Status	
Yes	19%
No	73%
Declined to Answer (or Unknown)	8%
Gender: Assigned sex at birth	
Male	38%
Female	35%
Declined to Answer (or Unknown)	27%
Current Gender Identity	
Male	31%
Female	31%
Transgender	11%
Gender Non-conforming	25%
Declined to Answer (or Unknown)	2%

In FY18, outreach to over 1,000 community members was conducted at various locations including Street Fairs, Community Agencies, and area events. During the reporting timeframe, a total of 15 new Peer Facilitators were trained. Fourteen Peer Facilitators attended Skill Building Consultation Trainings that were conducted on a monthly basis by the Program Manager. Seventeen ongoing peer support groups were held on a weekly or bi-weekly basis including the following: Queer Women; Butch-Stud; Female to Male; Women Coming Out; Middle-Aged Men; Married/Formerly Married Gay/Bisexual Men; Young Men; Queer Femmes; Transgender/Transsexual Support Group; Lesbians/Women of Color; Partners of Trans and Gender-Varient; Middle Eastern Women's Group; Senior Men; Bi-sexual Women; Aging Lesbians; Gender Varient Group; and QPAD – for Queer Men in their 20's and 30's.

In FY18, a total of 164 individuals participated in support groups throughout the year. Fourteen support group participants were referred to individual Mental Health Services. Demographics on individuals served through this program included the following:

PARTICIPANT DEMOGRAPHICS N=164	
Age Groups	
16-25 (Transition Age Youth)	34%
26-59 (Adult)	56%
Ages 60+ (Older Adult)	10%

Race	
American Indian or Alaska Native	3%
Asian	6%
Black or African American	5%
Native Hawaiian or Other Pacific Islander	3%
White	63%
More than one race	10%
Declined to Answer (or Unknown)	10%
Ethnicity: Hispanic or Latino	
Central American	5%
Mexican/Mexican-American/Chicano	47%
Puerto Rican	5%
South American	10%
Decline to Answer (or Unknown)	33%
Ethnicity: Non-Hispanic or Non-Latino	
African	4%
Asian Indian/South Asian	2%
Chinese	3%
Eastern European	12%
European	58%
Filipino	1%
Japanese	1%
Korean	2%
Middle Eastern	5%
More than one Ethnicity	3%
Other	6%
Decline to Answer (or Unknown)	3%
Primary Language Used	
English	98%
Declined to Answer (or Unknown)	2%

Sexual Orientation	
Gay or Lesbian	33%
Heterosexual or Straight	2%
Bisexual	24%
Questioning or Unsure	4%
Queer	31%
Other	4%
Declined to Answer (or Unknown)	2%
Disability	
Other Disability	23%
No Disability	77%
Veteran Status	
Yes	9%
No	91%
Gender: Assigned sex at birth	
Male	31%
Female	67%
Declined to Answer (or Unknown)	2%
Current Gender Identity	
Male	22%
Female	38%
Transgender	9%
Genderqueer	21%
Questioning or Unsure	4%
Other	6%

Transition Age Youth Trauma Support Project

Implemented through Covenant House this project provides supportive services for Transition Age Youth (TAY) who are suffering from the impact of trauma and/or other life stressors and are homeless, marginally housed, or housed but in need of supports. The project serves a wide range of youth from various cultural and ethnic backgrounds who share the common goal of living lives less impacted by trauma and more impacted by wellness. The project consists of the following four components: One-on-one sessions that assess individuals needs around trauma supports and support group readiness; psycho-educational support groups; youth social outings that provide TAY with exposure to healthy settings designed to enhance life skills and choices; and youth celebratory events that are held monthly to convene youth around a positive occasion to acknowledge the various small and large accomplishments of TAY participants, and build trust and community. Approximately 30-35 TAY receive services through this project a year.

PEI Goals: The goal of this program is to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the prevention of suicide.

In FY17, 67 TAY participated in one-on-one sessions, case management, support groups, and/or group outings and celebrations. Demographics on youth served were as follows:

CLIENT DEMOGRAPHICS N=67	
Age Group	
16-25 (Transition Age Youth)	100%
Race	
Asian	2%
Black or African American	70%
Native Hawaiian or Other Pacific Islander	0%
White	20%
Other	2%
More than one Race	6%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American	2%
Ethnicity: Non-Hispanic or Non-Latino	
Declined to Answer (or Unknown)	98%
Primary Language Used	
Declined to Answer (or Unknown)	100%
Sexual Orientation	
Declined to Answer (or Unknown)	100%

Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	75%
Female	25%
Current Gender Identity	
Male	75%
Female	25%

In FY18, 22 TAY participated in one-on-one sessions, case management, support groups, and/or group outings and celebrations. Demographics on youth served were as follows:

CLIENT DEMOGRAPHICS N=22	
Age Group	
16-25 (Transition Age Youth)	100%
Race	
American Indian or Alaska Native	4%
Black or African American	32%
White	23%
Other	18%
More than one Race	23%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American	84%
Puerto Rican	8%
South American	8%
Ethnicity: Non-Hispanic or Non-Latino	
Decline to Answer (or Unknown)	100%
Primary Language Used	
English	64%
Spanish	36%

Sexual Orientation	
Gay or Lesbian	18%
Heterosexual or Straight	50%
Bisexual	27%
Questioning or Unsure	5%
Disability	
Difficulty Seeing	27%
Mental (not mental health)	37%
Physical/Mobility Disability	9%
Chronic Health Condition	27%
Veteran Status	
Yes	2%
No	98%
Gender: Assigned sex at birth	
Male	77%
Female	23%
Current Gender Identity	
Male	60%
Female	19%
Transgender	13%
Genderqueer	4%
Questioning or Unsure	4%

ACCESS AND LINKAGE TO TREATMENT PROGRAM

Homeless Outreach and Treatment Team (HOTT)

The Homeless Outreach and Treatment Team (HOTT) program was established out of an effort to address the current homeless crisis, and as a result of input received through various MHSA community program planning processes. Utilizing a portion of PEI and CSS funds, blended with realignment and general funds HOTT is a three year pilot program to move homeless mentally ill individuals in Berkeley/Albany into permanent housing and to connect them into the web of services and supports that currently exist within the system of care. Key program components include the following evidence and experience based practices: Persistent and Consistent Outreach; Supportive Case Management; Linkage to Care; and Treatment.

A local consultant, Resource Development Associates, was hired to conduct a dedicated independent evaluation to assess the program accomplishments over the three-year timeframe, and to ascertain whether HOTT should continue past the initial funding period.

PEI Goals: The goal of this program is to connect individuals who have severe mental illnesses as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to, care provided by county mental health programs.

The HOTT Program began providing services in May 2017. Demographics on the five individuals that received services during the FY17 reporting timeframe were as follows:

PARTICIPANT DEMOGRAPHICS N= 5	
Age Groups	
26-59 (Adult)	80%
Ages 60+ (Older Adult)	20%
Race	
Black or African American	20%
White	80%
Ethnicity: Non-Hispanic or Non-Latino	
Non-Hispanic or Non-Latino	100%
Primary Language Used	
English	100%
Sexual Orientation	
Heterosexual or Straight	60%
Declined to Answer (or Unknown)	40%

Disability	
Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)	40%
Physical/mobility domain	60%
Chronic health condition	80%
Veteran Status	
Yes	20%
No	80%
Gender: Assigned sex at birth	
Male	60%
Female	40%
Current Gender Identity	
Male	40%
Female	60%

Program and Evaluation Components	
# of Unduplicated Individuals Served	5
# of Unduplicated Referrals Made to a Treatment Program	5
# of Individuals who Followed Through	5
Average Time Between Referral and Engagement in Services	2.8 days

During this reporting period, the "Duration of Untreated Mental Illness" was not collected.

In FY18, a local consultant, Resource Development Associates, was hired to conduct a dedicated independent evaluation to assess the program accomplishments and to ascertain whether HOTT should continue past the initial funding period. The initial report showed many positive findings including the following:

- HOTT is serving as an important resource for the local community and homeless service continuum
- The program has been very effective in persistent and consistent outreach, especially for chronically homeless individuals with a history of refusing services
- HOTT meets people where they are, in parks, encampments, motels
- The program has successfully connected homeless individuals to critical resources and service linkages

The City of Berkeley Homeless Outreach and Treatment Team (HOTT) Evaluation can be reviewed on the MHSA website:

https://www.cityofberkeley.info/uploadedFiles/Health_Human_Services/Level_3_-_Mental_Health/Berkeley-HOTT_Evaluation-Report.final.pdf

In FY18 through the first quarter of FY19, 289 individuals were served through this program. The HOTT Evaluation reported on numbers from January 2018 through October 2018 and staff provided data collected from July – December 2017. Demographics on individuals that received services through this program were as follows:

PARTICIPANT DEMOGRAPHICS N= 289	
Age Groups	
16-25 (Transition Age Youth)	<1%
26-59 (Adult)	6%
Ages 60+ (Older Adult)	1%
Declined to Answer (or Unknown)	92%
Race	
Asian	1%
Black or African American	33%
White	35%
Other	10%
Declined to Answer (or Unknown)	21%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American/Chicano	9%
Ethnicity: Non-Hispanic or Non-Latino	
Non-Hispanic or Non-Latino	65%
Declined to Answer (or Unknown)	26%
Primary Language Used	
English	65%
Other	3%
Declined to Answer (or Unknown)	32%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
Declined to Answer (or Unknown)	100%

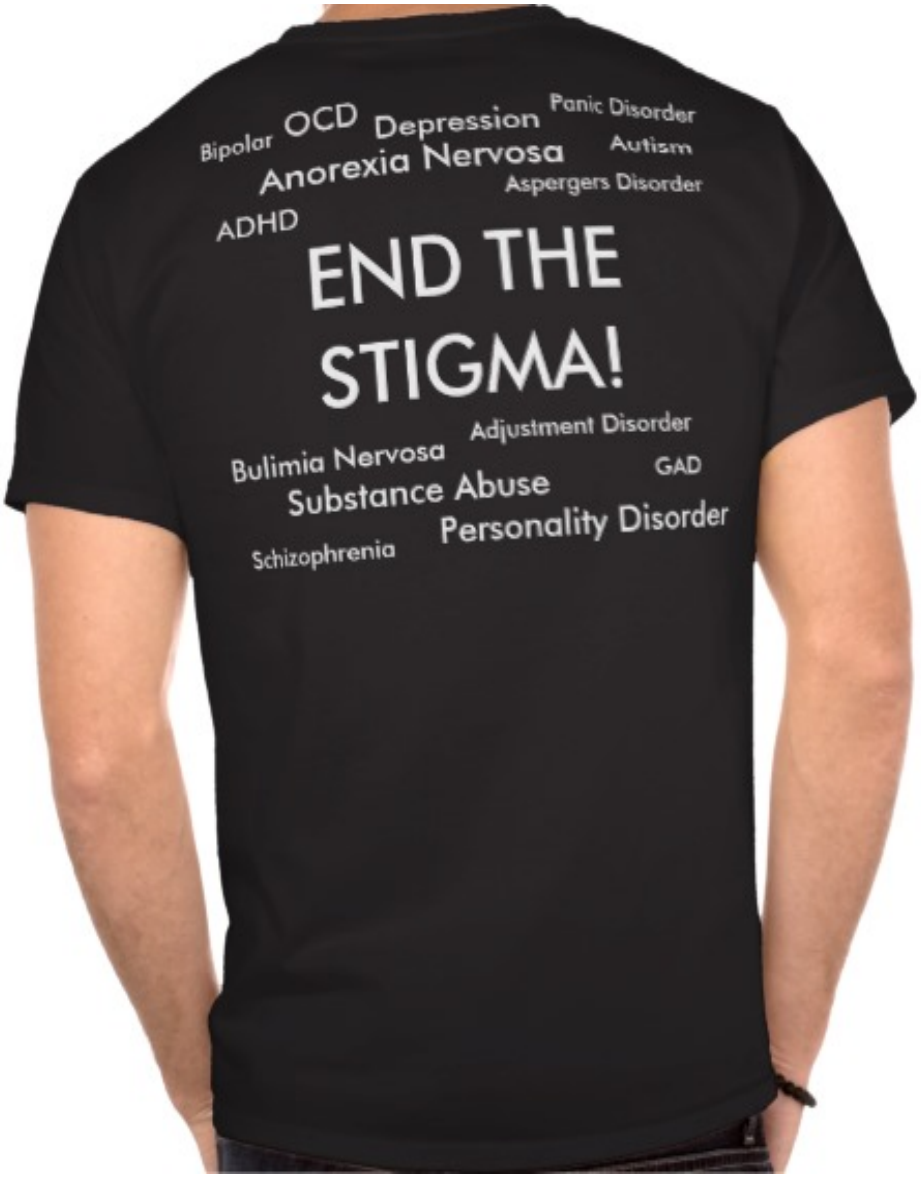
Gender: Assigned sex at birth	
Declined to Answer (or Unknown)	100%
Current Gender Identity	
Male	7%
Female	8%
Declined to Answer (or Unknown)	85%

The HOTT program made 921 referrals in 2018 for homeless individuals to many critical services and resources, including 92 referrals to mental health services.

Program and Evaluation Components	
# of Unduplicated Individuals Served	289
# of Unduplicated Referrals Made to a Treatment Program	92
# of Individuals who Followed Through	15
Average Time Between Referral and Engagement in Services	Unknown

The “Duration of Untreated Mental Illness” was not collected during this reporting period.

STIGMA AND DISCRIMINATION REDUCTION PROGRAM



Social Inclusion Program

The Social Inclusion program was created to combat stigma, attitudes and discrimination around individuals with mental health issues. Through this program, a "Telling Your Story" group provides mental health consumers with opportunities to be trained, compensated and empowered to share their stories of healing in a supportive peer environment. When they feel ready, consumers can elect to be community presenters, sharing their inspirational stories at pre-arranged local public venues to dispel myths and educate others. This program serves approximately 5-10 individuals a year.

PEI Goals: To reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families. To create changes in attitude, knowledge and/or behaviors related to seeking mental health services or related to mental illness.

In FY17, the "Telling Your Story" group met 22 times with 19 unduplicated individuals attending for a total of 149 visits. Groups averaged 6-7 attendees. Two panel presentations to BMH interns were conducted during the reporting timeframe and one experienced presenter from the group, was referred to be part of a video on mental illness. In order to gauge outcomes from this program, structured interviews with participants were conducted over a three-month period. During interviews, many participants described finding relief, inspiration and connection with others through the sharing of their stories. Additionally 63% of participants indicated that they were either 100% open, or more open about their mental illness as a result of being in the program. Program participants also indicated that as a result of participating in the program they have used their story, or life experience, to encourage and help others and to support individuals in the community.

Demographics on group participants are outlined below:

CLIENT DEMOGRAPHICS N=19	
Age Group	
26-59 (Adult)	36%
Ages 60+ (Older Adult)	32%
Declined to Answer (or Unknown)	32%
Race	
American Indian or Alaska Native	5%
Asian	11%
Black or African American	37%
Native Hawaiian or Other Pacific Islander	5%
White	32%
Other	5%
More than one Race	5%

Ethnicity: Hispanic or Latino	
Mexican/Mexican-American	5%
Puerto Rican	5%
Other	11%
Ethnicity: Non-Hispanic or Non-Latino	
African	26%
Asian Indian/South Asian	5%
European	11%
Filipino	11%
Japanese	11%
Middle Eastern	5%
Vietnamese	5%
Other	5%
More than one ethnicity	32%
Primary Language Used	
English	79%
Declined to Answer (or Unknown)	21%
Sexual Orientation	
Gay or Lesbian	5%
Heterosexual or Straight	58%
Bisexual	11%
Queer	5%
Declined to Answer (or Unknown)	21%
Disability	
Difficulty seeing	11%
Difficulty hearing, or having speech understood	26%
Mental domain not including mental illness(including but not limited to a mental disability, developmental disability, dementia)	11%
Physical/mobility domain	11%
Chronic health condition (including but not limited to chronic pain)	26%
Declined to Answer (or Unknown)	26%

Veteran Status	
Yes	5%
No	68%
Declined to Answer (or Unknown)	27%
Gender: Assigned sex at birth	
Male	26%
Female	42%
Declined to Answer (or Unknown)	32%
Current Gender Identity	
Male	26%
Female	42%
Declined to Answer (or Unknown)	32%

In FY18, the "Telling Your Story" group met 22 times with 16 unduplicated persons attending for a total of 169 visits. Groups averaged 7-8 attendees. In FY18 time was spent time discussing and practicing what makes a good story. One panel presentation was provided to BMH interns and it was well received.

In this reporting timeframe the program began collecting outcomes data. Measures were based on the assumption that individuals participating in "Telling Your Story" were finding meaning, transforming their lived experience and enhancing their recovery. The Recovery Assessment Scale (RAS) was used. After three measurements, it appeared that results were more impacted by what happened that day in the person's life than in the "Telling Your Story" group. Staff then assessed whether developing RBA measures would be a better way to assess the program.

The "Telling Your Story" group brainstormed and discussed criteria on what makes a good story. The list of criteria that was generated was re-visited at many meetings and each criteria was discussed by the group. The group then practiced giving feedback to each person based on the criteria. A survey that included the criteria, with emphasis on participants understanding and awareness of turning points in their stories was then developed. The survey was then administered towards the end of the fiscal year and the results were tallied. The results indicated that the highest rated question pertained to participants' confidence in telling a story that would change negative perceptions of mental illness. The results also guided the group to work on effectively using pauses and timing in telling a story.

Demographics on group participants are outlined below:

CLIENT DEMOGRAPHICS N=16	
Age Group	
26-59 (Adult)	37%
Ages 60+ (Older Adult)	37%
Declined to Answer (or Unknown)	26%
Race	
Asian	8%
Black or African American	50%
White	34%
Other	8%
Ethnicity: Hispanic or Latino	
Puerto Rican	8%
Declined to Answer (or Unknown)	92%
Ethnicity: Non-Hispanic or Non-Latino	
Declined to Answer (or Unknown)	100%
Primary Language Used	
English	75%
Declined to Answer (or Unknown)	25%
Sexual Orientation	
Gay or Lesbian	7%
Heterosexual or Straight	58%
Bisexual	14%
Queer	7%
Declined to Answer (or Unknown)	14%

Disability	
Difficulty Seeing	12%
Difficulty Hearing, or Having Speech Understood	16%
Mental (not mental health)	20%
Physical/Mobility Disability	12%
Chronic health condition	24%
Other Disability	4%
No Disability	8%
Declined to Answer (or Unknown)	4%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	33%
Female	58%
Declined to Answer (or Unknown)	9%
Current Gender Identity	
Male	33%
Female	58%
Declined to Answer (or Unknown)	9%

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

Per PEI State Regulations in addition to having the required "Outreach for Increasing Recognition of Early Signs of Mental Illness Program", mental health jurisdictions may also offer required Outreach for Increasing Recognition of Early Signs of Mental Illness as: a strategy within a Prevention program, a strategy within an Early Intervention program, a strategy within another program funded by PEI funds, or a combination thereof. Additionally, an Outreach for Increasing Recognition of Early Signs of Mental Illness program, may be provided through other MHSA components as long as it meets all of the program requirements.

High School Youth Prevention Project

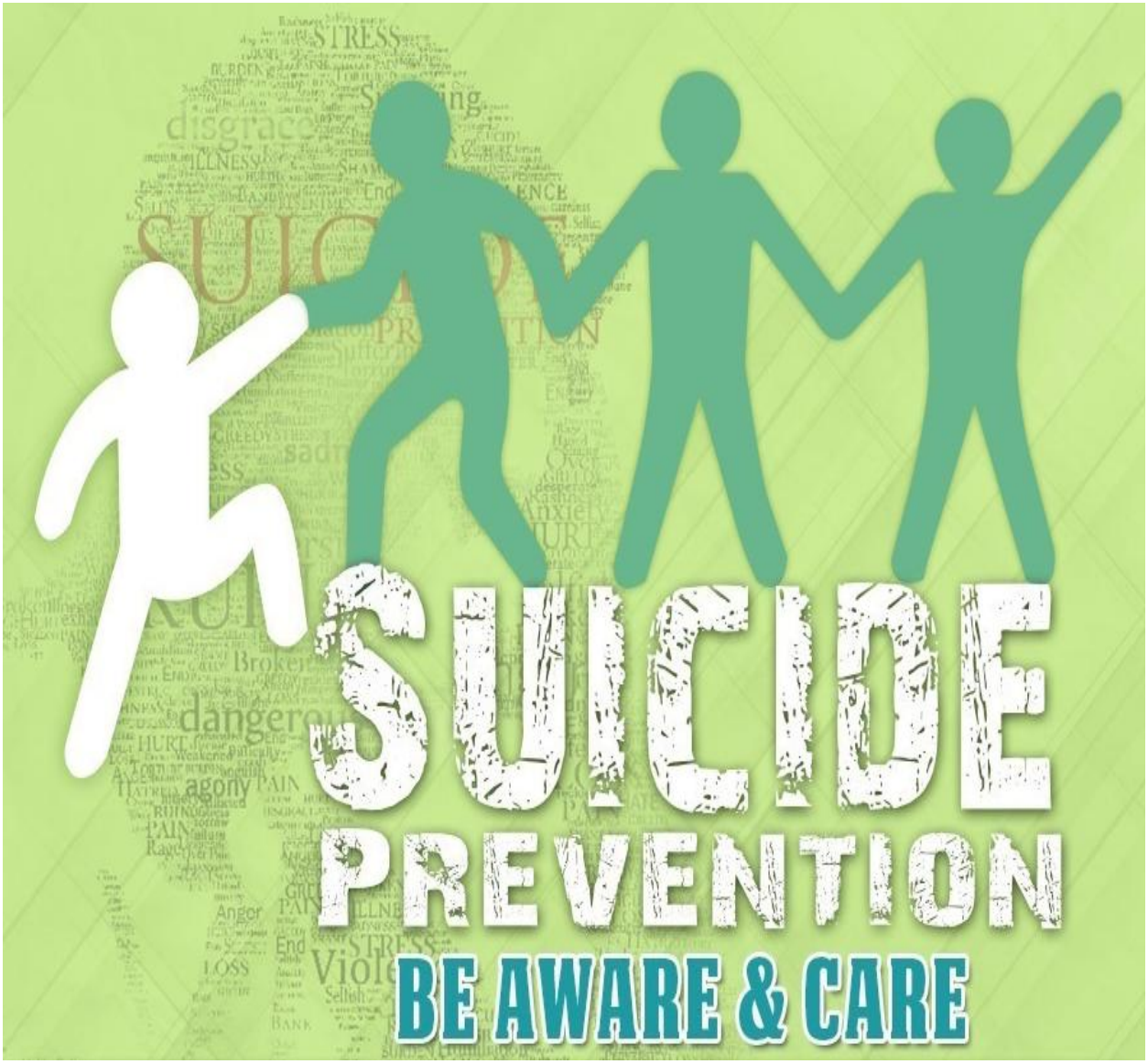
The High School Youth Prevention Program is listed on pages 15-18, as it is also classified as a Prevention and Early Intervention program. The required data elements for the "Outreach for Increasing Recognition of Early Signs of Mental Illness" component of this program were not collected in the reporting timeframes.

Mental Health First Aid

City of Berkeley Mental Health staff provide Mental Health First Aid training throughout the year. Mental Health First Aid is a groundbreaking public education program that helps the public identify, understand, and respond to signs of mental health issues and substance use disorders. Mental Health First Aid presents an overview of mental health issues and substance use disorders and introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and provides an overview of common treatments. Through this training a five step action plan is taught that encompasses the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care. The required data elements for the "Outreach for Increasing Recognition of Early Signs of Mental Illness" component of this program were not collected in the reporting timeframe,

SUICIDE PREVENTION

(OPTIONAL PEI PROGRAM)



Per PEI State Regulations Mental Health Jurisdictions have an option on whether to utilize MHSA PEI funds on Suicide Prevention programs. While the City of Berkeley has not previously chosen to utilize PEI funds to implement a local Suicide Prevention program, in FY18 Berkeley Mental Health began contributing funding to the California Mental Health Services Authority (CalMHSA) PEI Statewide Projects in order to obtain State resources locally on Suicide Prevention, Student Mental Health, and Stigma and Discrimination. Additionally, in FY18 the City of Berkeley began work on a local Suicide Prevention Plan. Data from CalMHSA as well as any local Suicide Prevention programs that are implemented as a result of a City of Berkeley Suicide Prevention Plan will be collected and reported on in future PEI Evaluation Reports.

APPENDIX B

Fiscal Year 2018 Annual Innovation Evaluation Report

City of Berkeley Mental Health Services Act (MHSA)

Fiscal Year 2018 Annual Innovation Evaluation Report

WELLNESS • RECOVERY • RESILIENCE

INTRODUCTION

Mental Health Services Act (MHSA) Innovation (INN) funds are to be are utilized for short-term projects that contribute to new learning in the mental health field. This MHSA component provides the opportunity to pilot test and evaluate new strategies that can inform future practices in communities/or mental health settings. INN projects can target any population and any aspect of the mental health system as long as the strategies or approaches that are being implemented address at least one of the following areas:

- Increase access to mental health services
- Increase access to mental health services for underserved groups
- Increase the quality of mental health services, including better outcomes
- Promote interagency collaboration

INN projects should also have one of the following primary practices: introduce new mental health practices or approaches that have never been done before; or make changes to existing mental health practices/approaches, including adapting them to a new setting or community; or introduce a new promising community-driven practice/approach that has been successful in non-mental health contexts or settings.

Per Mental Health Services Act (MHSA) State requirements, Mental Health jurisdictions are to submit an Innovation (INN) Evaluation Report to the Mental Health Services Oversight and Accountability Commission (MHSOAC) on an annual basis. The first INN Annual Report provided a report on Fiscal Year 2017 (FY17) Data. The City of Berkeley requested and was granted a one-month extension to complete this INN Evaluation Report. The "City of Berkeley Mental Health Services Act (MHSA) Fiscal Year 2017 Innovations Evaluation Report" is posted on the City of Berkeley Mental Health Division website.

New INN Regulations released in 2018 now require mental health jurisdictions to submit an Annual Evaluation Report to the State by June 30th of each fiscal year. The Evaluation Report should be included with the MHSA Annual Update or Three Year Program and Expenditure Plan and undergo a 30 Day Public Comment period and approval from the local governing board. Per state regulations in FY19, an FY2017/2018 Annual Innovations Evaluation Report (Annual INN Evaluation Report) that covers data from FY17/18 is due.

This Annual INN Evaluation Report provides descriptions of currently funded MHSA INN services, and reports on FY17/18 program and demographic data to the extent possible. The main obstacle in collecting data for this Annual Evaluation Report was due to vacancies in staffing that precluded the program from continuing during the reporting timeframe. While, it may be a multi-year process before the City of Berkeley will be able to present a complete data set for each INN Program on an Annual basis, ongoing efforts will continue towards accomplishing this goal.

BACKGROUND

On October 6, 2015, updated INN regulations designed by the Mental Health Services Oversight and Accountability Commission (MHSOAC) became effective. The new INN Regulations, included program and demographic data requirements that are to be reported to the MHSOAC through Annual INN Evaluation Reports. Per the new requirements, Mental Health Jurisdictions should report on the following INN Program and Demographic elements.

- Name of the Innovative Project.
- Whether and what changes were made to the Innovative Project during the reporting period and the reasons for the changes.
- Available evaluation data, including outcomes of the Innovative Project and information about which elements of the Project are contributing to outcomes.
- Program information collected during the reporting period, including for applicable Innovative Projects that serve individuals, number of participants served.
- All Demographic Data as applicable per project. (as outlined below)

INN Demographic Reporting Requirements

For the information reported under the various program categories, each program will need to report disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services by:

(A) The following Age groups:

- 0-15 (children/youth)
- 16-25 (transition age youth)
- 26-59 (adult)
- ages 60+ (older adults)
- Number of respondents who declined to answer the question

(B) Race by the following categories:

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or other Pacific Islander
- White
- Other
- More than one race
- Number of respondents who declined to answer the question

(C) Ethnicity by the following categories:

(i) Hispanic or Latino as follows

- Caribbean
- Central American
- Mexican/Mexican-American/Chicano
- Puerto Rican
- South American
- Other
- Number of respondents who declined to answer the question

(ii) Non-Hispanic or Non-Latino as follows

- African
- Asian Indian/South Asian
- Cambodian
- Chinese
- Eastern European
- European
- Filipino
- Japanese
- Korean
- Middle Eastern
- Vietnamese
- Other
- Number of respondents who declined to answer the question
- More than one ethnicity
- Number of respondents who declined to answer the question

(D) Primary language used listed by threshold languages for the individual county

- English
- Spanish
- Number of respondents who declined to answer the question

(D) Primary language used listed by threshold languages for the individual county

- English
- Spanish
- Number of respondents who declined to answer the question

(E) Sexual orientation

- Gay or Lesbian
- Heterosexual or Straight
- Bisexual
- Questioning or unsure of sexual orientation
- Queer
- Another sexual orientation
- Number of respondents who declined to answer the question

(F) Disability, defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness

- If Yes, report the number that apply in each domain of disability(ies)
  - Communication domain separately by each of the following:
    - difficulty seeing,
    - difficulty hearing, or having speech understood)
    - other, please specify
  - Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)
  - Physical/mobility domain
  - Chronic health condition (including but not limited to chronic pain)
  - Other (specify)
- No
- Number of respondents who declined to answer the question

(G) Veteran Status,

- Yes
- No
- Number of respondents who declined to answer the question

(H) Gender

(i) Assigned sex at birth:
(a) Male
(b) Female
(c) Number of respondents who declined to answer the question
(ii) Current gender identity:
(a) Male
(b) Female
(c) Transgender
(d) Genderqueer
(e) Questioning or unsure of gender identity
(f) Another gender identity
(g) Number of respondents who declined to answer the question.

Effective July 2018 amended INN regulations specified the following:

- For projects/programs serving children or youth younger than 18 years of age, the demographic information collected and reported should only be done so to the extent permissible by privacy laws
- For projects/programs serving minors younger than 12 years of age, demographic information shall be collected and reported, except for sexual orientation, current gender identity, and veteran status
- Information that cannot be obtained directly from the minor many be obtained from the minor's parent, legal guardian, or other authorized source.

CITY OF BERKELEY INN PROGRAMS

Trauma Informed Care Training for Educators

This INN project is the only project that was in operation during the reporting timeframe. The project implemented Trauma Informed Care (TIC) Training for educators (and interested parents) in three BUSD schools. The primary purposes of this project was to increase access to mental health services for students in need, increase access for underserved groups, and increase the quality of mental health services, including better outcomes. The project was designed to test whether a change in the mental health approach of TIC training for educators would assist students (particularly those who are underserved) in receiving the services and supports they need in direct response to trauma and stress induced behaviors. For students who were referred, the project would also examine the appropriateness of the mental health services they received. The project made a change to existing TIC for educator models through the following:

- Implementing a "Train the Trainer" model to build capacity and sustainability in the participating schools and to create an institutional culture of trauma informed educators;
- Implementing the project through an existing Learning Collaborative (2020 Vision) which would stay involved in, connected to, and provide support on the strategy on an ongoing basis through "Peer Support Learning Circles";
- Focusing on the educator's recognition of their own trauma/trauma triggers as a conduit to better understanding youth "acting out" behaviors;
- Inviting parents to participate in the training to assist them in recognizing their children's and their own trauma/trauma triggers and in seeking supports.

The Intended Outcomes were:

- To create a change in the way teachers view and handle problematic student behaviors (which often mask trauma);
- To create an increase in access to mental health services and supports for students in need; and

- To promote better mental health outcomes by increasing student referrals to "appropriate" mental health services.

Hatchuel Tabernik and Associates, an Independent Evaluator, measured the TIC Training of educators pre and post trauma perception surveys, and the number and type of mental health referrals compared to a baseline of the previous year.

In FY17, 93 individuals participated in TIC Trainings. The only demographic data that was collected during this timeframe was as follows:

PARTICIPANT DEMOGRAPHICS N=93	
Age Groups	
26-59 (Adult)	100%
Race	
Asian/Pacific Islander	8.5%
Black or African American	10%
White	60%
Other	4.3%
More than one Race	5.7%
Ethnicity	
Hispanic or Latino	11.4%
Gender	
Male	22.9%
Female	77.1%

There were not any changes to the INN Project during the FY17 reporting timeframe. Pre and Post Survey results demonstrated that participants had an increased sense of efficacy with trauma-induced behavior and mental health concerns among their students. As a result of the program, educators felt less challenged by behavior issues in their classroom, increased their knowledge around students' barriers to accessing services and how to handle and approach students' behavior issues, and felt more comfortable working with parents, especially around recommending that their child seek counseling.

While the FY17 data indicated that it was too early to determine the student impact of the program, baseline FY15/16 data on the number of students identified for "Response to Intervention"- RTI (a multi-tier approach to the early identification and support of students with learning and behavior needs, as a proxy for early disciplinary issues) and Mental Health follow-up, was collected and compared with the reporting timeframe. Fifty students were referred to

RTI, which was an increase from the 14 students in FY16, who were referred to the services. The number of students identified for Mental Health follow-up, remained the same, at 5 students each year.

The full evaluation data, including additional outcomes of the Innovative Project and information about which elements of the project are contributing to outcomes can be found in the "City of Berkeley Mental Health Services Act (MHSA) Fiscal Year 2017 Innovations Evaluation Report".

In FY18, due to staffing vacancies, this project was not able to be implemented. When staffing vacancies were filled in mid FY18, meetings were held with several BUSD principals who indicated that although their schools received a lot of positive benefits out of the TIC project, additional training requirements within the school system had been added for teachers and administrators that needed to be fulfilled over the next couple of years. As a result, the TIC Project would not be able to be prioritized within the school system at that time. In light of the changes in the school system, staff conducted outreach and found that four area Head Start Centers were interested in executing the same TIC Project for their early childhood educators and staff, to impact the children and families who are served at the centers.

As such, proposed changes to the population and funding amount of the original TIC Plan were vetted through community program planning, and an update to the TIC Plan underwent a 30-Day Public Review and Public Hearing process. The TIC Plan Update was approved through City Council in October 2018 and by the MHSOAC in December 2018. The proposed new funding amount for the remainder of the modified TIC project will be $340,000. The modified project implements TIC Training for Educators and interested parents in four local Head Start sites.

Technology Suite Project

In September 2018, following a four month community planning process and approval from City Council, the City of Berkeley Technology Suite Project was approved by the MHSOAC. This project allocates a total of $462,916 to join a Statewide Collaborative with other California counties to pilot a Mental Health Technology Project that will make various technology-based mental health services and supports available locally in Berkeley and Albany. The proposed INN project will seek to learn whether the Technology Suite Project will increase access to mental health services and supports; and whether it will increase the quality of mental health services, including leading to better outcomes.

Since plan approval the City of Berkeley has been working both internally and with the State collaborative on various aspects of this project to prepare for city wide implementation. It is envisioned that the technology suite apps will be locally available by September 2019.

PUBLIC COMMENTS

To: Erlinda Castro, Commissioner representing Albany on Berkeley Mental Health Commission
Ben Ludke, Commissioner representing Albany on Berkeley Mental Health Commission
Karen Klatt, Berkeley Mental Health Commission
Cc: Albany Social and Economic Justice Commission

From: Judy Kerr, Commissioner Albany Social and Economic Justice Commission

Date: May 31, 2019

Subject: **Mental Health Services Act Annual Update 2019-20 Public Comment**

Thank you for your dedication and work in service to the residents of the cities of Berkeley and Albany. Thank-you also for the opportunity to comment on the 2019-20 MHSA plans. My comments and recommendations are my own and are as summarized below.

General Comments:

- I fully support the Homeless Outreach and Treatment Team HOTT transition from pilot to full services partnership program. I applaud efforts to include .25 psychiatrist and 1.0 registered nurse on the team. *It may be helpful to consider an advanced practice nurse with a prescribing license to work in collaboration with the MD in providing medications assessment and recommendations.*

- I fully support the planning for an integrated primary care site to provide service to both Berkeley and Albany residents needing care and having qualifying Medi-Cal coverage. *It may be helpful to extend services to individuals with Medicare or other non-governmental coverage if that is feasible.*

- I fully support the continuation of the Berkeley Unified School District African-American Success Project. *It may be helpful to consider expansion to a broader population of students of color and non-native speakers and include Albany Unified School District in programming.*

- I fully support the addition of counseling services at senior centers. *It may be helpful to include in final draft the addition of programming at the Albany Senior Center. Recommend that projected budget increase by $25K to include counseling services for Albany seniors*.

Specific items for review in final draft (5/31/19 on-line) as listed by page number:

Page 10: Please consider including Albany in the questionnaire going forward. Sites where the questionnaire could be distributed include the AlbanyCARES program and the Albany Senior Center.

Page 14: In future HOTT reports please consider breaking out referral source data from Albany Police Department, AlbanyCARES, and Albany Shower Program. Having data specific to these Albany based programs will be useful to future program planning.

Page 17: Recommend expanding school based success project to AUSD campuses. Consider expansion of programming to include all students of color as well as non-English speaking students.

Page 24: Recommend including MHSA funding to support community events in Albany. Specifically support of City of Albany Chinese New Year Celebration as target event for support and outreach.

Page 31: Housing Services and Supports. Recommend considering addition of lack of affordable housing in Albany to the workload of the Housing Specialist with the goal to provide for collaboration between Albany landlords, HOTT clients and Albany Neighborhood Services. Increase FTE and budget allocation by 0.1 FTE to accommodate this increased workload.

Page 36: AlbanyCARES (formerly Albany Community Resource Center): Recommend that this pilot be extending for another 24 months with transition to FSP program when feasible.

Page 42: Albany Trauma Project: Request more detailed breakout of data from school based trauma program and Golden Gate Fields program. Recommend using the school based program as an entry point to expand AUSD project for students of color and non-native speakers. Also consider expanding Autism Screening Questionnaire Program (ASQ) to service preschool students enrolled in Albany Preschool under auspices of AUSD.

Page 59: High School Youth Prevention Programs: Recommend expanding to AHS

Page 65: Mindfulness Program: Recommend expanding to AHS.

Page 67: Trauma Informed Training: Recommend expanding training to invite AUSD teachers and staff.

General Budget Comments:

Administrative overhead at 10% should be compared to other Mental Health Service Act Program budgets. Is 10% comparable to the 23 county based MHSA programs that are equal or smaller in population service to Albany-Berkeley? If not, is the difference something that can be controlled?

While exact proportional spending of MHSA funds within the cities of Albany and Berkeley is not necessary it is, nevertheless, important to keep in mind that in the proposed $7M operating budget the per-capita spending on mental health programs in Albany and Berkeley calculates at roughly $49 per resident. Programming within Albany would calculate to somewhere between $90-100K for fiscal year 2019-20. Expanding programming to Albany and highlighting where programs overlap between Berkeley and Albany is helpful to transparency and equitable spending.

Public Comments
Mental Health Services Act (MHSA) Annual Update FY 19-20

Submitted By: Margaret C. Fine, JD, PhD

Date: Thursday, June 27, 2019

These public comments are written in my individual capacity and they do not represent the Mental Health Commission or the Cities of Berkeley and Albany.

Thank you for the opportunity to submit public comments on this Mental Health Services Act (MHSA) Annual Update FY 19-20, which provides direct state funding for estimated municipal expenditures in the amount of approximately $7,015,404.

Introduction

Currently, the sheer number of people who are homeless, and moreover those experiencing severe mental illness and substance use problems (or disorders), is an overwhelming tragedy in the San Francisco Bay Area. The population living in this geographical area is largely one of extremes between those living poverty and others living in wealth.

At this time, there are multitudes of people who are living on the streets in deplorable conditions without stable housing and an adequate standard of living. This crisis has an unyielding impact on the public mental health system, including the need to address both mental health and substance use among service users who use this system.

As recognized by the City of Berkeley, it is critical that public government systems have effective evaluation systems to provide oversight for service delivery. The MHSA Annual Update FY 19-20 highlights the need for evaluating the Division of Mental Health through the Results-Based Accountability (RBA) framework. RBA has become relatively common over decades for public sector management and evaluation.

These public comments thus consider the RBA framework as an evaluation system focused on improving internal management and performance of the Division of Mental Health. Specifically, the public comments focus on service delivery to people who are experiencing severe mental illness and substance use problems (or disorders).

Further, these public comments discuss a systems integrated approach and framework that complements using an RBA framework. Results-Based Accountability does not necessarily consider how multiple systems integrate with the Division of Mental Health for service users, but rather how people engage with a public mental health program provide through the Division of Mental Health for the Cities of Berkeley and Albany.

Overall Population Accountability for
Evaluating the Public Mental Health System in the Cities of Berkeley and Albany

Under the Mental Health Services Act (MHSA), the Division receives state funding for its Full Service Partnership (FSP) program that serves people with severe mental illness and likely co-occurring substance use problems (or disorders). These service users may be uninsured or are receiving state health insurance—all have nominal resources.

The Division of Mental Health also receives Medi-Cal reimbursement for specialty mental health services to these services users, as well as other sources of funding. Many service users have complex needs and multiple systems involvement throughout Alameda County. Both Results-Based Accountability and systems integrated frameworks rely on population accountability in order to evaluate programs funded by the Division of Mental Health.

Population accountability for people who are served by the public mental health system relies on identifying diverse groups of service users who use its programs. To do so, there is an essential need for collecting accurate, complete demographic data.

Further, MHSA funding is specifically designated to provide for those who are unserved, underserved or inappropriately served by the public mental health system. Frequently, they are living with disabling severe mental illness, unrelenting addictions and deteriorated physical health from chronic illness.

Many service users are experiencing rough living and sleeping on the street. Some service users can be highly sceptical of using the public mental health system and resistant to engaging with in mental health and/or substance use treatment (possibly also due to their own volition).

Many of these service users are impacted by personal and systemic marginalization and exclusion based on race, ethnicity, religion, gender identity and expression, sexual orientation, disability, age, veterans status and other protected status. They are frequently minorities who are disproportionality represented in the public mental health system and some of these service users belong to more than one protected group of people.

As it stands, the Division of Mental Health at least collects some demographic data based on its MHSA Full Service Partnership (FSP) caseload statistics. While the collected data is separated by African American, White, Hispanic, Asian Pacific Islander, Male/Female, there is a category for "**other**" which consistently represents approximately 20 to 50 percent of reported demographic caseload statistics.

There is also no demographic data for sexual orientation or gender identity despite reportedly an intake form for self-reporting SOGI data. There is no data collection showing groups of people who belong to more than one group and would likely be served by the public mental health system in the Cities of Berkeley and Albany.

For instance, there is no information as to the Division serving African American men who are older adult homeless veterans with multiple physical and mental disabilities. There is no

information showing whether the Division of Mental Health serves Spanish-speaking refugees who frequently experience severe depression, anxiety and PTSD from: 1) leaving their country of origin to escape brutal violence and persecution; 2) migrating across the southern border of the USA in order to escape; and 3) live in continuous fear of deportation as undocumented immigrants. There is also no data on homelessness and substance use.

It is further notable that the Division of Mental Health is aware its CalMHSA membership offers sexual orientation and gender identity training to collect demographic data. The Center for American Progress and the Fenway Institute also provide extensive information on SOGI data, in addition to scholarly and professional publications. For example, the National LGBT Health Education Center—part of the Fenway Institute—published a 24-page report on guidelines for collecting patient data on sexual orientation and gender identity in January 2018.

In reviewing the MHSA Prevention and Early Intervention FY 18 Report on Results-Based Accountability published by the City of Berkeley, it states that RBA is designed to define what result/outcome is hoped to achieved by using this framework and how RBA can measure progress on that result/outcome. Further, this Report states that RBA is a way to measure the success of the Division's programs and how they make a difference to and for the people we serve.

It is noteworthy that the RBA framework may not represent the scope of service delivery when service users, who may belong to more than one minority group, are not included as an integral part of population accountability. Moreover not collecting demographic data can perpetuate and reinforce stigma (and potentially discrimination) when a diverse group of people do not count as part of population accountability for evaluating programs.

In other words, Division of Mental Health is a public accommodation designed to serve protected groups of people under applicable law and policy. Consequently, it is recommended that the RBA framework provide population accountability that is tailored to account for these diverse groups of people regardless if the Division currently collects the data. This data needs be systematically gathered now regardless if Medi-Cal claims data and/or other data sources do not represent people belonging to more than one protected group of people or not include groups at all.

Overall, it is essential to generally assess diverse groups of people who may need access to the public mental health system, as opposed to solely looking at the existing populations served by the Division of Mental Health. Specific groups of people may also be hard-to-reach, particularly if they regard the public mental health system as not tailoring a range of interventions and services to those protected groups living at society's edges.

World Health Organization (WHO) – A Systems-Integrated Approach and Framework

Systems integration is a relevant, important approach and framework to meaningful service delivery across systems for diverse groups of service users living with severe mental illness and substance use. It incorporates an overarching, comprehensive whole person system of care for service users which can be used in tandem with Results-Based Accountability.

The World Health Organization (WHO) has issued its Mental Health Plan 2013-2020 which emphasizes a systems integrated approach and framework. The action plan includes following objectives to: 1) strengthen effective leadership and governance for mental health and 2) provide comprehensive, integrated and responsible mental health and social care services in community-based settings.

The WHO Action Plan further relies on cross-cutting principles and approaches, including a multisectoral approach. This approach focuses on comprehensive and coordinated responses for mental health, including for multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sectors (plus private sectors and country conditions).

In the United States, this multisector approach would provide systems integration for service users who live with severe mental illness and likely substance use (and disorders). Through adopting this approach and framework, these entities can address messy system boundaries and/or system fragmentation and isolated silos of service delivery.

Alameda County Whole Person Care Connect (among 25 counties with this program)

Alameda County Care Connect integrates individual service providers across physical and behavioural health, housing services and crisis systems for service users. Through standardization of practice, development of universal tools and sharing of service user health records, Alameda County Care Connect is designed to improve service users' engagement within an overall integrated care system of care.

The Alameda County Care Connect is designed to support navigating the health care system for individuals with complex medical, behavioural, social and housing needs. The Division of Mental Health for the Cities of Berkeley and Albany can make referrals for service users to Alameda County Care Connect when appropriate to meet highest level service user needs.

Assessing Systems-Integrated Program and Fiscal Accountability

The Systems-Integrated approach and framework is designed for robust program and fiscal accountability for service users engaged with multiple systems. This approach allows for qualitative researchers to explore the life narratives of service users from their own interviews, as well as from electronic and hard copy records. In this way, this approach provides understanding about critical details as they route through multiple systems.[1]

[1] The author of these public comments focused her doctorate dissertation on life narratives of African American young women (18-28) who had past involvement in both the child welfare and juvenile justice systems. She conducted more than 30 qualitative interviews without a gatekeeper and used nVivo software to analyse the rich, text-based interviews. Her doctorate dissertation further focused on applying international children's rights treaty standards under the United Nations Convention on the Rights of the Child. The treaty provides a valuable, comprehensive frame of reference for supporting "participation rights" under Article 12. In 2016, she earned her PhD in Sociology in the School of Law and Social Justice at the University of Liverpool in England. Since the USA does not focus on treaty standards she studied with scholars in Europe. The author also worked as a Deputy City Attorney in the Child Welfare Unit for the City of Philadelphia Law Department.

Initially, qualitative research is vastly needed to contextualise how service users describe their life journeys through multiple systems (if at all). By describing their routes in the systems, service users can explain their own understandings, thoughts, feelings, viewpoints and opinions about using the public mental health and related systems.

Service users can further characterize their human relationships with a broad range of individual service providers including with law enforcement, criminal court and incarceration systems' personnel. Overall it is essential for service users to participate in telling their narratives as they are at the heart of multiple systems and service delivery is, ostensibly, about them. In the same light, front-line staff can be interviewed to understand their interactions and interplay directly with service users.

Further, qualitative data analysis software such as NVivo—which is an industry standard—can provide deep analysis of rich text-based narratives from large volumes of data. Additional data from electronic records can be included. OCR (optical character recognition) technology can be used to recognize text contained in scanned documents. Consequently, these sources of information can shed light on: 1) the level and quality of systems integration and 2) the service providers' capability to provide whole person care based upon interviews with service users and front-line personnel.

Overall qualitative research is important to understand how multiple systems integrate, have messy boundaries, fragment and/or operate in silos as service users route (or do not route) through them. Moreover, this type of qualitative research can be used to contextualise statistical findings from aggregated quantitative data, methodology and analysis completed without participation from service users or front-line personnel (such as appears to be inherent in Results-Based Accountability).

Fiscal Impact and Accountability

Sacramento County conducted a study of cost distribution across 250 high-utilizing homeless individuals. The study examined the average annual cost to Sacramento County public systems across high-cost PSH-fit 250 individuals (2015-2016). The cost for the highest level of costs for one individual was approximately $150,000 during this annual year.

Overall this study found that the group of high-frequency users cost Sacramento County more than $11 million in 2015-2016 after breaking down the costs of services such as jail stays, ambulance transports, emergency police response and substance use/addictions and mental health treatment (Yoon-Hendricks, 2019).[2] The costs are not exhaustive and notably exclude physical healthcare and corrections costs, as well as not reflecting the impact on economic development. The attached summary provides further details.

Overall there are massive fiscal impacts as a result of this dire human crisis—which will not disappear and likely will expand into more public spaces. Robust fiscal information derived from examining precise details about how service users' route through these systems (or not when there is a gap) can illuminate the total amount of costs during fixed time periods.

[2] A. Yoon-Hendricks, "They were Sacramento County's 250 costliest, most vulnerable homeless. A new effort is helping." Sacramento Bee, January 25, 2019 [accessed June 27, 2019].

The qualitative information can further provide critical details to show the actual interplay (or not) with service users involved with multiple government systems. It is recommended that the City of Berkeley conduct this type of fiscal analysis on the 50 highest-level service users using its public mental health and related systems.

Results-Based Accountability (RBA)—Performance Measures

On the other hand, Results-Based Accountability uses performance measures to evaluate programs funded by the Division of Mental Health. The RBA framework asks three basic questions: 1) how much did you do, 2) how well did you do it and 3) is anyone better off. These questions are designed to assess if the Division of Mental Health achieves results/outcomes, based on performance measures, showing its programs are successful.

One recent example is reducing truancy for high school students who struggle coping with the effects of trauma on their lives. The Division of Mental Health provided funding for trauma support groups at high schools in the Albany Unified School District. RBA was used to evaluate whether the program was successful in improving their school attendance. The students evaluated the program and RBA reported reducing truancy for them.

Given the Results Based Accountability framework, it is recommended to determine, based on performance measures, if the Division of Mental Health has the capabilities to provide service users with the level and quality of the systems integrated whole person care similar to Alameda County Care Connect.

Systems-Integration with
Law Enforcement, Criminal Case Processing and Incarceration Systems

Both the Division of Mental Health and Alameda County Care Connect need to integrate systems in order to address service users who have involvement with law enforcement, criminal court and incarceration systems. Service users with severe mental illness and substance use problems may have frequent contact with these systems and it is imperative these systems are taken into account in order to minimize involvement.

For instance during incarceration, the state and federal governments may terminate public benefits such as Medi-Cal and Social Security Income (SSI) after specific time periods. At the same time, some individuals may be released without activated public health insurance and benefits, medication and scheduled psychiatric, substance use and other needed appointments with multiple systems providers. They may not have reliable arrangements for temporary shelter and access to food, bathrooms and showers.

Consequently, this situation may result in service users living at subsistence level in deplorable conditions on the street. It is also possible, they may experience psychosis from symptoms manifested as a result of untreated mental illness. They may also relapse into substance use, often methamphetamine, which can result in stimulant-induced psychosis.

Potentially the individual may have a crisis and require emergency crisis interventions to address their plight which is occurring in public space (hopefully without involving

aggression or violence). The systemic responses may involve multiple systems: public mental health, police and fire, emergency transport, emergency medical and criminal court and incarceration. The nature of the systemic response may also result in deescalating the crisis in public space or possibly exacerbating it.

Regardless of systems integrated care and performance measures, there must be meaningful partnerships between the Alameda County Santa Rita Jail and the Division of Mental Health (and Alameda County Care Connect). It is also unlikely to measure success of a Full Service Partnership program if the whole person care is not connected to broader development of a standardized crisis response, emergency medical and re-entry systems.

Improving the Public Mental Health System

Through a systems integrated approach and framework, it is possible to shape a cohesive public safety network with tailored, respectful service delivery to diverse people with unique, complex needs (as opposed to mainstream community members). It is also possible through Results-Based Accountability to provide results/outcomes that improve the quality of life for persons living with severe mental illness and substance use (and disorders).

Here are Additional Recommendations for the Division of Mental Health:

- Require substance use treatment staff training and Implementation of best practices.

  There is a need for an overall substance use program in order to train all staff about substance use, particularly methamphetamine use disorder and the effects of stimulant-induced psychosis. It is inane to expect a social services support specialist to support an entire public mental health system where a high number of service users also cope with substance use problems and disorders, particularly to methamphetamine. There is also a crucial need for staff training and implementation of best practices, including using harm reduction strategies to assist service users who need medication-assisted treatment.

- Expand Street-Level Systems Integration to Include Psychiatrists/Nurses (including through telehealth) and Attorneys on the Street (see Trust Health Center).

- Fund a Peer Navigation and Support Program in order to employ persons with lived experience to support and guide service users through the maze of multiple systems. There is evidence-based practice with proven benefits to both peers and the clients they benefit (see Steinberg Institute website)

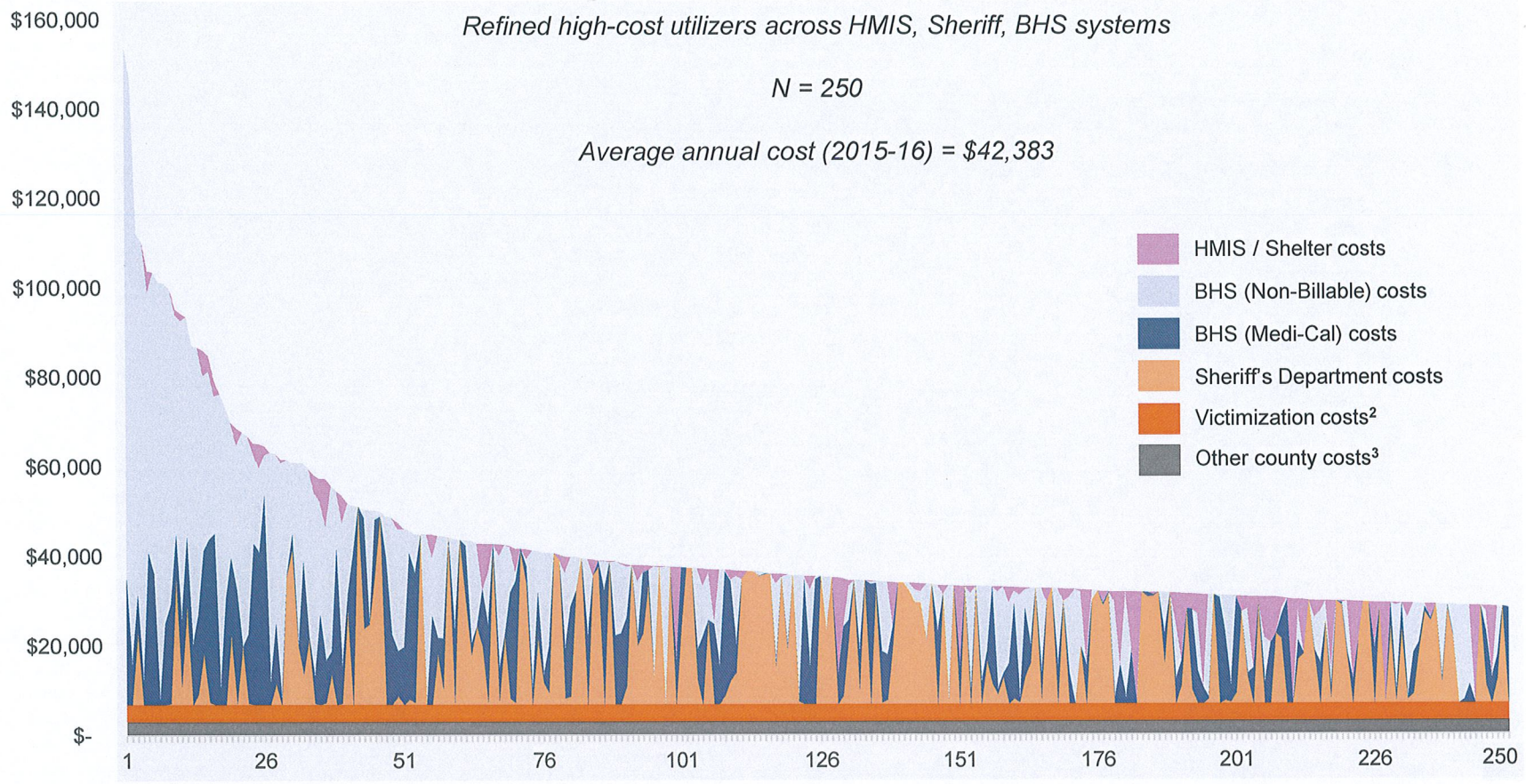
  Currently, there is pending California legislation to establish a peer certification process defining responsibilities, practice guidelines, supervision standards, curriculum, core competencies and other requirements. This bill would require the Department of Health Care Services to amend the Medicaid state plan to include certified peer support specialist services as a distinct service type for purposes of receiving Medi-Cal reimbursement given federal financial participation.

- Develop a Request for Proposal (RFP) for a competitive procurement process to provide emergency mental health crisis services 24/7 with a 60 minute response time in the Cities of Berkeley and Albany.

SUMMARY OF COST DISTRIBUTION ACROSS 250 HIGH-UTILIZING HOMELESS INDIVIDUALS IN SACRAMENTO COUNTY

Average annual cost to Sacramento County public systems across high-cost, PSH-fit 250 individuals (2015-16)[1]

Dollars (N=250)



1. Average annual cost calculated by averaging individual costs across analyzed systems in 2015 and 2016. Note that cost estimates are not exhaustive. Notable omissions include physical healthcare (deprioritized in part due to limited expected County budget impact), correctional health costs, and any reflection of impact on economic development. While costs are primarily County focused, some (such as billable BHS costs) may be reflective of other jurisdictional budgets; in other analyses, such as cost-benefit analysis, these costs are removed. "PSH-fit" estimated by reviewing 2015-2016 HMIS records, excluding individuals with any days spent in permanent supportive housing over the past 12 months, as well as those lacking (non-PSH) HMIS interactions in last 12 months, and focusing on those with longer and more-acute needs exhibited by a chronically homeless flag in HMIS and/or a recorded VI-SPDAT score >14 and/or a history of homelessness greater thank one year. 2. Average victimization cost based on estimates from McCollister et al. (The Cost of Crime to Society, 2010), intended to calculate the cost to society of various criminal acts, including both "tangible" costs (e.g., direct economic losses, property damage) and "intangible" costs (e.g., productivity loss, quality of life). Total victimization costs based on list of primary charges for top 250 population in 2015-16; for the sake of clarity (to smooth otherwise highly variable data), they have been averaged among this population, rather than applied to the relatively limited set of specific individuals to whom these victimization costs can be attributed. (Note that many charges, including most drug- and alcohol-related charges, do not incur a direct victimization cost.) 3. Assumes that high-utilizing homeless populations generate at least average costs to other County agencies. Includes non-specific core County costs (such as DHA – Admin, DHA – Aid Payments, Code Enforcement, Regional Parks, District Attorney) averaged across 2016 point-in-time count population.
Key sources: Sacramento Steps Forward, Sacramento Sheriff's Department, Sacramento Behavioral Health Services, Sacramento City and County Cost of Homelessness Estimates, McCollister et al.