CITY OF BERKELEY
MENTAL HEALTH

MENTAL HEALTH SERVICES ACT (MHSA)

FISCAL YEAR 2025-2026

ANNUAL UPDATE

RESOLUTION NO. 71,914-N.S.

MENTAL HEALTH SERVICES ACT (MHSA) FISCAL YEAR 2026 ANNUAL UPDATE

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

WHEREAS, MHSA includes five funding components: Community Services & Supports; Prevention and Early Intervention; Innovation; Workforce, Education and 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 Innovation funds on an annual basis and received one-time funding distributions for Workforce, Education & Training, and Capital Facilities and Technological Needs; and

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

WHEREAS, since the initial MHSA Plan in 2006, City Council has approved all MHSA Plans and Annual Updates, most recently on September 10, 2024 by Resolution No. 71,488-N.S., approving the MHSA FY2025 Annual Update; and

WHEREAS, City Council has also previously approved Innovation Plans, the uses of MHSA funding for local housing development projects, and 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 FY2026 Annual Update must be approved by City Council.

NOW THEREFORE, BE IT RESOLVED by the Council of the City of Berkeley that the MHSA FY2026 Annual Update that, incorporated herein as Exhibit A, is hereby approved.

BE IT FURTHER RESOLVED that the City Manager is authorized to forward the MHSA FY2026 Annual Update to appropriate State officials.

The foregoing Resolution was adopted by the Berkeley City Council on July 29, 2025 by the following vote:

Ayes: Bartlett, Blackaby, Humbert, Kesarwani, Lunaparra, O'Keefe, Taplin, Tregub, and Ishii.

Noes: None.

Absent: None.

Adena Ishii, Mayor

Attest:

Mark Numainville, City Clerk

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: City of Berkeley FY26 Annual Update

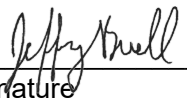
Local Mental Health Director	Program Lead
Name: Jeffrey Buell	Name: Karen Klatt
Telephone Number: (510) 981-7682	Telephone Number: (510) 981-7644
E-mail: JBuell@berkeleyca.gov	E-mail: KKlatt@berkeleyca.gov
Local Mental Health Mailing Address: 2640 Martin Luther King Jr. Way Berkeley, CA 94704	

I hereby certify that I am the official responsible for the administration of the City mental health services in and for the said City and that the City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this FY26 Annual Update, including stakeholder participation and non-supplantation requirements.

This FY26 Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The FY26 Annual Update was circulated to representatives of stakeholder interests and interested parties for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The Annual Update attached hereto, was adopted by the City Council on July 29, 2025.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant. All documents in the attached annual update are true and correct.

Jeffrey Buell — Local Mental Health Director/Designee

 — Signature

7/30/25 — Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

County: City of Berkeley FY26 Annual Update

Local Mental Health Director	County Auditor-Controller/City Financial Officer
Name: Jeffrey Buell	Name: Henry Oyekanmi
Telephone Number: (510) 981-7682	Telephone Number: (510) 981-7326
Email: JBuell@berkeleyca.gov	Email: Finance@berkeleyca.gov
County Mental Health Mailing Address: 2640 Martin Luther King Jr. Way Berkelev, CA 94704	

I hereby certify that the FY26 Annual Update is true and correct and that the City has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a County/City which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties/cities in future years. I declare under penalty of Perjury under the laws of this state that the foregoing and the attached FY26 Annual Update is true and correct to the best of my knowledge.

Jeffrey Buell — Local Mental Health Director (PRINT)

Signature — 7/30/25 — Date

I hereby certify that for the fiscal year ended June 30, 2024 the City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the City's financial statements are audited annually by an independent auditor and the most recent audit report is dated January 31, 2025 for the fiscal year ended June 30, 2024. I further certify that for the fiscal year ended June 30, 2024 the State MHSA distributions were recorded as revenues in the local MHS Fund; that City MHSA expenditures and transfers out were appropriated by the City Council and recorded in compliance with such appropriations; and that the City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing is true and Correct to the best of my knowledge.

Henry Oyekanmi — City Financial Officer (PRINT)

Signature — 8/13/25 — Date

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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 and Youth.
- 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.
- Innovation (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 peers 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 was designed to provide enhanced services and supports for seriously emotionally disturbed children, youth 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 member 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 these have included: Asian Pacific Islanders (API); Latinos/Latinas/Latinx (Latino/a/x); Lesbian, Gay, Bi-Sexual, Transgender, Queer/Questioning, Inter-Sexed, Agender, Plus others (LGBTQIA+); Older Adults; 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 an 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 a 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 MHSA monies that are allocated annually and may be spent over a five-year period. Workforce, Education & Training and Capital Facilities and Technological Needs funds had initial expenditure time periods of 10 years each and were to be utilized by the end of Fiscal Year 2018 or 2019. Per the City Council approved MHSA AB114 Reversion Expenditure Plan (which is posted on the City of Berkeley MHSA webpage), some CFTN and WET projects were continued past the original timeframes.

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 a City Council approved MHSA Fiscal Years 2023/2024 - 2025/2026 Three-Year Program and Expenditure Plan in place as well as Annual Updates for the fiscal year 2024/2025.

City of Berkeley MHSA Services

Since 2006, MHSA funding has been utilized to provide mental health services and supports in Berkeley. Additionally, from Fiscal Year 2011 (FY2011) through FY2020, the City of Berkeley also utilized a portion of MHSA funds to provide services in the City of Albany, although Albany is a part of the Alameda County total population. Beginning in FY2021, per agreement with Alameda County Behavioral Health Care Services (BHCS), the Division transitioned to only using MHSA funds for services and supports in Berkeley, and BHCS now provides MHSA funded services in Albany.

As a result of the City's approved MHSA Plans and Annual Updates, a number of services and supports have been implemented to address the various needs of the residents of Berkeley. Some of the many programs include the following:

- Intensive services for Children, TAY, Adults, and Older Adults
- Multi-Cultural Outreach engagement, trainings, projects, and events

- Increased mental health services and supports for homeless individuals
- Wellness Recovery services and activities
- Family Advocacy, Housing services and supports, and Benefits Advocacy
- Case management and mental health services and supports for TAY
- Trauma support services for unserved, underserved, and inappropriately served populations
- Increased mental health prevention, and intervention services for children and youth in area schools and communities
- A Wellness Recovery Center in collaboration with Alameda County Behavioral Health Care Services (BHCS)
- Funding for increased services for older adults and the API population; and
- Services for individuals experiencing co-occurring disorders.

Additionally, an outcome of the implementation of the MHSA is that mental health peers, family members and other stakeholders now regularly serve on several of the 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 role on MHSA programs and is comprised of mental health peers, family members, and community stakeholders.

This City of Berkeley MHSA Fiscal Year 2025/2026 (FY2026) Annual Update is a stakeholder informed plan that provides an update to the previously approved FY2024-2026 Three-Year Program and Expenditure Plan (Three-Year Plan). This Annual Update summarizes proposed program changes, descriptions of MHSA services that will be continued in FY2026, through the approved FY2024-2026 Three-Year Plan, and a reporting of FY2024 program data. This Annual Update outlines the funding and programming for the last year of operation of the MHSA prior to transitioning to the funding and programming requirements of the voter approved Behavioral Health Services Act.

The Behavioral Health Services Act

In 2023 Senate Bill 326 (SB326), the Modernization of the Mental Health Services Act (MHSA) and Assembly Bill 531, a Behavioral Health Infrastructure Bond for treatment facilities and supportive housing were linked and signed by the Governor. On March 5, 2024 the linked bill was on the ballot as one measure, Proposition 1, which was narrowly passed by the voters.

This legislation renames the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA) as it includes an allowance to utilize funding for services for individuals who have Substance Use Disorders. Beginning July 1, 2026, through the BHSA, the current five MHSA funding allocations will change to the following three components:

- Housing: For children and families, youth, adults and older adults living with severe mental illness or serious emotional disturbance and/or Substance Use Disorders who are experiencing homelessness or are at risk of homelessness, with 50% being prioritized for interventions for the chronically homeless.
- Full Service Partnership (FSP): Includes the use of funds for mental health, supportive services, and substance use disorder treatment services for Severely Mentally Ill Adults, Seriously Emotionally Disturbed Children and Youth, and individuals who experiences Substance Use Disorders.
- Behavioral Health Services and Supports: Includes early intervention, outreach and engagement, workforce education and training, capital facilities, technological needs, and innovative pilots and projects. A majority (51%) of funds must be used for Early Intervention services to assist in the early signs of mental illness or substance misuse, and 51% of the Early Intervention services and supports must be for individuals who are 25 years and younger.

Among other things, the BHSA will also make changes to the planning process and Three-Year Plans and Annual Updates. These changes will require the demonstration of coordinated behavioral health planning around all behavioral health funding received, and an integrated plan that includes all local behavioral health funding, services, and program outcomes. The Department of Health Care Services (DHCS) has recently released the new BHSA regulations. In preparation, the City has started pre-planning around the changes to MHSA and will begin engaging the community in the upcoming months to share information on the BHSA requirements and obtain input on local mental health needs.

MESSAGE FROM THE MENTAL HEALTH MANAGER

The City of Berkeley continues to face serious and evolving challenges that impact the behavioral health and well-being of its residents. Persistent racial and economic inequities, housing instability, and health disparities remain core concerns, while broader structural and policy shifts at the local, state, and federal levels further complicate the landscape. This Annual Update outlines how Berkeley's Behavioral Health Division will respond to these realities with a continued focus on equity, community engagement, and innovation.

In these last few years, significant changes to funding streams and cost structures have increased pressure on behavioral health services. Budget constraints at local, state, and federal levels of government, combined with policy shifts and rising service demands, are impacting how services are planned and delivered. Proposition 1 fundamentally shifts how the Behavioral Health Services Act (BHSA) will serve our local communities, and what the future will hold with respect to the services they support.

BHSA funding continues to serve as a vital source of support for a range of innovative and equity-focused mental health initiatives. Investments include the expansion of community-based outreach teams and new models of care that support crisis response, enhance connections to peer support and recovery services, and strengthen pathways to culturally responsive care.

While economic uncertainty and funding changes remain challenges across the behavioral health field, Berkeley's Behavioral Health Division remains focused on stability, equity, and innovation. We are closely monitoring evolving conditions and adjusting as needed to sustain core services and meet emerging needs.

The City of Berkeley presents this Annual Update with appreciation for the necessary collaboration and partnerships that are vital to support this work—community members, providers, staff, and peers alike. This dedication, hard work, and insight are essential as we move forward together.

Jeff Buell, LCSW
Manager of Mental Health Services

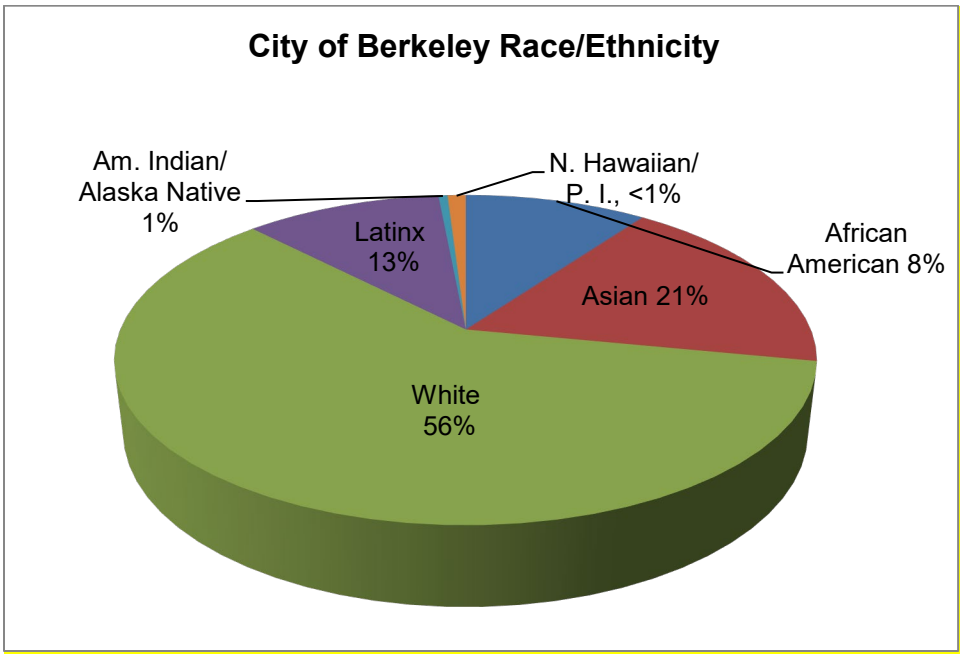
DEMOGRAPHICS

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. With a combined land mass of around 12.2 miles and a total population of approximately 118,962 (updated estimates since the 2020 census), the City of Berkeley is densely populated and larger than 23 of California's small counties.

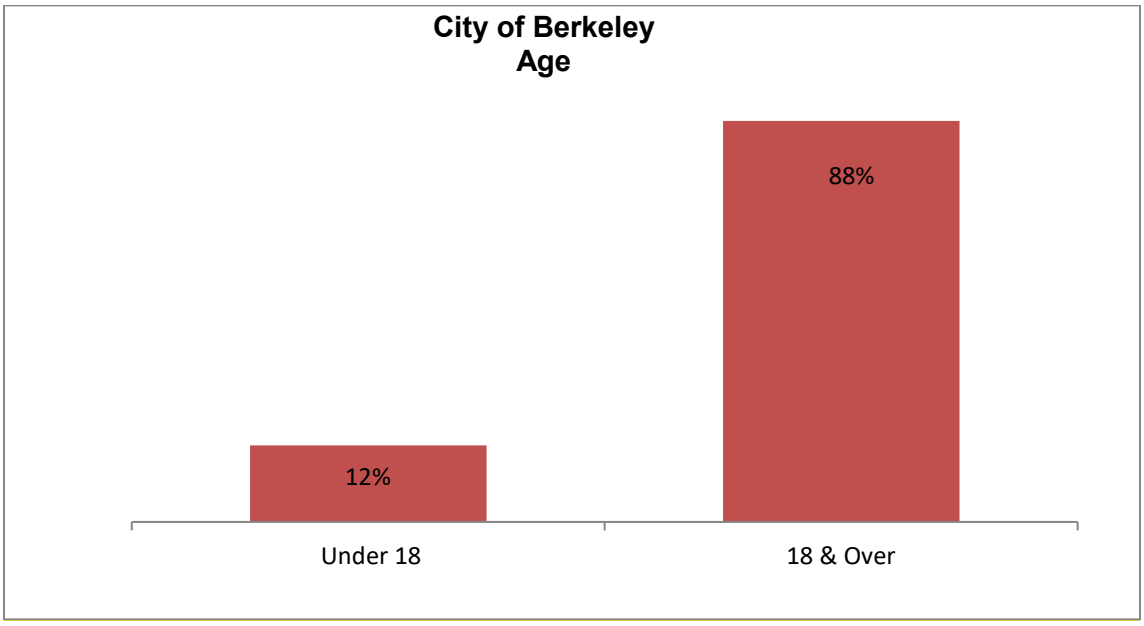
Race/Ethnicity

Berkeley is a diverse community with changing demographics. The African American population has decreased in recent years while the Latinx and Asian populations have both increased. Berkeley has a large student population, which provides housing for many of University of California's foreign students and their families. Threshold languages include English, Spanish, Farsi, Cantonese, and Vietnamese, and approximately 30% of Berkeley residents speak a language other than English at home. Berkeley is comprised of the following racial and ethnic demographics: African American; Asian; Latino/Latina/Latinx; White; American Indian/Alaska Native; and Native Hawaiian/Pacific Islander (P.I.). Demographics are outlined below:

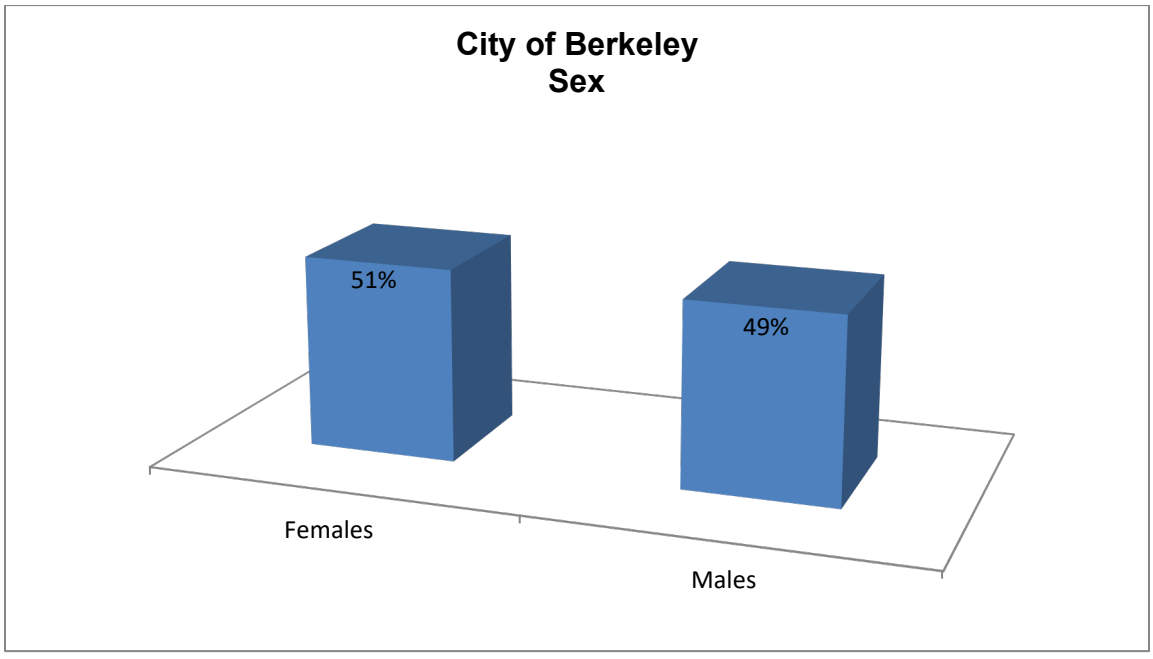


Age/Sex

As depicted in the table below, a large percentage of individuals in Berkeley are over the age of eighteen:



Sex demographics are as follows:



Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersexed, Agender, Plus (LBGTQIA+) Population

Per a brief by the Williams Institute, UCLA, entitled "LGBT Adults in Large US Metropolitan Areas" the LGBT population is 6.7% in the San Francisco Bay Area. According to the Brief, the estimated percentages of adults age 18 and older who identify as LGBT was derived from the Gallup Daily Tracking Survey which is an annual list-assisted random digit dial (70% cell phone, 30% landline) survey, conducted in English and Spanish, of approximately 350,000 U.S. adults ages 18 and up who reside in the 50 states and the District of Columbia. LGBT identity is based on response to the question, "Do you, personally, identify as lesbian, gay, bisexual, or transgender?" Respondents who answered "yes" were classified as LGBT. Respondents who answered "no" were classified as non-LGBT. Estimates derived from other measures of sexual orientation and gender identity may yield different results. (Conron,K.J, Luhur.W., Goldberg, S.K. Estimated Number of US LGBT Adults in Large Metropolitan Statistical Areas (MSA), (December 2020). The Williams Institute, UCLA. Los Angeles, CA.)

Income/Housing

With some of the highest housing costs in the Bay Area, the Berkeley median household income is $104,716. Nearly 18% of Berkeley residents live below the poverty line and approximately 27% of Berkeley children qualify for free and reduced lunches. While 43% of Berkeley residents own their own homes, there are many individuals experiencing homelessness including women, TAY, and Older Adults.

In order to measure the prevalence and characteristics of homelessness, a comprehensive street count of individuals experiencing homelessness is conducted in communities across the country every two years. According to the 2024 Alameda County Everyone Home Point-in-Time Count, which included a detailed assessment of the City of Berkeley, approximately 844 individuals were experiencing homelessness. Of this amount 47% were in some form of shelter, and 53% were unsheltered (as defined by someone whose primary residence is a car, park, abandoned building, or another place that isn't designed to be housing). These numbers represent a 20% decrease in the overall homeless population, and a 45% decrease in individuals who are unsheltered in Berkeley since the 2022 Alameda County Everyone Home Point-in-Time Count. Since 2021, there have been several initiatives to support individuals who are experiencing homelessness, and funding for new housing in the City, which has had a direct impact on individuals who are unhoused.

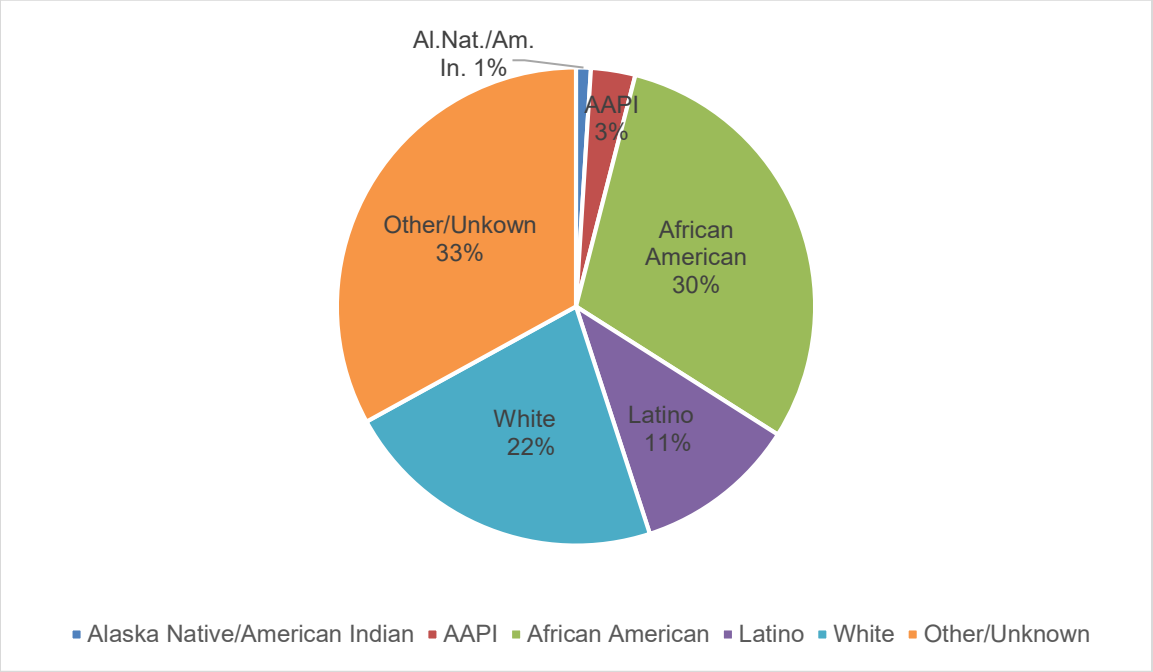
Education

Berkeley has a highly educated population: 9% of individuals aged 25 or older are high school graduates; and approximately 75% 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 in Berkeley. 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 provides the following services:

Crisis; Family, Youth & Children; High School Mental Health, Full Service Partnership Services, and Adult Services. Services include: assessment, assertive community treatment, individual and group therapy, case management, and crisis intervention. In addition to offering treatment, outreach, and support, some services are provided through a variety of community-based agencies and at school sites. As part of Crisis services, a Mobile Crisis Team operates seven days a week when fully staffed. 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. Per available data for the reporting timeframe, the Medi-Cal population was as follows:



COMMUNITY PROGRAM PLANNING

During the Community Program Planning (CPP) process one MHSA Advisory Committee meeting was held on Tuesday, April 29th, and four Community Input Meetings were held on the following dates/times:

- Tuesday, May 6th: 6:00pm-7:30pm
- Thursday, May 8th: 3:30pm-5:00pm
- Monday, May 12th: 6:00pm-7:30pm
- Wednesday, May 14th: 1:00-2:30pm

Announcements of the meetings were sent to MHSA Advisory Committee members, mental health peers, family members, representatives from community-based organizations, individuals from unserved, underserved and inappropriately served populations, HHCS Staff, City Commissioners, and other MHSA stakeholders.

During the MHSA Advisory and Community Input Meetings a presentation was conducted to provide information on MHSA background, funding, program requirements, the CPP process, and on upcoming changes to the funding requirements as a result of Proposition 1. The presentation also covered detailed information on the proposed MHSA FY2026 Annual Update and provided opportunities for input from the community.

An anonymous voluntary survey through Survey Monkey to obtain demographic information on individuals who participated in the CPP process, was administered during each meeting and to individuals who reached out by phone or email. Results of 19 individuals who voluntarily participated in the Survey were as follows:

DEMOGRAPHICS N = 19
(Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants. **Many participants were in more than one category).

- **Age Category**
  Transition Age Youth - <11
  Transition Age Youth - <11
  Adult - <11
  Older Adult - <11
  Declined to Answer to Answer (or Unknown) - <11

- **Gender Identity**
  Male - <11
  Female - <11
  Declined to Answer (or Unknown) - <11

- **Race/Ethnicity**
  Black or African American - <11
  White - <11

Latino/a/x - <11
Declined to Answer (or Unknown) - <11

- **Sexual Orientation**
  Heterosexual - <11
  Declined to Answer (or Unknown) - <11

- **Veteran Status**
  Veteran - <11
  Non-Veteran - <11
  Declined to Answer (or Unknown) - <11

- **Disability Status**
  Declined to Answer (or Unknown) – 19

- **Representative Categories**
  Consumer - <11
  Family Member of Consumer - <11
  Community Member or MHSA Stakeholder - <11
  Veteran - <11
  Representative of Mental Health Commission - <11
  Representative of Mental Health or Social Services Agency - <11
  Representative of Substance Use Disorder Agency - <11
  Representative of a Health Care Organization - <11
  Student, Staff, Representative or Parent of Student of Berkeley Unified School District - <11
  Student, Staff, Representative or Parent of UC Berkeley or Berkeley City College - <11
  Declined to Answer (or Unknown) - <11

As a method to continue to gather input from the community on this Annual Update, two additional Community Input meetings will be scheduled during the 30-Day Public Review. As with previous MHSA Plans and Annual Updates, a methodology utilized for conducting CPP for this Annual Update was implemented to enable a collaborative process to occur between BMH staff, MHSA Advisory Committee members, Community members and other MHSA stakeholders. Development of this Annual Update began with an internal examination of existing programs, unaddressed needs, and available funding which included a review of input received over the prior year and during previous MHSA planning processes. Following an internal review, proposed new additions were vetted through the MHSA Advisory Committee prior to engaging community members and other MHSA stakeholders.

Proposed program changes in this Annual Update include the following:

- Move an Assistant Management Analyst position that was previously approved for the Mental Health Manager, to the Adult Full Services Partnership.

- Transfer a portion of unspent CSS Funds to the WET Component, to provide future funding for the Workforce Development Coordinator position, and for stipends to support two student administrative interns, and six clinical interns.
- Transfer a portion of CSS Funds to the CFTN Component to support the future acquisition of a Mental Health facility, and/or mental health facility needs.
- Utilize previously approved funding to support the African American Holistic Resource Center, Sankofa Project.

The following program addition was also added as a result of input received during the 30-Day Public Review:

- Allocate an additional amount of funds for Insight Housing, to support the Russell Street Residence.

Details are outlined in the "Proposed Program Changes" section of this Annual Update.

During the Community Program Planning process, questions received were primarily around MHSA funded and area services, local housing, and the upcoming changes with BHSA. A concern was voiced regarding safety issues around placing individuals who have been homeless, at Senior Citizen housing sites and input received included: Ensuring individuals who have experienced homelessness are placed at a housing site that includes services to support them with acclimating to being housed; and to implement a program that provides individuals with the necessary services and supports to assist them in breaking the cycle of experiencing recurrent 5150 (hospitalization) events. An additional concern was around whether the Division has the appropriate level of staff resources for outreach, specifically to engage marginalized individuals and communities.

A 30-Day Public Review was held from Wednesday, May 28th through Thursday, June 26th to invite input on this Annual Update. A copy of the Annual Update was posted on the BMH MHSA website, and announcements of the 30-Day Public Review were mailed and/or emailed to community stakeholders and City staff. Individuals interested in providing input on this Annual Update were also able to attend two community meetings that were held during the 30-Day Public Review:

- Thursday, June 12th: 6:00pm-7:30pm
- Tuesday, June 17th: 5:00pm-6:30pm

Information on the Community Input Meetings were posted on the MHSA webpage and on the City's event calendar. Announcements of the meeting were also mailed and/or emailed to community stakeholders and City staff. For information regarding the Community Input Meetings, the Public Hearing, or the to provide input on the FY2026 Annual Update the public was invited to contact Karen Klatt, MHSA Coordinator, by phone (510) 981-7644, or email at: KKlatt@berkeleyca.gov

A Public Hearing on the Annual Update was held at 7:00pm on Thursday, June 26th, during the Mental Health Commission meeting. During the Public Hearing various

questions were asked and answered regarding some of the funding and programs within the FY2026 Annual Update. The Executive Director of Pacific Center for Human Growth submitted written input that was read during the Public Hearing. Written input is included in Appendix E of this Annual Update.

Following the Public Hearing the Mental Health Commission passed the following motion: M/S/C (Krishnan, Sol) Motion to approve the annual update with the stipulations of the figures being re-calculated on page 129.

> Ayes: Gu, Krishnan, Opton, Sol, Teague, Turner; Noes: None; Abstentions: None; Absent: Tregub, Prichett, Jones

Note that the Mental Health Commission motion refers to figures in the "FY2026 Projected Numbers To be Served and Estimated Cost Per Person" chart, which was on page 129 in the Draft FY2026 Annual Update.

There were four substantive comments received that warranted changes to the FY2026 Annual Update as follows:

- Provide additional funding for Insight Housing to help defray increased costs at the Russell Street Residence.
- Correct two errors that were found in the calculations of the "FY2026 Projected Numbers to Be Served and Estimated Cost Per Person Chart".
- Change the amount of funds to be utilized in FY2026 for the African American Holistic Resource Center.
- Update the expenditures from the Workforce, Education & Training Budget page, that were not previously carried forward to the Budget Summary page.

The Annual Update and Budget pages in this final version of the Annual Update have been edited to reflect these additions and changes. Additionally, further modifications to the format of the document have been made for accessibility purposes.

MHSA FISCAL YEAR 2025-2026 ANNUAL UPDATE

This City of Berkeley MHSA Fiscal Year 2025/2026 (FY2026) Annual Update is a stakeholder informed plan that provides an update to the previously approved MHSA FY2023/2024 – 2025/2026 Three-Year Program and Expenditure Plan (Three-Year Plan). This Annual Update summarizes proposed program changes, includes descriptions and updates of currently funded MHSA services that will be continued in FY2026 through the previously approved Three-Year Plan, and provides a reporting on FY2024 program data. Additionally, per state regulations, this Annual Update includes the Prevention and Early Intervention (PEI) Fiscal Year 2021/2022 – 2023/2024 Three-Year Evaluation Report (Appendix C). Although there were not any INN Programs in operation in FY2024, in order to comply with state regulations, an Innovation Fiscal Year 2023/2024 Annual Evaluation Report has also been included in Appendix D of this Annual Update.

As reported in previous MHSA Plans and Annual Updates, the Division has engaged in several initiatives over the past several years to increase data collection and evaluation efforts including the following:

- Impact Berkeley: In 2018, the Health Housing and Community Services (HHCS) Department implemented "Impact Berkeley". Central to this initiative 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. This has 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 measure and enhance progress towards these results. The results of this initiative are outlined in the PEI Community Education & Supports program section of this Annual Update.

- Results Based Accountability for all BMH Programs: Through a previously approved MHSA Annual Update the Division hired Resource Development Associates (RDA) to conduct a Results Based Accountability (RBA) Evaluation for all programs across the Division. RDA worked with the Division from FY2021-FY2024 to implement the RBA research methodology. An update of the activity's RDA conducted in FY2024 on this evaluation is included in this Annual Update.

  RBA outcomes in FY2024 are outlined throughout this Annual Update for the following MHSA funded internal programs: Children/Youth FSP; TAY, Adult and

Older Adult FSP; Homeless FSP; Wellness Recovery Services; Crisis Services; Transitional Outreach Team; Social Inclusion Project; and the High School Prevention Project. The complete set of RBA outcomes for all BMH programs is located in Appendix B.

- Program Evaluator: Per the approved FY2023 Annual Update, the Division hired a Program Evaluator who provided work and oversight through FY2024 on the RBA Evaluation. Since the ending of the RDA contract the Project Evaluator has directly taken over RBA Evaluation work, as well as other various data collection, analysis, and evaluation work within the Division.
- Per State requirements, Evaluation Reports for PEI and INN programs are also included in the Appendix of this Annual Update as follows:
- PEI Data Outcomes: Per MHSA PEI regulations, all PEI funded programs are required to collect state identified outcome measures (specific to the category of services provided) as well as detailed demographic information. PEI Evaluations are required to be included in each MHSA Annual Update or Three-Year Plan. See Appendix C for the Prevention & Early Intervention (PEI) Fiscal Year 2021/2022–2023/2024 (FY22-24) Three-Year Evaluation Report.
- INN Data Outcomes: Per MHSA INN regulations, all INN funded programs are required to collect state identified outcome measures and detailed demographic information. INN Evaluations are required to be included in each MHSA Annual Update or Three-Year Plan. Although there were not any INN Programs in operation in FY2024, in order to comply with state regulations, an Innovation (INN) Fiscal Year 2023/2024 Annual Evaluation Report has been included in Appendix D of this Annual Update.

PROPOSED PROGRAM CHANGES

The Division is proposing the following changes through this Annual Update:

Move Assistant Management Analyst position to Adult Full Services Partnership:
Through the previously approved Three-Year Plan, the Division received approval to hire an Assistant Management Analyst to support the Mental Health Manager. In an effort to support the need for administrative support, the Division is proposing to move this position to the Adult Full Services Partnership Program.

Provide previously approved MHSA funds for the African American Holistic Resource Center:
The African American/Black Professionals & Community Network (AABPCN) crafted a report titled "A Community Approach for African American/Black Culturally Congruent Services." This report identified challenges that the African American community faces in areas of education, employment, health, and mental health, housing, and community relationships. A vision and framework were provided in the report for the development of an African American Holistic Resource Center (AAHRC) in South Berkeley. The center will include the use of culturally congruent practices, embedded in an integrated service delivery system, which will help to decrease inequities and disparities in the African American community in Berkeley. The delivery of culturally congruent services at the AAHRC will provide African Americans with the support they need to decrease inequities and disparities, and build community.

One of the various components of the AAHRC will be Project Sankofa. Project Sankofa is focused on promoting mental wellness and is a campaign that aims to eradicate the stigma around mental health through love and compassion. It uses Black affirming methodologies to bring about a paradigm shift in how mental health and wellness are approached and communicated within communities of color. Deliverables include group/family/community mental health and wellness workshops and healing circles; community engagement activities; online social media campaign.

Through the MHSA FY2024-2026 Three-Year Plan, the Division received approval to provide $300,000 of Community Services and Supports (CSS) System Development Funds in FY2024 to support the AAHRC, Project Sankofa. Since FY2024, the allocation of funding, and implementation of the AAHRC Project Sankofa, has experienced some unexpected delays. However, in FY2026, the Division will allocate the previously approved $300,000 in funds for the AAHRC to implement Project Sankofa. It is envisioned that a contract with Healthy Black Families will be executed, who will serve as the fiscal administrator to the AAHRC for this project.

Provide a one-time funding Increase to support the Russell Street Residence:
Operated through Insight Housing, the Russell Street Residence provides permanent supportive housing for 17 formerly homeless adults who have experienced severe and persistent mental illness. Residents receive the following: supportive services; meals; therapeutic groups, activities and outings; transportation to medical appointments; and assistance with daily activities including laundry and personal hygiene.

Costs have increased since the contract was planned and executed, resulting in a shortfall of funds prior to the end of the planned contract. As such through this Annual Update the Division is proposing to allocate a one-time amount of $250,000 of CSS System Development funds for Insight Housing to help defray the increased costs at the Russell Street Residence.

Transfer Community Services and Supports funds to the Workforce, Education and Training component: For each year of the previously approved Three-Year Plan, the Division is able to transfer a portion of Community Services and Supports (CSS) System Development Funds to the Workforce, Education and Training (WET) component to fund the Workforce Development Coordinator position through the following process: Per MHSA Statute, (Welfare and Institutions Code, Section 5892 (b)): "In any year after 2007-08, programs for services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five years pursuant to this section."

Through this Annual Update the Division is proposing to transfer $344,426 of unspent CSS Funds to the WET Component. Once transferred, approximately $167,116 of funds will be used to support the Workforce Development Coordinator position. The remainder of funds, approximately $177,310 are being proposed to be utilized in the upcoming years on a Stipend Program to incentivize Student Interns to provide Clinical or Administrative work within the Division over a given period of time.

Transfer Community Services and Supports Funds to the Capital Facilities and Technological Needs component: Through this Annual Update the Division is proposing to transfer $1,300,000 of unspent Community Services and Supports (CSS) funds to the Capital Facilities and Technological Needs (CFTN) component through the following process:

Per MHSA Statute, (Welfare and Institutions Code, Section 5892 (b)): "In any year after 2007-08, programs for services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five years pursuant to this section."

Once funds have been transferred to CFTN, they will be utilized in the upcoming years to support various BMH facility needs, and/or as a match for the Department of Healthcare Services, Behavioral Health Continuum Infrastructure Program (BHCIP) should the City choose to apply. Uses of funds for facility needs may include but not be limited to the following: acquiring a new building, remodeling or renovating existing structures, and/or repairs, among other allowable CFTN related expenditures.

PROGRAM DESCRIPTIONS AND FY2024 DATA BY FUNDING COMPONENT

Outlined in this section per each funding component are descriptions of current City of Berkeley MHSA services that were continued through the previously approved Three-Year Plan and FY2024 program data. In FY2024, across all MHSA funded programs, approximately 5,208 individuals participated in some level of services and supports. Some of the FY2024 MHSA funded program highlights included: A reduction in psychiatric emergency services usage and/or incarceration days, and increased access to primary care services for severely mentally ill clients; step down to a lower level of care for some clients; services and supports for family members; increased services for individuals who are experiencing homelessness; Wellness Center services; co-occurring services for individuals who are experiencing both mental health needs and substance use disorders; community-based support group services; consumer driven wellness recovery activities; housing and benefits advocacy services; augmented prevention and early intervention services for children and youth in the schools and community; and supportive services for TAY, Adults and Older Adults in unserved, underserved and inappropriately served cultural and ethnic populations.

COMMUNITY SERVICES & SUPPORTS (CSS)

The Community Services & Supports (CSS) funding component primarily provides treatment services and supports for Severely Mentally Ill Adults and Seriously Emotionally Disturbed Children and Youth. Funding is provided in three areas of programming: Full Services Partnerships; Multicultural Outreach & Engagement; and System Development.

Following a year-long community planning and plan development process, the initial City of Berkeley Community Services & Supports (CSS) Plan was approved in September 2006. Since the approval of the original plan, Three-Year Plans or Annual Updates outlining proposed CSS funding and programming have been developed and approved on an annual basis. From the original CSS Plan and/or through subsequent plan updates, some of the many services the City of Berkeley has provided through CSS funding are as follows:

- Wrap-around Services for Children and their families
- TAY, Adult and Older Adult Intensive Treatment Services
- Supportive Services for Individuals experiencing homelessness
- Diversity & Multi-cultural Services
- TAY Case Management and Support Services
- Consumer Advocacy
- Wellness and Recovery Services
- Family Advocacy
- Transitional Outreach Team
- Support Groups for individuals

- A Wellness Recovery Center; and
- Benefits Advocacy.

Descriptions of each CSS funded program that were continued through the previously approved Three-Year Plan, and FY2024 data are outlined on the following pages. Throughout all CSS programs, demographic data representing numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

Full Service Partnerships (FSP)

Children/Youth Intensive Support Services Full Service Partnership
The Children/Youth Intensive Support Services Full Service Partnership (CFSP) is for children ages 0-21 and their families. This program is for children, youth 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 and youth 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 suicide attempt within the last six months from the date of referral.

The CFSP 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 CFSP 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 FY2024, a total of 14 children/youth and their families were served through this program. Demographics on those served were as follows:

DEMOGRAPHICS N = 14
*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  6 – 25 years – 14

- **Gender Identity**
  Male - <11
  Female - <11
  Declined to Answer - <11

- **Race/Ethnicity**
  Asian Pacific Islander - <11
  Black or African American - <11
  Latino/a/x - <11
  Other - <11

- **Sexual Orientation**
  Heterosexual - <11
  Lesbian/Gay/Bisexual/Queer/Questioning or Unknown - <11

Flex funds are used to provide various supports for FSP program participants and/or the families of program participants. In FY2024, flex funds were utilized as follows: 31 individuals/families received funding for food/groceries; 6 individuals/families received funds for clothing/hygiene; 2 individuals/families received funds for pharmacy needs; 14 individuals/families received funds for furniture/household items; 3 individuals/families received funding for Bus Passes or transportation; and 9 individuals/family members received funding for other various needs.

The CFSP team had staff turnover this fiscal year: The current Sr. Behavioral Health Clinician was hired during the fiscal year and has been working to grow in her role as the lead clinician on the team. Fortunately, she was hired from within the program and was aware of many aspects of the team and their work with our clients.

Program Successes:

- Increased referrals accepted due to having a fully staffed team.
- Opened cases and provide care to mono-lingual Spanish speaking families.
- Increased access to psychiatric medication services and the provision of individual/family therapy.
- Continued to reduce psychiatric hospitalizations and the usage of crisis services due to the care provided by the team and system coordination with the clients extended treatment team.
- Services continued to be provided by clinicians who mirrored the racial/ethnic identity of the populations served.
- Successfully, transitioned a TAY youth to an FSP program in Oakland and supported their transition to independent housing in the community.
- Continued to provide flex funding to support the needs of clients; this was extremely important as there was an increase in needs due to parent's loss of employment, the increase cost of goods and services, and parents continued to struggle with unresolved trauma. These funds supported the purchase of birthday/holiday gifts, food, household items, car repairs, hotel stays for unhoused families, pro-social activities for clients/their siblings, legal fees, summer camp attendance for a family, and clothing.
- Successfully supported client families to use the After-Hours service to reduce the need for emergency/crisis services.

Program Challenges:

- The primary challenge was to consistently engage caregivers who had multi-faceted stressors in the family system which made it difficult for them to meet with the clinician. This made it difficult for the family system to improve as most of the focused work was directed toward the youth rather than both supporting the youth's needs along with the changes that could help the entire system.

In FY2026 the projected number of individuals to be served per each age category is as follows: Children (0-15) years = 10; Transition Age Youth (16-25 years) = 11; Adults/Older Adults (26-60+) = 0.

The RBA Measures that were established for this FSP were as follows:

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is Anyone Better off?
• # of clients served • # of new clients opened for ongoing services • Average # of days in FSP for client • Average # of services hours per client per month • Average # of services per client per month	• % of clients who have at least completed one CANS/ANSA for each six-month period that they are in the program • % of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month • % of discharges from hospitalization or subacute who had a follow-up visit with CFSP staff within 7 business days • % of clients with no service gap of over 30 days • #/% of clients closed, by reason closed • % of clients or family members who participate in the survey**	• % of clients with a primary care visit in the last 12 months • % of clients who had a reduction in psychiatric care emergency services/inpatient/ crisis stabilization units in the last 12 months compared to the 12 months before enrollment** • % of clients with a decrease in hospitalizations/hospitalization days

*Demographic data was reported at the program level, where available
**Data not available for baseline reporting period, will be included in future rounds of reporting.

RBA Outcomes in FY2024 for this FSP are outlined on the following pages.

BMH RBA Report FY 2024

Reporting Period July 2023 - June 2024

Child Full Service Partnership (CFSP)

Process Outcomes ("How much did we do?")

14

Clients Served

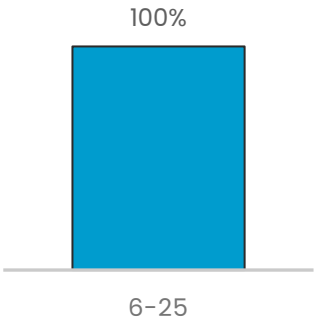
***De-identified (n<11)**

New Clients

Program Description: This team provides wrap around services to children and families with acute needs, who meet the following criteria: child is at risk of/has been removed from their parent/guardian; child is involved with the Juvenile Justice System or at risk of that; has been recently had a psychiatric hospitalization or is at risk of a hospitalization.

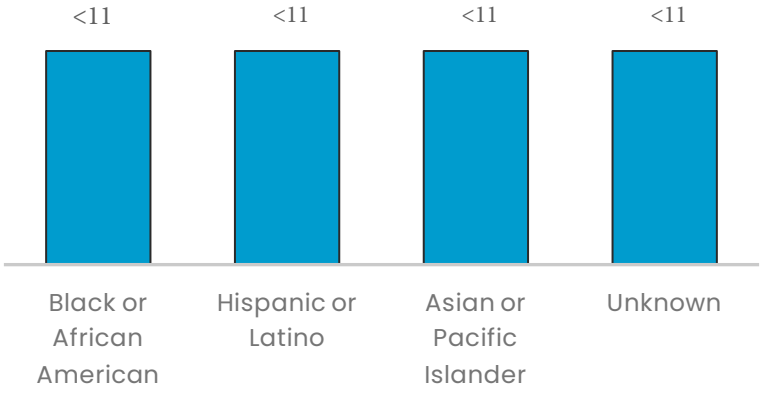
Demographics (Age)

Jul '23 - Jun '24 (n=14)



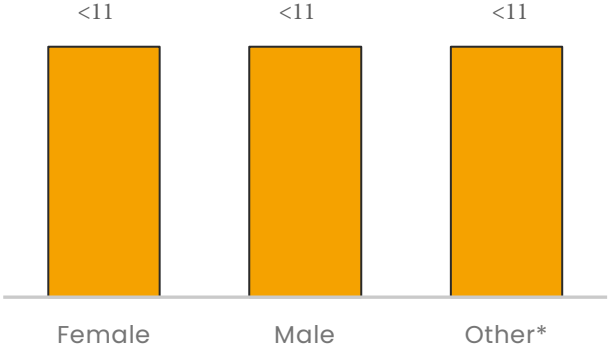
Demographics (Ethnicity)

Jul '23 - Jun '24 (n=14)



Demographics (Gender Identity)

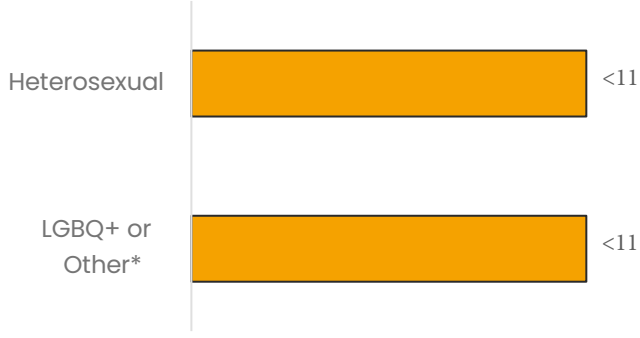
Jul '23 - Jun '24 (n=14)



*Other includes any identity that doesn't fit within the traditional male/female binary.

Demographics (Sexual Orientation)

Jul '23 - Jun '24 (n=14)

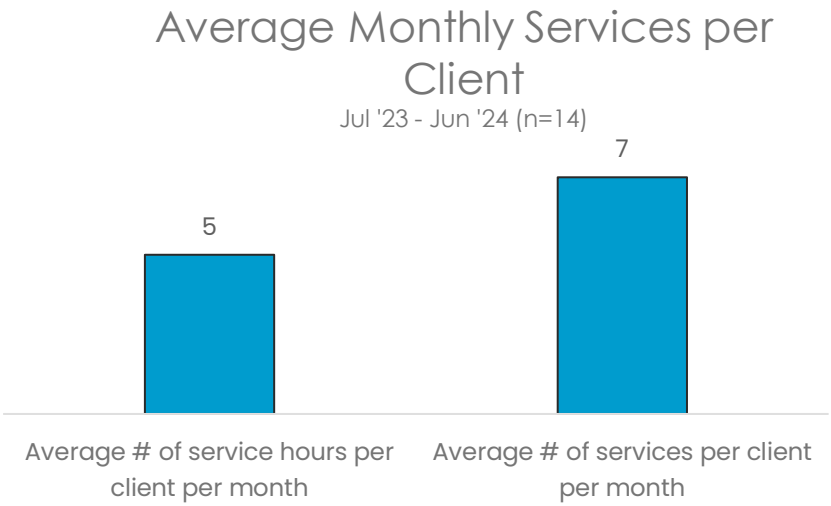


*LGBQ+ includes individuals who identify as lesbian, gay, bisexual,questioning, or other diverse sexual orientations. Other includes prefer not to answer or

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

Quality Outcomes ("How well did we do it?")

Service Consistency



90-100% n<15
Discharges from hospitalization or subacute who had a follow up visit with within 7 days

Retention and Stability

60-70% n<15
Clients receive an average of 4+ face-to-face visits per month

Clients Spend **300 days** in FSP on average

90-100% n<15
Clients with at least one completed CANS assessment every six months while in the program

70-80% n<15
Clients with no service gap of over 30 days

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

Impact Outcomes ("Is anyone better off?")

Client Outcome Improvements

50-60% n<15
Clients with a Primary care visit

90-100% n<15
Client reduction in psychiatric emergency services/inpatient/ crisis stabilization units

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients	Clients who were not served by the program in the previous fiscal year	Yellowfin
Average # of service hours per client per month	Average of hours of service in a month divided by clients served in a month. Includes all services recorded for clients. Does not include medcation services (MAA).	Yellowfin
Average # of services per client per month	Average services in a month divided by clients served in a month. Includes all services recorded for clients. Note: more than one service can be provided during a single contact. Does not include MAA	Yellowfin
% of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program	Of clients with a completed Child or Adult Needs and Strengths Assessment (CANS/ANSA), what percentage of them had an assessment at least every six months?	Objective Arts
% of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month	Clients must be been open to a provider for at least 30 days in order to be included in this metric. Phone contacts are included during the pandemic. Days in subacute or jail not counted, but services are counted.	Yellowfin
% of clients with no service gap of over 30 days	Maximum days each Level 1 client went without service during their episode(s) in the reporting period. Only considered clients open to a provider for at least a total of three months during the reporting fiscal year.	Yellowfin
% of discharges from hospitalization or subacute who had a follow up visit with FSP staff within 7 business days	Follow-up rates for individuals open to Level 1 providers at the time of mental health hospital discharge. *note: clients used to calculate follow up rates include those who didn't receive outreach and those who were lost to follow up (e.g. not contactable, not	Yellowfin
#/% of clients closed, by reason closed	Discharge reason for clients discharged during the reporting period	Yellowfin *Not presented due to delays in the reporting system
% of clients with a primary care visit	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/Community Health Center Network (CHCN) primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).	Yellowfin

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

Average # of days in FSP per client	The average number of days a client remains enrolled in the Full-Service Partnership (FSP) program.	Yellowfin
% of clients with a decrease in hospitalization days/admissions	Decrease in hospital days/admissions in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital day in the 12 months prior to admission and remained in the program for at least 1 year. Only available for fiscal years.	Yellowfin Note: Data Suppressed (<11 clients)

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

Adult Full-Service Partnership
The Adult Full-Service Partnership (AFSP) offers dedicated support services to individuals aged 18 and older (Transitional Age Youth, Adults, and Older Adults) facing severe mental illness. Grounded in the Assertive Community Treatment (ACT) approach, the program is designed to assist individuals encountering challenges in obtaining or sustaining housing, enduring frequent and/or prolonged psychiatric hospitalizations, and experiencing repeated or extended periods of incarceration. Priority populations include those from unserved, underserved, and culturally and ethnically marginalized communities.

The ACT approach maintains a low staff-to-client ratio of 10:1, enabling frequent and intensive support services to clients. Clients receive assistance in securing suitable housing, with the potential for temporary financial aid. The primary objectives of the program are to actively involve clients in their treatment and to reduce the instances of homelessness, hospitalization, and incarceration. In tandem, it seeks to improve employment and educational preparedness, encourage self-sufficiency, and support overall wellness and recovery. Through a targeted commitment to these goals, the Adult Full Services Partnership endeavors to significantly improve the lives of its participants.

In FY2024 a total of 66 TAY, Adults, and Older Adults participated in the program for all or part of the fiscal year. Demographics on those served include the following:

DEMOGRAPHICS N = 66*
*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  18 – 24 or Unknown - <11
  25 – 44 years – 21
  45 – 64 years – 20
  65 years and older – 20

- **Gender Identity**
  Male - 40
  Female - 26

- **Race/Ethnicity**
  Asian Pacific Islander - <11
  Black or African American - 38
  Latino/a/x - <11
  White – 23
  Decline to Answer or Unknown - <11

- **Sexual Orientation**
  Heterosexual - 54
  Lesbian/Gay/Bisexual/Queer/Questioning or Unknown – 12

Flex funds are used to provide supports for FSP program participants. In FY2024, 17 partners received rental and housing assistance; 44 received food and groceries; 6 received In-Home Assistance (cleaning, activities of daily living); and 32 partners were provided with clothing, furniture, hygiene products, and assistance with utility bills tr; and 24 partners received bus passes or other transportation assistance.

In FY2024 this program experienced an increase in clients served, improved service engagement, and better continuity of care. However, 7-day hospital follow-up rates declined, and clients continue to experience financial hardship, increasing the need for flex fund assistance. Overall, client outcomes improved, especially in reducing jail days, psychiatric emergency services use, and increasing primary care access. There were demographic shifts in the individuals served including the following: African American clients increased from 54% to 58%; White clients decreased from 40% to 35%; Latinx and Asian Pacific Islander clients remained stable; and a slightly higher proportion of clients declined to report their sexual orientation 15% in FY2024 vs. 13% in FY2023.

Program Successes:
Increase in the number of clients served:

- The total number of clients served increased slightly from 63 in FY2023, to 66 in FY2024.
- The number of new clients opened for ongoing services grew from 11 to 17, which reflected increased outreach and program engagement.

Higher Client Retention and Engagement:

- 67% of clients received 4 or more face-to-face outpatient visits per month, up from 60% in FY2023, which indicated stronger client participation.
- 56% of clients had no service gap over 30 days, compared to 39% in the previous year, which demonstrated improved care continuity.

Changes in hospitalization follow-up rates:

- 7-day follow-up rates after hospitalization declined from 88% in FY2023 to 63% in FY2024.
- 30-day follow-up rates remained strong at 88%, though slightly lower than 100% in FY2023.

Reduction in Incarceration and Psychiatric Emergency Services:

- 80% of clients had a reduction in jail days, a major improvement from 53% in FY23.
- 100% of clients saw a reduction in psychiatric emergency services/inpatient/crisis stabilization use, up 77% from the previous year.

Greater Access to Primary Care:

- 83% of clients had a primary care visit, compared to 76% in FY2023, showing better overall health engagement.

High 30-Day Hospital Follow-Up Rate:

- 88% of clients had a follow-up visit within 30 days post-hospitalization, ensuring continuity of care.

Flex Funds Helped Address Client Needs:

- 129 instances of flex fund support were provided, mainly for food, housing, transportation, and hygiene needs.

Program Challenges:
Decline in 7-Day Hospitalization Follow-Up Rates:

- The 7-day follow-up rate after hospitalization dropped from 88% in FY2023 to 63% in FY2024, suggesting a need for improvement in early post-hospitalization engagement.

Maintaining Client Engagement for Some Populations:

- Despite improved overall service engagement, some clients continue to struggle with consistent participation.

Increased Financial Hardship Among Clients:

- High demand for flex funds, particularly for food (44 instances), transportation (36 instances), and housing (17 instances), reflected continued financial instability.

Limited Staff Resources for Growing Service Needs:

- With increasing client engagement and service demand, staff balanced meeting client needs with maintaining quality care.

Based on previous years, in FY2026 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 0; Transition Age Youth (16-25 years): 3; Adults (26-59 years): 12; Older Adults (60+ years): 41.

The RBA measures that were established for this FSP were as follows:

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is Anyone Better off?
• # clients served • # of new clients opened for ongoing services • Average # of days in FSP per client • Average # of service hours per client per month • Average # of services per client per month	• % of clients who have at least completed one CANS/ANSA for each six-month period that they are in the program • % of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month • % of clients with no service gap of over 30 days • % of discharges from hospitalization or subacute who had a follow up visit with FSP staff within 7 and within 30 calendar days • #/% of clients closed, by reason closed • #/% of clients transferred to another level of care • % of clients who were satisfied with services**	• % of clients who had a reduction in jail days in the last 12 months compared to the 12 months before enrollment • % of clients who had a reduction in psychiatric emergency services/inpatient/crisis stabilization units in the last 12 months compared to the 12 months before enrollment • % of clients with a decrease in hospitalizations and hospitalization days • % of clients with a primary care visit in the last 12 months • % of clients who moved out of homelessness**

*Demographic data was reported at the program level, where available
**Data not available for baseline reporting period, will be included in future rounds of reporting

RBA Outcomes in FY2024 for this FSP are outlined on the following pages.

BMH RBA Report FY 2024

Reporting Period July 2023 - June 2024

Adult Full Service Partnership (AFSP)

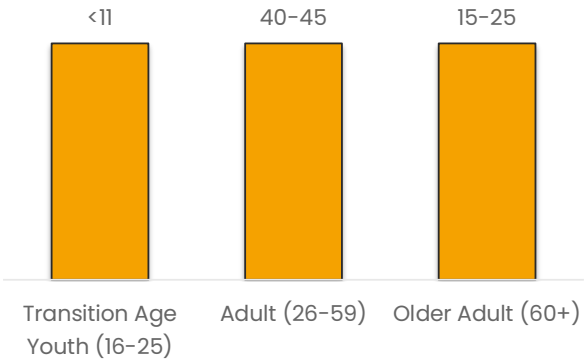
Process Outcomes ("How much did we do?")

66
Clients Served

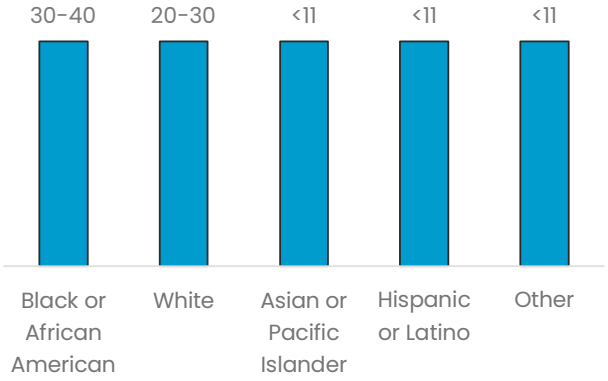
17
New Clients

Program Description: The Full-Service Partnership (FSP) team provides services to clients who are considered the highest need within our adult mental health service system. The FSP team is based on an Assertive Community Treatment (ACT) Model which involves low staff-to-client ratios at approximately 10:1 and a focus on providing care as a team rather than individual case load assignments. Services are primarily provided in the community rather than in an office setting.

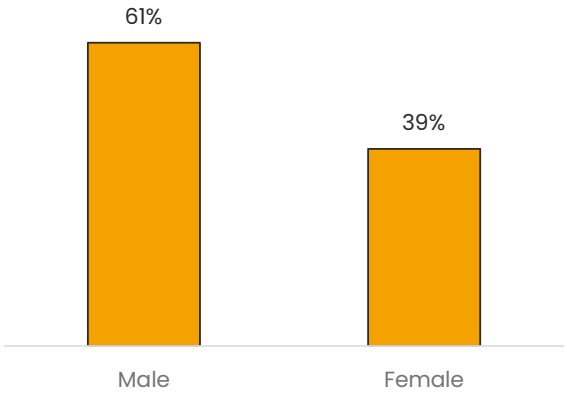
Demographics (Age)
Jul '23- Jun '24 (n=66)



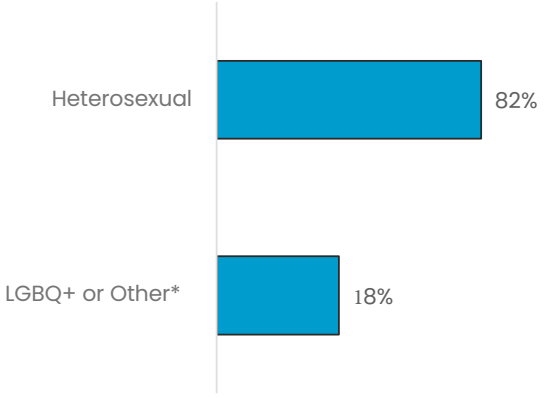
Demographics (Ethnicity)
Jul '23 - Jun '24 (n=66)



Demographics (Gender Identity)
Jul '23 - Jun '24 (n=66)



Demographic (Sexual Orientation)
Jul '23 - Jun '24 (n=66)



*LGBQ+ includes individuals who identify as lesbian, gay, bisexual, questioning, or other diverse sexual orientations. Other includes prefer not to answer, or unknown.

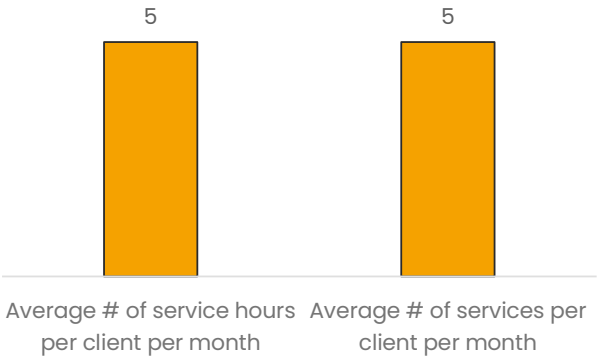
NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Quality Outcomes ("How well did we do it?")

Service Consistency

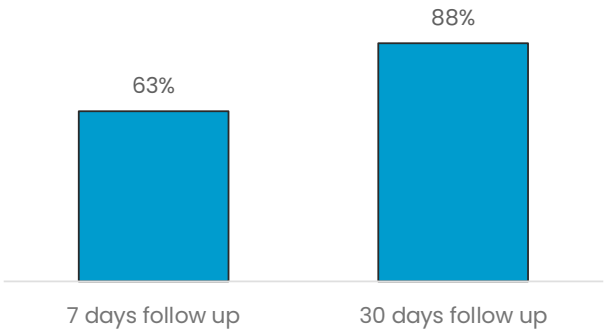
Average Monthly Services per Client

Jul '23 - Jun '24 (n=66)



Discharges from hospitalization or subacute who received FSP follow up within 7 and 30 days

Jul '23 - Jun '24 (n=20)



Retention and Stability

Clients Spend **4 years** in FSP on average

67% n=66
Clients receive an average of 4+ face-to-face outpatient visits per month

56% n=66
Clients with no service gap of over 30 days

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Impact Outcomes ("Is anyone better off?")

Client Outcome Improvements

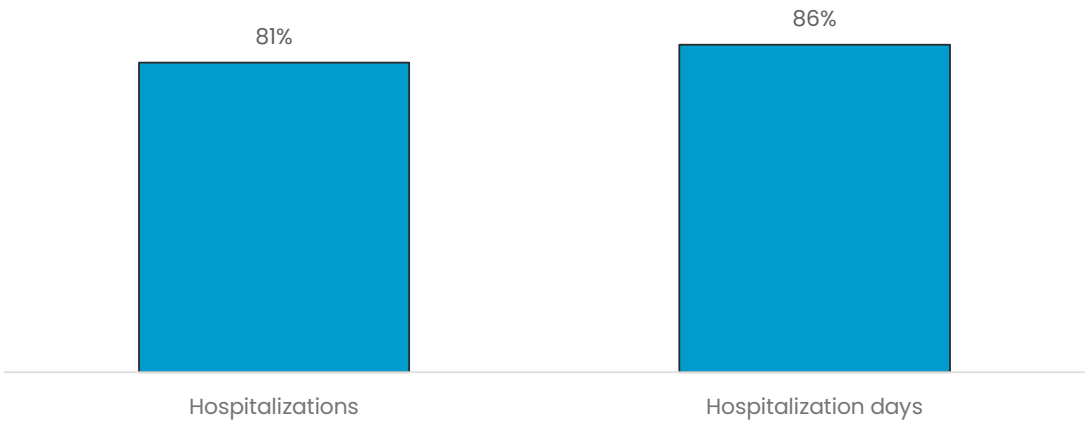
80-90% n<11
Clients who had a reduction in jail

100% n<11
Client reduction in psychiatric emergency services/inpatient/ crisis stabilization units

83% n=48
Clients with a Primary care visit

Clients with a decrease in hospitalizations/hospital days

Jul '23 - Jun '24 (n=20)



NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients	Clients who were not served by the program in the previous fiscal year	Yellowfin
Average # of service hours per client per month	Average of hours of service in a month divided by clients served in a month. Includes all services recorded for clients. Does not include medical services (MAA)	Yellowfin
Average # of services per client per month	Average services in a month divided by clients served in a month. Includes all services recorded for clients. Note: more than one service can be provided during a single contact. Does not include MAA	Yellowfin
% of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month	Clients must be been open to a provider for at least 30 days in order to be included in this metric. Phone contacts are included during the pandemic. Days in subacute or jail not counted, but services are counted.	Yellowfin
% of clients with no service gap of over 30 days	Maximum days each Level 1 client went without service during their episode(s) in the reporting period. Only considered clients open to a provider for at least a total of three months during the reporting fiscal year.	Yellowfin
% of discharges from hospitalization or subacute who had a follow up visit with FSP staff within 7 and within 30 calendar days	Follow-up rates for individuals open to Level 1 providers at the time of mental health hospital discharge. *note: clients used to calculate follow up rates include those who didn't receive outreach and those who were lost to follow up (e.g. not contactable, not responsive)	Yellowfin
#/% of clients closed, by reason closed	Discharge reason for clients discharged during the reporting period	Yellowfin Not presented due to delays in the reporting system
# of clients transferred to another level of care	Of clients discharged in the reporting period, # who were transferred to a full service partnership program, service team, or outpatient services in Alameda County within 90 days of discharge.	Yellowfin Data Suppressed (n<11)

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

% of clients who had a reduction in psychiatric emergency services/inpatient/crisis stabilization units	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in psychiatric emergency services, inpatient or crisis stabilization unit other than Amber House, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in jail and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients who had a reduction in jail days	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in jail days, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in hospital and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients with a primary care visit	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/Community Health Center Network (CHCN) primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).	Yellowfin
% of clients with a decrease in hospitalizations/hospitalization days	Decrease in hospital days/admissions in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital day in the 12 months prior to admission and remained in the program for at least 1 year. Only available for fiscal years.	Yellowfin
% of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program	Of clients with a completed Child or Adult Needs and Strengths Assessment (CANS/ANSA), what percentage of them had an assessment at least every six months?	No ANSA data is available for FY24

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Homeless Full-Service Partnership
The Homeless Full Services Partnership (HFSP) provides services to individuals primarily in the community, and in any temporary housing placement (e.g. shelter, unhoused encampment) who meet the following criteria:

- Adults (18 years and older);
- Unhoused and those at risk of being unhoused;
- Severe Mental Illness; and
- Significant impairments in functioning (e.g., frequent psychiatric hospital utilization, involvement in the criminal justice system, domestic violence survivors, trauma, severe co-occurring disorders).

The HFSP utilizes a team model for providing intensive treatment, meeting people up to several times per week. In FY2024, 47 individuals were served. Demographics on individuals served are as follows:

DEMOGRAPHICS N = 47*
*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  25 – 44 years and Unknown – <11
  45 – 64 years – 30
  65 years and older – 15

- **Gender Identity**
  Male - 34
  Female - 13

- **Race/Ethnicity**
  Asian Pacific Islander - <11
  Black or African American - 26
  Latino/a/x - <11
  White – 18
  Other - <11

- **Sexual Orientation**
  Heterosexual - 34
  Lesbian/Gay/Bisexual/Queer/Questioning or Unknown - 18

Flex funds are used to provide supports for HFSP program participants. During FY2024, 4 partners received rental and housing assistance; 20 received food and groceries; 28 partners received bus passes or transportation; 28 partners were provided with assistance with clothing/hygiene; and 4 partners were provided with other types of assistance.

Program Successes:
The HFSP program has demonstrated consistent growth and progress over the years. The number of clients served has increased from 36 in FY2022 to 47 in FY2024, reflecting a steady rise in demand and capacity. This growth also reflects the program's robust outreach and ability to meet community needs.

Client demographic trends show that the program effectively serves diverse populations, with notable increases in serving male clients (from 69% to 72%) and consistent engagement with Black or African American clients (remaining over 50% across all years). Additionally, the program has maintained a strong focus on service continuity, as evidenced by reduced service gaps over 30 days (maintained at 32% in the most recent year).

Noteworthy quality improvements included follow-up visits after discharges from hospitalization, with 50% of clients receiving timely follow-up care within both 7 and 30 days. Furthermore, impact measures indicated positive outcomes, including a 63% reduction in jail days and a 75% decrease in hospitalizations among clients, showcasing the program's effectiveness in stabilizing clients and reducing institutionalization.

The program's ability to achieve consistent levels of client satisfaction, maintain high engagement in face-to-face visits, and facilitate primary care connections in FY2024 further highlighted its holistic approach to client wellness.

Program Challenges:
While the program had significant success in FY2024, there were also areas in need of improvement to enhance client care and operational efficiency. One challenge was maintaining a consistent number of new clients opened for ongoing services. After a high intake of 35 new clients in FY2023, the number declined to 13 in FY2024, suggesting potential barriers to new client engagement or referral processes. This could also be due to issues with vacancies in the team bandwidth. The program also experienced a gradual decline in the average number of service hours from 8 to 6 hours per client per month. This trend may reflect the staffing constraints, increased caseloads, or challenges in maintaining intensive service delivery, that were experienced during the reporting timeframe.

Another concern was the reason for client closures. Often times the closures were due to non-engagement. This highlighted an opportunity to implement clearer tracking and reporting processes to understand client withdrawal patterns better and identify trends for early intervention. Finally, while progress in reducing hospitalization days was commendable, sustaining and expanding these improvements require continued investment in preventive care, crisis response, and collaboration with community partners.

Based on previous years, in FY26 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 0; Transition Age Youth (16-25 years): 2; Adults (26-59 years): 43; Older Adults (60+ years): 6.

The RBA Measures that were established for this FSP were as follows:

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is Anyone Better off?
• # of clients served • # of new clients opened for ongoing services • Average # of days in FSP for client • Average # of services hours per client per month • Average # of services per client per month	• % of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program • % of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month • % of discharges from hospitalization who had a follow up visit with HFSP staff within 7 and within 30 calendar days • % of clients with no service gap of over 30 days • #/% of clients closed, by reason closed • % of clients who were satisfied with services**	• # of clients housed** • # of clients who gained or maintained housing since enrollment** • % of clients who had a reduction in jail days in the last 12 months compared to the 12 months before enrollment • % of clients with a primary care visit in the last 12 months • % of clients who had a reduction in psychiatric care emergency services/inpatient/ crisis stabilization units in the last 12 months compared to the 12 months before enrollment • % of clients with a decrease in hospitalizations/hospitalization days • % of clients with an increase in the number of days in community living compared to 12 month period before enrollment**

*Demographic data was reported at the program level, where available

**Data not available for baseline reporting period, will be included in future rounds of reporting

RBA Outcomes in FY2024 for this FSP are outlined on the following pages.

BMH RBA Report FY 2024

Reporting Period July 2023 - June 2024

Homeless Full Service Partnership (HFSP)

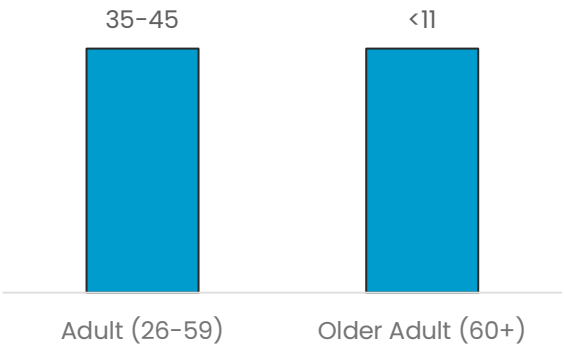
Process Outcomes ("How much did we do?")

47
Clients Served

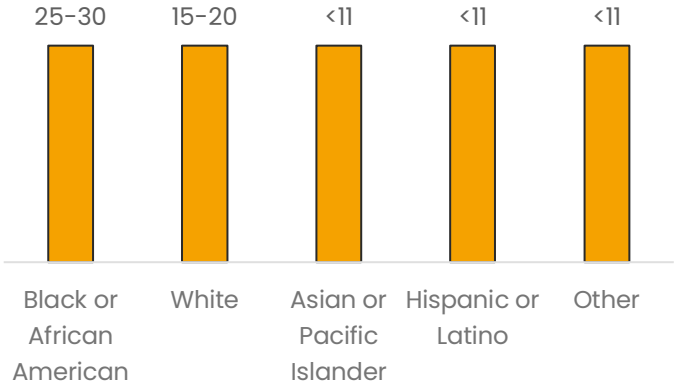
13
New Clients

Program Description: HFSP serves unhoused residents of Berkeley in an Assertive Community Treatment (ACT) model at high staff to client ratios, providing intensive case management and mental health services in a multi-disciplinary team approach. This team serves those with the highest level of need, supporting a population that is primarily unhoused and has multiple severe functional impairments.

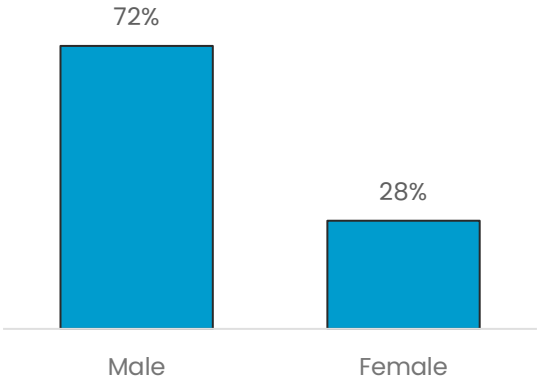
Demographics (Age)
Jul '23 - Jun '24 (n=47)



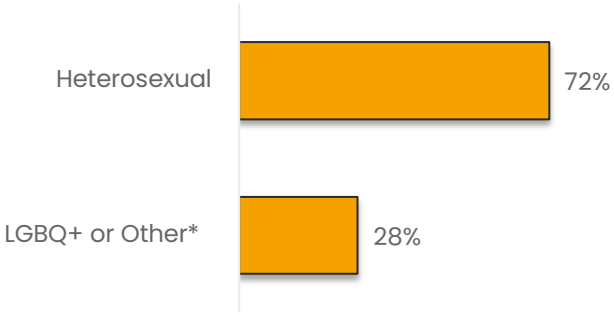
Demographics (Ethnicity)
Jul '23 - Jun '24 (n=47)



Demographics (Gender Identity)
Jul '23 - Jun '24 (n=47)



Demographics (Sexual Orientation)
Jul '23 - Jun '24 (n=47)



*LGBQ+ includes individuals who identify as lesbian, gay, bisexual, questioning, or other diverse sexual orientations. Other includes prefer not to answer or

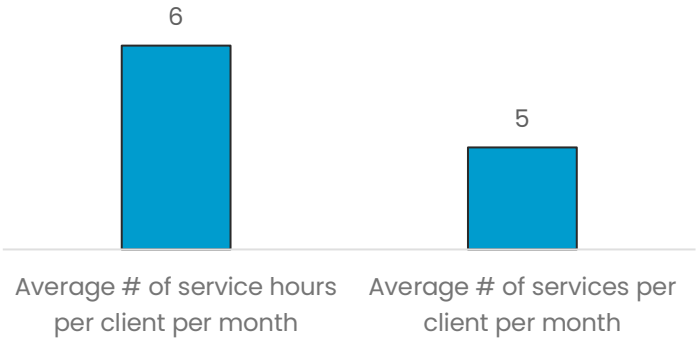
NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

Quality Outcomes ("How well did we do it?")

Service *Consistency*

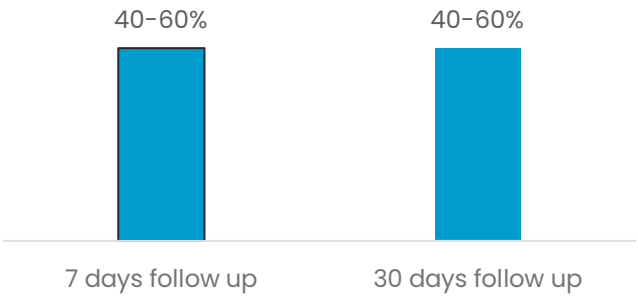
Average Monthly Services per Client

Jul '23 - Jun '24 (n=47)



Discharges from hospitalization or subacute who received FSP follow up within 7 and 30 days

Jul '23 - Jun '24 (n<11)



Retention and Stability

51% n=47
Clients receive an average of 4+ face-to-face outpatient visits per month

Clients spend **1.9 years** in FSP on average

32% n=47
Clients with no service gap of over 30 days

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

Impact Outcomes ("Is anyone better off?")

Client Outcome Improvements

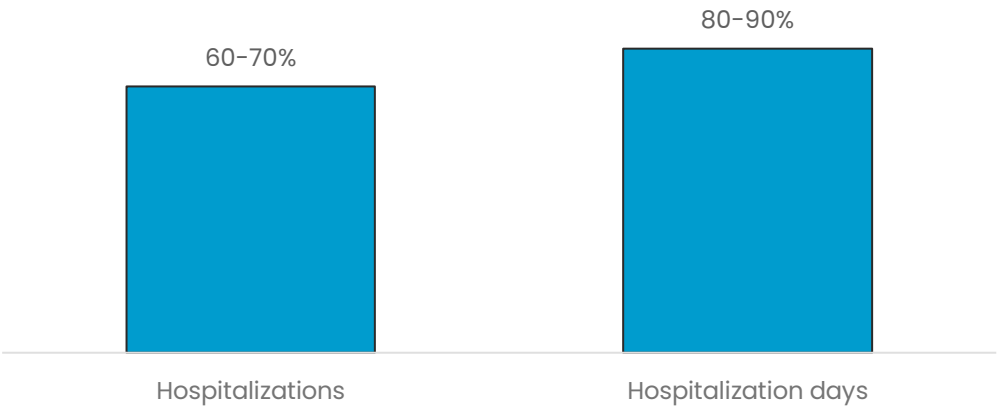
63% n<11
Clients who had a reduction in jail days

71% n<11
Client reduction in psychiatric emergency services/inpatient/ crisis stabilization units

68% n=38
Clients with a Primary care visit

Clients with a decrease in hospitalizations/hospital days

Jul '23 - Jun '24 (n<11)



NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients opened for ongoing services	Clients who were not served by the program in the previous fiscal year	Yellowfin
Average # of service hours per client per month	Average of hours of service in a month divided by clients served in a month. Includes all services recorded for clients. Does not include medical services (MAA)	Yellowfin
Average # of services per client per month	Average services in a month divided by clients served in a month. Includes all services recorded for clients. Note: more than one service can be provided during a single contact. Does not include MAA	Yellowfin
% of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month	Clients must be been open to a provider for at least 30 days in order to be included in this metric. Phone contacts are included during the pandemic. Days in subacute or jail not counted, but services are counted.	Yellowfin
% of clients with no service gap of over 30 days	Maximum days each Level 1 client went without service during their episode(s) in the reporting period. Only considered clients open to a provider for at least a total of three months during the reporting fiscal year.	Yellowfin
% of discharges from hospitalization or subacute who had a follow up visit with FSP staff within 7 and within 30 calendar days	Follow-up rates for individuals open to Level 1 providers at the time of mental health hospital discharge. *note: clients used to calculate follow up rates include those who didn't receive outreach and those who were lost to follow up (e.g. not contactable, not responsive)	Yellowfin
#/% of clients closed, by reason closed	Discharge reason for clients discharged during the reporting period	Yellowfin *Not presented due to delays in the reporting system
# of clients transferred to another level of care	Of clients discharged in the reporting period, # who were transferred to a full service partnership program, service team, or outpatient services in Alameda County within 90 days of discharge.	Yellowfin Note: Data Suppressed (<11 clients)

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

% of clients who had a reduction in psychiatric emergency services/inpatient/crisis stabilization units	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in psychiatric emergency services, inpatient or crisis stabilization unit other than Amber House, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in jail and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients who had a reduction in jail days	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in jail days, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in hospital and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients with a primary care visit	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/Community Health Center Network (CHCN) primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).	Yellowfin
% of clients with a decrease in hospitalizations/hospitalization days	Decrease in hospital days/admissions in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital day in the 12 months prior to admission and remained in the program for at least 1 year. Only available for fiscal years.	Yellowfin
% of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program	Of clients with a completed Child or Adult Needs and Strengths Assessment (CANS/ANSA), what percentage of them had an assessment at least every six months?	No data available; ANSA discontinued in Alameda County in FY24

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

Multicultural 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 Berkeley.

The Diversity & Multicultural Coordinator accomplishes these goals by**:**

- Providing cultural humility competency training to all behavioral health, community partners, and all stakeholders in Berkeley 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 the 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 Humility Competency Plan as needed.

In FY2024, this position was filled for a short period of time. As such, there is no data available during the reporting timeframe.

Transition Age Youth (TAY) Support Services
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 African Americans, Asian and Latino/a/x 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. This program has not been implemented over the past couple of years, it will not be implemented in FY2026.

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 and Family Advocacy Services. Together, both ensures that mental health peers 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, mental health peers and family members on Division committees; provision of family support & education; supported employment and vocational services; wellness activities; peer supportive services; and client advocacy. Some of the additional services and supports that CSS System Development provides funding for are as follows: Housing Services and Supports; Benefits Advocacy; Employment/Educational Services; Wellness Recovery Center; Counseling Services for Senior Citizens; Youth Case Management Services; Hearing Voices Groups; Transitional Outreach Team; Flex Funds and Sub-Representative Payee Services for clients, etc.

Wellness Recovery Services
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 peers for Division committees; convening committees around Wellness Recovery system initiatives; oversight/administration of peer stipends; convening and conducting meetings for the Berkeley “Peers Organizing Community Change (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 individuals desiring to express their treatment preferences in advance of a crisis, and is a participant on a number of local MHSA initiatives. The combination of individual services and system-level initiatives impact all clients and their family members across the system in a given year. During the reporting timeframe, there were approximately 448 clients in the BMH system.

Three positions were added in FY2023, to the Wellness Recovery Program. The vacant Assistant Mental Health Clinician position was filled and two Social Service Specialist positions, or Wellness Community Specialists, were hired to make the clinic more welcoming and provide peer support to individuals waiting to be seen at the clinic.

Adding these positions made more individuals aware of the wellness groups, community resources and support that the clinic has to offer.

Being fully staffed since late FY2023, the Wellness Recovery Team was able to bring some groups back in-person such as the Wellness Recovery Activities and to engage with people in the waiting room, offering resources, peer support, light refreshments and warm connections.

During the FY2024 reporting timeframe, some of the various activities of the Wellness Recovery Team that were conducted under the direction of the Consumer Liaison included:

Wellness Recovery Groups
Designed to promote self-care and independence, the Wellness Recovery Team builds on the talents of consumers, encouraging self-efficacy, psycho-education and motivation through multiple groups and interactions that can spark interest through wellness activities and social interactions as follows:

Wellness Through Passion (formally known as Wellness Recovery Activities)
The Wellness Through Passion group highlights consumer facilitation and creativity skills. The participants have the opportunity to bring in an activity that they are passionate about and would like to share with others in the group. They are able to practice facilitating an activity that includes participation, activities and discussion.

Serenity Steps (formally known as Walking Groups)
The Wellness Recovery Team provides walking groups to help with isolation, promote physical activities and socialization. The walks take place at local Berkeley parks and neighborhoods and they vary in physical intensity. The walks are advertised in the Wellness Recovery monthly calendar. The parks visited in FY24 were Ohlone, Grove Park, Cedar Rose, 4th street, Aquatic Park, Berkeley Marina, San Pablo Park and the University of California at Berkeley campus.

Museum Field Trips
In FY2024 the Wellness Recovery Team attended a museum trip to SFMOMA and Berkeley Art Museum and Pacific Film Archive. The Team arranged for participants to attend the museums to explore art and creative spaces in the community.

Hopeful Hearts (formally known as Card Party Groups)
This program is modeled after the Do-Send-A-Card program created by the San Francisco Mental Health Association. The BMH Wellness Recovery staff partnered with the Peer Wellness Collective formally known as “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.

Hopeful Hearts Card making groups are offered monthly in person and online. The name change came due because the Wellness Team wanted to expand the creative process where people could write poems, design cards, and use music for inspiration. Peers were encouraged to write inspirational messages in cards as well as design cards

with arts and crafts for individuals in psychiatric hospitals and Board & Cares. Peers could choose the card they wanted to receive. Through this program over 50 cards were created and given to the Reach-Out Program.

Emotional Wellness Circle (formally known as Mood Group)
Emotional Wellness Circle is designed for participants to share their thoughts and feelings in a safe place where support is offered. In FY2024 the group met mostly twice a month but a few months the group only met once due to conflicting events. The group focused on reviewing a Mood Scale to help identify their emotions, address the impacts of their choices, and discuss coping skills to use to process the emotions among non-judgmental peers and staff.

Peers Organizing Community Change
Peers Organizing for Community Change (POCC) is a community activism group designed to educate, advocate and lead and it is open to any community member who identifies as a peer, a person with lived mental health conditions. The committee meets once a month and focuses on the needs and concerns of Berkeley residents as well and provides input on the Mental Health Service Act. The members also volunteer for events the wellness team host in the community. In FY2024, the group met 10 times. Each year the committee is tasked with identifying and coordinating a community event to educate on a popular topic. For FY2024 the topic was “Empathic response to crisis” and Bonita House who operate the Specialized Care Unit was a guest speaker at the event.

In addition to support group activities Wellness staff also provide one-on-one support and resources to individuals in the waiting room of the Adult Clinic, as needed.

In FY2024, a total of 52 individuals participated in Wellness Recovery services. Demographics on individuals served are as follows:

DEMOGRAPHICS N = 52
*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  18 – 24 years and Unknown – <11
  25 – 44 years and Unknown – 22
  45 – 64 years – 15
  65 years and older – <11

- **Gender Identity**
  Male - 24
  Female 48

- **Race/Ethnicity**
  Asian Pacific Islander - <11
  Black or African American - 23
  Latino/a/x - <11

Native American - <11
White – 16
Multi-Racial - <11
Other - <11

- **Sexual Orientation**
  Heterosexual – 13
  Bisexual or Queer - <11
  Queer - <11

Program Successes:

- The team developed a structure for the groups and created materials that were cohesive with the theme and the wellness dimension featured for the month. From the newsletter to the topics in the group, everything was aligned.
- The welcoming services in the waiting room of the Adult Clinic were a bid success in building relationships, per testimonies from peers, patrons and staff. The warm welcoming services enabled anxiety to be reduced while people were waiting to be seen as engaging with a peer staff helped to reduce the fears and wait time for people being seen for appointments.
- The team also incorporated quarterly wellness mixers. These events focused on activities that were centered around wellness and recovery. The events were designed for peers to get to know the Wellness Recovery team, learn about services that are provided at Berkeley Mental Health, learn a new skill, and engage with community. The team held a Chat and Paint, Vision board, Ecotherapy and Social skills mixer and each event had between 10-40 individuals who attended.

Program Challenges:
The number of individuals attending groups was lower than anticipated. Having individuals attend groups on an on-going basis, is most ideal. Individuals who attend BMH can often be dealing with crisis situations and as such focusing on wellness activities is not always their main area of focus.

In FY26 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years) = 0; Transition Age Youth (16-25 years) = 3; Adults (25-59 years) = 30; Older Adults (60+ years) = 29.

The RBA measures for this program (which were combined with the Social Inclusion, Telling Your Story Project measures, as both are conducted by the same staff) were as follows:

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is Anyone Better off?
• # of participants served • # of different groups convened per year • # of group events held per year • # of group participants who meet the requirements for "Telling Your Story" (MHSA PEI Requirement)	• #/% of participants who return for group events	• #/% of participants who reported feeling less shame about their experiences and challenges • #/% of participants who reported progress in their recovery

RBA Outcomes in FY2024 for this program are outlined on the following pages.

BMH RBA Report FY 2024

Reporting Period July 2023 - June 2024

Wellness & Recovery Services

Process Outcomes ("How much did we do?")

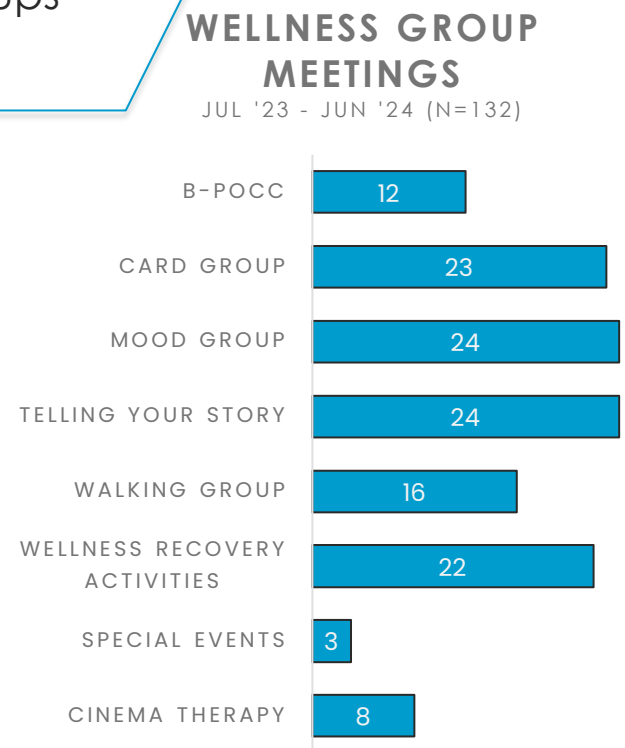
Program Description The Wellness and Recovery Program is designed to provide outreach, support, education, activities, and advocacy to consumer members living with mental illness and living in Berkeley. Wellness group activities include: Berkeley Peers Organizing Community Change (POCC), Card Groups, Mood Groups, Walking Groups, and Wellness Mixers.

52
Participants served

132
Group Events

8
Groups

20
Participants who meet requirements for "Telling Your Story"

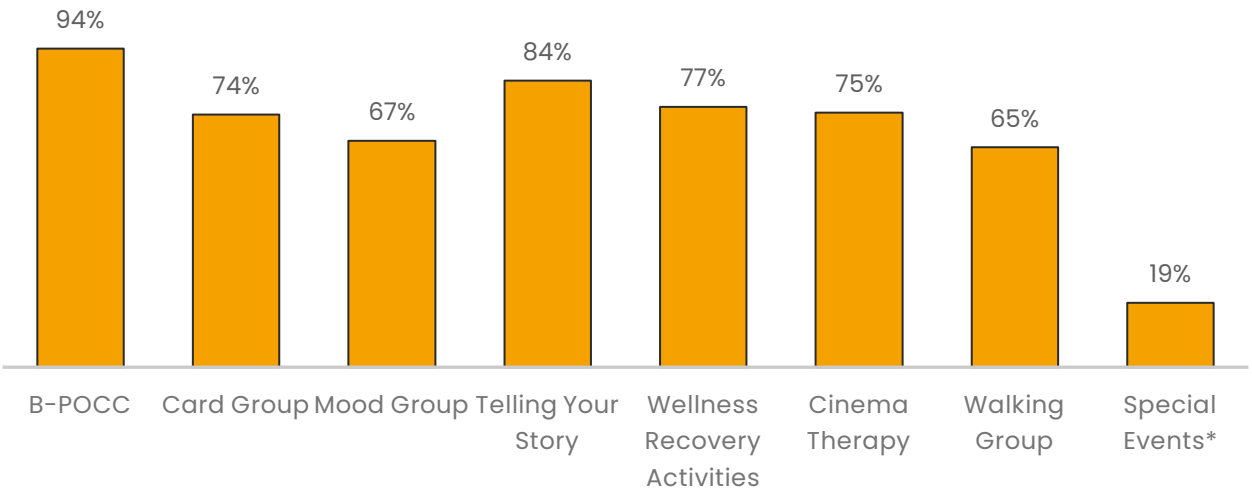


NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Quality Outcomes ("How well did we do it?")

Overall Group Engagement (Repeat Visits)

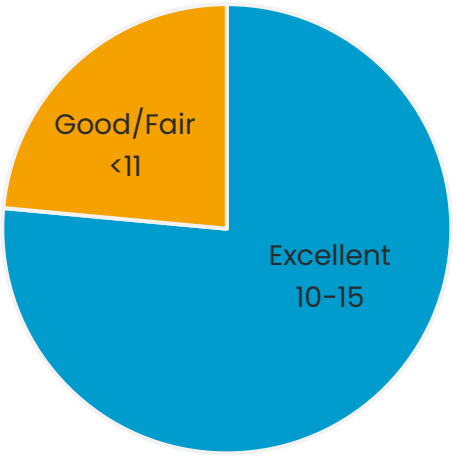
Jul '23 - Jun '24 (n=224)



*Special events, like social wellness mixers with different themes, attract a diverse mix of new attendees, which may result in lower level of returnees.

Interaction with a Wellness Team member in the Clinic Lobby

Jul '23 - Jun '24 (n=18)



71% n=52
Unduplicated participants who return for group events

Over 80% n=18
Participants rated the Lobby as Welcoming

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Measure	Definition	Data Source
# of Particpants Served	Total # of participants served	Wellness Recovery Group Attendance Tracker
Wellness Group Event Breakdown	Number of different types of groups (i.e. walking group, mood group, Telling Your Story group) convened	Wellness Recovery Group Attendance Tracker
# Group Events	Total number of meetings held	Wellness Recovery Group Attendance Tracker
# of Telling Your Story Participants	Total number of participants in all "Telling Your Story" meetings	Wellness Recovery Group Attendance Tracker
% of participants who return for group events	Of total number of participants, % who returned for more than one event or meeting	Wellness Recovery Group Attendance Tracker
% Overall Group Engagement (Repeat Visits)	Of total number of participants, % who returned for more than one event or meeting	Wellness Recovery Group Attendance Tracker
% Participants Rated the Lobby as Welcoming	Consumer perceptions of feeling welcomed entering the Clinic Lobby	Clinic Lobby Survey

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Family Support Services
A 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. The program provides both individual family services and supports as well as broader system–wide change initiatives.

This family/caregiver-centered program 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 delivered in a culturally responsive manner ensuring outreach to individuals of diverse ethnicities and language groups.

The Family Services Specialist serves as a key point of contact for family members who are accessing or attempting to access services, addressing their questions and concerns about the mental health system. The specialist provides support, referrals, and linkages to additional community resources as needed. Outreach is conducted through the existing BMH Family Support Group, NAMI of the East Bay, Mental Health Association of the East Bay, Alameda County Family Education and Resource Center (FERC), and the Mental Health Association of Alameda County. Additionally, outreach has been extended through participation in community events such as Juneteenth, Día de los Muertos, and Women, Infants & Children (WIC) events. Flyers and brochures have been distributed to City divisions and programs, including Aging Services-Senior Centers, Meals on Wheels, Social Services Unit, Public Health (West Berkeley Family Wellness Center)- WIC, Black Infant Health, Father Initiative and Parks and Recreation. Outreach efforts also include in-person interactions, phone calls, emails, mailings to community agencies, and engagement via community listservs and providing flyers/brochures for community events.

The Family Services Specialist also: coordinates forums for family members to share their experiences with the system; recruits family members for BMH committees; supports family members through a “Warm Line”; conducts a Family Support Group; and creates training opportunities to educate mental health staff on working effectively with families. These combined individual services and system-level initiatives have an impact on clients and their family members.

During the reporting timeframe, the following individual or group services and supports were conducted through this program:

Warm Line Phone Support: A Warm Phone Line provides compassionate support to family members seeking information, referrals, supports, and assistance in navigating the complex mental health system. Through the Warm Line, the Family Services Specialist helped families connect with services and resources as needed.

Family Support Group: An English-speaking Family Support Group was offered for parents, children, siblings, spouses, partners, significant others, and caregivers. The group met once a month for two hours. Additionally, monthly group reminder emails

provided family members with information, resources, and updates on community groups, BIPOC groups, events, and forums.

Individual Support: The Family Services Specialist met with families as needed to provide personalized support, assist them in prioritizing their needs, connect them with appropriate resources, navigate the mental health system, and develop coping skills to manage stress related to mental illness in the family.

In FY2024, 88 individuals received services through this program. Demographics of individuals served are outlined below:

DEMOGRAPHICS N = 88

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  0-18 years – <11
  19 – 24 or Unknown - <11
  25 – 44 years – 15
  45 – 64 years – 25
  65 years and older – 30
  Decline to Answer or Unknown - <11

- **Gender Identity**
  Male - 15
  Female - 45
  Decline to Answer or Unknown – 28

- **Race/Ethnicity**
  Asian Pacific Islander - <11
  Black or African American – 15
  Latino/a/x - <11
  Native American - <11
  White – 23
  Multi-racial - <11
  Other - <11
  Decline to Answer or Unknown - 17

- **Sexual Orientation**
  Heterosexual or Straight - 38
  Lesbian/Declined to Answer, or Unknown – 50

Program Successes

To expand awareness and accessibility of available services, the Family Services Specialist actively participated in the Alameda County Peer Learning Community, the Statewide Family Peer Workgroup, and engaged with organizations such as NAMI, FERC (Family Education Resource Center), and the Alameda County Mental Health

Association. These efforts helped increase outreach and ensure families were informed about the services and support available to them.

Program Challenges
The Family Services Specialist position had remained vacant for four years, which required extensive efforts to reintroduce available services. Outreach was necessary to connect with Mental Health Division staff and teams, other city agencies, community organizations, and the broader community to receive referrals for family members in need of support.

Based on previous years, in FY26 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 0; Transition Age Youth (16-25 years): 2; Adults (26-59 years): 28; Older Adults (60+ years): 42.

Employment Services
Previously, a BMH Employment Specialist provided services to support individuals 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 individuals who are gainfully employed and/or engaging in other meaningful activities such as school or volunteer work. Different strategies were implemented over time 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.

Up until there was a vacancy in the position, the Employment Specialist 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.

It was envisioned that once the Employment Specialist position was filled, work would be focused on utilizing an evidenced based model for supporting individuals with serious mental illness in obtaining and retaining competitive employment. To date, this position has remained vacant, while the City of Berkeley has spent time assessing 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.

Housing Services and Supports
A Housing Specialist previously provided housing resource services for clients including 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). Since this position has been vacant, all staff who work with clients have played a part in providing housing support, as needed. Some of the various places where clients with subsidies are housed are the Insight Housing Russell Street Residence Board and Care, McKinley House, and Lakehurst Hall.

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 FY2024, 10 clients were served through this program. Demographics on those served were as follows:

DEMOGRAPHICS N = 10
*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  25 – 44 years – <11
  45 – 64 years – <11

- **Gender Identity**
  Male - <11
  Female – <11

- **Race/Ethnicity**
  Black or African American – <11
  Latino/a/x - <11
  White – <11
  Other - <11
  Decline to Answer or Unknown - <11

- **Sexual Orientation**
  Declined to Answer, or Unknown - 10

Program Successes:
The majority of the SSI cases closed, resulted in the client getting SSI benefits. The other cases were closed when contact with the client was lost. Five cases that were open in the reporting period are still pending.

Program Challenges:
All of the SSI cases were negatively impacted by staffing issues at Social Security by the following: a call to the Social Security office took an hour or more of being on hold before being able to get through to a person; 20% - 30% of calls were never answered; some calls were spontaneously dropped while on hold; leaving a message did not help as the Social Security staff didn't have time to return calls during the workday so some

messages were not returned. A new SSI application could take over 6 months to get to the point where it started to be assessed for disability. The disability assessment process, once initiated, could take another 6 months or more to complete; and then to get benefits started and any retroactive pay received, it can be another 6 months. So even assuming a client won their case at the initial application stage, the earliest point possible in an SSI claim, they could expect to have to wait aa year and a half between applying and seeing any money. The longer waits exacerbated hardships for clients who were already struggling.

In FY2026 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 0; Transition Age Youth (16-25 years): 4; Adults (26-59 years): 6; Older Adults (60+ years): 0.

Flexible Funds for Level One Clients
A contract with the community-based organization, Berkeley Food & Housing Project (now known as Insight Housing), 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. This program is set up to aid any clients in need across the system in a given year. In FY24, there were a total of 448 clients in the BMH system.

Mobile Crisis Team (MCT) Expansion
Through a previously approved Three-Year 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:

- Increase in staff to expand the Mobile Crisis Team (MCT) capacity and hours of operation,
- 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.

The RBA Measures that were established for this program were as follows:

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is Anyone Better off?
• # of clients served • # of documented contacts	• % of clients who receive a visit (phone contact with client or hospital provider) in the 24 hours after hospitalization • % of Mobile Crisis Team who had a Crisis, Assessment Team staff attempt to contact • % of clients who were satisfied with services**	• None available at this time

*Demographic data was reported at the program level, where available
**Data not available for baseline reporting period, will be included in future rounds of reporting

RBA Outcomes in FY2024 for this program are outlined on the following pages.

BMH RBA Report FY 2024

Reporting Period: June 2023 - July 2024

Mobile Crisis Team (MCT)

Process Outcomes ("How much did we do?")

588

Clients Served

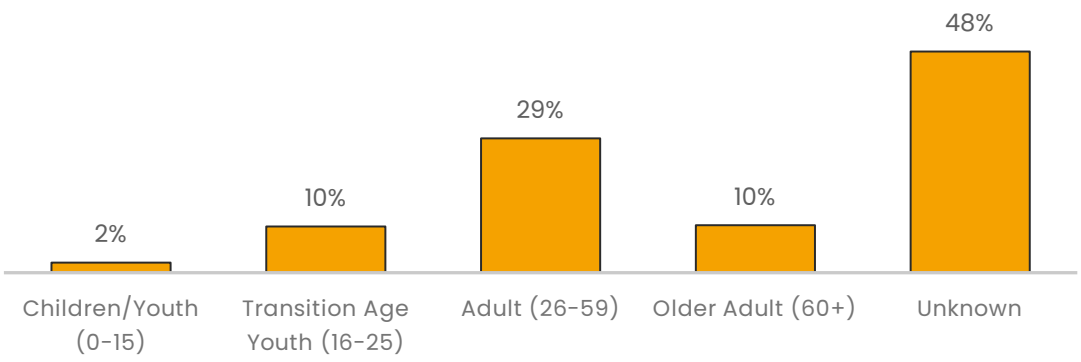
863

Responses to Incidents

Program Description:
The Mobile Crisis Team (MCT) serves residents of Berkeley, from 11:30am-10pm each day of the week when fully staffed. It provides crisis interventions, including but not limited to 5150 evaluations, consultations, and referrals/linkages.

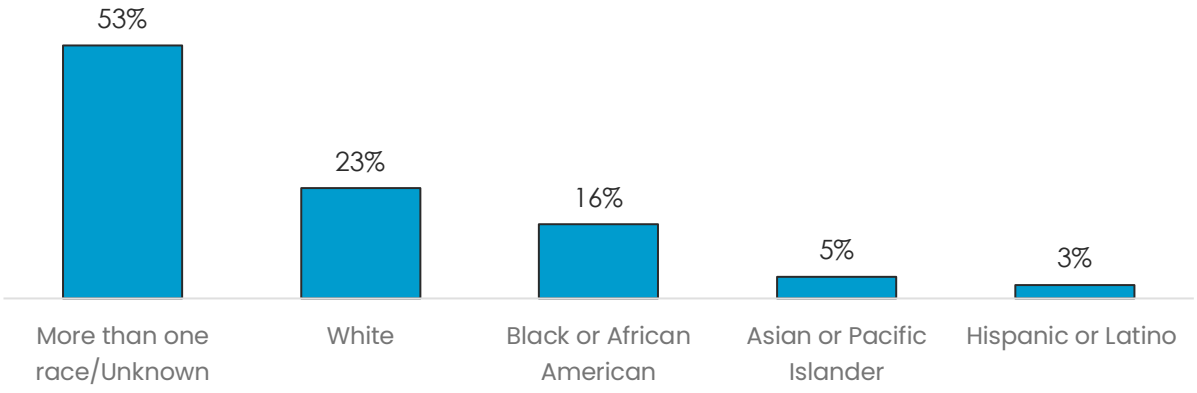
Demographics (Age)

Jul '23 - Jun '24 (n=588)



Demographics (Ethnicity)

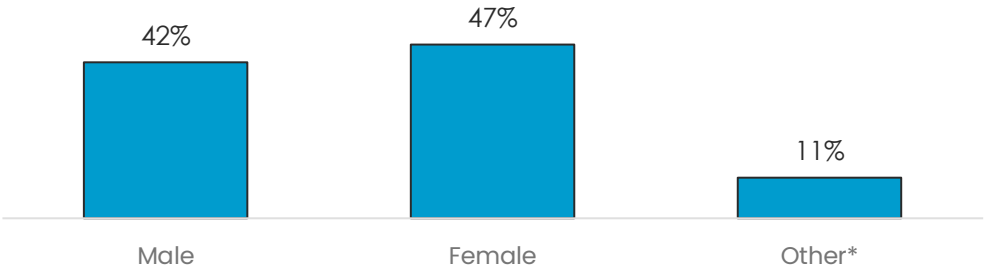
Jul '23 - Jun '24 (n=588)



NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Demographics (Gender Identity)

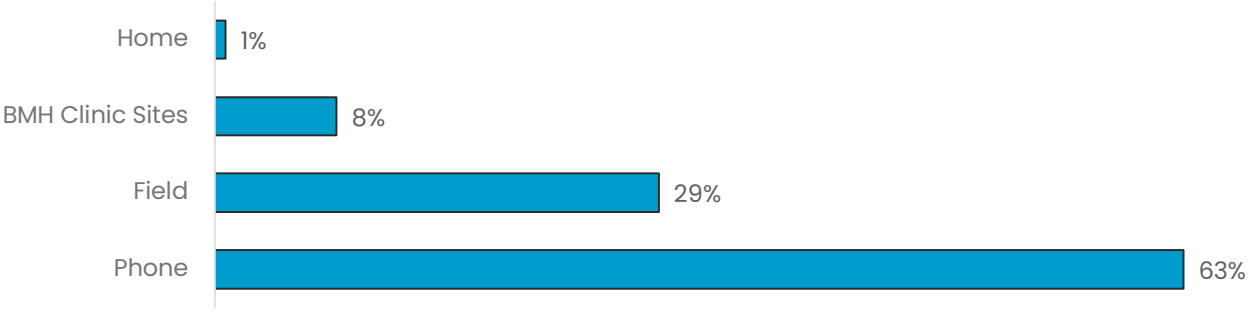
Jul '23 - Jun '24 (n=588)



*Other includes unknown or missing due to clients not disclosing, clinician unable to make the determination, or a crisis situation not allowing for more comprehensive data collection. It also includes any identity that doesn't fit within the traditional male/female binary. Sexual orientation data not available.

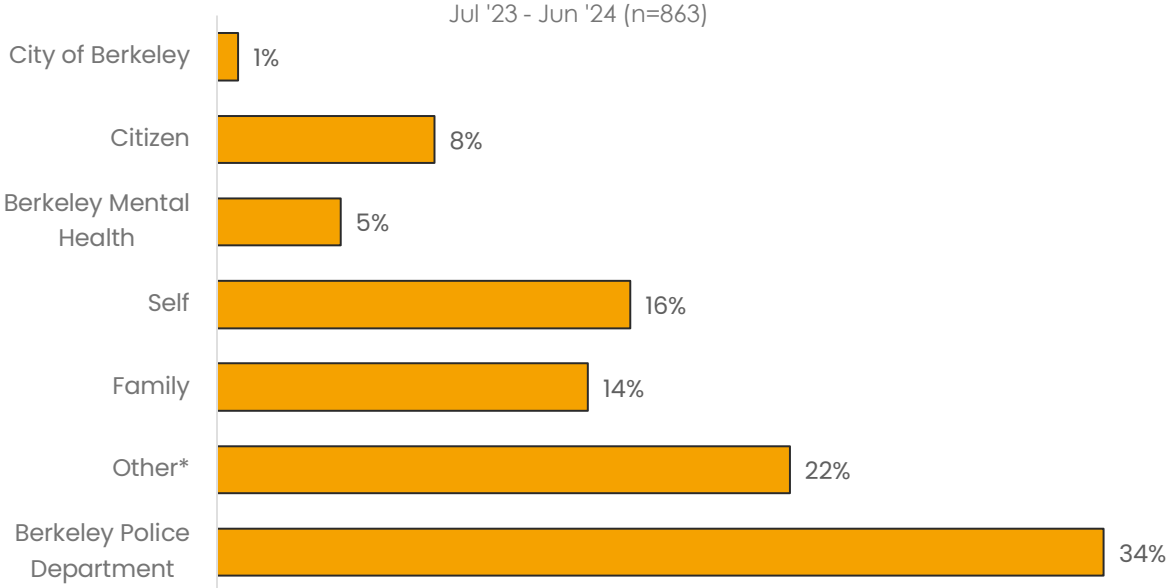
Client Contacts Made by Contact Type

Jul '23 - Jun '24 (n=863)



Referrals by Referring Party

Jul '23 - Jun '24 (n=863)

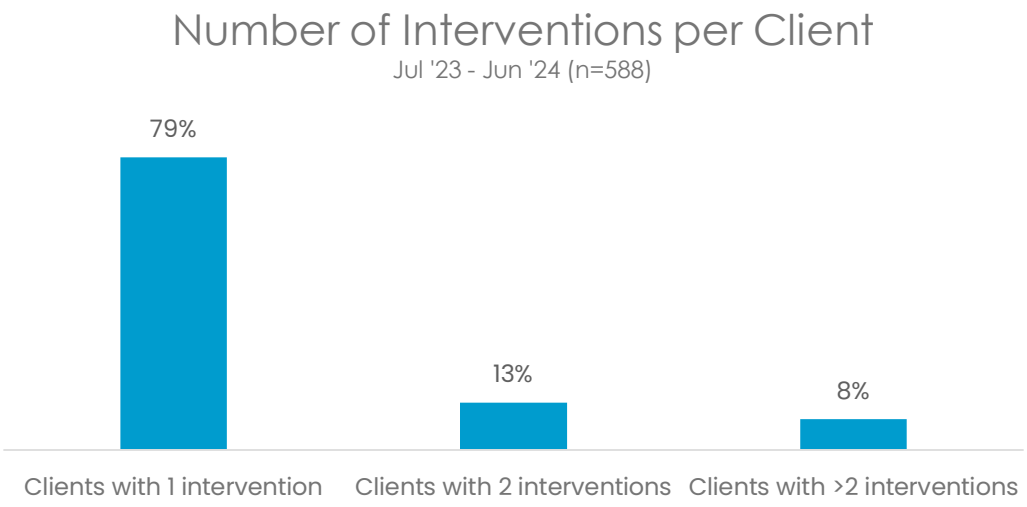


*Other includes responses involving Albany PD, UC PD, Berkeley Fire, Homeless Outreach, Neighborhood Services, Merchants, and follow-ups.

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Quality Outcomes ("How well did we do it?")

Service Consistency



Impact Outcomes ("Is anyone better off?")

The MCT program performed

198

5150 Evaluations

72% n=198

5150 Evaluations did Not Lead to Transport to a facility

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Measure	Definition	Data Source
# clients served	Total unique clients served	MCT Incident Log
# of client contacts made	# of client contacts made, by a. Field contacts b. Phone contacts c. Other	MCT Incident Log
# of referrals by referring party	# of crisis services referrals made to the MCT, by referring party (i.e. Berkeley Police Department, Berkeley Fire Department, Berkeley Mental Health, community, etc.)	MCT Incident Log
# of 5150 evaluations conducted	Total number of incidents with 5150 Evaluations of any sort	MCT Incident Log
Results of 5150 Evaluations	% of 5150 evaluations that did or did not result in transportation to a receiving facility for further evaluation	MCT Incident Log
Number of interventions per client	% of clients who had one, two, or more than two interventions on separate dates requiring service	MCT Incident Log

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Transitional Outreach Team (TOT)
The Transitional Outreach Team (TOT) follows up with individuals and families and provides interventions that address issues individuals experience either immediately prior to or following a mental health crisis. The goal of the team is brief outreach and engagement to assist the individual and/or family in getting connected to the resources they may need.

In FY2024, 60 individuals were served through this project. Demographics on those served were as follows**:**

DEMOGRAPHICS N = 60*
*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  0-15 years – <11
  16 – 25 or Unknown - <11
  26 – 59 years – 25
  60 years and older – <11
  Decline to Answer or Unknown - 19

- **Gender Identity**
  Male - 18
  Female - 27
  Transgender/Decline to Answer or Unknown – 15

- **Race/Ethnicity**
  Asian Pacific Islander - <11
  Black or African American – <11
  Latino/a/x - <11
  White – 17
  Multi-racial - <11
  Other - <11
  Decline to Answer or Unknown - 13

- **Sexual Orientation**
  Declined to Answer, or Unknown - 60

Services provided by this team are subject to the number of referrals that are generated by the Mobile Crisis Team crisis calls. Clients served by TOT often enter the crisis system with fewer resources such as collateral supports, lack of insurance, etc.

Program Successes:
- Continued successful follow-up with residents who had contact with Mobile Crisis by phone and/or in person.
- Connected individuals and families to needed and wanted mental health, housing, family, and other social services.

- 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 receiving homeless services and staff at homeless service provider agencies, including Dorothy Day, Building Opportunities for Self-Sufficiency (BOSS), Insight Housing, and others.
- Coordinated with other programs within the City's Mental Health Division, including the Crisis/Assessment/Triage (CAT) On Duty staff and field-based services such as Mobile Crisis (MCT).
- Continued to follow-up on hospital referrals and coordinated with individuals and hospital staff after a MCT contact.
- Served 10 more clients in FY24 compared to the previous reporting timeframe.

Program Challenges:

- The Data collection system that was utilized did not capture all of the necessary information that would support accurate outcome reporting. This remains an ongoing difficulty due to the limitations of the current system.
- Although the total number of individuals served in FY24 was more than FY23, it is still lower than previous years (ex: FY22) and there is not sufficient data to ascertain the cause(s) of the reduced numbers.

In FY2026 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 6; Transition Age Youth (16-25 years): 12; Adults (26-59 years): 38; Older Adults (60+ years): 9.

In a prior year, TOT was merged with the Crisis Assessment and Triage (CAT) Team due to staffing limitations and to increase flexibility of the staffing capacity. The RBA data represents combined data measures for TOT/CAT. The RBA measures that were established for TOT/CAT were as follows:

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is Anyone Better off?
• # of clients served • # of documented contacts	• % of clients who receive a visit (phone contact with client or hospital provider) in the 24 hours after hospitalization • % of Mobile Crisis Team who had a Crisis, Assessment Team staff attempt to contact • % of clients who were satisfied with services**	• None available at this time

*Demographic data was reported at the program level, where available

**Data not available for baseline reporting period, will be included in future rounds of reporting

RBA Outcomes in FY2024 for the combined TOT/CAT program are outlined on the following pages.

BMH RBA Report FY 2024

Reporting Period July 2023- June 2024

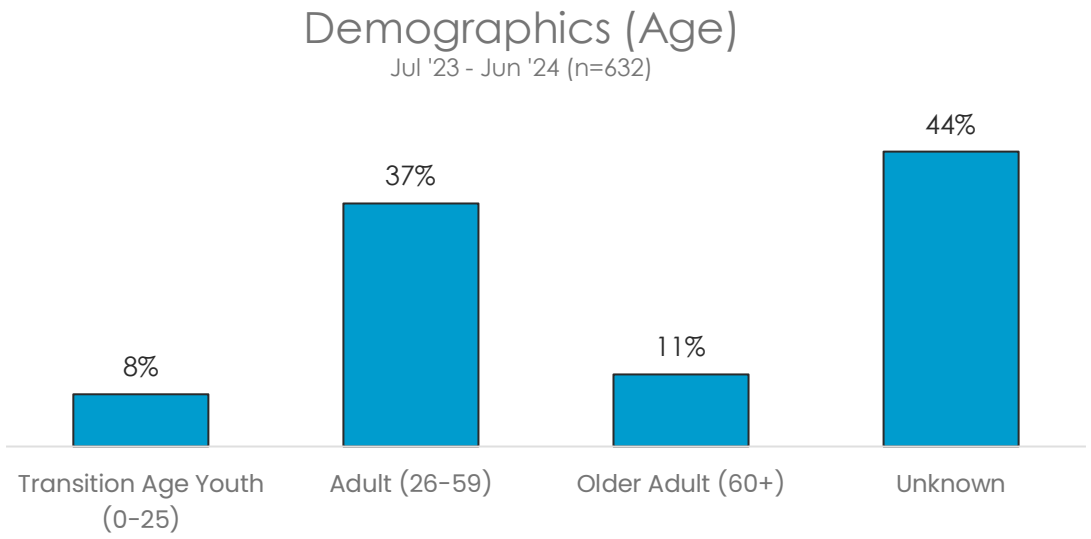
Crisis, Assessment, and Triage/Transitional Outreach Team (CAT/TOT)

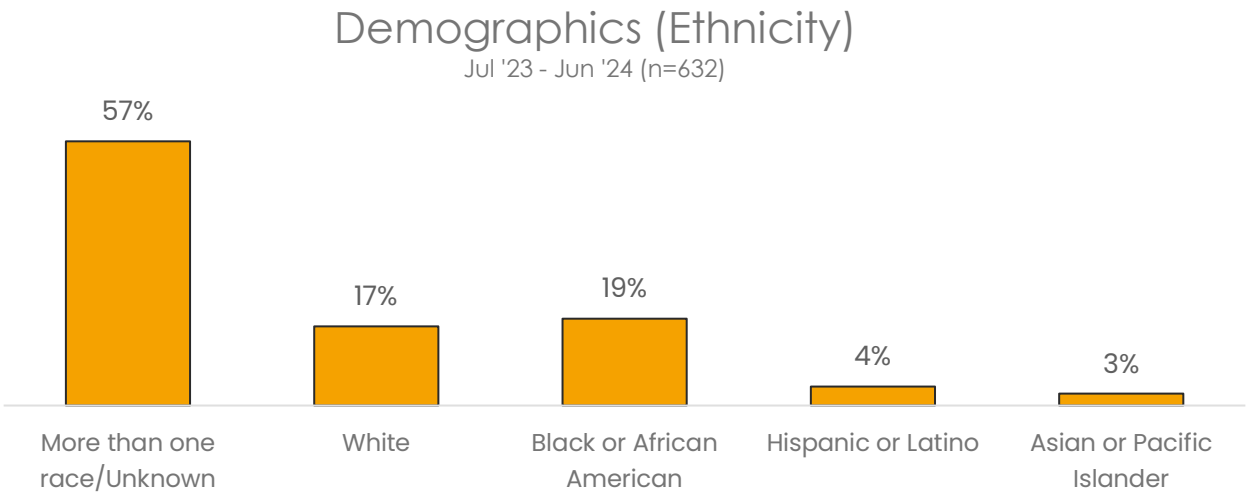
Process Outcomes ("How much did we do?")

632
Clients Served

1282
Contacts

Program Description
CAT/TOT is BMH's intake and follow-up team for Adult Mental Health Services. This team provides screening/assessment for ongoing mental health services, linkage to community-based resources, crisis support, and coordination with other agencies. Services include, but are not limited to: psychiatric services, transportation, food access, medical care, health insurance, benefits, legal assistance, affordable housing listings, utilities and energy assistance resources. Services are provided in person at the clinic, as well as via the team phone line.

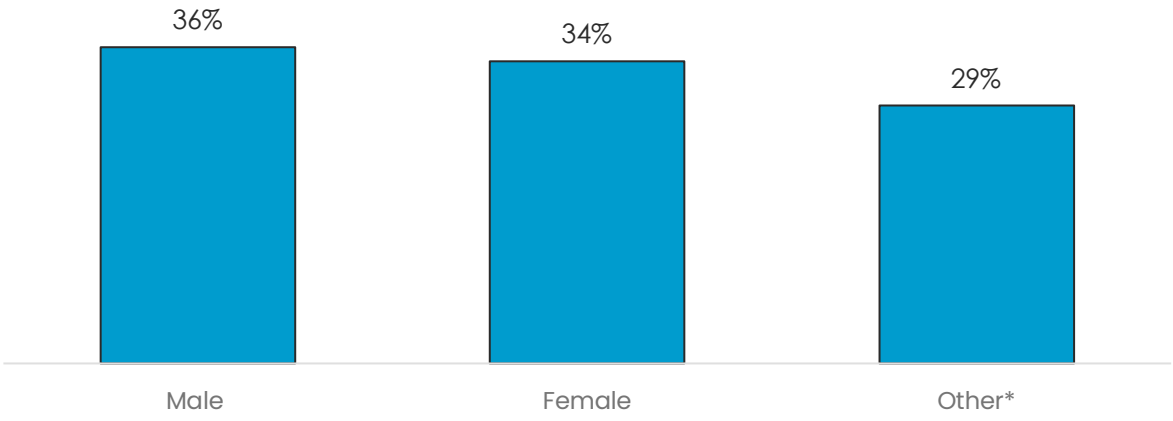




NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Demographics (Gender Identity)

Jul '23 - Jun '24 (n=632)

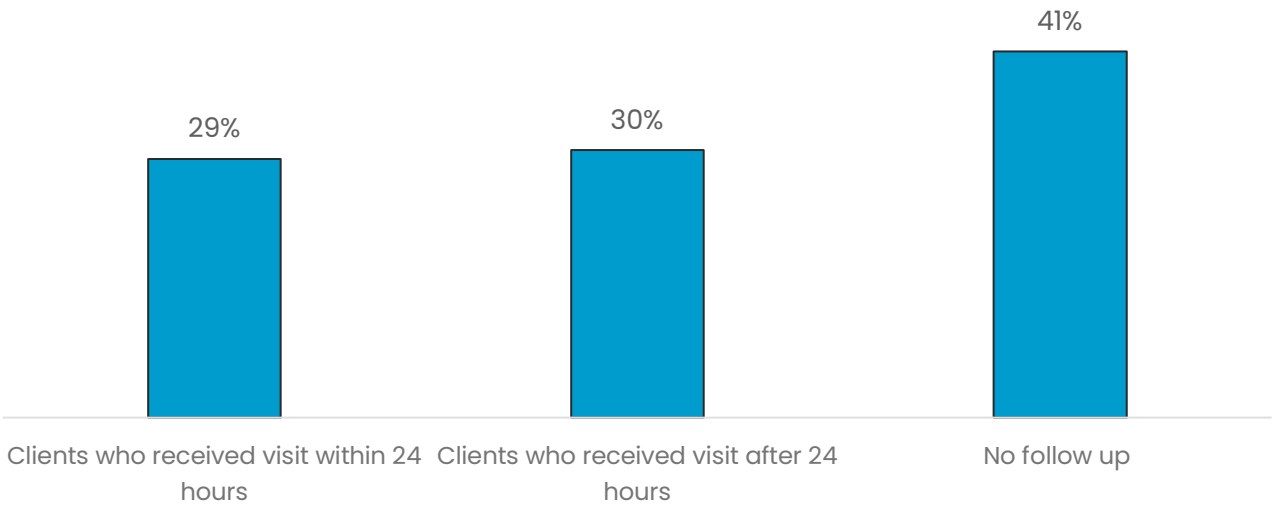


*Other includes unknown or missing due to clients not disclosing, clinician unable to make the determination, or a crisis situation not allowing for more comprehensive data collection. It also includes any identity that doesn't fit within the traditional male/female binary. Sexual orientation data not available.

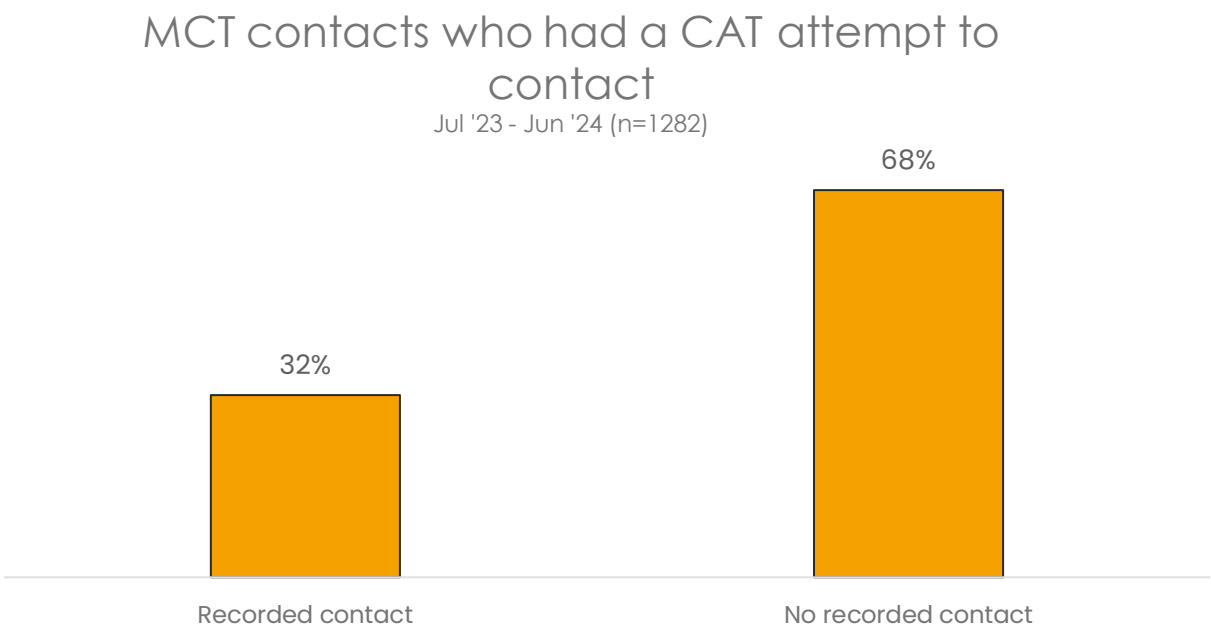
Quality Outcomes ("How well did we do it?")

Follow-up after hospitalization

Jul '23 - Jun '24 (n=56)



NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.



NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Measure	Definition	Data Source
# clients served	Total clients served	MCT & CAT Incident Log
# of documented contacts	Total number of documented incidents	MCT & CAT Incident Log
% of clients who receive a visit (phone contact with client or hospital service provider) in the 24 hours after hospitalization	% of clients who receive a visit (phone contact with client or hospital service provider) in the 24 hours after hospitalization. Reasons for no follow up may include no viable contact information, client was not amenable to follow-up services, or the client is already connected to follow-up services provided by another agency.	MCT & CAT Incident Log
% of MCT contacts who had a CAT attempt to contact	Of Client IDs in MCT contact log, % which also have record in CAT contact log. Reasons for no contact may include no viable contact information or client declined contact.	MCT & CAT Incident Log

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Sub-Representative Payee Program
The Sub-representative Payee Program is implemented through the contractor, Building Opportunities for Self-Sufficiency (BOSS). Through this program services are provided to individuals who are in need of a payee to assist with managing their money. Approximately 79 individuals receive services a year.

In FY2024, 66 individuals were served. Demographics on individuals served were as follows:

DEMOGRAPHICS N = 66*
*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  18 – 24 years or Unknown – <11
  25 – 44 years - <11
  45 – 64 years – 24
  65 years and older – 29

- **Gender Identity**
  Male – 45
  Female – 21

- **Race/Ethnicity**
  Asian Pacific Islander - <11
  Black or African American – 39
  White – 19
  Multi-racial - <11

- **Sexual Orientation**
  Heterosexual or Straight – 16
  Lesbian/Gay/Declined to Answer, or Unknown - 50

Program Successes:
- The Representative Payee Manager supported participants within the program.
- There was an increased caseload through BMH referrals as well as a strengthened collaboration between BOSS and BMH.
- Many clients had big improvements in their quality of life, including better mental and physical health, thanks to the careful management of their benefits.
- The program has also helped clients stay housed by ensuring rent and utilities were paid on time, reducing the risk of losing housing vouchers due to power shut-offs.
- Several clients who had been chronically homeless for over 10 years were able to save for housing deposits and transition into Shelter Plus Care Housing, which was a huge milestone for them.

Program Challenges:

- Not all clients had an assigned Case Manager to help with non-financial needs like finding stable housing, attending medical appointments, or accessing clean clothing.
- Many clients also struggled to attend day treatment programs due to a lack of information or transportation, which limits their opportunities for positive, structured activities.
- Some client's mental health or substance use challenges, made it hard for them to stay motivated and engaged with services offered.

These are all areas that BOSS is continuing to work to improve.

In FY2026 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 0; Transition Age Youth (16-25 years): 4; Adults (26-59 years): 80; Older Adults (60+ years): 75.

Hearing Voices Support Groups

The Hearing Voices Support Groups are offered through a contract with the Bay Area Hearing Voices Network. It is the only community organization which offers online peer-led groups for adults who hear voices and have other unusual experiences. Participants who attend groups regularly express that the continuity helps them to stay out of mental hospitals, deal with stigma as well as stress and difficult experiences associated with the voice hearing experiences.

Free weekly drop-in Support Groups are provided for individuals who experience voices, visions, special messages, unusual beliefs or extreme states of consciousness. The support groups are co-facilitated by trained group facilitators whom have lived experience in the mental health system. A separate support group for Family Members of individual participants is also provided.

In FY2024, a total of 1,841 individuals were served through weekly online support groups. Demographics on individuals served were as follows:

DEMOGRAPHICS N = 1,841*

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  18 – 24 years – 93
  25 – 44 years – 276
  45 – 64 years – 1,105
  65 years and older – 367

- **Gender Identity**
  Male – 717
  Female – 957

Transgender – 81
Other/Non-binary – 86

- **Race/Ethnicity**
  Asian or Asian Pacific Islander – 74
  Black or African American – 239
  Latino/a/x – 166
  White – 957
  Multi-racial – 239
  Other/Declined to Answer, or Unknown – 166

- **Sexual Orientation**
  Heterosexual or Straight – 1,288
  Lesbian or Gay – 55
  Bisexual – 93
  Questioning – 166
  Declined to Answer, or Unknown - 239

In FY2024 two weekly online adult hearing voices groups were added on the weekends: an adult hearing voices support group, and a discussion group to explore the voice world in its entirety. Three new members were added to the board of directors, two family members and a voice hearer/group facilitator. A Social Media program to reach Transitional Age Youth on Facebook, Instagram, and Reddit headed by three of hearing voices members was also added.

Program Successes:

- Attendance in the adult hearing voices groups and family groups continued to be strong, with more attendees than in the last reporting period.
- Three social media platforms to reach Transitional Age Youth were created on Reddit, Instagram, and Facebook. Currently the Facebook page has 1,357 members; the Instagram page has 108 followers; and the Reddit group has 1,236 experiencers, and 6 moderators.
- The Reddit Hearing Voices page recently received over 4,000 unique visits in one week and 1,600 of the users were youth. Youth constitute 25.7% of all Facebook Messenger users, 31.7% on Instagram, and 44% on the Reddit platform. The webpages for each of the groups/platforms are as follows:

  Reddit group: https://www.reddit.com/r/HearingVoicesNetwork/
  Facebook group: https://www.facebook.com/groups/hearingvoicesgroupsupport
  Instagram platform: https://www.instagram.com/ba_hvn/

- Outreach to Transitional Age Youth (ages 18-25) who hear voices or experience other unusual/distressing experiences began, through the Social Media Program staffed by volunteers who have lived experience.

Program Challenges:

- Not having enough funding to implement additional services for TAY and adults.
- Additional community outreach in schools, clinics, and mental health education programs was needed.

Results from a survey questionnaire of group participants on the impact of the groups were as follows:

How have the groups helped you?

- “I hear voices. I need this group.”
- “Wonderful people speaking in regard to their shared experience of hearing voices.”
- “Made good friends.”
- “Friendship, common values and goal; suggestions from experience.”
- “It helps me to accept my sister's experience of hearing voices and having unusual beliefs.”
- “Camaraderie.”
- “Helped with better understanding of how to approach our son and we are not alone in this journey.”
- “Support.”
- “It gives me the support and tools I need to survive, and thrive, each day.”
- “It's great to hear so many different experiences.”
- “The Bay Area Hearing Voices Network community has been a colossal help.”
- “Every time I have participated, it has been a great experience. Everyone is so supportive and what I like the most is that the message always is one of hope and love for our loved one. Also, the practical information has been very useful.”
- “This group has helped me find ways to deal with my loved one. I have learned better ways to talk to my loved one.”
- “People are so kind.”
- “It gives me a safe space to share my voice hearing experiences.”

What do you like about the group?

- “I can talk about religion, politics, sex and drugs as they relate to my schizophrenia.”
- “Well moderated, kind shares, and generally a no-judgement zone.”
- “Listening.”
- “Kindness and understanding, sympathetic.”
- “Supportive and caring group of participants.”
- “There's a lot of humility and some humor.”
- “How it's facilitated, our understanding this is another way of looking at life.”
- “I like that the facilitators have lived experience.”
- “Hearing different life experiences.”
- “Comraderie and information.”

- “Everyone can share without fear of censorship or outcast about their experiences.”
- “The camaraderie and willingness to share what has worked for them in supporting their loved one.”
- “The honesty and vulnerability of the group members and the facilitators.”
- “I like that I can be open about my experiences.”
- “Support.”
- “Everyone respects each other.”

How have you seen your life improve since you started coming to group?

- “I am better oriented.”
- “I've felt as though my pain is being heard by someone real, somewhere.”
- “I am less anxious.”
- “More calm.”
- “I feel better after a Monday meeting when I have had a rough time earlier.”
- “Oh, yes! My son is now living with me after over 8 years in hospitals and behavioral health centers.”
- “I am more patient and understanding with my son.”
- “Mental faculties improving, able to maintain a sleep state more in accordance with the norm, posture and G.I. improvements.”
- “The help has been all encompassing from the mental experience, behavioral outcomes, and the physical health standpoint.”
- “Our relationship with our daughter and with each other has improved as we have gained more understanding of the voice hearing experience. We don't want to fix our daughter but facilitate her choices.”
- “I think my husband and I treat our son with more respect and kindness AND also treat ourselves with more respect and kindness.”
- “I have become more optimistic”.
- “Less anxiety.”
- “I have a better understanding on how the voice world works.”

Why do you feel safe in the group (or why not)?

- “I can complain about psych meds without being censored.”
- “Well moderated, kind shares, and generally a no-judgement zone.”
- “Nice people.”
- “No judgement; all sympathy.”
- “Everyone is respectful.”
- “Good boundaries, compassionate participants, respect all around.”
- “Respect. Shared experiences.”
- “I like the structure when the facilitator has a theme.”

- “I know that nobody will ever tell anything that goes on in the group outside the group. I trust the group members.”
- “The people in the group are not threatening.”
- “It is a safe space. There is no judgment, no offense. We are all there to help and be helped.”
- “Everyone is very supportive.”
- “The lack of judgment. This value we hold for our loved ones carries over to the way we treat each other.”
- “Everything is confidential and I feel it’s a safe place to be open.”
- “Facilitators care about everyone.”
- “What is said there, stays there.”

Describe your overall experience in the group.

- “t's been a much better experience than the local mental hospital and NAMI (National Alliance on Mental Illness).”
- “It feels like a place for identifying shared experience and attempting to heal or find help to heal.”
- “Enjoy meeting people and sharing.”
- “Invaluable support and compassion.”
- “I feel supported in the group. I like to listen to hear other peoples' experience see similar and differences with my situation.”
- “I'm grateful for the gift of a new way to see our situation and the hope of new possibilities.”
- “Helpful. Welcoming. Honest.”
- “Positive.”
- “Existentially validating and empowering.”
- “It has been a wonderful opportunity for us to connect with others who provide care and support to their loved ones. It sometimes feels so overwhelming that the message of hope that we receive every time we participate helps go on in this difficult and challenging role we have as parents of an adult daughter who feels safer interacting with her voices and beings than with humans, whom she doesn't trust.”
- “Like church, a school of love.”
- “Overall experience is very positive.”
- “Freeing.”

How has the group helped you to deal with stigma?

- “Misery loves company. There is an epidemic of mental illness going on. Perhaps we will get political power to make things better for the mentally ill? We get stigmatized unfairly and we must make our voices heard.”
- “It helps me realize I'm not alone.”

- “By normalizing the experience of our loved one, and us the family member feeling isolated and our circle of family/friends who truly understand our situation is limited.”
- “I'm not alone.”
- “Not too ashamed and feeling like a loser.”
- “I feel proud to say my son hears voices and sometimes say he has a diagnosis of schizophrenia (just so people understand).”
- “Again, validation. Knowing there is a community of the similar and an avenue for healthy discourse on certain topics is an essential need for self-actualization.”
- “We know that we are not the only ones in this role and that our loved ones are not the only ones with these experiences. We like hearing about things that have worked for other families. Over the years I have seen so many different kinds of people come to these family support groups and that alone has helped me to see that having a family member who hears voices crosses race and poverty and education lines. Instead of feeling less than I have actually come to feeling more than. Honored as someone said last night in my group, to be associated with someone like my son.”
- “Yes, because after this group I’ve been able to tell close friends and coworkers about my loved one’s experiences.”

How do you feel supported by the facilitators (or not)?

- “I have voices and they let me talk about it.”
- “Thoughtful questions from them, generally showed a care for the group's charter and the importance of understanding it.”
- “They are always attentive.”
- “Reflective listening.”
- “Salient point is reflected back by the facilitator. They encourage you and may provide an alternate view when necessary.”
- “They give everyone a chance to be heard and encourage us to share our experiences which helps ourselves and others.”
- “They are honest, listening attentively, and provide great feedback.”
- “They ask if they can provide feedback and then do so.”
- “They are great listeners and give great advice which we are free to take or leave.”
- “They show that they are hearing what each person shares.”
- “They lead with their heart.”
- “The facilitators are always supportive and have recommendations and great input. They are also empathetic.”
- “They speak from their own experience.”
- “They help me think about what I am saying.”

In FY2026 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 0; Transition Age Youth (16-25 years): 89; Adults (26-59 years): 1,052; Older Adults (60+ years): 642.

Berkeley Wellness Center
The Berkeley Wellness Center is an MHSA funded collaboration between the City of Berkeley, Mental Health Division and the Alameda County BHCS. This program implemented through the community-based organization, Bonita House, provides: mental health and substance use disorder counseling; living skills training; educational activities; pre-vocational training; wellness recovery programming; support groups; referrals to community resources; computer training; Art Therapy and other activities. The main goals of the program are to assist individuals in functioning as highly as possible so they can become integrated into the community.

In FY2024, 48 individuals participated in this program. Demographics on individuals served were as follows:

DEMOGRAPHICS N = 48*
*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  18 – 24 years – <11
  25 – 44 years – 12
  45 – 64 years – 20
  65 years and older – <11
  Declined to Answer, or Unknown – <11

- **Gender Identity**
  Male – 20
  Female – 28

- **Race/Ethnicity**
  Asian or Asian Pacific Islander – <11
  Black or African American – <11
  Latino/a/x – <11
  White – 22
  Other – <11
  Unknown – <11

- **Sexual Orientation**
  Heterosexual or Straight – 16
  Declined to Answer, or Unknown - 32

In FY2024 a new Program Manager was hired in September and under new management, programs were expanded. Plans for continued expansion of program offerings were implemented. Navigation provisions and resource information was consolidated and actively offered in a greeting and entrance program. Outreach plans

were created and implemented ranging from on the ground to coordination with fellow service programs.

Program Successes:

- The client response to new programing was enthusiastic.
- Since creating and implementing outreach plans, the numbers of new clientele increased daily, and new clients became repeat visitors to the center.
- Navigation services were easier to access, and clients were therefore inquiring about various needs more often and staff were better equipped to provide answers.

Program Challenges:

- Program staff continued to work on how to make the building more visible.
- Funding limitations.
- Creating public awareness of services and particularly making meaningful connections with Board and Care facilities.
- Reintegration of previous clients that had stalled their use of services.
- Balancing the social issues arising in the meeting of various levels of cognition, emotional stability, sobriety, and class among the clients.

In FY26 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 0; Transition Age Youth (16-25 years): 0; Adults (26-59 years): 175; Older Adults (60+ years): 50.

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 Division utilizes existing City job classifications for 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 also 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 having “lived experience” and as peer or family member providers. In 2018, a peer provider was hired to support the Wellness Recovery services work. This position became vacant in December 2021, and it wasn’t filled until the third quarter of FY2023.

Two additional positions were added through the FY2022 Annual Update, to increase the Wellness Recovery work and enable a greater ability to provide a variety of peer led services, and the provision of activities and supports to individuals in the waiting room. These positions were hired in the third quarter of FY2023 and have been integral in expanding the services of the Wellness Recovery Team.

Case Management for Youth and Transition Age Youth
In response to a high need for additional services and supports for youth and Transition Age Youth (TAY) who experience mental health issues and may be homeless or marginally housed, case management services for TAY are provided through a local community partner, Youth Spirit Artworks (YSA). This project serves approximately 50 individuals a year.

In FY2024, 56 youth were served through this project. Demographic data on youth participants is outlined below:

DEMOGRAPHICS N = 56*
*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  16 – 25 years – 56

- **Gender Identity**
  Male – 11
  Female – 33
  Genderqueer/Gender non-conforming/Transgender - <11

- **Race/Ethnicity**
  Asian or Asian Pacific Islander – <11
  Black or African American – 22
  Latino/a/x – 12
  White – <11
  More than one race – <11

- **Sexual Orientation**
  Heterosexual or Straight – 26
  Lesbian or Gay – <11
  Bisexual – <11
  Pansexual/Queer/Questioning/Asexual - <11
  Declined to Answer, or Unknown - <11

At the beginning of FY2024 Case Management Services were provided through UCB MSW interns and were shifted in September 2023, to a Peer Navigator model.

Program Successes:
All program participants were a part of the Youth Leadership Program that included training, planning, and events. Art workshops were also offered to support youth with creative expression in their youth leadership. A pathway through youth leadership that aligned with going deeper in practice with learned leadership skills also supported youth with information and opportunities for Community Organizing, Events and Production, and Galley Exhibition.

Program Challenges:
In FY2024, there were no program challenges reported.

In FY2026 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 15; Transition Age Youth (16-25 years): 50; Adults (26-59 years): 0; Older Adults (60+ years): 0.

Additional Services for Asian Pacific Islanders
The Asian Pacific Islander (API) 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 FY2019 Annual Update to allocate CSS System

Development funds to contract with a local community-based organization, or to partner with Alameda County BHCS, to increase funding for a contractor selected for similar purposes. It was envisioned that the contractor would provide access to additional services and supports for this population. In FY2020 and FY2022 three separate RFP processes were executed to find a community partner that the Division could contract with who would provide these services, however the Division was unable to secure a Contractor. At present, the Division is currently in the process of assessing how best to partner with a local community agency to implement these services.

Results Based Accountability Evaluation
Per the previously approved MHSA FY2019 Annual Update, the Division allocated CSS System

Development funds for a consultant who would conduct an evaluation on all BMH programs across the system utilizing the “Results Based Accountability” (RBA) framework. The RBA framework measures how much was done, how well it was done, and whether individuals are better off as a result of the services they received. A competitive RFP process was executed, and Resource Development Associates (RDA) was the chosen consultant. RDA worked with the Division from FY2021-FY2024 to execute this evaluation.

In FY2024, RDA worked with the Division and the Program Evaluator to continue to implement the RBA Framework to evaluate program outcomes and to develop the internal capacity for the Program Evaluator to focus on implementing and tracking RBA evaluation measures across BMH programs. RBA development efforts made substantial progress during the reporting timeframe. Key achievements included the establishment of program and division-level RBA measures, the collection and integration of FY2023 data, and the development of dashboards for the division and across service programs. This process included addressing new changes between external and internal data reports and facilitating data review sessions with program teams to analyze impact measures and outcomes.

RDA conducted the following Data Collection, Evaluation, and Reporting activities:

Twenty-seven meetings were conducted for BMH staff including:

- 12 Turn the curve meetings for all programs in the division,
- 9 individual meetings with program managers to review data for the dashboard and provide technical support on data collection,
- 2 meetings with the Executive Leadership Team to review dashboards,
- 2 Feedback sessions with non-management and management staff,
- 1 Visioning and action planning session to support RBA sustainability of implementation,
- 1 Focus group training to implement at the client level.

Key Activities – Dashboard, Analysis and Reporting:

- Completed dashboards for Interval 2 and Fiscal Year 2023,
- Tracked 140 performance measures for data collection and reporting,
- Cleaned and analyzed raw data for internal reporting,
- Reviewed Dashboard data to prevent the identification of individuals for publicly released information,
- Created an external facing division level dashboard to be used to report out on the data for the division and 12 programs,
- Populated the remaining available FY24 data and annotated remaining measures with an asterisk if data was unavailable due to delays in the County reporting system,
- Revisited existing RBA measures to ensure continued relevance.

There were some challenges in FY2024 due to the County's transition to a new client reporting and billing system which impacted the RBA data collection. The ongoing configuration process affected procedure codes, reporting tables, and service categories. These challenges were addressed, with a resolution anticipated in FY2025. The complete set of RBA outcomes for all BMH programs is located in Appendix B.

Counseling Services for Older Adults
Older Adults who only have Medicare insurance currently have great difficulty accessing mental health services, despite consistent input on the need for support for this population. In an effort to increase mental health services and supports for older adults, the Division allocated funding in the approved FY2020 MHSA Annual Update to support this population. MHSA funds are transferred to the Aging Services Division of HHCS, to implement various counseling services for older adults through the Wright Institute.

A total of 159 individuals received services in FY2024, demographics on individuals served are outlined below:

DEMOGRAPHICS N = 159*

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  26 – 59 years – 18
  60 years and older – 141

- **Gender Identity**
  Male – 34
  Female – 119
  Another Gender Identity/Unknown - <11

- **Race/Ethnicity**
  Asian or Asian Pacific Islander – <11
  Black or African American – <11
  White – <11
  More than one Race – 24
  Other – 12
  Declined to Answer, or Unknown – <11

- **Sexual Orientation**
  Heterosexual or Straight – 1130
  Gay or Lesbian – 19
  Bisexual – <11
  Declined to Answer, or Unknown – <11

Program Successes:

- The partnership between the Aging Services Division and the Wright Institute continued to work well.
- Program contacts from the Wright Institute provided clear and timely communication via email and let the Aging Services Division staff know in advance of any mental health counseling program offerings and changes.
- Both the individual and group counseling sessions were well attended, as were the informal workshops that Wright Institute presented on various topics. Workshops and sessions were offered at both senior centers, as well as at the Institute itself.

Program Challenges:

In FY2024, there were no notable program challenges reported.

In FY2026 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 0; Transition Age Youth (16-25 years): 0; Adults (26-59 years): 5; Older Adults (60+ years): 85.

Substance Use Disorder Services

A large portion of individuals who currently receive services at BMH are also experiencing co-occurring disorders, having both mental health issues and substance

use disorders (SUD). In an effort to increase the capacity to serve individuals with SUD, funds were previously allocated through the MHSA FY2022 Annual Update for the Division to work with a local SUD provider to co-locate SUD services at the Mental Health Adult clinic. In FY2023 a contract was executed with Options Recovery Services. This collaboration has increased the provision of SUD services for BMH clients, provides an opportunity for staff to obtain consultations on SUD services, and makes referrals into SUD services outside of BMH an easier process for individuals.

In FY2024, 31 individuals received services. Demographics on individuals served are outlined below:

DEMOGRAPHICS N = 31*

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  18 – 24 years – <11
  25 – 44 years – <11
  45 – 64 years – 13
  65 years and older – <11
  Declined to Answer, or Unknown – <11

- **Gender Identity**
  Male – 16
  Female – 11
  Other/Declined to Answer, or Unknown – <11

- **Race/Ethnicity**
  Asian or Asian Pacific Islander – <11
  Black or African American – 13
  Latino/a/x – <11
  White – <11
  Multi-racial – <11
  Declined to Answer, or Unknown – <11

- **Sexual Orientation**
  Heterosexual or Straight – 15
  Lesbian or Gay – <11
  Other – <11
  Declined to Answer, or Unknown – <11

Program Successes:

In FY2024, individual counseling services were expanded, allowing a larger number of clients to be reached on a weekly basis. On average, individual counseling was provided to 10 clients each week, in addition to group counseling. These tailored sessions addressed specific needs related to mental health, and substance use challenges, and were designed to assist with coping strategies, the management of triggers, and to build resilience. By increasing the availability of individual counseling,

the program was better able to meet clients where they were in their recovery journey, providing more consistent and accessible support to foster long-term wellness.

The program continued to have close collaborations with community partners, such as CenterPoint, Lifelong, and others, to ensure that individuals received comprehensive care for their treatment needs beyond what was provided. These partnerships enabled better support for individuals who required specialized services that fell outside the scope of this program. As a result of these efforts, four individuals were placed in additional treatment programs tailored to their specific needs, ensuring that they had access to the right level of care and support. These placements were outside the BMH program, which allowed for more targeted interventions based on each individual's circumstances. Two additional individuals were enrolled in the Options Recovery intensive outpatient treatment program, which was a higher level of care for their substance use issues. This program provided intensive, structured treatment while allowing participants to maintain a degree of independence as they worked toward their recovery goals. By continuing to work in partnership with these organizations and expanding the range of treatment options, the program was able to address the diverse and complex needs of the individuals served.

Program Challenges:
Some individuals in the program experienced severe mental health symptoms that created significant obstacles to their engagement in treatment. Some of the various symptoms included anxiety, depression, paranoia, and increased substance use, which impacted their motivation, energy levels, and ability to interact with others in a group setting. As a result, these individuals frequently missed scheduled group sessions. These symptoms also often led individuals to cancel or reschedule individual counseling appointments, which interrupted the continuity of their care and hampered the therapeutic progress that may have otherwise been achieved through participation in regular sessions. This inconsistency posed a challenge, as it disrupted the structured support that the program is designed to offer, making it harder for counselors to maintain a therapeutic rapport and keep individuals on track with their treatment goals. To address these challenges, a goal attainment treatment approach was implemented in FY2025 which will be evaluated over the next fiscal year. This treatment approach will focus on setting personalized, achievable goals that are broken down into manageable steps, making it easier for individuals to see progress and stay motivated even when symptoms interfere with their engagement.

In FY2026 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 0; Transition Age Youth (16-25 years): 0; Adults (26-59 years): 24; Older Adults (60+ years): 7.

Specialized Care Unit
Through the approved FY2022 Annual Update, the Division allocated a portion of one-time CSS and PEI funds to be leveraged with other City funds to support the Specialized Care Unit (SCU). Implemented through Bonita House, the SCU is Berkeley's new behavioral health crisis response team without the involvement of law

enforcement. The SCU consists of trained crisis-response field workers who respond to behavioral health occurrences that do not pose an imminent threat to safety.

In FY2023, MHSA funds directly supported start-up costs of the program including recruitment, hiring, and training of Bonita House staff. Training included crisis support training through Bonita House's Crisis Training Academy as well as the design and training of Berkeley-specific procedures for the SCU program. Additionally, this funding supported the salaries of the SCU program management staff as additional team members were hired. During this time, program management staff worked closely with the City of Berkeley to create the policies and procedures for a SCU that aligned with the implementation recommendations from the Berkeley community. In early FY2024, the SCU began providing services to the community.

On-site management at Martin Luther King Jr. House
The Martin Luther King Jr. House is a 12-unit single room occupancy (SRO) complex with shared living spaces that serves the disabled community in Berkeley. Per the approved FY2023 Annual Update, the Division allocated a portion of CSS System Development funds to provide on-site property management at this SRO for a short period of time. A contract was executed through the Housing and Community Services Division of HHCS with Resources for Community Development to provide management and oversight of this SRO, through December 2024.

Short-term housing for individuals on the Homeless FSP
Through the approved FY2023 Annual Update the Division allocated a portion of MHSA FSP Funds to support short-term housing for individuals receiving services on the Homeless FSP. It was envisioned that the funding would be utilized to provide housing in trailers located at 701 Harrison Street, and daily living supports for four individuals. Since the approval of the FY2023 Annual Update, the Division learned that it will not be possible to utilize the Harrison Street trailers for this purpose. As such, the funding allocated for this purpose, will be re-purposed for other short-term housing sites for individuals in need.

PREVENTION & EARLY INTERVENTION (PEI)

The Prevention & Early Intervention (PEI) funding component is for strategies to recognize the 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.

The original City of Berkeley PEI was approved in April 2009. Since the approval of the original plan, Three-Year Plans or Annual Updates outlining proposed PEI funding and programming, have been approved on an annual basis. Through the original PEI Plan and/or subsequent plan updates, some of the many services the City of Berkeley has provided through this MHSA funding component have included:

- 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 peers and family members; and
- Intervention services for at-risk children.

PEI Reporting Requirements
Per MHSA PEI regulations, all PEI funded programs are require to collect specified state identified outcome measures and detailed demographic information. MHSA also requires Evaluation Reports for PEI funded programs. PEI Evaluations are required to be included in each MHSA Annual Update or Three-Year Plan. Included in Appendix C of this Annual Update is the Prevention & Early Intervention (PEI) Fiscal Year 2021-2022 – 2023-2024 (FY2022-2024) Three-Year Evaluation Report.

Impact Berkeley
In FY2018, 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. This has 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. The results of this initiative are outlined in each of the projects funded through the PEI Community Education & Supports program.

Results Based Accountability Evaluation for all BMH Programs
Through the approved FY2019 Annual Update the Division executed a Request for Proposal (RFP) process to hire a consultant to conduct a Results Based Accountability Evaluation (RBA) for all programs across the Division, and Resource Development Associates (RDA) was the chosen vendor. RDA worked with the Division from FY2021-FY2024 to implement the RBA research methodology. An update of the activities conducted by RDA in FY2024 on this evaluation is included in the CSS Section of this Three-Year Plan.

RBA outcomes in FY2024 are outlined in this Annual Update for the following MHSA PEI funded internal programs: Social Inclusion Project, and the High School Prevention Project. The complete set of RBA outcomes for all BMH programs is located in Appendix B.

PEI Regulations
Per MHSA PEI State Regulations, Mental Health jurisdictions are to utilize PEI funds to implement 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. Programs and/or strategies within programs can also be combined. Jurisdictions may also opt to utilize some PEI funds to implement a Suicide Prevention program. The definitions of each program that were funded through FY2024 are outlined below along with the City of Berkeley corresponding program:

PEI Program Type	Program Definition	City of Berkeley PEI Program(s)
Prevention	A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors.	• Mental Health Promotion Campaign • High School Prevention • DMIND • MEET • African American Success

PEI Program Type	Program Definition	City of Berkeley PEI Program(s)
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.	• High School Prevention • Be A Star • DMIND • MEET • African American Success • Supportive Schools • Community Education and Supports
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.	• Mental Health First Aid (non-PEI funded program)
Stigma and Discrimination	Direct 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.	• Social Inclusion
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.	• High School Prevention
OPTIONAL Suicide Prevention	Activities to prevent suicide as a consequence of mental illness.	• CalMHSA PEI Statewide Project

Beginning January 1, 2020, per Senate Bill (SB) 1004, Welfare and Institutions Code (WIC) 5840.7 (a) directed the Mental Health Oversight and Accountability Commission (MHSOAC) to establish priorities for the use of MHSA PEI funds. Section 5840.7 (d)(1) states that mental health jurisdictions shall, through their MHSA Three-Year Program and Expenditure Plans and Annual Updates, focus use of their PEI funds on the Commission-established priorities or other priorities as determined through their respective, local stakeholder processes. If a mental health jurisdiction chooses to focus on priorities other than, or in addition to those established by the Commission, "the plan shall include a description of why those programs are included and metrics by which the effectiveness of those programs is to be measured" (WIC Section 5840.7 (d)(1)).

Current MHSOAC priorities for the use of PEI funding are as follows:

- Childhood trauma prevention and early intervention to deal with the early origins of mental health needs,
- Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan,
- Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college,
- Culturally competent and linguistically appropriate prevention and intervention, including community defined evidence practices (CDEPs),
- Strategies targeting the mental health needs of older adults,
- Early identification programming of mental health symptoms and disorder, including but not limited to, anxiety, depression, and psychosis.

In order to meet the requirements, each mental health jurisdiction is required to show in the PEI Component of the Three-Year Plan or Annual Update the following:

- Which specific PEI priorities the mental health jurisdictions plan addresses, an estimate of the share of PEI funding allocated to each priority, and an explanation of how stakeholder input contributed to those allocations,
- If the mental health jurisdiction has determined to pursue alternative or additional priorities to those listed in Section 5840.7(a), how the determinations were made through its stakeholder process,
- For any alternative or additional priority identified by the mental health jurisdiction, what metric or metrics relating to assessment of the effectiveness of programs intended to address that priority the county will measure, collect, analyze, and report to the Commission, in order to support statewide learning.

All MHSA programs and projected funding amounts were vetted through the Community Program Planning process for this Annual Update. Many PEI projects meet multiple established priorities. Per PEI regulations, outlined below are the City of Berkeley PEI programs, priorities, and FY2026 projected funding amounts:

CITY OF BERKELEY PEI PROGRAMS	PEI PRIORITIES	FY26 Projected Funding Per Priority
• Mental Health Promotion Campaign	Includes a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors.	$100,000
• Supportive Schools	Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.	$110,000

CITY OF BERKELEY PEI PROGRAMS	PEI PRIORITIES	FY26 Projected Funding Per Priority
• High School Youth Prevention Project	Youth Engagement and Outreach Strategies that target secondary school and transition age youth	$580,697
• Mental Health Peer Mentor Program	Youth Engagement and Outreach Strategies that target secondary school and transition age youth	$46,389
• Dynamic Mindfulness Program	Youth Engagement and Outreach Strategies that target secondary school and transition age youth	$95,000
• African American Success Project	Youth Engagement and Outreach Strategies that target secondary school and transition age youth Culturally competent and linguistically appropriate prevention and intervention including community defined evidence practices (CDEPs)	$150,000
• Social inclusion	Culturally competent and linguistically appropriate prevention and intervention, including community defined evidence practices (CDEPs)	$10,000
• Community Education & Supports (LGBTQIA+ Trauma Support Project; SoulSpace Project; Latinx Trauma Support Project)	Culturally competent and linguistically appropriate prevention and intervention, including community defined evidence practices (CDEPs)	$300,000
• Community Education & Supports (TAY Trauma Support Project)	Youth Engagement and Outreach Strategies that target secondary school and transition age youth not in college.	$32,046
• Community Education & Supports (Living Well Project)	Strategies targeting the mental health needs of older adults.	$32,046

PEI Funded Children and Youth and TAY Services

Per MHSA regulations 51% of PEI funds are to be used on services and supports for Children, Youth, and TAY. Small counties, of which the City of Berkeley is considered, may elect to forego this regulation as long as a community vetted, locally approved justification is provided as to why children and youth services are funded at a lower level. Since the initial PEI Plan, the City of Berkeley has allocated more than 51% of PEI funds to services and supports for children, youth and TAY as the majority of PEI funds has been utilized to serving these populations. All City of Berkeley PEI programs in FY2026 will provide some level of services for children and youth and/or Transition Age Youth. Five programs are in the Berkeley Unified School District (BUSD).

Programs and services funded with PEI funds that were approved to be continued in FY2026 through the previously approved Three-Year Plan, are outlined below by PEI Program type, along with FY2024 data. Throughout all PEI programs, demographic data representing numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

Prevention Programs

Prevention Program – Includes a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors.

Mental Health Promotion Campaign
As a result of the impact of the COVID-19 pandemic, and public input around the overwhelming need for mental health supports in the community, the Division proposed through the FY22 Annual Update to allocate PEI funds for a community Mental Health Promotion Campaign to support the wellness and self-care of Berkeley residents. The Division will partner with the community and consider using a social marketing firm to develop and implement the campaign.

PEI Goals: The goal of this campaign is to increase prevention efforts and response to early signs of emotional and behavioral health problems.

PEI Priority: Culturally competent and linguistically appropriate prevention and intervention; including Community Defined Evidence Practices (CDEPs).

It is anticipated that this campaign will be implemented in FY2026.

Early Intervention Programs

Early Intervention Program – Provides 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.

The City of Berkeley Early Intervention programs are as follows:

Early Childhood Health and Wellness Program
From the first PEI Plan through FY2024 the Early Childhood Health and Wellness program (formerly named the Be A Star Project) has been a collaboration with the City of Berkeley's Public Health Department. It has provided a coordinated system in Berkeley 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 targeted low income families, including those with teen parents, who were experiencing homelessness, substance use disorders, or were in danger of foster care. Services include triage, assessment, treatment and referrals to appropriate community-based or specialist services as needed. Children and families were 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 were to identify, screen and assess families early, and connect them with services and supports as needed.

The program utilized 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 contained simple questions for parents to answer that reflected developmental milestones for each age group. Answers were scored and helped to determine whether the child's development was on schedule or whether the child should be referred for a developmental checkup with a professional. Over 400 children were 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.

PEI Priority: Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.

In FY2024, a total of 2,596 children were screened through this program (207 at BUSD, and 2,389 at the Help Me Grow sites) however data was not collected on all individuals screened. Although all 2,389 of the individuals that were either screened or were screened and received services, were aged 0-15, the data elements listed below show the demographics of the 207 children screened at BUSD as follows:

DEMOGRAPHICS N = 207*

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  0 – 15 (Children/Youth) – 207

- **Race/Ethnicity**
  Asian or Asian Pacific Islander – 40
  Black or African American – 57
  White – 37
  More than one Race– 20

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Other (Hispanic or Latino/a/x not specified on ethnicity) – 53

- **Ethnicity: Non-Hispanic or Latino/Latina/Latinx**
  Declined to Answer (or Unknown) – 154

- **Primary Language**
  English – 99

Spanish – 40
Declined to Answer, or Unknown – 68

- **Disability**
  Declined to Answer (or Unknown) - 207

- **Gender: Assigned Sex at Birth**
  Male – 68
  Female – 119

Program Successes:

- A new Public Health Nurse (PHN) started in October 2023, coming with many years of experience working with young children and families, school nurse experience, and PHN case management for children ages 0-3 years old in foster care. The PHN quickly connected with the Alameda County Help Me Grow Collaborative and the Medical Home Project's Special Needs Committee and became an active representative for Berkeley in the Help Me Grow Collaborative and the Special Needs Committee. Her experience in early childhood and resource navigation were assets in her prevention and early intervention work with providers and families with young children.
- On-site technical assistance visits to all Berkeley Help Me Grow providers continued into this year and went well.
- Conducted 2,596 developmental screenings through the Ages and Stages Questionnaire (ASQ) and the Modified Checklist for Autism in Toddlers (MCHAT) in Berkeley, including BUSD preschools and Berkeley Help Me Grow pediatric provider sites combined.
- A total of 150 referrals were made for resources to support following areas identified from the screenings:
  - Communication
  - Community resources, basic needs, childcare
  - Parent Support/ Parent/Child Relationship
  - General Developmental Guidance
  - Fine and Gross Motor Skills
  - Sensory Skills
  - Autism/ADHD Diagnosis
  - Behavioral Concerns
  - Trauma/Childhood Event
  - Mental Health

Program Challenges:

- The Help Me Grow Collaborative collected and analyzed the data from all HMG sites in Alameda County, not just Berkeley, so it took time to collect and synthesize the data and to receive the Berkeley specific data.

- Help Me Grow sites did not collect race/ethnicity, language spoken data, or gender; BUSD did not collect specific ethnicity data, gender identity, sexual orientation for this age group, nor all languages spoken.

Beginning in FY2025, the MHSA PEI funding for this program was discontinued, as the Public Health Division transitioned these program activities to the Maternal, Child and Adolescent (MCAH) Program.

Supportive Schools Program
Through this program leveraged MHSA PEI funds support the provision of mental health prevention and early intervention services at each of the Elementary Schools in Berkeley. 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 bring about mental health, including the reduction of school failure and the removal of children from their homes.

PEI Priority: Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.

In FY2024 Early Intervention Services were provided at each of the BUSD elementary schools. BUSD sub-contracted with local agencies to provide early intervention services based upon the standard of evidence-based practices. Bay Area Community Resources (BACR), Child Therapy Institute (CTI), and Lifelong Medical (Lifelong) were subcontracted to provide services at BUSD elementary schools.

Supports for each school per each service provider, and numbers served in FY2024 were as follows:

Elementary School	Agency/Provider	Number of Students Served
• Cragmont • Emerson • John Muir • Malcolm X • Oxford • Ruth Acty • Sylvia Mendez • Thousand Oaks	Bay Area Community Resources (BACR)	331
• Bay Area Arts Magnet (BAM) • Washington	Child Therapy Institute	65
• Rosa Parks	Lifelong Medical Care	40
Total		**436**

Information on services provided, successes, and challenges with each sub-contractor are outlined below:

Bay Area Community Resources (BACR):
Provided services to improve emotional functioning and success in school and life, including individual and group therapy, family consultation, conflict resolution/restorative justice, suicide prevention, check-in/check-out, crisis intervention, and classroom presentations. BACR used many different therapy modalities as well as classroom support to develop skills and health.

Additionally, the BACR Counselor participated in weekly Coordination of Services (COST), Student Success Team (SST), and Individualized Education Program (IEP) meetings for students, providing mental health and trauma informed perspectives. BACR consulted with school staff on many issues and provided trauma informed coaching for teachers needing support. BACR also provided referrals and care coordination to outside providers, parenting classes/support groups, crisis hotlines, and other programs.

Program Successes:
In FY2024 BACR provided the following services:

- Trauma-Informed individual and group therapy, family and school support
- Groups of social skills and coping with issues such as grief and parental separation
- Crisis support and mental health check-ins
- Targeted support to students with school refusal and attendance issues
- Classroom presentations on socio-emotional topics, identity, empathy, accepting differences conflict resolution, skill-building in class and on the yard
- Parent coaching, consultation and community resources, including pediatricians and outside providers
- Collaborative coaching with teachers to enhance the positive learning environment
- Restorative Justice sessions
- Coordinated services with school staff and external providers
- Established linkages to vital community resources.

In addition, BACR provided Classroom/School-wide Presentations to 503 attendees, and 642 individuals received small group services around the subject matters of:

- Social skills
- Coping with parental separation
- Anxiety
- Empathy
- Identification of feelings

Program Challenges:
The biggest challenge continued to be the increase in cost to fund the program. These increases required the district to make cuts in other programming areas, as well as moving resources around to be able to continue providing ongoing services at the same rate as in the previous year.

Child Therapy Institute (CTI): Provides services and supports for students and supports at Berkeley Arts Magnet (BAM) and Washington Elementary School.

Program Successes:
CTI staff continued to meet with students individually and in groups.

Program Challenges:
There were few direct challenges, however, a significant challenge continued to be the increase in the costs to fund the program. These increases have required the district to make cuts in other programming areas, as well as to move resources around to be able to continue providing ongoing services at the same rate as in the previous year.

Lifelong Medical:
A Licensed Clinical Social Worker (LCSW), two Master of Social Work (MSW) interns, and one Marriage and Family Therapist (MFT) trainee provided individual counseling to students, family counseling, and mental health consultation to caregivers and school staff. Several Social Skills groups were run by the LCSW, interns, and in collaboration with a learning specialist. These groups were tailored to the needs of the individuals in each group and provided community building, social skills practice, regulation strategies, and support to many students across all grade levels. Full-class support was provided in several classrooms. School staff and students were also supported with crisis support/suicide assessment and consultation as needed throughout the year. The LCSW provided consultations with caregivers and referrals to mental health services in the community.

The Family Resource Center (FRC) Supervisor regularly attended COST meetings at Rosa Parks. The FRC Supervisor and interns attended staff meetings, SST and IEP meetings. All counselors regularly collaborated with teachers, families, classroom aides and staff in the afterschool program. One of the FRC interns participated and re-started a Rainbow Families group (for families who identify as LBGTQ and allies). FRC staff are integrated into the school community.

Program Successes:
This was a successful year which included building relationships and fostering a sense of belonging and community. The LCSW, Clinical Director, and other Lifelong staff provided training to the MSW interns and MFT trainee. Trainings including trauma responsive care, child therapy models, regulation strategies including Zones of Regulation, Cognitive-Behavioral Therapy, grief, working with teachers and caregivers, and many other topics. There was a particular focus on training in anti-racist practice. Lifelong hired a consultant who specialized in cross-cultural clinical practice and anti-racist counseling practice that provided multiple trainings and staff consultation. This

support was particularly important and helped FRC staff intervene when there were multiple incidents of racism that impacted students and school staff.

The LCSW and counseling interns worked hard to be a visible and integrated part of the community. FRC staff identified a need for kids to have safe, supportive environments to practice social skills and work on connections with each other. Gaps in social-emotional learning were identified as a result of the pandemic. Groups were prioritized this year in order to meet that need. FRC staff worked thoughtfully and collaboratively with teachers to think about how to configure groups where students could feel seen and heard. Staff considered many factors including race, culture, gender expression, and temperament in creating these groups.

The FRC staff continued to provide more intensive support to some students through individual counseling and collaboration with teachers and caregivers. The interns and trainee were able to refine their skills in comprehensive assessment, treatment planning, and implementation of age appropriate and culturally appropriate interventions. Many students made significant progress this year, and FRC staff were an integral part of the support team that helped guide them. During the reporting timeframe, 140 students participated in group sessions and 28 staff members received information or training.

Program Challenges:
There were few direct challenges, however, a significant challenge continued to be the increase in the cost to fund the program. These increases required the district to make cuts in other programming areas, as well as moving resources around to be able to continue providing ongoing services at the same rate as in previous year.

Demographic data provided by BUSD on 436 students that were served through this project in FY2024, is outlined below:

DEMOGRAPHICS N = 436*
*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  0 – 15 (Children/Youth) – 436

- **Race/Ethnicity**
  American Indian or Alaska Native - 13
  Asian – 22
  Black or African American – 93
  Native Hawaiian/Pacific Islander - <11
  White – 137
  More than one Race– 61
  Other – 16
  Declined to Answer (or Unknown) – 92

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Mexican/Mexican American – Chicano - <11
  Other – 60
  Declined to Answer (or Unknown) - <11

- **Ethnicity: Non-Hispanic or Latino/Latina/Latinx**
  African – 12
  Chinese - <11
  European – 28
  Filipino - <11
  Japanese - <11
  Korean - <11
  Vietnamese - <11
  Other - <11
  Declined to Answer (or Unknown) – 316

- **Primary Language**
  Spanish – 16
  English/Declined to Answer, or Unknown – 420

- **Sexual Orientation**
  Declined to Answer, or Unknown – 436

- **Disability**
  Mental domain not including a mental illness/Physical mobility/domain/Other – 15
  Chronic health condition (including but not limited to chronic pain) – 31
  Declined to Answer (or Unknown) – 390

- **Veteran Status**
  No– 43

- **Gender: Assigned Sex at Birth**
  Male – 38
  Female – 52
  Declined to Answer or Unknown – 346

- **Current Gender Identity**
  Male – 173
  Female – 150
  Transgender or Another Gender Identity - <11
  Genderqueer - 12
  Declined to Answer or Unknown – 92

In FY2026 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 480; Transition Age Youth (16-25 years): 0; Adults (26-59 years): 0; Older Adults (60+ years): 0.

Community Education & Supports
Through five community-based organizations, 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 including: African Americans; Latino/a/x; LGBTQIA+; TAY; and Senior Citizens.

In FY2024 the Community Education & Supports program participated in the HHCS Results-Based Accountability (RBA) Evaluation. In an aggregated summary across the five projects within this program the following work was conducted: 397 Support Groups/Workshops; 822 Support Group/Workshop encounters; 31 Outreach activities; 2,120 Outreach Contacts; and 296 Referrals.

Descriptions of the five projects within the Community Education & Supports program along with FY2024 data and RBA evaluation results, are outlined below:

- **Transition Age Youth Trauma Support Project**

Implemented through Youth Spirit Artworks 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 project is to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the prevention of suicide.

PEI Priorities:
- Culturally competent and linguistically appropriate prevention and intervention; including Community Defined Evidence Practices (CDEPs)
- Youth engagement and outreach strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college

In FY2024, 52 youth participated in one or more program services. Demographics on youth served were as follows:

DEMOGRAPHICS N = 52*

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  16 - 25 (Transition Age Youth) – 52

- **Race/Ethnicity**
  Asian – <11
  Black or African American – 18
  White – <11
  More than one Race – <11
  Other – 11

- **Ethnicity: Latino/Latina/Latinx**
  Mexican/Mexican American – Chicano – 12

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  African – 18
  Asian Indian/South Asian - <11
  Middle Eastern - <11
  More than one ethnicity - <11
  Declined to Answer (or Unknown) - <11

- **Primary Language**
  English – 52

- **Sexual Orientation**
  Heterosexual or Straight – 22
  Lesbian or Gay – <11
  Bisexual – <11
  Queer - <11
  Questioning or Unsure of sexual orientation - <11
  Another sexual orientation - <11
  Declined to Answer, or Unknown – <11

- **Disability**
  Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability or dementia) - <11
  Chronic health condition (including but not limited to chronic pain) - <11
  Declined to Answer or Unknown – 47

- **Veteran Status**
  No – 52

- **Gender: Assigned Sex at Birth**
  Male – 37
  Female – 15

- **Current Gender Identity**
  Male – 12
  Female – 30
  Transgender or Another Gender Identity - <11
  Genderqueer – <11
  Another Gender Identity – <11

Program Successes:
Some of the successes experienced in the reporting timeframe were aligned with changes to make the program more youth centered and informed. The Out of the Binary Fashion Show was the first event done in several years that was 100% facilitated, planned, and executed by participants in the program. Although time was spent training youth on all of these areas, youth were able to take those skills and develop something that was completely their own. The same followed into the Mural Workshop in which youth created their own ideas for the mural. They drew and designed the mural and painted on their own. This allowed the youth to feel a sense of autonomy and independence to create their own pieces and to work alongside individuals with experience in the community. This resulted in more youth coming into the program. Another success was the change in focus to offering intergenerational events that brings individuals from the Adeline community together to celebrate art, history, and community. A community brunch at the studio was held that included several Adeline community members and youth including renowned artist Edyth Boone. This event was the first to bring community members together to discuss upcoming programs and projects. At the end of the Mural Workshop, there was a Mural Reveal engagement that brought artists, Adeline community members, and youth together to celebrate the Mural created by the youth. The program successfully created safety, dignity and belonging that brought more youth to the space and gave them the freedom to participate in services and creatively express themselves.

Project Challenges:
The main challenges during the reporting timeframe was around a loss of some of the overall funding to the agency. Loosing funding caused the agency to cut stipends and some of the positions. The loss in funding pushed the agency to align in a different more efficient positive direction.

In FY2026 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 0; Transition Age Youth (16-25 years): 85; Adults (26-59 years): 0; Older Adults (60+ years): 0.

➢ Trauma Support Project for LGBTQIA+ 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 LGBTQIA+ 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 LGBTQIA+ community. Weekly or bi-weekly support groups are held throughout the year targeting various

populations and needs within the LBGTQIA+ 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. Approximately 250 individuals a year are served through this project.

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.

PEI Priorities:

- Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs).
- Youth Engagement and Outreach Strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college.
- Strategies targeting the mental health needs of older adults.

In FY2024, a total of 94 individuals were served. Demographics on individuals served include the following:

DEMOGRAPHICS N = 94*

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  16 - 25 (Transition Age Youth) – <11
  25 – 59 (Adult) – 71
  Ages 60+ (Older Adult) - <11
  Declined to Answer (or Unknown) - <11

- **Race**
  Asian – <11
  Black or African American – <11
  White – 62
  More than one Race – <11
  Other – 11
  Declined to Answer (or Unknown) - <11

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Mexican/Mexican American – Chicano – <11
  South American - <11
  Other - <11
  Declined to Answer (or Unknown) - <11

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  African – <11
  Asian Indian/South Asian - <11
  Chinese - <11
  Eastern European - <11
  European – 20
  Filipino - <11
  Japanese - <11
  Other - <11
  Declined to Answer (or Unknown) - 24

- **Primary Language**
  English – 93
  Other/Declined to Answer (or Unknown) - <11

- **Sexual Orientation**
  Heterosexual or Straight – <11
  Lesbian or Gay – 14
  Bisexual – <11
  Queer - <11
  Questioning or Unsure of sexual orientation - <11
  Another sexual orientation - 41
  Declined to Answer, or Unknown – <11

- **Disability**
  Difficulty Hearing or Having Speech Understood - <11
  Mental Domain not including a mental illness (including but not limited to a learning disability, developmental disability or dementia) - <11
  Physical/mobility domain - <11
  Chronic health condition (including but not limited to chronic pain) - <11
  Other (Specify) - <11
  No Disability - <11
  Declined to Answer or Unknown – 68

- **Veteran Status**
  Yes – <11
  No – 92
  Declined to Answer (or Unknown) - <11

- **Gender: Assigned Sex at Birth**
  Declined to Answer (or Unknown) - 94

- **Current Gender Identity**
  Male – 19
  Female – 16
  Transgender – 16
  Genderqueer – <11

Questioning or Unsure - <11
Another Gender Identity – 34

RBA Outcomes during the reporting timeframe were as follows: 261 Support Groups were conducted reaching 143 individuals; 26 Outreach activities were conducted reaching approximately1,780 individuals; 13 individuals attended Train the Trainer sessions to become Peer Support Group Facilitators; and 38 Peer Support Group Facilitators attended Skill Building Workshops. There were 71 referrals for additional services and supports. The number and type of referrals included: 28 Mental Health; 16 Physical Health; 3 Social Services; 1 Housing; 23 Other unspecified services. To assess the project services, a self-administered Peer Support Group Survey was distributed to all peer group members. Survey results were as follows:

- 92% indicated they would recommend the organization to a friend or family member
- 92% felt like staff and facilitators were sensitive to their cultural background
- 88% reported they deal more effectively with daily problems
- 79% indicated they have trusted people they can turn to for help
- 81% felt like they belong in their community.

Program Successes:
The monthly consultation meetings for Peer Group facilitators was moved to Saturdays with the hope of gaining more attendance. With the move to the new location, facilitators were invited to return to the building and we staff worked on the hybridization of the new space. The move also provided the opportunity to renew outreach efforts. New location announcements were created and distributed.

With feedback from facilitators, the scope of the diversity, equity, and inclusion trainings and this year's DEI offerings were Power & Positionality, Supporting Neurodivergence, Mediating Conflict, and Accessibility in Support Spaces. There was strong attendance for these training sessions with an average of 7 facilitators in attendance per session. There were 14 new facilitators onboarded, and facilitation training for 2 facilitators from Asian Health Services was provided.

Program Challenges:
A few groups had to end due to a lack of facilitators. Another big challenge was that more community members wanted in-person groups but facilitators were still working on adjusting back to in-person groups. There was attrition in attendance during the reporting timeframe, and hybrid meetings were implemented in the next fiscal year to address this issue. The program continued to work on ways to utilize the new space as much as possible and in various ways to offer more avenues for individuals to access resources.

In FY2026 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 0; Transition Age Youth (16-25 years): 27; Adults (26-59 years): 141; Older Adults (60+ years): 40.

- **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 80 Older Adults a year.

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.

PEI Priorities:

- Culturally competent and linguistically appropriate prevention and intervention; including Community Defined Evidence Practices (CDEPs).
- Strategies targeting the mental health needs of older adults.

In FY2024, a total of 38 individuals participated in the Living Well Workshop Series program. Demographics of Workshop participants are outlined below:

DEMOGRAPHICS N = 38*

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  Ages 60+ (Older Adult) – 17
  Declined to Answer (or Unknown) – 21

- **Race**
  Asian – <11
  Black or African American – <11
  Native Hawaiian or other Pacific Islander - <11
  White – <11
  Other – <11
  Declined to Answer or Unknown – 18

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Declined to Answer or Unknown – 38

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  Declined to Answer or Unknown – 38

- **Primary Language**
  English/Other – <11
  Declined to Answer or Unknown – 33

- **Sexual Orientation**
  Declined to Answer, or Unknown – 38

- **Disability**
  Difficulty Seeing - <11
  Difficulty Hearing or Having Speech Understood - <11
  Mental (not mental health) - <11
  Physical/mobility disability - <11
  Other Disability – <11
  Declined to Answer or Unknown – 26

- **Veteran Status**
  Declined to Answer or Unknown – 38

- **Gender: Assigned Sex at Birth**
  Declined to Answer or Unknown – 38

- **Current Gender Identity**
  Male – <11
  Female – 14
  Declined to Answer or Unknown – 14

RBA Outcomes during the reporting timeframe were as follows: 4 outreach and informational events were conducted reaching 111 individuals. A total of 78 individuals participated in the Living Well Workshop series and 99 received engagement services. There were 11 referrals for additional services and supports. The number and type of referrals included: 1 Mental Health; 2 Physical Health; 1 Social Services; 2 Housing; 5 other unspecified services.

Project Successes:
The Center for Independent Living's "Living Well with a Disability" workshop series and the PEERS support group were both well-attended and impactful, reaching 78 older adults in Berkeley during the reporting timeframe. Outside of the workshops, 99 older adults in Berkeley received 1-on-1 supports, services, and referrals with a total of 612 hours spent providing these individual services and referrals in the reporting period.

The Senior and Aging Engagement Coordinator witnessed increased mental, physical, and emotional health issues with attendees of the group, and worked to adapt

programming to meet the needs and concerns of attendees. The Coordinator also increased the 1-on-1 services and referrals in order to provide additional support to individuals in need, especially in the realm of mental health, legal advocacy, referrals for assistive technology and residential access supports, general technology assistance, and more.

Other highlights from the reporting period included diverse outreach in the community by the Senior and Aging Engagement Coordinator, including attending a day-long conference on Elder Abuse held by Legal Assistance for Seniors, where the Coordinator was able to meet other service providers and legal advocates that work with older adults, and collaborate on challenges, resources, and referrals. The Coordinator also tabled at the annual Berkeley Juneteenth Festival, at the GoldenReady Emergency Preparedness event, and more.

Project Challenges:
The greatest challenge related to comprehensive data tracking and gathering demographic and survey information from Living Well and PEERS attendees. For a time, the Senior and Aging Engagement Coordinator was not comprehensively tracking the referrals made as part of the 1-on-1 services, and then departed the organization before the Program Director could work closely with her to try to trace back some of those supports and services offered; thus, the referral numbers looked artificially low, even though the Coordinator was visiting multiple seniors at their homes or at the senior centers to work with them 1-on-1, several times per week. The Senior and Aging Coordinator shared that workshop attendees were often reticent to provide the in-depth demographic information requests. Once hired, the new Senior and Aging Engagement Coordinator will be supported in developing strategies to confidentially and comprehensively gather required data and demographics.

In FY2026 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 0; Transition Age Youth (16-25 years): 0; Adults (26-59 years): 30; Older Adults (60+ years): 130.

- **Soul Space Project**

Implemented through ONTRACK Program Resources, the Soul Space project assists African Americans in Berkeley with accessing culturally, ethnically, and linguistically responsive and trauma-informed prevention and early intervention services. Project services include: community education; outreach and engagement; individual quality of life assessments; coaching; empowerment planning; referrals; navigation supports; support groups; and life skills training.

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.

PEI Priorities:

- Culturally competent and linguistically appropriate prevention and intervention; including Community Defined Evidence Practices (CDEPs).
- Youth Engagement and Outreach Strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college.
- Strategies targeting the mental health needs of older adults.

In FY2024, 7 individuals were served. Demographics on individuals served are as follows:

DEMOGRAPHICS N = 7*

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  26 – 59 Adults – <11
  65 years and older – Older Adults – <11

- **Race/Ethnicity**
  Black or African American – <11
  Declined to Answer or Unknown – – <11

- **Ethnicity: Non-Hispanic or Latino/Latina/Latinx**
  Declined to Answer or Unknown – 7

- **Primary Language**
  English – 7

- **Sexual Orientation**
  Heterosexual or Straight – 7

- **Disability**
  Mental (not mental health) – <11
  Chronic Health Condition - <11
  No Disability – <11

- **Veteran Status**
  Declined to Answer or Unknown – 7

- **Gender: Assigned Sex at Birth**
  Male – <11
  Female – <11

- **Current Gender Identity**
  Male – <11
  Female – <11

RBA Outcomes during the reporting timeframe were as follows: 2 Community Education Trainings were conducted to 43 attendees, and 229 individuals were reached through outreach and engagement services. A total of 7 individuals received case management and/or participated in Support Groups. There were 7 referrals for additional services and supports.

Project Successes:

- A support group for Black men, “Black Men Alive and Well,” aimed at building participants’ resilience and well-being was conducted.
- Two community education workshops with Deanna Robinson were held: “Creating a Culture of Healing: Black Mental Health Wellness Strategies” and “Processing Pain While Building a Healing Culture: Black Mental Health Wellness Strategies”.
- A two-part provider education training with Roland Williams was held, “Medication-Assisted Treatment for Black Populations” in June.
- After exhaustive searches, ONTRACK hired 2 case managers for Soul Space and placed a project manager onsite in Berkeley.
- Soul Space leased office and program space in South Berkeley, in the historical heart of Berkeley’s African America/Black community and hired two well-qualified empowerment advocates. The increased capacity enabled the program to ramp up the outreach and direct service activities.

Project Challenges:

- Early in the fiscal year, the case manager resigned. The program support team worked diligently to move clients through their empowerment plans and transition them to other community resources or close out their cases. Recruitment began immediately for the vacant position but there was difficulty finding applicants who brought the required combination of skillsets: case management expertise, deep understanding of African American/Black communities particular needs for mental health support, and experience working with African American/Black communities. The search process involved reviewing 40 resumes submitted in response to initial posts, numerous hours revising the recruitment strategy and outreach, and interviewing more than 28 candidates before finding qualified individuals aligned with Soul Space’s values and approach to case management.
- The original North Berkeley office space was unsuitable to the program needs, so the program moved to a new space in South Berkeley that was closer to public transportation and more accessible to African American communities. Unforeseen flooding and mildew rendered the office space permanently unusable, necessitating a time-consuming search for another space. Finding an affordable and culturally appropriate space proved more difficult than anticipated, but the program was able to acquire access, and relocate to another space in South Berkeley that proved to be appropriate for the program needs.

In FY2026 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 0; Transition Age Youth (16-25 years): 2; Adults (26-59 years): 21; Older Adults (60+ years): 2.

➢ Latinx Trauma Support Project

Implemented through East Bay Sanctuary Covenant the Latinx Trauma Support Project assists low-income, Latinx families in Berkeley in accessing culturally, ethnically, and linguistically responsive and trauma-informed prevention and intervention services. Project services are in direct response to, and in collaboration with, Latinx community members, and are largely facilitated by individuals from within the targeted community and conducted in Spanish or an indigenous language. Services include: One-on-one outreach and support; support groups; staff and partner training and warm referrals.

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.

PEI Priorities:

- Culturally competent and linguistically appropriate prevention and intervention; including Community Defined Evidence Practices (CDEPs).
- Youth engagement and outreach strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college.
- Strategies targeting the mental health needs of older adults.

In FY2024, this project served 653 individuals. Demographics on individuals served were as follows:

DEMOGRAPHICS N = 653*

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  0 – 15 – Children and Youth or Unknown – 28
  16 - 25 (Transition Age Youth) – 148
  25 – 59 (Adult) – 442
  60+ - Older Adults – 35

- **Race**
  Asian – <11
  Black or African American – 17
  White – <11
  Other – 601
  More than one Race – <11
  Declined to Answer (or Unknown) - <11

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Mexican/Mexican American – Chicano – 127
  Central American - 345
  South American – 43
  Other – 29
  Declined to Answer or Unknown – 49

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  African – 12
  Asian Indian/South Asian - <11
  European – <11
  Filipino - <11
  Middle Eastern - <11
  Vietnamese - <11
  Other - <11
  More than one ethnicity – <11
  Declined to Answer (or Unknown) - 12

- **Primary Language**
  English – 56
  Spanish – 533

- **Sexual Orientation**
  Heterosexual or Straight – 308
  Gay or Lesbian – 86
  Bisexual – <11
  Questioning or Unsure of sexual orientation - <11
  Queer - <11
  Another sexual orientation – <11
  Declined to Answer, or Unknown – 243

- **Disability**
  Difficulty Seeing – <11
  Other - <11
  No Disability – 614
  Declined to Answer or Unknown – 26

- **Veteran Status**
  No – 630
  Declined to Answer (or Unknown) - 23

- **Gender: Assigned Sex at Birth**
  Male – 327
  Female - 326

- **Current Gender Identity**
  Male – 321
  Female – 318
  Transgender/Genderqueer/Another Gender Identity – 14

RBA Outcomes during the reporting timeframe were as follows: 9 Support Group sessions were conducted reaching 75 individuals, and 247 individuals received One-on-One Supports. A total of 7 Trainings were conducted, reaching 91 individuals. There were 207 warm referrals for additional services and supports. The number and type of referrals included: 29 Mental Health; 12 Physical Health; 75 Social Services; 91 other unspecified services.

Support Group feedback per participant self-report was as follows:

- 100% reported they liked participating in the Support Group;
- 100% indicated they would recommend the organization to a friend or family member;
- 100% indicated they felt safe, included and respected;
- 100% reported that they were able to deal more effectively with daily problems;
- 100% reported increased feelings of supports after participating in the support group.

Training feedback per participant self-report was as follows:

- 100% of participants indicated that they were satisfied with the training;
- 100% of participants indicated that the information in the training was informative;
- 100% of participants indicated that the training would help them in their work.

Project Successes:

- Continued to provide integrated support to low-income Latinx immigrants through case management, warm referrals, trilingual hotline, support groups, mental health support, and trainings, as well as quarterly retreats for LGBTQ asylum seekers and Mam women.
- Successfully initiated contact with Berkeley High School newcomer program to share resources with families, and continued to provide one-on-one support for Latinx and Mam asylum seekers, including wraparound services for unaccompanied minors and warm referrals to mental health and other services.
- Provided 6 trauma-informed trainings for 66 unique participants. These included an annual training for the incoming cohort of law students interns who directly assisted with the clients' asylum cases during the school year. These trainings made it much more likely for the law students to identify their clients' need for mental health services and reach out to the Support Services team to make these connections.

- Expanded one-on-one services to include assistance with obtaining public benefits. Program staff developed sufficient expertise on this topic to train student interns to screen clients for eligibility for benefits such as Medi-Cal and CalFresh, help them apply, and, crucially, help them overcome barriers like inadequate documentation if their applications were rejected.
- The OLAS LGBTQ Sanctuary Project held a support group weekend retreat with 16 LGBTQ participants. Participants felt empowered to share their accomplishments as immigrants in the U.S., including learning English, opening their own businesses, pursuing higher education, and obtaining asylum or residency status. Additionally, the OLAS Sanctuary Project held a one-day retreat in Berkeley for 24 participants, 6 of whom were new to the program. Many participants expressed feelings of trust, safety, and comfort with expressing themselves through the group activities. This provided safe spaces for participants to rest, share their experiences as LGBTQ immigrants, and practice different forms of art expression. Activities were led by trained facilitators, including licensed therapists. Participants walked away from these experiences having felt seen and heard and part of a community. As LGBTQ immigrants, many of the participants have experienced hate incidents in both their home countries and the U.S. They unanimously feel that OLAS provides a safe space for healing and processing these experiences among their peers, and shared that each retreat built their self-confidence and their connections with other participants.
- Two storytelling workshops were held for Indigenous Mam, Latinx, and LGBTQ asylum seekers that focused on finding and expressing their voice. One workshop was in collaboration with teaching artists at Berkeley Repertory Theatre (BRT). Participants were guided to create poetry and performances based on their stories and share them in classrooms and at community events, which helped to build empathy in the broader community. The experience was cathartic, with strengthened connections, community, and confidence, along with opportunities to share one’s journey and give/receive support.
- The Amplifying Sanctuary Voices (ASV) team held a storytelling performance event in partnership with Berkeley Repertory Theater - In Dialogue. The performance featured four Latinx and immigrant community members who shared their stories with over 50 attendees. The event was incredibly moving and a great success; the performers shared that they felt proud of their bravery to stand up and share their story and audience members reflected on the power of hearing personal narratives in a performance setting. ASV is excited to continue supporting community storytelling in a setting that promotes participants’ healing and empowerment.

Project Challenges:
While there were no significant program challenges in FY24, the Support Services team was hoping to host three student interns over the summer, however two withdrew for personal reasons at the last minute. Staff was able to cover, but this was still a disappointment and prompted thinking and planning on how to get firmer intern commitments going forward.

In FY2026 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 10; Transition Age Youth (16-25 years): 150; Adults (26-59 years): 400; Older Adults (60+ years): 35.

Prevention & Early Intervention Combined Programs

Prevention Program – Includes a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors.

Early Intervention Program – Provides 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.

The City of Berkeley Prevention & Early Intervention combined programs are as follows:

Dynamic Mindfulness Program (DMind)
Dynamic Mindfulness (DMind) is an evidence-based trauma-informed program implemented in 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 is 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 chronic stress, trauma, and 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, anger management, and/or getting frequent referrals, or suspensions and at high risk of school failure. DMind also enables teacher and staff well-being, which has been shown to enhance student learning. Program components include in-class and after-school DMind sessions for students, student peer leadership development, and training and coaching of school staff**.**

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.

PEI Priorities:

- Youth engagement and outreach strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college.

- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

During the reporting timeframe, data on numbers served and demographics was not provided.

Program Successes:
In FY2024, DMIND was provided in three middle schools and two high schools within the Berkeley Unified School District. Over 300 students and a dozen staff to submitted their feedback on the program. The results were inspiring with over 90% of students indicating that as a result of participating in the program they were able to consistently and effectively manage their stress, anger, and anxiety; focus and concentrate; be self-aware; make responsible decisions; have healthy relationships with peers and staff; and be ready and motivated to learn. Additionally, 100% of teachers indicated that they were able to consistently and effectively manage their stress, anger, and anxiety; focus and concentrate; be self-aware; make responsible decisions; have healthy relationships with students and colleagues; have a positive classroom climate; and sustain their well-being as educators. Those same teachers also indicated that their students were able to consistently and effectively manage their stress, anger, and anxiety; focus and concentrate; be self-aware; make responsible decisions; have healthy relationships with peers and staff; and be ready and motivated to learn.

Many of the staff and students surveyed also made sure to include some notes of appreciation and gratitude for providing this program to their school communities. A teacher from Martin Luther King Jr. Middle School noted, “my students have really benefited from this practice.” Another teacher at that school echoed these remarks and added, “the kids [were] able to focus a lot better on the day they participated in the program and they were more productive!” A Counselor from Willard Middle School expressed her thanks as well, sharing, “Students have really enjoyed having a space to practice Mindfulness!” The Vice Principal of School Climate & Student Wellness at Berkeley High School made sure to include a note acknowledging the inclusivity of the practice adding, “this program directly impacts Black students who choose to access the services in lieu of other staff or programs.” The Mindful Yoga program at Berkeley Technology Academy and Berkeley Independent Study also received high praise from teachers who shared “students are all reflecting positive things and noticing their growth. All are really appreciative of the space the program holds for them to slow down and get in tune with their bodies.”

Students added their notes of appreciation as well expressing how impactful this program has been for them. A Berkeley Independent Study student shared, “I especially enjoyed yoga class this week. I tried a lot of new poses and I could feel my balance improving throughout the week…I can’t wait for next week’s class!” A 7th grade student at Willard Middle School shared that she “loved Mindfulness Group a lot! I hope the instructor loved teaching us because I loved and was grateful to have her.”

Program Challenges:
There were no program challenges submitted during the reporting timeframe.

In FY2026 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 517; Transition Age Youth (16-25 years): 31; Adults (26-59 years): 68; Older Adults (60+ years): 0.

Mental and Emotional Education Team (MEET)
The Mental and Emotional Education Team (MEET) also referred to as the Mental Health Peer Education (MHPE) program, implements a peer-to-peer mental health education curriculum to 9th graders, and an internship program for a cohort of high school students to serve as peers to their fellow students. The goals of the program are 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, and basic coping and intervention skills. This model of peer-to-peer education can contribute to reducing mental health stigma, increasing students' understanding and use of coping skills, and increasing students' awareness and use of school-based mental health support services.

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.

PEI Priorities:

- Youth engagement and outreach strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college.
- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

Peer relationships are a primary component of adolescent development, including placing higher value on social influence, learning to navigate interpersonal communication and conflict, exploring personal and community identities, and learning how to foster healthy relationships. This is especially significant for students from marginalized communities, who have fewer teachers, counselors, clinicians, and role models at school who share their identities. For many students who are impacted by systemic racism, economic stress, and/or are living in immigrant or mixed status families, it can be difficult to speak about these experiences with adult school staff who may have vastly different life experiences. When young people have the opportunity to speak with peers who have had similar experiences and can relate to their circumstances, they are less isolated, more connected to school, identify as more hopeful and empowered, and act as change agents in their school and communities.

In additional to providing student peer educators with the opportunity to develop relational and emotional skills, a peer-to-peer program also serves as a workforce development program in which students learn concrete skills and can explore possible future careers in the mental health field. Peer-to-peer program grant students the opportunity to learn job skills, while simultaneously developing school-based relationships and connections which has been shown to increase attendance, grades, and self-esteem.

During the fall of FY2024, the MEET program supervisor led 20 mental health peer educators in 28 weekly trainings and one full day training for the purpose of developing leadership skills, learning and practicing communication skills, learning about mental health needs and resources, and providing mental health education and support for their peers. Many of the peer educators also participated in the City of Berkeley Youthworks program, where they participated in weekly meetings to learn and develop job readiness skills. In addition to the weekly training sessions, the peer educators also participated in one or more internship projects, including creating mental health presentations for Freshman classes, developing multilingual presentations for ELL English classes, creating videos and posters to spread information about mental health, creating and disseminating information about tobacco and marijuana prevention, and hosting or participating in events to spread awareness about mental health and the BHS Wellness Center. All peer educators had the opportunity to provide one-on-one mentorship to other students, either on a one-time basis or through weekly or biweekly meetings.

In the Spring of FY2024 a second cohort of 12 mental health peer educators participated in 8 weekly trainings and one full day training for the purpose of building community, exploring their own values and biases, learning and practicing communication skills, and learning about mental health needs and resources. After completing their training, this cohort of peer educators were prepared to begin in FY2025, with mentoring and engaging in internship projects.

In FY2024, 32 individuals were served through this program. Demographics on individuals served were as follows:

DEMOGRAPHICS N = 32*

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  0 – 15 – Children and Youth – 32

- **Race**
  Asian – <11
  Black or African American – 14
  White – <11
  Other – <11
  More than one Race – <11
  Declined to Answer (or Unknown) - <11

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Mexican/Mexican American – Chicano – <11
  Central American – <11
  South American – <11
  Other – <11
  Declined to Answer or Unknown – <11

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  African – <11
  Asian Indian/South Asian - <11
  Eastern European – <11
  Middle Eastern - <11
  Vietnamese - <11
  Other - <11
  Declined to Answer or Unknown – <11

- **Primary Language**
  English – 19
  Spanish – <11
  Declined to Answer or Unknown – <11

- **Sexual Orientation**
  Heterosexual or Straight – 17
  Gay or Lesbian – <11
  Bisexual – <11
  Questioning or Unsure of sexual orientation - <11
  Queer - <11
  Another sexual orientation – <11
  Declined to Answer, or Unknown – <11

- **Disability**
  Difficulty Seeing – <11
  Difficulty Hearing or having speech understood - <11
  Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability or dementia) - <11
  No Disability – 22

- **Veteran Status**
  No – 32

- **Gender: Assigned Sex at Birth**
  Declined to Answer, or Unknown – 32

- **Current Gender Identity**
  Male – <11
  Female – 23
  Genderqueer – <11
  Questioning or unsure of gender identity - <11
  Another Gender Identity – <11
  Declined to Answer, or Unknown – <11

Program Successes:
Accomplishments of MEET Students

- Completed semester long training in order to learn the skills to be peer mentors;
- Developed informational and interactive presentation for U-9 Freshman Seminar classes. The students facilitated 28 educational presentations, which reached over 750 students. The presentations aimed to support freshman students to foster greater comfort in discussing mental health, recognize and practice positive coping skills, and learn about how to access mental health resources in and outside of BHS;
- Created and led informational presentations in English and Spanish for all four levels of ELL English, which included information about mental health, addressed the connection between mental health and migration, and shared resources about how to access mental health support at BHS;
- Provided at least 65 one-on-one or small group mentoring sessions to approximately 27 students;
- Served almost 100 shifts in the Wellness Center, during which they were available for drop-in mentorship support, introduced new students to the offerings of the Wellness Center, and helped with the daily maintenance of the Wellness Center;
- Developed, filmed, and edited 9 informational videos about a variety of mental health topics to spread awareness about mental health to other BHS students. Five films were submitted to the Directing Change film competition, three of which were formally recognized (2nd place in Suicide Prevention category, Honorable Mention in Suicide prevention category, and Special Recognition in Athletics & Mental Health);
- Planned and hosted three school-wide events to provide information and support for stress reduction and mental health awareness;
- Provided information and tours of the new BHS Wellness Center for the Wellness Center Grand Opening (December 2023) & BHS Open House (March 2024).

Number of BHS students served by MEET students:

- 32 students participated as peer educators in the MEET program;
- 750+ Freshman students received classroom presentations;
- 50+ students in the Multilingual Program received classroom presentations;
- 35+ students received one-on-one mentorship from a mental health peer educator;
- All 3200 BHS students viewed MEET videos through the Student Bulletin

Program Challenges:
A significant challenge continued to be the increase in costs to fund the program. These increases required the school district to make cuts in other programming areas, as well as move resources around to be able to continue providing ongoing services.

In FY2026 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 35; Transition Age Youth (16-25 years): 0; Adults (26-59 years): 0; Older Adults (60+ years): 0.

African American Success Project
The African American Success Project (AASP) implements “Umoja” - a daily elective class offered at Longfellow Middle School, that serves approximately 40% of the African American students at that location. Umoja provides African American students a safe affinity space to explore their cultural heritage and identity, while building positive peer relationships establishing relational trust with adults. Umoja provides an ongoing focus on social and emotional development, including building skills, habits and mindsets that enable self-regulation, interpersonal skills, perseverance and resilience.

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.

PEI Priorities:
- Culturally competent and linguistically appropriate prevention and intervention, including Community Defined Evidence Practices (CDEPs).
- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

In FY2024 46 students participated in this project. Outlined below are demographics on individuals served through this project:

DEMOGRAPHICS N = 46*
*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  0 – 15 – Children and Youth – 46

- **Race**
  Asian – <11
  Black or African American – 35
  More than one Race – <11

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Other – <11

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  Declined to Answer or Unknown – 46

- **Primary Language**
  English – 46

- **Sexual Orientation**
  Declined to Answer, or Unknown – 46

- **Disability**
  Other – <11

- **Veteran Status**
  No – 46

- **Gender: Assigned Sex at Birth**
  Male – 28
  Female – 18

- **Current Gender Identity**
  Declined to Answer, or Unknown – 46

Program Successes:
There were no program successes submitted during the reporting timeframe.

Program Challenges:
During the fiscal year, the program did not serve 8th-grade students as in past years. This caused a reduction in the number of participants served.

Based on previous years, in FY2026 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 55; Transition Age Youth (16-25 years): 0; Adults (26-59 years): 0; Older Adults (60+ years): 0.

Access and Linkage to Treatment

Access and Linkage to Treatment Program – Connects 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.

Prevention & Early Intervention Combined Program with Access and Linkage to Treatment Component Strategy

Access and Linkage to Treatment Program or Strategy – Connects 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.

Prevention Program – Includes a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors.

Early Intervention Program – Provides 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.

The City of Berkeley has one Prevention & Early Intervention combined program that also has an Access and Linkage to Treatment component:

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) and has become a successful partnership between BUSD and the Public Health and Mental Health Divisions of Berkeley's HHCS Department. The program provides 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, 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.

The Berkeley High School (BHS) and Berkeley Technology Academy (BTA) Health Centers are both multidisciplinary co-locations of the City of Berkeley's Mental Health and Public Health Divisions. The Health Center team provides a range of Prevention/Early Intervention (PEI) services and also functions as an Access and Linkage to Treatment program. Culturally and linguistically diverse staff provide services in English and Spanish. Translation services in all other languages are available using a language line.

The Health Centers are operational year-round, Monday through Friday, from 8:30 AM-4 PM, with a daily closure from 12-1 PM for lunch and administrative tasks. There are brief periodic closures due to BUSD's academic calendar and in these instances some services are still provided via telehealth when possible. When fully operational, services can be accessed via student drop-in and/or via scheduled appointment. Services can also be requested via Jotform, an online, HIPAA-compliant, referral platform. This referral platform can be accessed is accessible via QR code on informational flyers that

are posted across campus and also online in several locations including the Health Center website. Students can self-refer using Jotform, and parents/caregivers, staff, and friends are also able to refer someone else using this method. Additionally, students, parents/caregivers, and staff are able to request services via phone by calling the Health Center main phone number. Hours of operation at Berkeley Technology Academy Health Center are more limited due to the small student population and staffing constraints. When BTA students are unable to access a needed service at that Health Center, they are referred to BHS Health Center for those needed services.

Health Center staff frequently facilitate linkages on behalf of youth and their families, depending upon a given need. Behavioral Health Clinicians ("BHCs") conduct initial assessments with students in order to screen for a variety of health and mental health needs, considering accessibility, insurance status, acuity, and risk factors to support with decision-making around level of care considerations and related linkages. BHCs provide students with short-term behavioral health services—crisis, individual, group—as needed irrespective of insurance status and all students are eligible to receive these free and confidential services. BHCs also link youth/families with more intensive needs to additional services depending upon their specific needs and insurance status. BHCs provide this linkage support via internal referrals (e.g. EPSDT Medi-Cal services; Full Service Partnership team; psychiatry/medication management), Alameda County Access, as well as linkages to services through private insurance carriers. BHCs also sometimes make internal on-campus referrals to the 504 and Special Education programs when some type of mental or physical health condition may be impeding a youth's ability to adequately access their education. BHCs also support youth and their families who are uninsured with accessing and enrolling in Medi-Cal and other relevant programs that support health and well-being.

As an Access and Linkage to Treatment Program, the Health Center's Mental Health Program Supervisor monitors all referrals in order to ensure timely responsiveness and follow up that supports engagement in treatment. All BHCs have access to and monitor incoming referrals that are submitted via Jotform and respond to referrals on a rotating basis. The MH Program Supervisor monitors and responds to referrals via phone and checks voicemail multiple times per day. In instances where a staff person responds to a referral but is unable to make contact with the referring party, staff will follow up at least three times in an effort to support engagement. The Jotform referral inquires about preferred method of contact and also inquires about whether a youth can be pulled from class in order to conduct an initial assessment. Staff utilize these preferences in order to inform outreach efforts and increase the likelihood of establishing and supporting engagement.

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

PEI Priorities:

- Youth engagement and outreach strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college.
- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

During the reporting timeframe, the Health Center had the following positions: a full-time Mental Health Program Supervisor, a full-time Mental Health Clinical Supervisor (vacant), four full-time Behavioral Health Clinicians, and a cohort of three part-time graduate-level trainees. One Behavioral Health Clinician II was on administrative leave from January through June 2024. Two graduate-level trainees concluded their respective traineeships in January 2024 and February 2024. One Behavioral Health Clinician II promoted into the vacant Mental Health Clinical Supervisor position in May 2024.

In FY2024, approximately 210 students received services through this project. Demographics on youth served are outlined below:

DEMOGRAPHICS N = 210*

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  0 – 15 – Children and Youth – 52
  16 – 25 Years – 158

- **Race**
  Asian – 21
  Black or African American – 44
  White – 42
  More than one Race – 57

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Other – 46

- **Primary Language**
  English – 178
  Spanish – 22
  Other/Declined to Answer, or Unknown – <11

- **Sexual Orientation**
  Heterosexual or Straight - 116
  Gay/Lesbian/Bisexual/Questioning/Another Sexual Orientation/Declined to Answer or Unknown – 94

- **Disability**
  Declined to Answer, or Unknown – 210

- **Veteran Status**
  No – 210

- **Gender: Assigned Sex at Birth**
  Declined to Answer, or Unknown – 210

- **Current Gender Identity**
  Male – 61
  Female - 113
  Other – 36

Program Successes:

- Continued to provide the full suite of in-person mental health, reproductive & sexual health, and first aid services for the duration of the school year.
- The Mental Health (MH) team was able to resume its graduate-level training program and provided an array of multi-tiered individual, group and crisis services.
- Continued to use the Jotform application for referrals in order to streamline accessibility and minimize barriers to care.
- Maintained a collaborative and productive relationship with BHS's Coordination of Services Team (COST) throughout the school year in order to ensure that appropriate referrals were made to the Health Center and other programs.
- Continued to build strong working relationships with BHS Administration, especially the Principal, Vice Principal of Climate & Wellness, and MH & Well-Being Coordinator.
- BHS Leadership, along with Health Center leadership and City of Berkeley HHCS Departmental leadership, were able to successfully implement and open a differentiated Wellness Center space at BHS along with a continuum of tiered wellness support services in December 2023.
- For Q3 and Q4, the Wellness Center provided a differentiated universal (Tier 1) and targeted (Tier 2) support space for students that did not previously exist.
- Continued to build upon and improve existing relationships and partnerships with other BHS stakeholders. To this end, the MH team collaborated with several different on-campus programs throughout the year such as the Multilingual Program, McKinney Vento Program, Special Education Program, and Intervention Counselors.

Program Challenges:

- The MH Team experienced multiple vacancies in the supervisor, clinician, and trainee classifications. These vacancies impacted the team's overall capacity,

including individual and group service provision as well as on call crisis coverage. Furthermore, staffing shortages across the Health Center's Public Health Team, both administrative and clinical, impacted service provision, operational capacity, and integration across Divisions.

- The Health Center's Electronic Health Record (EHR), NextGen, provided limited functionality. This contributed to delays with data collection, analysis, and reporting. These challenges constrained supervisory decision-making that could have improved efficiencies and improvements in service provision.
- The MH team also continued to use multiple EHRs and applications that are not integrated with one another and do not interface with one another. This made clinical documentation more cumbersome and time-consuming for all staff and also made data collection and analysis more laborious.

In FY2026 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 139; Transition Age Youth (16-25 years): 209; Adults (26-59 years): 0; Older Adults (60+ years): 0.

The RBA Measures that were established for this program were as follows:

Process Measures **How much did we do?**	**Quality Measures** **How well did we do it?**	**Impact Measures** **Is Anyone Better off?**
• # of clients served • # of clients opened for ongoing services • # of services provided by service type	• # of clients screened for depression, trauma, and substance use • # of clients contacted within a week following a referral to the High School Health Center (HSHC) • % of school population served • % of clients satisfied with services, as measured by % of clients who agree with the following: HSHC Staff… -Treat me with respect -Listen carefully to what I have to say • Make me feel like there's an adult at school who cares about me	• % of clients able to receive needed care, as measured by % of clients who agree with the following: The HSHC… -Is easy to get help from when I need it -Helps me to meet many of my health needs

*Demographic data was reported at the program level, where available

RBA Outcomes in FY2024 for this program are outlined on the following pages.

BMH RBA Report FY 2024

Reporting Period: July 2023 - June 2024

High School Health Center (HSHC)

Process Outcomes ("How much did we do?")

210

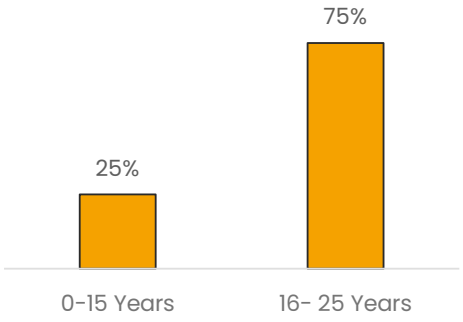
Clients Served

Program Description

The HSHC team provides mental health services on site at Berkeley High School; these services include individual and group therapy, crisis assessments, and drop in support. The program also hosts graduate students for training.

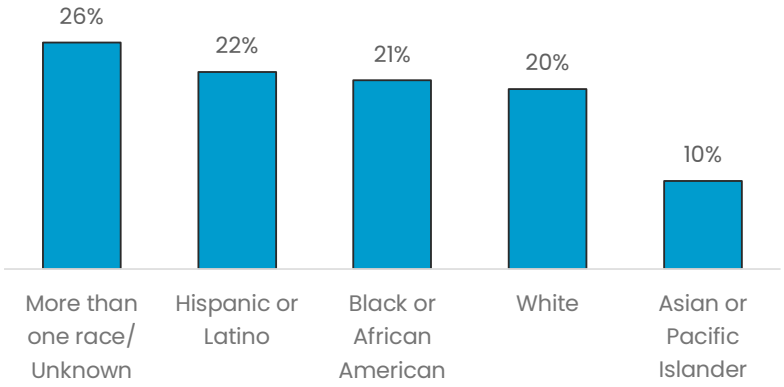
Demographics (Age)

Jul '23 - Jun '24 (n=210)



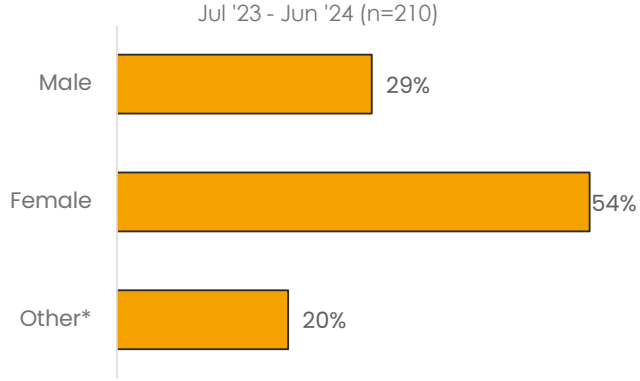
Demographics (Ethnicity)

Jul '23 - Jun '24 (n=210)



Demographics (Gender Identity)

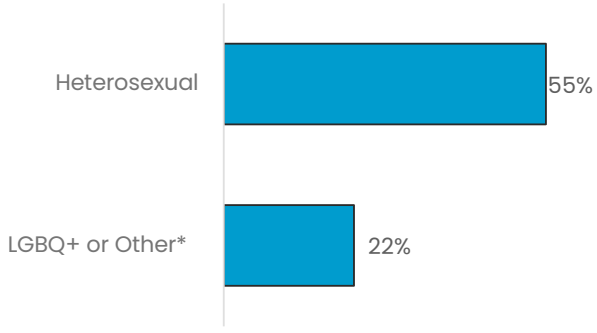
Jul '23 - Jun '24 (n=210)



*Other includes any identity that doesn't fit within the traditional male/female binary.

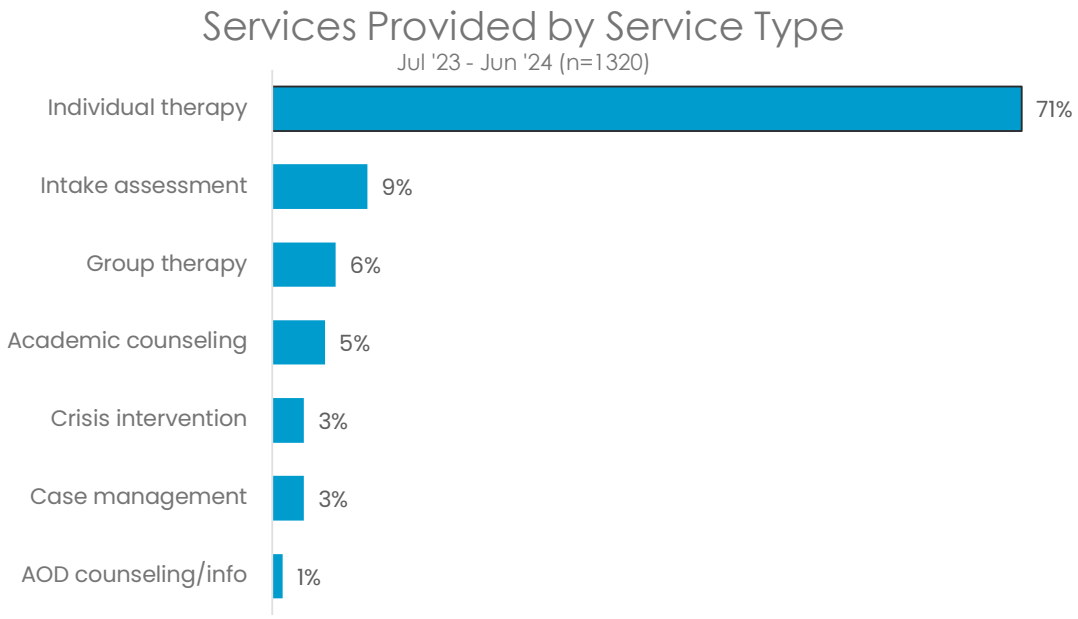
Demographics (Sexual Orientation)

Jul '23 - Jun '24 (n=210)

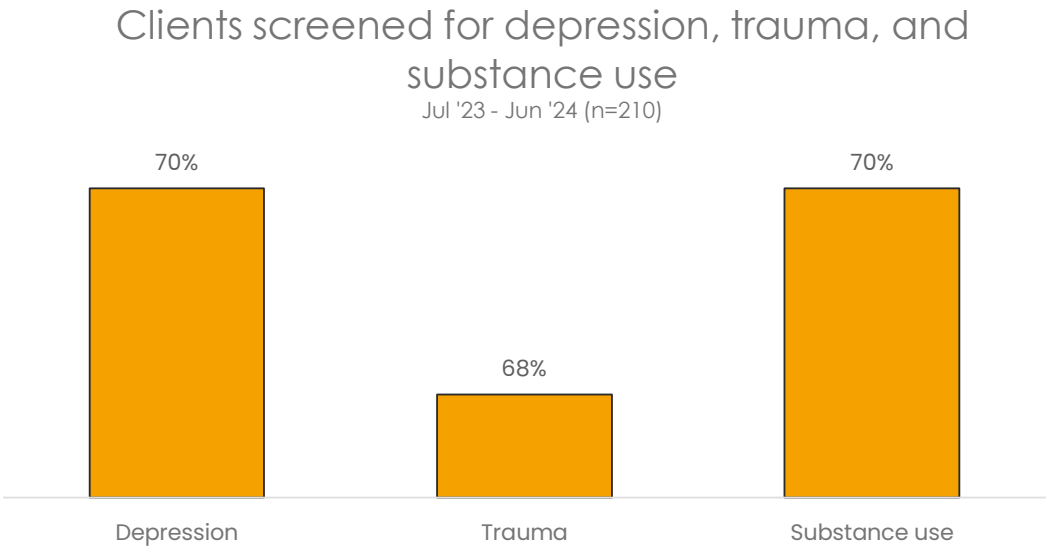


*LGBQ+ includes individuals who identify as lesbian, gay, bisexual, questioning, or other diverse sexual orientations. Other includes prefer not to answer or unknown.

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.



Note: Multiple services could be provided in one visit (e.g. crisis assessment and referral) so total services by type is greater than total encounters.



NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Quality Outcomes ("How well did we do it?")

1 in 17 Students received services
6.43% of the School Population (3,267 students)

Service Consistency

96% n=126
Students felt treated with respect

96% n=105
Students felt like there's an adult who cares about

98% n=118
Students felt heard about what they have to say

96% n=129
Report Easy Access to Needed Care

97% n=113
Able to Get Help When Needed

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Measure	Definition	Data Source
# clients served	Total clients served	NextGen
# of services provided by service type	# of services coded as behavioral_service with codes BHSV1-8. Key code accompanies NextGen data. Each incident could include more than one service provided.	NextGen
% clients screened for depression, trauma, and substance use	Percent of total clients that were recorded as having been screened for depression, trauma, and/or substance abuse at least one time during reporting period.	NextGen
% referrals to HSHC followed up within one week	Percentage of referrals that had 7 days or less between referral date and response date. Calculation reflects % of total referrals, not % of total clients.	Jotform Not presented due to delays in the reporting system
% of school population served	Unique clients served by HSHC divided by total student population of BHS and BTA.	DataQuest
% of clients satisfied with services	% of responses marked as "agree" or "strongly agree" for various survey questions. Note: these responses are from all students who accessed the health center and answered the survey, not just those who received mental health services.	Berkeley SBHC Client Survey
% of clients able to receive needed care	% of responses marked as "agree" or "strongly agree" for various survey questions. Note: these responses are from all students who accessed the health center and answered the survey, not just those who received mental health services.	Berkeley SBHC Client Survey

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

STIGMA AND DISCRIMINATION PROGRAM

Stigma and Discrimination Program - Directs 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.

The City of Berkeley Stigma and Discrimination program is as follows:

Social Inclusion Program
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.

PEI Priority: Culturally competent and linguistically appropriate prevention and intervention, including community defined evidence practices (CDEPs).

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 peers with opportunities to be trained, compensated and empowered to share their stories of healing in a supportive peer environment. When they feel ready, individuals 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 10-20 individuals a year.

In FY2024, 20 unduplicated individuals participated in the program. Demographics on program participants served were as follows:

DEMOGRAPHICS N = 20*
*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  26 – 59 Adults – 15
  Ages 60+ - Older Adult/Decline to Answer or Unknown – <11

- **Race**
  American Indian or Alaskan Native – <11
  Asian – <11
  Black or African American – <11
  White – 42
  More than one Race – <11

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Declined to Answer, or Unknown – 20

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  Declined to Answer, or Unknown – 20

- **Primary Language**
  English – 20

- **Sexual Orientation**
  Heterosexual or Straight - <11
  Bisexual – <11
  Queer – <11
  Declined to Answer or Unknown – 15

- **Disability**
  Declined to Answer, or Unknown – 20

- **Veteran Status**
  No – 20

- **Gender: Assigned Sex at Birth**
  Male – 12
  Female or Unknown – <11

- **Current Gender Identity**
  Male – 12
  Female/Declined to Answer, or Unknown – <11

Program Successes:
The Telling Your Story group has grown to having more consistent attendees in person and calling in to the zoom platform then all other BMH groups. The group continued to be conducted by having the structure of a brainstorming session and a sharing component. Per staff report, many participants benefitted from listening to answers to questions that staff developed based on the topics of discussions, as well as through staff assistance with formulating their story. The topics of the month went beyond the SAMHSA Eight Dimensions of Wellness to include areas of interest. Some participants enjoyed having the group virtually in the comfort of their home, as they felt safe and the hassle of commuting was eliminated. Other participants enjoyed connecting with others in-person and more individuals attended when they dropped in at the clinic. According to staff, participants were more prepared during their shares and they enjoyed the support they received from their peers.

Program Challenges:
In FY2024, the Telling Your Story group had a few challenges, which the staff have been working to improve to make the group more enjoyable for all participants. Over the course of the last two years, staff hosted the group online and in-person and at times, this caused some delays to the start of the group due to individuals arriving at

different times and having to update all participants. The structure is for people to attend both, the first is a brainstorming group to be prepared for the second group with sharing.

Managing and making sure everyone engaged was difficult as individuals who joined by Zoom, called in so staff were unable to see participants faces. For individuals who primarily came to the group on Zoom, the questionnaire that required their feedback went unanswered, therefore staff wasn't able to obtain a full report of how the group was helping individuals to feel confident with sharing their story.

In FY2026 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 0; Transition Age Youth (16-25 years): 1; Adults (26-59 years): 5; Older Adults (60+ years): 5.

The RBA measures and outcomes for this program are reported with the CSS System Development, Wellness Recovery program.

Suicide Prevention Program

Suicide Prevention Program – An optional program that provides activities to prevent suicide as a consequence of mental illness.

Through FY2024, the City of Berkeley had one Suicide Prevention Program that was a partnership with the California Mental Health Services Authority as follows:

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. Contributing jurisdictions are members of a CalMHSA board that provides direction into the types of initiatives that are implemented. One of the initiatives that was implemented is the PEI Statewide Projects. With an approved combined funding level of $40 million per year for four years during the timeframe of FY2011 through FY2015, 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 mental health jurisdictions. In order to continue to sustain programming, CalMHSA previously asked jurisdictions to allocate 4% of their annual local PEI allocation each year to these statewide initiatives. In the City of Berkeley, this varied from year to year depending on the amount of PEI revenue received.

In FY2024, through this initiative resources on Suicide Prevention, Student Mental Health and Stigma and Discrimination reached approximately 1,520 individuals. Additionally, resources were distributed via email to local schools, community agencies and community members.

Through the approved FY2025 Annual Update the Division eliminated the annual allocation of local PEI funding for this initiative.

INNOVATION (INN)

The MHSA Innovation (INN) funding component is for short-term pilot projects that increase new learning in the mental health field.

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.

INN Reporting Requirements
Per MHSA INN regulations, all INN funded programs have to collect state identified outcome measures and detailed demographic information. INN Evaluations are required to be included in each MHSA Annual Update or Three-Year Plan. Although there were not any INN Programs in operation in FY2024, in order to comply with state regulations, an Innovation Fiscal Year 2023/2024 Annual Evaluation Report has been included in Appendix D of this Annual Update.

Since the initial plan was approved, INN requirements were changed to require approvals from the State Mental Health Services Oversight and Accountability Commission (MHSOAC) in addition to local approval.

In May 2016, the second MHSA INN Plan was approved by the MHSOAC. This plan implemented a Trauma Informed Care Project in BUSD for students, educators, and school staff**.** A contract was executed with Hatchuel, Tabernik & Associates (HTA) as the evaluator on the project. HTA created the Trauma Informed Systems Evaluation Report for this project. In December 2018**,** a Trauma Informed Care Plan Update was subsequently approved by the MHSOAC which added funds to this project and switched the initial target population from BUSD students and staff, to children, teachers and parents at YMCA Head Start sites in Berkeley. As with the initial project, HTA conducted the evaluation and provided the Early Childhood Trauma and Resiliency Project – Final 3-Year Evaluation Report, for this project.

In September 2018, the Division received approval from the MHSOAC for a third INN project to allocate funds to join the Technology Suite Project (later re-named

Help@Hand Project). This project operated through September 2023 providing access to free mental health applications to individuals who lived, worked or attended school in Berkeley. The Division participated in a State Evaluation with other counties in this project. The evaluation was conducted by the University of California at Irvine, (UCI) who created the Help@Hand Final Report. Additionally, following a competitive recruitment process, the Division entered into a contract with Hatchuel, Tabernik & Associates who conducted the City of Berkeley Help@Hand Evaluation.

Encampment-based Mobile Wellness Center Project
In April 2022, the Division received approval to implement an Encampment-Based Mobile Wellness Center Project from the Berkeley City Council and the State Mental Health Oversight and Accountability Commission (MHSOAC). This project pilots a Mobile Wellness Center at Homeless encampments in Berkeley. The Mobile Wellness Center project provides an on-site, customizable menu of services that are chosen by individuals who reside at the encampments. The project is led by peers with lived experience of homelessness, and includes partners from encampment communities to encourage participation, help define service needs, and support service provision at the site. The project was implemented in FY2025 through Options Recovery Services who was chosen through a competitive Request for Proposal (RFP) process.

The project seeks to learn whether on-site wellness center services have a positive impact on mental health outcomes including an increase in the uptake of mental health services. It will also assess the impact of how having individuals from the community help to provide services, shapes service delivery, and the participant satisfaction with services. The program will include an evaluation.

In FY2026 the projected number of individuals to be served per each age category is as follows: Children/Youth (0-15 years): 0; Transition Age Youth (16-25 years): 36; Adults (26-59 years): 480; Older Adults (60+ years): 96.

WORKFORCE, EDUCATION & TRAINING (WET)

The Workforce, Education & Training (WET) funding component is primarily for strategies to identify and remedy mental health occupational shortages, promote cultural competency and the employment of mental health peers and family members in the workplace

The City of Berkeley's WET Plan was approved in July 2010. A subsequent update was approved in May 2013. Specific programs in the approved WET Plan included:

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

WET programs were funded for an initial period through FY18 and FY19, and per the local MHSA AB114 Reversion Expenditure Plan (which is posted on the City of Berkeley MHSA Webpage) the Graduate Level Training Stipend Program was extended through FY20. Since the end of the WET Plan and the Reversion Expenditure Plan, in order to fund new programs and services out of the WET component, the state requires that funds are transferred to WET from the CSS funding component, through an approved MHSA Plan or Annual Update.

Outlined below is a description of the Loan Repayment Program that the Division is proposing to continue in this Annual Update, and the continued annual transfer of funds from CSS to WET to fund the Workforce Development Coordinator position.

Greater Bay Area Workforce, Education and Training Regional Partnership - Loan Repayment Program

The Department of Health Care Access and Information (HCAI) (formerly the Office of Statewide Health Planning and Development) allocated $40 million in Workforce, Education and Training funds for Regional Partnerships across the state for various mental health workforce strategies. A total of 2.6 million of funds was allocated to the Greater Bay Area (GBA) Workforce, Education & Training Regional Partnership. In order to participate in the GBA Regional Partnership, and receive a portion of funds to implement workforce development strategies, mental health jurisdictions were required to contribute a portion of local funds towards this initiative. The Division allocated funds for this program through previously approved MHSA Plans and Annual Updates.

Through this initiative, which is administered through California Mental Health Services Authority (CalMHSA), the City is participating in a Loan Repayment Program. This program enables eligible staff to apply to have a portion of their Student Loan paid, in exchange for working at BMH for a given period of time.

Since inception, 15 BMH staff have participated in the Loan Repayment Program, which will be in operation until January 2026.

Workforce Development Coordinator
Through the previously approved Three-Year Plan the Division proposed to transfer CSS System Development Funds to the WET Component to fund the Workforce Development Coordinator position through the following process:

Per MHSA Statute, (Welfare and Institutions Code, Section 5892 (b)): "In any year after

2007 -08, programs for services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five years pursuant to this section."

This position that was hired in early FY2024, supports staff recruitment and retention for the Division; oversees Intern recruitment; and coordinates training and support for graduate level interns.

Through this Annual Update the Division is proposing to transfer $344,426 of unspent CSS Funds to the WET Component. Once transferred, approximately $167,116 of funds will be used to support the Workforce Development Coordinator position. The remainder of funds, approximately $177,310, are being proposed to be utilized in the upcoming years on a Stipend Program to incentivize Student Interns to provide Clinical or Administrative work within the Division over a given period of time.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

The Capital Facilities and Technological Needs (CFTN) funding component is for capital projects on owned buildings and on mental health technology projects.

The City of Berkeley CFTN Plan was approved 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 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 supports, psychiatric medication support, Full Services Partnership Intensive Case Management Teams, Clinical services, Mobile Crisis, and Transitional Outreach Services. Construction on the Adult Clinic began in FY2019, and in June 2021, the renovation was completed, staff moved back into the building, and the clinic was re-opened for services.

Through this Annual Update, the Division is proposing to transfer $1,300,000 of unspent CSS Funds to the CFTN component through the following process:

Per MHSA Statute, (Welfare and Institutions Code, Section 5892 (b)): "In any year after

2007 -08, programs for services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five years pursuant to this section."

Funds will be utilized in the upcoming years to support various BMH facility needs, and/or as a match for the Department of Healthcare Services, Behavioral Health Continuum Infrastructure Program (BHCIP) should the City choose to apply. Uses of funds for facility needs may include but not be limited to the following: acquiring a new building, remodeling or renovating existing structures, and/or repairs, among other allowable CFTN related expenditures.

FY2026 PROJECTED NUMBERS TO BE SERVED AND ESTIMATED COST PER PERSON*

**(Includes estimated FY26 costs attributed to the MHSA Funding component)*

COMMUNITY SERVICES & SUPPORTS PROGRAMS		
Program/Estimated Program Costs*	Projected Numbers to Be Served Per Each Age Group	Estimated Cost Per Person*
Children & Youth Full Services Partnership $398,593	Children/Youth (0-15 years): 12 Transition Age Youth (16-25 years): 9 Adults (26-59 years): 0 Older Adults (60+ years): 0	$18,981
Adult Full Services Partnership $843,307	Children/Youth (0-15 years): 0 Transition Age Youth (16-25 years): 3 Adults (26-59 years): 12 Older Adults (60+ years): 41	$15,059
Homeless Full Services Partnership $843,781	Children/Youth (0-15 years): 0 Transition Age Youth (16-25 years): 2 Adults (26-59 years): 43 Older Adults (60+ years): 6	$16,545
Wellness Recovery Services $730,206	Children/Youth (0-15 years): 0 Transition Age Youth (16-25 years): 3 Adults (26-59 years): 30 Older Adults (60+ years): 29	$11,778
Family Services $105,914 **Doesn't include $24,879 of costs in the Full Services Partnership programs	Children/Youth (0-15 years): 0 Transition Age Youth (16-25 years): 2 Adults (26-59 years): 28 Older Adults (60+ years): 42	$1,471
Benefits Advocacy Services $20,000	Children/Youth (0-15 years): 0 Transition Age Youth (16-25 years): 4 Adults (26-59 years): 6 Older Adults (60+ years): 0	$2,000
Transitional Outreach Team $515,871	Children/Youth (0-15 years): 6 Transition Age Youth (16-25 years): 12 Adults (26-59 years): 38 Older Adults (60+ years): 9	$7,936
Sub-Representative Payee Services $100,000	Children/Youth (0-15 years): 0 Transition Age Youth (16-25 years): 4 Adults (26-59 years): 80 Older Adults (60+ years): 75	$629
Hearing Voices Support Groups $46,941	Children/Youth (0-15 years): 0 Transition Age Youth (16-25 years): 89 Adults (26-59 years): 1,052 Older Adults (60+ years): 64	$39
Berkeley Wellness Center $437,500	Children/Youth (0-15 years): 0 Transition Age Youth (16-25 years): 0 Adults (26-59 years): 175 Older Adults (60+ years): 50	$1,944
Case Management Services for Transition Age Youth $100,000	Children/Youth (0-15 years): 15 Transition Age Youth (16-25 years): 50 Adults (26-59 years): 0 Older Adults (60+ years): 0	$1,538

COMMUNITY SERVICES & SUPPORTS PROGRAMS		
Program/Estimated Program Costs*	Projected Numbers to Be Served Per Each Age Group	Estimated Cost Per Person*
Counseling Services for Older Adults $100,000	Children/Youth (0-15 years): 0 Transition Age Youth (16-25 years): 0 Adults (26-59 years): 5 Older Adults (60+ years): 85	$1,111
Substance Use Disorder Services $250,000	Children/Youth (0-15 years): 0 Transition Age Youth (16-25 years): 0 Adults (26-59 years): 24 Older Adults (60+ years): 7	$8,064

PREVENTION & EARLY INTERVENTION PROGRAMS		
Program/Estimated Program Costs*	Projected Numbers To Be Served Per Each Age Group	Estimated Cost Per Person*
Supportive Schools Program $110,000	Children/Youth (0-15 years): 480 Transition Age Youth (16-25 years): 0 Adults (26-59 years): 0 Older Adults (60+ years): 0	$229
Community Education/Support Program Transition Age Youth Trauma Support Project $32,046	Children/Youth (0-15 years): 0 Transition Age Youth (16-25 years): 85 Adults (26-59 years): 0 Older Adults (60+ years): 0	$377
Community Education/Support Program Trauma Support Project for LGBTQIA Population $100,000	Children/Youth (0-15 years): 0 Transition Age Youth (16-25 years): 27 Adults (26-59 years): 141 Older Adults (60+ years): 40	$481
Program/Estimated Program Costs*	Projected Numbers To Be Served Per Each Age Group	Estimated Cost Per Person*
Community Education/Support Program Living Well Project $32,046	Children/Youth (0-15 years): 0 Transition Age Youth (16-25 years): 0 Adults (26-59 years): 30 Older Adults (60+ years): 130	$200
Community Education/Support Program SoulSpace Project $100,000	Children/Youth (0-15 years): 0 Transition Age Youth (16-25 years): 2 Adults (26-59 years): 21 Older Adults (60+ years): 2	$4,000
Community Education/Support Program Latinx Trauma Support Project $100,000	Children/Youth (0-15 years): 10 Transition Age Youth (16-25 years): 150 Adults (26-59 years): 400 Older Adults (60+ years): 35	$168
Dynamic Mindfulness (DMIND) Program $95,000	Children/Youth (0-15 years): 517 Transition Age Youth (16-25 years): 31 Adults (26-59 years): 68 Older Adults (60+ years): 0	$154
Mental and Emotional Education Team $46,389	Children/Youth (0-15 years): 35 Transition Age Youth (16-25 years): 0 Adults (26-59 years): 0 Older Adults (60+ years): 0	$1,325
African American Success Project $150,000	Children/Youth (0-15 years): 55 Transition Age Youth (16-25 years): 0	$2,727

PREVENTION & EARLY INTERVENTION PROGRAMS		
Program/Estimated Program Costs*	Projected Numbers To Be Served Per Each Age Group	Estimated Cost Per Person*
	Adults (26-59 years): 0 Older Adults (60+ years): 0	
High School Youth Prevention Program $580,697	Children/Youth (0-15 years): 139 Transition Age Youth (16-25 years): 209 Adults (26-59 years): 0 Older Adults (60+ years): 0	$1,669
Social Inclusion Program $10,000	Children/Youth (0-15 years): 0 Transition Age Youth (16-25 years): 1 Adults (26-59 years): 5 Older Adults (60+ years): 5	$909

INNOVATION PROGRAMS		
Program/Estimated Program Costs*	Projected Numbers To Be Served Per Each Age Group	Estimated Cost Per Person*
Encampment-based Mobile Wellness Project $600,000	Children/Youth (0-15 years): 0 Transition Age Youth (16-25 years): 36 Adults (26-59 years): 480 Older Adults (60+ years): 96	$980

BUDGET NARRATIVE

The enclosed budget provides estimated revenue and expenditures for this Annual Update. The Division obtains financial projections from the state on the amount of MHSA revenue to be allocated in a given year. Financial projections for this FY26 Annual Update reflect a decrease in MHSA funds, to what was previously estimated in the approved FY2024-2026 Three-Year Plan.

In this FY26 Annual Update, due to changes in the projected revenue/budget in the 5-year forecast, the Division proactively paused the hiring for some previously approved staff positions out of caution, so that funds would not be expended as quickly. Departmental Fiscal staff were able to run revenue analyses earlier than in previous years, resulting in the ability to shift some personnel costs to other mental health funding sources. These shifts will enable the Division to use all of its appropriate revenue sources more evenly and prevent any funds from running out too soon.

Beginning in FY27, MHSA will shift to the new BHSA fiscal and program requirements. MHSA unspent funding amounts at the end of FY26, will be utilized in future years to transition to BHSA.

APPENDIX A

PROGRAM BUDGETS

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

County: City of Berkeley Date: 7/16/25

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY25/26 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	14,683,671	3,072,640	2,336,621	253,073	0	
2. Estimated New FY2025/26 Funding	4,371,317	1,092,829	287,587			
3. Transfer in FY 2025/26	(1,644,426)			344,426	1,300,000	
4. Transfer Local Prudent Reserve in FY 2025/26						
5. Estimated Available Funding for FY 2025/26	19,186,128	4,198,254	2,632,835	597,499	1,300,000	
B. Estimated FY25/26 Expenditures	8,275,495	1,903,291	600,000	344,426	1,000,000	
G. Estimated FY25/26 Unspent Fund Balance	10,910,633	2,294,963	2,032,835	253,073	300,000	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Unspent Local Prudent Reserve on June 30, 2024	1,233,738
2. Contributions to the Local Prudent Reserve in FY2025/26	0
3. Distributions from the Local Prudent Reserve in FY2025/26	0
4. Estimated Local Prudent Reserve balance on June 30, 2025	1,233,738

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

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

County: City of Berkeley Date: 7/16/25

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. TAY, Adult & Older Adult FSP	2,015,704	843,307	707,829	464,567		
2. Children's FSP	826,465	398,593	330,521	97,351		
3. Homeless FSP	1,736,908	843,781	411,749	481,379		
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	230,457	139,434		91,024		
2. CSS System Development	3,859,129	3,013,567	390,629	454,933		
3.						
4.						
5.						
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	1,885,016	1,392,388	229,973	262,656		
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	10,553,679	6,631,070	2,070,700	1,851,909	0	0
FSP Programs as Percent of Total	69.1%					

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

County: City of Berkeley Date: 7/16/25

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. High School Prevention Program	408,805	290,349	30,371	88,086		
2. African American Success Project	37,500	37,500				
3. Dynamic Mindfullness	71,250	71,250				
4. Mental Health Peer Education Program (MEET)	34,792	34,792				
5. Mental Health Promotion Campaign	100,000	100,000				
6.						
7.						
8.						
9.						
10.						
PEI Programs - Early Intervention						
11. Community Education & Supports	364,092	364,092				
12. High School Prevention Program	408,805	290,349	30,371	88,086		
13. African American Success Project	112,500	112,500				
14. Dynamic Mindfullness	23,750	23,750				
15. Mental Health Peer Education Program (MEET)	11,597	11,597				
16. Supportive Schools	110,000	110,000				
17.						
18.						
19.						
PEI Programs - Stigma & Discrimination						
20. Social Inclusion	10,000	10,000				
PEI Programs - Outreach for Incr. Recog. Of Mental Illness						
21.						
PEI Administration	619,686	447,113	43,787	128,786		
PEI Assigned Funds						
Total PEI Program Estimated Expenditures	2,312,776	1,903,291	104,528	304,957	0	0

FY 2025/26 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: City of Berkeley Date: 7/16/25

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. MHSA INN Encampment	600,000	600,000				
2.						
3.						
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						
Total INN Program Estimated Expenditures	600,000	600,000	0	0	0	0

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

County: City of Berkeley Date: 7/16/25

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce Development Coordinator	167,116	167,116				
2. Intern Stipends	177,310	177,310				
3.						
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	344,426	344,426	0	0	0	0

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

County: City of Berkeley Date: 7/16/25

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Mental Health facility purchases, remodels, renovations, and/or repairs	1,300,000	1,300,000				
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	1,000,000	1,000,000				

APPENDIX B

RESULTS BASED ACCOUNTABILITY (RBA) FY2024 BERKELEY MENTAL HEALTH DIVISION MEASURES AND OUTCOMES

BMH RBA Report FY 2024

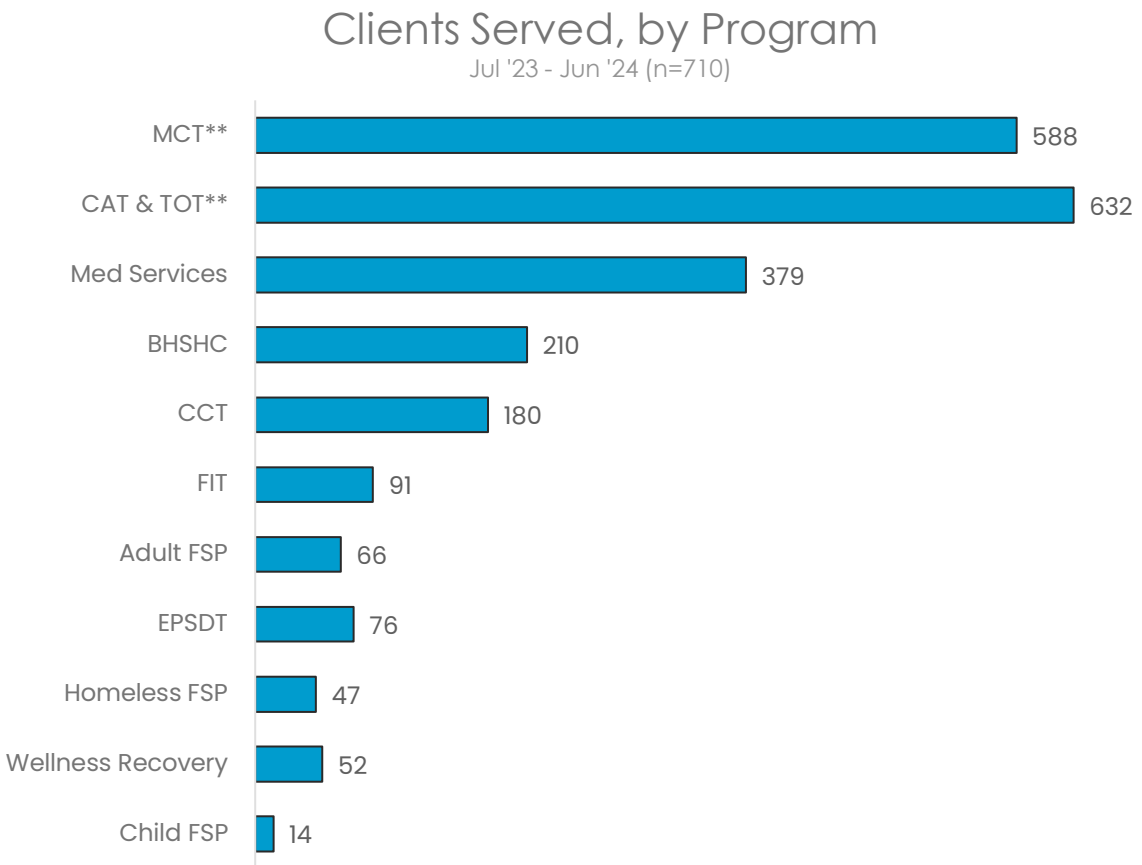
Reporting Period July 2023- June 2024

Berkeley Mental Health - Division-Level

Process Outcomes ("How much did we do?")

Description: Berkeley Mental Health provides mental health services to eligible adults, children, youth, and their families. Services focus on low-income residents and unhoused people with severe mental illnesses. Staff provide counseling and case management services with the goal of helping people to better manage their mental health symptoms, obtain and maintain housing and other community resources, and move forward in their recovery.

710 Unduplicated Clients Served (includes FSPs, CCT, FIT, ERMHS, EPSDT, HSHC, Medical Services, and Wellness)

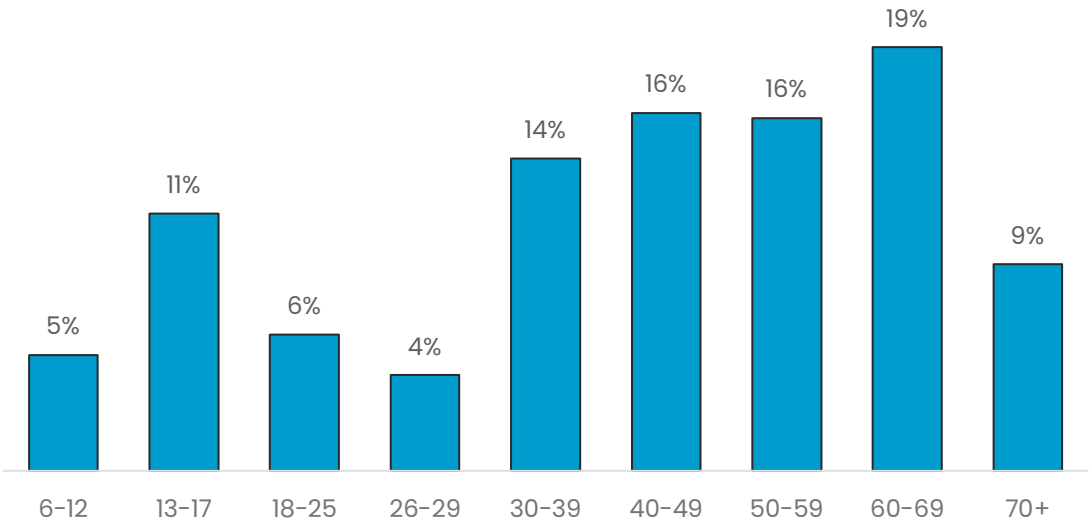


*A single client may be served by multiple programs, but these are unduplicated numbers within each program.
**All but MCT and CAT & TOT include only clients who have gone through a service enrollment process.

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

BMH Demographics (Age)

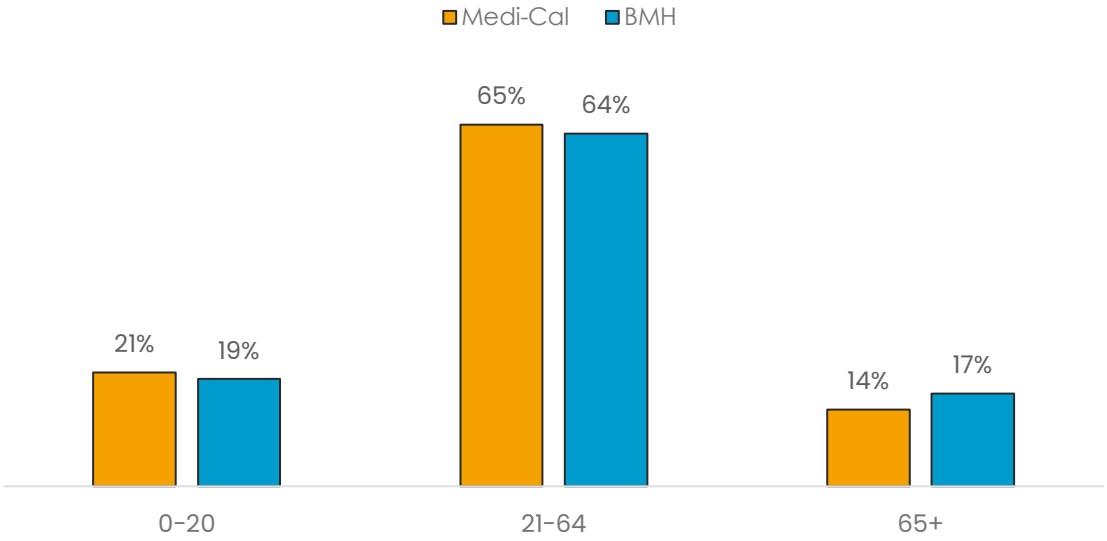
Jul '23 - Jun '24 (n=448)



*All but MCT and CAT & TOT , Wellness Recovery, and Berkeley High Health Center

Berkeley Medi-Cal Eligible and BMH Clients (Age Demographics)

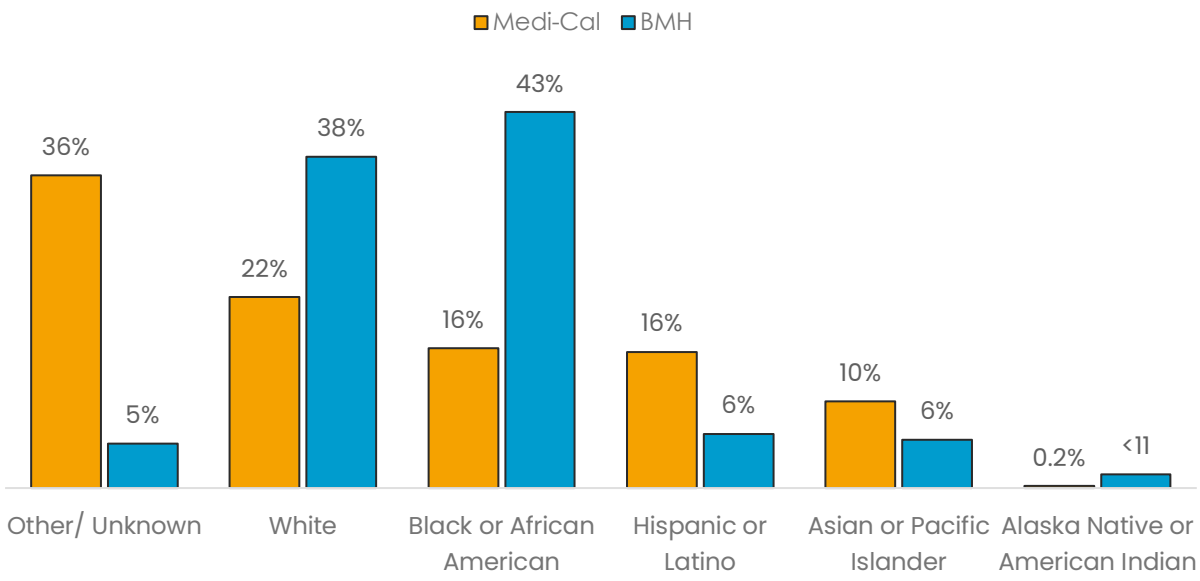
Jul '23 - Jun '24



NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

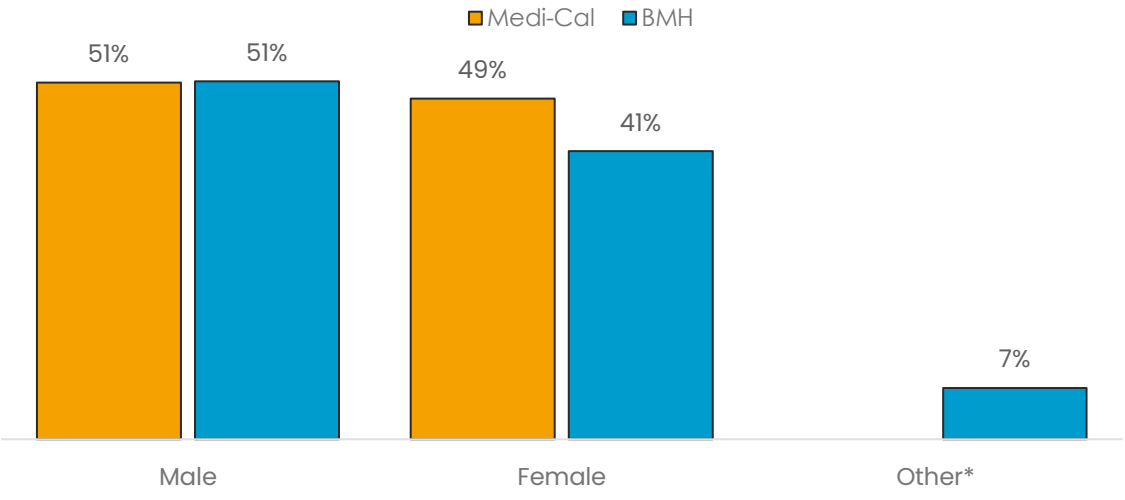
Berkeley Medi-Cal Eligible and BMH Clients (Ethnicity)

Jul '23 - Jun '24



Berkeley Medi-Cal Eligible and BMH Clients (Gender Identity)

Jul '23 - Jun '24

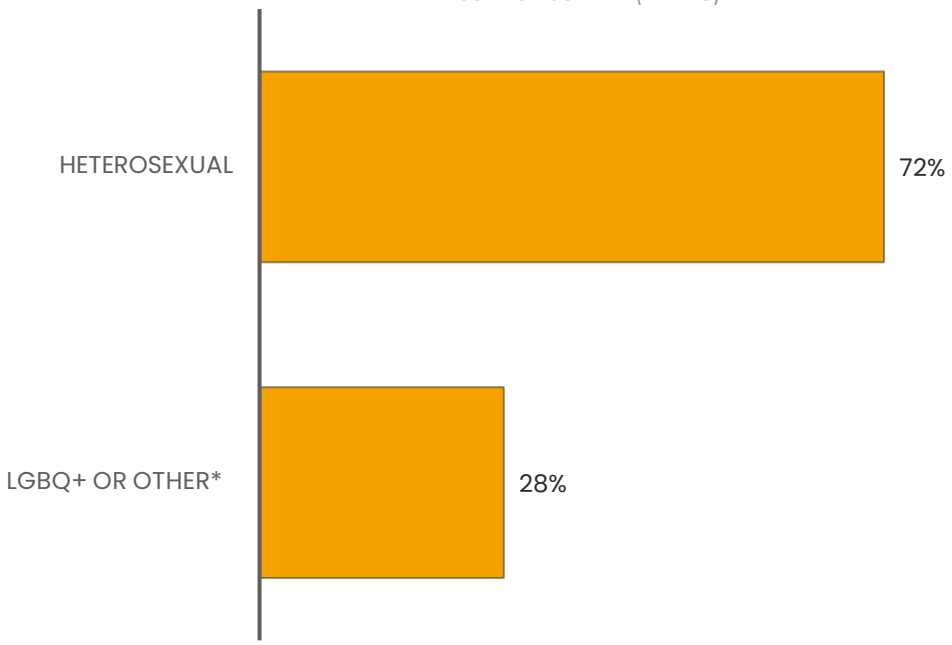


*Other includes any identity that doesn't fit within the traditional male/female binary.
(Other orientation data is not available for Medi-Cal)

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

BMH Demographics (Sexual Orientation)

Jul '23 - Jun '24 (n=448)



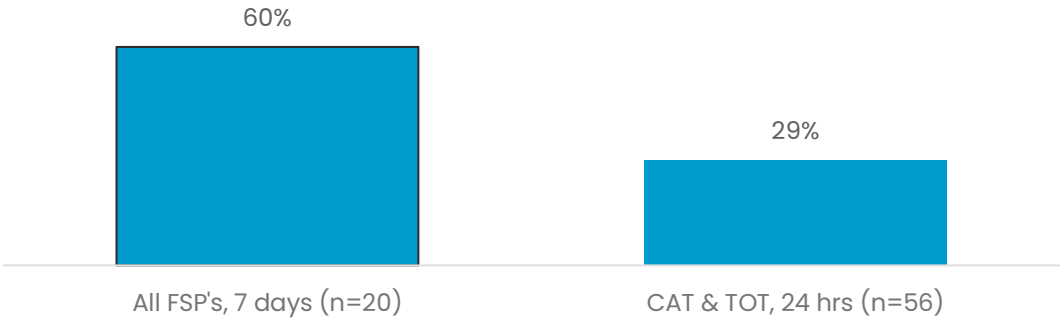
*LGBQ+ includes individuals who identify as lesbian, gay, bisexual, questioning, or other diverse sexual orientations. Other includes prefer not to answer or unknown.
(Sexual orientation data is not available for Medi-Cal)

Quality Outcomes ("How well did we do it?")

Responsiveness of Service

Discharges from hospitalization or subacute who had a follow up visit within 7 calendar days

Jul '23 - Jun '24



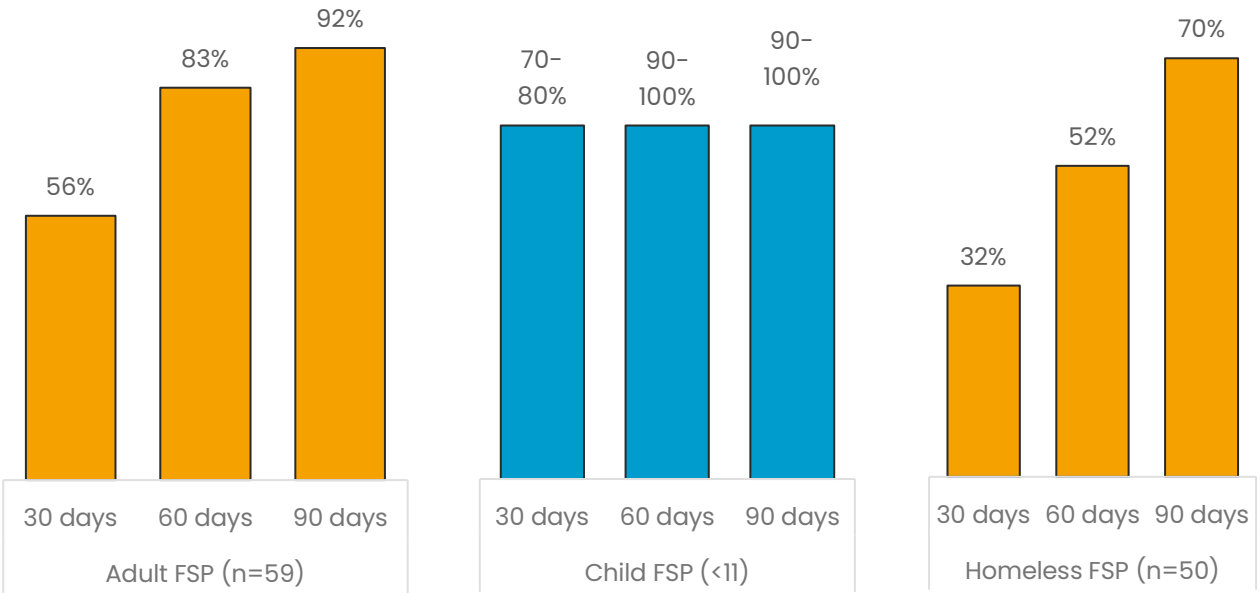
*To ensure data privacy, all Full Service Partnership (FSP) programs were combined into a single "All FSPs, 7 days" category. Data for CCT has been suppressed due to having fewer than 11 clients. The FIT program data was not available.

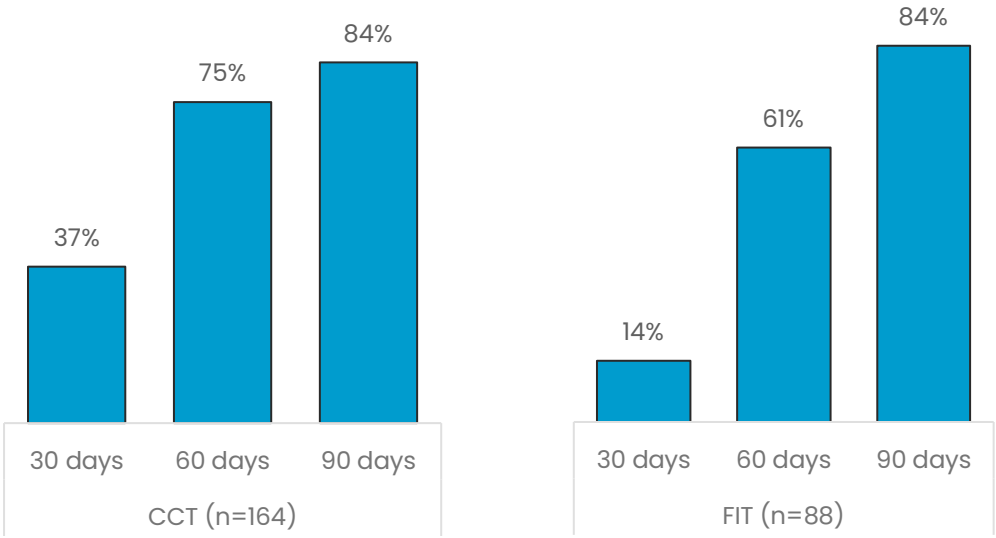
NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

Consistency of Service

Clients with no service gap over 30, 60, or 90 days

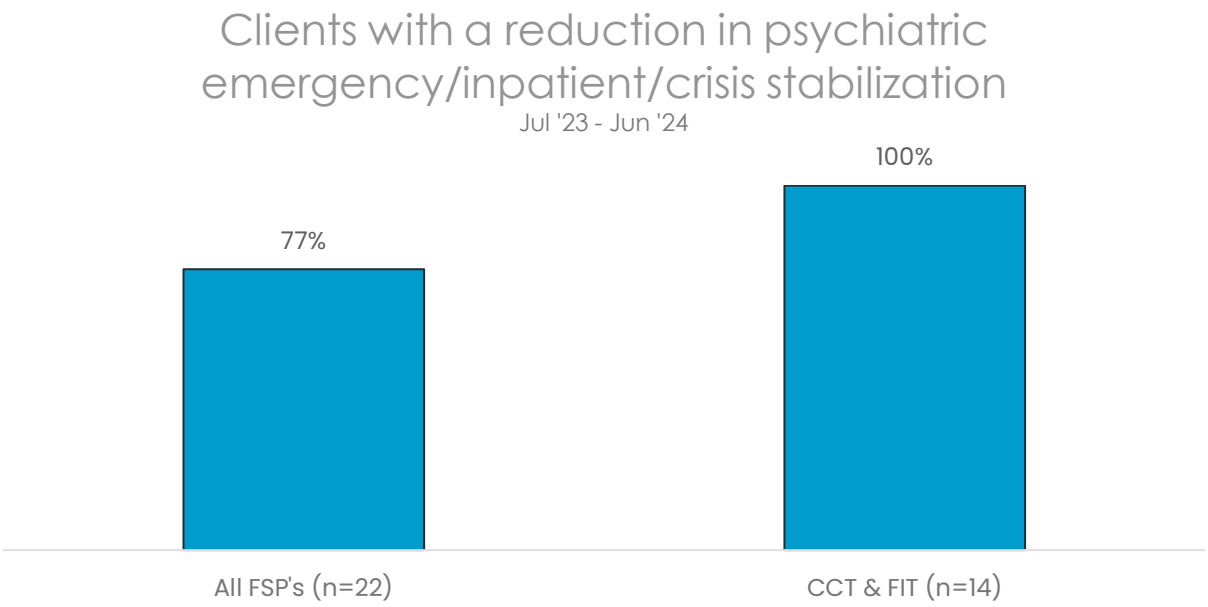
Jul '23 - Jun '24

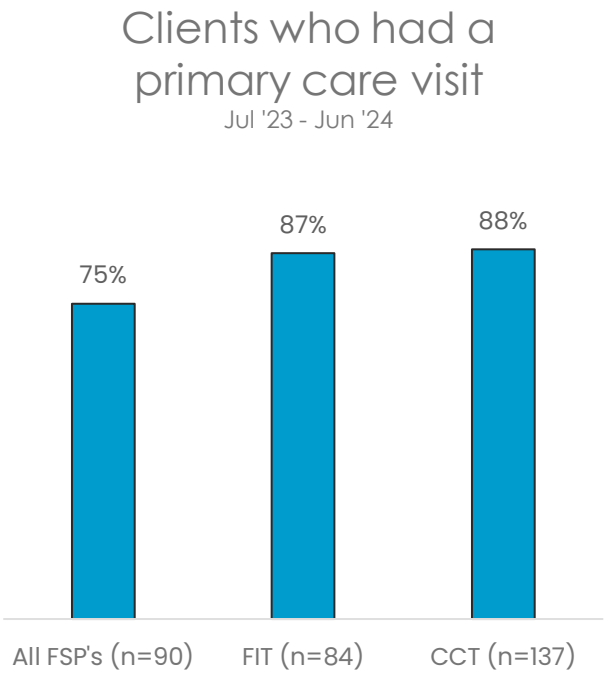




NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

Impact Outcomes ("Is anyone better off?")





*To ensure data privacy, all Full Service Partnership (FSP) programs were combined into a single "All FSPs, category. Some data for CCT and FIT has been suppressed due to having fewer than 11 clients or program data was not available.

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

Measure	Definition	Data Source
# clients served	Total number of clients served during the reporting period. Available for: all clients served for Adult FSP, Children's FSP, Homeless FSP, CCT, FIT, ERMHS, EPSDT, High School Health Center, Medical Services, and Wellness & Recovery Services. Does not include clients from MCT, CAT/TOT (may be duplicated)	Yellowfin, NextGen, Wellness Recovery Group Attendance
Responsiveness of service (% of discharges from hospitalization or subacute who had a follow up visit within specified time period)	Follow-up rates for individuals open to providers at the time of MH hospital discharge. Expected follow-up time period set by programs. Available for: Adult FSP, Children's FSP, Homeless FSP, CCT, FIT, CAT & TOT. *note: clients used to calculate follow up rates include those who didn't receive outreach and those who were lost to follow up (e.g. not contactable, not responsive)	Yellowfin, CAT Contact Log
Consistency of service (% of clients with no service gap over 30/60/90 days)	% of clients with less than 30/60/90 days maximum without service during their episode(s) in the fiscal year. Only includes clients open to a provider for at least a total of 1/2/3 months during the reporting fiscal year. Available for: Adult FSP, Children's FSP, Homeless FSP, CCT, FIT.	Yellowfin
% of clients who had a reduction in days in psychiatric emergency services/inpatient/crisis stabilization units	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in psychiatric emergency services, inpatient or crisis stabilization unit other than Amber House, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in jail and/or subacute) for six or more months during the current fiscal year or the prior fiscal year. Available for: Adult FSP, Children's FSP, Homeless FSP, CCT, FIT.	Yellowfin
% of clients with a decrease in incarcerations	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in jail days, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in hospital and/or subacute) for six or more months during the current fiscal year or the prior fiscal year. Available for: Adult FSP, Children's FSP, Homeless FSP, CCT, FIT.	Yellowfin

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

% clients who had a primary care visit in the last year	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/Community Health Center Network (CHCN) primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, mental health hospital, and/or jail). Available for: Adult FSP, Children's FSP, Homeless FSP, CCT, FIT.	Yellowfin

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

BMH RBA Report FY 2024

Reporting Period: June 2023 - July 2024

Medical Services

Process Outcomes ("How much did we do?")

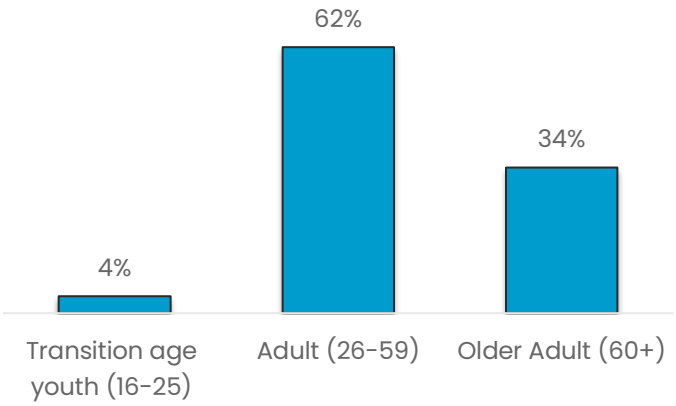
379

Clients Served

Program Description: The Medical Services Team provides psychiatric and nursing services to patients on Adult Services (FIT, CCT, & FSP), Crisis Services, and Family, Youth, and Children's Services.

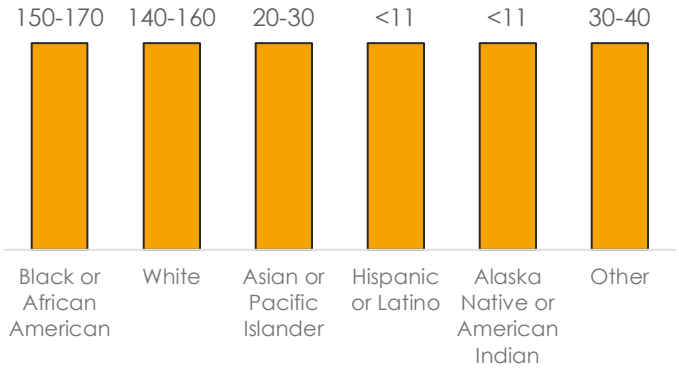
Demographics (Age)

Jul '23 - Jun '24 (n=379)



Demographics (Ethnicity)

Jul '23 - Jun '24 (n=379)



Quality Outcomes ("How well did we do it?")

56% n=379
Appointments kept

Impact Outcomes ("Is anyone better off?")

43% n=379
Clients connected to a primary care provider

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Measure	Definition	Data Source
# clients served	Total clients served. Due to the discrepancy between client counts in Yellowfin and internal documents, Yellowfin is used for overall client count while internal totals are used for specific measures.	Yellowfin
% of appointments kept	Of scheduled appointments, % which were kept during the reporting period	MD Attendance Tracker
% of clients connected to a primary care provider	Of total clients, % who had Primary Care Practitioner (PCP) listed in Primary Care Tracker at least one month during the reporting period.	Primary Care Provider Tracker

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

BMH RBA Report FY 2024

Reporting Period: July 2023 - June 2024

Focus on Independence Team (FIT)

Process Outcomes ("How much did we do?")

91

Clients Served

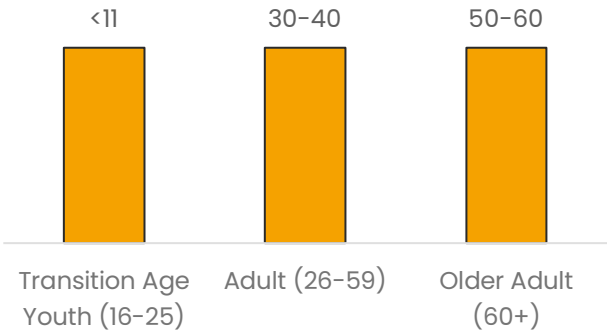
1

New Clients

Program Description: The Focus on Independence Team is responsible for providing services to clients who have graduated from higher levels of care within the clinic. Services are provided both in the field and in the clinic depending on client needs.

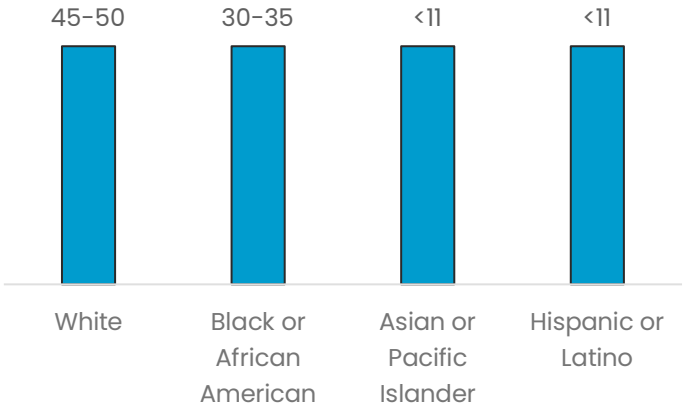
Demographics (Age)

Jul '23 - Jun '24 (n=91)



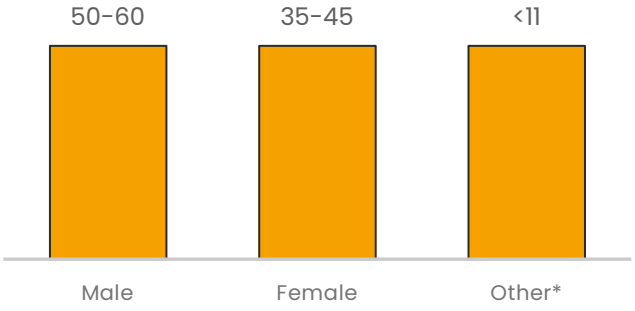
Demographics (Ethnicity)

Jul '23 - Jun '24 (n=91)



Demographics (Gender Identity)

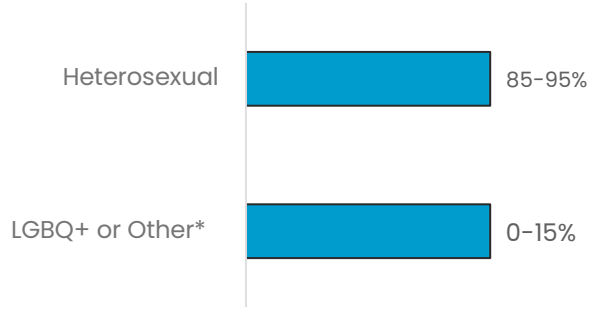
Jul '23 - Jun '24 (n=91)



*Other includes any identity that doesn't fit within the traditional male/female binary.

Demographics (Sexual Orientation)

Jul '23 - Jun '24 (n=91)

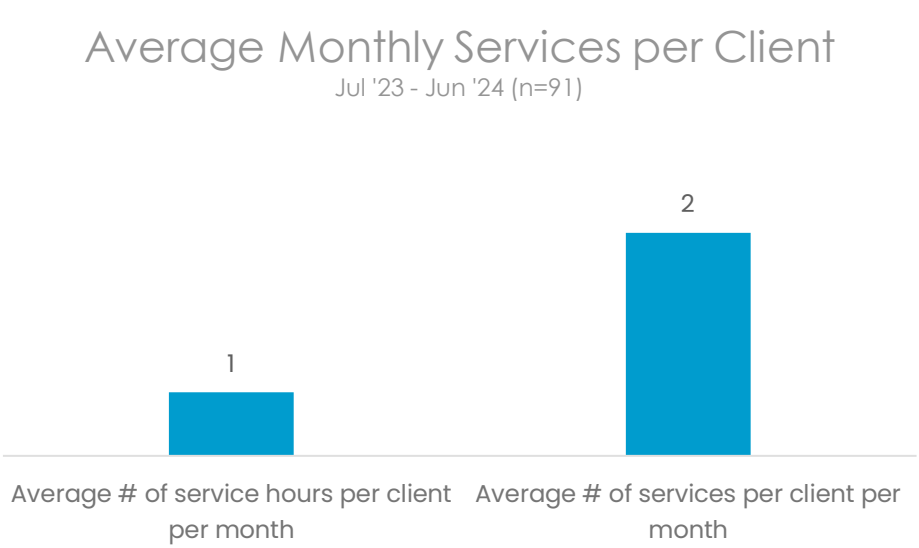


*LGBQ+ includes individuals who identify as lesbian, gay, bisexual, questioning, or other diverse sexual orientations. Other includes prefer not to answer or unknown.

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Quality Outcomes ("How well did we do it?")

Service Consistency



Retention and Stability

Clients spend
8 Years in FIT on average

61% n=88
Clients with no service gap of over 60 days

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Impact Outcomes ("Is anyone better off?")

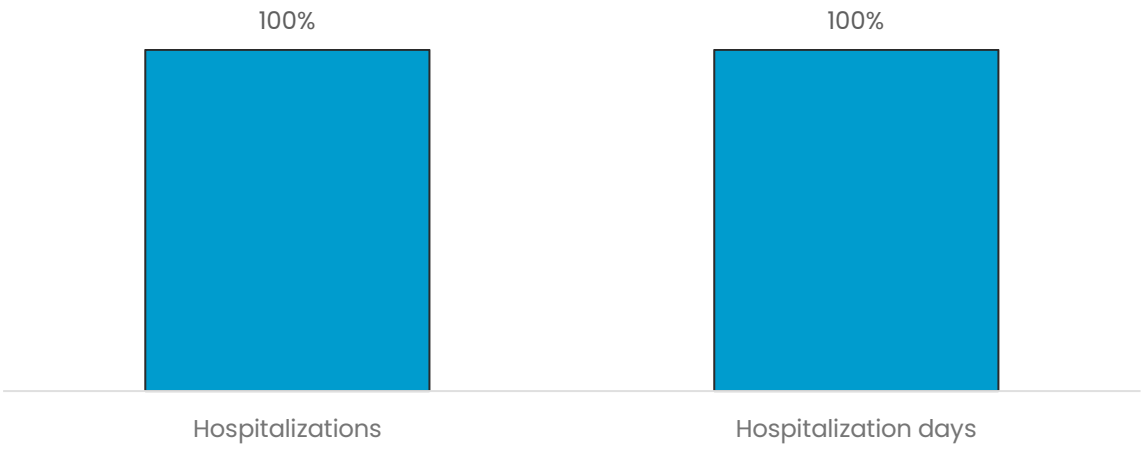
Client Outcome Improvements

87% n=84
Clients with a Primary care visit

100% n<11
Client reduction in psychiatric emergency services/inpatient/ crisis stabilization units

Clients with a decrease in hospitalizations/hospital days

Jul '23 - Jun '24 (n<11)



NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients	Clients who were not served by the program in the previous fiscal year	Yellowfin
Average # of service hours per client per month	Average of hours of service in a month divided by clients served in a month. Includes all services recorded for clients. Does not include medical services (MAA)	Yellowfin
Average # of services per client per month	Average services in a month divided by clients served in a month. Includes all services recorded for clients. Note: more than one service can be provided during a single contact. Does not include MAA	Yellowfin
% of clients who receive follow-up care after a mental health hospitalization or crisis	% of clients who receive a follow-up appointment with a partner provider after being discharged from a mental health hospitalization, crisis stabilization unit, psychiatric health facility, or justice system.	Yellowfin
% of clients with no service gap of over 60 days	% of clients with less than 90 days maximum without service during their episode(s) in the fiscal year. Only includes clients open to a provider for at least a total of three months during the reporting fiscal year.	Yellowfin
% of discharges from hospitalization or subacute who had a follow up visit with staff within 7 and within 30 calendar days	Follow-up rates for individuals open to Level 1 providers at the time of mental health hospital discharge. *note: clients used to calculate follow up rates include those who didn't receive outreach and those who were lost to follow up (e.g. not contactable, not responsive)	Yellowfin
#/% of clients closed, by reason closed	Discharge reason for clients discharged during the reporting period	Yellowfin Not presented due to delays in the reporting system
#/% of clients transferred to another level of care	Of clients discharged in the reporting period, # who were transferred to a full service partnership program, service team, or outpatient services in Alameda County within 90 days of discharge	Yellowfin Data Suppressed (n<11)

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

% of clients who had a reduction in psychiatric emergency services/inpatient/crisis stabilization units	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in psychiatric emergency services, inpatient or crisis stabilization unit other than Amber House, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in jail and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients with a decrease in hospitalizations/hospitalization days	Decrease in hospital days/admissions in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital day in the 12 months prior to admission and remained in the program for at least 1 year. Only available for fiscal years.	Yellowfin
% of clients with a primary care visit	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/Community Health Center Network (CHCN) primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).	Yellowfin

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BMH RBA Report FY 2024

Reporting Period: July 2023 - June 2024

Comprehensive Community Treatment Team (CCT)

Process Outcomes ("How much did we do?")

180

Clients Served

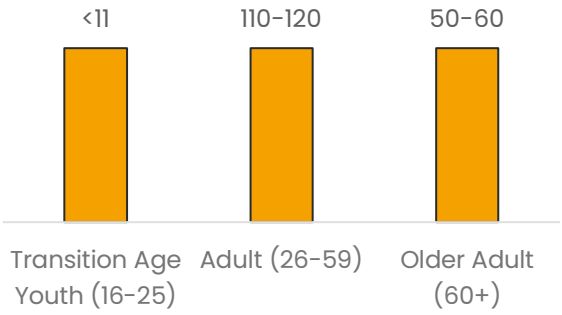
28

New Clients

Program Description: The CCT team is responsible for providing services to adults with severe and persistent mental illness who require specialty mental health services. Staff provide case management, therapeutic services, and group services both in the field and in the clinic.

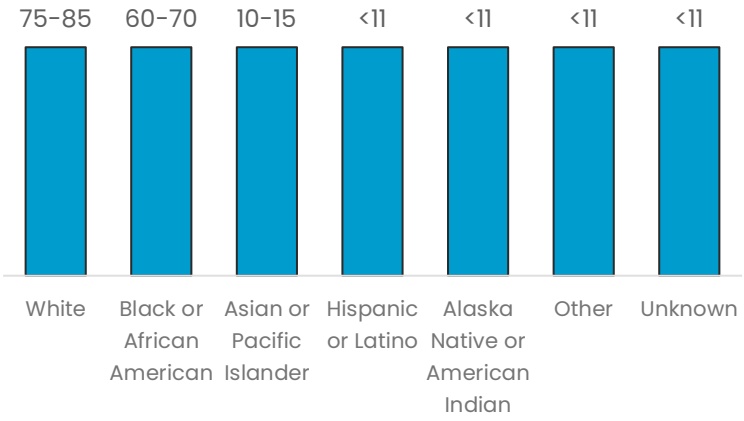
Demographics (Age)

Jul '23 - Jun '24 (n=180)



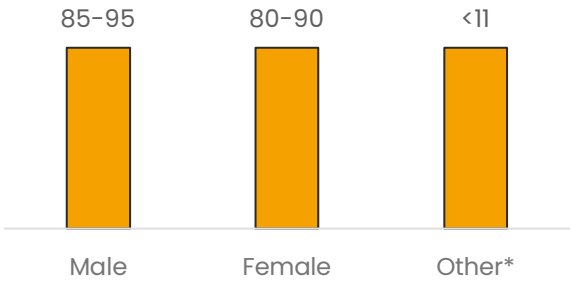
Demographics (Ethnicity)

Jul '23 - Jun '24 (n=180)



Demographics (Gender Identity)

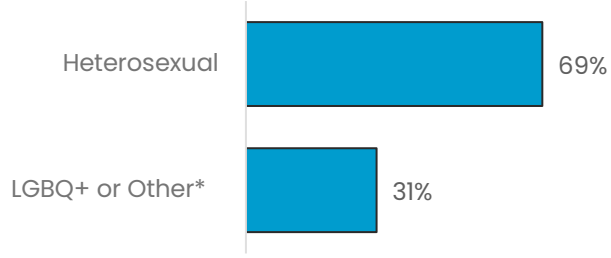
Jul '23 - Jun '24 (n=180)



*Other includes any identity that doesn't fit within the traditional male/female binary.

Demographics (Sexual Orientation)

Jul '23 - Jun '24 (n=180)



*LGBQ+ includes individuals who identify as lesbian, gay, bisexual, questioning, or other diverse sexual orientations. Other includes prefer not to answer or unknown.

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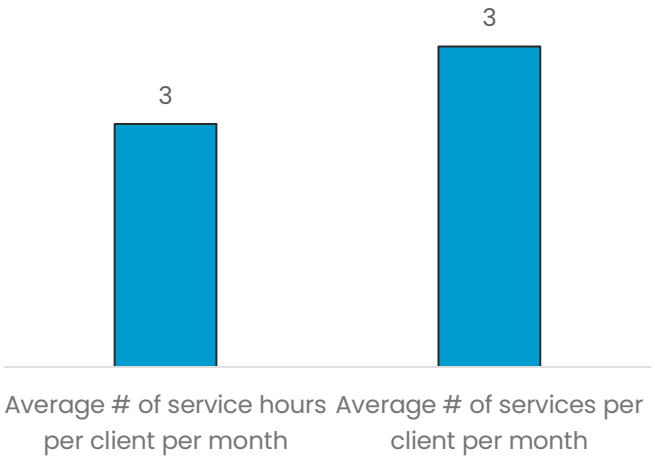
Quality Outcomes ("How well did we do it?")

Service Consistency

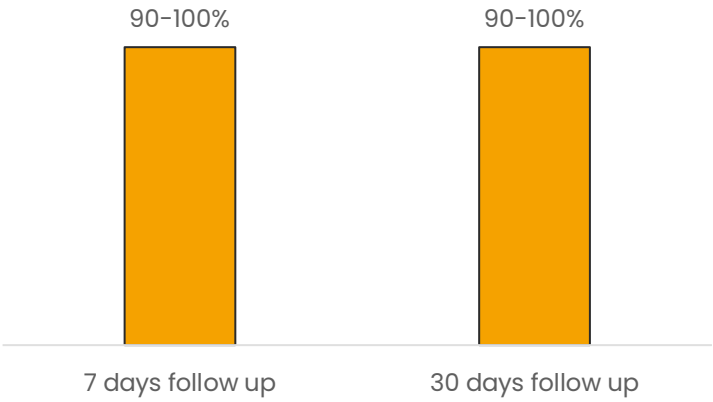
Average Monthly Services per Client

Jul '23 - Jun '24 (n=180)



Discharges from hospitalization or subacute who received follow up within 7 and 30 days

Jul '23 - Jun '24 (n<11)



Retention and Stability

Clients spend
4 Years in CCT on average

75% n=164
Clients with no service gap of over

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Impact Outcomes ("Is anyone better off?")

Client Outcome Improvements

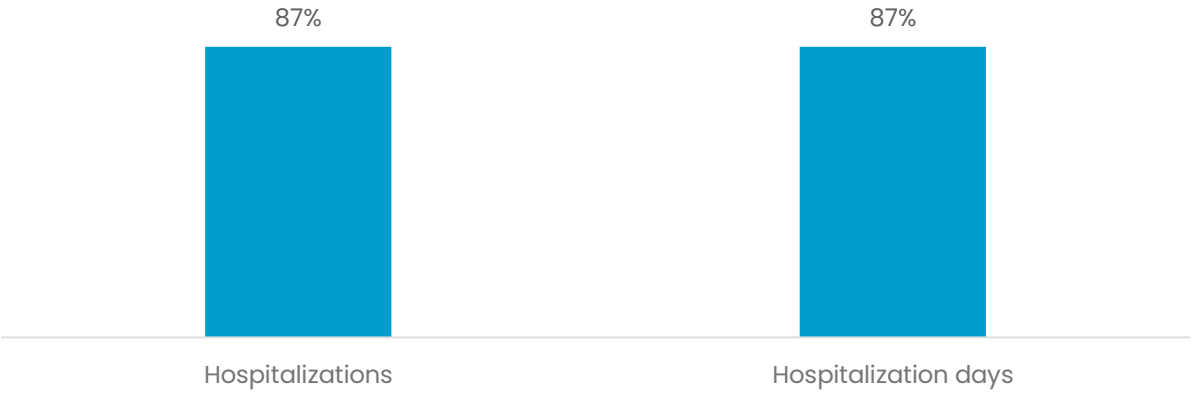
100% n<11
Clients who had a reduction in jail days

100% n<11
Client reduction in psychiatric emergency services/inpatient /crisis stabilization units

88% n=137
Clients with a Primary care visit

Clients with a decrease in hospitalizations/hospital days

Jul '23 - Jun '24 (n=23)



NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients	Clients who were not served by the program in the previous fiscal year	Yellowfin
Average # of services per client per month	Average services in a month divided by clients served in a month. Includes all services recorded for clients. Note: more than one service can be provided during a single contact. Does not include MAA	Yellowfin
% of clients with no service gap of over 60 days	% of clients with less than 90 days maximum without service during their episode(s) in the fiscal year. Only includes clients open to a provider for at least a total of three months during the reporting fiscal year.	Yellowfin
% of discharges from hospitalization or subacute who had a follow up visit with staff within 7 and within 30 calendar days	Follow-up rates for individuals open to Level 1 providers at the time of mental health hospital discharge. *note: clients used to calculate follow up rates include those who didn't receive outreach and those who were lost to follow up (e.g. not contactable, not responsive)	Yellowfin
#/% of clients closed, by reason closed	Discharge reason for clients discharged during the reporting period	Yellowfin Not presented due to delays in the reporting system
#/% of clients transferred to another level of care	Of clients discharged in the reporting period, # who were transferred to a full service partnership program, service team, or outpatient services in Alameda County within 90 days of discharge	Yellowfin Data Suppressed (n<11)
% of clients who had a reduction in psychiatric emergency services/inpatient/crisis stabilization units	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in psychiatric emergency services, inpatient or crisis stabilization unit other than Amber House, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in jail and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

% of clients with a decrease in hospitalizations/hospitalization days	Decrease in hospital days/admissions in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital day in the 12 months prior to admission and remained in the program for at least 1 year. Only available for fiscal years.	Yellowfin
% of clients with a decrease in jail days	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in jail days, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in hospital and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients with a primary care visit	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/Community Health Center Network (CHCN) primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).	Yellowfin

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

BMH RBA Report FY 2024

Reporting Period: June 2023 - July 2024

Mobile Crisis Team (MCT)

Process Outcomes ("How much did we do?")

588

Clients Served

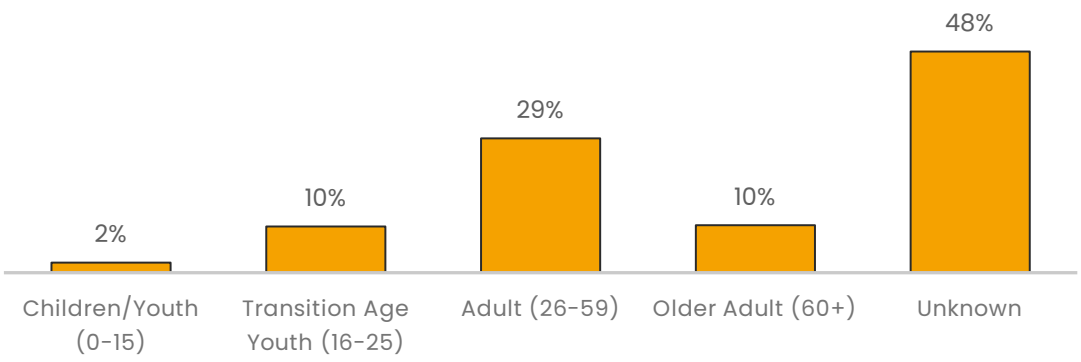
863

Responses to Incidents

Program Description:
The Mobile Crisis Team (MCT) serves residents of Berkeley, from 11:30am-10pm each day of the week when fully staffed. It provides crisis interventions, including but not limited to 5150 evaluations, consultations, and referrals/linkages.

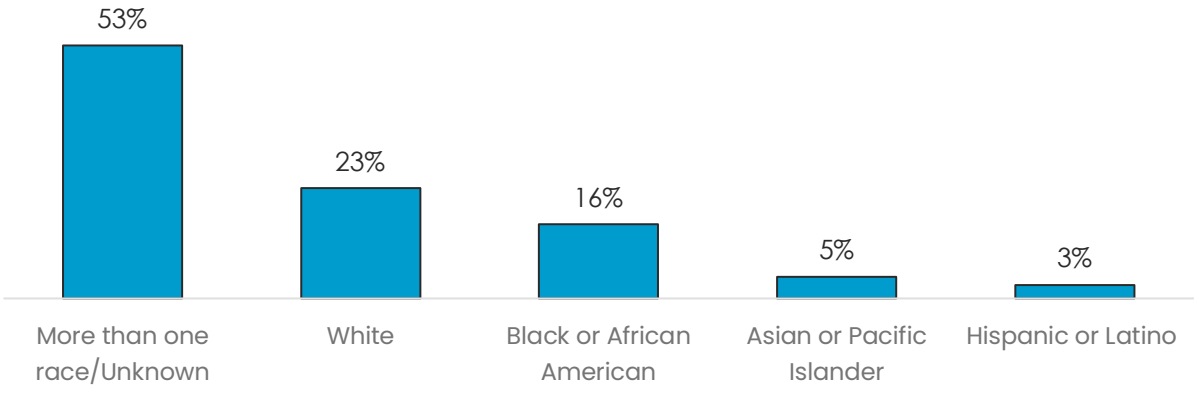
Demographics (Age)

Jul '23 - Jun '24 (n=588)



Demographics (Ethnicity)

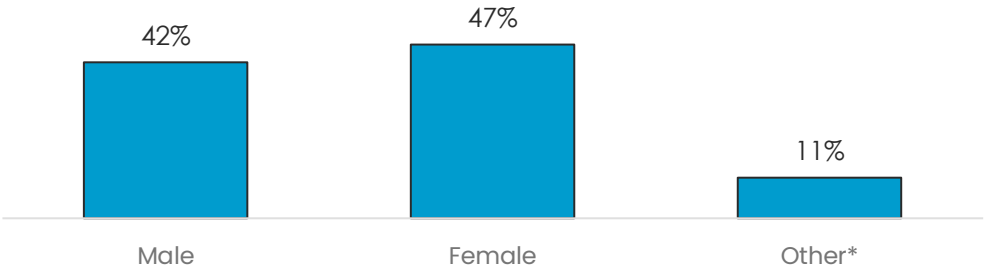
Jul '23 - Jun '24 (n=588)



NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Demographics (Gender Identity)

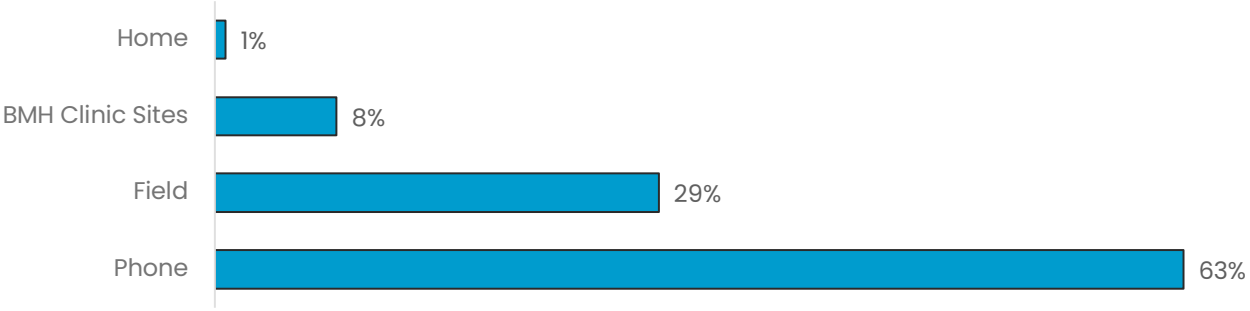
Jul '23 - Jun '24 (n=588)



*Other includes unknown or missing due to clients not disclosing, clinician unable to make the determination, or a crisis situation not allowing for more comprehensive data collection. It also includes any identity that doesn't fit within the traditional male/female binary. Sexual orientation data not available.

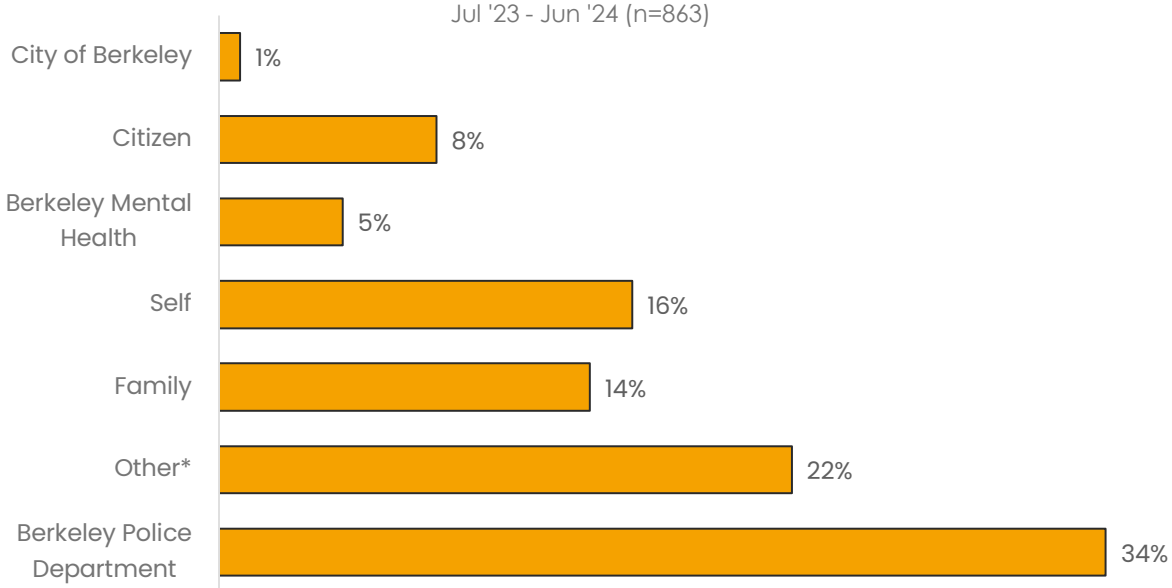
Client Contacts Made by Contact Type

Jul '23 - Jun '24 (n=863)



Referrals by Referring Party

Jul '23 - Jun '24 (n=863)

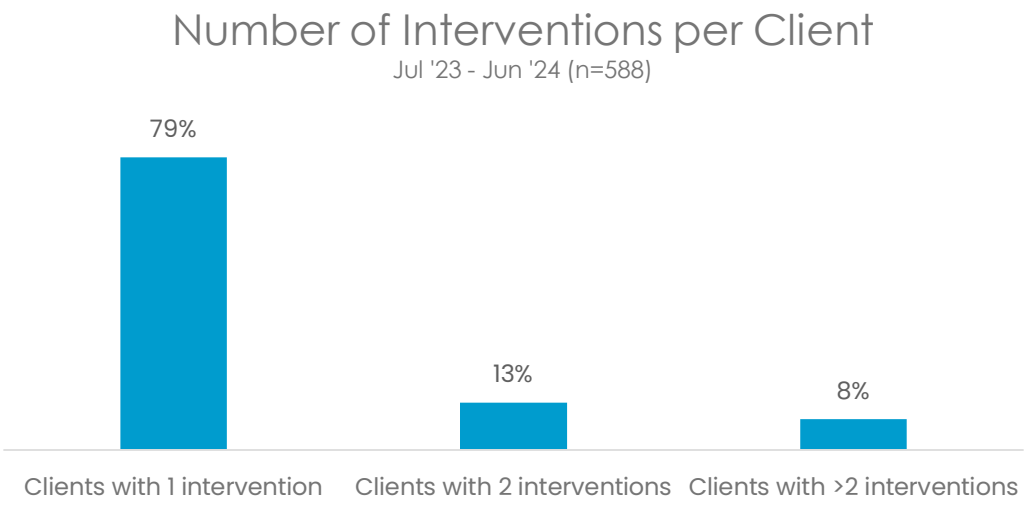


*Other includes responses involving Albany PD, UC PD, Berkeley Fire, Homeless Outreach, Neighborhood Services, Merchants, and follow-ups.

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Quality Outcomes ("How well did we do it?")

Service Consistency



Impact Outcomes ("Is anyone better off?")

The MCT program performed

198

5150 Evaluations

72% n=198

5150 Evaluations did Not Lead to Transport to a facility

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Measure	Definition	Data Source
# clients served	Total unique clients served	MCT Incident Log
# of client contacts made	# of client contacts made, by a. Field contacts b. Phone contacts c. Other	MCT Incident Log
# of referrals by referring party	# of crisis services referrals made to the MCT, by referring party (i.e. Berkeley Police Department, Berkeley Fire Department, Berkeley Mental Health, community, etc.)	MCT Incident Log
# of 5150 evaluations conducted	Total number of incidents with 5150 Evaluations of any sort	MCT Incident Log
Results of 5150 Evaluations	% of 5150 evaluations that did or did not result in transportation to a receiving facility for further evaluation	MCT Incident Log
Number of interventions per client	% of clients who had one, two, or more than two interventions on separate dates requiring service	MCT Incident Log

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BMH RBA Report FY 2024

Reporting Period July 2023- June 2024

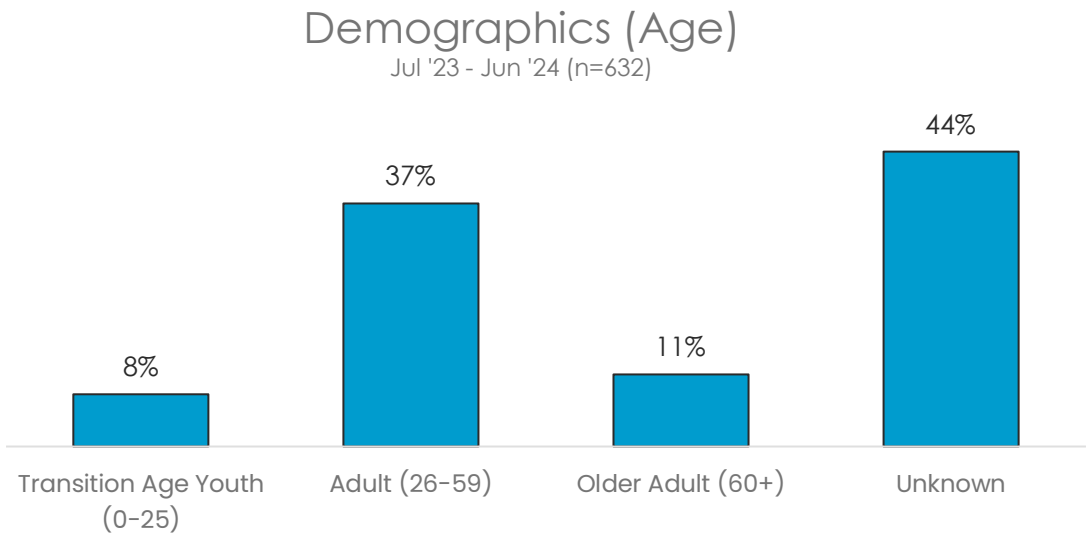
Crisis, Assessment, and Triage/Transitional Outreach Team (CAT/TOT)

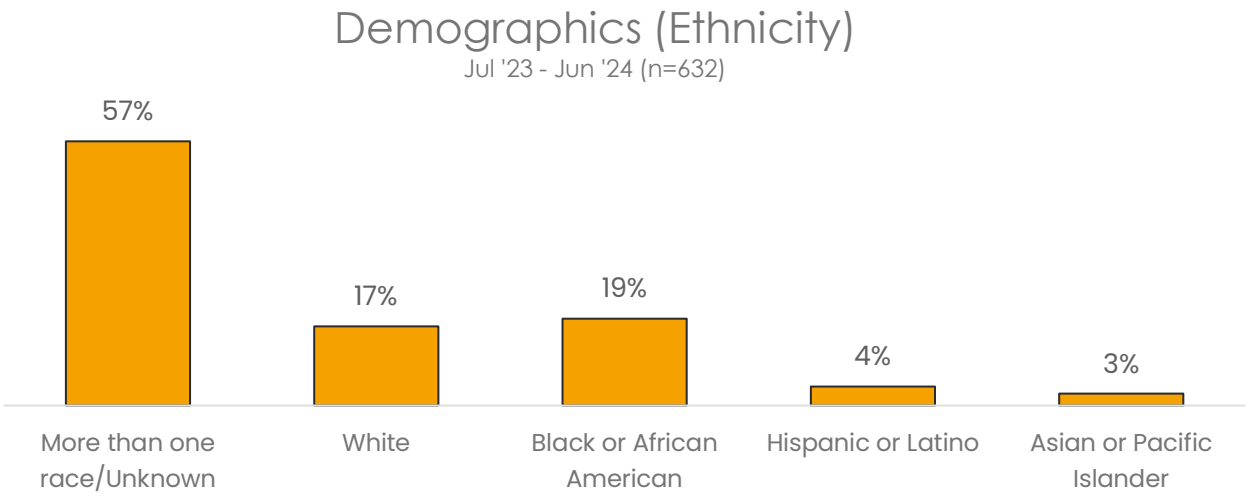
Process Outcomes ("How much did we do?")

632
Clients Served

1282
Contacts

Program Description
CAT/TOT is BMH's intake and follow-up team for Adult Mental Health Services. This team provides screening/assessment for ongoing mental health services, linkage to community-based resources, crisis support, and coordination with other agencies. Services include, but are not limited to: psychiatric services, transportation, food access, medical care, health insurance, benefits, legal assistance, affordable housing listings, utilities and energy assistance resources. Services are provided in person at the clinic, as well as via the team phone line.

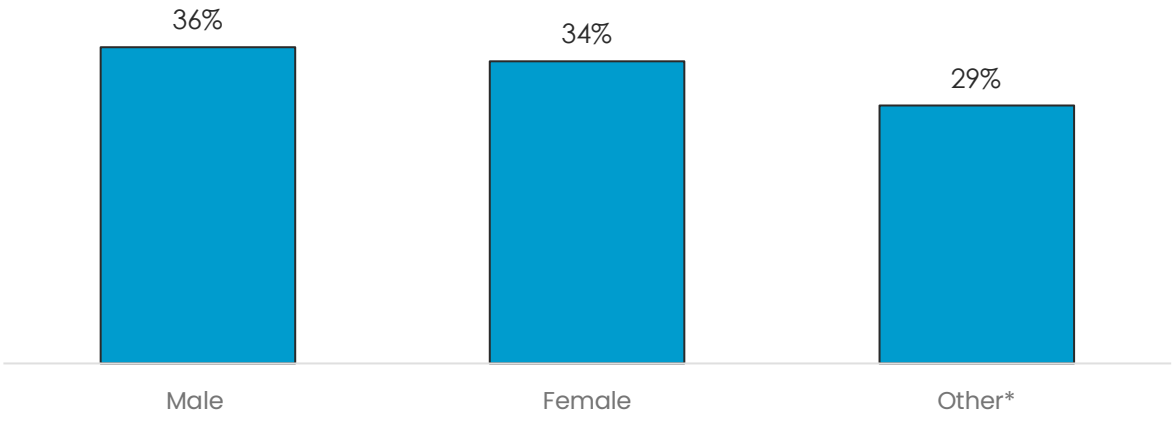




NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Demographics (Gender Identity)

Jul '23 - Jun '24 (n=632)

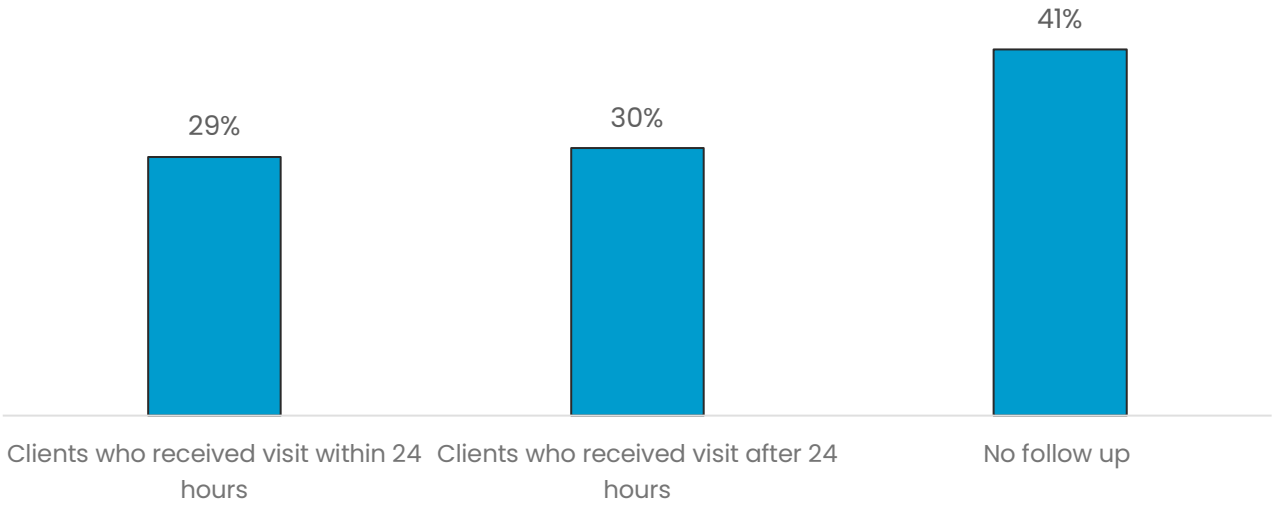


*Other includes unknown or missing due to clients not disclosing, clinician unable to make the determination, or a crisis situation not allowing for more comprehensive data collection. It also includes any identity that doesn't fit within the traditional male/female binary. Sexual orientation data not available.

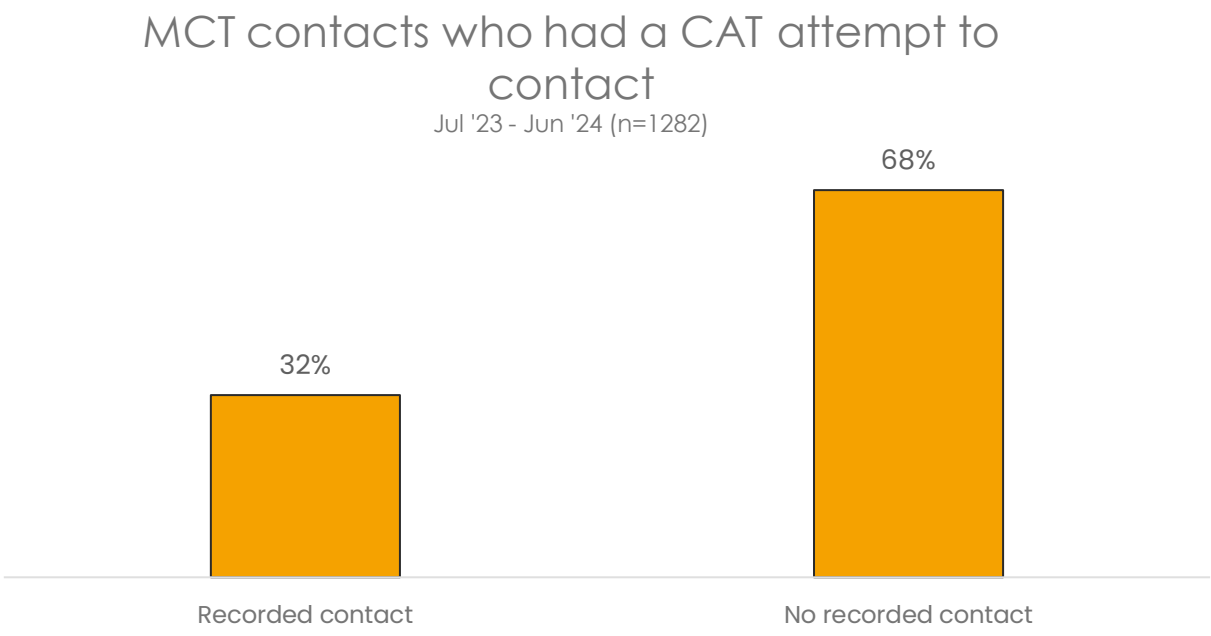
Quality Outcomes ("How well did we do it?")

Follow-up after hospitalization

Jul '23 - Jun '24 (n=56)



NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.



NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Measure	Definition	Data Source
# clients served	Total clients served	MCT & CAT Incident Log
# of documented contacts	Total number of documented incidents	MCT & CAT Incident Log
% of clients who receive a visit (phone contact with client or hospital service provider) in the 24 hours after hospitalization	% of clients who receive a visit (phone contact with client or hospital service provider) in the 24 hours after hospitalization. Reasons for no follow up may include no viable contact information, client was not amenable to follow-up services, or the client is already connected to follow-up services provided by another agency.	MCT & CAT Incident Log
% of MCT contacts who had a CAT attempt to contact	Of Client IDs in MCT contact log, % which also have record in CAT contact log. Reasons for no contact may include no viable contact information or client declined contact.	MCT & CAT Incident Log

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BMH RBA Report FY 2024

Reporting Period July 2023 - June 2024

Child Full Service Partnership (CFSP)

Process Outcomes ("How much did we do?")

14

Clients Served

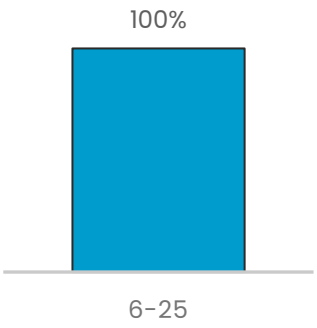
***De-identified (n<11)**

New Clients

Program Description: This team provides wrap around services to children and families with acute needs, who meet the following criteria: child is at risk of/has been removed from their parent/guardian; child is involved with the Juvenile Justice System or at risk of that; has been recently had a psychiatric hospitalization or is at risk of a hospitalization.

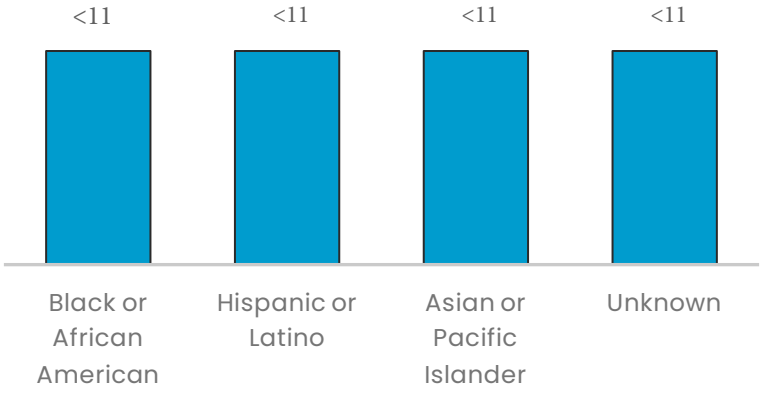
Demographics (Age)

Jul '23 - Jun '24 (n=14)



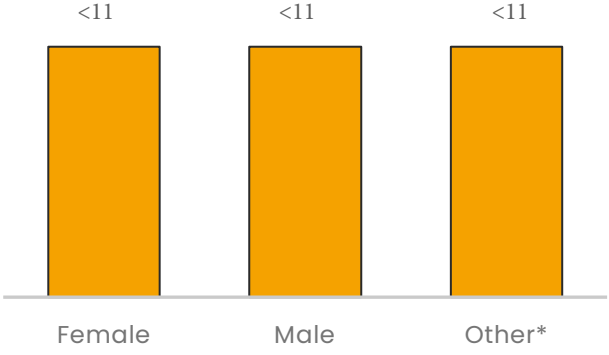
Demographics (Ethnicity)

Jul '23 - Jun '24 (n=14)



Demographics (Gender Identity)

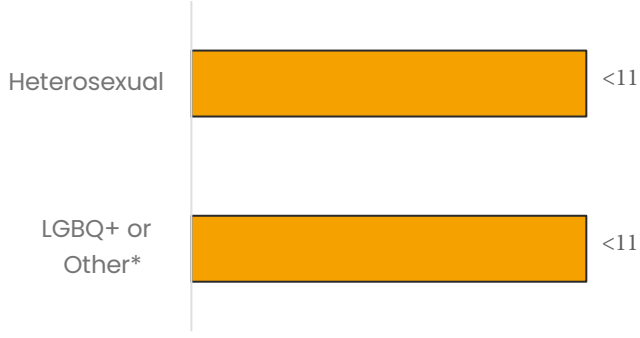
Jul '23 - Jun '24 (n=14)



*Other includes any identity that doesn't fit within the traditional male/female binary.

Demographics (Sexual Orientation)

Jul '23 - Jun '24 (n=14)



*LGBQ+ includes individuals who identify as lesbian, gay, bisexual,questioning, or other diverse sexual orientations. Other includes prefer not to answer or

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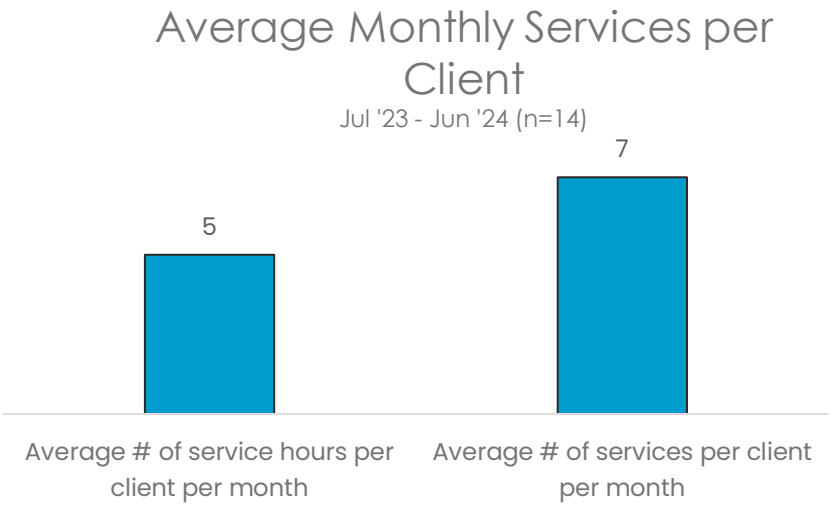
Quality Outcomes ("How well did we do it?")

Service Consistency



90-100% n<15
Discharges from hospitalization or subacute who had a follow up visit with within 7 days

Retention and Stability

60-70% n<15
Clients receive an average of 4+ face-to-face visits per month

Clients Spend **300 days** in FSP on average

90-100% n<15
Clients with at least one completed CANS assessment every six months while in the program

70-80% n<15
Clients with no service gap of over 30 days

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

Impact Outcomes ("Is anyone better off?")

Client Outcome Improvements

50-60% n<15
Clients with a Primary care visit

90-100% n<15
Client reduction in psychiatric emergency services/inpatient/ crisis stabilization units

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients	Clients who were not served by the program in the previous fiscal year	Yellowfin
Average # of service hours per client per month	Average of hours of service in a month divided by clients served in a month. Includes all services recorded for clients. Does not include medcation services (MAA).	Yellowfin
Average # of services per client per month	Average services in a month divided by clients served in a month. Includes all services recorded for clients. Note: more than one service can be provided during a single contact. Does not include MAA	Yellowfin
% of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program	Of clients with a completed Child or Adult Needs and Strengths Assessment (CANS/ANSA), what percentage of them had an assessment at least every six months?	Objective Arts
% of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month	Clients must be been open to a provider for at least 30 days in order to be included in this metric. Phone contacts are included during the pandemic. Days in subacute or jail not counted, but services are counted.	Yellowfin
% of clients with no service gap of over 30 days	Maximum days each Level 1 client went without service during their episode(s) in the reporting period. Only considered clients open to a provider for at least a total of three months during the reporting fiscal year.	Yellowfin
% of discharges from hospitalization or subacute who had a follow up visit with FSP staff within 7 business days	Follow-up rates for individuals open to Level 1 providers at the time of mental health hospital discharge. *note: clients used to calculate follow up rates include those who didn't receive outreach and those who were lost to follow up (e.g. not contactable, not	Yellowfin
#/% of clients closed, by reason closed	Discharge reason for clients discharged during the reporting period	Yellowfin *Not presented due to delays in the reporting system
% of clients with a primary care visit	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/Community Health Center Network (CHCN) primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).	Yellowfin

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

Average # of days in FSP per client	The average number of days a client remains enrolled in the Full-Service Partnership (FSP) program.	Yellowfin
% of clients with a decrease in hospitalization days/admissions	Decrease in hospital days/admissions in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital day in the 12 months prior to admission and remained in the program for at least 1 year. Only available for fiscal years.	Yellowfin Note: Data Suppressed (<11 clients)

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

BMH RBA Report FY 2024

Reporting Period July 2023 - June 2024

Adult Full Service Partnership (AFSP)

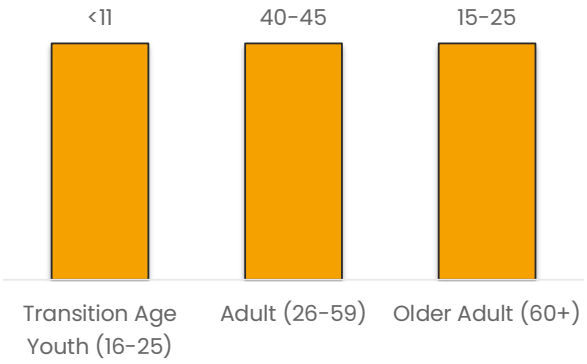
Process Outcomes ("How much did we do?")

66
Clients Served

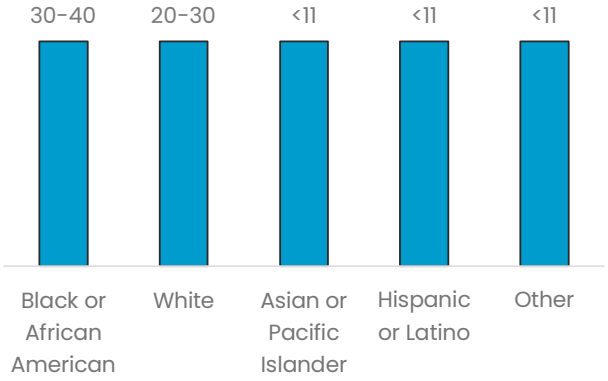
17
New Clients

Program Description: The Full-Service Partnership (FSP) team provides services to clients who are considered the highest need within our adult mental health service system. The FSP team is based on an Assertive Community Treatment (ACT) Model which involves low staff-to-client ratios at approximately 10:1 and a focus on providing care as a team rather than individual case load assignments. Services are primarily provided in the community rather than in an office setting.

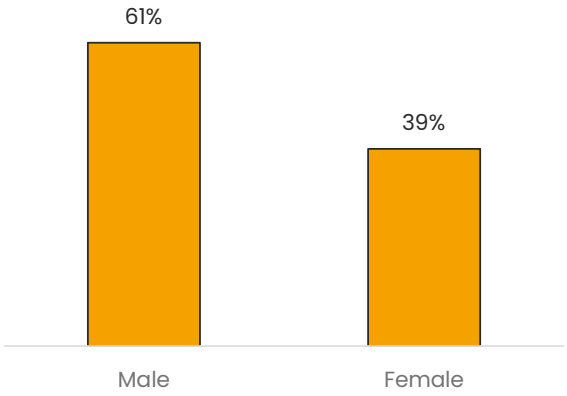
Demographics (Age)
Jul '23- Jun '24 (n=66)



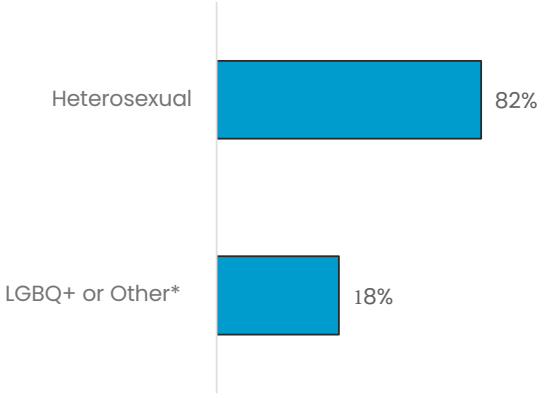
Demographics (Ethnicity)
Jul '23 - Jun '24 (n=66)



Demographics (Gender Identity)
Jul '23 - Jun '24 (n=66)



Demographic (Sexual Orientation)
Jul '23 - Jun '24 (n=66)



*LGBQ+ includes individuals who identify as lesbian, gay, bisexual, questioning, or other diverse sexual orientations. Other includes prefer not to answer, or unknown.

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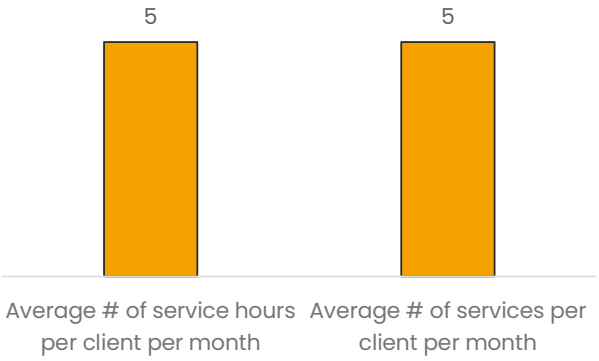
Quality Outcomes ("How well did we do it?")

Service Consistency

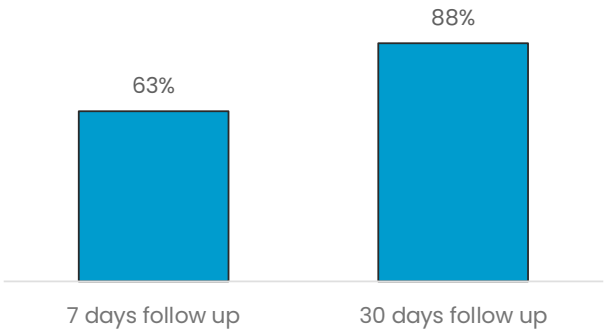
Average Monthly Services per Client

Jul '23 - Jun '24 (n=66)



Discharges from hospitalization or subacute who received FSP follow up within 7 and 30 days

Jul '23 - Jun '24 (n=20)



Retention and Stability

Clients Spend **4 years** in FSP on average

67% n=66
Clients receive an average of 4+ face-to-face outpatient visits per month

56% n=66
Clients with no service gap of over 30 days

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Impact Outcomes ("Is anyone better off?")

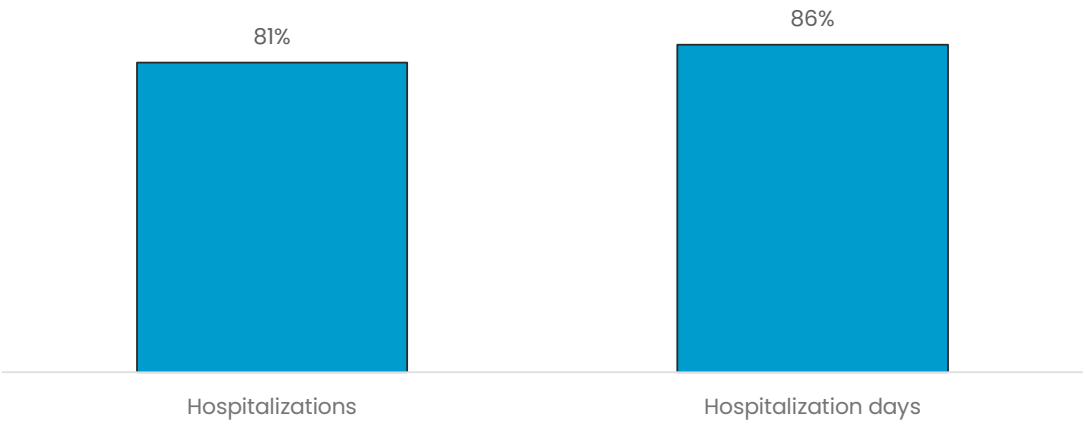
Client Outcome Improvements

80-90% n<11
Clients who had a reduction in jail

100% n<11
Client reduction in psychiatric emergency services/inpatient/ crisis stabilization units

83% n=48
Clients with a Primary care visit

Clients with a decrease in hospitalizations/hospital days
Jul '23 - Jun '24 (n=20)



NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients	Clients who were not served by the program in the previous fiscal year	Yellowfin
Average # of service hours per client per month	Average of hours of service in a month divided by clients served in a month. Includes all services recorded for clients. Does not include medical services (MAA)	Yellowfin
Average # of services per client per month	Average services in a month divided by clients served in a month. Includes all services recorded for clients. Note: more than one service can be provided during a single contact. Does not include MAA	Yellowfin
% of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month	Clients must be been open to a provider for at least 30 days in order to be included in this metric. Phone contacts are included during the pandemic. Days in subacute or jail not counted, but services are counted.	Yellowfin
% of clients with no service gap of over 30 days	Maximum days each Level 1 client went without service during their episode(s) in the reporting period. Only considered clients open to a provider for at least a total of three months during the reporting fiscal year.	Yellowfin
% of discharges from hospitalization or subacute who had a follow up visit with FSP staff within 7 and within 30 calendar days	Follow-up rates for individuals open to Level 1 providers at the time of mental health hospital discharge. *note: clients used to calculate follow up rates include those who didn't receive outreach and those who were lost to follow up (e.g. not contactable, not responsive)	Yellowfin
#/% of clients closed, by reason closed	Discharge reason for clients discharged during the reporting period	Yellowfin Not presented due to delays in the reporting system
# of clients transferred to another level of care	Of clients discharged in the reporting period, # who were transferred to a full service partnership program, service team, or outpatient services in Alameda County within 90 days of discharge.	Yellowfin Data Suppressed (n<11)

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

% of clients who had a reduction in psychiatric emergency services/inpatient/crisis stabilization units	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in psychiatric emergency services, inpatient or crisis stabilization unit other than Amber House, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in jail and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients who had a reduction in jail days	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in jail days, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in hospital and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients with a primary care visit	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/Community Health Center Network (CHCN) primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).	Yellowfin
% of clients with a decrease in hospitalizations/hospitalization days	Decrease in hospital days/admissions in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital day in the 12 months prior to admission and remained in the program for at least 1 year. Only available for fiscal years.	Yellowfin
% of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program	Of clients with a completed Child or Adult Needs and Strengths Assessment (CANS/ANSA), what percentage of them had an assessment at least every six months?	No ANSA data is available for FY24

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

BMH RBA Report FY 2024

Reporting Period July 2023 - June 2024

Homeless Full Service Partnership (HFSP)

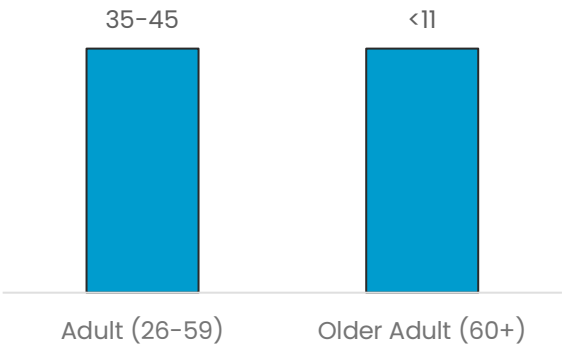
Process Outcomes ("How much did we do?")

47
Clients Served

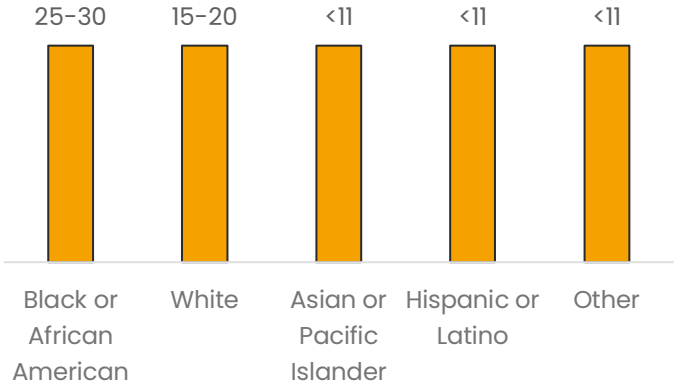
13
New Clients

Program Description: HFSP serves unhoused residents of Berkeley in an Assertive Community Treatment (ACT) model at high staff to client ratios, providing intensive case management and mental health services in a multi-disciplinary team approach. This team serves those with the highest level of need, supporting a population that is primarily unhoused and has multiple severe functional impairments.

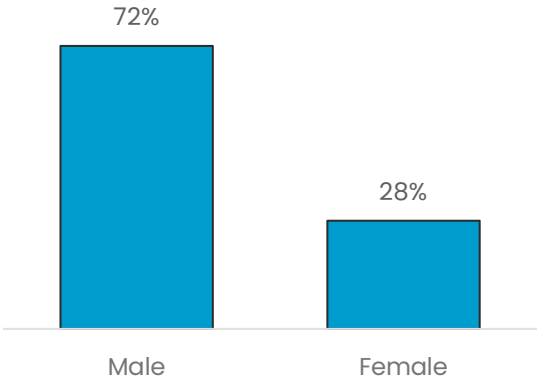
Demographics (Age)
Jul '23 - Jun '24 (n=47)



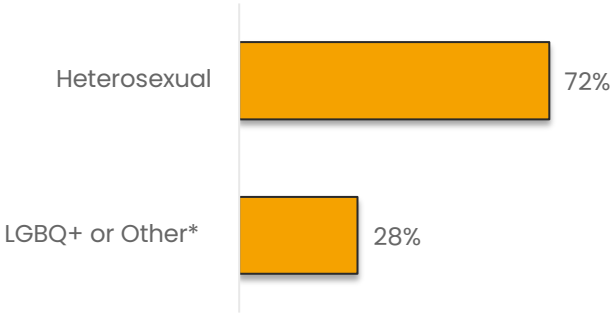
Demographics (Ethnicity)
Jul '23 - Jun '24 (n=47)



Demographics (Gender Identity)
Jul '23 - Jun '24 (n=47)



Demographics (Sexual Orientation)
Jul '23 - Jun '24 (n=47)



*LGBQ+ includes individuals who identify as lesbian, gay, bisexual, questioning, or other diverse sexual orientations. Other includes prefer not to answer or

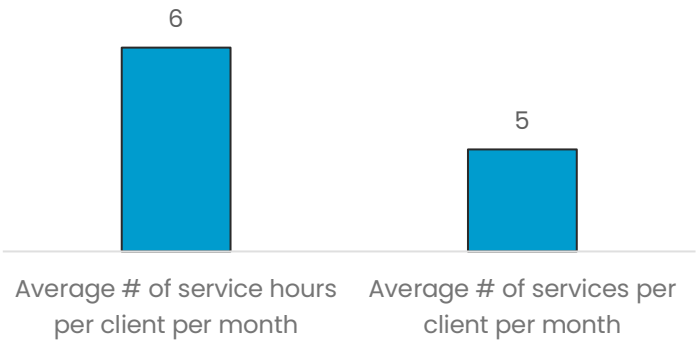
NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

Quality Outcomes ("How well did we do it?")

Service *Consistency*

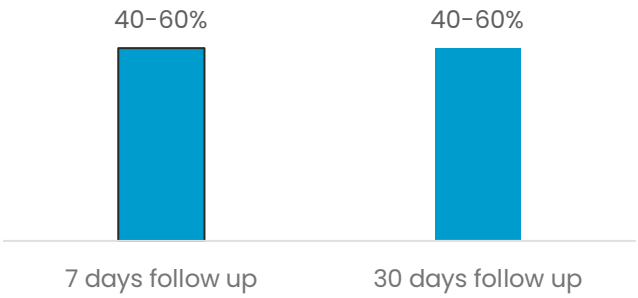
Average Monthly Services per Client

Jul '23 - Jun '24 (n=47)



Discharges from hospitalization or subacute who received FSP follow up within 7 and 30 days

Jul '23 - Jun '24 (n<11)



Retention and Stability

Clients spend **1.9 years** in FSP on average

51% n=47
Clients receive an average of 4+ face-to-face outpatient visits per month

32% n=47
Clients with no service gap of over 30 days

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Impact Outcomes ("Is anyone better off?")

Client Outcome Improvements

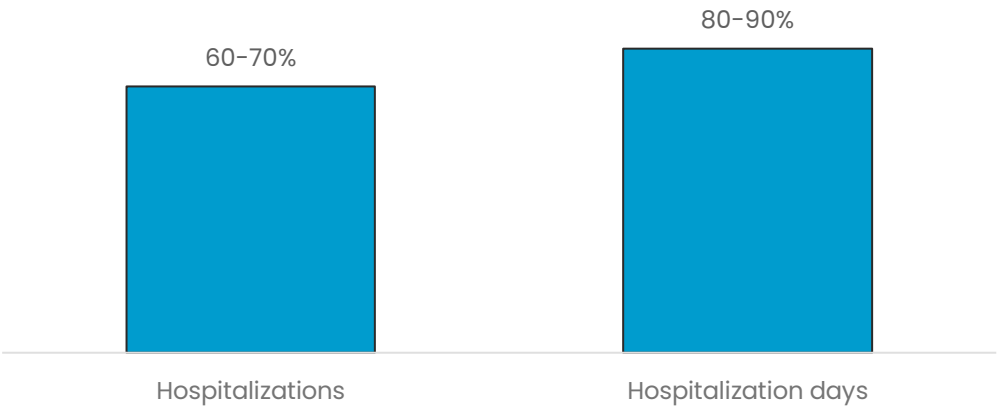
63% n<11
Clients who had a reduction in jail days

71% n<11
Client reduction in psychiatric emergency services/inpatient/ crisis stabilization units

68% n=38
Clients with a Primary care visit

Clients with a decrease in hospitalizations/hospital days

Jul '23 - Jun '24 (n<11)



NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients opened for ongoing services	Clients who were not served by the program in the previous fiscal year	Yellowfin
Average # of service hours per client per month	Average of hours of service in a month divided by clients served in a month. Includes all services recorded for clients. Does not include medical services (MAA)	Yellowfin
Average # of services per client per month	Average services in a month divided by clients served in a month. Includes all services recorded for clients. Note: more than one service can be provided during a single contact. Does not include MAA	Yellowfin
% of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month	Clients must be been open to a provider for at least 30 days in order to be included in this metric. Phone contacts are included during the pandemic. Days in subacute or jail not counted, but services are counted.	Yellowfin
% of clients with no service gap of over 30 days	Maximum days each Level 1 client went without service during their episode(s) in the reporting period. Only considered clients open to a provider for at least a total of three months during the reporting fiscal year.	Yellowfin
% of discharges from hospitalization or subacute who had a follow up visit with FSP staff within 7 and within 30 calendar days	Follow-up rates for individuals open to Level 1 providers at the time of mental health hospital discharge. *note: clients used to calculate follow up rates include those who didn't receive outreach and those who were lost to follow up (e.g. not contactable, not responsive)	Yellowfin
#/% of clients closed, by reason closed	Discharge reason for clients discharged during the reporting period	Yellowfin *Not presented due to delays in the reporting system
# of clients transferred to another level of care	Of clients discharged in the reporting period, # who were transferred to a full service partnership program, service team, or outpatient services in Alameda County within 90 days of discharge.	Yellowfin Note: Data Suppressed (<11 clients)

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted, and may not visually reflect actual counts.

% of clients who had a reduction in psychiatric emergency services/inpatient/crisis stabilization units	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in psychiatric emergency services, inpatient or crisis stabilization unit other than Amber House, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in jail and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients who had a reduction in jail days	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in jail days, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in hospital and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients with a primary care visit	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/Community Health Center Network (CHCN) primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).	Yellowfin
% of clients with a decrease in hospitalizations/hospitalization days	Decrease in hospital days/admissions in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital day in the 12 months prior to admission and remained in the program for at least 1 year. Only available for fiscal years.	Yellowfin
% of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program	Of clients with a completed Child or Adult Needs and Strengths Assessment (CANS/ANSA), what percentage of them had an assessment at least every six months?	No data available; ANSA discontinued in Alameda County in FY24

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BMH RBA Report FY 2024

Reporting Period July 2023 - June 2024

Wellness & Recovery Services

Process Outcomes ("How much did we do?")

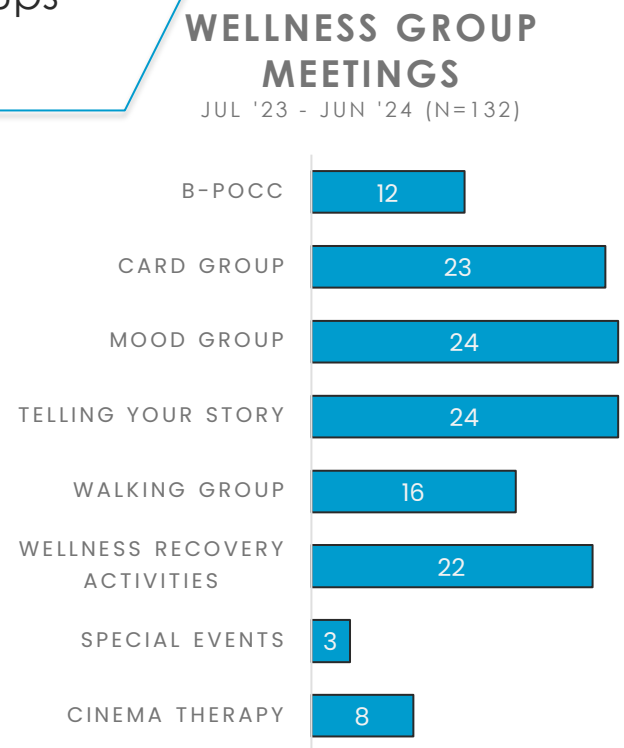
Program Description The Wellness and Recovery Program is designed to provide outreach, support, education, activities, and advocacy to consumer members living with mental illness and living in Berkeley. Wellness group activities include: Berkeley Peers Organizing Community Change (POCC), Card Groups, Mood Groups, Walking Groups, and Wellness Mixers.

52
Participants served

8
Groups

132
Group Events

20
Participants who meet requirements for "Telling Your Story"

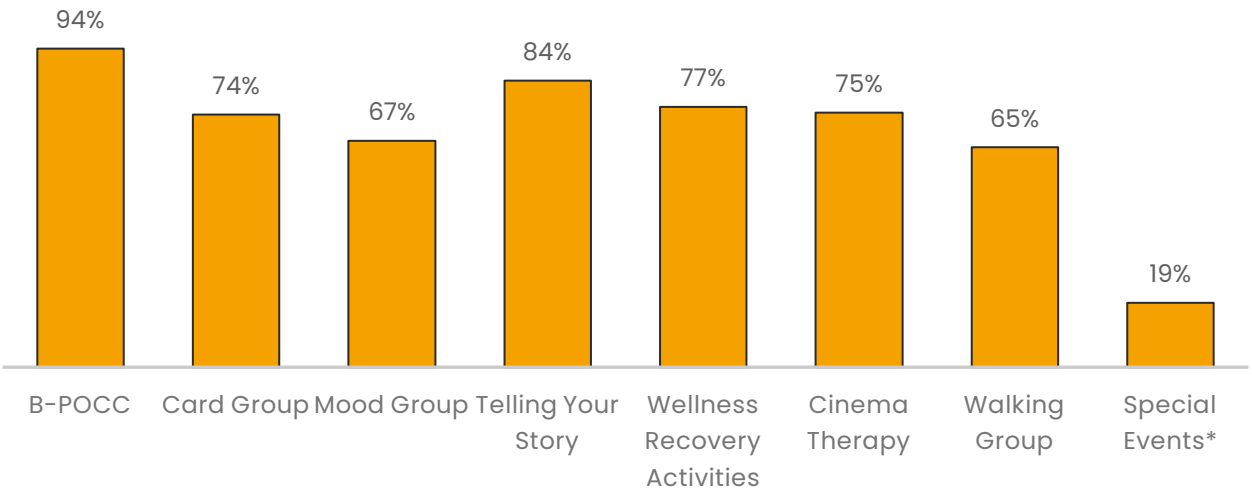


NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Quality Outcomes ("How well did we do it?")

Overall Group Engagement (Repeat Visits)

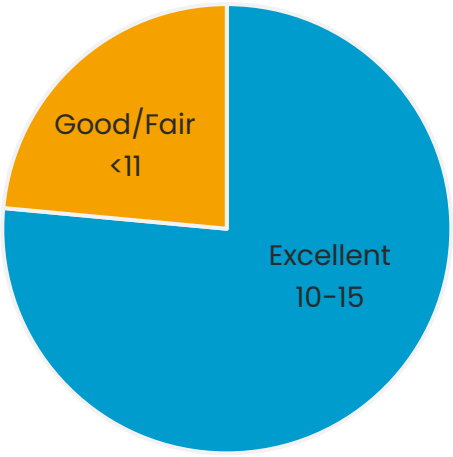
Jul '23 - Jun '24 (n=224)



*Special events, like social wellness mixers with different themes, attract a diverse mix of new attendees, which may result in lower level of returnees.

Interaction with a Wellness Team member in the Clinic Lobby

Jul '23 - Jun '24 (n=18)



71% n=52
Unduplicated participants who return for group events

Over 80% n=18
Participants rated the Lobby as Welcoming

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Measure	Definition	Data Source
# of Particpants Served	Total # of participants served	Wellness Recovery Group Attendance Tracker
Wellness Group Event Breakdown	Number of different types of groups (i.e. walking group, mood group, Telling Your Story group) convened	Wellness Recovery Group Attendance Tracker
# Group Events	Total number of meetings held	Wellness Recovery Group Attendance Tracker
# of Telling Your Story Participants	Total number of participants in all "Telling Your Story" meetings	Wellness Recovery Group Attendance Tracker
% of participants who return for group events	Of total number of participants, % who returned for more than one event or meeting	Wellness Recovery Group Attendance Tracker
% Overall Group Engagement (Repeat Visits)	Of total number of participants, % who returned for more than one event or meeting	Wellness Recovery Group Attendance Tracker
% Participants Rated the Lobby as Welcoming	Consumer perceptions of feeling welcomed entering the Clinic Lobby	Clinic Lobby Survey

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BMH RBA Report FY 2024

Reporting Period: July 2023 - June 2024

High School Health Center (HSHC)

Process Outcomes ("How much did we do?")

210

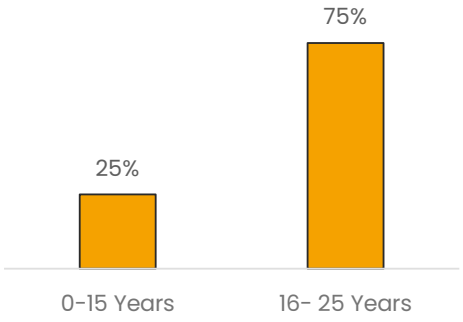
Clients Served

Program Description

The HSHC team provides mental health services on site at Berkeley High School; these services include individual and group therapy, crisis assessments, and drop in support. The program also hosts graduate students for training.

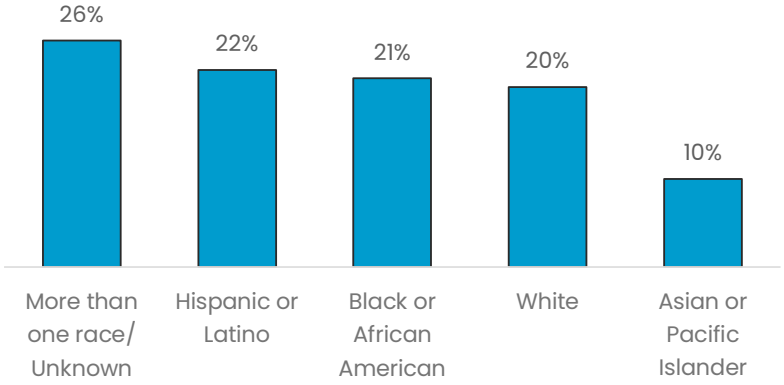
Demographics (Age)

Jul '23 - Jun '24 (n=210)



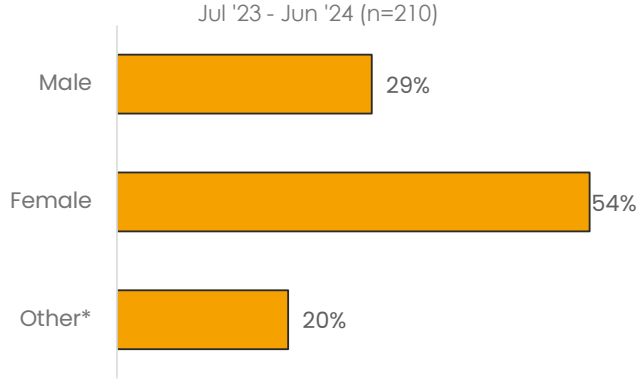
Demographics (Ethnicity)

Jul '23 - Jun '24 (n=210)



Demographics (Gender Identity)

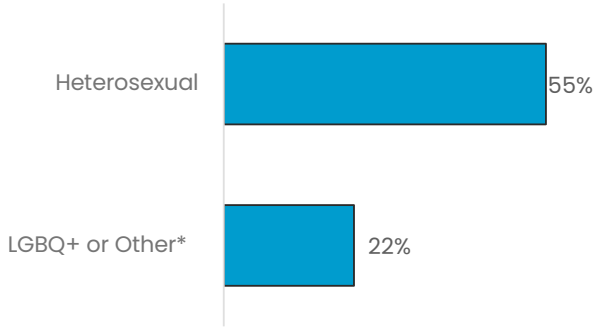
Jul '23 - Jun '24 (n=210)



*Other includes any identity that doesn't fit within the traditional male/female binary.

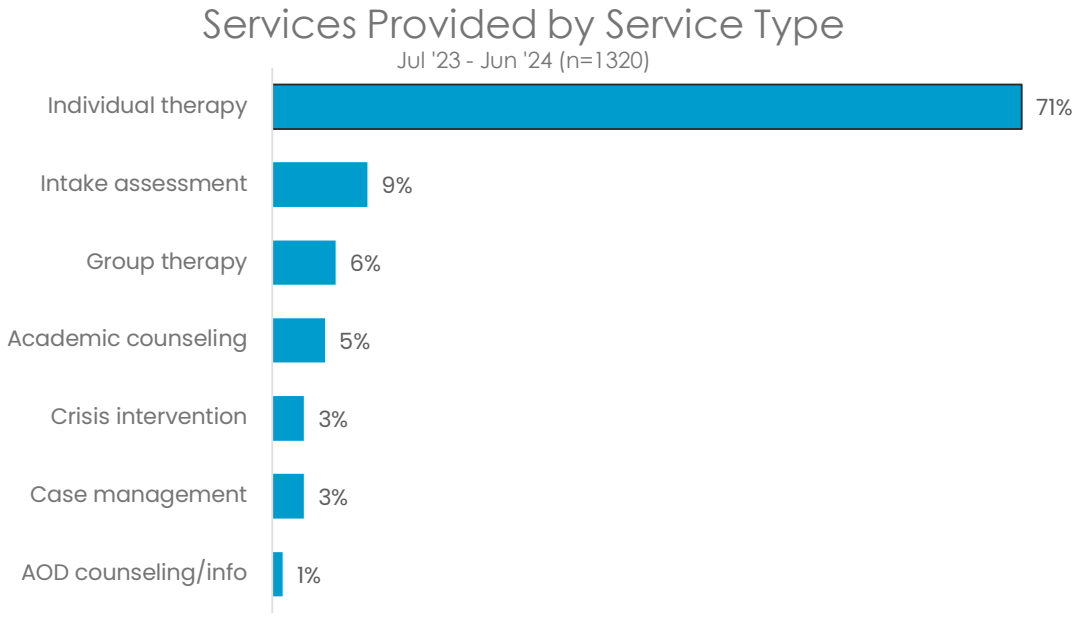
Demographics (Sexual Orientation)

Jul '23 - Jun '24 (n=210)

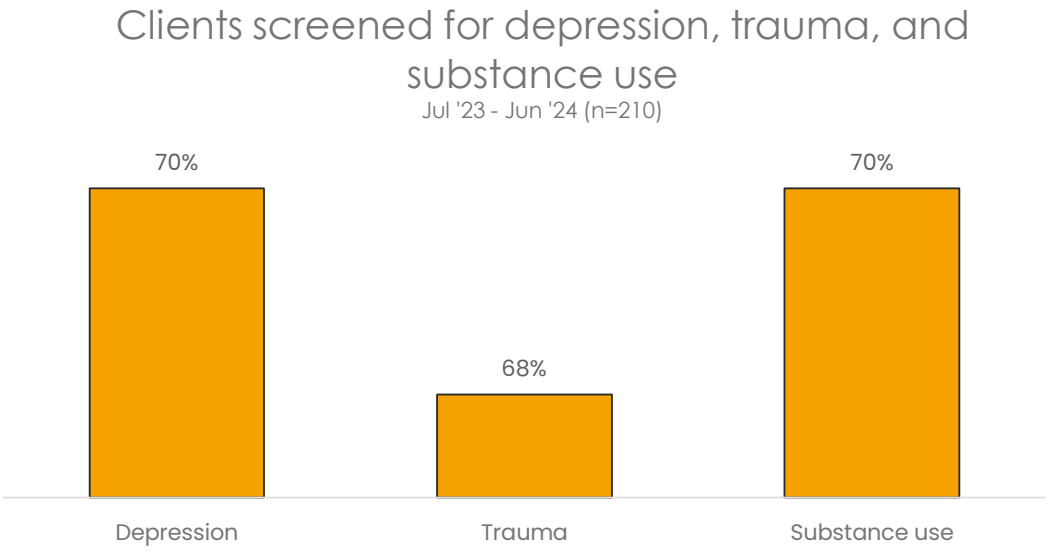


*LGBQ+ includes individuals who identify as lesbian, gay, bisexual, questioning, or other diverse sexual orientations. Other includes prefer not to answer or unknown.

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.



Note: Multiple services could be provided in one visit (e.g. crisis assessment and referral) so total services by type is greater than total encounters.



NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Quality Outcomes ("How well did we do it?")

1 in 17 Students received services
6.43% of the School Population (3,267 students)

Service Consistency

96% n=126
Students felt treated with respect

96% n=105
Students felt like there's an adult who cares about

98% n=118
Students felt heard about what they have to say

96% n=129
Report Easy Access to Needed Care

97% n=113
Able to Get Help When Needed

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Measure	Definition	Data Source
# clients served	Total clients served	NextGen
# of services provided by service type	# of services coded as behavioral_service with codes BHSV1-8. Key code accompanies NextGen data. Each incident could include more than one service provided.	NextGen
% clients screened for depression, trauma, and substance use	Percent of total clients that were recorded as having been screened for depression, trauma, and/or substance abuse at least one time during reporting period.	NextGen
% referrals to HSHC followed up within one week	Percentage of referrals that had 7 days or less between referral date and response date. Calculation reflects % of total referrals, not % of total clients.	Jotform Not presented due to delays in the reporting system
% of school population served	Unique clients served by HSHC divided by total student population of BHS and BTA.	DataQuest
% of clients satisfied with services	% of responses marked as "agree" or "strongly agree" for various survey questions. Note: these responses are from all students who accessed the health center and answered the survey, not just those who received mental health services.	Berkeley SBHC Client Survey
% of clients able to receive needed care	% of responses marked as "agree" or "strongly agree" for various survey questions. Note: these responses are from all students who accessed the health center and answered the survey, not just those who received mental health services.	Berkeley SBHC Client Survey

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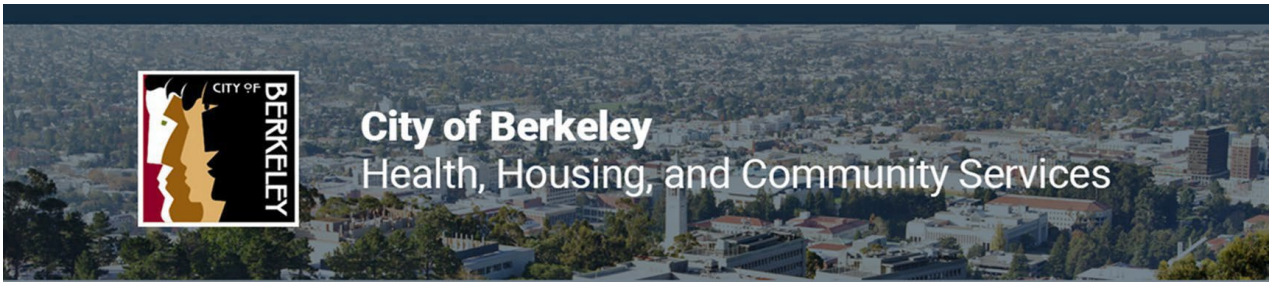
APPENDIX C

PREVENTION AND EARLY INTERVENTION

FY2021-2022 – FY2023-2024

THREE YEAR EVALUATION REPORT



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

Prevention and Early Intervention (PEI)

Fiscal Years 2021/2022 - 2023/2024

Three Year Evaluation Report

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:

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 MHSA State requirements, mental health jurisdictions are required to submit a PEI Evaluation Report to the Mental Health Services Oversight and Accountability Commission (MHSOAC) on an annual basis. Additionally, a Three-Year PEI Evaluation Report is due to the MHSOAC every three years. Regulations also require mental health jurisdictions to submit PEI Evaluation Reports to the State Department of Healthcare Services (DHCS). The PEI Evaluation Report is to 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 the MHSA Fiscal Year 2026 (FY2026) Annual Update, the Prevention and Early Intervention (PEI) Fiscal Years 2021-2022, 2022-2023, and 2023-2024 Three-Year Evaluation Report is due.

This Three-Year PEI Evaluation Report provides descriptions of currently funded MHSA services, and reports on program and demographic data during the reporting timeframe.

Impact Berkeley Initiative
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, and will soon be integrated into the remainder. This has 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. RBA outcomes during the reporting timeframe for the Community Education & Supports program are outlined in this report.

Results Based Accountability Evaluation for all BMH Programs
Through the FY19 MHSA Annual Update the Division hired Resource Development Associates (RDA) to conduct a Results Based Accountability (RBA) Evaluation for all programs across the Division. RDA worked with the Division from FY2021-FY2024 to implement the RBA research methodology, and evaluate program results. RBA outcomes during the reporting period are outlined in this report for the following MHSA PEI funded programs: Social Inclusion Project, and the High School Prevention Project.

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.

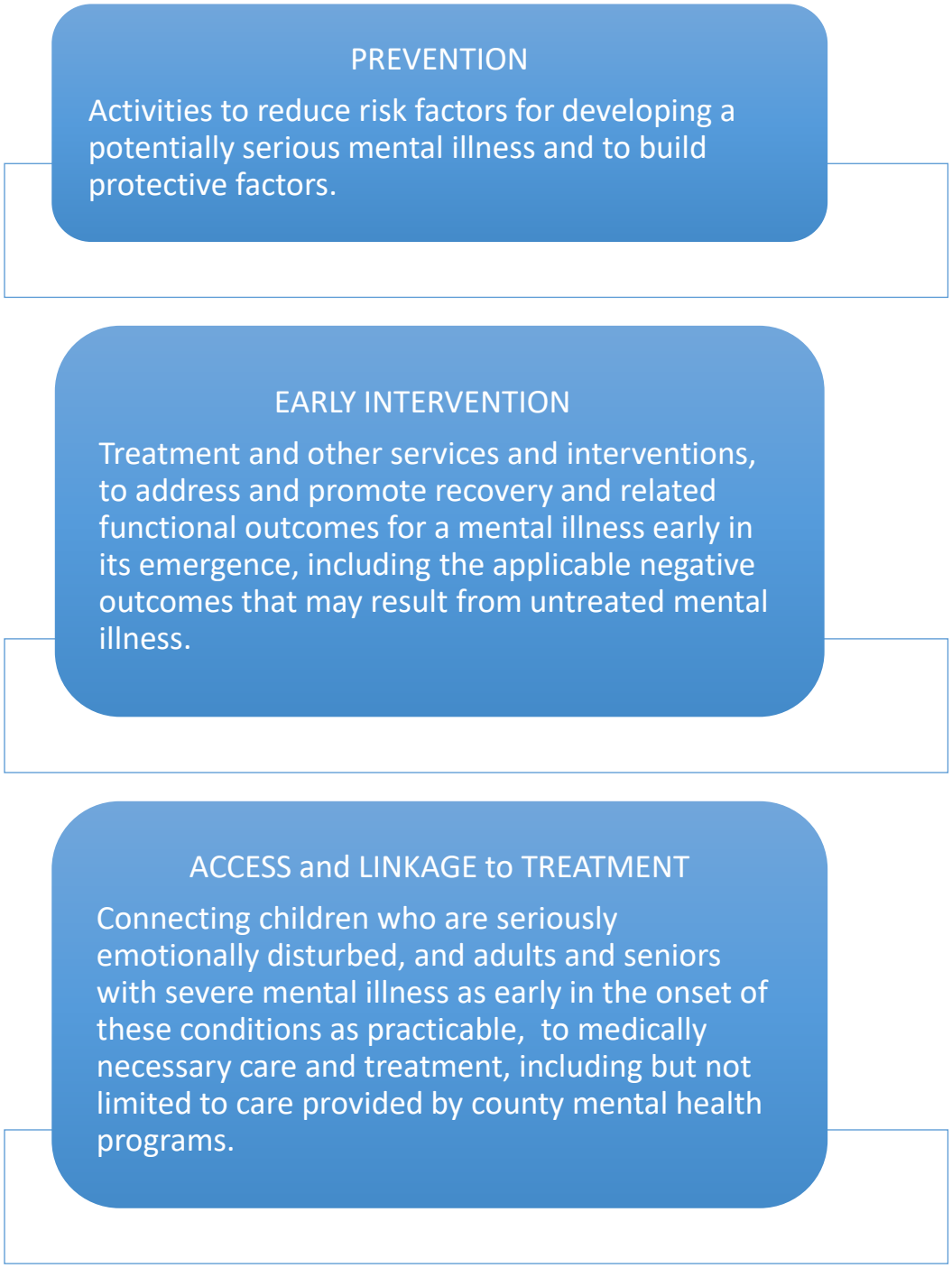
In April 2009, following a nine-month long Community Planning Process, the original City of Berkeley PEI plan was approved. Since the approval of the original plan, Three-Year Plans or Annual Updates outlining proposed PEI funding and programming have been developed and approved on an annual basis. Based 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:

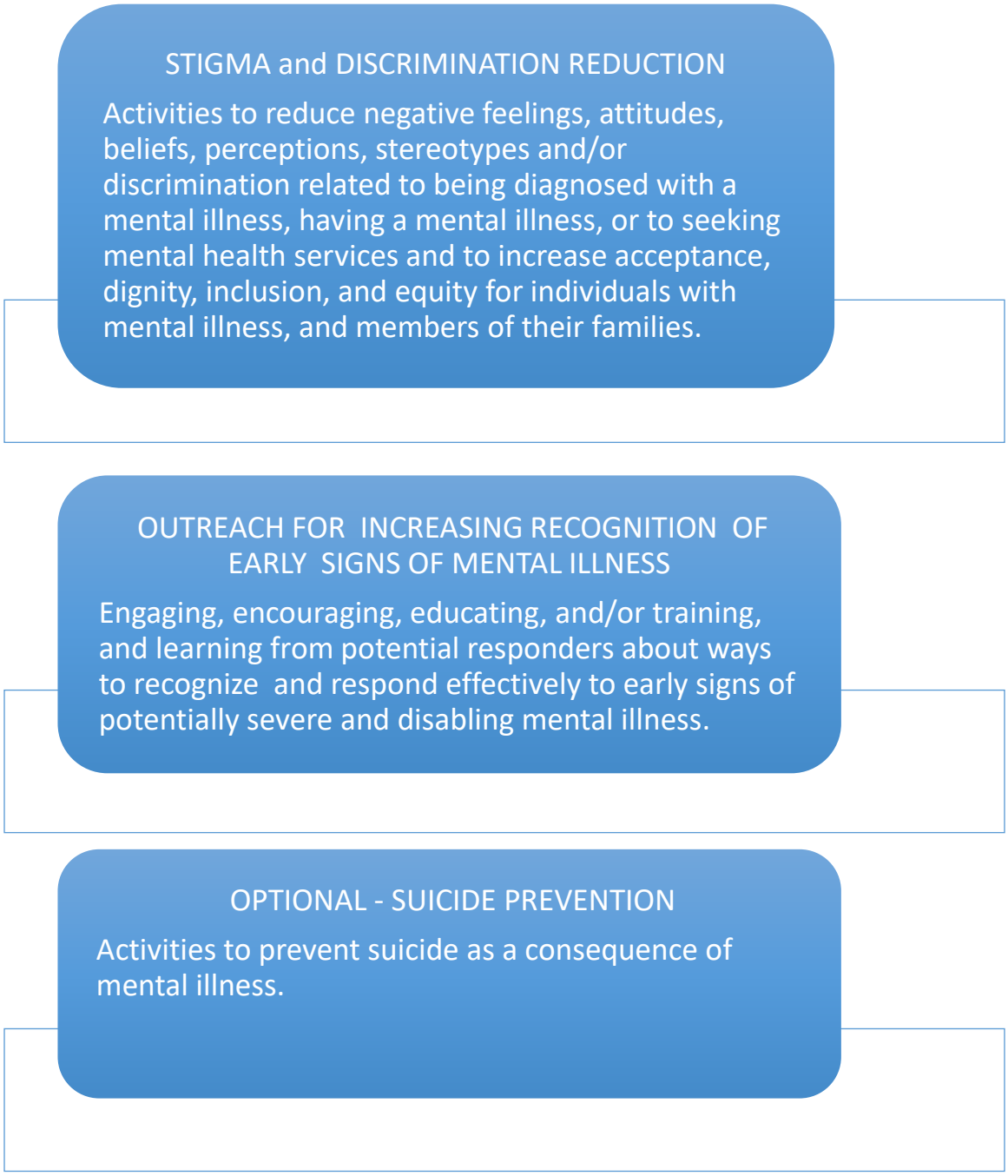
PEI Programs	Key Community Mental Health Needs	PEI Priority Populations
Behavioral-Emotional Assessment, Screening, Treatment and Referral – (BE A STAR) Program	➢ At-Risk Children, Youth and Young Adult Populations	• Children and Youth in Stressed Families • Children and Youth at Risk for School Failure • Underserved Cultural Populations

PEI Programs	Key Community Mental Health Needs	PEI Priority Populations
Supportive Schools Program Community Based Child & Youth Risk Prevention Program		
High School Youth Prevention Project Mental Health Peer Mentor Program Dynamic Mindfulness Program African American Success 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
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
Homeless Outreach & Treatment Team (HOTT)* Specialized Care Unit	➢ 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
Social Inclusion	➢ Stigma and Discrimination ➢ Psycho-social Impact of Trauma	• Trauma Exposed Underserved Cultural Populations

*This program was not in operation in FY2022

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 more recent PEI State Regulations, Mental Health jurisdictions are to utilize PEI funds to implement 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. Programs or strategies within programs can also be combined. 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 should 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.

PEI Regulations, also include 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	➢ 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

PROGRAM TYPE	PROGRAM DEFINITION	PROGRAM AND DATA COLLECTION REQUIREMENTS
	applicable negative outcomes that may result from untreated mental illness.	➢ 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, 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.	➢ Collect the number of individuals reached by activity (e.g., # who participated in each service or activity) ➢ 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

PROGRAM TYPE	PROGRAM DEFINITION	PROGRAM AND DATA COLLECTION REQUIREMENTS
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 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 PEI PROGRAMS

Since the release of the 2018 PEI Regulations, the City of Berkeley has regularly reviewed PEI programs to ensure they fit within the required program definitions. As a result, PEI funded programs were re-classified from the previous construct. Outlined below is a listing of the PEI program type, definition and the City of Berkeley programs that were funded during the timeframe of this report:

PEI Program Type	Program Definition	City of Berkeley PEI Program(s)
Prevention	A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors.	• Mental Health Promotion Campaign • High School Prevention • DMIND • MEET • African American Success
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.	• High School Prevention • Be A Star • Community-based Child & Youth Program • DMIND • MEET • African American Success • Supportive Schools • Community Education and Supports • Specialized Care Unit
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.	• Mental Health First Aid (non-MHSA funded program)
Stigma and Discrimination	Direct 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.	• Social Inclusion
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	• High School Prevention • Specialized Care Unit

PEI Program Type	Program Definition	City of Berkeley PEI Program(s)
	medically necessary care and treatment, including but not limited to care provided by county mental health programs.	
OPTIONAL Suicide Prevention	Activities to prevent suicide as a consequence of mental illness.	• CalMHSA PEI Statewide Project

Beginning January 1, 2020, per Senate Bill (SB) 1004, Welfare and Institutions Code (WIC) 5840.7 (a) directed the Mental Health Oversight and Accountability Commission (MHSOAC) to establish priorities for the use of MHSA PEI funds. Section 5840.7 (d)(1) states that mental health jurisdictions shall, through their MHSA Three-Year Program and Expenditure Plans and Annual Updates, focus use of their PEI funds on the Commission-established priorities or other priorities as determined through their respective, local stakeholder processes. If a mental health jurisdiction chooses to focus on priorities other than or in addition to those established by the Commission, "the plan shall include a description of why those programs are included and metrics by which the effectiveness of those programs is to be measured" (WIC Section 5840.7 (d)(1)).

Current MHSOAC priorities for the use of PEI funding are as follows:

- Childhood trauma prevention and early intervention to deal with the early origins of mental health needs;
- Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan;
- Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college;
- Culturally competent and linguistically appropriate prevention and intervention, including community defined evidence practices (CDEPs);
- Strategies targeting the mental health needs of older adults;
- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

In order to meet the requirements, each mental health jurisdiction is required to show in the PEI component of the Three-Year Plan or Annual Update the following:

- Which specific PEI priorities the mental health jurisdictions plan addresses, an estimate of the share of PEI funding allocated to each priority, and an explanation of how stakeholder input contributed to those allocations;

- If the mental health jurisdiction has determined to pursue alternative or additional priorities to those listed in Section 5840.7(a), how the determinations were made through its stakeholder process;
- For any alternative or additional priority identified by the mental health jurisdiction, what metric or metrics relating to assessment of the effectiveness of programs intended to address that priority the county will measure, collect, analyze, and report to the Commission, in order to support statewide learning.

Many PEI projects meet multiple established priorities. Per PEI regulations, outlined below is a crosswalk of the City of Berkeley PEI Programs with the MHSOAC PEI Priorities for programs during the reporting timeframe:

CITY OF BERKELEY PEI PROGRAMS	PEI PRIORITIES
• Be A Star • Community-based Child & Youth At Risk Program • Supportive Schools	Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.
• High School Youth Prevention Project • Mental Health Peer Mentor Program • Dynamic Mindfulness Program • Specialized Care Unit • African American Success Project	Youth Engagement and Outreach Strategies that target secondary school and transition age youth with a priority on partnership with college mental health programs, and transition age youth not in college. Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis. Culturally competent and linguistically appropriate prevention and intervention, including community defined evidence practices (CDEPs).
• Mental Health Promotion Campaign • Social Inclusion • Community Education & Supports	Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs). Youth Engagement and Outreach Strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college. Strategies targeting the mental health needs of older adults.

This PEI Three-Year Evaluation Report documents program measures and demographic elements to the extent data was available.

PEI FUNDED CHILDREN AND YOUTH AND TAY SERVICES

Per MHSA regulations 51% of PEI funds are to be used on services and supports for Children, Youth, and TAY. Small counties, of which the City of Berkeley is considered, may elect to forego this regulation as long as a community vetted, locally approved justification is provided as to why children and youth services are funded at a lower level.

Since the initial PEI Plan, the City of Berkeley has allocated more than 51% of PEI funds to services and supports for children, youth and TAY as the majority of PEI funds has been utilized to serving these populations. All City of Berkeley PEI programs in FY2025 will provide services for children and youth and/or Transition Age Youth. Five programs are in the Berkeley Unified School District (BUSD).

Programs and services funded with PEI funds that were approved to be continued in FY2025 through the previously approved Three-Year Plan, are outlined below by PEI Program type, along with FY2023 data.

Prevention Program

Prevention Program - A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors.

Through the FY2022 Annual Update the City of Berkeley funded the following Prevention initiative:

Mental Health Promotion Campaign

As a result of the impact of the pandemic and public input around the overwhelming need for mental health supports in the community, the Division proposed through the FY2022 Annual Update to allocate PEI funds for a community Mental Health Promotion Campaign to support the wellness and self-care of Berkeley residents. The Division will partner with the community and may consider using a social marketing firm to develop and implement the campaign.

PEI Goals: The goal of this campaign is to increase prevention efforts and response to early signs of emotional and behavioral health problems.

PEI Priority: Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs).

It is envisioned that this campaign will be implemented in FY2026 and the Division will continue to work with the community to determine how to best promote mental health and wellness in Berkeley.

Early Intervention Programs

Early Intervention Program - Provides 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.

During this reporting timeframe the City of Berkeley Early Intervention programs have been as follows:

Early Childhood Health and Wellness Program
The Early Childhood Health and Wellness Program (formerly the Be A Star project) has been a collaboration with the City of Berkeley's Public Health Department since the initial PEI Plan. This program provides a coordinated system in Berkeley 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, state-subsidized Early Childhood Development Centers; and area pre-schools and schools. 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.

PEI Priority: Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.

In FY2022, a total of 1,654 children were screened through this program (183 at BUSD, and 1,471 at the Help Me Grow sites) however data was not collected on all individuals screened. Only Race/Ethnicity data was collected on a subset the 183 children screened at BUSD as follows:

DEMOGRAPHICS N = 183

- **Age Category**
  0 – 15 (Children Youth) – 100%
- **Race**
  Asian – 19%
  Black or African American – 25%
  White – 20%
  More than one Race – 8%
  Other – 4%
- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Mexican/Mexican-American/Chicano – 24%
- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  Declined to Answer, or Unknown – 100%
- **Primary Language**
  Declined to Answer, or Unknown – 100%
- **Disability**
  Declined to Answer, or Unknown – 100%
- **Gender: Assigned Sex at Birth**
  Declined to Answer, or Unknown – 100%

<u>Program Successes:</u>

- On-site technical assistance visits to all Berkeley Help Me Grow providers resumed and the visits went well.
- The program conducted 1,654 ASQ developmental screenings in Berkeley.

- Berkeley Unified School District (BUSD) referred a total of 53 preschool students and the Help Me Grow providers referred 94 infants/children.
- Approximately 78% of all Help Me Grow referrals reached their goals.

Program Challenges:

- There continued to be an impact of the COVID-19 pandemic on program services which decreased the number of screenings that were conducted.
- Staffing changes/turnovers at the Berkeley Help Me Grow sites impacted the continuity of the partnership with the program.
- The Help Me Grow sites do not collect race/ethnicity, language spoken data, or gender; and BUSD does not collect specific ethnicity data, language spoken, or gender for all students who received an ASQ.
- There was a delay in getting the annual data for the Help Me Grow sites.

In FY2023, a total of 2,339 children were screened through this program (255 at BUSD, and 2,084 at the Help Me Grow sites) however data was not collected on all individuals screened. Although all 2,339 of the individuals that were either screened or were screened and received services, were aged 0-15, the other data elements were only collected on the 255 children screened at BUSD as follows:

DEMOGRAPHICS N = 255

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

- **Age Category**
  0 – 15 (Children Youth) – 100%
- **Race**
  American Indian or Alaska Native – *
  Asian – 17%
  Black or African American – 30%
  White – 19%
  More than one Race – *
- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Mexican/Mexican-American/Chicano – 25%
- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  Declined to Answer, or Unknown – 100%
- **Primary Language**
  English – 51%
  Spanish – 18%
  Declined to Answer, or Unknown – 31%
- **Disability**
  Declined to Answer, or Unknown – 100%

- **Gender: Assigned Sex at Birth**
  Male – 44%
  Female – 56%

Program Successes:

- On-site technical assistance visits to all Berkeley Help Me Grow providers continued and went well.
- 2,339 ASQ developmental screenings were conducted in Berkeley, BUSD preschools and Berkeley Help Me Grow pediatric provider sites combined.
- Berkeley Help Me Grow sites conducted a total of 2,084 screenings, across all sites averaging a 20% increase in children screened from the previous year.
- Referrals to resources & follow-up: BUSD referred a total of 64 preschool students and Help Me Grow providers referred 94 infants/children.
- Approximately 72% of all Help Me Grow referrals had their goals met.

Program Challenges:

- The Early Childhood Health and Wellness Public Health Nurse vacancy occurring in May 2023 and staffing vacancies/turnovers at the Berkeley Help Me Grow provider sites impacted the continuity of services, with the need to introduce/train/orient provider sites to ASQ implementation, tracking, and resource referrals to clients.
- Help Me Grow sites did not collect race/ethnicity, language spoken data, or gender; BUSD does not collect specific ethnicity data, gender, sexual orientation for this age group. BUSD does collect language spoken students that are not reflected on this PEI Report, for example, data reflected Arabic, Vietnamese, Russian, Mandarin, Cantonese, Urdu, and other languages not on this report form.
- There were delays in receiving the annual infographic data for Help Me Grow sites. The Help Me Grow Collaborative collects and analyzes the data from all Help Me Grow sites in Alameda County so it takes time to collect and synthesize the data and to receive the Berkeley specific data.

In FY2024, a total of 2,596 children were screened through this program (207 at BUSD, and 2,389 at the Help Me Grow sites) however data was not collected on all individuals screened. Although all 2,389 of the individuals that were either screened or were screened and received services, were aged 0-15, the data elements listed below show the demographics of the 207 children screened at BUSD as follows:

DEMOGRAPHICS N = 207

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  0 – 15 (Children Youth) – 207
- **Race**
  Asian/American Indian or Alaska Native – 40
  Black or African American – 57
  White – 37
  More than one Race – 20
- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Mexican/Mexican-American/Chicano – 53
- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  Declined to Answer, or Unknown – 154
- **Primary Language**
  English – 99
  Spanish – 40
  Declined to Answer, or Unknown – 68
- **Disability**
  Declined to Answer, or Unknown – 207
- **Gender: Assigned Sex at Birth**
  Male – 88
  Female – 119

Program Successes:

- A new Public Health Nurse (PHN) started in October 2023, coming with many years of experience working with young children and families, school nurse experience, and PHN case management for children ages 0-3 years old in foster care. The PHN quickly connected with the Alameda County Help Me Grow Collaborative and the Medical Home Project's Special Needs Committee and became an active representative for Berkeley in the Help Me Grow Collaborative and the Special Needs Committee. Her experience in early childhood and resource navigation were assets in her prevention and early intervention work with providers and families with young children.
- On-site technical assistance visits to all Berkeley Help Me Grow providers continued into this year and went well.
- Conducted 2,596 developmental screenings through the Ages and Stages Questionnaire (ASQ) and the Modified Checklist for Autism in Toddlers (MCHAT) in Berkeley, including BUSD preschools and Berkeley Help Me Grow pediatric provider sites combined.
- A total of 150 referrals were made for resources to support following areas identified from the screenings:

- Communication
- Community resources, basic needs, child care
- Parent Support/ Parent/Child Relationship
- General Developmental Guidance
- Fine and Gross Motor Skills
- Sensory Skills
- Autism/ADHD Diagnosis
- Behavioral Concerns
- Trauma/Childhood Event
- Mental Health

Program Challenges:

- The Help Me Grow Collaborative collected and analyzed the data from all HMG sites in Alameda County, not just Berkeley, so it took time to collect and synthesize the data and to receive the Berkeley specific data.
- Help Me Grow sites did not collect race/ethnicity, language spoken data, or gender; BUSD did not collect specific ethnicity data, gender identity, sexual orientation for this age group, nor all languages spoken.

Beginning in FY2025, the MHSA PEI funding for this program was discontinued, as the Public Health Division transitioned these program activities to the Maternal, Child and Adolescent (MCAH) Program.

Community-Based Child & Youth at Risk Prevention Program

Through FY2022, the Community-Based Child & Youth Risk Prevention program targeted children (aged 0-5) who were impacted by multiple risk factors including trauma, family or community violence, familial distress, and/or family substance abuse, (among other issues). A BMH clinician served as the Mental Health Consultant on this project providing information, services and supports to teachers and parents at the YMCA Head Start program in South Berkeley. Services included individual case consultation for teachers and parents, group consultations, classroom observations and interventions, assessments, brief treatment, and referrals to other resources as needed. The main goals were to reduce risk factors or other stressors, and promote positive cognitive, social, and emotional well-being. This program served approximately 50 Children & Youth a year.

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

PEI Priority: Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.

This program was discontinued in April 2022 when the BMH Mental Health Consultant received a promotion to a different position. Once that position was vacated the YMCA

Head Start program decided to create an internal staff position for a Mental Health Specialist.

In FY2022, 41 children were served through this program. Demographics on those served is as follows:

DEMOGRAPHICS N = 41

- **Age Category**
  0 – 15 (Children Youth) – 100%
- **Race**
  Asian – 5%
  Black or African American – 44%
  White – 2%
  Other – 12%
  More than one Race – 2%
- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Declined to Answer, or Unknown – 35%
- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  Declined to Answer, or Unknown – 100%
- **Primary Language**
  Declined to Answer, or Unknown – 100%
- **Disability**
  Declined to Answer, or Unknown – 100%
- **Gender: Assigned Sex at Birth**
  Declined to Answer, or Unknown – 100%

Program Successes:

- Returned to in-person Mental Health Consultations in the summer of 2021 which enabled the provision of in-person classroom consultation and direct interventions with children and teachers; increased visibility and interactions with parents; and helped to improve the overall collaborations with administrators, teachers, and parents.
- Participated in-person in meetings with parents, teachers and administrators to provide direct consultation around behavior management in the classroom and at home.
- Modeled parent engagement strategies for teachers, advocates and staff. Modeling how to have difficult conversations using a trauma-informed perspective is essential to mental health consultations.
- Provided in vivo conflict management among teachers and with parents as well as provided case management and support as conflicts occurred.

- Return to in-person care also enabled the Mental Health Consultant to be able to observe classrooms and child behaviors over a period of time at different times of the day which allowed for better overall clinical understanding of the children's behaviors and needs, and improved their ability to make recommendations for services and classroom interventions.

Program Challenges:

- The onsite manager at the YMCA resigned mid-year, which made collaborating with the teachers and classroom staff challenging.
- There were center and classroom closures due to flooding in the infant room.
- COVID-19 pandemic exposures continued to impact the center and caused temporary classroom closures that created disruptions to the continuity of care.

In FY2023, this program was discontinued as the YMCA Head Start program created a staff position for an internal Mental Health Specialist.

Supportive Schools Program

Through this program leveraged MHSA PEI funds support the provision of mental health prevention and early intervention services at each of the Elementary Schools in Berkeley. Services include: outreach; mental health programming; classroom; group; one-on-one psycho-social education and support; and consultation with parents and/or teachers.

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.

PEI Priority: Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.

Program results during the reporting timeframe were as follows:

In FY2022 Early Intervention Services were provided at each of the BUSD elementary schools. BUSD sub-contracted with local agencies to provide early intervention services

based upon the standard of evidence-based practices. Bay Area Community Resources (BACR), Child Therapy Institute (CTI), and Lifelong Medical (Lifelong) were subcontracted to provide services at BUSD elementary schools.

BACR provided services to improve emotional functioning and success in school and life, including individual and group therapy, family consultation, conflict resolution/restorative justice, suicide prevention, check-in/check-out, crisis intervention, and classroom presentations. Additionally, BACR participated in weekly Coordination of Services (COST), Student Success Team (SST), and Individualized Education Program (IEP) meetings for students, providing mental health and trauma informed perspectives. BACR consulted with staff on many issues and provided trauma informed coaching for teachers needing support. BACR also made referrals to outside providers, parenting classes/support groups, crisis hotlines, and other programs. Due to the continuation of the impacts of the COVID-19 pandemic, BACR also provided resource networking and support for families in navigating the public health crisis.

Lifelong Medical Provided a Licensed Clinical Social Worker (LCSW) and interns who provided individual counseling to students, family counseling, and mental health consultation to caregivers and school staff. Full-class support was provided in several classrooms. The full class support was tailored to the needs of the teacher and class and consisted of community building, regulation strategies such as Zones of Regulation, and social emotional learning.

Supports for each school per each service provider, and numbers served in FY2022 were as follows:

Elementary School	Agency/Provider	Number of Students Served
• Cragmont • Emerson • John Muir • Malcolm X • Oxford • Ruth Acty • Sylvia Mendez • Thousand Oaks	Bay Area Community Resources (BACR)	420
• Bay Area Arts Magnet (BAM) • Washington	Child Therapy Institute	55
• Rosa Parks	Lifelong Medical Care	116
Total		**591**

Demographic data provided by BUSD on 591 students that were served through this project in FY2022, is outlined below:

DEMOGRAPHICS N = 591

- **Age Category**
  0 – 15 (Children Youth) – 100%
- **Race**
  American Indian or Alaska Native - 3%
  Asian – 6%
  Black or African American – 25%
  Native Hawaiian/Pacific Islander - <1%
  White – 47%
  More than one Race – 20%
  Declined to Answer (or Unknown) - 1%
- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Unspecified Hispanic or Latino/Latina/Latinx - 34%
  South American – <1%
  Declined to Answer (or Unknown) - 1%
- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  Black or African American - 15%
  Asian Indian/South Asian - <1%
  Chinese - 1%
  Eastern European - 27%
  European – 1%
  Filipino - 1%
  Other - 4%
  More than one Ethnicity - 8%
  Declined to Answer, or Unknown – 7%
- **Primary Language**
  English – 25%
  Spanish – 3%
  Declined to Answer, or Unknown – 72%
- **Sexual Orientation**
  Declined to Answer, or Unknown – 100%
- **Disability**
  Communication Domain - <1%
  Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia) - 5%
  Declined to Answer, or Unknown – 8%

- **Veteran Status**
  No – 100%

- **Gender: Assigned Sex at Birth**
  Male – 15%
  Female – 14%
  Declined to Answer, or Unknown – 71%

- **Current Gender Identity**
  Male – 53%
  Female – 44%
  Transgender - <1%
  Genderqueer - <1%
  Other Gender Identity – 2%

In FY2023 Early Intervention Services were provided at each of the BUSD elementary schools. BUSD sub-contracted with local agencies to provide early intervention services based upon the standard of evidence-based practices. Bay Area Community Resources (BACR), Child Therapy Institute (CTI), and Lifelong Medical (Lifelong) were subcontracted to provide services at BUSD elementary schools.

Supports for each school per each service provider, and numbers served in FY2023 were as follows:

Elementary School	Agency/Provider	Number of Students Served
• Cragmont • Emerson • John Muir • Malcolm X • Oxford • Ruth Acty • Sylvia Mendez • Thousand Oaks	Bay Area Community Resources (BACR)	644
• Bay Area Arts Magnet (BAM) • Washington	Child Therapy Institute	37
• Rosa Parks	Lifelong Medical Care	133
Total		814

Information on services provided, successes, and challenges with each sub-contractor are outlined below:

Bay Area Community Resources (BACR): Provided services to improve emotional functioning and success in school and life, including individual and group therapy, family consultation, conflict resolution/restorative justice, suicide prevention, check-in/check-

out, crisis intervention, and classroom presentations. BACR used many different therapy modalities as well as classroom support to develop skills and health. Additionally, the BACR Counselor participated in weekly Coordination of Services (COST), Student Success Team (SST), and Individualized Education Program (IEP) meetings for students, providing mental health and trauma informed perspectives. BACR consulted with school staff on many issues and provided trauma informed coaching for teachers needing support. BACR also made referrals to outside providers, parenting classes/support groups, crisis hotlines, and other programs.

Program Successes:

- A total of 644 individuals were served.
- 90% of youth in therapy showed improved emotional functioning and resiliency through
- the CANS and/or Stages of Change scale.
- 85% of students receiving classroom education reported gaining skills or knowledge.
- 95% of Caregivers reported that they are satisfied with the services their children/family
- received.
- 100% of school personnel reported that BACR is a great partner and supports their goals.

Program Challenges:
The biggest challenge was the increase in cost to fund the program. These increases required the district to make cuts in other programming areas, as well as moving resources around to be able to continue providing ongoing services at the same rate as in the previous year. An additional challenge was ensuring that each school site had an equivalent 1.0 FTE BACR counselor at all BUSD elementary schools, as there was a shortage of credentialed therapist and counselors and BACR had to compete with other agencies for employees.

Child Therapy Institute (CTI): Continued providing services at Bay Area Arts Magnet and Washington Schools.

Program Successes:
CTI staff met with 37 students individually and in groups.

Program Challenges:
There were few direct challenges, however, a significant challenge is the increase in the costs to fund the program. These increases have required the district to make cuts in other programming areas, as well as to move resources around to be able to continue providing ongoing services at the same rate as in the previous year.

Lifelong Medical: A Licensed Clinical Social Worker (LCSW) and interns provided individual counseling to students, family counseling, and mental health consultation to

caregivers and school staff. Full-class support was provided in several classrooms. The full class support was tailored to the needs of the teacher and class and consisted of community building, regulation strategies such as Zones of Regulation, and social emotional learning.

Program Successes:
A total of 52 students received individual counseling and 81 students participated in group services. The Family Resource Center (FRC) was a valuable resource and support to children, families, and school staff during the reporting timeframe. Through individual counseling, groups, and as-needed support, the FRC staff worked hard to help make Rosa Parks a place of healing and joy. The Rosa Parks community experienced the ripple effects of global pandemic and many losses in the community. FRC created spaces for students to experience a sense of belonging and connection. FRC helped children develop regulation and coping strategies to help them manage their emotions so that they could be more present in the classroom for learning. FRC developed deep relationships with students in order to help guide them in the process of making sense of the many scary and sad experiences they have had over the past few years. Additionally, FRC provided consultation and referrals to mental health services in the community.

Program Challenges:
There were few direct challenges, however, a significant challenge was the increase in the cost to fund the program. These increases required the district to make cuts in other programming areas, as well as moving resources around to be able to continue providing ongoing services at the same rate as in previous year.

Demographic data provided by BUSD on 814 students that were served through this project in FY2023, is outlined below:

DEMOGRAPHICS N = 814
*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

- **Age Category**
  0 – 15 (Children Youth) – 100%
- **Race**
  American Indian or Alaska Native - 3%
  Asian – *
  Black or African American – 26%
  Native Hawaiian/Pacific Islander - *
  White – 35%
  More than one Race – 26%
  Declined to Answer (or Unknown) - *

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Mexican/Mexican American – Chicano - *
  Other – 29%
  Declined to Answer (or Unknown) - *

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  African - *
  Asian Indian/South Asian - *
  Chinese - *
  Eastern European - *
  European – *
  Middle Eastern - *
  Other – 13%
  More than one Ethnicity - *
  Declined to Answer, or Unknown – 55%

- **Primary Language**
  English – *
  Spanish – 13%
  Other Language – *
  Declined to Answer, or Unknown – 81%

- **Sexual Orientation**
  Declined to Answer, or Unknown – 100%

- **Disability**
  No Disability – *
  Declined to Answer, or Unknown – 96%

- **Veteran Status**
  No – 100%

- **Gender: Assigned Sex at Birth**
  Male – 50%
  Female – 40%
  Declined to Answer, or Unknown – *

- **Current Gender Identity**
  Male – 44%
  Female – 40%
  Another Gender Identity – *
  Declined to Answer, or Unknown – 17%

In FY2024 Early Intervention Services were provided at each of the BUSD elementary schools. BUSD sub-contracted with local agencies to provide early intervention services based upon the standard of evidence-based practices. Bay Area Community Resources (BACR), Child Therapy Institute (CTI), and Lifelong Medical (Lifelong) were subcontracted to provide services at BUSD elementary schools.

Supports for each school per each service provider, and numbers served in FY2024 were as follows:

Elementary School	Agency/Provider	Number of Students Served
• Cragmont • Emerson • John Muir • Malcolm X • Oxford • Ruth Acty • Sylvia Mendez • Thousand Oaks	Bay Area Community Resources (BACR)	331
• Bay Area Arts Magnet (BAM) • Washington	Child Therapy Institute	65
• Rosa Parks	Lifelong Medical Care	40
Total		**436**

Information on services provided, successes, and challenges with each sub-contractor are outlined below:

Bay Area Community Resources (BACR): Provided services to improve emotional functioning and success in school and life, including individual and group therapy, family consultation, conflict resolution/restorative justice, suicide prevention, check-in/check-out, crisis intervention, and classroom presentations. BACR used many different therapy modalities as well as classroom support to develop skills and health.

Additionally, the BACR Counselor participated in weekly Coordination of Services (COST), Student Success Team (SST), and Individualized Education Program (IEP) meetings for students, providing mental health and trauma informed perspectives. BACR consulted with school staff on many issues and provided trauma informed coaching for teachers needing support. BACR also provided referrals and care coordination to outside providers, parenting classes/support groups, crisis hotlines, and other programs.

<u>Program Successes:</u>
In FY2024 BACR provided the following services:

- Trauma-Informed individual and group therapy, family and school support;
- Groups of social skills and coping with issues such as grief and parental separation;
- Crisis support and mental health check-ins;
- Targeted support to students with school refusal and attendance issues;
- Classroom presentations on socio-emotional topics, identity, empathy, accepting differences conflict resolution, skill-building in class and on the yard;

- Parent coaching, consultation and community resources, including pediatricians and outside providers;
- Collaborative coaching with teachers to enhance the positive learning environment;
- Restorative Justice sessions;
- Coordinated services with school staff and external providers;
- Established linkages to vital community resources.

In addition, BACR provided Classroom/School-wide Presentations and small groups: 503 total of number of attendees for classroom presentations and 642 for groups in subject matters of:

- Social skills;
- Coping with parental separation;
- Anxiety;
- Empathy;
- Identification of feelings.

Program Challenges:
The biggest challenge continued to be the increase in cost to fund the program. These increases required the district to make cuts in other programming areas, as well as moving resources around to be able to continue providing ongoing services at the same rate as in the previous year.

Child Therapy Institute (CTI):

Program Successes:
CTI continues to provide quality services and supports for students at Berkeley Arts Magnet (BAM) and Washington Elementary School. CTI staff meets with students individually and in groups providing.

Program Challenges:
There were few direct challenges, however, a significant challenge continued to be the increase in the costs to fund the program. These increases have required the district to make cuts in other programming areas, as well as to move resources around to be able to continue providing ongoing services at the same rate as in the previous year.

Lifelong Medical:
A Licensed Clinical Social Worker (LCSW), two Master of Social Work (MSW) interns, and one Marriage and Family Therapist (MFT) trainee provided individual counseling to students, family counseling, and mental health consultation to caregivers and school staff. Several Social Skills groups were run by the LCSW, interns, and in collaboration with a learning specialist. These groups were tailored to the needs of the individuals in each group and provided community building, social skills practice, regulation strategies, and support to many students across all grade levels. Full-class support was

provided in several classrooms. School staff and students were also supported with crisis support/suicide assessment and consultation as needed throughout the year. The LCSW provided consultations with caregivers and referrals to mental health services in the community.

The Family Resource Center (FRC) Supervisor regularly attended COST meetings at Rosa Parks. The FRC Supervisor and interns attended staff meetings, SST and IEP meetings. All counselors regularly collaborated with teachers, families, classroom aides and staff in the afterschool program. One of the FRC interns participated and re-started a Rainbow Families group (for families who identify as LBGTQ and allies). FRC staff are integrated into the school community.

Program Successes:
This was a successful year which included building relationships and fostering a sense of belonging and community. The LCSW, Clinical Director, and other Lifelong staff provided training to the MSW interns and MFT trainee. Trainings including trauma responsive care, child therapy models, regulation strategies including Zones of Regulation, Cognitive-Behavioral Therapy, grief, working with teachers and caregivers, and many other topics. There was a particular focus on training in anti-racist practice. Lifelong hired a consultant who specialized in cross-cultural clinical practice and anti-racist counseling practice that provided multiple trainings and staff consultation. This support was particularly important and helped FRC staff intervene when there were multiple incidents of racism that impacted students and school staff.

The LCSW and counseling interns worked hard to be a visible and integrated part of the community. FRC staff identified a need for kids to have safe, supportive environments to practice social skills and work on connections with each other. Gaps in social-emotional learning were identified as a result of the pandemic. Groups were prioritized this year in order to meet that need. FRC staff worked thoughtfully and collaboratively with teachers to think about how to configure groups where students could feel seen and heard. Staff considered many factors including race, culture, gender expression, and temperament in creating these groups.

The FRC staff continued to provide more intensive support to some students through individual counseling and collaboration with teachers and caregivers. The interns and trainee were able to refine their skills in comprehensive assessment, treatment planning, and implementation of age appropriate and culturally appropriate interventions. Many students made significant progress this year, and FRC staff were an integral part of the support team that helped guide them. During the reporting timeframe, 140 students participated in group sessions and 28 staff members received information or training.

Program Challenges:
There were few direct challenges, however, a significant challenge continued to be the increase in the cost to fund the program. These increases required the district to make cuts in other programming areas, as well as moving resources around to be able to continue providing ongoing services at the same rate as in previous year.

Demographic data provided by BUSD on 436 students that were served through this project in FY2024, is outlined below:

DEMOGRAPHICS N = 436

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  0 – 15 (Children Youth) – 436
- **Race**
  American Indian or Alaska Native – 13
  Asian – 22
  Black or African American – 93
  Native Hawaiian/Pacific Islander – <11
  White – 137
  More than one Race – 61
  Other – 16
  Declined to Answer (or Unknown) – 92
- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Mexican/Mexican American – Chicano - <11
  Other – 60
  Declined to Answer (or Unknown) – <11
- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  African – 12
  Chinese – <11
  European – 28
  Filipino - <11
  Japanese - <11
  Korean - <11
  Vietnamese - <11
  Other – <11
  Declined to Answer, or Unknown – 316
- **Primary Language**
  Spanish – 16
  English/Declined to Answer, or Unknown – 420
- **Sexual Orientation**
  Declined to Answer, or Unknown – 436
- **Disability**
  Mental domain not including a mental illness/Physical mobility domain/Other – 15
  Chronic health condition (including but not limited to chronic pain) - 31
  Declined to Answer, or Unknown – 390

- **Veteran Status**
  No – 436

- **Gender: Assigned Sex at Birth**
  Male – 38
  Female – 52
  Declined to Answer, or Unknown – 346

- **Current Gender Identity**
  Male – 173
  Female – 150
  Transgender or Another Gender Identity – <11
  Gender Queer – 12
  Declined to Answer, or Unknown – 92

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 including: African Americans; Latino/a/x; LGBTQIA+; TAY; and Senior Citizens. All services are conducted through area community-based organizations.

Through five community-based organizations, 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 including: African Americans; Latino/a/x; LGBTQIA+; TAY; and Senior Citizens.

Program results during the reporting timeframe are outlined below:

In FY2022 three of the five contractors in the Community Education & Supports project participated in the HHCS Results-Based Accountability (RBA) Evaluation. RBA evaluation results are presented in an aggregated format across all programs as follows:

How Much Did We Do?	How Well Did We Do It?	Is Anyone Better Off?
• 527 Support Groups/Workshops • 2,427 Support Groups/Workshop Encounters • 121 Individual Contacts (2 of 3 programs reporting) • 132 Outreach Activities • 1.815 Outreach Contacts • 443 Referrals	• 94% of program respondents reported satisfaction with the services they received • Referrals by type: 135 Mental Health 55 Social Services 72 Physical Health 20 Housing 161 Other Services	• 90% of program participants reported an increase in social supports or trusted people they can turn to for help • 92% of program participants reported positive changes in terms of coping strategies, feeling anxious or overwhelmed

In FY2023 the Community Education & Supports program participated in the HHCS Results-Based Accountability (RBA) Evaluation. In an aggregated summary across the five projects within this program the following work was conducted: 549 Support Groups/Workshops; 2,693 Support Group/Workshop encounters; 476 Outreach activities; 4,001 Outreach Contacts; and 393 Referrals.

In FY2024 the Community Education & Supports program participated in the HHCS Results-Based Accountability (RBA) Evaluation. In an aggregated summary across the five projects within this program the following work was conducted: 397 Support Groups/Workshops; 822 Support Group/Workshop encounters; 31 Outreach activities; 2,120 Outreach Contacts; and 296 Referrals.

Descriptions of the five projects within the Community Education & Supports program along with data and RBA evaluation results, are outlined below:

- **Transition Age Youth Trauma Support Project**

Implemented through Youth Spirit Artworks. 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 project is to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the prevention of suicide.

PEI Priorities:

- Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs).
- Youth engagement and outreach strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college.

In FY2022, 105 TAY participated in one or more program services. Demographics on youth served were as follows:

DEMOGRAPHICS N = 105

- **Age Category**
  16 – 25 - (Transition Age Youth) – 99%
  26-59 (Adults) – 1%
- **Race**
  American Indian or Alaska Native – 1%
  Asian – 4%
  Black or African American – 12%
  White – 2%
  More than one Race – 8%
  Declined to Answer (or Unknown) – 47%
- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Other – 12%
  Declined to Answer (or Unknown) – 14%
- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  Declined to Answer, or Unknown – 74%
- **Primary Language**
  Declined to Answer, or Unknown – 100%
- **Sexual Orientation**
  Heterosexual or Straight – 22%
  Gay or Lesbian – 13%
  Declined to Answer, or Unknown – 65%
- **Disability**
  Declined to Answer, or Unknown – 100%
- **Veteran Status**
  No – 100%
- **Gender: Assigned Sex at Birth**
  Declined to Answer, or Unknown – 100%

- **Current Gender Identity**
  Male – 23%
  Female – 11%
  Genderqueer – 7%
  Declined to Answer, or Unknown – 59%

Project Successes:

- Improved and integrated Art as Therapy content, and ironed out logistics.
- Successfully engaged increasing numbers of youth into Art as Therapy and Peer Mentoring over the reporting timeframe. Art as Therapy sessions consisted of activities that both teach art and provided a forum for sharing challenges common to TAY.
- Conducted outreach to 59 youth, made numerous contacts to other providers and organizations, and conducted events to publicize project services.
- Although, the program was not able to consistently conduct youth surveys, per staff report, youth indicated that services were helpful. Increased attendance was also an indication that Art as Therapy and Peer Mentoring sessions were valuable to the youth participants.
- Despite challenges with engagement, project outreach efforts resulted in 21 TAY trying out the Behavioral Health support groups. This progress was disrupted by staff turnover, and attendance dropped off towards the end of the year.
- The project engaged 29 new TAY into Peer Mentoring training this year. Meetings were held on a weekly basis at the Tiny House Village (THEV) serving the residents there, as well as other youth in the community. Transportation was provided for youth at the studio so they could easily.
- Many of the youth were pursuing education in the social services field or they wanted to explore this opportunity to see if they wanted to be in the field. The youth received training on healthy communication, coping with crisis and de-escalation, giving constructive feedback, health insurance and other topics. Youth were encouraged and supported to share and teach topics they found interesting to their peers.
- Six events were planned and conducted with 55 total youth in attendance. Youth expressed that they enjoyed and valued these events and would attend more if offered.

Project Challenges:

- Project challenges were compounded by the agency's rapid growth over the past two years, staff turnover, and lagging recruitment for the management function needed to operationalize the expansion, develop infrastructure, and implement better systems to gather client data and track outcomes.

- Engaging youth in services was challenging due to continued concerns and fears about the COVID-19 pandemic, and staff turnover, and the process of nearly doubling the services offered by this contractor during the COVID-19 pandemic.
- The holiday season seemed to impact responsiveness from the school district as school staff prepared for the end of the semester and district closures during the holidays. During this time, Omicron also became a serious threat and schools were again overwhelmed with new and changing restrictions. These factors caused significant barriers to having a consistent presence at the schools, along with delays in communication regarding the project implementation efforts and coordinating outreach and logistics for groups and events.
- The project social worker engaged both staff and students at Berkeley High School (BHS) and Berkeley Technical Academy (BTA), attended weekly staff meetings at BTA, conducted outreach to students on both campuses, and presented about PEI activities in classes at different times throughout the year, although consistency was difficult to achieve during the COVID-19 pandemic and holiday season. Despite these efforts, students were not readily engaged and attendance was inconsistent. Reports were that staff seemed to be ambivalent about new initiatives. Feedback from two students indicated that they (and their friends) didn't want mental health type services and that they didn't want to attend groups during their free period when they have a break from classes.
- By the beginning of March 2022 many of the existing program participants obtained full time jobs and could no longer commit to the project activities.

In FY2023, YSA went through many changes. A new program model was crafted and implemented with the intention of redesigning and refining the organization's programs and theory of change. Staff received training on theory of change, program development, ACES Science, trauma informed practices, the politics of trauma, facilitation skills, positive youth development, strength-based model, community resilience model, somatic awareness, individual coaching, housing navigation skills and curriculum and evaluation introduction. This change and shift in culture expanded the program offerings. The components and activities were designed with specific outcomes in mind and with the intention to increase intervention, engagement, and opportunities for the young people being served.

In FY2023, 83 youth participated in one or more program services. Demographics on youth served were as follows:

DEMOGRAPHICS N = 83
*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

- **Age Category**
  16 – 25 - (Transition Age Youth) – 100%

- **Race**
  American Indian or Alaska Native – *
  Asian – *
  Black or African American – 48%
  White – 12%
  More than one Race – 28%
  Declined to Answer (or Unknown) – *

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Mexican/Mexican American-Chicano – 18%
  Declined to Answer (or Unknown) – 15%

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  African – *
  Declined to Answer, or Unknown – 66%

- **Primary Language**
  English – 100%

- **Sexual Orientation**
  Heterosexual or Straight – 27%
  Gay or Lesbian – *
  Bisexual – 33%
  Questioning or Unsure of sexual orientation – *
  Another sexual orientation – *
  Declined to Answer, or Unknown – 26%

- **Disability**
  Declined to Answer, or Unknown – 100%

- **Veteran Status**
  No – 100%

- **Gender: Assigned Sex at Birth**
  Male – 21%
  Female – 28%
  Declined to Answer, or Unknown – 51%

- **Current Gender Identity**
  Male – 25%
  Female – 28%
  Transgender – *
  Genderqueer – *
  Another Gender Identity – *
  Declined to Answer, or Unknown – 25%

During the reporting timeframe 6 Behavioral Health Education Groups were conducted reaching 99 individuals; 100 Peer Mentoring sessions were conducted reaching 75 individuals; 108 Art Therapy sessions were conducted reaching 107 individuals; and 32 individuals participated in 6 events.

Feedback per participant self-report was as follows:

- 84% reported that groups were helpful;
- 70% of Art as Therapy participants reported that they feel their Behavioral Health is improved or very improved.

Program Successes:
Youth participated and were engaged in the program changes. Youth engaged in being trained in theory of change and understood the feedback loop and how YSA would assess them to help evaluate program effectiveness, satisfaction, facilitator engagement. In addition, youth engaged in leadership development through facilitation, curriculum, and event planning training to assist in their future developments in leading peers and community.

Youth within the village were also connected to youth leadership opportunities, and were engaged in life skills development such as financial wellness, and cooking workshops. Both workshops were created to assist youth in being financially independent and well, while redirecting learned survival skills into resilience building opportunities that create building blocks for growth. Youth led and organized a fashion show “Out Of The Binary” where they created all of the fashion pieces for the runway. Youth also planned, organized, advertised, and facilitated the entire event using skills that they acquired through youth leadership meetings, and youth leadership training spaces. A total of 30 referrals & Linkages were provided to youth in Berkeley.

YSA was able to gain a deep understanding on how to shape the Art as Therapy workshops, the Peer to Peer led Pathways with practical, experiential engagement and opportunity to lead as well as the Behavioral Health support given to participants through relationship workshops offered out of our Youth Empowerment Meetings.

Project Challenges:
A big program challenge was dealing with staff training and buy-in. Many of YSAs staff were former youth participants and many struggled with similar challenges as the youth that were being served. During this time YSA was challenged with staff understanding the importance of data collection and evaluation. Staff were not trained on using data to drive programmatic changes, which at times led to resistance and eventually the loss of some staff.

In FY2024, 52 youth participated in one or more program services. Demographics on youth served were as follows:

DEMOGRAPHICS N = 52

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Category**
  16 – 25 - (Transition Age Youth) – 52

- **Race**
  Asian – <11
  Black or African American – 18
  White – <11
  More than one Race – <11
  Declined to Answer (or Unknown) – <11

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Mexican/Mexican American-Chicano – 12

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  African – 18
  Asian Indian/South Asian – <11
  Middle Eastern – <11
  More than one ethnicity – <11
  Declined to Answer, or Unknown – <11

- **Primary Language**
  English – 52

- **Sexual Orientation**
  Heterosexual or Straight – 22
  Gay or Lesbian – <11
  Bisexual – <11
  Queer – <11
  Questioning or Unsure of sexual orientation – <11
  Another sexual orientation – <11
  Declined to Answer, or Unknown – <11

- **Disability**
  Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability or dementia) – <11
  Chronic health condition (including but not limited to chronic pain) – <11
  Declined to Answer, or Unknown – 47

- **Veteran Status**
  No – 52

- **Gender: Assigned Sex at Birth**
  Male – 37
  Female – 15

- **Current Gender Identity**
  Male – 12
  Female – 30
  Transgender – <11
  Genderqueer – <11
  Another Gender Identity – <11

Program Successes:
Some of the successes experienced in the reporting timeframe were aligned with changes to make the program more youth centered and informed. The Out of the Binary Fashion Show was the first event done in several years that was 100% facilitated, planned, and executed by participants in the program. Although time was spent training youth on all of these areas, youth were able to take those skills and develop something that was completely their own. The same followed into the Mural Workshop in which youth created their own ideas for the mural. They drew and designed the mural and painted on their own. This allowed the youth to feel a sense of autonomy and independence to create their own pieces and to work alongside individuals with experience in the community. This resulted in more youth coming into the program. Another success was the change in focus to offering intergenerational events that brings individuals from the Adeline community together to celebrate art, history, and community. A community brunch at the studio was held that included several Adeline community members and youth including renowned artist Edyth Boone. This event was the first to bring community members together to discuss upcoming programs and projects. At the end of the Mural Workshop, there was a Mural Reveal engagement that brought artists, Adeline community members, and youth together to celebrate the Mural created by the youth. The program successfully created safety, dignity and belonging that brought more youth to the space and gave them the freedom to participate in services and creatively express themselves.

Project Challenges:
The main challenges during the reporting timeframe was around a loss of some of the overall funding to the agency. Loosing funding caused the agency to cut stipends and some of the positions. The loss in funding pushed the agency to align in a different more efficient positive direction.

- **Trauma Support Project for LGBTQIA+ 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 LGBTQIA+ 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 LGBTQIA+ community. Approximately 12-15 weekly or bi-weekly support groups are held throughout the year targeting various populations and needs within the LBGTQIA+ 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. Approximately 250 individuals a year are served through this project.

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.

PEI Priorities:

- Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs).
- Youth Engagement and Outreach Strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college.
- Strategies targeting the mental health needs of older adults.

In FY2022, a total of 439 support groups were conducted, serving 45 individuals. Program results and individual's demographics on individuals served are outlined below:

DEMOGRAPHICS N = 45

- **Age Category**
  16 – 25 - (Transition Age Youth) – 29%

26-59 (Adult) – 62%
Ages 60+ (Older Adult) – 2%
Declined to Answer (or Unknown) – 7%

- **Race**
  Asian – 16%
  Black or African American – 11%
  White – 42%
  More than one Race – 13%
  Declined to Answer (or Unknown) – 18%

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Caribbean – 2%
  Central American – 2%
  Puerto Rican – 2%
  South American – 2%
  Declined to Answer, or Unknown – 2%

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  African – 4%
  Asian Indian/South Asian – 7%
  Chinese – 2%
  Eastern European – 2%
  European – 22%
  Filipino – 2%
  Korean – 4%
  Middle Eastern – 2%
  More than one ethnicity – 20%
  Declined to Answer, or Unknown – 24%

- **Primary Language**
  English – 98%
  Declined to Answer, or Unknown – 2%

- **Sexual Orientation**
  Heterosexual or Straight – 7%
  Gay or Lesbian – 9%
  Bisexual – 18%
  Questioning or Unsure of sexual orientation – 9%
  Queer – 22%
  Another sexual orientation – 24%
  Declined to Answer, or Unknown – 11%

- **Disability**
  Difficulty Seeing – 2%
  Mental (not Mental Health) – 9%
  Chronic health condition – 4%

Other (Specify) – More than one disability – 7%
No Disability – 78%

- **Veteran Status**
  No – 98%
  Declined to Answer, or Unknown – 2%

- **Gender: Assigned Sex at Birth**
  Declined to Answer, or Unknown – 100%

- **Current Gender Identity**
  Male – 4%
  Female – 13%
  Transgender – 31%
  Genderqueer – 11%
  Questioning or Unsure – 4%
  Another Gender Identity – 29%
  Declined to Answer, or Unknown – 7%

*(From Project staff report, the state PEI demographic data requirements requires the inclusion of percentages, therefore they had to code folx – used to explicitly signal the inclusion of groups commonly marginalized - with any multiple identities, into some form of a "multiple identity" category or "other" category. For example, in the ethnicity section when folx selected multiple ethnicities, it was reported as "More than one ethnicity." While this strategy generally works well to reduce confusion by ensuring legible percentages, this manner of reporting is reductive and doesn't allow for the full picture of the data. For instance, someone who identified as both Native and white is only being reported as "multiple races" and therefore, the category for Native participants is blank. This caused it to appear as though there weren't any Native participants in the project, when there were. The demographic reporting structure required simply does not allow for the level of detail and nuance needed to have a fuller picture of the project data).

There were 76 referrals for additional services and supports. The number and type of referrals was as follows: 24 Mental Health; 27 Physical Health; 2 Social Services; 23 other unspecified services. To assess the project services, a self-administered Peer Support Group Survey was distributed to all peer group members. Survey results were as follows:

- 81% indicated they would recommend the organization to a friend or family member;
- 77% felt like staff and facilitators were sensitive to their cultural background;
- 77% reported they deal more effectively with daily problems;
- 70% indicated they have trusted people they can turn to for help;
- 79% felt like they belong in their community.

Program Successes:

- The impact of the COVID-19 pandemic continued to be felt throughout the LGBTQIA+ community. The project continued providing peer groups online, providing spaces for the community members to gather; to receive and provide emotional support, feel a sense of belonging and connection; and to share resources.
- Some folx were not able to move to the online space due to privacy concerns, other safety issues, lack of devices, or unstable Wi-Fi. Despite that, the peer group facilitators reported that many of their group members expressed appreciation for the access to the virtual space during a time of increased isolation, especially those with chronic pain, disability, transportation or other barriers to in-person services.
- Community members also asked about the possibilities of additional new groups in FY2023 including:
- Q-Finity for neurodiverse folx; a group focusing on the needs of the QT polyamorous community; a parent's group; as well as a restarting of the Thursday Night Men's group. New peer group facilitators were scheduled to be onboarded in Aug 2022.
- Opportunities for project outreach increased dramatically through the website, and through the Meetup, Instagram and Facebook accounts.
- A few quotes from feedback forms on the support group were as follows:

  "I love the sense of community and support I feel in the group."
  "Thank You for holding the space."
  "I found the group understanding and supportive and [it] makes me feel I am not alone on an island, as others have [the] same circumstances."

Program Challenges:

- With more online offerings, the facilitators had additional work to do. For example, checking their email frequently, coping with technology issues, navigating facilitation while some group members and even facilitators joined via phones. These challenges were used as an opportunity to evaluate how to support facilitators as the project migrates to an in-person/hybrid, model and how facilitators can be set up to easily navigate the technological needs.
- While COVID-19 pandemic protocols were developed the project space was in transition since it was purchased by a development corporation and that hindered the ability to fully return to all in-person services.
- The contractor that implements this project experienced big leadership changes in the Executive Director, Clinical Director, Finance Director and Community Programs Director positions. These shifts impacted staff capacity and resulted in some schedule changes until the vacancies were able to be filled.

- The project will be examining ways to broaden and deepen community engagement, especially to community members who live at intersections of disabled, trans, and Black, Indigenous, and People Of Color (BIPOC) communities. An outreach committee was assembled to better track and prioritize engagement with more of a systematic approach.
- Although there was a decrease in numbers on the demographic sheets gathered on the peer group members and therefore, a lower number of group members reported, the number of duplicated participants was 2,118 in FY2022, which indicated that despite lower unduplicated participants, individuals who joined groups returned regularly to meetings.

Project staff will continue to evaluate issues of attrition and Zoom fatigue while exploring in-person and hybrid models of meeting, as well as ways to improve completion and submission of the demographic forms and surveys by peer group members.

In FY2023, a total of 261 individuals were served. Demographics on individuals served include the following:

DEMOGRAPHICS N = 261
*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

- **Age Groups**
  16 – 25 - (Transition Age Youth) – 13%
  26-59 (Adult) – 67%
  Ages 60+ (Older Adult) – 17%
  Declined to Answer (or Unknown) – *

- **Race**
  American Indian or Alaska Native – *
  Asian – *
  Black or African American – *
  White – 58%
  More than one Race – *
  Other – *
  Declined to Answer (or Unknown) – *

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Caribbean – *
  Mexican/Mexican-American Chicano – *
  Puerto Rican – *
  South American – *

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  African – *
  Asian Indian/South Asian – *%
  Chinese – *%

Eastern European – *
European – 26%
Filipino – *
Korean – *
Middle Eastern – *
Vietnamese – *
More than one ethnicity – 14%
Other – *
Declined to Answer, or Unknown – 29%

- **Primary Language**
  English – 97%
  Spanish – *
  Declined to Answer, or Unknown – *

- **Sexual Orientation**
  Heterosexual or Straight – *
  Gay or Lesbian – 19%
  Bisexual – 10%
  Questioning or Unsure – *
  Queer – 12%
  Another sexual orientation – 49%
  Declined to Answer, or Unknown – *

- **Disability**
  Difficulty Hearing or Having Speech Understood – *
  Mental Domain not including a mental illness (including but not limited to a learning disability, developmental disability or dementia) – 8%
  Physical/mobility domain – *
  Chronic health condition (including but not limited to chronic pain) – 8%
  Other (Specify) – 17%
  No Disability – 64%

- **Veteran Status**
  Yes – *
  No – 95%
  Declined to Answer, or Unknown – *

- **Gender: Assigned Sex at Birth**
  Declined to Answer, or Unknown – 100%

- **Current Gender Identity**
  Male – 15%
  Female – 12%
  Transgender – 29%
  Genderqueer – *
  Questioning or Unsure – *

Another Gender Identity – 37%
Declined to Answer, or Unknown – *

There were 88 referrals for additional services and supports. The number and type of referrals were as follows: 47 Mental Health; 20 Physical Health; 12 Social Services; 3 Housing; 6 Other unspecified services. To assess the project services, a self-administered Peer Support Group Survey was distributed to all peer group members. Survey results were as follows:

- 98% indicated they would recommend the organization to a friend or family member;
- 95% felt like staff and facilitators were sensitive to their cultural background;
- 88% reported they deal more effectively with daily problems;
- 84% indicated they have trusted people they can turn to for help;
- 85% felt like they belong in their community.

Program Successes:

- Peer groups continued to run uninterrupted and to be a vital support to the LGBTQIA+ community during the reporting timeframe.
- 92.4% of participants reported that the peer support group(s) they attended helped them to feel safe talking about their gender.
- 88% reported that the peer support group(s) they attended helped them to feel safe in talking about their sexuality.
- The primary goal in FY2023 was to increase capacity and reduce burnout for the group facilitators. To that end,16 new facilitators were on-boarded and an additional 3 facilitators were re-trained at their request.
- A full set of Diversity Equity and Inclusion trainings were also offered including one that was co-facilitated by a peer facilitator and our Community Programs Director.

Program Challenges:

- During quarter three facilitators were struggling with the Diversity Equity and Inclusion trainings offered and felt they were ready to move beyond the basics of inclusion and wanted more tools to interact with group members around issues of race, privilege, neurodivergence etc.
- In quarter four, the Diversity Equity and Inclusion training was co-facilitated by the Community Programs Director and a peer group facilitator and focused on lowering barriers to access and creating a more inclusive and welcoming space.

In FY2024, a total of 94 individuals were served. Demographics on individuals served include the following:

DEMOGRAPHICS N = 94

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Groups**
  16 – 25 - (Transition Age Youth) – <11
  26-59 (Adult) – 71
  Ages 60+ (Older Adult) – <11
  Declined to Answer (or Unknown) – <11

- **Race**
  Asian – <11
  Black or African American – <11
  White – 62
  More than one Race – <11
  Other – <11
  Declined to Answer (or Unknown) – <11

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Mexican/Mexican-American Chicano – <11
  South American – <11
  Other – <11
  Declined to Answer, or Unknown – <11

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  African – <11
  Asian Indian/South Asian – <11
  Chinese – <11
  Eastern European – <11
  European – 20
  Filipino – <11
  Japanese – <11
  Other – <11
  Declined to Answer, or Unknown – 24

- **Primary Language**
  English – 93
  Other/Declined to Answer, or Unknown – <11

- **Sexual Orientation**
  Heterosexual or Straight – <11
  Gay or Lesbian – 14
  Bisexual – <11
  Questioning or Unsure – <11
  Queer – <11
  Another sexual orientation – 41
  Declined to Answer, or Unknown – <11

- **Disability**
  Difficulty Hearing or Having Speech Understood – <11
  Mental Domain not including a mental illness (including but not limited to a learning disability, developmental disability or dementia) – <11
  Physical/mobility domain – <11
  Chronic health condition (including but not limited to chronic pain) – <11
  Other (Specify) – <11
  No Disability – <11
  Declined to Answer, or Unknown – 68

- **Veteran Status**
  Yes – <11
  No – 92
  Declined to Answer, or Unknown – <11

- **Gender: Assigned Sex at Birth**
  Declined to Answer, or Unknown – 94

- **Current Gender Identity**
  Male – 19
  Female – 16
  Transgender – 16
  Genderqueer – <11
  Questioning or Unsure – <11
  Another Gender Identity – 34

RBA Outcomes during the reporting timeframe were as follows: 261 Support Groups were conducted reaching 143 individuals; 26 Outreach activities were conducted reaching approximately1,780 individuals; 13 individuals attended Train the Trainer sessions to become Peer Support Group Facilitators; and 38 Peer Support Group Facilitators attended Skill Building Workshops. There were 71 referrals for additional services and supports. The number and type of referrals included: 28 Mental Health; 16 Physical Health; 3 Social Services; 1 Housing; 23 Other unspecified services.

To assess the project services, a self-administered Peer Support Group Survey was distributed to all peer group members. Survey results were as follows:

- 92% indicated they would recommend the organization to a friend or family member;
- 92% felt like staff and facilitators were sensitive to their cultural background;
- 88% reported they deal more effectively with daily problems;
- 79% indicated they have trusted people they can turn to for help;
- 81% felt like they belong in their community.

Program Successes:
The monthly consultation meetings for Peer Group facilitators was moved to Saturdays with the hope of gaining more attendance. With the move to the new location, facilitators were invited to return to the building and we staff worked on the hybridization of the new space. The move also provided the opportunity to renew outreach efforts. New location announcements were created and distributed.

With feedback from facilitators, the scope of the diversity, equity, and inclusion trainings and this year's DEI offerings were Power & Positionality, Supporting Neurodivergence, Mediating Conflict, and Accessibility in Support Spaces. There was strong attendance for these training sessions with an average of 7 facilitators in attendance per session. There were 14 new facilitators onboarded, and facilitation training for 2 facilitators from Asian Health Services was provided.

Program Challenges:
A few groups had to end due to a lack of facilitators. Another big challenge was that more community members wanted in-person groups but facilitators were still working on adjusting back to in-person groups. There was attrition in attendance during the reporting timeframe, and hybrid meetings were implemented in the next fiscal year to address this issue. The program continued to work on ways to utilize the new space as much as possible and in various ways to offer more avenues for individuals to access resources.

- **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 project is to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the prevention of suicide.

PEI Priorities:

- Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs).
- Strategies targeting the mental health needs of older adults.

In FY2022, 47 Living Well Workshop sessions were conducted. 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 project. In all, 14 Senior Citizens participated in the Living Well Workshops. Demographics of Workshop participants are outlined below:

DEMOGRAPHICS N = 14

- **Age Groups**
  26-59 (Adult) – 7%
  Ages 60+ (Older Adult) – 93%

- **Race**
  Asian – 7%
  Black or African American – 14%
  White – 65%
  Other – 7%
  More than one Race – 7%

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Other – 7%
  Declined to Answer, or Unknown – 7%

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  European – 14%
  Other – 7%
  Declined to Answer, or Unknown – 79%

- **Primary Language**
  English – 100%

- **Sexual Orientation**
  Heterosexual or Straight – 7%
  Questioning or Unsure – 7%
  Declined to Answer, or Unknown – 86%

- **Disability**
  Difficulty Seeing – 7%
  Difficulty Hearing or Having Speech Understood – 7%
  Mental (not mental health) – 21%
  Physical/mobility domain – 14%
  Chronic health condition – 7%
  Other Disability – 29%
  No Disability – 7%
  Declined to Answer, or Unknown – 8%

- **Veteran Status**
  No – 100%

- **Gender: Assigned Sex at Birth**
  Male – 21%
  Declined to Answer, or Unknown – 79%

- **Current Gender Identity**
  Male – 21%
  Female – 79%

During the reporting timeframe 14 outreach and informational events were conducted reaching 38 individuals, with 45 unduplicated individuals receiving further engagement services. There were 257 referrals for additional services and supports. The number and type of referrals were as follows: 80 Mental Health; 35 Physical Health; 20 Social Services; 20 Housing; 102 other unspecified services. A total of 100% of project participants completed a Living Well Workshop Series. Feedback per participant self-report was as follows:

- 100% reported they felt satisfied with the workshops;
- 100% indicated an improvement in feeling satisfied in general;
- 100% had increased feelings of social supports;
- 100% felt prepared to make positive changes; and
- 100% reported they felt less overwhelmed and helpless.

Project Successes**:**
The workshops were well attended with lively engagement. The workshops provided a safe space where some of the participants were able to share painful testimonies of isolation, sadness and fear and others of loneliness. Many missed their families, their grandchildren, and friends. To help participants stay connected 96 tele-support group sessions were held. Living Well Program virtual/tele-workshops were offered every Monday and tele-support groups every Tuesday. In December and May laptops and technical training were provided to previous participants and individuals who completed The Living Well Workshop Series.

Project Challenges:
Some participants had to travel out of state to support adult children with life-threatening illnesses and two struggled with potentially life-threatening diagnoses themselves. There was a lot of uncertainty revolving around the COVID-19 pandemic. Many participants had difficulties connecting with others due to the technological gap. The Workshop Series facilitator also had to learn systems that had not been used before.

In FY2023, a total of 73 individuals participated in the Living Well Workshop Series program. Demographics of Workshop participants are outlined below:

DEMOGRAPHICS N = 73
*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

- **Age Groups**
  26-59 (Adult) – *
  Ages 60+ (Older Adult) – 88%
  Declined to Answer (or Unknown) – *

- **Race**
  Asian – 23%
  Black or African American – 22%
  White – 34%
  Other – *
  More than one Race – *
  Declined to Answer (or Unknown) – *

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Mexican/Mexican-American Chicano – *
  Other – *
  Declined to Answer, or Unknown – *

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  Asian Indian/South Asian – 12%
  Chinese – *
  European – 19%
  Middle Eastern – *
  More than one Ethnicity – *
  Other – 25%

Declined to Answer, or Unknown – 32%

- **Primary Language**
  English – 79%
  Other – *
  Declined to Answer, or Unknown – 20%

- **Sexual Orientation**
  Heterosexual or Straight – *
  Declined to Answer, or Unknown – 99%

- **Disability**
  Difficulty Seeing – 12%
  Difficulty Hearing or Having Speech Understood – 22%
  Mental (not mental health) – 14%
  Physical/mobility domain – 15%
  Chronic health condition – 22%
  Other Disability – *
  No Disability – *
  Declined to Answer, or Unknown – 14%

- **Veteran Status**
  Yes – *
  No – 71%
  Declined to Answer, or Unknown – 21%

- **Gender: Assigned Sex at Birth**
  Male – 15%
  Female – 69%
  Declined to Answer, or Unknown – 16%

- **Current Gender Identity**
  Male – 14%
  Female – 71%
  Other – *
  Declined to Answer, or Unknown – 14%

During the reporting timeframe 4 outreach and informational events were conducted reaching 51 individuals. A total of 99 individuals participated in the Living Well Workshop series and 72 received engagement services. There were 149 referrals for additional services and supports. The number and type of referrals were as follows: 46 Mental Health; 27 Physical Health; 38 Social Services; 26 Housing; 12 other unspecified services. Project participants completed a Living Well Workshop Series. Feedback per participant self-report was as follows:

- 93% reported they felt satisfied with the workshops;
- 93% indicated an improvement in feeling satisfied in general;

- 93% had increased feelings of social supports;
- 93% felt prepared to make positive changes; and
- 93% reported they felt less overwhelmed and helpless.

Project Successes:

- The Living Well with a Disability programming continued to be well attended, especially the PEERS group, which is a peer-based support and discussion group focused on mental and emotional health for seniors.
- New seniors attended every quarter, and participant survey's demonstrated positive outcomes.
- Due to the success of the program, the Senior and Aging Engagement Specialist received numerous requests to host Living Well workshops at additional locations.

Project Challenges:

- The Living Well program continued to experience the impacts of the ongoing pandemic; older adults are still at higher risk for complications from Covid-19. Some staff also got COVID/experienced long COVID, which impacted the program.
- A majority of participants expressed that they did not feel comfortable answering all of the demographic and life situation questions required by the MHSA reporting. The Management Team is continuing to work with the Senior and Aging Engagement Specialist to devise strategies to support getting the required information, and also to ensure that trust, confidentiality, and person-centered services remain at the core of the work.
- The Center for Independent Living transferred to a new customer relationship management (CRM) software called MiCil, and the shift between the two CRMs, as well as the on-ramp period to get Living Well staff familiar with the new system and ensure it was accessible to them, created challenges in getting numbers and reports in in a timely manner.
- There was also some transition in Senior Management staff, which led to a delay in invoicing and financial reports on a couple of occasions.
- The agency had an Interim Executive Director during the reporting timeframe and has continued search for a new Executive Director.
- The program structure shifted to include more managers, which will hopefully alleviate some of the challenges, particularly around data management.
- A Data and Reporting Specialist was hired, who works closely with the Senior and Aging Engagement Specialist to ensure Living Well data is tracked in an accurate and comprehensive manner.

It is anticipated that these issues will be ameliorated within the current fiscal year, as the Living Well program systems, policies, and procedures are being revised and revitalized.

A majority of participants expressed that they did not feel comfortable answering all of the demographic and life situation questions required by the MHSA reporting. The Management Team is continuing to work with the Senior and Aging Engagement Specialist to devise strategies to support getting the required information, and also to ensure that trust, confidentiality, and person-centered services remain at the core of the work.

In FY2024, a total of 38 individuals participated in the Living Well Workshop Series program. Demographics of Workshop participants are outlined below:

DEMOGRAPHICS N = 38

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Groups**
  Ages 60+ (Older Adult) – 17
  Declined to Answer (or Unknown) – 21

- **Race**
  Asian – <11
  Black or African American – <11
  Native Hawaiian or Other Pacific Islander – <11
  White – <11
  Other – <11
  Declined to Answer (or Unknown) – 18

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Declined to Answer, or Unknown – 38

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  Declined to Answer, or Unknown – 38

- **Primary Language**
  English – <11
  Declined to Answer, or Unknown – 33

- **Sexual Orientation**
  Declined to Answer, or Unknown – 38

- **Disability**
  Difficulty Seeing – <11
  Difficulty Hearing or Having Speech Understood – <11
  Mental (not mental health) – <11
  Physical/mobility disability – <11

Other Disability – <11
Declined to Answer, or Unknown – 26

- **Veteran Status**
  Declined to Answer, or Unknown – 38

- **Gender: Assigned Sex at Birth**
  Declined to Answer, or Unknown – 38

- **Current Gender Identity**
  Male – <11
  Female – 14
  Declined to Answer, or Unknown – 14

RBA Outcomes during the reporting timeframe were as follows: 4 outreach and informational events were conducted reaching 111 individuals. A total of 78 individuals participated in the Living Well Workshop series and 99 received engagement services. There were 11 referrals for additional services and supports. The number and type of referrals included: 1 Mental Health; 2 Physical Health; 1 Social Services; 2 Housing; 5 other unspecified services.

Project Successes**:**
The Center for Independent Living's "Living Well with a Disability" workshop series and the PEERS support group were both well-attended and impactful, reaching 78 older adults in Berkeley during the reporting timeframe. Outside of the workshops, 99 older adults in Berkeley received 1-on-1 supports, services, and referrals with a total of 612 hours spent providing these individual services and referrals in the reporting period.

The Senior and Aging Engagement Coordinator witnessed increased mental, physical, and emotional health issues with attendees of the group, and worked to adapt programming to meet the needs and concerns of attendees. The Coordinator also increased the 1-on-1 services and referrals in order to provide additional support to individuals in need, especially in the realm of mental health, legal advocacy, referrals for assistive technology and residential access supports, general technology assistance, and more.

Other highlights from the reporting period included diverse outreach in the community by the Senior and Aging Engagement Coordinator, including attending a day-long conference on Elder Abuse held by Legal Assistance for Seniors, where the Coordinator was able to meet other service providers and legal advocates that work with older adults, and collaborate on challenges, resources, and referrals. The Coordinator also tabled at the annual Berkeley Juneteenth Festival, at the GoldenReady Emergency Preparedness event, and more.

Project Challenges:
The greatest challenge related to comprehensive data tracking and gathering demographic and survey information from Living Well and PEERS attendees. For a time, the Senior and Aging Engagement Coordinator was not comprehensively tracking

the referrals made as part of the 1-on-1 services, and then departed the organization before the Program Director could work closely with her to try to trace back some of those supports and services offered; thus, the referral numbers looked artificially low, even though the Coordinator was visiting multiple seniors at their homes or at the senior centers to work with them 1-on-1, several times per week. The Senior and Aging Coordinator shared that workshop attendees were often reticent to provide the in-depth demographic information requests. Once hired, the new Senior and Aging Engagement Coordinator will be supported in developing strategies to confidentially and comprehensively gather required data and demographics.

- **SoulSpace Project**

The SoulSpace Project for African Americans is implemented through ONTRACK Program Resources. This project assists African Americans in Berkeley to access culturally, ethnically, and linguistically responsive and trauma-informed prevention and early intervention services. Project services include: community education; outreach and engagement; individual quality of life assessments; coaching; empowerment planning; referrals; navigation supports; support groups; and life skills training.

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.

PEI Priorities:

- Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs).
- Youth Engagement and Outreach Strategies that target secondary school and transition age, with a priority on partnership with college mental health programs, and transition age youth not in college.
- Strategies targeting the mental health needs of older adults.

Program results during the reporting timeframe are outlined below.

This project began operating in the last month of the 2nd Quarter of FY2022. During that timeframe ONTRACK served 16 individuals in intensive case management, including a

total of 45 empowerment activities, and support groups. Demographics on individuals served through this project were as follows:

DEMOGRAPHICS N = 38

- **Age Groups**
  Transition Age Youth (16-25) – 19%
  Adults (26-59) – 62%
  Ages 60+ (Older Adult) – 19%

- **Race**
  Black or African American – 100%

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Other – 100%

- **Primary Language**
  English – 100%

- **Sexual Orientation**
  Heterosexual or Straight – 94%
  Another sexual orientation – 6%

- **Disability**
  Mental (not mental health) – 6%
  Physical/mobility disability – 6%
  Physical/mobility disability – 88%

- **Veteran Status**
  No – 100%

- **Gender: Assigned Sex at Birth**
  Male – 56%
  Female – 44%

- **Current Gender Identity**
  Male – 56%
  Female – 44%

Project Successes**:**
Despite a program starting date of December, 1, 2021, ONTRACK launched the SoulSpace project and accomplished the following during the reporting timeframe:

- Hired two staff who have deep familiarity with Berkeley.
- Secured a work space.
- Built out the case management platform, Apricot by Social Solutions, to match the system used by Berkeley—City Data Services.

- Conducted outreach and began implementing services.
- In order to quickly gain a foot in Berkeley's mental health provider network, the contractor established several partnerships with longstanding organizations in the City of Berkeley including:
    - A partnership with Options for Recovery which included their co-hosting an in-person public education event with Roland Williams, an expert in co-existing substance use and mental health concerns among African Americans. The contractor also provided one-to-one empowerment services for some of their dually-diagnosed clients as well as members of their staff working through the compassion fatigue that often accompanies work with this population.
    - Through a partnership with Building Opportunities for Self-Sufficiency (BOSS), the contractor conducted onsite—and off-site-one-to-one and group empowerment services to their otherwise unsheltered population of African Americans.
- Conducted two well-reviewed community education events. Dr. La Tanya Takla conducted a 2-part series on trauma informed care to African Americans, and Roland Williams conducted an in-person workshop at the Veterans Memorial Building.

<u>Project Challenges:</u>

- The contractor experienced a number of challenges during the program period, several of which have been rectified since the ending of the June 30, 2022 MHSA reporting period.
  The truncated MHSA 2021-2022 service period was short due to a contract execution date of December 1, 2021, and a delay in final contracting processes.
- Outreach efforts to community members was restricted due to the COVID-19 pandemic, which meant greater reliance on social media and outreach to other community organizations who were seeking to adapt to their own challenges.
- The initial location of the Soul Space office in West Berkeley was less accessible to community members than the current location in North Berkeley on Adeline Street.

In FY2023, 35 individuals were served. Demographics on individuals served are as follows:

DEMOGRAPHICS N = 35

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

- **Age Groups**
  Transition Age Youth (16-25) – 14%
  Adults (26-59) – 69%
  Ages 60+ (Older Adult) – 17%

- **Race**
  Black or African American – 86%
  Declined to Answer (or Unknown) – 11%

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Declined to Answer (or Unknown) - *

- **Primary Language**
  English – 100%

- **Sexual Orientation**
  Heterosexual or Straight – 89%
  Bisexual - *
  Another sexual orientation - *
  Declined to Answer (or Unknown) – *

- **Disability**
  Mental (not mental health) – *
  Physical/mobility disability – 14%
  No Disability – 77%
  Declined to Answer (or Unknown) – *

- **Veteran Status**
  Declined to Answer (or Unknown) – 100%

- **Gender: Assigned Sex at Birth**
  Male – 37%
  Female – 63%

- **Current Gender Identity**
  Male – 37%
  Female – 63%

During the reporting timeframe 20 Community Education Trainings were conducted and 417 individuals were reached through outreach and engagement services. A total of 19 individuals received case management and 20 participated in Support Groups. There were 4 referrals for additional services and supports.

Project Successes:

- Community Engagement: Soul Space Berkeley successfully integrated itself into the Berkeley community and has become a recognized and trusted resource for individuals seeking wellness and support services. Partnerships with community agencies, Building Opportunities for Self Sufficiency (BOSS) and Options for Recovery, yielded a reciprocal referral stream that has been beneficial.
- Expanded Services: One of the major accomplishments was the ability to serve individuals in the community effectively. The case management services proved

to be highly beneficial assisting individuals in finding mental health resources; adjusting to life after the pandemic; offering financial education; and offering a safe place where individuals could openly express their needs and employment assistance.

- Family Support: Entire families the Soul Space services, reflecting the broad impact of the programs on the community. This demonstrates programs ability to address holistic well-being at both the individual and family levels. Soul Space will continue to offer family services given the need.
- Successful Women's Group: The establishment and success of the women's group “Crown Never Off” was a testament to the value of the services provided. This group provided a supportive and empowering space for women within the community.
- Community Recognition: Soul Space established meaningful connections with community organizations, enhancing the presence and reputation within the Berkeley community. The commitment to building community relationships yielded positive results.

Project Challenges:

- Staffing: Soul Space experienced staff turnover amid growth and an increased demand for services. Recruitment for new staff to ensure the right team is in place to meet the needs of the expanding program is an ongoing challenge given the program budget. In FY2024, two new staff were hired. Soul Space is seeking additional funding to support the current staffing arrangement.
- Location Accessibility: In FY2023, OnTrack, the provider of the SoulSpace project, was relocated to a space within Inter-City Services. However, due to various building issues, this space was temporary and OnTrack had to relocate again to its current space in South Berkeley.

In FY2024, 7 individuals were served. Demographics on individuals served are as follows:

DEMOGRAPHICS N = 7

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Groups**
  Adults (26-59) – <11
  Ages 60+ (Older Adult) – <11

- **Race**
  Black or African American – <11
  Declined to Answer (or Unknown) – <11

- **Ethnicity: Hispanic or Latino/Latina/Latinx**

Declined to Answer (or Unknown) - 7

- **Primary Language**
  English – 7

- **Sexual Orientation**
  Heterosexual or Straight – 7

- **Disability**
  Mental (not mental health) – <11
  Chronic Health Condition – <11
  No Disability – <11

- **Veteran Status**
  Declined to Answer (or Unknown) – 7

- **Gender: Assigned Sex at Birth**
  Male – <11
  Female – <11

- **Current Gender Identity**
  Male – <11
  Female – <11

RBA Outcomes during the reporting timeframe were as follows: 2 Community Education Trainings were conducted to 43 attendees, and 229 individuals were reached through outreach and engagement services. A total of 7 individuals received case management and/or participated in Support Groups. There were 7 referrals for additional services and supports.

Project Successes**:**

- A support group for Black men, “Black Men Alive and Well,” aimed at building participants’ resilience and well-being was conducted.
- Two community education workshops with Deanna Robinson were held: “Creating a Culture of Healing: Black Mental Health Wellness Strategies” and “Processing Pain While Building a Healing Culture: Black Mental Health Wellness Strategies”.
- A two-part provider education training with Roland Williams was held, “Medication-Assisted Treatment for Black Populations” in June.
- After exhaustive searches, ONTRACK hired 2 case managers for Soul Space and placed a project manager onsite in Berkeley.
- Soul Space leased office and program space in South Berkeley, in the historical heart of Berkeley’s African America/Black community and hired two well-qualified empowerment advocates. The increased capacity enabled the program to ramp up the outreach and direct service activities.

Project Challenges:

- Early in the fiscal year, the case manager resigned. The program support team worked diligently to move clients through their empowerment plans and transition them to other community resources or close out their cases. Recruitment began immediately for the vacant position but there was difficulty finding applicants who brought the required combination of skillsets: case management expertise, deep understanding of African American/Black communities particular needs for mental health support, and experience working with African American/Black communities. The search process involved reviewing 40 resumes submitted in response to initial posts, numerous hours revising the recruitment strategy and outreach, and interviewing more than 28 candidates before finding qualified individuals aligned with Soul Space's values and approach to case management.
- The original North Berkeley office space was unsuitable to the program needs, so the program moved to a new space in South Berkeley that was closer to public transportation and more accessible to African American communities. Unforeseen flooding and mildew rendered the office space permanently unusable, necessitating a time-consuming search for another space. Finding an affordable and culturally appropriate space proved more difficult than anticipated, but the program was able to acquire access, and relocate to another space in South Berkeley that proved to be appropriate for the program needs.

➢ Latinx Trauma Support Project

Implemented through East Bay Sanctuary Covenant began the Latinx Trauma Support Project assists low-income, Latinx families in Berkeley to access culturally, ethnically, and linguistically responsive and trauma-informed prevention and intervention services. Project services are in direct response to, and in collaboration with, Latinx community members, and are largely facilitated by individuals from within the targeted community and are conducted in Spanish or an indigenous language. Services include: One-on-one outreach and support; support groups; staff and partner training and warm referrals.

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.

PEI Priorities:

- Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs).
- Youth Engagement and Outreach Strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college.

- Strategies targeting the mental health needs of older adults.

Program results during the reporting timeframe were as follows:

In FY2022, this project began implementing services. Over the course of the year a total of 224 individuals were served. Demographics on individuals served through this project were as follows:

DEMOGRAPHICS N = 224

- **Age Groups**
  Children and Youth (0-15)- 2%
  Transition Age Youth (16-25) – 13%
  Adults (26-59) – 82%
  Ages 60+ (Older Adult) – 1%
  Declined to Answer (or Unknown) – 2%

- **Race**
  American Indian or Alaska Native – 10%
  Asian – 1%
  Black or African American – <1%
  White – 2%
  Other – 85%
  Declined to Answer, or Unknown – 2%

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Central American – 45%
  Mexican/Mexican-American/Chicano – 29%
  South American – 8%
  Other – 8%
  Declined to Answer, or Unknown – 7%

- **Ethnicity: Non-Hispanic or Latino/Latina/Latinx**
  African - <1%
  Asian Indian/South Asian – 1%
  Chinese - <1%
  Eastern European - <1%
  Middle Eastern - <1%
  Other - <1%

- **Primary Language**
  English – 3%
  Spanish – 83%
  Declined to Answer, or Unknown – 14%

- **Sexual Orientation**
  Heterosexual or Straight – 43%
  Gay or Lesbian - 28%
  Questioning or unsure of sexual orientation – 1%
  Queer – 1%
  Another sexual orientation – 2%
  Decline to Answer or Unknown – 25%

- **Disability**
  Difficulty seeing – <1%
  Other – <1%
  No Disability - 95%
  Decline to Answer or Unknown – 4%

- **Veteran Status**
  No – 91%
  Decline to Answer or Unknown – 9%

- **Gender: Assigned Sex at Birth**
  Male – 49%
  Female – 50%
  Decline to Answer or Unknown – 2%

- **Current Gender Identity**
  Male – 46%
  Female – 50%
  Transgender – 1%
  Genderqueer – 1%
  Declined to answer or Unknown – 2%

During the reporting timeframe 41 Support Group sessions were conducted reaching 26 individuals, and 76 individuals received One-on-One Supports. A total of 49 Trainings were conducted, reaching 78 individuals. There were 110 warm referrals for additional

services and supports. The number and type of referrals were as follows: 31 Mental Health; 10 Physical Health; 33 Social Services; 36 other unspecified services.

Support Group feedback per participant self-report was as follows:

- 100% reported they liked participating in the Support Group;
- 100% indicated they would recommend the organization to a friend or family member;
- 100% indicated they felt safe, included and respected;
- 100% reported that they were able to deal more effectively with daily problems;
- 100% reported increased feelings of supports after participating in the support group.

Training feedback per participant self-report was as follows:

- 98% pf participants indicated that they were satisfied with the training;
- 100% of participants indicated that the information in the training was informative;
- 100% of participants indicated that the training would help them in their work.

Project Successes:

- In the first fiscal year of this contract, an effective and efficient support services project was built to better serve members of the Latinx community through a holistic trauma-informed approach.
- Having a dedicated staff allowed the project to connect more deeply with Latinx community members, offering early intervention and prevention education, one-on-one supports, warm referrals to a wide range of social and mental health services, and two support groups (one for LGBTQ Latinx asylum seekers and one for Indigenous Maya Mam women).
- The project trained a total of seventy-eight staff and employees of partner agencies in the trauma-informed approach. These trainings were designed after the Program Manager interviewed key stakeholders within the organization about their understanding of trauma and what training needs they saw for improving our services. Externally, customized trainings for partners working in healthcare, education, and social services were also provided.
- The Support Services Manager strengthened partnerships with community agencies around a range of services that clients desperately needed, including health care, public benefits, services for survivors of domestic violence, housing, and many other needs.
- A sophisticated comprehensive system for identifying the resources available to community members and tracking referrals after initial contact using the Airtable platform, was created and utilized.

Project Challenges:
An early challenge was that the project was not able to hire a Support Services Program Manager until two months after the grant began, however despite this delay, project goals were still met.

In FY2023, this project served 339 individuals. Demographics on individuals served were as follows:

DEMOGRAPHICS N = 339
*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

- **Age Groups**
  Children and Youth (0-15) - *
  Transition Age Youth (16-25) – *
  Adults (26-59) – 84%
  Ages 60+ (Older Adult) – *
  Declined to Answer (or Unknown) – *

- **Race**
  American Indian or Alaska Native – *
  Asian – *
  Black or African American – *
  White – *
  Other – 85%
  Declined to Answer, or Unknown – *

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Central American – 47%
  Mexican/Mexican-American/Chicano – 35%
  South American – *
  Other – *
  Declined to Answer, or Unknown – *

- **Ethnicity: Non-Hispanic or Latino/Latina/Latinx**
  African - *
  Asian Indian/South Asian – *
  Cambodian - *
  Eastern European - *
  European - *
  Japanese - *
  Korean - *
  Other - *

- **Primary Language**
  English – *
  Spanish – 87%
  Declined to Answer, or Unknown – *

- **Sexual Orientation**
  Heterosexual or Straight – 43%
  Gay or Lesbian - 36%
  Bisexual - *
  Queer – *
  Another sexual orientation – *
  Decline to Answer or Unknown – 18%

- **Disability**
  Other – *
  No Disability - 93%
  Decline to Answer or Unknown – *

- **Veteran Status**
  No – 100%

- **Gender: Assigned Sex at Birth**
  Male – 44%
  Female – 55%
  Decline to Answer or Unknown – *

- **Current Gender Identity**
  Male – 41%
  Female – 55%
  Transgender – *
  Genderqueer – *
  Another Gender Identity – *

During the reporting timeframe 7 Support Group sessions were conducted reaching 132 individuals, and 94 individuals received One-on-One Supports. A total of 8 Trainings were conducted, reaching 30 individuals. There were 152 warm referrals for additional services and supports. The number and type of referrals were as follows: 32 Mental Health; 8 Physical Health; 44 Social Services; 68 other unspecified services.

Support Group feedback per participant self-report was as follows:

- 100% reported they liked participating in the Support Group;
- 98% indicated they would recommend the organization to a friend or family member;
- 100% indicated they felt safe, included and respected;
- 95% reported that they were able to deal more effectively with daily problems;
- 98% reported increased feelings of supports after participating in the support group.

Training feedback per participant self-report was as follows:

- 100% of participants indicated that they were satisfied with the training;
- 100% of participants indicated that the information in the training was informative;
- 100% of participants indicated that the training would help them in their work.

Project Successes:

- Continued to provide integrated support to low-income Latinx immigrants through case management, warm referrals, trilingual hotline, support groups, mental health support, and trainings, as well as quarterly retreats for LGBTQ asylum seekers and Mam women.
- Due to growth in the Support Services program an additional caseworker was hired, which helped clients connect to more public benefits, including Medi-Cal and CalFresh.
- In addition to 1x1 support, a support group was offered reaching 24 LGBTQ asylum seekers and a storytelling workshop reaching 17 people.
- Utilized undergraduate interns for 16-24 hours a week to provide direct service to individuals, and to assist with administrative tasks.
- Hosted four Trauma-Informed trainings for staff and partner organizations providing legal and mental health services to asylum seekers. Staff trainings on Wellness and Domestic Violence Prevention were also conducted. The Support Services team attended a training on Motivational Interviewing and participated in a convening of Bay Area nonprofits serving unaccompanied immigrant youth.
- Provided a training on Mental Health First Aid and suicide prevention, one for law student volunteers, and one in Spanish for outreach workers.
- Partnered with “No Separate Survival”, a participatory documentary project, to offer asylees a chance to get behind the camera and share their perspectives as storytellers, and hosted a film screening for asylum seekers and their families in a single-day support group event.
- The OLAS LGBT Sanctuary Project held a retreat on the theme, “The Pride of Being,” to empower participants to be proud of their unique identities, and to build community with each other.
- Connected clients to services such as rental assistance, state-funded medical services, mental health services, and more.
- Planned an integrated wellness workshop for clients, which took place in the Fall of 2023. The workshop covered topics such as sleep and stress, and offered a range of culturally appropriate approaches including Talk Therapy and traditional Mayan herbal remedies.
- The Community Education Manager and Amplifying Sanctuary Voices Team led two “Tell Your Story” workshop training sessions to help community members learn how to share their immigration stories with legislators and the public. These

workshops helped community members find power and confidence in sharing their lived experiences to advocate for a greater cause.

- The OLAS LGBTQ Asylum Program Coordinator, led a support group retreat for new and returning members focused on the immigrant identity. Activities allowed participants to safely share their migration stories and discuss the dynamics of acculturation and chosen family.

Project Challenges:
It continued to be a challenge to connect clients with mental health services in a timely fashion, as the shortage of mental health workers seemingly only deepened. We stayed in close touch with groups like “Partnerships for Trauma Recovery” to make sure we had up-to-date information on which providers are accepting new patients and what wait times our clients could expect. A Team Member who specializes in working with teenagers and transition-aged youth, offered a support group for her clients, however it proved to be difficult to recruit for the group, as the need to earn money often overwhelmed all other needs of the potential participants.

In FY2024, this project served 653 individuals. Demographics on individuals served were as follows:

DEMOGRAPHICS N = 653
*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Groups**
  Children and Youth (0-15) - 28
  Transition Age Youth (16-25) – 148
  Adults (26-59) – 442
  Ages 60+ (Older Adult) – 35

- **Race**
  Asian – <11
  Black or African American – 17
  White – <11
  Other – 601
  More than one Race – <11
  Declined to Answer, or Unknown – 11

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Central American – 345
  Mexican/Mexican-American/Chicano – 127
  South American – 43
  Other – 29
  Declined to Answer, or Unknown – 49

- **Ethnicity: Non-Hispanic or Latino/Latina/Latinx**
  African - 12
  Asian Indian/South Asian – <11
  European - <11
  Filipino - <11
  Middle Eastern - <11
  Vietnamese - <11
  Other - <11
  Declined to Answer, or Unknown – 12

- **Primary Language**
  English – 56
  Spanish – 533

- **Sexual Orientation**
  Heterosexual or Straight – 308
  Gay or Lesbian - 86
  Bisexual - <11
  Queer – <11
  Another sexual orientation – <11
  Decline to Answer or Unknown – 243

- **Disability**
  Difficulty Seeing - <11
  Other – <11
  No Disability - 614
  Decline to Answer or Unknown – 26

- **Veteran Status**
  No – 630
  Decline to Answer or Unknown – 23

- **Gender: Assigned Sex at Birth**
  Male – 327
  Female – 326

- **Current Gender Identity**
  Male – 321
  Female – 318
  Transgender/Genderqueer/Another Gender Identity – 14

RBA Outcomes during the reporting timeframe were as follows: 9 Support Group sessions were conducted reaching 75 individuals, and 247 individuals received One-on-One Supports. A total of 7 Trainings were conducted, reaching 91 individuals. There were 207 warm referrals for additional services and supports. The number and type of referrals included: 29 Mental Health; 12 Physical Health; 75 Social Services; 91 other unspecified services.

Support Group feedback per participant self-report was as follows:

- 100% reported they liked participating in the Support Group;
- 100% indicated they would recommend the organization to a friend or family member;
- 100% indicated they felt safe, included and respected;
- 100% reported that they were able to deal more effectively with daily problems;
- 100% reported increased feelings of supports after participating in the support group.

Training feedback per participant self-report was as follows:

- 100% of participants indicated that they were satisfied with the training;
- 100% of participants indicated that the information in the training was informative;
- 100% of participants indicated that the training would help them in their work.

Project Successes:

- Continued to provide integrated support to low-income Latinx immigrants through case management, warm referrals, trilingual hotline, support groups, mental health support, and trainings, as well as quarterly retreats for LGBTQ asylum seekers and Mam women.
- Successfully initiated contact with Berkeley High School newcomer program to share resources with families, and continued to provide one-on-one support for Latinx and Mam asylum seekers, including wraparound services for unaccompanied minors and warm referrals to mental health and other services.
- Provided 6 trauma-informed trainings for 66 unique participants. These included an annual training for the incoming cohort of law students interns who directly assisted with the clients' asylum cases during the school year. These trainings made it much more likely for the law students to identify their clients' need for mental health services and reach out to the Support Services team to make these connections.
- Expanded one-on-one services to include assistance with obtaining public benefits. Program staff developed sufficient expertise on this topic to train student interns to screen clients for eligibility for benefits such as Medi-Cal and CalFresh, help them apply, and, crucially, help them overcome barriers like inadequate documentation if their applications were rejected.
- The OLAS LGBTQ Sanctuary Project held a support group weekend retreat with 16 LGBTQ participants. Participants felt empowered to share their accomplishments as immigrants in the U.S., including learning English, opening their own businesses, pursuing higher education, and obtaining asylum or residency status. Additionally, the OLAS Sanctuary Project held a one-day retreat in Berkeley for 24 participants, 6 of whom were new to the program. Many participants expressed feelings of trust, safety, and comfort with expressing

themselves through the group activities. This provided safe spaces for participants to rest, share their experiences as LGBTQ immigrants, and practice different forms of art expression. Activities were led by trained facilitators, including licensed therapists. Participants walked away from these experiences having felt seen and heard and part of a community. As LGBTQ immigrants, many of the participants have experienced hate incidents in both their home countries and the U.S. They unanimously feel that OLAS provides a safe space for healing and processing these experiences among their peers, and shared that each retreat built their self-confidence and their connections with other participants.

- Two storytelling workshops were held for Indigenous Mam, Latinx, and LGBTQ asylum seekers that focused on finding and expressing their voice. One workshop was in collaboration with teaching artists at Berkeley Repertory Theatre (BRT). Participants were guided to create poetry and performances based on their stories and share them in classrooms and at community events, which helped to build empathy in the broader community. The experience was cathartic, with strengthened connections, community, and confidence, along with opportunities to share one's journey and give/receive support.
- The Amplifying Sanctuary Voices (ASV) team held a storytelling performance event in partnership with Berkeley Repertory Theater - In Dialogue. The performance featured four Latinx and immigrant community members who shared their stories with over 50 attendees. The event was incredibly moving and a great success; the performers shared that they felt proud of their bravery to stand up and share their story and audience members reflected on the power of hearing personal narratives in a performance setting. ASV is excited to continue supporting community storytelling in a setting that promotes participants' healing and empowerment.

Project Challenges:

While there were no significant program challenges in FY2024, the Support Services team was hoping to host three student interns over the summer, however two withdrew for personal reasons at the last minute. Staff was able to cover, but this was still a disappointment and prompted thinking and planning on how to get firmer intern commitments going forward.

PREVENTION & EARLY INTERVENTION COMBINED PROGRAMS

Prevention Program – Includes a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors.

Early Intervention Program – Provides 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.

The City of Berkeley Prevention & Early Intervention combined programs are as follows:

Mental Health Peer Education Program

The Mental and Emotional Education Team (MEET) program implements a peer-to-peer mental health education curriculum to 9th graders and an internship program for a cohort of high school students to serve as peers to their fellow students. The goals of the program are 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, and basic coping and intervention skills.

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.

PEI Priorities:

- Youth Engagement and Outreach Strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college.
- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

In FY2022, although the funding was allocated for this program, it was not implemented by BUSD.

In FY2023, the MEET program was relaunched after having been discontinued for a couple of years. During this reporting timeframe,15 MEET Peer Educators participated in weekly trainings and in a 1 full day training for the purposes of developing leadership skills, learning about mental health needs and resources, and providing mental health education for their peers. The trained Peer Educators then presented in eight U-9 Freshman Seminar Classes.

Five of the MEET students participated in the City of Berkeley Health Justice (HJI) Internships with MEET as their internship site. The HJI interns participated in an additional weekly meeting and acted as leaders within MEET by developing the PowerPoint presentation and leading practice sessions with other MEET peer educators to prepare for their classroom presentations.

In FY2023, 15 individuals were served through this program. Demographics on individuals served were as follows:

DEMOGRAPHICS N = 15

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

- **Age Groups**
  Children and Youth (0-15) – 100%

- **Race**
  Asian – *
  Black or African American – 33%
  White – 33%
  More than one Race – 27%
  Declined to Answer, or Unknown – *

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Other – 3%
  Declined to Answer, or Unknown – 12%

- **Ethnicity: Non-Hispanic or Latino/Latina/Latinx**
  African - *
  Asian Indian/South Asian – *
  Other – 13%
  Declined to Answer, or Unknown – 46%

- **Primary Language**
  Declined to Answer, or Unknown – 100%

- **Sexual Orientation**
  Heterosexual or Straight – 20%
  Gay or Lesbian - *
  Bisexual – 27%
  Questioning or unsure of sexual orientation – 20%
  Queer – 13%

Other - *
Decline to Answer or Unknown – 13%

- **Disability**
  Difficulty Seeing – 13%
  Mental domain not including a mental illness (ncluding but not limited to a learning disability, developmental disability or dementia) - *
  Other – *
  No Disability – 60%
  Decline to Answer or Unknown – 13%

- **Veteran Status**
  No – 100%

- **Gender: Assigned Sex at Birth**
  Decline to Answer or Unknown – 100%

- **Current Gender Identity**
  Male – 13%
  Female – 67%
  Genderqueer - *
  Questioning or unsure of gender identity – 13%
  Decline to Answer or Unknown – *

Program Successes:

- Developed informational PowerPoint and presentation for U-9 Freshman Seminar classes.
- Completed 8 educational presentations to U-9 Freshman Seminar classes.
- Presentations reached over 200 students and aimed to foster greater comfort in discussing mental health, provide information about common mental health issues, reduce mental health stigma, teach coping skills, and show students how to access mental health resources in and outside of Berkeley High School.
- Five MEET students participated in the City of Berkeley Health Justice (HJI) Internships with MEET as their internship site. The HJI interns acted as leaders within MEET by developing the PowerPoint presentation and leading practice sessions to prepare for their classroom presentations.
- Created informational posters about depression, anxiety, coping skills, and selfcare to be posted across campus.
- Helped design mental health survey questions that were used in the district-wide Mental Health Needs Assessment.
- Conducted over 40 interviews of Berkeley High Students for the district-wide Mental Health Needs Assessment.
- Assisted in designing a BHS Wellness Website.

- Nine weekly trainings and one full day training was facilitated for MEET students to foster community, learn about common mental health concerns and prepare to facilitate presentations to U-9 freshmen.
- HJI MEET interns met with the training facilitator an additional 5 times to support their development of the PowerPoint presentation, foster their leadership within MEET, and provide feedback and assistance in creating mental health informational posters.
- Each MEET participant co-facilitated at least 2 classroom presentations.
- MEET students taught over 200 students (all U-9 freshmen) in their classrooms by facilitating the PowerPoint presentation and interactive activities focusing on mental health and coping skills.
- Feedback from MEET peer educators, U-9 students, and teachers was overall positive. 93% of MEET Peer Educators reported that they learned more about mental health and 100% reported that they felt comfortable or very comfortable expressing themselves within the group.

Program Challenges:
A significant challenge was the increase in costs to fund the program. These increases required the school district to make cuts in other programming areas, as well as move resources around to be able to continue providing ongoing services.

During the fall of FY2024, the MEET program supervisor led 20 mental health peer educators in 28 weekly trainings and one full day training for the purpose of developing leadership skills, learning and practicing communication skills, learning about mental health needs and resources, and providing mental health education and support for their peers. Many of the peer educators also participated in the City of Berkeley Youthworks program, where they participated in weekly meetings to learn and develop job readiness skills. In addition to the weekly training sessions, the peer educators also participated in one or more internship projects, including creating mental health presentations for Freshman classes, developing multilingual presentations for ELL English classes, creating videos and posters to spread information about mental health, creating and disseminating information about tobacco and marijuana prevention, and hosting or participating in events to spread awareness about mental health and the BHS Wellness Center. All peer educators had the opportunity to provide one-on-one mentorship to other students, either on a one-time basis or through weekly or biweekly meetings.

In the Spring of FY2024 a second cohort of 12 mental health peer educators participated in 8 weekly trainings and one full day training for the purpose of building community, exploring their own values and biases, learning and practicing communication skills, and learning about mental health needs and resources. After completing their training, this cohort of peer educators were prepared to begin in FY2025, with mentoring and engaging in internship projects.

In FY2024, 32 individuals were served through this program. Demographics on individuals served were as follows:

DEMOGRAPHICS N = 32

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Groups**
  Children and Youth (0-15) – 32

- **Race**
  Asian – <11
  Black or African American – 14
  White – <11
  Other - <11
  More than one Race – <11
  Declined to Answer, or Unknown – <11

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Central American – <11
  Mexican/Mexican American Chicano – <11
  South American – <11
  Other – <11
  Declined to Answer, or Unknown – <11

- **Ethnicity: Non-Hispanic or Latino/Latina/Latinx**
  African – <11
  Asian Indian/South Asian – <11
  Ester European – <11
  Middle Eastern – <11
  Vietnamese – <11
  Other – <11
  Declined to Answer, or Unknown – <11

- **Primary Language**
  English – 19
  Spanish – <11
  Declined to Answer, or Unknown – <11

- **Sexual Orientation**
  Heterosexual or Straight – 17
  Gay or Lesbian - – <11
  Bisexual – <11
  Questioning or unsure of sexual orientation – <11
  Queer – <11
  Another Sexual orientation – <11
  Decline to Answer or Unknown – <11

- **Disability**
  Difficulty Seeing – <11
  Difficulty Hearing or having speech understood – <11
  Mental domain not including a mental illness (ncluding but not limited to a learning disability, developmental disability or dementia) - <11
  Other – *
  No Disability – 22

- **Veteran Status**
  No – 32

- **Gender: Assigned Sex at Birth**
  Decline to Answer or Unknown – 32

- **Current Gender Identity**
  Male – <11
  Female – 23
  Genderqueer - <11
  Questioning or unsure of gender identity – - <11
  Another Gender Identity - <11
  Decline to Answer or Unknown - <11*

Program Successes:
Accomplishments of MEET Students

- Completed semester long training in order to learn the skills to be peer mentors;
- Developed informational and interactive presentation for U-9 Freshman Seminar classes. The students facilitated 28 educational presentations, which reached over 750 students. The presentations aimed to support freshman students to foster greater comfort in discussing mental health, recognize and practice positive coping skills, and learn about how to access mental health resources in and outside of BHS;
- Created and led informational presentations in English and Spanish for all four levels of ELL English, which included information about mental health, addressed the connection between mental health and migration, and shared resources about how to access mental health support at BHS;
- Provided at least 65 one-on-one or small group mentoring sessions to approximately 27 students;
- Served almost 100 shifts in the Wellness Center, during which they were available for drop-in mentorship support, introduced new students to the offerings of the Wellness Center, and helped with the daily maintenance of the Wellness Center;
- Developed, filmed, and edited 9 informational videos about a variety of mental health topics to spread awareness about mental health to other BHS students. Five films were submitted to the Directing Change film competition, three of

which were formally recognized (2nd place in Suicide Prevention category, Honorable Mention in Suicide prevention category, and Special Recognition in Athletics & Mental Health);
- Planned and hosted three school-wide events to provide information and support for stress reduction and mental health awareness;
- Provided information and tours of the new BHS Wellness Center for the Wellness Center Grand Opening (December 2023) & BHS Open House (March 2024).

Number of BHS students served by MEET students:
- 32 students participated as peer educators in the MEET program;
- 750+ Freshman students received classroom presentations;
- 50+ students in the Multilingual Program received classroom presentations;
- 35+ students received one-on-one mentorship from a mental health peer educator;
- All 3200 BHS students viewed MEET videos through the Student Bulletin.

Program Challenges:
A significant challenge continued to be the increase in costs to fund the program. These increases required the school district to make cuts in other programming areas, as well as move resources around to be able to continue providing ongoing services.

Dynamic Mindfulness Program (DMind)

DMind is an evidence-based trauma-informed program implemented in 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 is 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 chronic stress/trauma/PTSD from Adverse Childhood Experiences (ACEs), and/or disengagement from school, chronic absences, and significant behavioral challenges, including emotion regulation, impulse control, anger management, and/or getting frequent referrals/suspensions and at high risk of school failure. DMind also enables teacher and staff well-being, which has been shown to enhance student learning. Program components include in-class and after-school DMind sessions for students, student peer leadership development, and training and coaching of school staff.

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.

PEI Priorities:

- Youth Engagement and Outreach Strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college.
- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

Program results during the reporting timeframe are outlined below:

In FY2022, DMIND was provided both live on-line, and in-person. Training and coaching services were also provided through this program. The training and coaching services build capacity among teachers and staff, so they have the skills for their own self-care, stress resilience and personal sustainability, and for the professional application with students to teach emotional regulation as well as social-emotional learning. Training and coaching was also used to build capacity among student peer leaders, with structured opportunities for application in conflict resolution, peer mediation, restorative justice circles, and leading DMIND practice in their classrooms. Additionally, this program provided videos to the schools and Yoga at Independent Study. A total of 1,546 students and 139 teachers/school staff received services through this program during the reporting timeframe as follows:

School	Number of Students Served	Number of School Staff Served
• Berkeley High School	455	76
• Berkeley Technical Institute	28	12
• King Middle School	248	15
• Longfellow Middle School	127	19
• Willard Middle School	688	17

Total	**1,546**	**139**

Demographic data on individuals served in FY2022 was not provided by BUSD.

In FY2023, services were directly provided to 550 students and 66 staff. An additional 2,000 unduplicated students were reached through knowledge and skills shared by individuals who received direct services. Additionally, there were many more students who practiced along with the online curricular supports by accessing the DMind video library (containing over 300 brief DMind practices), and the "Mood Shifter" for emotion regulation in the programs InPower Mobile App. The big post-COVID change was going from online to in-person services/programs, including in-class sessions by Niroga instructors, as well as staff (teachers, counselors, administrators) training and coaching sessions.

The only demographic data provided by BUSD on individuals who were served in FY2023, was as follows: 0-15 years = 84%; 16-25 years = 5%; 26-59 years = 11%.

Program Successes:

- Successfully pivoted from online to in-person programming after the COVID lockdown ended.
- Staff (teachers and counselors) reported that there was a substantial increase in student mental health issues, leading to challenging student behaviors, e.g. disruptive, distracted, disengaged (fight/flight/freeze), saying they were seeing a certain 'feral quality' to many students (as they re-learned socializing after the long period of social isolation because of COVID), Even so, staff and students responded very positively to the in-person movement-based mindfulness program.

In addition to engaging students, this program also works with school staff to (a) enhance their own personal sustainability (self-care, stress resilience and healing from vicarious trauma) as well as (b) professional application with their students (emotion regulation, de-escalation, focus/attention/engagement). This not only built staff capacity and ensured adequate DMind 'dosage' for enabling neuroplasticity and neurogenesis to rewire their brains and change behavior, but also provided a multiplier factor of ~30-40 (typical class size in middle and high schools, and nominal caseload for counselors), significantly increasing the reach and scope of programming, serving a much larger group of unduplicated students than would have been otherwise possible given budgetary limitations.

Program Challenges:
Program staff witnessed significant levels of overwhelmed school staff which limited their ability to participate in the capacity-building training and coaching offerings.

During the FY2024 reporting timeframe, data on numbers served and demographics was not provided.

Program Successes:
In FY2024, DMIND was provided in three middle schools and two high schools within the Berkeley Unified School District. Over 300 students and a dozen staff to submitted their feedback on the program. The results were inspiring with over 90% of students indicating that as a result of participating in the program they were able to consistently and effectively manage their stress, anger, and anxiety; focus and concentrate; be self-aware; make responsible decisions; have healthy relationships with peers and staff; and be ready and motivated to learn. Additionally, 100% of teachers indicated that they were able to consistently and effectively manage their stress, anger, and anxiety; focus and concentrate; be self-aware; make responsible decisions; have healthy relationships with students and colleagues; have a positive classroom climate; and sustain their well-being as educators. Those same teachers also indicated that their students were able to consistently and effectively manage their stress, anger, and anxiety; focus and concentrate; be self-aware; make responsible decisions; have healthy relationships with peers and staff; and be ready and motivated to learn.

Many of the staff and students surveyed also made sure to include some notes of appreciation and gratitude for providing this program to their school communities. A teacher from Martin Luther King Jr. Middle School noted, “my students have really benefited from this practice.” Another teacher at that school echoed these remarks and added, “the kids [were] able to focus a lot better on the day they participated in the program and they were more productive!” A Counselor from Willard Middle School expressed her thanks as well, sharing, “Students have really enjoyed having a space to practice Mindfulness!” The Vice Principal of School Climate & Student Wellness at Berkeley High School made sure to include a note acknowledging the inclusivity of the practice adding, “this program directly impacts Black students who choose to access the services in lieu of other staff or programs.” The Mindful Yoga program at Berkeley Technology Academy and Berkeley Independent Study also received high praise from teachers who shared “students are all reflecting positive things and noticing their growth. All are really appreciative of the space the program holds for them to slow down and get in tune with their bodies.”

Students added their notes of appreciation as well expressing how impactful this program has been for them. A Berkeley Independent Study student shared, “I especially enjoyed yoga class this week. I tried a lot of new poses and I could feel my balance improving throughout the week…I can’t wait for next week’s class!” A 7th grade student at Willard Middle School shared that she “loved Mindfulness Group a lot! I hope the instructor loved teaching us because I loved and was grateful to have her.”

Program Challenges:
There were no program challenges submitted during the reporting timeframe.

African American Success Project

The African American Success Project (AASP) implements “Umoja” - a daily elective class offered at Longfellow Middle School. Umoja provides African American students a safe affinity space to explore their cultural heritage and identity, while building positive peer relationships and establishing relational trust with adults. Umoja provides an ongoing focus on social and emotional development, including building skills, habits and mindsets that enable self-regulation, interpersonal skills, perseverance and resilience. This project aligns with stated needs found in key BUSD initiatives, and strategic actions, including but not limited to the: Black Lives Matter Resolution, Local Control & Accountability Plan (LCAP), the African American Success Framework (AASF), and the Comprehensive Coordinated Early Intervention Services (CCEIS) Plan.

This project provides a unique chance to expose learners to content traditionally overlooked by educational institutions. Umoja course lessons are rooted in African and African American cultural precepts, and are composed to guide African American learners through:

- An exploration of their identities;
- An interrogation (questioning or query) of their ancestral history;
- Development of a positive sense of purpose and cultural pride;
- Envisioning their futures and outlining a path for fulfillment;
- Developing an awareness of their communal role.

Direct services for parents and guardians:
The project seeks to increase entry points for caregivers to be informed and involved in their child’s learning. Highlights in this area include:

- Providing digital newsletters, and updates using email marketing;
- Coordinating and hosting parent teacher conferences;
- Individual parent meetings/contacts, including advising, problem-solving, and updates regarding student progress;

- Hosting events including the Annual Kwanzaa celebration, and an end of the year meeting to gather qualitative program feedback.

Direct services for students (academic, social, behavioral):

- School-day cultural enrichment designed to uplift and empower African American learners using African centered pedagogical approaches;
- Equity centered support sessions (weekly);
- Structured class check-in sessions.

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.

PEI Priorities:

- Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs).
- Youth engagement and outreach strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college.
- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

Program results during the reporting timeframe were as follows:

In FY2022, 73 students participated in this project. Outlined below are demographics on individuals served through this project:

DEMOGRAPHICS N = 73

- **Age Groups**
  Children and Youth (0-15) – 100%

- **Race**
  Black or African American – 79%
  More than one Race – 10%
  Declined to Answer, or Unknown – 1%

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Hispanic/Latino/Latina/Latinx – 10%

- **Primary Language**
  English – 96%
  Other – <11

- **Sexual Orientation**
  Decline to Answer or Unknown – 100%

- **Disability**
  Other – 25%

- **Veteran Status**
  No – 100%

- **Gender: Assigned Sex at Birth**
  Male – 53%
  Female – 47%

- **Current Gender Identity**
  Male – 53%
  Female – 47%

Worth noting is this project's continued emphasis on school success and reinforcing literary skills. In addition to incorporating literacy structures into the class setting, the project made a strategic investment to establish a classroom library, which affords students access to over 100 unique titles. Efforts were made to select books written by Black/African American authors whose books feature Black/African American history, culture, and stories. Building the library was in direct response to a student survey conducted in a prior school year in which project participants indicated they would read more, if books were available that reflected their lived experience and related to their cultural background.

In FY2023, 53 students participated in this project. Outlined below are demographics on individuals served through this project:

DEMOGRAPHICS N = 53
*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

- **Age Groups**
  Children and Youth (0-15) – 100%

- **Race**
  Black or African American – 66%
  Declined to Answer, or Unknown – 34%

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Other - *

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  Other - *

- **Primary Language**
  English – 100%

- **Sexual Orientation**
  Decline to Answer or Unknown – 100%

- **Disability**
  No – 72%
  Decline to Answer or Unknow – 28%

- **Veteran Status**
  No – 100%

- **Gender: Assigned Sex at Birth**
  Male – 45%
  Female – 55%

- **Current Gender Identity**
  Decline to Answer or Unknow – 100%

Program Successes:

- *Learning Outcomes*: 6th-grade participants demonstrated significant growth in Literacy on the BUSD STAR Assessment.
- *Learning Experiences*: Participants were exposed to a variety of learning experiences, including field trips, STEM enrichment, and guest speakers
- 6th-grade participants visited the Ramses the Great exhibit at the DeYoung Museum.
- School Yard Raps: All participants had the opportunity to attend the Ourstory: The Black History musical. The musical aligned with the program curriculum, and many students
- reported increased interest and engagement with the performance since they prior knowledge of the content. Additionally, this learning experience uplifted the significance of Black History Month and allowed students to be affirmed.
- College Trips: Umoja 7th graders visited Cal Berkeley and California State University, East Bay.
- Berkeley Historical Society: Participants were visited by members of the Berkeley Historical Society, who provided a guest lecture about local Black History that students learned in class.
- STEM Enrichment Club: 6th-grade boys gained access to a STEM Enrichment Club provided by Bay Area Sigmas. Four monthly Saturday sessions were held during the second semester. STEM Enrichment Club participants built STEM competencies using science-related activities.
- BUSD Black History Oratorical Festival: Umoja participants had a strong showing at the 2023 BUSD Black History Oratorical Festival and, for the third year in a row, placed as finalists for the secondary division. The winner of the 2022 and 2023 secondary division was an Umoja participant. An Umoja participant also placed third in the secondary division for 2023.

- Community Engagement: For the fourth consecutive year, Umoja held an annual Kwanzaa recognition. The 2022 Kwanzaa event was a great success and brought together many
- families and staff for an evening of celebration and shared learning.
- Professional Development: The Umoja team provided professional learning opportunities for Longfellow staff, including an annual presentation to support them in preparing for Black History Month.
- The Umoja team joined professional learning efforts provided under the BUSD African American Success Framework, which provided a year-long cultural competence training series for Longfellow staff.
- Collaboration: The Umoja instructor actively collaborated with the Longfellow team to create a safe, welcoming, and inclusive school environment by helping to organize and host community engagements like the annual Rites of Passage Ceremony. They also attended Grade Level Team meetings, Content/Department Team meetings, IEP meetings, etc., to support Umoja participants. Their voices and perspectives about best supporting African-American students should be highlighted as a valuable resource to the school community.
- Partnerships: The Umoja team strategically partnered with organizations to meet program
- needs, including The City of Berkeley, The Mind of Milan LLC, AM1 Media, Freedom Soul Media Education Initiatives, Jason Seals and Associates, Bay Area Sigmas, Marcus Books, RT Fisher Educational Enterprises, and the Berkeley Public School Fund. These organizations provided financial support, subject matter expertise, services, and resources to keep the program running.

Program Challenges:
During the fiscal year, the program did not serve 8th-grade students as in past years. This caused a slight reduction in the number of participants served. Confusion regarding the course selection process and available options likely contributed to this circumstance.

In FY2024 46 students participated in this project. Outlined below are demographics on individuals served through this project:

DEMOGRAPHICS N = 46
*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Groups**
  Children and Youth (0-15) – 46

- **Race**
  Asian - <11
  Black or African American – 35
  More than one race – <11

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Other - <11

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  Decline to Answer or Unknow - 46

- **Primary Language**
  English – 46

- **Sexual Orientation**
  Decline to Answer or Unknown – 46

- **Disability**
  Other – <11

- **Veteran Status**
  No – 46

- **Gender: Assigned Sex at Birth**
  Male – 28
  Female – 18

- **Current Gender Identity**
  Decline to Answer or Unknow – 46

Program Successes:
There were no program successes submitted during the reporting timeframe.

Program Challenges:
During the fiscal year, the program did not serve 8th-grade students as in past years. This caused a reduction in the number of participants served.

ACCESS AND LINKAGE TO TREATMENT AND PREVENTION & EARLY INTERVENTION COMBINED PROGRAM

Access and Linkage to Treatment Programs – Connects 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.

Prevention Programs – Includes a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors.

Early Intervention Programs – Provides 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.

The City of Berkeley has one combined Prevention, Early Intervention program that also has an Access to Linkage and Treatment program component:

High School Youth Prevention Program

This program operates in conjunction with other health school related services offered at Berkeley High School (BHS) and Berkeley Technology Academy (BTA) and has become a successful partnership between BUSD and the Public Health and Mental Health Divisions of Berkeley's HHCS Department. The program provides 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, 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 at the High School Health Center or in the community for follow-up care and intervention and/or treatment.

The Berkeley High School (BHS) and Berkeley Technology Academy (BTA) Health Centers are both multidisciplinary co-locations of the City of Berkeley's Mental Health and Public Health Divisions. The Health Center team provides a range of Prevention/Early Intervention (PEI) services and also functions as an Access and Linkage to Treatment program. Culturally and linguistically diverse staff provide services in English and Spanish. Translation services in all other languages are available using a language line.

The Health Centers are operational year-round, Monday through Friday, from 8:30 AM-4 PM, with a daily closure from 12-1 PM for lunch and administrative tasks. There are brief periodic closures due to BUSD's academic calendar and in these instances some services are still provided via telehealth when possible. When fully operational, services can be accessed via student drop-in and/or via scheduled appointment. Services can also be requested via Jotform, an online, HIPAA-compliant, referral platform. This referral platform can be accessed is accessible via QR code on informational flyers that are posted across campus and also online in several locations including the Health Center website. Students can self-refer using Jotform, and parents/caregivers, staff, and friends are also able to refer someone else using this method. Additionally, students, parents/caregivers, and staff are able to request services via phone by calling the Health Center main phone number. Hours of operation at Berkeley Technology Academy Health Center are more limited due to the small student population and staffing constraints. When BTA students are unable to access a needed service at that Health Center, they are referred to BHS Health Center for those needed services.

Health Center staff frequently facilitate linkages on behalf of youth and their families, depending upon a given need. Behavioral Health Clinicians ("BHCs") conduct initial assessments with students in order to screen for a variety of health and mental health needs, considering accessibility, insurance status, acuity, and risk factors to support with decision-making around level of care considerations and related linkages. BHCs provide students with short-term behavioral health services—crisis, individual, group—as needed irrespective of insurance status and all students are eligible to receive these free and confidential services. BHCs also link youth/families with more intensive needs to additional services depending upon their specific needs and insurance status. BHCs provide this linkage support via internal referrals (e.g. EPSDT Medi-Cal services; Full Service Partnership team; psychiatry/medication management), Alameda County Access, as well as linkages to services through private insurance carriers. BHCs also sometimes make internal on-campus referrals to the 504 and Special Education programs when some type of mental or physical health condition may be impeding a youth's ability to adequately access their education. BHCs also support youth and their families who are uninsured with accessing and enrolling in Medi-Cal and other relevant programs that support health and well-being.

As an Access and Linkage to Treatment Program, the Health Center's Mental Health Program Supervisor monitors all referrals in order to ensure timely responsiveness and follow up that supports engagement in treatment. All BHCs have access to and monitor incoming referrals that are submitted via Jotform and respond to referrals on a rotating basis. The MH Program Supervisor monitors and responds to referrals via phone and

checks voicemail multiple times per day. In instances where a staff person responds to a referral but is unable to make contact with the referring party, staff will follow up at least three times in an effort to support engagement. The Jotform referral inquires about preferred method of contact and also inquires about whether a youth can be pulled from class in order to conduct an initial assessment. Staff utilize these preferences in order to inform outreach efforts and increase the likelihood of establishing and supporting engagement.

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

PEI Priorities:

- Youth engagement and outreach strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college.
- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

During the reporting timeframe, The Health Center resumed hosting a cohort of three graduate-level trainees (0.6 FTE each) due to stabilization of full-time staff capacity, which contributed to increased service capacity for the duration of the 22-23 school year. One full-time (1.0 FTE) Behavioral Health Clinician II obtained a promotional opportunity outside of the City of Berkeley and transitioned out of his role in early August 2022. This position was temporarily vacant and eventually backfilled by a new Behavioral Health Clinician II in late November 2022. One additional full-time (1.0 FTE) Behavioral Health Clinician I position was added to the High School Mental Health team in late October 2022, and this staff was based across multiple sites (0.4 FTE at Berkeley High School; 0.4 FTE at Berkeley Technology Academy; and 0.2 FTE at K-8 School-Based).

In April 2023, as a result of a Division-wide structural reorganization, High School Mental Health became a standalone program separate from Family, Youth & Children's Services. As part of this reorganization, a new full-time (1.0 FTE) Mental Health

Program Supervisor position was created. The team's existing full-time (1.0 FTE) Mental Health Clinical Supervisor was promoted into this new position in April 2023, and the Mental Health Clinical Supervisor position has since remained vacant.

In FY2022, approximately 233 students received services through this project. Demographics on youth served are outlined below:

DEMOGRAPHICS N = 233

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Groups**
  Children and Youth (0-15) – 33%
  16 – 25 – 67%

- **Race**
  American Indian or Alaska Native – 2%
  Asian – 7%
  Black or African American – 17%
  Native Hawaiian or other Pacific Islander- <1%
  White – 33%
  More than one race – 14%
  Other – 11%
  Declined to Answer (or Unknown) – 16%

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Other – 22%
  Declined to Answer (or Unknown) – 16%

- **Primary Language**
  English – 93%
  Spanish – 6%
  Declined to Answer (or Unknown) – 1%

- **Sexual Orientation**
  Gay or Lesbian or Bisexual or Questioning or Queer, or Unsure or Another Sexual Orientation – 21%
  Heterosexual or Straight – 35%
  Decline to Answer or Unknown – 44%

- **Disability**
  Decline to Answer or Unknown – 100%

- **Veteran Status**
  No – 100%

- **Gender: Assigned Sex at Birth**
  Male – 21%
  Female – 45%
  Gender non-conforming, Transgender, Genderqueer – 11%
  Declined to Answer (or Unknown) – 23%

- **Current Gender Identity**
  Male – 21%
  Female – 44%
  Transgender – 3%
  Genderqueer – 7%
  Another Gender Identity - <1%
  Declined to Answer (or Unknown) – 25%

Program Successes:

- Resumed providing the full range of services when students returned to full-time in-person learning.
- Following multiple staff transitions during the summer of 2021, this project was able to add two diverse, experienced, highly skilled, licensed clinicians, one of whom is a native bilingual Spanish speaker. Both clinicians quickly became part of a cohesive and collaborative mental health team and have integrated well into the larger Health Center team.
- The mental health team was able to substantially increase service utilization year-over-year compared to the FY2021 school year. As half of the student body were new to campus in FY2022, the project focused more of its efforts on outreach in order to familiarize students with the array of services.
- The mental health team maintained the use of the JotForm application for referrals. The team also integrated QR code technology into the referral form so that it can be more easily accessed and completed by students and school staff.
- The mental health team maintained a collaborative and productive relationship with the Berkeley High School Coordination of Services Team (OST) throughout the school year in order to ensure that appropriate referrals were made to the program.
- The mental health team was able to support students by providing an array of crisis support services following the tragic death of a Berkeley High School student in April 2022.
- The mental health team was also able to build upon and improve existing relationships and partnerships with Berkeley High School stakeholders. To this end the team collaborated with several different on-campus programs throughout the year such as the Multi-cultural Program, McKinney Vento Program, Special Education Program, and Intervention Counselors. The team also conducted stakeholder meetings at the end of the school year in order to elicit feedback

around the services that are provided with a focus on how to improve collaboration, advance equity, and improve service accessibility.

Program Challenges:

- Two newly hired full-time Mental Health Clinicians were onboarded in FY2022 in September and November. From August through December 2021 one full-time bilingual Mental Health Clinician was on parental leave. These staffing limitations contributed to the teams reduced service capacity during the Fall 2021 timeframe.
- Due to staff transitions during the preceding summer, the project was not able to host a cohort of graduate-level trainees, which also contributed to reduced service capacity during the FY2022 school year.
- As a result of reduced staffing and service capacity, the mental health team did not facilitate support groups during the FY2022 school year.
- Berkeley High School administration and staff also experienced difficulties with the transition back to full-time in-person learning and it took time to rebuild coordinated systems for supporting a range of student's needs. Project leadership and Berkeley High School Administration continued to develop relevant protocols during the courses of the school year to better support student accessibility to needed services.

Results Based Accountability (RBA) measures for this project are as follows:

Process Measures **How much did we do?**	**Quality Measures** **How well did we do it?**	**Impact Measures** **Is Anyone Better off?**
• # of clients served • # of clients opened for ongoing services • # of services provided by service type	• # of clients screened for depression, trauma, and substance use • # of clients contacted within a week following a referral to the High School Health Center (HSHC) • % of school population served • % of clients satisfied with services, as measured by % of clients who agree with the following: HSHC Staff… -Treat me with respect -Listen carefully to what I have to say • Make me feel like there's an adult at school who cares about me	• % of clients able to receive needed care, as measured by % of clients who agree with the following: The HSHC… -Is easy to get help from when I need it -Helps me to meet many of my health needs

*Demographic data was reported at the program level, where available

Measure	Definition	Data Source
# clients served	Total clients served	ETO/RedCap
# services provided by service type	# of services coded as behavioral_service with codes BHSV1-8. Key code accompanies Redcap data. Each incident could include more than one service provided.	ETO/RedCap
% clients screened for depression, trauma, and substance use	Percent of total clients that were recorded as having been screened for depression, trauma, and/or substance abuse at least one-time during reporting period.	ETO/RedCap
% referrals to HSHC followed up within one week	Percentage of referrals that had 7 days or less between referral date and response date. Calculation reflects % of total referrals, not % of total clients.	Referral Log
% of school population served	Unique clients served by HSHC divided by total student population	ETO/RedCap; BHS data
% of clients satisfied with services, as measured by % of clients who agree with various statements	% of responses marked as "agree" or "strongly agree" for various survey questions. Note: these responses are from all students who accessed the health center and answered the survey, not just those who received mental health services.	Berkeley SBHC Client Survey

Data Development Agenda: measures the team is interested in reporting on but for which reliable data was not available:

- Responsiveness of service (e.g. x days following qualifying event)
- % of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program

The RBA outcomes for FY2022 are outlined on the following pages.

High School Health Center (HSHC)
RBA Outcomes
Reporting Period: July 2021-June 2022 (Baseline)

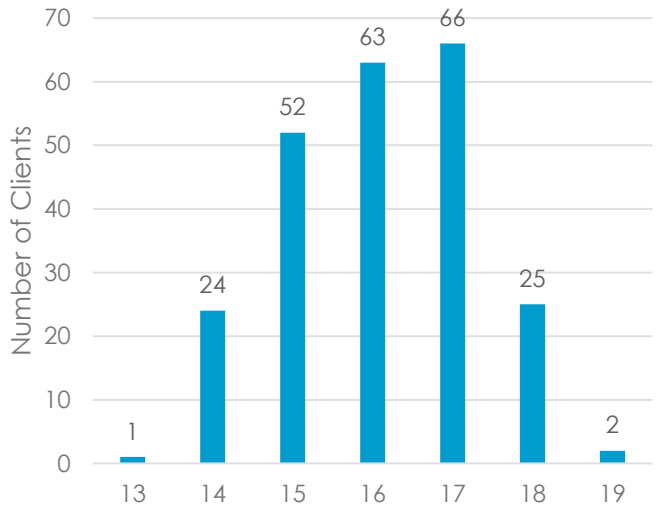
Process Outcomes ("How much did we do?")

233
Clients Served

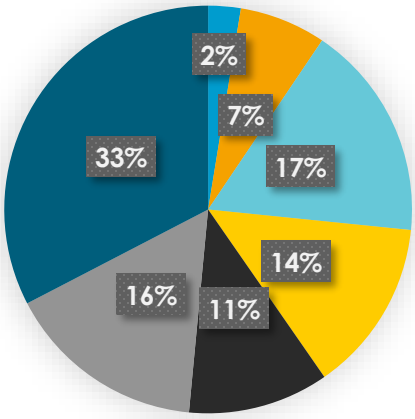
represents 20 clients

Program Description
The HSHC team provides mental health services on site at Berkeley High School; these services include individual and group therapy, crisis assessments, and drop in support. The program also hosts graduate students for training.

Demographics (Age)

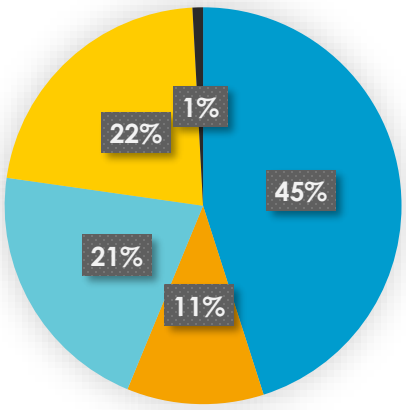


Demographics (Race)



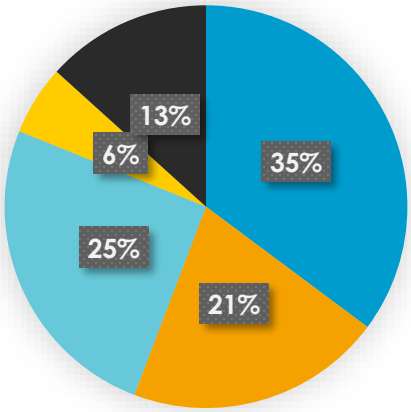
- Alaska Native or American Indian (2%)
- Asian or Pacific Islander (7%)
- Black or African American (17%)
- More than one race (14%)
- Other (11%)
- Prefer not to answer (16%)
- White (33%)

Demographics (Gender Identity)



- Female (45%)
- Gender nonconforming, transgender, genderqueer (11%)
- Male (21%)
- Missing (22%)
- Prefer not to answer (1%)

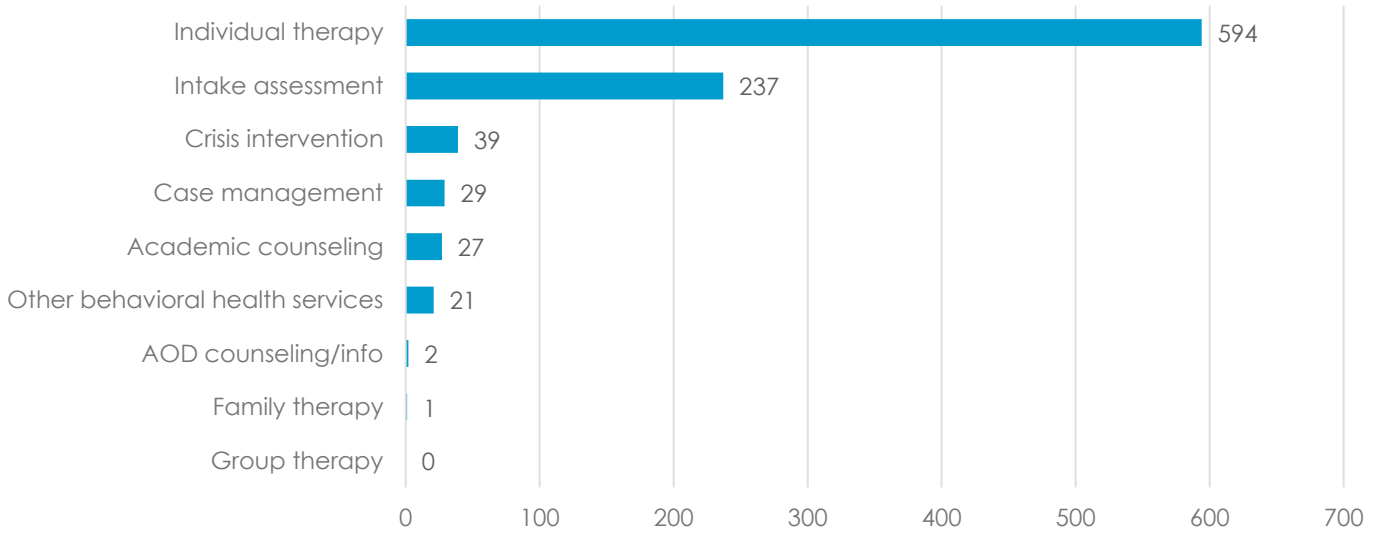
Demographics (Sexual Orientation)



- Heterosexual (35%)
- LGBTQ* (21%)
- Missing (25%)
- Prefer not to answer (6%)
- Unknown/unsure (13%)

*includes students who self-identified as aromantic, asexual, bisexual, gay, homosexual, lesbian, pansexual, queer, and questioning

Services Provided by Service Type

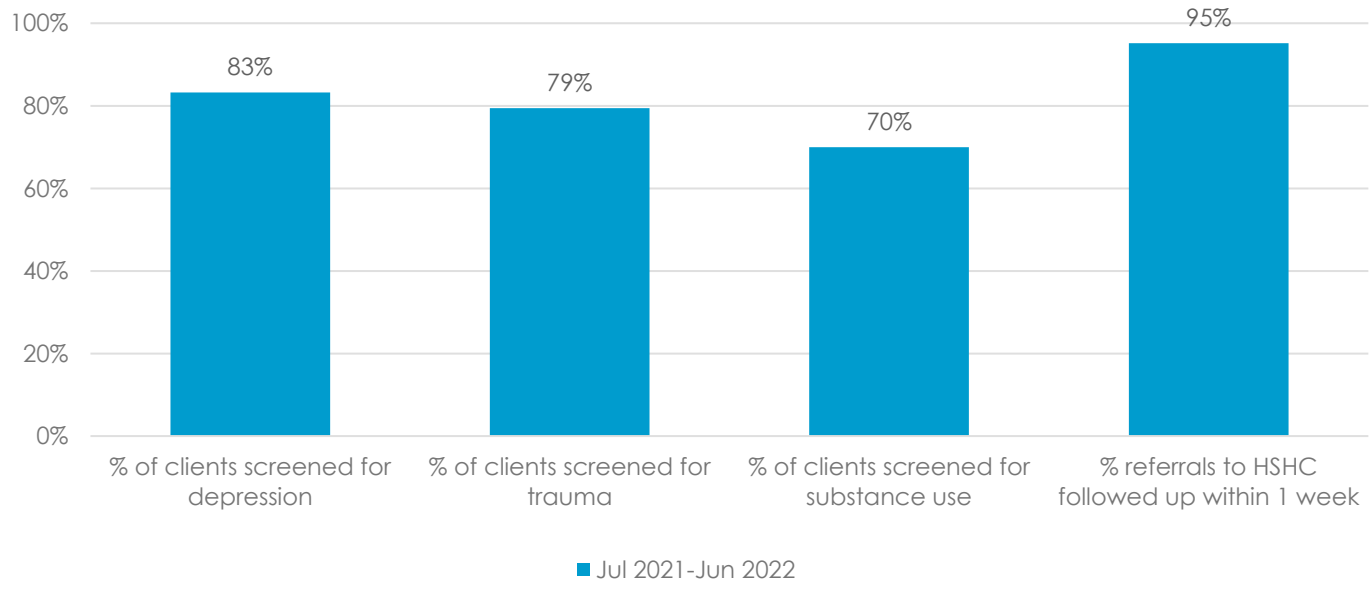


Note that multiple services could be provided in one visit (e.g. crisis assessment and referral) so total services by type (n=950) is greater than total encounters (n=846)

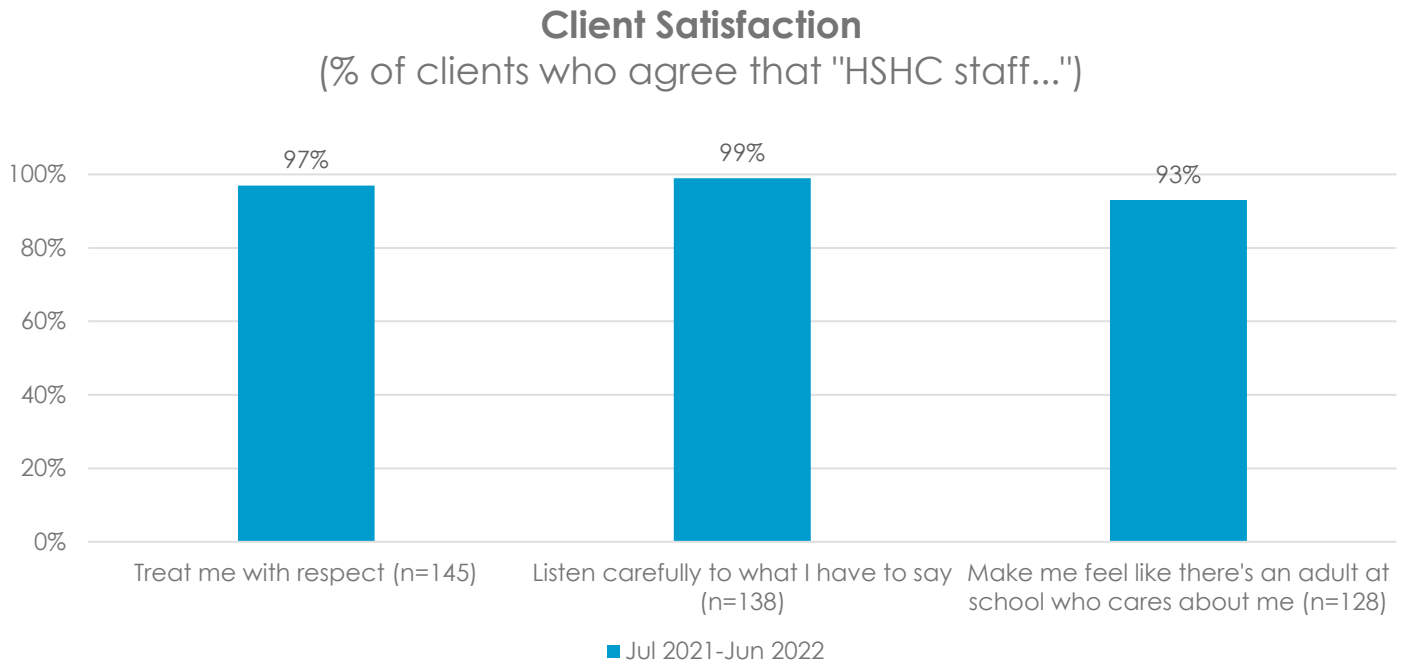
Quality Outcomes ("How well did we do it?")

In 2021-2022, the HSHC program served **7%** of the school population.

Service Consistency



Impact Outcomes ("Is anyone better off?")



In FY2023, approximately 244 students received services through this project. Demographics on youth served are outlined below:

DEMOGRAPHICS N = 244

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

- **Age Groups**
  Children and Youth (0-15) – 24%
  16 – 25 – 76%

- **Race**
  American Indian or Alaska Native – *
  Asian – 11%
  Black or African American – 20%
  White – 22%
  More than one race – 18%
  Other – 22%
  Declined to Answer (or Unknown) – *

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Other – 32%
  Declined to Answer (or Unknown) – *

- **Primary Language**
  English – 83%
  Spanish – 14%
  Other - *
  Declined to Answer (or Unknown) – *

- **Sexual Orientation**
  Gay or Lesbian – *
  Heterosexual or Straight – 49%
  Bisexual – 13%
  Questioning or Unsure of Sexual Orientation - *
  Queer - *
  Another Sexual Orientation - *
  Decline to Answer or Unknown – 21%

- **Disability**
  Decline to Answer or Unknown – 100%

- **Veteran Status**
  No – 100%

- **Gender: Assigned Sex at Birth**
  Male – 34%
  Female – 66%

- **Current Gender Identity**
  Male – 31%
  Female – 55%
  Transgender – *
  Genderqueer – 11%
  Another Gender Identity - *

Program Successes:

- Continued to provide the full suite of in-person mental health, reproductive & sexual health, and first aid services for the duration of the school year.
- The Mental Health (MH) team was able to resume its graduate-level training program and provide a wider array of multi-tiered services with the resumption of support groups.
- Substantially increase service utilization year-over-year compared to 21-22 school year.
- Continued to use the Jotform application for referrals in order to streamline accessibility and minimize barriers to care.
- Maintained a collaborative and productive relationship with BHS's Coordination of Services Team (COST) throughout the school year in order to ensure that appropriate referrals were made to the Health Center and other programs.
- Due to a vacancy and new position, the Health Center was able to recruit two diverse, experienced, highly skilled clinicians, one of whom is a native bilingual Spanish speaker. Both new clinicians quickly became part of a cohesive and collaborative mental health team and integrated well into the larger Health Center team.
- Provided an array of crisis support services following the tragic deaths of two BHS students in October 2022.
- Health Center leadership continued to develop strong working relationships with BHS admin, especially the BHS Principal, new Vice Principal of Climate & Wellness, and 504/COST Program Supervisor. Health Center leadership, City of Berkeley HHCS Departmental leadership, and the BHS VP of Climate & Wellness also developed a plan to open a differentiated Wellness Center space at BHS along with a continuum of tiered wellness support services, to be implemented in the 23-24 school year by BHS staff with additional funding support and partnership from City of Berkeley.
- Continued to build upon and improve existing relationships and partnerships with other BHS stakeholders. To this end, the MH team collaborated with several different on-campus programs throughout the year such as the Multilingual

Program, McKinney Vento Program, Special Education Program, and Intervention Counselors.

Program Challenges:

- From August through November 2022, one full-time bilingual Behavioral Health Clinician II position was vacant. This vacancy negatively impacted individual and group service provision as well as On Call crisis coverage. Nevertheless, the resumption of a graduate-level training program helped to offset some of these negative impacts.
- Staffing shortages across the Health Center's Public Health team, both administrative and clinical, contributed to less consistently available First Aid and Reproductive & Sexual Health services. This, in turn, negatively impacted students' ability to access integrated services. As a result of reduced administrative capacity, the MH Clinical Supervisor and MH team were also responsible for additional, sometimes time-consuming administrative tasks.
- Quality Assurance (QA)/Quality Improvement (QI) and related encounter data extraction/analysis were constrained for the duration of the 22-23 school year due the to an abrupt resignation of the City IT staff person who managed the Health Center's EHR, NextGen. As a result of this, other City IT staff were not sufficiently cross-trained to provide technical support. Furthermore, NextGen vendor staff were often unresponsive to the needs and requests of the Health Center program. This contributed to significant delays with data analysis and reporting, which contributed to additional challenges with data collection across demographic categories and also constrained supervisory decision-making that could have improved efficiencies and improvements in service provision.
- The MH team also continued to use multiple EHRs and applications that are not integrated with one another. This made clinical documentation more cumbersome and time-consuming for all staff.

The RBA outcomes for FY2023, are outlined on the following pages.

BMH RBA Report FY 2023

Reporting Period: July 2022 - June 2023

High School Health Center (HSHC)

Process Outcomes ("How much did we do?")

244

Clients Served

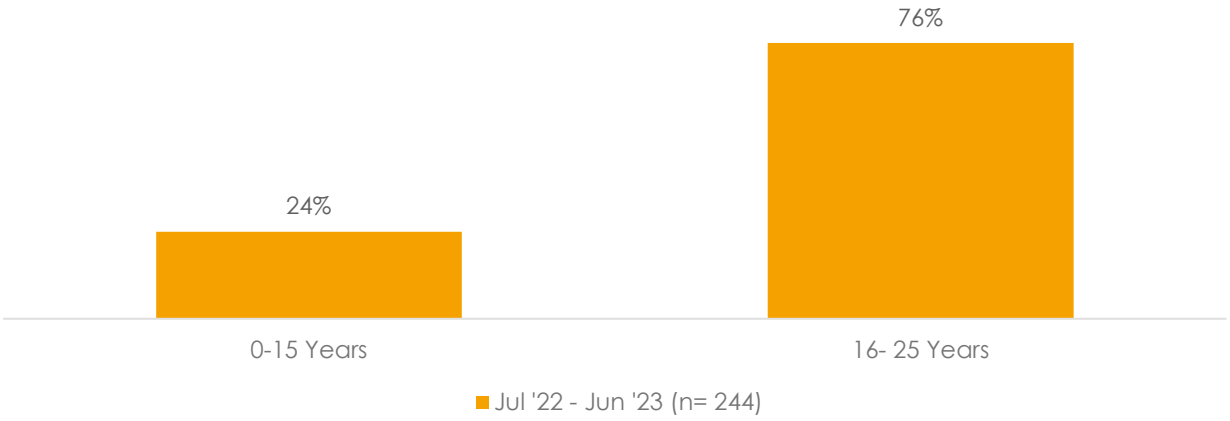
Program Description

The HSHC team provides mental health services on site at Berkeley High School; these services include individual and group therapy, crisis assessments, and drop in support. The program also hosts graduate students for training.

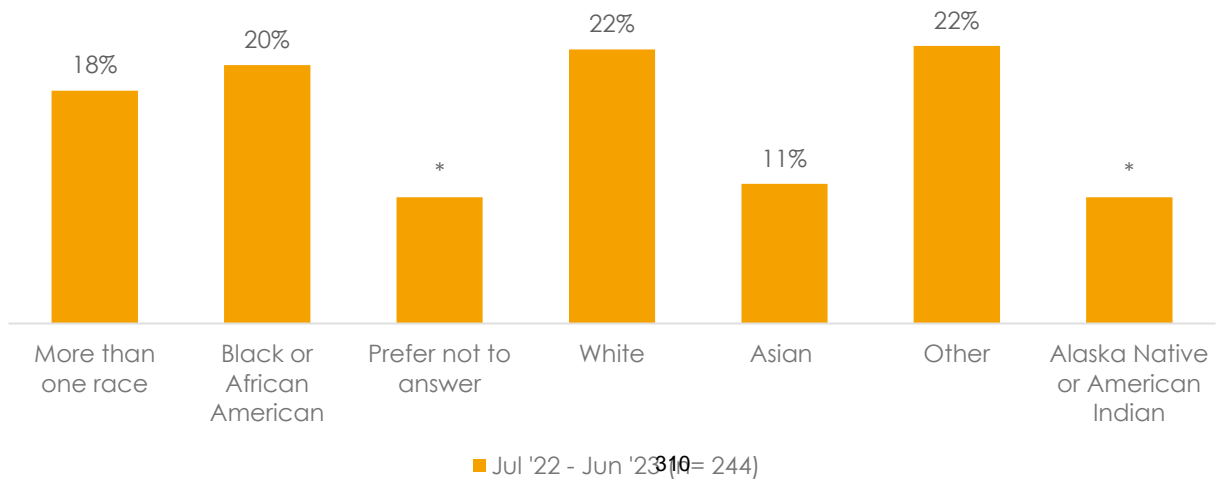
Program Updates

HSHC hired two new full time staff and onboarded 3 master's-level interns in the 2022-2023 school year. This allowed the team to serve more clients and restart groups. HSHC had significant challenges with their EHR, resulting in barriers to quality control.

Demographics (Age)

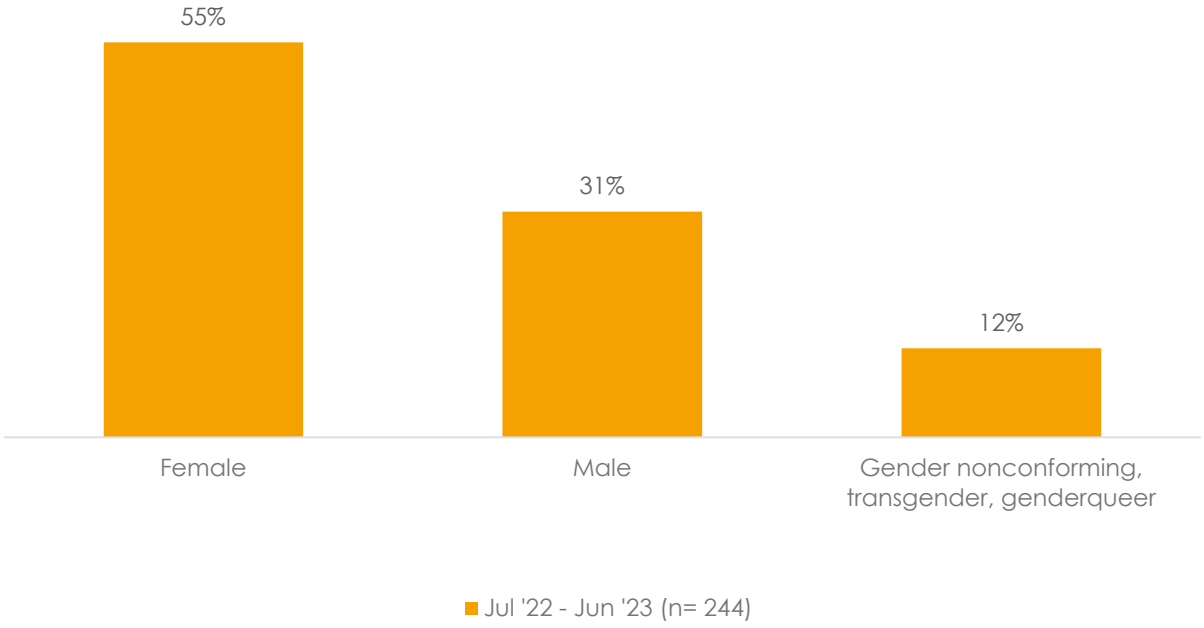


Demographics (Ethnicity)

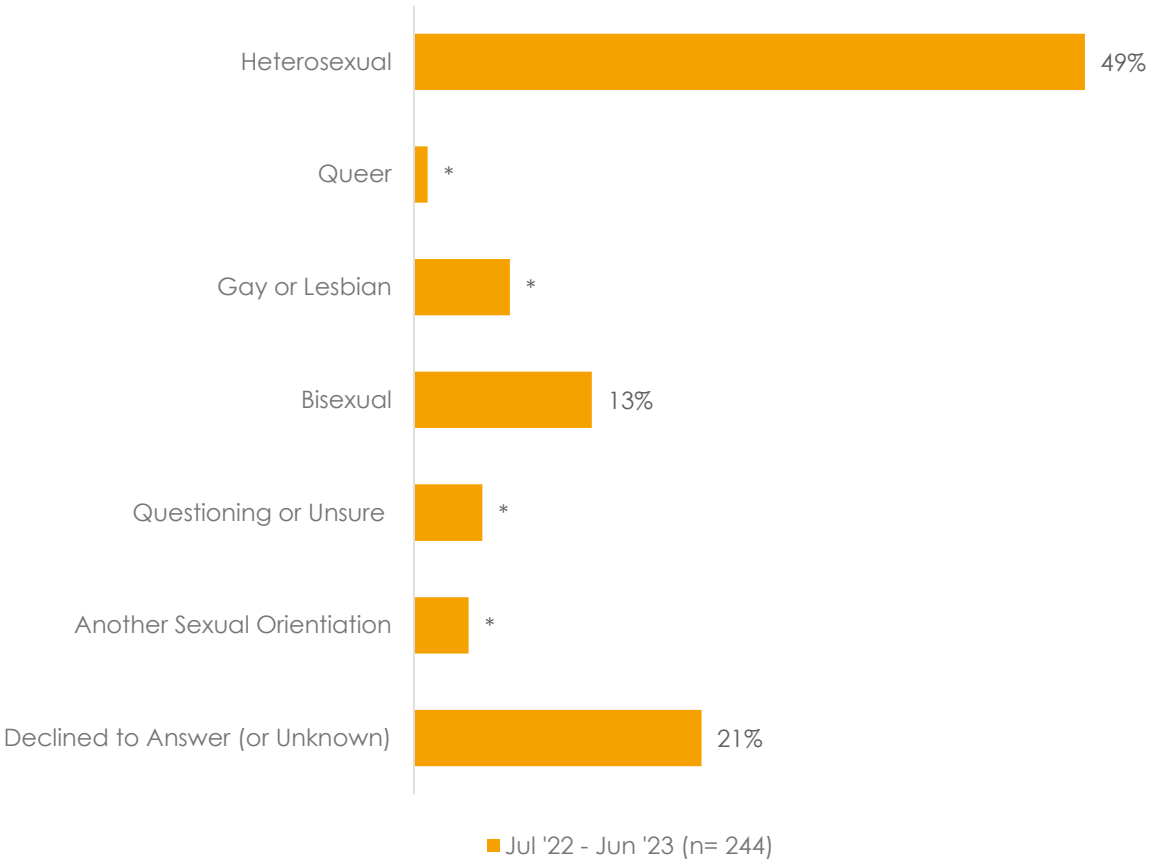


NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Demographics (Gender Identity)

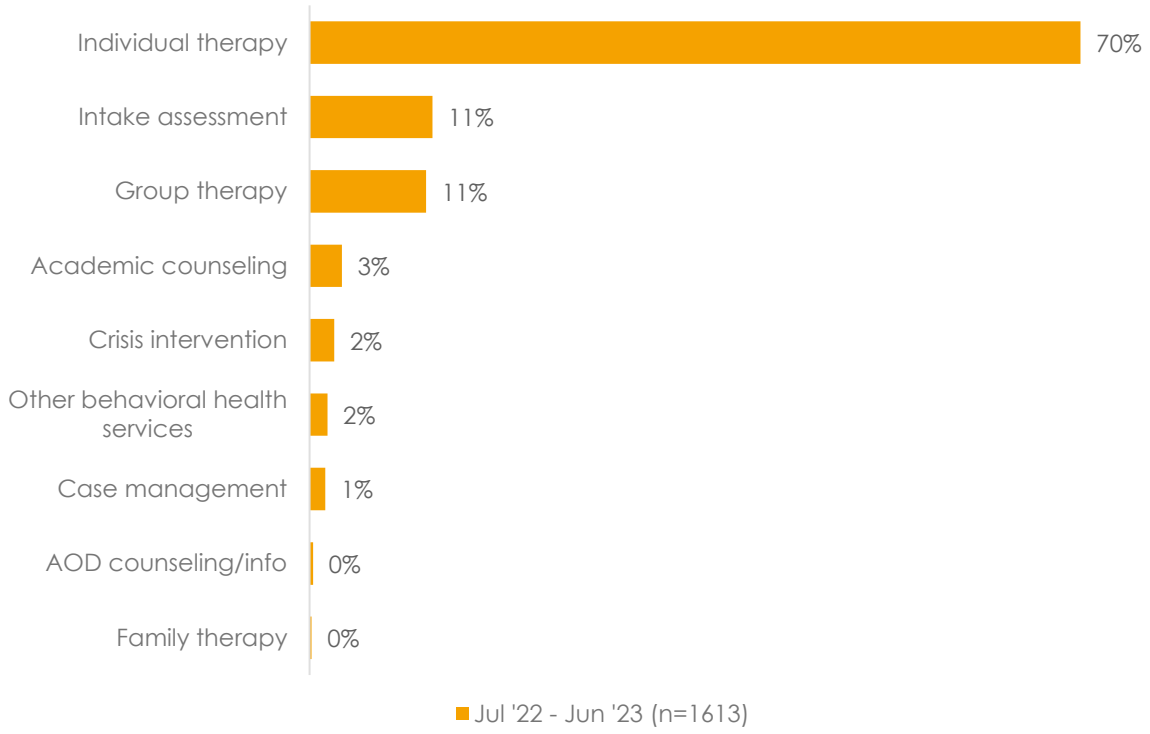


Demographics (Sexual Orientation)



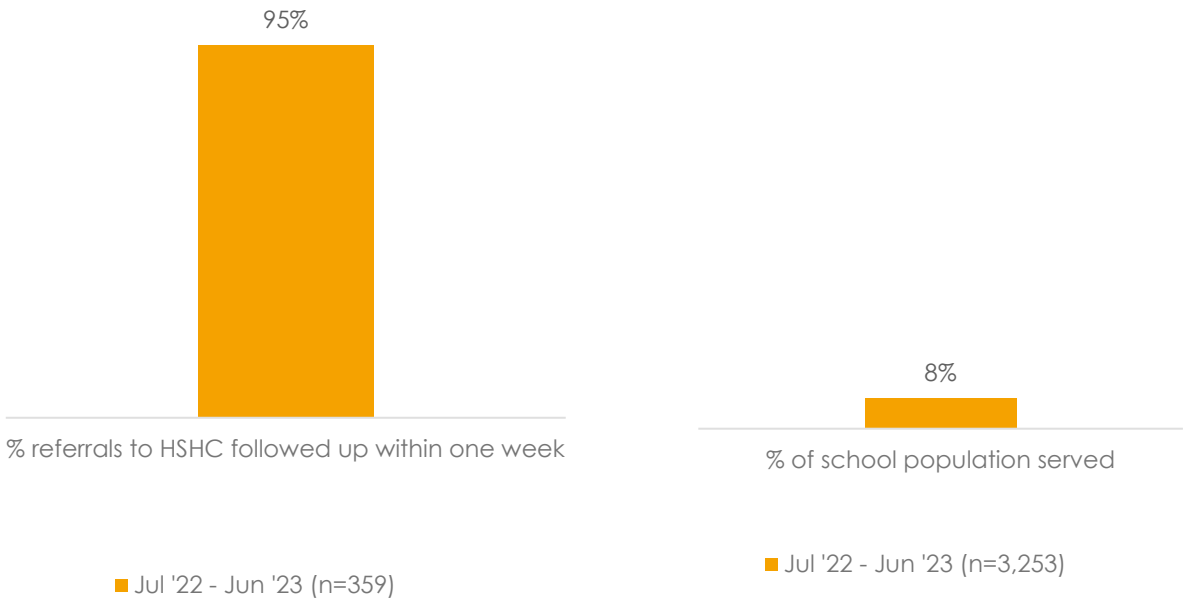
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Services Provided by Service Type

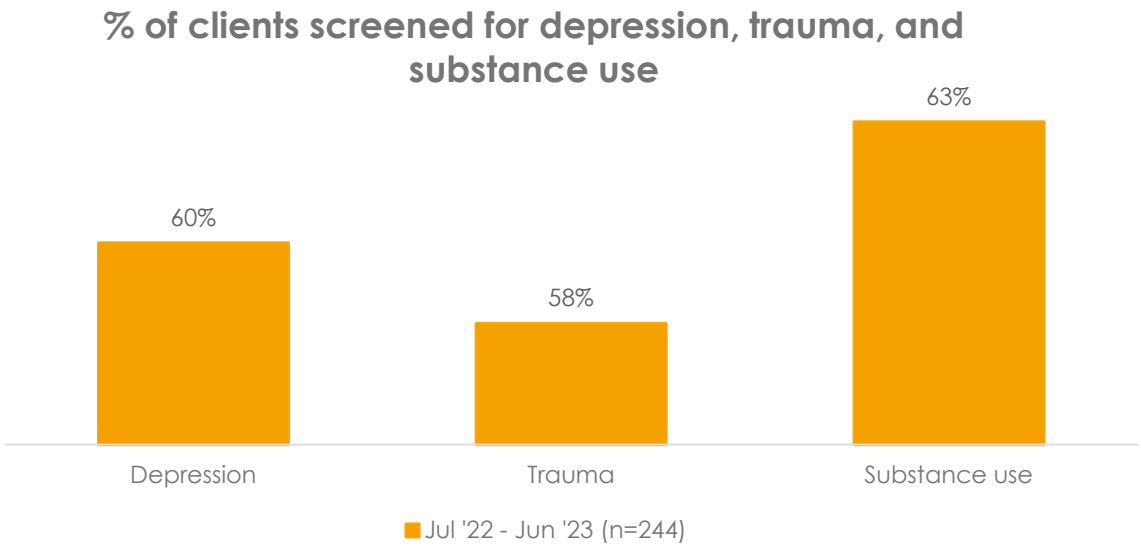


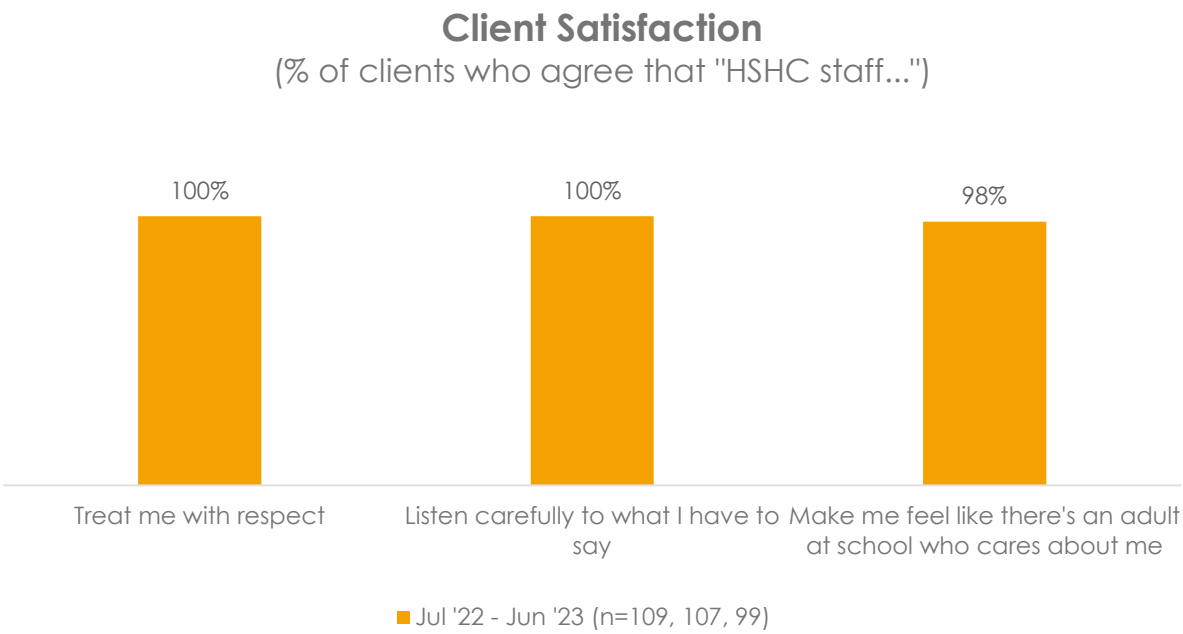
Note that multiple services could be provided in one visit (e.g. crisis assessment and referral) so total services by type is greater than total encounters.

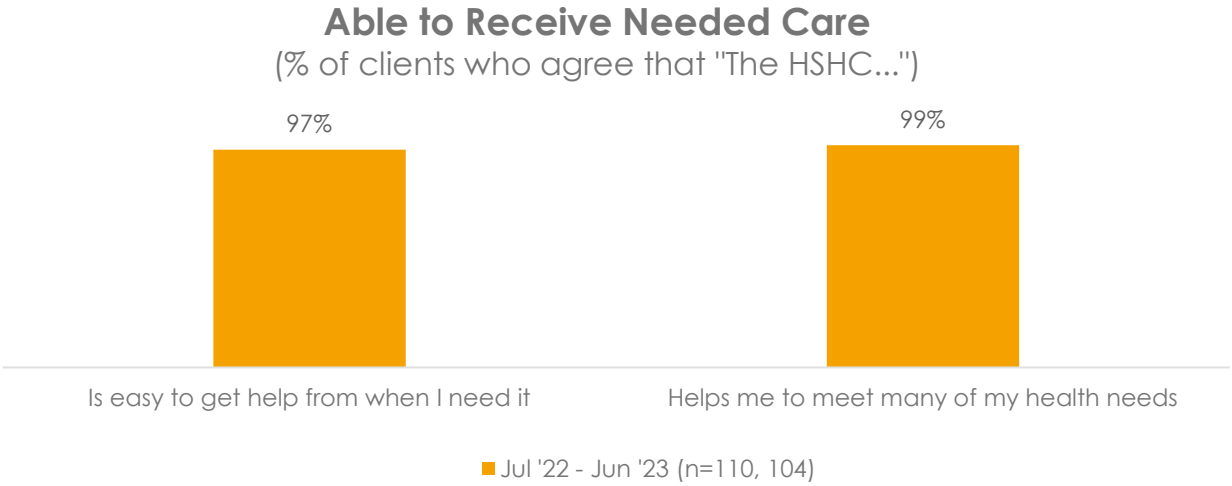
Quality Outcomes ("How well did we do it?")



NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.







NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Measure	Definition	Data Source
# clients served	Total clients served	NextGen
# of services provided by service type	# of services coded as behavioral_service with codes BHSV1-8. Key code accompanies NextGen data. Each incident could include more than one service provided.	NextGen
% clients screened for depression, trauma, and substance use	Percent of total clients that were recorded as having been screened for depression, trauma, and/or substance abuse at least one time during reporting period.	NextGen
% referrals to HSHC followed up within one week	Percentage of referrals that had 7 days or less between referral date and response date. Calculation reflects % of total referrals, not % of total clients.	Jotform
% of school population served	Unique clients served by HSHC divided by total student population of BHS and BTA.	NextGen; DataQuest
% of clients satisfied with services	% of responses marked as "agree" or "strongly agree" for various survey questions. Note: these responses are from all students who accessed the health center and answered the survey, not just those who received mental health services.	Berkeley SBHC Client Survey
% of clients able to receive needed care	% of responses marked as "agree" or "strongly agree" for various survey questions. Note: these responses are from all students who accessed the health center and answered the survey, not just those who received mental health services.	Berkeley SBHC Client Survey

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

In FY2024, the Health Center had the following positions: a full-time Mental Health Program Supervisor, a full-time Mental Health Clinical Supervisor (vacant), four full-time Behavioral Health Clinicians, and a cohort of three part-time graduate-level trainees. One Behavioral Health Clinician II was on administrative leave from January through June 2024. Two graduate-level trainees concluded their respective traineeships in January 2024 and February 2024. One Behavioral Health Clinician II promoted into the vacant Mental Health Clinical Supervisor position in May 2024.

In FY2024, approximately 210 students received services through this project. Demographics on youth served are outlined below:

DEMOGRAPHICS N = 210

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Groups**
  Children and Youth (0-15) – 52
  16 – 25 – 158

- **Race**
  Asian – 21
  Black or African American – 44
  White – 42
  More than one race – 57

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Other – 46

- **Primary Language**
  English – 178
  Spanish – 22
  Other/Declined to Answer (or Unknown) - <11

- **Sexual Orientation**
  Heterosexual or Straight - 116
  Gay/Lesbian/Bisexual/Questioning/Another Sexual Orientation/Decline to Answer or Unknown – 94

- **Disability**
  Decline to Answer or Unknown – 210

- **Veteran Status**
  No – 210

- **Gender: Assigned Sex at Birth**
  Decline to Answer or Unknown – 210

- **Current Gender Identity**
  Male – 61
  Female – 113
  Other - 36

Program Successes:

- Continued to provide the full suite of in-person mental health, reproductive & sexual health, and first aid services for the duration of the school year.
- The Mental Health (MH) team was able to resume its graduate-level training program and provided an array of multi-tiered individual, group and crisis services.
- Continued to use the Jotform application for referrals in order to streamline accessibility and minimize barriers to care.
- Maintained a collaborative and productive relationship with BHS's Coordination of Services Team (COST) throughout the school year in order to ensure that appropriate referrals were made to the Health Center and other programs.
- Continued to build strong working relationships with BHS Administration, especially the Principal, Vice Principal of Climate & Wellness, and MH & Well-Being Coordinator.
- BHS Leadership, along with Health Center leadership and City of Berkeley HHCS Departmental leadership, were able to successfully implement and open a differentiated Wellness Center space at BHS along with a continuum of tiered wellness support services in December 2023.
- For Q3 and Q4, the Wellness Center provided a differentiated universal (Tier 1) and targeted (Tier 2) support space for students that did not previously exist.
- Continued to build upon and improve existing relationships and partnerships with other BHS stakeholders. To this end, the MH team collaborated with several different on-campus programs throughout the year such as the Multilingual Program, McKinney Vento Program, Special Education Program, and Intervention Counselors.

Program Challenges:

- The MH Team experienced multiple vacancies in the supervisor, clinician, and trainee classifications. These vacancies impacted the team's overall capacity, including individual and group service provision as well as on call crisis coverage. Furthermore, staffing shortages across the Health Center's Public Health Team, both administrative and clinical, impacted service provision, operational capacity, and integration across Divisions.

- The Health Center’s Electronic Health Record (EHR), NextGen, provided limited functionality. This contributed to delays with data collection, analysis, and reporting. These challenges constrained supervisory decision-making that could have improved efficiencies and improvements in service provision.
- The MH team also continued to use multiple EHRs and applications that are not integrated with one another and do not interface with one another. This made clinical documentation more cumbersome and time-consuming for all staff and also made data collection and analysis more laborious.

The RBA outcomes for FY2024 are outlined on the following pages:

BMH RBA Report FY 2024

Reporting Period: July 2023 - June 2024

High School Health Center (HSHC)

Process Outcomes ("How much did we do?")

210

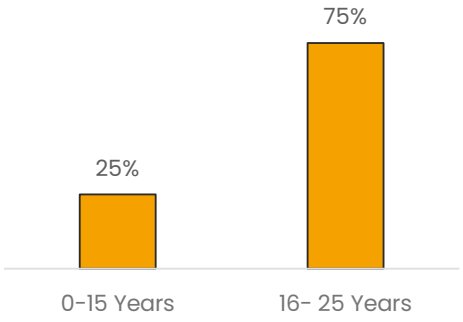
Clients Served

Program Description

The HSHC team provides mental health services on site at Berkeley High School; these services include individual and group therapy, crisis assessments, and drop in support. The program also hosts graduate students for training.

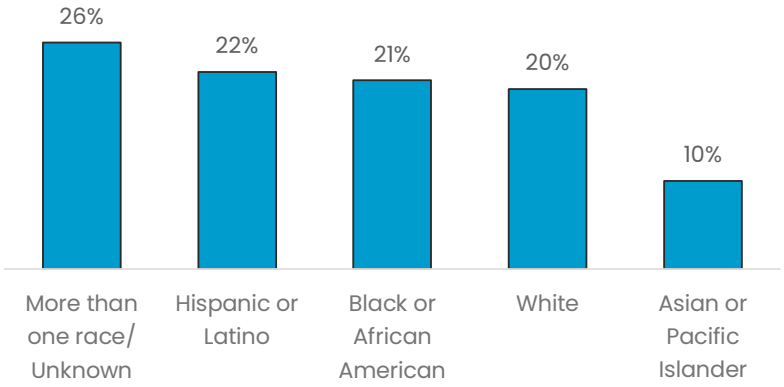
Demographics (Age)

Jul '23 - Jun '24 (n=210)



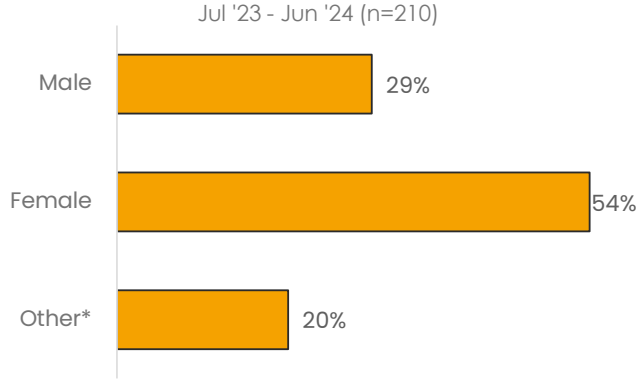
Demographics (Ethnicity)

Jul '23 - Jun '24 (n=210)



Demographics (Gender Identity)

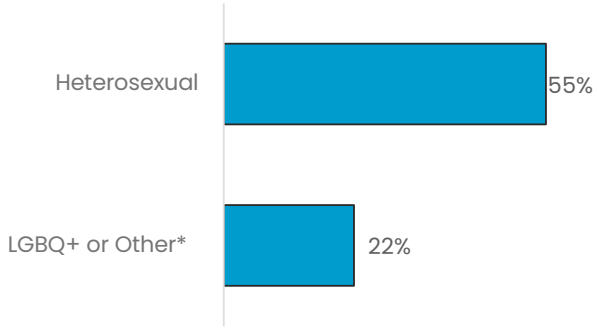
Jul '23 - Jun '24 (n=210)



*Other includes any identity that doesn't fit within the traditional male/female binary.

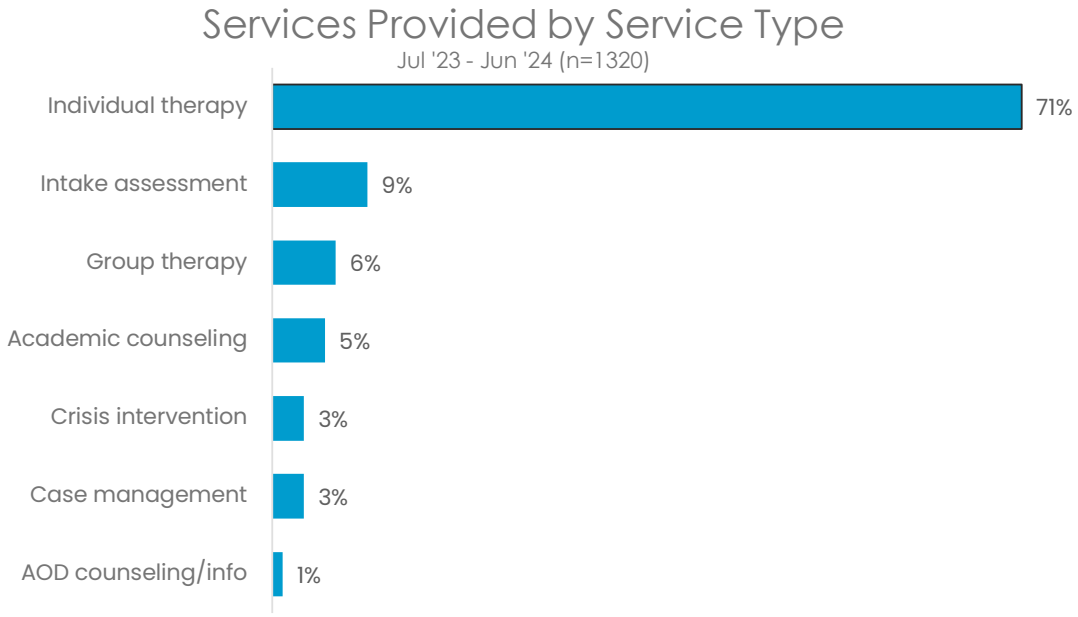
Demographics (Sexual Orientation)

Jul '23 - Jun '24 (n=210)

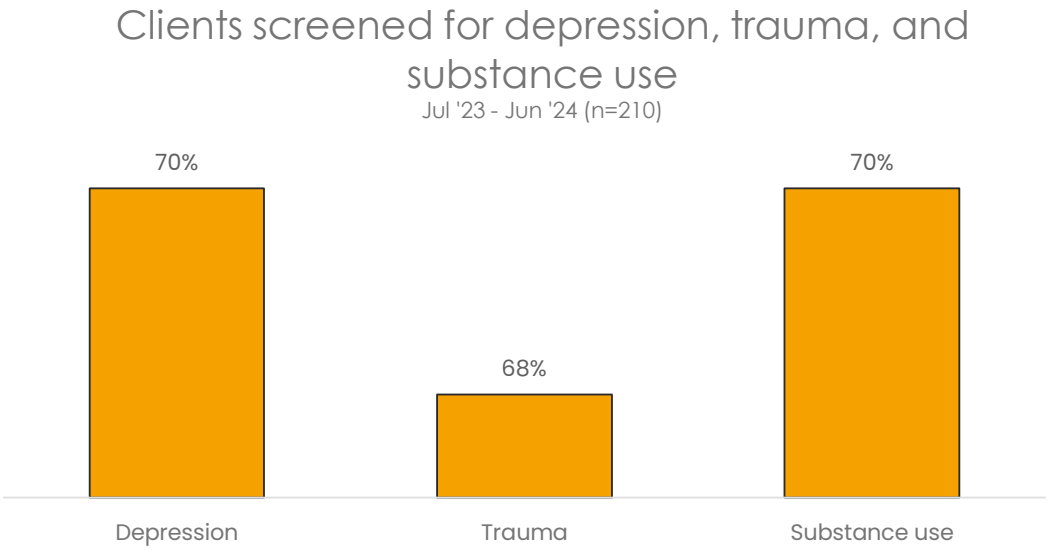


*LGBQ+ includes individuals who identify as lesbian, gay, bisexual, questioning, or other diverse sexual orientations. Other includes prefer not to answer or unknown.

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.



Note: Multiple services could be provided in one visit (e.g. crisis assessment and referral) so total services by type is greater than total encounters.



NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Quality Outcomes ("How well did we do it?")

1 in 17 Students received services
6.43% of the School Population (3,267 students)

Service Consistency

96% n=126
Students felt treated with respect

98% n=118
Students felt heard about what they have to say

96% n=105
Students felt like there's an adult who cares about

96% n=129
Report Easy Access to Needed Care

97% n=113
Able to Get Help When Needed

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Measure	Definition	Data Source
# clients served	Total clients served	NextGen
# of services provided by service type	# of services coded as behavioral_service with codes BHSV1-8. Key code accompanies NextGen data. Each incident could include more than one service provided.	NextGen
% clients screened for depression, trauma, and substance use	Percent of total clients that were recorded as having been screened for depression, trauma, and/or substance abuse at least one time during reporting period.	NextGen
% referrals to HSHC followed up within one week	Percentage of referrals that had 7 days or less between referral date and response date. Calculation reflects % of total referrals, not % of total clients.	Jotform Not presented due to delays in the reporting system
% of school population served	Unique clients served by HSHC divided by total student population of BHS and BTA.	DataQuest
% of clients satisfied with services	% of responses marked as "agree" or "strongly agree" for various survey questions. Note: these responses are from all students who accessed the health center and answered the survey, not just those who received mental health services.	Berkeley SBHC Client Survey
% of clients able to receive needed care	% of responses marked as "agree" or "strongly agree" for various survey questions. Note: these responses are from all students who accessed the health center and answered the survey, not just those who received mental health services.	Berkeley SBHC Client Survey

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

ACCESS & LINKAGE TO TREATMENT AND EARLY INTERVENTION COMBINED PROGRAM

Access and Linkage to Treatment Programs – Connect 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.

Early Intervention Programs – Provide 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.

During the reporting timeframe, the City of Berkeley provided funding for one Early Intervention program that also had an Access to Treatment program component. The program was as follows:

Specialized Care Unit

Through the approved FY2022 Annual Update, the Division allocated a portion of one-time CSS and PEI funds to be leveraged with other City funds to support the Specialized Care Unit (SCU). Implemented through Bonita House, the SCU is Berkeley's new behavioral health crisis response team without the involvement of law enforcement. The SCU consists of trained crisis-response field workers who respond to behavioral health occurrences that do not pose an imminent threat to safety.

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.

PEI Priority: Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

In FY2023, MHSA funds directly supported start-up costs of the program including recruitment, hiring, and training of Bonita House staff. Training included crisis support training through Bonita House's Crisis Training Academy as well as the design and training of Berkeley-specific procedures for the SCU program. Additionally, this funding supported the salaries of the SCU program management staff as additional team members were hired. During this time, program management staff worked closely with the City of Berkeley to create the policies and procedures for a SCU that aligned with the implementation recommendations from the Berkeley community. The SCU began providing services in early FY2024.

STIGMA AND DISCRIMINATION PROGRAM

Stigma and Discrimination programs - Direct 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. The City of Berkeley has one Stigma and Discrimination 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 10-20 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.

PEI Priority: Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs).

In FY2022, 13 unduplicated individuals participated in the program. Demographics on program participants served were as follows:

DEMOGRAPHICS N = 13

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Groups**
  25 – 59 (Adult) – 38.5%
  Ages 60+ (Older Adult) - 38.%
  Declined to Answer (or Unknown) – 23%

- **Race**
  Asian – 8%
  Black or African American – 23.5%
  White – 38.5%
  Other – 15%
  Declined to Answer (or Unknown) – 15%

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Mexican/Mexican-American Chicano – 8%
  Puerto Rican – 8%

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  African – 15%
  European – 15%
  Japanese – 8%
  Other – 31%
  Decline to Answer or Unknown – 31%

- **Primary Language**
  English – 84%
  Declined to Answer (or Unknown) – 16%

- **Sexual Orientation**
  Heterosexual or Straight – 54%
  Gay or Lesbian – 8%
  Bisexual – 15%
  Questioning or Unsure – 8%
  Decline to Answer or Unknown – 15%

- **Disability**
  Difficulty Hearing – 15%
  Mental Domain not including a mental illness – 15%
  Physical Mobility domain – 31%
  Chronic Health Condition – 23%
  Other (Specify): - 8%
  Decline to Answer or Unknown – 31%

- **Veteran Status**
  Yes – 77%
  No – 33%

- **Gender: Assigned Sex at Birth**
  Male – 15.4%
  Female – 69.2 %
  Decline to Answer or Unknown – 15.4%

- **Current Gender Identity**
  Male – 15%
  Female – 54%
  Questioning or Unsure – 8%
  Another gender identity – 8%
  Decline to Answer or Unknown – 15%

Program Successes:
The Telling Your Story group had more consistent attendees who were prepared to share based on the topics provided. The structure of having a brainstorming session proved to be really beneficial for the attendees. Some participants enjoyed having the group virtually in the comfort of their home, they felt safer and the hassle of commuting was eliminated. Participants felt more prepared during their shares and enjoyed the support they received from their peers.

Program Challenges:
The Telling Your Story group challenges were a lack of in-person connection and some participants who didn't have access to Zoom were unable to see others on the screen. This group provided gift cards for each session that a person participated within the program guidelines. There was a challenge for some individuals to come into the office to sign for the gift cards which created some distain from the participants, or they waited months before they decided to have their gift card mailed. A similar gift card challenge was that some participants waited for months until they picked them up, so it would be worth the commute they had to make to come to the office.

In FY2022, as the Social Inclusion – Telling Your Story Project, is conducted by the same staff who operate Wellness Recovery Services, the Results Based Accountability (RBA) Measures for this project were combined with the Wellness Recovery program measures. The RBA measures are as follows:

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is Anyone Better off?
• # of participants served • # of different groups convened per year • # of group events held per year • # of group participants	• #/% of participants who return for group events	• #/% of participants who reported feeling less shame about their experiences and challenges

who meet the requirements for "Telling Your Story" (MHSA PEI Requirement)		• #/% of participants who reported progress in their recovery

Measure	Definition	Data Source
# participants served	Total # of participants served	Wellness Recovery Group Attendance Tracker
# of different group convened	Number of different types of groups (i.e. walking group, mood group, Telling Your Story group) convened	Wellness Recovery Group Attendance Tracker
Group events	Total number of meetings held	Wellness Recovery Group Attendance Tracker
# of participants who meet the requirements for "Telling Your Story"	Total number of participants in all "Telling Your Story" meetings	Wellness Recovery Group Attendance Tracker
# of participants who return for group events	Of total number of participants, % who returned for more than one event or meeting	Wellness Recovery Group Attendance Tracker
% of participants who reported feeling less shame about their experiences and challenges	Of participants who took the survey, percent who responded "agree" or "strongly agree" to the question.	Telling Your Story Survey
% of participants who reported recognizing progress in their recovery	Of participants who took the survey, percent who responded "agree" or "strongly agree" to the question.	Telling Your Story Survey

Data Development Agenda: measures the team is interested in reporting on but for which reliable data was not available:

- Advance Directives Data:
- -#/% of participants with an Advance Directive completed
- -#/% of participants able to advocate for themselves with service providers
- Equity of services (e.g. client demographics compared to MediCal population)
- % of clients who were satisfied with services

In FY2022, the RBA outcomes for this program were as follows:

Wellness & Recovery Services RBA Outcomes

Reporting Period: July 2021-June 2022 (Baseline)

Process Outcomes ("How much did we do?")

Program Description The Wellness and Recovery Program is designed to provide outreach, support, education, activities, and advocacy to consumer members living with mental illness and living in Berkeley. Wellness group activities include: Berkeley Pool of Consumer Champions (POCC), Card Groups, Mood Groups, Walking Groups, and field trips.

35

Participants served

8

Different groups convened

139

Group events

20

Participants who meet the requirements for "Telling Your Story"

represents 10 clients/events/groups

Quality Outcomes ("How well did we do it?")

71%

of participants returned for group events

Impact Outcomes ("Is anyone better off?")

4 out of 5

participants reported feeling less shame about their experiences and challenges (n=5).

3 out of 5

participants reported recognizing progress in their recovery (n=5).

In FY2023, 10 unduplicated individuals participated in the program. Demographics on program participants served were as follows:

DEMOGRAPHICS N = 10

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

- **Age Groups**
  25 – 59 (Adult) – *
  Ages 60+ (Older Adult) - *

- **Race**
  Black or African American – *
  White – *
  Other – *

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Mexican/Mexican-American Chicano – *
  Puerto Rican – *

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  African – *
  Easter European – *
  Other – *
  Decline to Answer or Unknown – *

- **Primary Language**
  English – 100%

- **Sexual Orientation**
  Heterosexual or Straight – *
  Bisexual – *
  Decline to Answer or Unknown – *

- **Disability**
  Difficulty Seeing - *
  Difficulty Hearing – *
  Mental Domain not including a mental illness – *
  Physical Mobility domain – *
  Chronic Health Condition – *
  Other (Specify): - *

- **Veteran Status**
  No – 100%

- **Gender: Assigned Sex at Birth**
  Male – *
  Female – *

- **Current Gender Identity**
  Male – *
  Female – *

Program Successes:
In FY2023, the Telling Your Story group has grown to having more consistent attendees in person and on the zoom platform. Some participants enjoyed having the group virtually in the comfort of their home, they felt safer, and the hassle of commuting was eliminated. Other individuals enjoyed connecting in-person with participants who, joined the group in the same way. The group continued to be conducted through the structure of a brainstorming session and a sharing component. The topics of discussion were focused on the Eight Dimensions of Wellness. Per staff report, many participants benefitted from listening to answers to questions that staff developed based on the topics of discussions, as well as through staff assistance with formulating their story. Per staff report, participants felt more prepared during their shares and enjoyed the support they received from their peers.

Program Challenges:
In FY2023, the Telling Your Story group had a few challenges, which provided the staff have been working to improve to make the group more enjoyable for all participants. Over the course of the last two years, staff hosted the group online and in-person and at times, this caused some delays to the start of the group due to individuals arriving at different times and having to update all participants. Managing and making sure everyone engaged was difficult as individuals who joined by Zoom, called in so staff were unable to see participants faces. For individuals who primarily come to the group on Zoom, the questionnaire that required their feedback went unanswered, therefore staff wasn't able to obtain a full report of how the group was helping individuals to feel confident with sharing their story. Managing both platforms can be complicated and it lacks the in-person connection. This group was held twice a month and even though there was a brainstorming session of topics to discuss, some members didn't seem to come prepared to share based on the topic at the next group and this may be due to memory or not fully being engaged in the group when people are calling in on Zoom. The last challenge was the number of participants, a very consistent group of individuals participated, however staff would like to do more outreach to engage potential group participants, in an effort make a positive impact for more individuals in the community.

The RBA outcomes for FY2023 are outlined on the following pages:

BMH RBA Report FY 2023

Reporting Period July 2022 - June 2023

Wellness & Recovery Services

Process Outcomes ("How much did we do?")

Program Description The Wellness and Recovery Program is designed to provide outreach, support, education, activities, and advocacy to consumer members living with mental illness and living in Berkeley. Wellness group activities include: Berkeley Peers Organizing Community Change (POCC), Card Groups, Mood Groups, Walking Groups, and field trips.

Program Updates The Wellness Recovery Team added two Social Services Specialist positions to the program. Adding these positions made more people aware of the wellness groups, events and support that the clinic has to offer.

49

Participants served

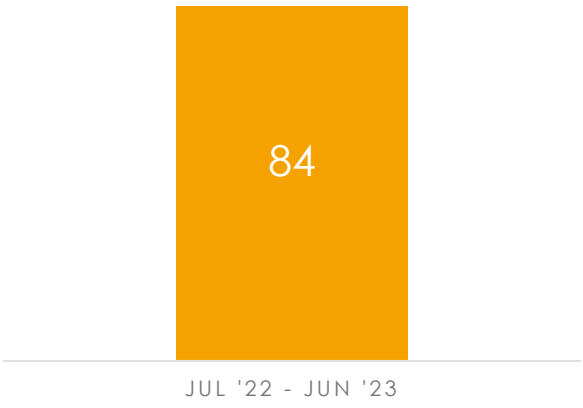
10

Participants who meet requirements for "Telling Your Story"

7

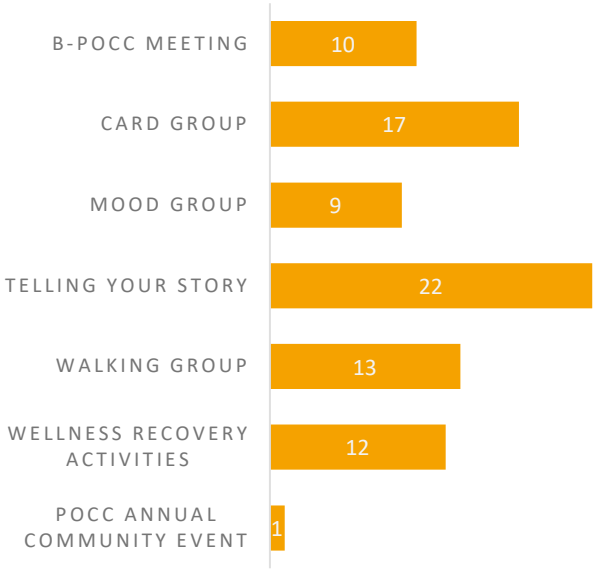
Different groups convened

WELLNESS GROUP MEETINGS ACROSS 7 DISTINCT GROUPS



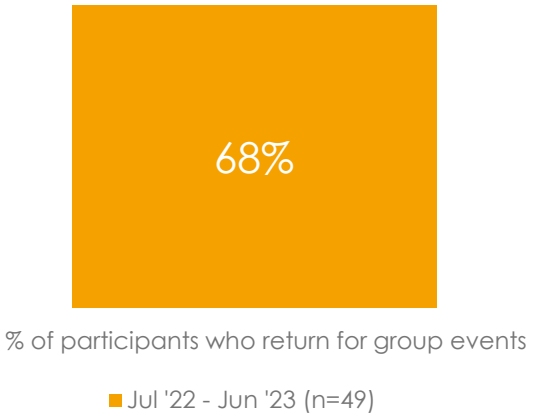
WELLNESS GROUP MEETINGS

JUL '22 - JUN '23 (N=84)

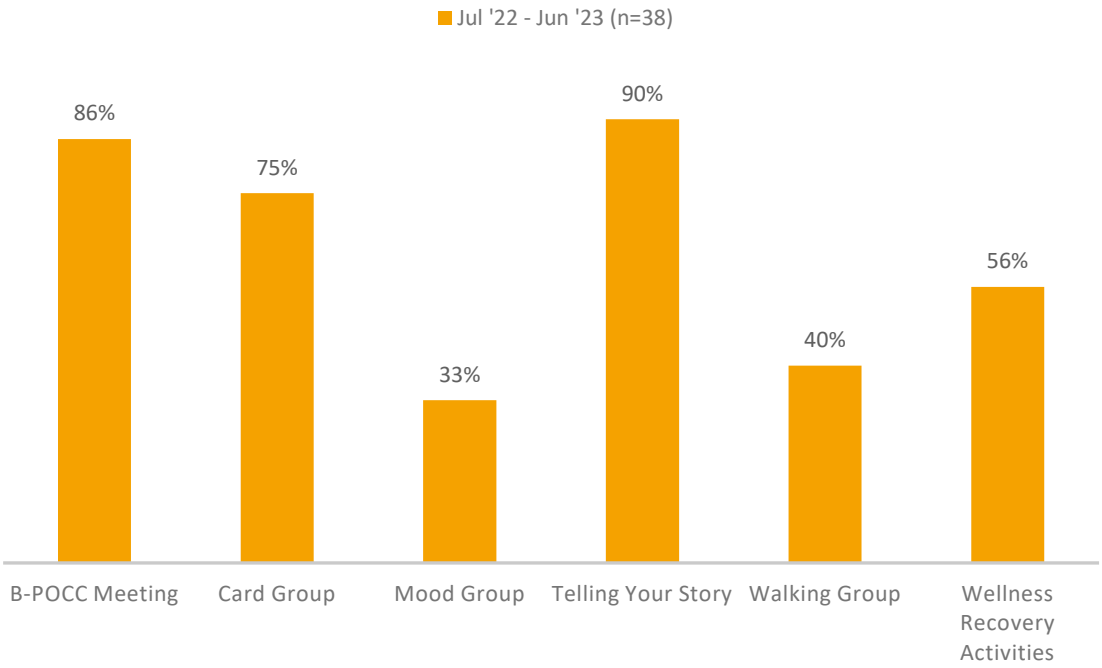


Quality Outcomes ("How well did we do it?")

Total Returning Participants



% Repeat Attendees for Wellness Groups



Measure	Definition	Data Source
# participants served	Total # of participants served	Wellness Recovery Group Attendance Tracker
# of different groups convened	Number of different types of groups (i.e. walking group, mood group, Telling Your Story group) convened	Wellness Recovery Group Attendance Tracker
Average # of group events held per 6 months	Total number of meetings held	Wellness Recovery Group Attendance Tracker
# of participants who meet the requirements for "Telling Your Story"	Total number of participants in all "Telling Your Story" meetings	Wellness Recovery Group Attendance Tracker
% of participants who return for group events	Of total number of participants, % who returned for more than one event or meeting	Wellness Recovery Group Attendance Tracker
% of participants reporting feeling less shame about their experiences and challenges	Percentage of survey respondents who agree or strongly agree that they feel less shame about their experiences and challenges	Telling Your Story Survey
% of participants reporting recognizing progress in their recovery	Percentage of survey respondents who agree or strongly agree that they recognize progress in their recovery	Telling Your Story Survey

In FY2024, 20 unduplicated individuals participated in the program. Demographics on program participants served were as follows:

DEMOGRAPHICS N = 20

*Numbers that are 11 or less are displayed as <11 and/or have been combined or masked to protect the privacy and confidentiality of individual participants.

- **Age Groups**
  26-59 (Adult) – 15
  Ages 60+ (Older Adult) or Unknown – <11

- **Race**
  American Indian or Alaska Native - <11
  Asian – <11
  Black or African American – <11
  White – <11
  More than one Race – <11

- **Ethnicity: Hispanic or Latino/Latina/Latinx**
  Declined to Answer, or Unknown – 20

- **Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx**
  Declined to Answer, or Unknown – 20

- **Primary Language**
  English – 20

- **Sexual Orientation**
  Heterosexual or Straight – <11
  Bisexual – <11
  Queer – <11
  Declined to Answer, or Unknown – 15

- **Disability**
  Declined to Answer, or Unknown – 20

- **Veteran Status**
  No – 20

- **Gender: Assigned Sex at Birth**
  Male – 12
  Female – <11

- **Current Gender Identity**
  Male – 12
  Female – <11

Program Successes:
The Telling Your Story group has grown to having more consistent attendees in person and calling in to the zoom platform then all other BMH groups. The group continued to be conducted by having the structure of a brainstorming session and a sharing component. Per staff report, many participants benefitted from listening to answers to questions that staff developed based on the topics of discussions, as well as through staff assistance with formulating their story. The topics of the month went beyond the SAMHSA Eight Dimensions of Wellness to include areas of interest. Some participants enjoyed having the group virtually in the comfort of their home, as they felt safe and the hassle of commuting was eliminated. Other participants enjoyed connecting with others in-person and more individuals attended when they dropped in at the clinic. According to staff, participants were more prepared during their shares and they enjoyed the support they received from their peers.

Program Challenges:
In FY2024, the Telling Your Story group had a few challenges, which the staff have been working to improve to make the group more enjoyable for all participants. Over the course of the last two years, staff hosted the group online and in-person and at times, this caused some delays to the start of the group due to individuals arriving at different times and having to update all participants. The structure is for people to attend both, the first is a brainstorming group to be prepared for the second group with sharing.

Managing and making sure everyone engaged was difficult as individuals who joined by Zoom, called in so staff were unable to see participants faces. For individuals who primarily came to the group on Zoom, the questionnaire that required their feedback went unanswered, therefore staff wasn't able to obtain a full report of how the group was helping individuals to feel confident with sharing their story.

The RBA outcomes for FY2024 are outlined on the following pages:

BMH RBA Report FY 2024

Reporting Period July 2023 - June 2024

Wellness & Recovery Services

Process Outcomes ("How much did we do?")

Program Description The Wellness and Recovery Program is designed to provide outreach, support, education, activities, and advocacy to consumer members living with mental illness and living in Berkeley. Wellness group activities include: Berkeley Peers Organizing Community Change (POCC), Card Groups, Mood Groups, Walking Groups, and Wellness Mixers.

52
Participants served

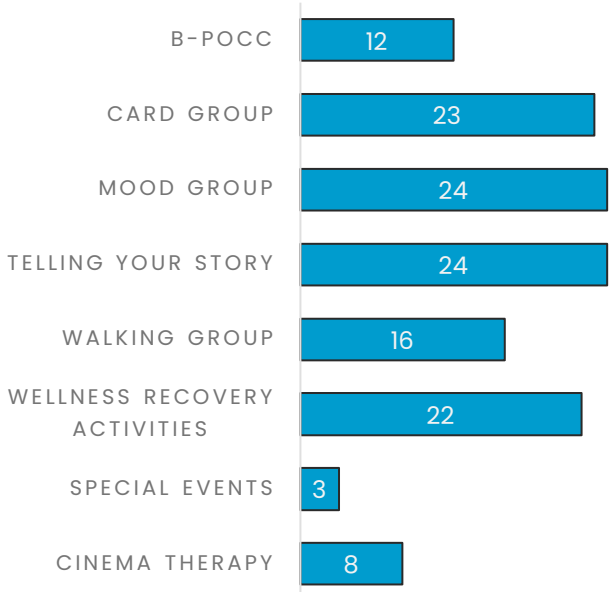
132
Group Events

8
Groups

20
Participants who meet requirements for "Telling Your Story"

WELLNESS GROUP MEETINGS

JUL '23 - JUN '24 (N=132)

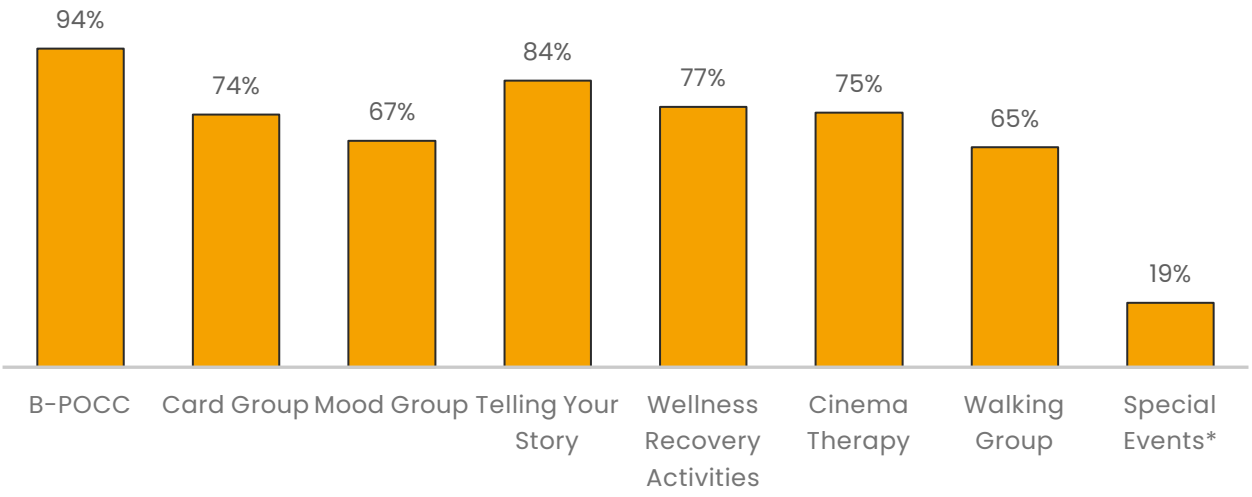


NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Quality Outcomes ("How well did we do it?")

Overall Group Engagement (Repeat Visits)

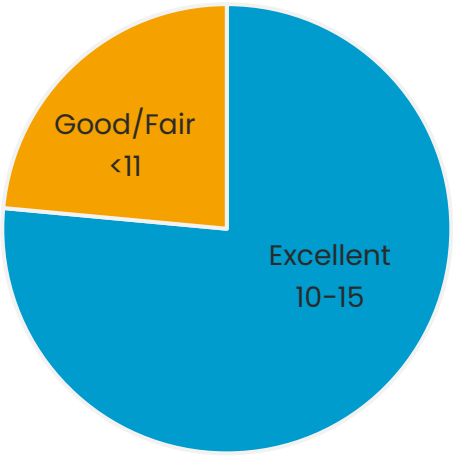
Jul '23 - Jun '24 (n=224)



*Special events, like social wellness mixers with different themes, attract a diverse mix of new attendees, which may result in lower level of returnees.

Interaction with a Wellness Team member in the Clinic Lobby

Jul '23 - Jun '24 (n=18)



71% n=52
Unduplicated participants who return for group events

Over 80% n=18
Participants rated the Lobby as Welcoming

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

Measure	Definition	Data Source
# of Particpants Served	Total # of participants served	Wellness Recovery Group Attendance Tracker
Wellness Group Event Breakdown	Number of different types of groups (i.e. walking group, mood group, Telling Your Story group) convened	Wellness Recovery Group Attendance Tracker
# Group Events	Total number of meetings held	Wellness Recovery Group Attendance Tracker
# of Telling Your Story Participants	Total number of participants in all "Telling Your Story" meetings	Wellness Recovery Group Attendance Tracker
% of participants who return for group events	Of total number of participants, % who returned for more than one event or meeting	Wellness Recovery Group Attendance Tracker
% Overall Group Engagement (Repeat Visits)	Of total number of participants, % who returned for more than one event or meeting	Wellness Recovery Group Attendance Tracker
% Participants Rated the Lobby as Welcoming	Consumer perceptions of feeling welcomed entering the Clinic Lobby	Clinic Lobby Survey

NOTE: Due to privacy protections, data representing fewer than 11 individuals have been combined, masked, suppressed, or reported in ranges. The graphs have been adjusted and may not visually reflect actual counts.

OUTREACH FOR RECOGNIZING THE EARLY SIGNS OF MENTAL ILLNESS

Outreach for Recognizing the Early Signs of Mental Illness Program - 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.

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 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.

Mental Health First Aid

City of Berkeley Mental Health staff has previously implemented a Mental Health First Aid Training to the community through non-MHSA funds. 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.

PEI Goals: The goal of this campaign is to increase prevention efforts and response to early signs of emotional and behavioral health problems.

PEI Priorities:

- Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs).
- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

Due to vacancies in staff, Mental Health First Aid trainings was not provided during the reporting timeframe.

SUICIDE PREVENTION

Suicide Prevention Programs (Optional) - Activities to prevent suicide as a consequence of mental illness.

The City of Berkeley has one PEI funded Suicide Prevention program:

California Mental Health Services Authority (CalMHSA) PEI Statewide Projects

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 the Division began contributing 4% of PEI funding to the California Mental Health Services Authority (CalMHSA) to participate in the PEI Statewide Projects Initiative to locally obtain State resources on Suicide Prevention, Student Mental Health, and Stigma and Discrimination.

PEI Goals: The goal of this campaign is to increase prevention efforts and response to early signs of emotional and behavioral health problems.

PEI Priorities:

- Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs).
- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

In FY2022, through this initiative resources on Suicide Prevention, Student Mental Health and Stigma and Discrimination reached approximately 1,624 individuals. Additionally, resources were distributed via email to local schools, community agencies and community members.

In FY2023, through this initiative resources on Suicide Prevention, Student Mental Health and Stigma and Discrimination reached approximately 1,624 individuals. Additionally, resources were distributed via email to local schools, community agencies and community members.

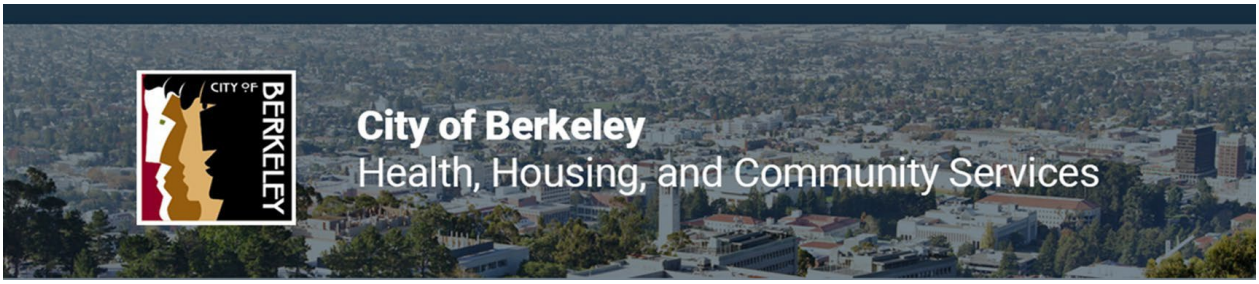
In FY2024, through this initiative resources on Suicide Prevention, Student Mental Health and Stigma and Discrimination reached approximately 1,520 individuals. Additionally, resources were distributed via email to local schools, community agencies and community members. Through the approved FY2025 Annual Update the Division eliminated the annual allocation of local PEI funding for this initiative.

APPENDIX D

INNOVATION

FY2023-2024

ANNUAL EVALUATION REPORT



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

Innovations (INN)

Fiscal Year 2023/2024 Annual Evaluation Report

INTRODUCTION

Mental Health Services Act (MHSA) Innovation (INN) funds are to be 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 and 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 State Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (MHSOAC) on an annual basis. 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, the MHSA INN Fiscal Year 2023-2024 (FY2024) Annual Evaluation Report is due.

This state required FY2024 INN Annual Evaluation Report includes a description of the INN Encampment-based Mobile Wellness Center Project, which was the only approved project during the reporting timeframe. This project was implemented in FY2025 through Options Recovery Services.

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 INN Annual 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 changes were made to the Innovative Project during the reporting period, a description of the changes 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, and the 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

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 may be obtained from the minor's parent, legal guardian, or other authorized source.

CITY OF BERKELEY INN PROGRAMS

A description of the INN program that was approved, but not implemented in FY24, is outlined below:

Encampment-based Mobile Wellness Center Project

In April 2022, the Division received approval to implement an Encampment-Based Mobile Wellness Center Project from the Berkeley City Council and the State Mental Health Oversight and Accountability Commission (MHSOAC). This project pilots a Mobile Wellness Center at Homeless encampments in Berkeley. The Mobile Wellness Center project provides an on-site, customizable menu of services that are chosen by individuals who reside at the encampments. The project is led by peers with lived experience of homelessness, and includes partners from encampment communities to encourage participation, help define service needs, and support service provision at the site. The project was implemented in FY 2025 through Options Recovery Services who was chosen through a competitive Request for Proposal (RFP) process.

The project seeks to learn whether on-site wellness center services have a positive impact on mental health outcomes including an increase in the uptake of mental health services. It will also assess the impact of how having individuals from the community help to provide services, shapes service delivery, and the participant satisfaction with services.

APPENDIX E

PUBLIC COMMENTS

From: Lasara Firefox Allen, MSW, CEO
To: Klatt, Karen
Subject: Public comment on MHSA funding.
Date: Thursday, June 26, 2025 4:44:55 PM

WARNING: This is not a City of Berkeley email. Do not click links or attachments unless you trust the sender and know the content is safe.

Karen,

I will be at the meeting this evening, but wanted to be sure to log my thoughts during the open comment period:

We are facing a possible loss of 1/3 of our budget in FY 26-27. We are doing all we can to pivot to a billable structure for service delivery, but the reprioritization of PEI funds at the state level is negatively impacting our service delivery capacity.

We are also aware that there are many orgs that will be unable to pivot to billable services, and will see themselves closing their doors between now and 2026. My heart goes out to them, and their communities, and our shared community members, who will be losing access to services that improve quality of life and prevent a down-hill slide into worsening health.

I agree that we need more funds for housing and substance use disorder treatment. I only wish that we were not defunding life-saving services in order to deliver this programming. I fear that in a few years' time the issues will be so much worse due to an acute lack of prevention-based care.

Further, our community--the LGBTQIA+ community in the East Bay--is facing such immense stressors right now, with the political and social climates getting ever more dangerous. And this is not only at the national level; right on our street a community member was assaulted in a violent hate crime just a few weeks ago. The chilling effect is here. It is in our neighborhoods.

We will do all we can to continue showing up for our community members, even as our funding is continually stripped away.

In community, resistance, and queer joy,
-Lasara

P.S. I would love to meet with you soon at our new(ish) space on Center St. Let me know what works for you. Thank you.

INTERNAL EMAIL ADDRESS ONLY, please do not share.
Support LGBTQIA+ mental health. DONATE HERE!

Support LGBTQIA+ mental health. DONATE HERE!

Lasara Firefox Allen (they/them/Mx.)
CEO
Pacific Center for Human Growth
2130 Center St, Ste 200, Berkeley, CA 94704
www.pacificcenter.org| Facebook | Instagram
W: (510) 992-6207 C: (707) 293-5153
Schedule: M-F 7:30 AM-3:30 PM
(Available in-office at Center Street by request.)

Check us out on Candid.

Want to meet? Schedule HERE.

Know The Land: Pacific Center is located on unceded Ohlone/Chochenyo land.

Upcoming Days Out of Office:
May 16, 19.
June 5,6.
Org Closures for Collective Rest:
May 17: Collective Day Out of Office for Malcolm X.
Summer Break: June 30 - July 44, Fall Break: Nov 24 - 28, Winter Break: Dec 22 - Jan 2.

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