Greetings!

Your input and comments are invited on the **Mental Health Services Act (MHSA) FY23 Annual Update**. This Annual Update is currently posted for a 30 Day Public Review to provide an opportunity for community input.

In order to provide input please respond by **5:00pm on June 23rd** by directing your feedback via email, phone or mail to:

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City of Berkeley Mental Health
1521 University Ave.
Berkeley, CA 94703
(510) 981-7644
KKlatt@cityofberkeley.info

A Public Hearing will be held on the Annual Update at 7:00pm on Thursday June 23rd, during the Mental Health Commission meeting which will be held on the Zoom platform. Individuals interested in providing input on this Annual Update can also attend one of four community meetings that will be held by Zoom during the 30-Day Public Review. The meeting dates and times are as follows:
Monday, June 13: 6:00-7:30pm
Tuesday, June 14: 1:00-2:30pm
Thursday, June 16: 6:00-7:30pm
Wednesday, June 22: 3:00-4:30pm

Information on the Community Input meetings has been posted on the MHSA webpage and on the City's Event calendar. To provide input on the MHSA FY23 Annual Update or obtain information on how to access the Community Input meetings or the Public Hearing, contact Karen Klatt, (510) 981-7644, KKlatt@cityofberkeley.info.

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

FY2022/2023 Annual Update

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BACKGROUND AND OVERVIEW

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

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

- Community Services & Supports (CSS): Primarily provides treatment services and supports for Severely Mentally Ill Adults and Seriously Emotionally Disturbed Children 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.
- Innovations (INN): For short-term pilot projects designed to increase new learning in the mental health field.
- Workforce, Education & Training (WET): Primarily for strategies to identify and remedy mental health occupational shortages, promote cultural competency and the employment of mental health consumers and family members in the workplace.
- Capital Facilities and Technological Needs (CFTN): For capital projects on owned buildings and on mental health technology projects.

Among other things, the MHSA provides enhanced services and supports for Seriously Emotionally Disturbed children, 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 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 2020/21 - 2022/23 Three Year Program and Expenditure Plan (Three Year Plan) in place which covers each funding component. Since 2006, as a result of the City's approved MHSA plans, a number of new services and supports have been implemented to address the various needs of the residents of Berkeley including 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.

Additionally, an outcome of the implementation of the MHSA is that mental health consumers, family members and other stakeholders now regularly serve on several of BMH internal

decision-making committees. These individuals share their “lived experience” and provide valuable input which has become an integral component that informs the Division on the implementation of MHSA services and supports. Even prior to the passage of Proposition 63, BMH convened (and has since maintained) an MHSA Advisory Committee which serves in an advisory capacity on MHSA programs and is comprised of mental health consumers, family members, and individuals from unserved, underserved and inappropriately served populations, among other community stakeholders.

MHSA funding is based on a percentage of the total population in a given area. The amount of MHSA funds the City of Berkeley receives is comprised of a calculation based on the total population in Berkeley. MHSA funding has been utilized to provide mental health services and supports in Berkeley. Additionally, from Fiscal Year 2011 (FY11) through FY20, the City of Berkeley has 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 FY21, per agreement with Alameda County BHCS, the Division transitioned to only using MHSA funds for services and supports in Berkeley, and ACBHCS now provides MHSA funded services in Albany.

This City of Berkeley MHSA FY2022-2023 (FY23) Annual Update is a stakeholder informed plan that provides an update to the previously approved Three Year Plan. This Annual Update summarizes proposed program changes and additions, includes descriptions and updates of currently funded MHSA services, and provides a reporting on FY21 program data.

MESSAGE FROM THE HEALTH, HOUSING AND COMMUNITY SERVICES DIRECTOR

Our community faces enormous challenges. Racial injustice, health inequities, isolated families and children, far too many unhoused people, and a continuing pandemic; are just a few of the myriad of issues impacting the mental health of residents of Berkeley. At the same time, the COVID-19 pandemic has made providing care more difficult. Over the past two years, Mental Health Division staff and community providers have worked hard to adapt to this changing landscape and to provide services in new ways. Through the use of tele-health and with the help of vaccinations, improved testing, and personal protective equipment, clinical and peer staff have continued to maintain care and connection both virtually and in person. Despite these efforts, many children, youth, adults, and families still remain disconnected and need support. The coming year will require all of us, to work together to collaborate on providing this needed care. We are excited to bring on a new Mental Health Manager who will lead us in this on-going work. An important part of our community's response to these enormous needs will be made possible by the MHSA FY23 Annual Update.

This Annual Update reflects community input the Division has received within the past year from a wide variety of stakeholders. Ongoing funds will be utilized to provide services and supports to vulnerable populations in Berkeley. Services in the proposed plan include outreach, assessment, and treatment for children to older adults; with a focus on increasing health equities across racial, ethnic and cultural populations. New funding in this Annual Update will be utilized to: increase staffing, program capacity and supports on the Homeless Full Services Partnership and the Adult Full Services Partnership; support quality assurance and program outcomes for the Adult Services programs; build an internal resource for program evaluation; provide short-term housing for individuals served on the Homeless Full Services Partnership; support the Bay Area Hearing Voices Network in providing outreach, technology, and program administration; provide on-site program management at the Martin Luther King House; and enable the Division to participate in the Greater Bay Area Regional Partnership Student Loan Repayment program.

Some of the various MHSA accomplishments within the past year included utilizing Innovations funds to make mental health apps available at no cost to adults who live, work or go to school in Berkeley; increasing services and supports to individuals who are unhoused through the Homeless Full Service Partnership; and obtaining local and state approvals to implement a new Mobile Wellness Center project in FY23, in order to ensure services that promote mental health well-being are available at area homeless encampments.

While economic uncertainty still remains, MHSA funds increased in FY22 and are expected to remain at that increased amount in FY23, so we have thankfully not yet seen decreases in funding. In coming years, we will closely watch both revenue and expenditures to ensure that we are able to sustain existing mental health programming. The Mental Health Division presents the City of Berkeley's MHSA FY23 Annual Update with much appreciation for the efforts, input and partnership of our community partners, consumers, Mental Health Commission, and City staff.

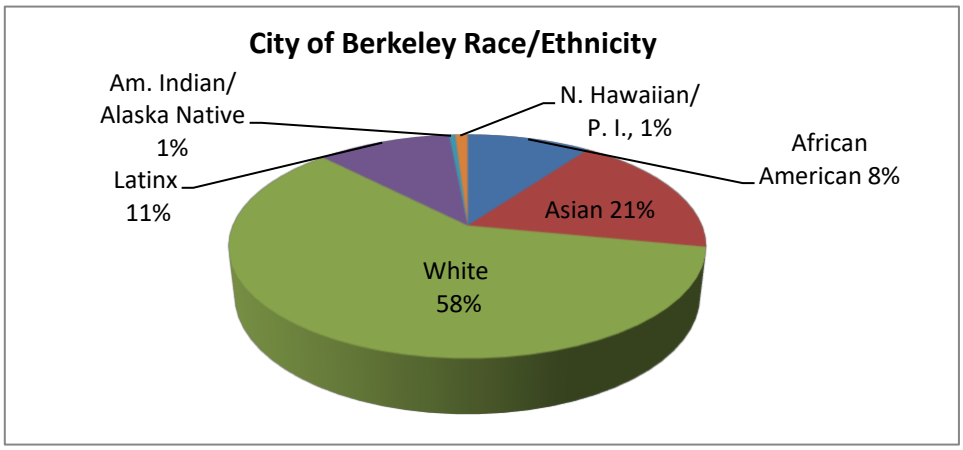
DEMOGRAPHICS

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 124,321 the City of Berkeley is densely populated and larger than 23 of California's small counties.

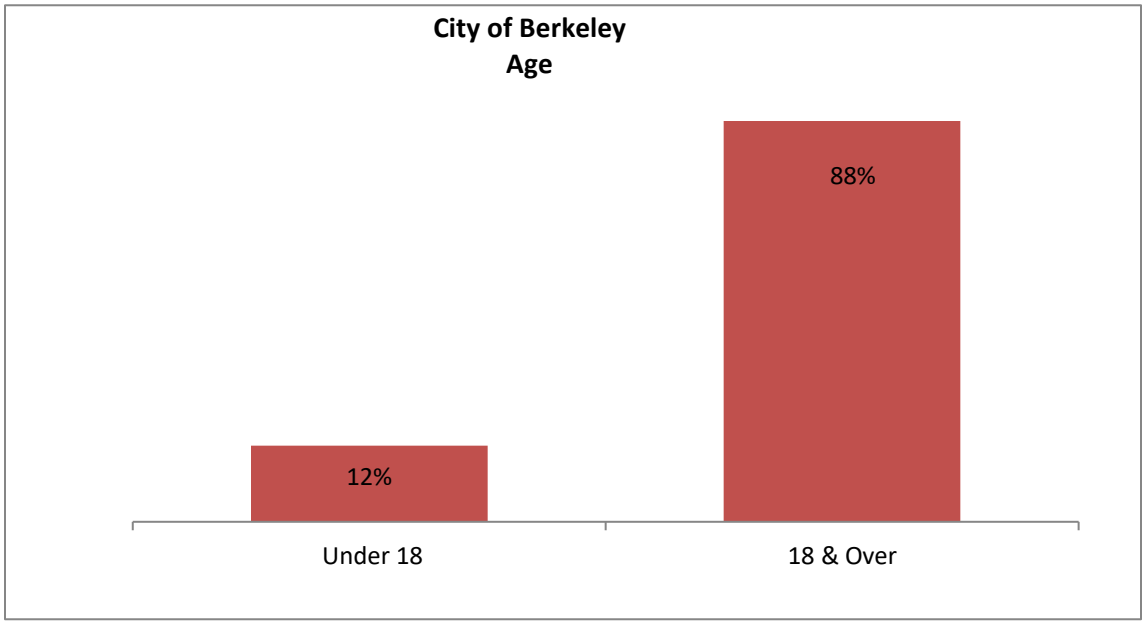
Race/Ethnicity

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 29% 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:

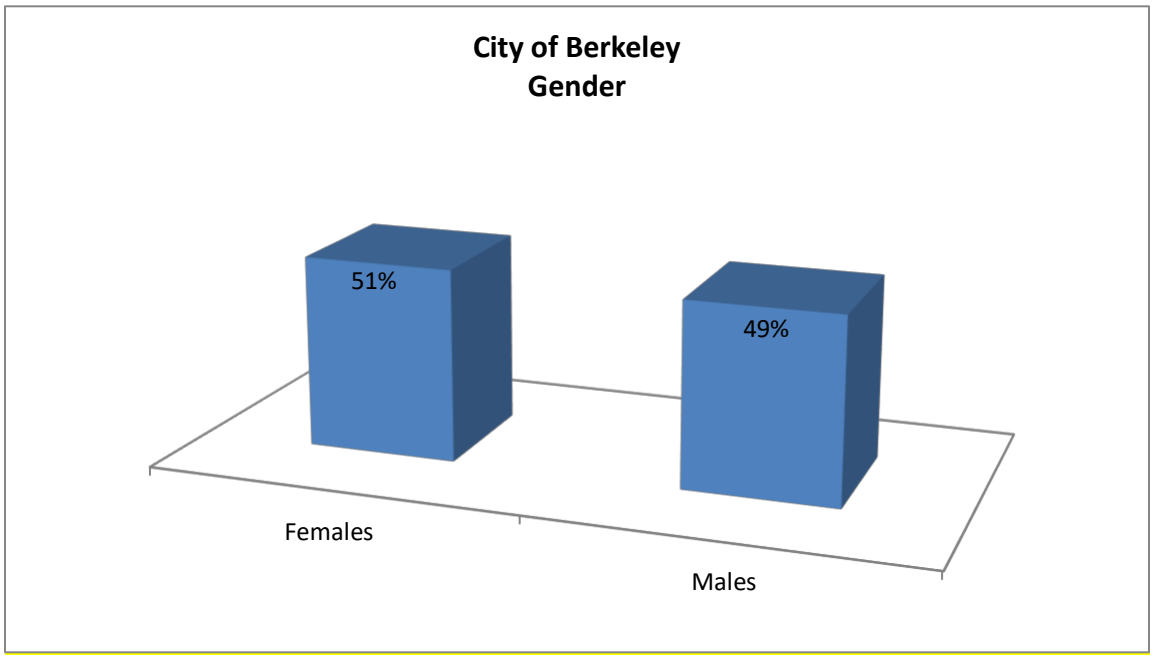


Age/Gender

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



Gender 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

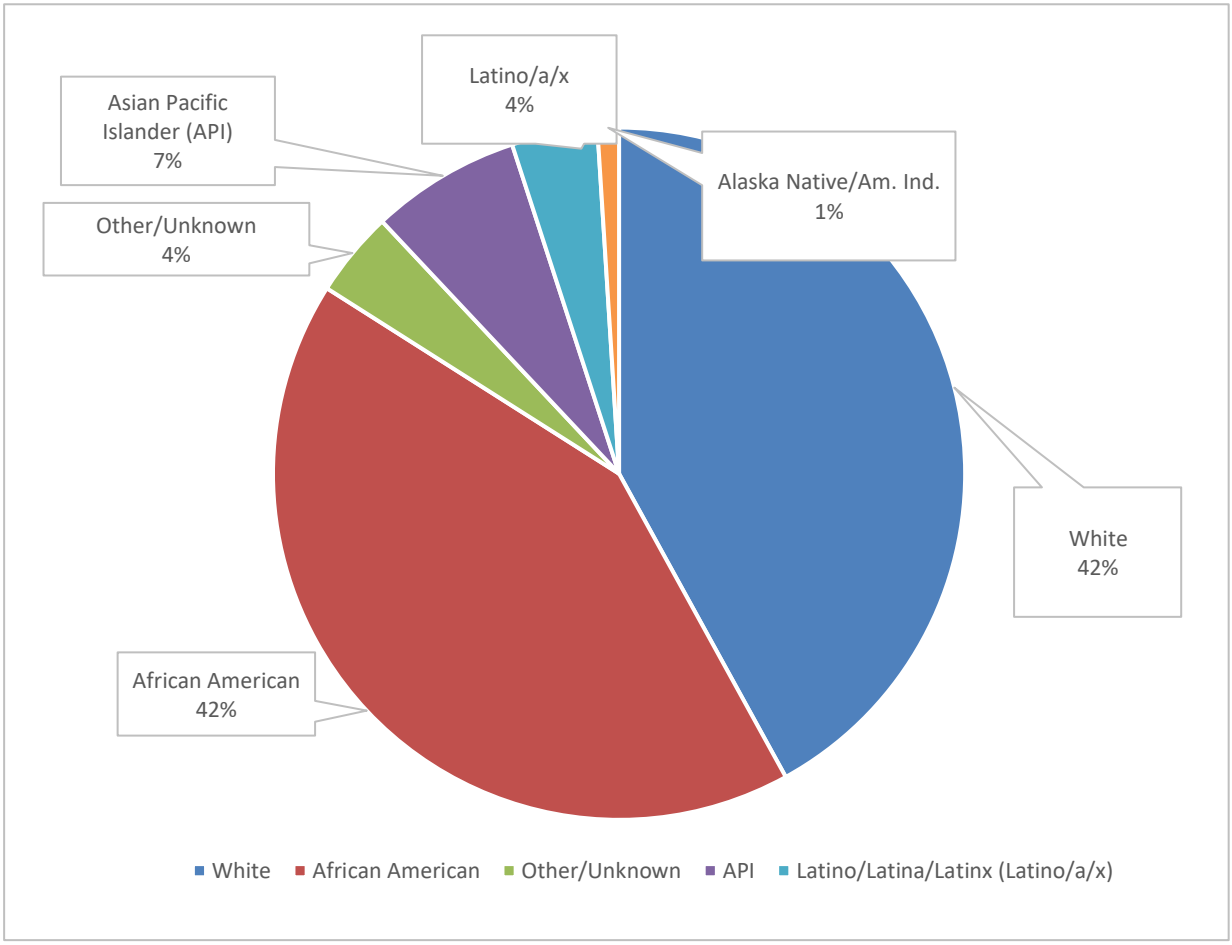
With some of the highest housing costs in the Bay Area, the Berkeley median household income is $91,259. Nearly 18% of Berkeley residents live below the poverty line and approximately 42% of Berkeley children qualify for free and reduced lunches. While 43% of Berkeley residents own their own homes, there are many homeless individuals including women, TAY, and Older Adults. In Berkeley, approximately 46% of the homeless population meets the federal definition for chronic homelessness (adults unaccompanied by children, who have at least one disability and have been homeless for over a year, or four or more times in the last year). This is a disproportionately high percentage compared to other municipalities, and a sub-group with higher rates of both mental illness and substance abuse.

Education

Berkeley has a highly educated population: 97% of individuals aged 25 or older are high school graduates; and approximately 73% 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 has several units providing services: Access; Family, Youth & Children; and Adult Services. Services include: assessment, assertive community treatment, individual and group therapy, case management, and crisis intervention. In addition to offering homeless outreach and support, some services are provided through a variety of community-based agencies and at school sites. As part of the Access unit, a Mobile Crisis Response Team operates seven days a week. The majority of mental health services provided by BMH are aimed towards the Medi-Cal and uninsured population; as such it is important to note the ways in which the Medi-Cal population demographics differ from the overall demographics in Berkeley. Using data available from Alameda County, the Medi-Cal population in Berkeley in 2021 was as follows:


Latino/a/x
4%
Asian Pacific
Islander (API)
7%
Alaska Native/Am. Ind.
1%
Other/Unknown
4%
White
42%
African American
42%
White
African American
Other/Unknown
API
Latino/Latina/Latinx (Latino/a/x)

Community Program Planning Process

The Community Program Planning (CPP) process for this City of Berkeley MHSA FY23 Annual Update was conducted while a global pandemic was still occurring. During this time one MHSA Advisory Committee meeting was held on Tuesday, May 3rd and six Community Input Meetings were held on the following dates/times:

- Monday, May 2nd: 3:00-4:30pm
- Thursday May 5th: 11:00am-12:30pm
- Tuesday May 10th: 1:00-2:30pm
- Wednesday May 11th: 6:00-7:30pm
- Thursday, May 12th: 6:00-7:30pm
- Monday, May 16th: 6:00-7:30pm

Announcements of the meetings were sent to MHSA Advisory Committee members, consumers, family members, representatives from community-based organizations, individuals from unserved, underserved and inappropriately served populations, HHCS Staff, City Commissioners, and other MHSA stakeholders. Additional outreach regarding opportunities on how to inform the MHSA FY23 Annual Update was conducted with the Mental Health Commission through email and presentations at the April 28th and May 26th Commission meetings.

During the MHSA Advisory and Community Input Meetings which were conducted through the Zoom platform, a presentation was conducted to provide information on MHSA background, funding, program requirements, and the CPP process. The presentation also covered detailed information on the proposed MHSA FY23 Annual Update and provided opportunities for input from the community. An anonymous voluntary online survey through Survey Monkey, was administered during each meeting to obtain demographic information on meeting participants. Individuals who joined the meetings by phone were contacted following the meeting to have the opportunity to voluntarily participate in the survey. Survey results of 15 individuals who either participated in Community Input Meetings or provided input by phone were as follows:

DEMOGRAPHICS N=15		
Gender Identity	*Participant Number*	*% of total*
Male	3	20%
Female	9	60%
Declined to Answer (or Unknown)	3	20%
Race/Ethnicity		
Race/Ethnicity	*Participant Number*	*% of total*
African American	3	20%
Asian Pacific Islander	1	7%
White	6	40%
Latino/a/x	1	7%
Other	1	7%
Declined to Answer (or Unknown)	3	20%
Age Category		
Age Category	*Participant Number*	*% of total*
Adult (Ages 26-59)	8	53%
Older Adult (Ages 60+)	4	27%
Declined to Answer (or Unknown)	3	20%

Sexual Orientation		
Sexual Orientation	*Participant Number*	*% of total*
Heterosexual	9	60%
Gay or Lesbian	1	7%
Declined to Answer (or Unknown)	5	33%
Veteran		
Veteran Status	*Participant Number*	*% of total*
Veteran	1	7%
Non-Veteran	11	73%
Declined to Answer (or Unknown)	3	20%
Disability Status		
Disability Status	*Participant Number*	*% of total*
Disabled	3	20%
Not Disabled	7	47%
Declined to Answer (or Unknown)	5	33%
Representative Categories		
Representative Status	*Participant Number*	*% of total*
Consumer	4	27%
Family Member of Consumer	2	13%
Parent, Student or Representative of Berkeley Unified School District	1	7%
Representative of Community Based Organization	3	20%
City of Berkeley Staff	3	20%
Other	2	13%
Declined to Answer (or Unknown)	3	20%

*Some participants were in more than one category.

As a method to continue to gather input from the community on this Annual Update, 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 and other MHSA stakeholders. Development of the MHSA FY23 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 ideas and potential programs were vetted through the MHSA Advisory Committee prior to engaging other stakeholders.

Proposed additions considered in this process include:

- Increase staffing on the Homeless Full Services Partnership and the Adult Full Services Partnership to build capacity and supports for each program;
- An additional position for the Adult Services programs to support quality assurance and program outcomes;
- An additional position to build the internal capacity for program evaluation and to support the Division-wide Results Based Accountability evaluation;
- Allocate funding for short-term housing for individuals served on the Homeless Full Services Partnership;
- Increase funding for the Bay Area Hearing Voices Network for outreach, technology, and program administration;

- Provide funding for on-site program management at the Martin Luther King House;
- Allocate a small amount of additional funds to participate in the Greater Bay Area Regional Partnership Student Loan Repayment program.

During the CPP process questions were answered regarding various MHSA programs and funding. Input received during this process was as follows:

- A nutritionist should be hired or a collaboration with Public Health should be initiated to support the wellness recovery of individuals receiving services at BMH with healthy weight weight management.
- Suggest changing the term, or redefining the language, of "Mental Health Illness".
- We need to see more information to help make meaningful contributions and recommendations. There is not enough information on how to add funding to a large complex component.
- We need to come up with a plan to get the community invested in participating in the community program planning process and on the MHSA Advisory Committee. It could be that there is stigma around mental health but we have a lack of success in attracting the community in participating in these community meetings.
- Individuals need long term treatment, not services (blankets, toothbrushes, etc.). I don't hear that individuals are receiving treatment and I don't hear any success stories. Individuals are wandering the streets and dying on the streets in my neighborhood and they aren't getting the treatment that they need. It's miserable for them and for the residents living around it to witness. Treatment should be mandatory for individuals who are living in these conditions as they are unable to help themselves.
- Utilize unspent PEI funds to provide Dynamic Mindfulness (DMind) training, coaching, and supports to Head Start staff. (Dmind is an evidence-based trauma-informed program. validated by independent researchers as a transformative strategy for teaching skills for optimal stress resilience and healing from trauma, through mindful action, centering and breathing).
- Utilize unspent PEI funds to add the InPower mobile App into the Supportive Schools project, the High School Prevention Project, and the Community Education and Supports project. (InPower is a mobile App that provides two minute mindful movement practices using video animation and audio narration, that can help guide the user to regulate powerful emotions by changing how they feel in stressful moments and/or at times of anger, sadness, anxiety, worry, and/or tiredness. InPower ensures physical, emotional, and social well-being for youth, adults and older adults).
- Utilize unspent INN funds to add the InPower App to the Mental Health Apps that are available to the community through the Help@Hand project.
- Implement the Mental and Emotional Education Team (MEET) program in the High School in FY23. (MHSA has provided PEI funding to implement MEET in the Berkeley High School. MEET 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. In the past several years by the choice of the Berkeley High School, the MEET program has not been implemented).

A 30-Day Public Review is currently being held from Wednesday, May 25th through Thursday, June 23rd to invite input on this MHSA Annual Update. A copy of the Annual Update has been posted on the BMH MHSA website. A hard copy of the Annual Update is accessible for reviewing at the reference section of the Berkeley Public Library on 2090 Kittredge Street. Announcements of the 30-Day Public Review were mailed and/or emailed to community stakeholders and City staff. A Public Hearing will be held at 7:00pm on Thursday June 23rd, during the Mental Health Commission meeting which will be conducted on the Zoom platform. Individuals interested in providing input on this Annual Update can also attend one of four community meetings that will be held by Zoom during the 30-Day Public Review. The meeting dates and times are as follows:
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Information on the Community Input Meetings has been posted on the MHSA webpage and on the City's event calendar. Announcements of the meetings have been mailed and/or emailed to community stakeholders and City staff. To provide input on the MHSA FY23 Annual Update or obtain information on how to access the Community Input Meetings or the Public Hearing, contact Karen Klatt, (510) 981-7644, KKlatt@cityofberkeley.info.

MHSA FY2022/2023 Annual Update

This City of Berkeley's MHSA FY2022/2023 (FY23) Annual Update is a stakeholder informed plan that provides an update to the previously approved MHSA FY20/21 – 22/23 Three Year Program and Expenditure Plan (Three Year Plan). The Annual Update summarizes proposed program changes and additions, includes descriptions and updates of currently funded MHSA services that are proposed to be continued in the next year, and a reporting on FY21 program data. Additionally, per state regulations, this Annual Update includes the Prevention and Early Intervention (PE) Fiscal Year (FY) 2018/2019 – 2020/2021 Three Year Evaluation Report (Appendix A), and the Innovations (INN) FY2022/2021 Annual Evaluation Report (Appendix B).

While some MHSA programs collected outcome and client self-report measures, the majority of the data that was collected in FY21 was still more process related. However, as reported in previous MHSA Plans and Updates, a few initiatives that are currently underway to evaluate the outcomes of several MHSA programs are as follows:

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

RBA has been incorporated into selected programs within the Department. 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 begin measuring and enhancing progress towards these results. Page 54 of this Three Year Plan provides an aggregated summary of some of the results of this initiative.

- Results Based Accountability Evaluation for all BMH Programs: Through the approved FY19 Annual Update the Division executed a Request for Proposal (RFP) process to hire a consultant who will implement a Results Based Accountability Evaluation for all programs across the Division, and Resource Development Associates (RDA) was the chosen vendor. In FY21 RDA began working with the Division to implement the RBA research methodology. An update of the work on this evaluation is included on pages 40-41 of this Annual Update.

- PEI Data Outcomes: Per MHSA PEI regulations, all PEI funded programs have to collect additional state identified outcome measures (specific to the category of services provided) as well as detailed demographic information. Beginning in FY19, PEI Evaluations were required to be included in each MHSA Annual Update or Three Year Plan. See Appendix A for the Prevention & Early Intervention Fiscal Years (FY) 2018/2019 - 2020/2021 Three Year Evaluation Report.

- INN Data Outcomes: Per MHSA INN regulations, all INN funded programs have to collect additional state identified outcome measures and detailed demographic information. Beginning in FY19, INN Evaluations were required to be included in each MHSA Annual Update or Three Year Plan. See Appendix B for the Innovations (INN) Fiscal Year (FY) 2020/2021 Annual Evaluation Report.

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

PROPOSED NEW FUNDING ADDITIONS

The Division is proposing to add several new positions, and supportive services through this Annual Update, and will be discontinuing one program. Proposed new additions are a result of community needs that have arisen since the Three Year Plan was approved. Funding amounts for the proposed additional staffing outlined below are calculated based on staff being hired by mid FY23 with 30% of the costs of the positions offset by Medi-Cal reimbursement. The proposed staffing and services to be added or discontinued through this MHSA Annual Update, are as follows:

Increase Program Capacity on the Homeless Full Services Partnership (FSP)

The Homeless Full Service Partnership (FSP) provides services and supports for homeless individuals who are experiencing mental health needs. As this FSP is rapidly reaching program capacity, the Division is proposing to utilize MHSA Community Services and Supports (CSS) FSP Funds to expand this program through the addition of the following positions:

- 2 Social Service Specialists - $107,491
- 1 Behavioral Health Clinician II - $63,082

Increase Program Capacity on the Adult Full Services Partnership (FSP)

The Adult Full Services Partnership (FSP) is the largest program in the MHSA Community Services and Supports funding component. This FSP provides intensive support services to TAY, Adults and Older Adults with severe mental illness using an Assertive Community Treatment (ACT) approach. The program focuses on serving individuals who have had difficulty with obtaining or maintaining housing; frequent and/or lengthy psychiatric hospitalizations; and/or frequent or lengthy incarcerations. Priority populations also include individuals from un-served, underserved and inappropriately served cultural communities. In order to increase the program capacity and organization of this FSP, the Division is proposing to add the following positions through MHSA CSS FSP Funds:

- 1 Social Service Specialist - $53,745
- 1 Senior Behavioral Health Clinician II - $68,741

Increase Administrative Support for Adult Programs

Berkeley Mental Health (BMH) Adult Services is comprised of the following three large programs: Adult FSP, Comprehensive Community Treatment, and Focus on Independence. The programs provide a continuum of services and supports for individuals in need. In order to provide administrative support for each program in meeting Quality Assurance and performance outcomes, the Division is proposing to add the following position through MHSA CSS System Development Funds and MHSA FSP Funds:

- 1 Assistant Management Analyst - $53,738

Create internal capacity for Program Evaluation

Feedback received over previous years focused on implementing evaluation measures that help BMH, MHSA Stakeholders, and community members more fully understand and determine how well programs are meeting participant and community needs. Integral to this type of outcome measure is to engage the voice of the program participant around the services they received. As a result of this feedback in the previously approved MHSA FY19 Annual Update, BMH allocated funds to hire a Consultant to 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. In FY19 a competitive RFP process was executed, and Resource Development Associates (RDA) was the chosen consultant. RDA is currently in the process of working with the Division on this evaluation.

In order to create the internal capacity to collect and report on the RBA outcomes as well as future evaluations, the Division is proposing to utilize MHSA CSS System Development Funds to hire the following administrative position to support this work:

- 1 Community Services Specialist III - $74,686

Add funding to support on-site management at Martin Luther King 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. This SRO is currently experiencing a need for increased property management. Through this Annual Update the Division is proposing to allocate $107,890 of CSS System Development Funds to support the Martin Luther King Jr. House in acquiring on-site property management

Increase short-term housing for individuals on the Homeless FSP

Through this Annual Update the Division is proposing to allocate $120,000 of MHSA FSP Funds to support short-term housing for individuals receiving services on the Homeless FSP. The funding will be utilized to provide housing, three meals a day, utilities, 24/7 security, housing navigation and the maintenance of Trailers for four individuals at 701 Harrison Street.

Increase funding for Bay Area Hearing Voices Network

The Division currently provides MHSA funding to the Bay Area Hearing Voices Network to implement free support groups for individuals in Berkeley who experience voices, visions, special messages, unusual beliefs or extreme states of consciousness. The support groups are co-facilitated by trained group leaders whom have lived experiences in the mental health system. Through this Annual Update, the Division is proposing to increase the funding amount by $12,205 to support program outreach, technology costs and administrative services. With the proposed increase the new annual project amount will be $46,941 which will be funded through CSS System Development Funds.

Provide additional funding for the Greater Bay Area Workforce, Education & Training Regional Partnership

The Office of Statewide Health Planning and Development (OSHPD) allocated $40 million in Workforce, Education and Training funds through FY25 for Regional Partnerships across the state for various mental health workforce strategies. A total of 2.6 million of OSHPD was allocated to the Greater Bay Area (GBA) Workforce, Education & Training Regional Partnership. In order to participate in the GBA Regional Partnership, mental health jurisdictions were required to contribute a portion of local funds towards this initiative. For the Berkeley contribution the amount was $40,127, which the Division allocated through the previously approved Three Year Plan.

Since the approval of the Three Year Plan, the Division has participated in meetings with representatives from other counties in the GBA Regional Partnership. All participating counties decided to allocate these funds to implement the Loan Repayment program. This program will enable funds to be made available to repay a portion of student loans for a given number of staff who are in hard-to-fill positions, in exchange for a number of years of service in the Public Mental Health system.

Since the approval of the Three Year Plan some local counties decided not to participate in this initiative. As a result, the GBA Regional Partnership was notified that each participating mental health jurisdiction will need to increase the amount of funds they are contributing to this initiative. The additional amount for Berkeley is $1,361. Per this Annual Update, the Division is

proposing to transfer $1,361 of CSS System Development Funds to the Workforce, Education and Training (WET) funding 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 to participate in this initiative, which is being administered through a joint powers authority, the California Mental Health Services Authority (CalMHSA). Through this Annual Update the Division is requesting to enter into a Participation Agreement with CalMHSA to allocate the designated funds to participate in this initiative.

Adult Clinic Repair and Renovation Study on Adjacent Property

Construction on the Adult Clinic began in FY19, and in June 2021, the renovation was completed, staff moved back into the building, and the clinic was re-opened for services. There is approximately $199,572 in remaining CFTN Funds. It is anticipated that approximately $35,000 of these funds will be utilized in FY23 to alleviate water damage at the Adult Clinic and $75,000 will be utilized to conduct a Renovation Study on the adjacent property to the Adult Clinic (2636 Martin Luther King Jr. Way) where some Adult Clinic staff offices are located.

Discontinue Community-Based Child & Youth Risk Prevention Program

The Community-Based Child & Youth Risk Prevention Program is funded through the MHSA PEI component that targets children (aged 0-5) who are impacted by multiple risk factors including trauma, family or community violence, familial distress, and/or family substance abuse, (among other issues). A BMH clinician has 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 have 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 of the program have been to reduce risk factors or other stressors, and promote positive cognitive, social, and emotional well-being. In FY23 this program will be discontinued, as the YMCA Head Start program has hired an internal staff to fill this role.

PROGRAM DESCRIPTIONS AND FY21 DATA BY FUNDING COMPONENT

Outlined in this section per each funding component are descriptions of current City of Berkeley MHSA services along with FY21 program data. Across all MHSA funded programs, in FY21, approximately 3,805 individuals participated in some level of services and supports. Additionally, a total of 561 individuals attended BMH Diversity and Multi-cultural trainings and/or events. As with FY20, among the largest of accomplishments in FY21 is that almost all MHSA funded services were able to continue providing services in some capacity during the pandemic. Some of the FY21 MHSA funded program highlights included: A reduction in psychiatric

inpatient hospital and/or incarceration days for severely mentally ill clients; a decrease in the number of days severely mentally ill clients spent homeless; step down to a lower level of care for some clients; services and supports for homeless or marginally housed TAY, who are suffering from mental illness; services and supports for family members; multicultural trainings, projects and events; Wellness Center services; consumer driven wellness recovery activities; housing, and benefits advocacy services and supports for clients; augmented prevention and intervention services for children and youth in the schools and community; increased outreach, and support services for homeless TAY, Adults and Older Adults and individuals in unserved, underserved and inappropriately served cultural and ethnic populations.

COMMUNITY SERVICES & SUPPORTS (CSS)

Following a year-long community planning and plan development process, the initial City of Berkeley 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 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;
- Homeless Services;
- Multi-cultural Outreach & Engagement;
- 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 and updates for each CSS funded program and FY21 data are outlined below:

FULL SERVICE PARTNERSHIPS (FSP)

Children/Youth Intensive Support Services Full Service Partnership

The Intensive Support Services Full Service Partnership (FSP) 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 Children/Youth FSP program utilizes wraparound as the treatment model. Wraparound differs from many service delivery strategies, in that it provides a comprehensive, holistic, youth and family-driven way of responding when children or youth experience serious mental health or behavioral health challenges. The model puts the child or youth and family at the center. With the help of the FSP team, the family and young person take the lead in deciding their vision and goals. Team member's work together to put the goals into an action plan, monitor how well it is working, and make changes to it as needed. The projected number of individuals to be served in FY23 by each age category is as follows: 9 individuals aged 6-12; 9 individuals aged 13-17; and 2 individuals aged 18-21.

In FY21, a total of 17 children/youth and their families were served through this program. Demographics on those served were as follows:

DEMOGRAPHICS N=17		
Age	*Number Served*	*% of total*
6-12 years	5	29%
13-17 years	9	53%
18-21 years	3	18%
Gender Identity	*Number Served*	*% of total*
Male	11	65%
Female	6	35%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*% of total*
African American	10	59%
Asian Pacific Islander	1	6%
White	4	23%
Latino/a/x	2	12%
Sexual Orientation		
Heterosexual or Straight	12	71%
Declined to State or Unknown*	5	29%

Flex funds are used to provide various supports for FSP program participants and/or the families of program participants. In FY21, flex funds were utilized as follows: 8 individuals/families received funding for food/groceries; 3 individuals/families received funds for clothing/hygiene; 1 individual/family received funds for furniture/household items; and 6 individuals/family members received funding for other various needs.

<u>Program Successes:</u>

- Seven individuals met and/or exceeded the stated objectives in their treatment plan.

- Successfully transitioned client care to Zoom at the beginning of the Pandemic. Staff were able to successfully support their clients/families to utilize the platform and to regularly have scheduled appointments.
- Increased linkages to psychiatric medication services, and individual/family therapy. Three individuals who were over 18 years of age were referred to BMH Adult Services for medication support.
- Reduced psychiatric hospitalizations and usage of crisis services.
- Services were provided by clinicians who mirrored the racial/ethnic identity of the populations served.
- The FSP Team was able to provide flex funds to support the felt needs of clients during the pandemic. This supported the purchase of food, household items, clothing/hygiene, and other various needs.
- As the shelter in place was eliminated for Berkeley residents, staff were able to engage individuals safely in public settings which improved engagement and the quality of care provided.

Program Challenges:

- Providing FSP level care to clients and families via Zoom during the Pandemic was extremely difficult as staff and families implemented safety protocols to reduce the risk of exposure to COVID-19. Families also reported high levels of Zoom fatigue since all services and academics were provided on line, which impacted consistent engagement in services.
- Reduction in referrals to the program due to the fact that families were sheltered in place at home. This reality made it difficult for natural supports (i.e. school staff) to see the students who could benefit from services and make the subsequent referrals.
- Staff were only able to provide services in English due to the resignation of the Spanish speaking clinician. Other BMH Family & Children's Services behavioral health clinicians were able to fill in to support these individuals and families.

TAY, Adult and Older Adult Full Service Partnership

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

The team utilizes an ACT approach which maintains a low staff-to-client ratio (12:1) that allows for frequent and intensive support services. Individuals are provided assistance with finding appropriate housing and in some cases may qualify for temporary financial assistance. The primary goals of the program are to engage clients in their treatment and to reduce days spent homeless, hospitalized and/or incarcerated. Goals also include increasing, employment and educational readiness; self-sufficiency; and wellness and recovery. The projected number of individuals to be served in each age category in FY23 is as follows: 5 Transition Age Youth; 55 Adults; and 15 Older Adults.

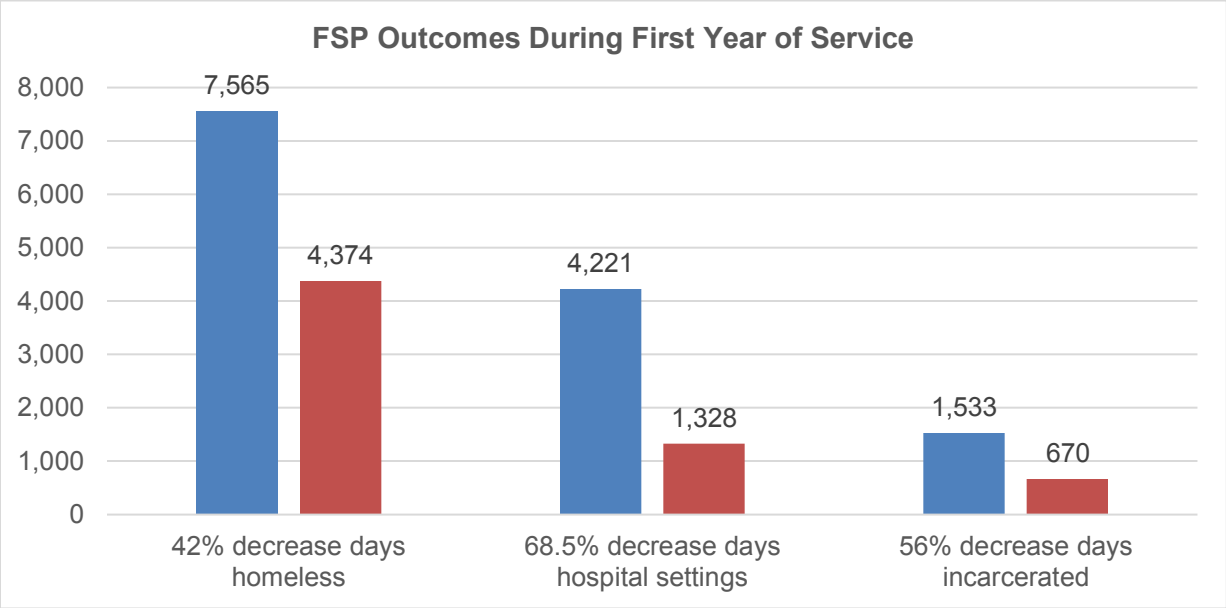
In FY21 a total of 79 TAY, Adults, and Older Adults participated in the program for all or part of the fiscal year. Demographics on those served include the following:

DEMOGRAPHICS N=79		
Gender Identity	*Number Served*	*% of total*
Male	47	59%
Female	25	32%
Pangender	1	1%
Declined to Answer (or Unknown)	6	8%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*% of total*
African American	35	44%
Asian Pacific Islander	1	1%
White	36	46%
Latino/a/x	4	5%
Declined to Answer (or Unknown)	3	4%
Age Category		
Age Category	*Number Served*	*% of total*
Transition Age Youth	4	5%
Adult	56	71%
Older Adult	19	24%
Sexual Orientation		
Heterosexual	52	66%
Bisexual	3	4%
Gay	2	2.5%
Pansexual	2	2.5%
Declined to Answer (or Unknown)	20	25%

Flex funds are used to provide supports for FSP program participants. In FY21, 20 partners received rental and housing assistance; 28 received food and groceries and 25 partners were provided with miscellaneous assistance with cleaning, clothing, bus passes, furniture, etc. FSP outcomes included the following: 11 partners were dis-enrolled from the program during FY21, 4 partners met treatment goals and graduated to lower levels of care (36%), 4 partners were transferred to a new Full Service Partnership team specializing in individuals who are chronically homeless (36%), 1 partner moved out of the county (9%), 1 partner died (9%), 1 partner could not be located (9%). 7 new partners were enrolled and completed services.

There were 71 FSP program participants in FY21 who completed at least 1 full year of service in the program and are included in the program outcome report data. There were positive outcomes with regard to reductions in days spent homeless, in hospital settings and/or incarcerated. There was a 42% reduction in days spent homeless. Partners spent 7,565 days homeless (on the street, couch surfing and in shelters) the year before program enrollment and 4,374 days homeless during the first year of program participation. There was a 68.5% reduction in days spent in hospital settings (Psychiatric Emergency, acute psychiatric inpatient, IMDs, MHRCs, state psychiatric hospitals and medical hospitals, SNF) during the first year of program participation. Partners spent 4,221 days in hospital settings the year before program enrollment and 1,328 days in these settings during the first year of program participation. There was a 56% reduction of days spent incarcerated during the first year of program participation. Partners spent 1,533 days incarcerated (jail and prison) the year prior to program enrollment

as compared with 670 days incarcerated during the first year of program participation. Outcomes are outlined in the chart below:



Overall, as with previous years, the program continued to have strong outcomes with regard to reducing days spent in hospital settings (68.5%) and days spent incarcerated (56%). The program continues to have more modest success with reducing the number of days spent homeless for participants (42%). Program challenges included the ongoing housing crisis in the Bay Area, staff vacancies, and the ongoing COVID-19 pandemic.

Program Challenges:

- Bay Area Housing Crisis: As the Bay Area housing crisis has continued, finding safe and affordable housing is extremely difficult as housing prices continue to rise and are among the most expensive in the country. Licensed Board & Cares that provide clients 24/7 support and monitor medication adherence have also been closing down. Single Room Occupancy Hotels have been raising their monthly rates such that clients are not able to afford staying there without housing subsidies.
- Coordinated Entry System: The Coordinated Entry System in Alameda County is intended to address homelessness more efficiently and equitably. The system standardizes the assessment process and prioritizes resources for individuals who are assessed to have the highest need. Helping the highest need homeless individuals get through the assessment process can be challenging given the need for clients to participate in an assessment appointment. Also, some individuals served in the FSP were reluctant to acknowledge their mental health and substance use issues which in turn lowered their “needs” assessment score and chances of obtaining permanent supported housing resources.
- COVID-19 Pandemic: The COVID-19 pandemic continued to present challenges in FY21 in providing services to clients. In-person visits continued to occur at somewhat reduced levels to minimize unnecessary risks to clients and staff. Hospitals, Board and Cares and various other programs closed sites to visitors during periods of outbreak.

- Staffing: Retaining and hiring staff was difficult. Several staff left the team and it has been very difficult to fill those vacancies. There have been significantly fewer applicants over the past year than in years past. Staff that applied for and were offered positions reported receiving multiple job offers from other organizations. The pandemic has likely played a role in the hiring crisis. The FSP requires working in the community with individuals who are considered the highest need within the service system. The work can be challenging. Current employees also had to manage their concerns about possible exposure to COVID-19 while doing front line services as well as managing their burnout as staffing levels decreased. It is anticipated that the current vacancies will be filled in the coming fiscal year.

Going forward the FSP will continue to develop staff expertise in treating co-occurring substance use disorders by providing ongoing training in Motivational Interviewing. The team will also continue to work on increasing fidelity to the Assertive Community Treatment model.

Homeless Full Service Partnership

Through the previously approved MHSA FY20 Annual Update, and as a result of the need to ensure ongoing services and supports for homeless individuals following the ending of the Homeless Outreach and Treatment Team (HOTT) Pilot Program, a Homeless Full Services Partnership was developed. This program provides services and supports for homeless individuals who are experiencing mental health needs. It was implemented in the last quarter of FY21. During that timeframe one individual was served. The projected number of individuals to be served through this program in FY23 by age category is as follows: 5 Transition Age Youth; 35 Adults; and 10 Older Adults.

MULTI-CULTURAL OUTREACH AND ENGAGEMENT

Diversity & Multicultural Services

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

The Diversity & Multicultural Coordinator accomplishes these goals by:

- Providing cultural 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 Competency Plan as needed.

Program services, events and activities conducted in FY21, are summarized below:

Activity Update

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

Diversity & Multicultural Trainings & Events: (Culturally Diverse Participants)

- Latino/Latinx Conference 2020 – Latino Intercambio: Together We Are Stronger!/Juntos Somos Fuertes! Friday, October 23, 2020.
  (Zoom Event - 110 individuals attended this event) - Attendees included staff, consumers, family members, community partners, students, and residents. This training was a collaboration with the City of Berkeley Public Health and Aging Services Divisions; BAHIA, Inc.; and RISE.
- BMH Event - Black Expressions of the Soul in All Forms – Celebrating Black Joy – Thursday, February 18, 2021- (Zoom Event - 62 individuals attended this event) - Attendees included staff, consumers, and residents.
- Black History Month Youth Celebration - Thursday, February 20, 2021 - (Zoom Event - 46 individuals attended this event) - Attendees included youth, family members, teachers, staff, and residents. This event was a collaboration with BUSD.
- Berkeley in Solidarity with Asian Americans and Pacific Islanders – May 10, 2021 – A collaboration with the University of California at Berkeley (Zoom Event – 73 individuals attended this event) – Attendees included students, professors, staff and residents.
- May Is Mental Health Month – COVID-19: Challenges, Hope, and Resiliency - Increasing Community Mental Health and Wellness – May 26, 2021 - (Zoom Event - 52 individuals attended this event) - Attendees included staff, consumers, and residents.
- PRIDE Month 2021 - Transgender Tay: Finding Self and Love in Transition – Thursday, June 17, 2021 (Zoom Event - 15 individuals attended this event) - Attendees included staff, consumers, and residents.

Staff Training Coordinator

The Staff Training Coordinator prepares, facilitates, presents, monitors, evaluates and documents training activities for BMH's system of care. The position also collaborates with staff from state, counties, local agencies and community groups in order to enhance staff development of employees in the cities of Berkeley, and other areas in the region.

The Training Coordinator accomplishes these goals by:

- Providing staff training in the area of behavioral health to all stakeholders in Berkeley and other geographic locations in the region as a collaborative partner;

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

Workforce, Education, and Training (WET) Services: (Culturally Diverse Participants)

- "Motivational Interviewing: Introductory & Continuing the Journey - Wednesday, September 2, 2020, and Thursday, September 3, 2020 - (Zoom Event - 56 individuals attended this training) - Attendees included staff and community partners.
- Berkeley Mental Health - Dr. Hardy - Staff Cultural Humility 2 - Day Training – 2020 (September 14th & 21st; September 15th & 22nd; September 16th & 23rd; September 17th & 24th) – Zoom Event - BMH Staff Attended
- Suicide Prevention and Intervention Skills Building Workshop - Friday, November 13, 2020 - (Zoom Event - 48 individuals attended this training) - Attendees included staff and community partners.
- City of Berkeley - Law & Ethics for County Healthcare Providers - Wednesday, March 10, 2021 - (Zoom Event - 43 individuals attended this training) Attendees included staff and community partners.

Committees/Groups:

- BMH Diversity & Multicultural Committee, Chair
- BMH Staff Training Committee, Chair
- Alameda County BHCS PRIDE Committee Member
- BHS Community Resource Committee
- Statewide Spirituality Liaison, Spirituality Initiative Committee Member
- State and County Ethnic Services Managers/Cultural Competency Coordinators, Committee Member
- Alameda County BHCS African American Steering Committee for Health and Wellness, Committee Member
- BMH Health Equity Committee – Co-Chair
- African American Holistic Resource Center, Community Leadership Committee, Co-Chair

Outreach and Engagement:

- Native American Health Center – Indigenous Community
- Black Infant Health –Women & Children
- Berkeley Drop-In – Homeless Population
- McGee Baptist Church – African Americans
- The Way Christian Center – African Americans
- Village Connect, Inc., African American & Latino/a/x populations
- Pacific Center – LGBTQI2-S Community
- BAHIA, Inc. – Latino/a/x population
- Healthy Black Families – African American Women & Children Population

- BUSD – Staff, Students, and Families

Due to the COVID-19 pandemic all trainings went virtual and online from May 2020-present.

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.

In FY21, a total of 129 TAY individuals were served. Demographics on individuals served were as follows:

DEMOGRAPHICS N=129		
Gender Identity	*Number Served*	*% of Total*
Male	82	64%
Female	47	36%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*% of Total*
African American	71	55%
American Indian or Alaska Native	4	3%
Asian Pacific Islander	5	4%
White	19	15%
Latino/a/x	34	26%
More than one Race	15	12 %
Other	11	8%
Declined to Answer (or Unknown)	4	3%
Age Category		
Age	*Number Served*	*% of Total*
16-25 years	129	100%
Sexual Orientation		
Sexual Orientation	*Number Served*	*% of Total*
Gay or Lesbian	13	10%
Heterosexual or Straight	80	62%
Bisexual	16	12%
Questioning or unsure	4	3%
Other	1	1%
Declined to Answer (or Unknown)	15	12%

During FY21, 345 outreach activities were conducted with a total of 126 duplicated contacts. A total of 129 individuals participated in ongoing mental health program services. There were 476 referrals to the following services and supports: 112 Mental Health; 104 Physical Health; 87 Social Services; 76 Housing; and 97 other unspecified services. Per a Satisfaction Survey that was administered, youth participants reported the following: 96% indicated satisfaction with the treatment services they received; 22% exited the program into stable housing; and 39% became employed or entered into school.

In FY21 there were both changes in leadership and a move of the program to a new location. These changes were challenging but ultimately fruitful and provided immeasurable benefits for youth who participated in the program.

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 consumers and family members are informed of, and able to be involved in, opportunities to provide input and direction in the service delivery system and/or to participate in recovery-oriented or other supportive services of their choosing. Strategies designed to reach program goals include: developing policies that facilitate the Division in becoming more Wellness & Recovery oriented and consumer/family member driven; outreach to, and inclusion of, consumers and family members on Division committees; provision of family support & education; supported employment and vocational services; wellness activities; peer supportive services; 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 System Integration

The BMH Wellness Recovery Team works with staff, stakeholders, community members and clients to advance the goals of Wellness and Recovery on a system wide level. In order to accomplish these goals, some of the various tasks include: recruiting consumers for Division committees; convening committees around Wellness Recovery system initiatives; oversight/administration of peer stipends; convening and conducting meetings for the Berkeley “Pool of Consumer Champions (POCC)”; working with staff to develop various Wellness and Recovery related policy and procedures; and oversight of the Division’s “Wellness Recovery Activities”. The Consumer Liaison is also a resource person around “Mental Health Advance Directives” for consumers desiring to express their treatment preferences in advance of a crisis; and is a participant on a number of local MHSA initiatives. The combination of individual services and system-level initiatives impact all clients and their family members across the system in a given year. In FY21, there were a total of 418 clients in the BMH system.

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

Berkeley Pool of Consumer Champions (POCC)

In FY21, the Berkeley Pool of Consumer Champions (POCC) met seven times, as meetings were paused for awhile due to the pandemic. During the meetings the POCC primarily focused on creating a position for new members, reviewing the mission statement, and having members apply for roles and responsibilities within the POCC. The Alameda County POCC has 2 identified positions, a Chair and Note-Taker for their meetings, so the Berkeley POCC decided to make all 6 stipend positions, roles for members who have to apply to hold a position. The following six positions were created along with job descriptions: Chair, Note-Taker, Outreach, Ambassador to the City, MHSA/MHC representative, and Event's Organizer. The Berkeley POCC also has a member who is a representative of the Alameda County POCC Steering Committee. Other activities the POCC focused on were: presenting about their work at the Alameda County POCC Steering Committee; attending the cultural holiday event online; helping out with food giveaways in person; making executive decisions for the entire POCC, reviewing polices; and organizing the POCC conference. A total of 14 unduplicated individuals participated in the POCC meetings and activities.

Wellness Recovery Activities

Designed with, and building on the talents of consumers, wellness recovery activities is a group that highlights consumer facilitation and creativity skills. In FY21, due to the COVID-19 pandemic and shelter in place protocol, this group was not held.

Walking Groups

In FY21 the Wellness Recovery Team began walking groups to help with isolation and the restrictions of having groups indoors. This group is a new addition to the Wellness Recovery Activities/groups. The walks took place at local parks and neighborhoods in Berkeley and they varied in physical intensity. People were required to wear masks and socially distance. The walks were advertised in the Wellness Recovery monthly newsletter. There were 43 walks scheduled throughout the year. During the colder months in January and February walks were not scheduled due to the increase of COVID-19 cases and weather. The parks visited were Ohlone, Grove, Strawberry Creek, Codornices, Aquatic, and San Pablo Park and the University of California at Berkeley campus and Rose Garden. A total of 11 unduplicated individuals participated in the Walking Groups.

Field Trips

In FY21 all field trips were canceled due to shelter-in-place and COVID-19 restrictions.

Card Party Groups

In FY21 a total of 40 Card Party groups were offered to inspire consumers to create inspirational cards for individuals in psychiatric hospitals. This program is modeled after the Do-Send-A-Card program created by the San Francisco Mental Health Association. BMH Wellness Recovery staff partnered with the Alameda Network of Mental Health Clients' Reach-Out Program to distribute the cards that were created from the Card Party groups when they visit the hospitals throughout the County. Patients can choose the card they want to receive. Through this program 184 cards were created and given to the Reach-Out Program. This program has been

operating on the zoom platform and the participants used their personal craft materials to make cards for others. A total of 13 unduplicated individuals participated in the Card Party Groups.

Mood Groups

The Mood group is designed for people to share their thoughts and feelings in a safe place where support is also offered. In FY21 the weekly support group focused on reviewing moods scales to help people identify where they are and then share whatever they wanted among non-judgmental peers. This group was impacted in the attendance by the COVID-19 pandemic and began again in February 2021. A total of 8 unduplicated individuals participated in 9 groups.

Mental Health Advance Directives

One-on-One Consultations on Mental Health Advance Directives are available through Wellness Recovery Staff. Although consultations were advertised in the Wellness Recovery Newsletter, in FY21 there weren't any individuals who requested this service.

The Wellness Recovery Team also conducted and participated in the following activities during the reporting timeframe: Developed a monthly Newsletter in April 2020 and the newsletter has been written, edited and prepare by the Wellness Staff every month of the FY 20-21. The team began to published a 6-page newsletter highlighting wellness tool, community resources, food recipes, fun activities, information about diagnosis, and interviews with community members. These mailings were sent to approximately 150 individuals via mail and another 130 individuals via email; Worked on the development of a Mission Statement for the Wellness Recovery Team: hosted a special we small group for the "We move for health" event for Berkeley residents, Participated in the planning and implementation of the May is Mental Health Month event in Berkeley, Health and Human Resource and Education Center-10x10 8 Dimensions of Wellness, "We move for Health 10x10 campaign, POCC listen sessions and Alameda County Peer Support Specialist certification forums; Conducted Consumer Perception surveying in June 2021 by mail, during the State survey period as well as submitting completed surveys to the state; The following conferences were attended– CAMHPRO LEAD Conference in Sacramento and many put on by the Mental Health Division.

Hearing Voices Support Groups

The Hearing Voices Support Groups are offered through a contract with the Bay Area Hearing Voices Network. A weekly free drop-in Support Group is for adults who experience voices, visions, special messages, unusual beliefs or extreme states of consciousness. The support group is co-facilitated by trained group leaders both of whom have lived experience in the mental health system. Per the approved MHSA FY20 Annual Update, two additional new support groups were implemented through this program in December 2019, one for Transition Age Youth and one for Family Members of individual participants.

In FY21, 590 individuals were served through weekly online support groups. A survey questionnaire was sent to group participants in January 2021 with a total of 25 individuals responding to the survey. The survey results were as follows:

DEMOGRAPHIC SURVEY RESPONSES N=25		
Gender Identity	*Number Served*	*% of total*
Male	7	28%
Female	15	60%

Declined to Answer (or Unknown)	3	12%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*% of total*
African American	1	4%
Asian Pacific Islander	3	12%
White	15	60%
Latino/a/x	5	20%
More than one Race	1	4%
Age Category		
Age Category	*Number Served*	*% of total*
Adult	14	56%
Older Adult	11	44%
Sexual Orientation		
Heterosexual or Straight	14	56%
Bi-Sexual	2	8%
Gay	4	16%
Declined to Answer (or Unknown)	5	20%

Responses to some of the survey questions on the impact of the group were as follows:

How has the group helped you?

- Knowing that we are not alone. Getting others people opinions on different situations. I appreciate hearing about other people's experiences, especially when they resonate with mine. It's so freeing to share experiences in such a nonjudgmental space. Even though I've only gone a couple of times so far, I've been able to share and get advice about issues that were really troubling me. has given me tips and insights on communicating with my loved one. Let me know I'm not alone with this issue.
- support group fellowship with others who hear voices It helps me find the strength to go out into the world after being with people who understand what I'm going through.
- Validation to understand my own experiences and provide support to others who have different challenges but equally significant ones. To have a community.
- It helped me normalize myself
- To feel not so alone with these problems
- I get ideas for how to manage life with my loved one.
- Normalized the situation
- Allowed me to talk to folks about my voices.
- it is an open forum where I can let loose and say what I need to say about my voices
- By a lot it helps me understand others and myself
- Really supportive
- This group has helped me understand how to support and handle people who hear voices.
- I feel less alone knowing other people hear voices, too.
- Given me a safe haven to talk about our situation here with our son.
- Group has offered me support and new perspectives on my family relationships and myself.

- Its nice to talk to other people who hear voices.
- Showing me that I am not alone.
- Place to talk about hearing voices

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

- My life has changed knowing that I have the support.
- Knowing that I can turn to the group at difficult times.
- Continues being a challenge
- I have more hope for the future.
- I have community. I also have the support to advocate for the alternative senses if reality community in my work life and personal life as well.
- I have more self respect and I respect my limits more and have a better relationship with myself
- not yet except for feeling better about the future
- When I was participating regularly I had improved relationships
- Less depression and anxiety during the time I am talking to the group.
- Been able to talk to people a lot more compared to less social activity
- more aware of my voices
- It's an outlet and hope. It is something I look forward to.
- I don't need to filter as much in this group as I do in other groups.
- Our son respects that both of his parents are spending time each week in an effort to better understand him. And we parents are doing a better job talking to the other about our different ways of being with our son.
- It gives me a place to talk for support for 2 hours.
- Better understanding of my voices

Family Support Services

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

The Family Services Specialist serves as a point of contact for family members who are currently accessing or attempting to access services and/or who have questions and concerns about the mental health system, providing them with supports, and as needed, referrals to additional community resources. Outreach is provided to families through existing BMH family support groups, NAMI of the East Bay, community clinics and the Alameda County Family Education Resource Center (FERC). Additionally, the Family Services Specialist coordinates forums for family members to share their experiences with the system; recruit's family members to serve on BMH committees; supports family members through a "Warm line"; conducts a

Family Support Group; and creates training opportunities to educate mental health staff on how to effectively work with families. The combination of individual services and system-level initiatives impact all clients and their family members across the system in a given year. In FY21, there were a total of 438 clients in the BMH system.

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

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

Family Support Group: Provides supports for parents, children, siblings, spouses, significant others or caregivers. The group met once a month for two hours.
As the Family Services Specialist position has been vacant since April 2019, the previous position holder has continued the Family Support Group and occasional Warm Line Phone support. In addition, the global COVID-19 pandemic resulted in a pause of the Family Support Group which is reflected in the low number of individuals served.

During FY21 a total of 15 family members were served. Demographics of individuals served are outlined below:

DEMOGRAPHICS N=15		
Gender Identity	*Number Served*	*Percent of Total Number Served*
Male	5	33%
Female	10	67%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*Percent of Total Number Served*
African American	1	7%
Asian Pacific Islander	2	13%
White	7	47%
Declined to answer (or unknown)	5	33%
Age Category		
Age in Years	*Number Served*	*Percent of Total Number Served*
25-44 years	1	7%
45-64 years	10	67%
65+ years	4	26%
Sexual Orientation		
Declined to answer (or unknown)	15	100%

Employment Services

Previously, a BMH Employment Specialist provided services to support consumers in job readiness and accessing employment opportunities. It was envisioned that these services would at a minimum, create and nurture supported vocational, educational and volunteer “try-

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

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

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

Housing Services and Supports

The Housing Specialist provides housing resource services for clients; working with landlords to increase housing opportunities; collaborating with case management staff, landlords, and Board & Care Managers to provide additional supports for clients who are already housed; and working in tandem with the City of Berkeley HHCS Department Hub (which serves as a single entry point into emergency shelter and transitional housing, where clients are triaged based on their housing and service needs). Some of the various places where clients with subsidies are housed are the Berkeley Food and Housing Project 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 FY21, 9 clients were served through this agency. Demographics on those served were as follows:

DEMOGRAPHICS N=9		
Gender Identity	*Number Served*	*Percent of Total Number Served*
Male	5	56%
Female	4	44%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*Percent of Total Number Served*
African American	3	34%
White	4	44%
Latino/a/x	1	11%
Other	1	11%
Age Category		
Age	*Number Served*	*Percent of Total Number Served*
18-24 years	2	22%
25-44 years	5	56%
45-64 years	2	22%
Sexual Orientation		
Declined to Answer (or Unknown)	9	100%

Pandemic related challenges of connecting with disabled and homeless or indigent clients made it more difficult to keep cases moving along, and harder to get cases started or finished. Additionally, the Social Security Administration's challenges for these clients were magnified by the pandemic as the administration was harder to contact and slower to process every aspect of a claim. All case processes took a longer period of time. Among It all, there was a 100% success rate of clients who won their claim, as each time a case was closed in FY21, it was due to the client successfully being awarded public benefits.

Flexible Funds for Level One Clients

A contract with the community-based organization, Berkeley Food & Housing Project, enables flexible funds to be used with clients across the system for supports such as housing, clothing assistance, food, transportation, etc. This use of flexible funds aids individuals in achieving better stability in areas where they are less capable of addressing their daily living needs. This program is set up to aid any clients in need across the system in a given year. In FY21, there were a total of 418 clients in the BMH system.

Mobile Crisis Team (MCT) Expansion

Through the previously approved MHSA FY14/15 - 16/17 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.

Transitional Outreach Team (TOT)

The Transitional Outreach Team (TOT) was added thru the previously approved FY16 MHSA Annual Update to support Crisis Services, through interventions that address issues individuals experience either immediately prior to, or following a mental health crisis. This team, follows up with individuals and families that have had a recent crisis. The goal of the team is brief outreach and engagement to assist the individual and/or family in getting connected to the resources they may need.

In FY21, 306 individuals were served through this project. Demographics on those served were as follows**:**

DEMOGRAPHICS N=306		
Gender Identity	*Number Served*	*Percent of Total Number Served*
Male	151	49%
Female	143	47%
Transgender	3	1%
Declined to Answer (or Unknown)	9	3%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*Percent of Total Number Served*
African American	65	21%
Asian	24	8%
White	94	31%
Latino/a/x	18	6%
Other	105	34%
Age Category		
Age in Years	*Number Served*	*Percent of Total Number Served*
0-18	22	8%
18-25	34	11%
25-44	90	29%
45-64	59	19%
65+	28	9%
Declined to Answer (or Unknown)	73	24%
Sexual Orientation		
Declined to Answer (or Unknown)	306	100%

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. As a result of the pandemic many services were switched from in-person to telephone supports and tele-health.

Outcomes of the program during the reporting timeframe:

- Continuation of successful follow up with residents who have had contact with Mobile Crisis by phone and/or in person.

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

Program Successes:

- The TOT provided numerous individuals and families with follow up services. These services continued as the newer staff gained more skill and facility with the program and working with the population.
- Responses from service recipients have been generally positive and conveyed an appreciation of services received.
- Started regular discussions and integration of cultural humility training, and practices into both teams and client care.
- Continued to link individuals who may have had barriers, ambivalence, or difficulty engaging with the mental health system to appropriate and desired services through persistent outreach and engagement at inpatient facilities and in the community.

Program Challenges:

- Facility and system issues affecting the BMH Adult Services Program as a whole continue to affect consistency.
- Outreach efforts are hampered by system issues outside of BMH, for example, the County psychiatric facility's decisions regarding patient admission/length of stay over which TOT Staff have no control.
- TOT as a program has continued to struggle with the best way to coordinate care with other units within the City system. Staff continue to work on improving procedures and protocols that support the program mission and clarify roles.
- The data collection system does not capture all necessary information that would support accurate outcome reporting.
- The COVID-19 pandemic changed many service procedures and availability of services to the public, including with the TOT. Facilities that normally would have accepted in person services and visits were no longer open; many resources changed their operating hours/availability; many services closed or were no longer accessible; and many residents

refocused their efforts on basic needs rather than mental health service linkages which changed the interface and usage of the TOT services.

Sub-Representative Payee Program

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

In FY20, Sub-Representative Payee services was contracted out to Building Opportunities for Self Sufficiency (BOSS) who were chosen through a competitive RFP process. BOSS began these services in April 2019. Approximately 79 individuals receive services a year. In FY21, 78 individuals were served. Demographics on individuals served were as follows:

DEMOGRAPHICS N=78		
Gender Identity	*Number Served*	*% of total*
Male	56	72%
Female	22	28%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*% of total*
African American	46	59%
Asian Pacific Islander	3	4%
Latino/a/x	6	8%
Native American	1	1%
White	25	32%
More than one Race	3	4%
Age Category		
Age In Years	*Number Served*	*% of total*
18-24	4	5%
25-44	14	18%
45-64	26	33%
65 years or older	34	44%
Sexual Orientation		
Declined to Answer (or Unknown)	78	100%

Berkeley Wellness Center

The Berkeley Wellness Center is an MHSA funded collaboration between the City of Berkeley, Mental Health Division and Alameda County BHCS. This program implemented through the community-based organization, Bonita House, provides: mental health and substance abuse counseling; living skills training; community integration and educational activities and opportunities; 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. The Berkeley Wellness Center opened in November 2019 and was open for in-person services up until the closure of offices in March

2020 due to the pandemic. Beginning in March 2020 and through FY21, services were provided via phone or tele-health. Group services, Crisis support and other mental health services were also provided via the Zoom platform.

In FY21, 78 individuals participated in this program. Demographics on individuals served were as follows:

DEMOGRAPHICS N=78		
Gender Identity	*Number Served*	*% of total*
Male	27	35%
Female	51	65%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*% of total*
African American	8	10%
White	53	69%
Latino/a/x	5	6%
Other	12	15%
Age Category		
Age in Years	*Number Served*	*% of total*
25-44 years	19	24%
45-64 years	59	76%
Sexual Orientation		
Declined to State (or Unknown)	100	100%

Program Successes:
The Berkeley Wellness Center pivoted their services to attempt to continue to address needs during the shelter-in-place environment. This included running virtual groups and meeting with individuals over the phone and via zoom. For the average 3-4 clients that were regularly participating, the continuation of these groups in a virtual platform was very useful. Though everyone has been encouraged to return to the physical space, the addition of a virtual option in addition to in-person services is something that will continue to expand access and going forward a hybrid services approach will continue to be maintained so that individuals who are not able or ready to participate in person can continue to be apart of program activities.

Program Challenges**:**
During the COVID-19 shelter-in-place many Wellness Center participants were unable to access the technology that would have enabled them to connect to the virtual platforms; be it due to lacking devices or skills to use the devices. They either did not own the technology or their underlying mental health symptoms factored into their lack of desire to use the technology to connect with services. Some individuals preferred to wait until the Wellness Center was open again for in-person services.

BMH Peer and Family Member Positions

Since the first MHSA Plan, BMH has included positions for peers and family members with lived experience to be added to various programs throughout the Division. The BMH Division utilizes existing City job classifications to create an employment track for peer or family member providers. The entry level position is Community Health Worker, the mid-level is Assistant Mental Health Clinician, and the top-level is Social Services Specialist. All of these classifications are used broadly for differing purposes throughout the City. For the specific

positions where the MHSA Plan envisioned utilizing peer or family providers, BMH has had success in establishing employment lists where there are applicants who describe themselves as peer providers or family member providers. In 2018, a Peer Specialist was hired to support the Wellness Recovery services work. This position became vacant in December 2021 and the Division is currently seeking to fill the vacancy.

Two additional positions were added through the FY22 Annual Update, to increase the Wellness Recovery work. The addition of peer staff will 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. It is envisioned that this service addition will create a more welcoming environment for individuals waiting for their appointments.

Case Management for Youth and Transition Age Youth

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

In March 2020, due to the pandemic, YSA was forced to close its facilities in Berkeley. Staff and youth participants quickly transitioned to online services. During the pandemic, staff social workers communicated with youth primarily through phone calls and tele-conferencing via the Zoom platform. As YSA transitioned back to in-person service provision, remote services remained as an option.

In FY21, a total of 30 youth were served through this project. Demographic data on youth participants is outlined below:

DEMOGRAPHICS N=30		
Gender Identity	*Number Served*	*% of total*
Male	11	37%
Female	11	37%
Gender Queer	1	3%
Transgender	4	13%
Gender Non-Conforming	2	7%
Declined to Answer (or Unknown)	1	3%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*% of total*
African American	13	44%
Asian Pacific Islander	4	13%
White	2	7%
Latino/a/x	6	20%
Other	4	13%
More than one race	7	23%
Declined to Answer (or Unknown)	1	3%
Age Category		
Age Category	*Number Served*	*% of total*
0-18 years	14	47%
18-24 years	16	53%

Sexual Orientation		
Heterosexual or Straight	12	40%
Bisexual	10	33%
Gay	3	10%
Lesbian	4	13%
Queer	1	4%

Program Successes**:** Successes included getting staff and youth trained in the use of Zoom for remote conferencing for meetings and workshops and laying the groundwork for a larger referral system. Outreach and collaborations were expanded with the County's Department of Juvenile Probation and with agencies who work with youth in the Berkeley Schools and individuals involved with Juvenile Justice.

Program Challenges**:** Service delivery the entire year was a challenge, due to the pandemic. Program services were delivered remotely, via phone or Zoom meetings. This made it much more difficult to reach and engage new youth Outreach work to engage disenfranchised youth and provide case management is much more effective if there is face-to-face interaction and peer support. During the year, many of the agencies YSA receives referrals from, were not in operation.

The pandemic also made it more difficult to hire new staff that YSA needed to provide case management and mental health services, and new staff had a more difficult time engaging youth, as there were fewer opportunities, due to the physical distancing requirements, to develop a trusting relationship.

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 FY19 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 FY20 and in FY22 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. As a result, the Division will re-assess the best way to provide additional services and supports for the API population.

Results Based Accountability Evaluation

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

As a result, in the previously approved MHSA FY19 Annual Update, BMH 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 will measure how much was done, how well it was done, and whether individuals are better off as a result of the services they received. In FY19 a competitive RFP process was executed, and Resource Development Associates (RDA) was the chosen consultant.

In FY21, the following activities occurred for the RBA evaluation project:

- A contract was executed with Resource Development Associates (RDA), to conduct a comprehensive process to develop RBA outcomes measures for all internal Mental Health Division programs.
- A Work Plan for the full RBA project was developed
- A Community Advisory Group (CAG), consisting of key stakeholders for the project (community members, Alameda County BHCS, MH Division staff), was created to provide input and guidance throughout the life of the project.
- A data dictionary of existing data measures available for mental health division programs was developed.
- Monthly meetings for mental health program teams were initiated. These meeting were focused on developing understanding of the RBA methodology, and supporting program teams in developing RBA outcome measures.

Updates on this evaluation will be reported in future MHSA Plans and Updates.

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 mental health services for this population. In an effort to increase mental health services and supports for older adults, the Division allocated additional funding in the approved FY20 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. The Aging Services Division issued a Request For Proposal (RFP), and in FY22 services began to be provided through the chosen contractor, the Wright Institute.

Substance Use Disorder Services

A large portion of individuals who currently receive services at BMH are also suffering from co-occurring disorders, having both mental health issues and substance use disorders (SUD). In an effort to increase the capacity to serve individuals with SUD, funds were previously allocated through the MHSA FY22 Annual Update for the Division to work with a local SUD provider to co-locate SUD services at the Mental Health Adult clinic. This will increase the provision of SUD services for BMH clients, provide an opportunity for staff to obtain consultations on SUD services, and will make referrals into SUD services outside of the Mental Health Adult clinic easier for consumers. The contract with a local provider for these increased SUD services is currently in the process of being executed.

Specialized Care Unit

On July 14, 2020 City Council passed Resolution No, 69,501-N.S.; a package of items providing direction for the development of a new paradigm of public safety in Berkeley. One of the items adopted by City Council directed the City Manager to analyze and develop a pilot program to re-assign non-criminal police service calls to a Specialized Care Unit (SCU). The SCU will consist

of trained crisis-response field workers who will respond to behavioral health occurrences that do not pose an imminent threat to safety without the involvement of law enforcement. The SCU will be implemented as a pilot model and lessons-learned will inform the long-term implementation. Through the approved FY22 Annual Update, the Division proposed to allocate a small portion of CSS and PEI funds to be leveraged with other City funds for this pilot program. This allocation was a one-time MHSA funding amount, while the City determines how to best fund this initiative.

In FY22, Resource Development Associates (RDA), chosen through a competitive Request for Proposal (RFP) process to evaluate the current crisis system in Berkeley, received an expanded scope of work to provide recommendations on the implementation of the SCU. To oversee and advise RDA in their work, the City formed an SCU Steering Committee consisting of Health, Housing and Community Services Department and Fire Department staff, and community representatives from the Mental Health Commission and the Berkeley Community Safety Commission. The Steering Committee met from January 2021 through January 2022 and advised on RDA's completion of three critical reports. The first two reports summarized crisis response programs in the United States and internationally as well as gathered perspectives from community and City stakeholders regarding the crisis response system. This included gathering input from City of Berkeley and Alameda County agencies, local community-based organizations (CBOs), local community leaders, and utilizers of Berkeley's crisis response services. These reports laid the foundation for the twenty-five recommendations that were the subject of the third and final report to inform the SCU model. Each recommendation put forth in the final report is deeply rooted in the stakeholder feedback included in the two previous reports.

The work of the SCU Steering Committee has now transitioned from planning to implementation. It is envisioned that the SCU will begin operations in late FY22 or early FY23 through a community partner that will be chosen through a competitive Request for Proposal process.

PREVENTION & EARLY INTERVENTION (PEI)

The original City of Berkeley Prevention & Early Intervention (PEI) Plan 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. From the original PEI Plan and/or through subsequent plan updates, some of the many services the City of Berkeley has provided through the PEI funding component are as follows:

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

PEI Reporting Requirements

Per MHSA PEI regulations, all PEI funded programs must collect specified state identified outcome measures and detailed demographic information. MHSA also requires Evaluation Reports for PEI funded programs. Beginning in FY19, PEI Evaluations were required to be included in each MHSA Annual Update or Three Year Plan. Included in Appendix A of this Annual Update is the Prevention & Early Intervention (PEI) Fiscal Year (FY) 2018/2019 – 2020/2021 Three Year Evaluation Report.

Impact Berkeley

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

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

RBA has been incorporated into selected programs within the Department. 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. Page 54 of this Annual Update provides an aggregated summary of some of the results of this initiative.

PEI Regulations

Per 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 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 Succes
Early Intervention	Treatment and other services and interventions, including relapse prevention, to address and promote recovery and related	• High School Prevention • Be A Star • DMIND

	functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that may result from untreated mental illness.	• MEET • African American Success • Supportive Schools • Child & Youth At Risk • 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-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.	• Homeless Outreach and Treatment* • High School Prevention • Specialized Care Unit
OPTIONAL Suicide Prevention	Activities to prevent suicide as a consequence of mental illness.	• CalMHSA PEI Statewide Project

*Prior project that was in operation during FY21, the reporting timeframe of this annual update)

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)).

At the time of the writing of this Annual Update, the MHSOAC had not established additional priorities to the following specifically enumerated required priorities in WIC Section 5840.7 (a) for the use of PEI funding:

- 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;
- Culturally competent and linguistically appropriate prevention and intervention;
- 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 FY23 projected funding amounts:

CITY OF BERKELEY PEI PROGRAMS	PEI PRIORITIES	FY23 Projected Funding Per Priority
• Be A Star • Supportive Schools	Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.	$144,658
• High School Youth Prevention Project • Mental Health Peer Mentor Program • Dynamic Mindfulness Program • African American Success Project • Specialized Care Unit	Youth Engagement and Outreach Strategies that target secondary school and transition age youth, 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	$308,663 $376,663 $100,000
• Mental Health Promotion Campaign • Social Inclusion • Community Education & Supports	Culturally competent and linguistically appropriate prevention and intervention Youth Engagement and Outreach Strategies that target secondary school and transition age youth,	$409,000 $32,046

CITY OF BERKELEY PEI PROGRAMS	PEI PRIORITIES	FY23 Projected Funding Per Priority
	with a priority on partnership with college mental health programs 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.

Currently, seven out of ten local PEI programs provide services for children and youth, 6 of which are in the Berkeley Unified School District (BUSD). Programs are as follows: Behavioral-Emotional Assessment, Screening, Treatment and Referral (BE A STAR); Supportive Schools Project; Mental Emotional Education Team (MEET); Dynamic Mindfulness (DMIND); African American Success Project; High School Youth Prevention Project, and the TAY Trauma Support Project. Additionally, from FY11 through FY20, the City of Berkeley utilized a portion of PEI funds to provide services for children, youth and TAY in the Albany Unified School District, through the Albany Trauma Project.

Programs and services funded with PEI funds, and FY21 data are outlined below by PEI Program type.

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.

Through the FY22 Annual Update the City of Berkeley funded the following Prevention initiative that will be implemented in FY23:

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 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.

It is envisioned that this campaign will get implemented in FY23 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.

The City of Berkeley Early Intervention programs are as follows:

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

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

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

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

In FY21, a total of 2,203 children were screened through this program however data was not collected on all individuals screened. Only Race/Ethnicity data was collected on a subset of 141 children as follows:

DEMOGRAPHICS N=2,203	
Age Groups	
0-15 (Children/Youth)	100%

Race N=141	
Asian	30%
Black or African American	32%
White	8%
More than one Race	1%
Other	29%
Ethnicity: Hispanic or Latino/Latina/Latinx N=141	
Unspecified Hispanic or Latino/Latina/Latinx	29%
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:

- A total of 154 referrals to resources/services were made as a result of the developmental screens conducted at BUSD preschools and pediatric sites.
- Overall, there was an increase in developmental screenings in pediatric settings. For example, when compared to data in FY20, two Berkeley pediatric sites increased their number of screenings by 211% and 76%.
- Sites demonstrated great adaptability due to the challenges that COVID-19 caused. Several sites were able to transition to doing developmental screenings online. Be A Star was able to provide training and Technical Assistance to help ensure a smooth transition.

Program Challenges:

- Although many pediatric sites and BUSD preschools were able to provide more services this year, there were still challenges caused by COVID-19, including delayed trainings for pediatric sites and decreases in available referral services.
- Be A Star staffing was impacted by the City of Berkeley's COVID-19 response. All Public Health nursing positions supported the emergency response in some capacity. A new Be A Star Public Health Nurse started in January 2021 and there has been a transition as this nurse has settled into the role.
- There were program challenges in being able to collect an accurate full data set as some of the Berkeley pediatric sites do not collect and report out on various demographic information and other screening sites only captured general demographic information.

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 FY21 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. Additionally, a counselor provided support at two elementary schools. As a result of the pandemic, schools began the year in distance learning. BUSD then transitioned to small cohorts at each elementary school, before moving to in-person learning in the spring of 2021. During the academic year, supports were provided both virtually, and in-person.

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 consults with staff on many issues and provides trauma informed coaching for teachers, and referrals to outside providers, parenting classes/support groups, crisis hotlines, and other programs.

In addition, other agency and district staff providers led social skills groups, early intervention social and emotional support, playground social skills, “check in/check out,” individual counseling, and support for parents and guardians from diverse backgrounds. As aligned with priority and focus on equity, providers participated in COST team meetings, and linked parents and guardians with resources within the school district, and in the community.

Supports for each school per each service provider, and numbers served in FY21 were as follows:

Elementary School	Agency/Provider	Number of Students Served
• Cragmont • Emerson • Malcolm X • Oxford • Ruth Acty • Thousand Oaks	Bay Area Community Resources (BACR)	115
• Bay Area Arts Magnet (BAM) • Washington	Child Therapy Institute	39

• John Muir • Sylvia Mendez	School Site Counselor	25
• Rosa Parks	Lifelong Medical Care	No Data Available
Total		**179**

Demographic data provided by BUSD on 179 students that were served through this project in FY21, is outlined below:

DEMOGRAPHICS N= 179	
Age Group	
0-15 (Children/Youth)	100%
Race	
American Indian or Alaska Native	1%
Asian	6%
Black or African American	25%
Native Hawaiian/Pacific Islander	1%
White	33%
More than one Race	19%
Declined to Answer (or Unknown)	11%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Central American	1%
Mexican/Mexican-American/Chicano	1%
South American	1%
Declined to Answer (or Unknown)	20%
Ethnicity: **Non-Hispanic or Non- Latino/Latina/Latinx**	
American Indian	1%
Asian Indian/South Asian	1%
Chinese	1%
Eastern European	1%
Filipino	1%
Korean	1%
More than one Ethnicity	3%
Declined to Answer (or Unknown)	68%

Primary Language Used	
English	30%
Spanish	4%
Other	1%
Declined to Answer (or Unknown)	65%
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)	11%
Declined to Answer (or Unknown)	88%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	53%
Female	43%
Declined to Answer (or Unknown)	4%
Current Gender Identity	
Male	52%
Female	43%
Non-binary	1%
Other Gender Identity	4%

Community-Based Child & Youth Risk Prevention Program

This program targets children (aged 0-5) who are impacted by multiple risk factors including trauma, family or community violence, familial distress, and/or family substance abuse, (among other issues). A BMH clinician has 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 include 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 are to reduce risk factors or other stressors, and promote positive cognitive, social, and emotional well-being. This program serves approximately 50 Children & Youth a year.

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

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

In FY21, 49 children were served through this program. Demographics on those served is as follows:

DEMOGRAPHICS N=49	
Age Groups	
0-15 (Children/Youth)	100%
Race	
American Indian	2%
Asian	12%
Black or African American	45%
White	14%
More than one Race	5%
Declined to Answer (or Unknown)	22%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Declined to Answer or Unknown	100%
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 Unlknown)	100%

Program Successes:

All of the general mental health consultation duties outlined below continued to be provided remotely via Tele-Care/Zoom until they were transitioned to in-person services in early FY22:

- Facilitated weekly Early Childhood Mental Health Reflective Case Consultation group/meetings to five classrooms. Case consultation meetings allowed teachers to develop clear plans and interventions for individual children and families in their classroom that present with high risk factors including but not limited to: complicated family dynamics; trauma; mental health concerns; social-emotional needs; and/or overall developmental needs.
- Provided general classroom observation to five infant care, toddler care and pre-school classrooms, serving a total of 49 children.

- Provided individual and group consultation to the Center Program Supervisor, 15-20 Early Childhood Teachers, and two family advocates
- Coordinated with the Inclusion Program which includes Inclusion Specialists and a Speech Pathologist to help observation and assessment efforts that facilitate early intervention screenings and referrals to BUSD and the Regional Center.
- Provided planning and assistance with implementation of behavior plans for children with behavioral and social-emotional needs.
- Provided direct interventions around classroom interventions including providing visuals and classroom tools to help teach children self-regulation skills, social skills, and skills to help with transitions, and to improve the overall functioning of individual children in the classroom setting.
- Provided individual mental health consultations to parents, and provided direct psycho-education around developmental concerns, social-emotional issues/behavioral concerns, parenting issues, and information regarding mental health services as well as information regarding community services including First 5 Alameda, Help Me Grow, the Regional Center, primary care Doctors, and BUSD services.

Program Challenges:

- The downside of continuing services and not being on site was not having access to families. This posed some difficulties in being able to build relationships with children and families directly.
- There was an increased need to provide crisis interventions during the pandemic as staff managed the stress of returning to their work as essential workers in the middle of a pandemic.
- There was an increase of collective stress as a result of the pandemic.
- As the pandemic continued into FY21 the center continued to experience disruptions to care with staff and children being quarantined at times.
- It was a challenge to work off-site during the COVID-19 pandemic to observe the child and teacher interactions. With not being onsite in-person there were no continuous conversations, spontaneous consultations, nor in-vivo modeling interactions. The ability to demonstrate for staff by working with the children and practicing certain interventions with children in-person along with observing staff implementing the techniques was limited.
- There was no ability to model in-person for the teachers, as these elements were a part of the challenge in working remotely via telehealth (Zoom).

In FY23, this program will be discontinued as the YMCA Head Start program has created a staff position for an internal Mental Health Specialist.

Community Education & Supports

The Community Education & Supports program implements culturally-responsive psycho-educational trauma support services for individuals (18 and above) in various cultural, ethnic and age specific populations that are unserved, underserved and inappropriately served in Berkeley including: African Americans; Latino/a/x; LGBTQIA+; TAY; and Senior Citizens. All services are conducted through area community-based organizations. In FY21, three of the five projects were in operation as indicated in the data below. In order to ensure fair contracting opportunities in the City, in FY21 the Community Education & Supports services were put out

for a re-bid through a Request for Proposal Process for the FY22 services. Updates on those services will be reported in the next Three Year Plan.

In FY21 the Community Education & Supports projects 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?
• 578 Support Groups/Workshops • 1,247 Support Groups/Workshop Encounters • 118 Individual Contacts (2 of 3 programs reporting) • 2,524 Outreach Activities • 225 Outreach Contacts • 1,179 Referrals	• 9 Support groups or workshop sessions attended on average per person • 85% Survey respondents reported satisfaction with services • Referrals by type: 223 Mental Health 200 Social Services 213 Physical Health 124 Housing 419 Other Services	• 86% of program participants reported an increase in social supports or trusted people they can turn to for help (2 of 3 programs reporting) • 90% of program participants reported positive changes in terms of coping strategies, feeling anxious or overwhelmed (2 of 3 programs reporting)

Descriptions for each project within the Community Education & Supports program and FY21 data are outlined below:

- **Transition Age Youth Trauma Support Project**

In FY21 this project was implemented through the Covenant House, Youth Engagement Advocacy Housing (YEAH!) program. 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;
- Youth engagement and outreach strategies that target secondary school and transition age youth.

In FY21, 150 TAY participated in one or more project services. Services were continued during the pandemic through tele-health and tele-conferencing platforms. Support Group sessions included: Harm Reduction and Substance Use; Mindfulness; Coping Skills; Creative Expression, among others. There was a total of 9 Youth Social Outings with 37 unduplicated TAY

participants, and 68 unduplicated TAY, participated in 18 Youth Celebratory Events. Demographics on youth served were as follows:

DEMOGRAPHICS N = 150	
Age Group	
16-25 (Transition Age Youth)	100%
Race	
American Indian or Alaska Native	3%
Asian	3%
Black or African American	57%
Native Hawaiian or Other Pacific Islander	1%
White	15%
More than one Race	15%
Other	3%
Decline to Answer (or Unknown)	3%
Ethnicity: Latino/Latina/Latinx	
Central American	14%
Mexican/Mexican-American	9%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	19%
Asian Indian/South Asian	1%
European	4%
Filipino	1%
Japanese	1%
More than one Ethnicity	21%
Other	29%
Declined to Answer (or Unknown)	1%
Primary Language Used	
English	89%
Spanish	11%
Sexual Orientation	
Gay or Lesbian	6%
Heterosexual or Straight	47%
Bisexual	12%

Questioning or unsure	4%
Other	20%
Declined to Answer (or Unknown)	11%
Disability Status	
Mental (not mental health)	15%
Physical/Mobility Disability	4%
Chronic Health Condition	3%
Other Disability	31%
No Disability	35%
Declined to Answer (or Unknown)	12%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	61%
Female	39%
Current Gender Identity	
Male	60%
Female	37%
Transgender	3%

During the reporting timeframe 2,510 outreach activities were conducted. There were 493 referrals for additional services and supports. The number and type of referrals was as follows: 112 Mental Health; 104 Physical Health; 87 Social Services; 76 Housing; 114 other unspecified services. A total of 25% of project participants received individual counseling; 24% exited the project into stable housing; 53% obtained employment or entered school during the project. Per participant feedback, 79% reported being satisfied with project services.

- **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;
- Youth Engagement and Outreach Strategies that target secondary school and transition age youth.
- Strategies targeting the mental health needs of older adults.

In FY21, 12 outreach activities reached approximately 155 duplicated individuals. A total of 480 support groups were conducted. Through 20 Peer Support groups, weekly or bi-weekly sessions were conducted which were all led by a trained facilitator on Zoom. All of the long time running peer groups were offered and one new group was added. A total of 69 individuals participated in support groups throughout the year. Demographics on individuals served include the following:

DEMOGRAPHICS N=69	
Age Groups	
16-25 (Transitional Age Youth)	26%
26-59 (Adult)	46%
Ages 60+ (Older Adult)	20%
Declined to Answer (or Unknown)	8%
Race	
American Indian or Alaska Native	4%
Asian	13%
Black or African American	6%
Native Hawaiian or Pacific Islander	1%
White	41%
More than one Race	14%
Declined to Answer (or Unknown)	21%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Caribbean	1%
Central American	1%
Mexican/Mexican-American/Chicano	1%
South American	1%

Declined to Answer (or Unknown)	4%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	4%
Asian Indian/South Asian	3%
Chinese	7%
Eastern European	6%
European	43%
Filipino	1%
Korean	1%
Vietnamese	1%
More than one Ethnicity	16%
Other	1%
Declined to Answer (or Unknown)	9%
Primary Language Used	
English	100%
Sexual Orientation	
Gay or Lesbian	25%
Heterosexual or Straight	6%
Bisexual	12%
Questioning or Unsure	3%
Queer	22%
Other	29%
Declined to Answer (or Unknown)	3%
Disability	
Difficulty Seeing	1%
Difficulty Hearing or Having Speech Understood	3%
Mental (not Mental Health)	4%

Physical/Mobility Disability	6%
Chronic Health Condition	14%
No Disability	36%
Declined to Answer (or Unknown)	36%
Veteran Status	
Yes	1%
No	99%
Gender: Assigned Sex at Birth	
Male	30%
Female	36%
Declined to Answer (or Unknown)	34%
Current Gender Identity	
Male	6%
Female	23%
Transgender	33%
Genderqueer	9%
Questioning or Unsure	4%
Other	23%
Declined to Answer (or Unknown)	2%

During the reporting timeframe 38 Peer Facilitators were trained. The offering of Skills Building Workshops that included trainings on Intersectionality; Disability, Justice and Accessibility; and Micro-aggressions were provided to 38 Peer Facilitator participants. Services were adjusted to accommodate for the pandemic, and Support Group and other services were able to continue virtually on the Zoom platform. There were 91 referrals for additional services and supports. The number and type of referrals was as follows: 51 Mental Health; 7 Physical Health; 7 Social Services; 26 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:

- 93% indicated they would recommend the organization to a friend or family member;
- 79% felt like staff and facilitators were sensitive to their cultural background;
- 93% reported they deal more effectively with daily problems;
- 71% indicated they have trusted people they can turn to for help;
- 86% felt like they belong in their community.

Project Successes:

- Of the 20 peer support groups that were running prior to Shelter-In-Place (SIP), 19 groups successfully transitioned to Zoom and flourished on the virtual platform and 1 new group was launched.
- Staff increased consultation meeting frequency to support the facilitators for a portion of the fiscal year.
- Peer groups gained returning attendees who had moved out of town and who, for a variety of reasons, ie, disability, transportation barriers and child-care and other caregiving needs, were able to attend due to online access.
- Three 6-hour Facilitator Orientation and Trainings were provided to community members welcoming them as trained peer group facilitators.
- Three Diversity, Equity and Inclusion trainings were offered: Intersectionality; Disability, Justice and Accessibility; and Micro-aggressions.
- A Social Work student provided case management and wellness checks to older adults.
- A handful of peer groups requested to hold their meetings throughout the winter break when the agency is typically closed for all services.
- Peer group facilitators were invited to join the white accountability group or the Black, Indigenous and People of Color (BIPOC) affinity group (spaces to discuss various challenges, explore and examine topics relating to privilege and oppression, dynamics of power, etc.) to explore how they show up in relationships for added accountability and support.
- The virtual/online outreach started to pick up by the end of the fiscal year. To make up for the reduction in outreach opportunities, email lists were utilized with community partners and networks and social media platforms, such as Meet-up, Instagram, and Facebook to inform and engage the community.
- A new pilot clinical consultation 'on-call' system was offered for facilitators to access a clinician to be invited to their virtual group space as needed should a group member bring mental health concerns and/or behaviors outside of the peer group scope of service.

Project Challenges:

- Continual adjustment to being in the virtual space. There was a learning curve for peer group facilitators in navigating the virtual space, for which program staff and fellow peer group facilitators provided support and guidance. Zoom safety tips and guidelines were created to assist the facilitators.
- Some community members, including a few peer group facilitators, were no longer able to attend their peer group when it moved to a virtual space due to a lack of privacy in their home, anxiety when in virtual spaces, or the lack of the necessary equipment and/or sufficient internet connection.
- Since paper forms were adapted to be received digitally, many group members had challenges completing and submitting the demographic forms.
- Due to the Shelter In Place, the typical in-person outreach opportunities drastically declined.
- Peer group facilitators expressed concern for their group members' stress level in regards to the anxiety producing November Presidential election, and the aftermath of the January 6th

violent events in Washington DC.

- **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;
- Strategies targeting the mental health needs of older adults.

In FY21, 49 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 25 Senior Citizens participated in the Living Well Workshops. Demographics of Workshop participants are outlined below:

DEMOGRAPHICS N=25	
Age Groups	
26-59 (Adult)	16%
Age 60+ (Older Adult)	84%
Race	
Asian	4%
Black or African American	56%
White	28%
Other	12%

Ethnicity: Hispanic or Latino/Latina/Latinx	
Caribbean	4%
South American	4%
Other	8%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	36%
Eastern European	8%
European	20%
Filipino	4%
More than one Ethnicity	4%
Other	12%
Primary Language Used	
English	96%
Spanish	4%
Sexual Orientation	
Gay or Lesbian	4%
Heterosexual or Straight	76%
Bisexual	8%
Other	4%
Declined to Answer (or Unknown)	8%
Disability	
Physical/mobility disability	24%
Chronic health condition	24%
Other Disability	16%
No Disability	28%
Declined to Answer (or Unknown)	8%
Veteran Status	
Yes	4%
No	96%

Gender: Assigned Sex at birth	
Male	16%
Female	84%
Current Gender Identity	
Male	16%
Female	80%
Other	4%

During the reporting timeframe 2 outreach and informational events were conducted reaching 12 individuals, with 93 unduplicated individuals receiving further engagement services. Services were moved to virtual format providing tele-workshops and tele-support services to accommodate the pandemic. There were 595 referrals for additional services and supports. The number and type of referrals were as follows: 60 Mental Health; 102 Physical Health; 106 Social Services; 48 Housing; 279 other unspecified services. A total of 88% of project participants completed a Living Well Workshop Series. Feedback per participant self-report was as follows:

- 91% reported they felt satisfied with the workshops;
- 91% indicated an improvement in feeling satisfied in general;
- 91% had increased feelings of social supports;
- 91% felt prepared to make positive changes; and
- 88% reported they felt less overwhelmed and helpless.

Project Successes**:**
To help seniors 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 laptops and technical training were provided to previous participants and also in May to participants who completed The Living Well Workshop Series.

Project Challenges:
The workshops were well attended with lively engagement. Some Living Well seniors gave painful testimonies of isolation, sadness and fear and others of loneliness. Many missed their families, their grandchildren, and friends. Some needed 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 seniors had difficulties connecting with others due to the technological gap. The Workshop Series facilitator also had to learn systems she never had to use before.

SoulSpace Project

In FY22, following a competitive Request For Proposal (RFP) process, OnTrack Program Resources began implementing the SoulSpace Project for African Americans in Berkeley. The 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; assessment; coaching; 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;
- Youth Engagement and Outreach Strategies that target secondary school and transition age youth.
- Strategies targeting the mental health needs of older adults.

This project was not in operation in FY21. Future MHSA Three Year Plans and Annual Updates will include a reporting on the data and activities of this project.

- **Latinx Trauma Support Project**

In FY22, following a competitive Request For Proposal (RFP) process, East Bay Sanctuary Covenant began implementing the Latinx Trauma Support Project. This 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 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.
- Youth Engagement and Outreach Strategies that target secondary school and transition age youth.
- Strategies targeting the mental health needs of older adults.

This project was not in operation in FY21. Future MHSA Three Year Plans and Annual Updates will include a reporting on the data and activities of this project.

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)

Through the previously approved MHSA FY19 Annual Update BMH allocated PEI funds to support the BUSD Dynamic Mindfulness (DMind) Program. BUSD partners with the Niroga

Institute to provide DMind for students and staff at Berkeley High, Berkeley Technology Academy, Berkeley Independent Study, MLK Jr., Willard, and Longfellow. 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, training and coaching of school staff, and program evaluation.

PEI Goals: The goal of this program is to bring about mental health, including the reduction of school failure 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.
- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

Due to the pandemic, in FY21 all supports were shifted to online in the second half of the school year. Data on individuals served were not provided by BUSD. Per anecdotal evidence from site leadership, the program presents positive use.

Mental and Emotional Education Team (MEET)

Through the previously approved MHSA FY19 Annual Update BMH provides PEI funds to support the BUSD MEET Program. This 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.
- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

In FY21 and FY22, this program was not in operation.

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.

Umoja 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**:**
Umoja seeks to increase entry points for caregivers to be informed and involved in their child's learning. Highlights in this area include:

- Community meetings/engagements (monthly typically).
- Coordinating and hosting Parent teacher conferences.
- Individual parent meetings/contacts, including advising, problem-solving, and updates regarding student progress.
- Coordinating and hosting community events: Kwanzaa Celebration, Black History Month event and activities.

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 Prioritiy:

- Culturally competent and linguistically appropriate prevention and intervention.
- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

In FY21, 63 students participated in this project. Outlined below are demographics on individuals served through this project:

DEMOGRAPHICS N=63	
Age Groups	
Children/Youth (0-15)	100%
Race	
Black or African American	68%
More than one Race	11%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Hispanic/Latino/Latina/Latinx	21%
Primary Language	
English	98%
Other	2%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Other	8%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	56%
Female	44%
Current Gender Identity	
Male	56%
Female	44%

ACCESS AND LINKAGE TO TREATMENT PROGRAM

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.

The City of Berkeley had one Access and Linkage to Treatment Program from April 2017-March 2021:

Homeless Outreach and Treatment Team (HOTT)

The Homeless Outreach and Treatment Team (HOTT) program was established out of an effort to address the homeless crisis, and as a result of input received through various MHSA

community program planning processes. Utilizing a portion of PEI and CSS funds, blended with realignment and general funds HOTT is a pilot program to support homeless mentally ill individuals in Berkeley and to connect them into the web of services that currently exist within the system of care. Key program components include the following: Persistent and Consistent Outreach; Supportive Case Management; Linkage to Care; and Treatment. HOTT was in operation until March 2021 when the Homeless FSP began.

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.

The HOTT program was a three-year pilot project that was originally intended to run from May 2017 through April 2020. Due to the COVID-19 pandemic, the program was extended through February 2021 with a redirected focus mainly towards encampment outreach, in addition to the original purpose of serving unhoused Berkeley residents with linkage, resource, housing, and short-term treatment services.

A local consultant, Resource Development Associates (RDA), was hired to conduct a dedicated independent evaluation to assess the program accomplishments and to ascertain whether HOTT should continue past the initial funding period.

The RDA Homeless Outreach and Treatment Team Final Evaluation Report (which is located on the City of Berkeley MHSA webpage) covered the timeframe from January 2018 – February 2020, showed the following program outcomes:

- A total of 4,435 total encounters were conducted with individuals who were either enrolled or non-enrolled in the program, averaging 171 encounters per month;
- The number of contacts provided in-person in the field was 73%, while 26% were provided by phone;
- A total of 81% of HOTT encounters were with clients who were enrolled in the program;
- Enrolled clients had an average of 20 total encounters with HOTT staff, with an average of 4 encounters per month;
- During encounters, HOTT staff provided at least 1,845 material supports and services (including food, transportation or BART or bus passes, Hygiene Kits, Emergency Housing Vouchers, Blankets, etc.); to respond to clients' immediate and longer-term needs;
- During 488 encounters, HOTT provided emergency or temporary housing vouchers (e.g., for a motel) to individuals who required immediate shelter;
- Approximately three-quarters of enrolled clients (75%) and over a third of non-enrolled individuals (38%) were referred or connected to housing support services;
- In addition to connecting individuals to housing services, HOTT also connected individuals to other supportive services to help reduce or address initial barriers to obtaining housing;
- Approximately 27% of HOTT clients and 6% of non-enrolled individuals successfully enrolled in social service benefits. In comparison, only 9% of HOTT clients and 1% of non-enrolled clients ultimately enrolled in mental health services;
- Over 58% of all HOTT clients, and 9% of non-enrolled individuals obtained emergency or temporary housing (e.g., motel or shelter) at some point during their engagement with

HOTT. In comparison, 12% of HOTT clients and 1% of non-enrolled individuals obtained permanent housing;

- To assess changes in self-sufficiency, HOTT staff completed a Client Self-Sufficiency Matrix (SSM) on enrolled clients at program intake, on a quarterly basis after program enrollment, and/or at program discharge. Overall, HOTT clients' SSM scores remained relatively unchanged from baseline to follow-up.

During interviews that were conducted with several HOTT existing and previous clients regarding their experience with the program, interviewees reported the following:

- "They help people, not just me. I introduce people on the street to them, and I say you can talk to the HOTT team and they will help you."
- "I really didn't expect anything, but when I called the City, they said someone [from HOTT] would meet me right then. They got me a hotel room that day. I wasn't expecting the City to help."
- "They were so helpful. I felt like if I didn't get the hotel room, they would have let me stay at their personal house."

In addition to these interviews, RDA conducted focus groups with HOTT clients during a previous year of the evaluation, and developed brief client impact stories based on clients' experiences. In one of the impact stories, client self-report was as follows:

"I would still be on the streets and probably dead if it wasn't for HOTT. I could have died and no one would have cared. Doctors told me I had months to live and I gave up on living. I gave up on everything for help. No one cared but the HOTT team did care. I'm the type of person that never asks for help, and here they were offering to help and they never gave up on me. I lived on the same spot for six years and never got medical care. They checked up on me and came back multiple times, even though I was turning them away in the beginning. I figured HOTT team was just like the other programs where they would just disappear after the first meeting. But I know the HOTT team is there. And everything the HOTT team said they would do came true. Now I am in hospice care getting the care that I need. I don't know how much longer I have to live, but it's a hell of a lot longer than a couple months which is what the doctors said. This gives me the opportunity to live my life with dignity. The HOTT team provided me with the positive energy just like hospice care that is so needed for people like me."

The program continued into FY21 which was past the original end-date and the evaluation timeline. Data, and successes and challenges in FY21 are outlined below. In FY21, 91 individuals were served. Demographics on individuals served were as follows:

DEMOGRAPHICS N= 91	
Age Groups	
25-44 years	21%
45-64	25%
65 years and older	8%
Declined to Answer (or Unknown)	46%

Race	
Black or African American	37%
Latino/a/x	5%
White	43%
Other	15%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Declined to State (or Unknown)	100%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
Declined to Answer (or Unknown)	100%
Gender: Assigned Sex at Birth	
Declined to Answer (or Unknown)	100%
Current Gender Identity	
Male	58%
Female	40%
Transgender	2%
Sexual Orientation	
Declined to Answer (or Unknown)	100%

In FY21 Flex funds were used to provide various supports for HOTT program participants including: Hotel stays/rental or housing assistance for 42 participants; Food/groceries for 26 participants; Bus passes or transportation for 3 participants; and on Pharmacy needs for 1 participant.

Due to the nature of the many brief interactions attempting to engage with clients, as well as trying to avoid barriers to bringing clients into services, some data wasn't able to be collected in order to best support effective service provision. Additionally, some limitations to the current data collection system prevented certain data from being gathered and provided for this project and report.

Program Successes:

The HOTT pilot demonstrated that a dedicated team of workers could effectively engage and work with a large number of unhoused residents providing short term services and connections to longer term treatment and care. It also demonstrated that the team could be flexible in redirecting its efforts to support the needs of the unhoused community during the pandemic:

- HOTT was responsive to both enrolled and unenrolled clients when providing outreach and engagement: responding to community referrals, providing direct in-person outreach, and responding to immediate service calls and needs.
- The project provided an array of material supports, including but not limited to basic necessities, transportation (direct and voucher), hygiene kits, emergency housing/respite support, COVID-related supplies (masks, testing, resource information, sanitizer, etc).
- HOTT facilitated linkages and referrals to treatment, housing, primary care, material support, and other community resources.
- Community needs were supported by encampment outreach by the HOTT, including outreach, material support, and other COVID related needs.

Program Challenges:
With the change in HOTT's mission and staffing, it became increasingly difficult to effectively serve the community. The needs and resources in the community, especially due to COVID-19, drastically changed:

- Staff left the team steadily over this time period from a supervisor and 4 staff until only one staff was left, and then the program ended.
- With the pandemic, many of the resources to which the HOTT team would normally link clients had either: changed their hours, gone to only remote service, changed their services available, or closed their doors.
- The directions from the Emergency Operations Center (EOC) during the pandemic were not consistent due to the changing nature of the COVID-19 response. This also made consistent services difficult to maintain.
- Since most of the services HOTT was directed to perform during this time period were COVID-19/encampment outreach related, the previous linkage services were no longer the focus of the team and its work.

HOTT continued to be in operation until March 2021, when the Homeless FSP was fully implemented.

ACCESS AND LINKAGE TO TREATMENT AND PREVENTION & EARLY INTERVENTION COMBINED PROGRAM

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 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 combined Access and Linkage to Treatment and Prevention & Early Intervention combined program:

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.

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

In FY21, approximately 101 students received services through this project. Demographics on youth served are outlined below:

DEMOGRAPHICS N=101	
Age Groups	
0-15 Years	27%
16-25 Years	73%
Race	
Asian	16%
Black or African American	15%
White	32%
More than one Race	19%

Other	10%
Declined to Answer (or Unknown)	8%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Other	32%
Declined to Answer (or Unknown)	9%
Primary Language	
English	87%
Spanish	13%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	40%
Female	60%
Current Gender Identity	
Male	37%
Female	52%
Transgender	3%
Genderqueer	8%

Program Successes:

- In spite of the numerous and multi-faceted challenges associated with COVID-19 and distance learning, the Health Center was still able to provide mental health counseling services to over 100 students and was able to provide longer-term support to more students due to the lower than typical number of unduplicated clients. The Health Center was able to host a small, diverse, and talented graduate-level MFT trainee cohort.
- Adapted care provision to utilize these new platforms and was able to flexibly provide services while also mitigating potential safety risks associated with COVID-19.
- During the course of the school year, the Health Center's mental health team was able to develop and implement use of a JotForm application in order to digitize referral processes, make referrals accessible online, and thereby improve overall accessibility. Transition to this HIPAA-compliant online referral process has been maintained into the FY22 school year and is now being more broadly used by all Health Center programs.
- The online referral process was implemented in January 2021 and promoted across student/parent bulletins, emails to the school community from BHS and BTA principals, and

presentations to teacher leads and other school staff. Upon successfully implementing this new method for referrals, the Health Center phased out use of its phone-based Mental Health Warm Line, which was initially utilized in Spring 2020 shortly after the COVID-19 pandemic began. The Warm Line was phased out in order to simplify the referral pathway for accessing mental health services from the Health Center.

- Throughout the COVID-19 pandemic and for the duration of the FY21 school year, the Health Center's mental health team maintained a positive and collaborative relationship with school administration, the BHS and BTA COST teams, and the school-based Intervention and IEP counselors. Collaboration and coordination with school-based stakeholders enabled program staff to effectively triage and refer students/families to EPSDT/ERMHS services in addition to short-term Health Center services.

Program Challenges:

- During the FY21 school year, BUSD provided all educational instruction via remote "distance learning" using platforms like Zoom and Google Meet due to COVID-19-related safety concerns. Students were not present on campus from the start of the school year in August 2020 through spring break in April 2021. From mid-April through early June of 2021, a small percentage of the student body was on campus two hours per day, 2-3 days per week. Health Center counseling rooms were not usable for in-person services due to spatial limitations, inadequate social distancing, and inadequate ventilation. An alternative physical space on the BHS campus was identified for crisis-only use during this timeframe.
- For the duration of the FY21 school year, one Health Center clinician was on parental leave. The Health Center's graduate-level trainee cohort was also downsized by 50%, from four to two, due to COVID-19-related constraints.
- Up until COVID-19, the Health Center relied upon a paper-based referral process where referrals needed to be submitted in person to staff. Accessing services remotely was not feasible until workflow adjustments were made, which required technological advancements and collaboration with the City's IT department. The planning and implementation of a digital, online, HIPAA-compliant referral portal took approximately five months.

ACCESS AND LINKAGE TO TREATMENT AND EARLY INTERVENTION COMBINED PROGRAM

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.

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.

Through the FY22 Annual Update the City of Berkeley provided a one-time amount of CSS and PEI funding to support a pilot program. Per PEI program type definitions, this program would be considered as an Access to Treatment and Early Intervention combined program. The program is as follows:

Specialized Care Unit

As outlined in the CSS section of this Annual Update, on July 14, 2020 City Council passed Resolution No, 69,501-N.S; a package of items providing direction for the development of a new paradigm of public safety in Berkeley. One of the items adopted by City Council directed the City Manager to analyze and develop a pilot program to re-assign non-criminal police service calls to a Specialized Care Unit (SCU). The SCU will consist of trained crisis-response field workers who will respond to behavioral health occurrences that do not pose an imminent threat to safety without the involvement of law enforcement. The SCU will be a pilot model that will inform the long-term implementation of the program. Through the approved FY22 Annual Update, the Division proposed to allocate a small portion of CSS and PEI funds to be leveraged with other City funds for this pilot program. This allocation was a one-time MHSA funding amount, while the City determines how to best fund this initiative.

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 FY22, Resource Development Associates (RDA), who was chosen through a competitive Request For Proposal (RFP) process to evaluate the current crisis system in Berkeley, received an expanded scope of work to provide recommendations on the implementation of the SCU. To oversee and advise RDA in their work, the City formed an SCU Steering Committee consisting of Health, Housing and Community Services Department and Fire Department staff, and community representatives from the Mental Health Commission and the Berkeley Community Safety Commission. The Steering Committee met from January 2021 through January 2022 and advised on RDA's completion of three critical reports. The first two reports summarized crisis response programs in the United States and internationally as well as gathered perspectives from community and City stakeholders regarding the crisis response system. This included gathering input from City of Berkeley and Alameda County agencies, local community-based organizations (CBOs), local community leaders, and utilizers of Berkeley's crisis response services. These reports laid the foundation for the twenty-five recommendations that were the subject of the third and final report to inform the SCU model. Each recommendation put forth in the final report is deeply rooted in the stakeholder feedback included in the two previous reports.

The work of the SCU Steering Committee has now transitioned from planning to implementation. It is envisioned that the SCU will begin operations in late FY22 or early FY23 through a community partner that will be chosen through a competitive Request for Proposal process.

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.

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.

In FY21, the "Telling Your Story" group held 25 meetings with 21 unduplicated persons attending for a total of 168 visits. This group has met through the virtual platform "zoom". On average there were 6.72% attendees. Program participants spent time discussing and practicing what makes a good story based on the topics given by the instructors. Demographics on individuals served were as follows:

DEMOGRAPHICS N= 21	
Age Groups	
26-59 (Adult)	52%
Ages 60+ (Older Adult)	48%
Race	
Asian	5%
Black or African American	9%
Native Hawaiian or other Pacific Islander	5%
White	71%
Other	5%
More than one Race	5%

Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	14%
Asian Indian/South Asian	5%
European	14%
Filipino	9%
Japanese	5%
Middle Eastern	5%
Declined to Answer (or Unknown)	48%
Primary Language Used	
English	100%
Sexual Orientation	
Gay or Lesbian	5%
Heterosexual or Straight	52%
Bisexual	9%
Another Sexual Orientation	5%
Declined to Answer (or Unknown)	29%
Disability	
Difficulty Hearing	14%
Mental Domain not including a mental illness	14%
Physical Mobility domain	14%
Chronic Health Condition	14%
Other (Specify): PTSD	10%
Declined to Answer (or Unknown)	34%
Veteran Status	
No	48%
Declined to Answer (or Unknown)	52%
Gender: Assigned sex at birth	
Declined to Answer (or Unknown)	100%
Current Gender Identity	
Male	14%
Female	67%
Declined to Answer (or Unknown)	19%

Program Successes:
The Telling Your Story group has grown to having more consistent attendees who better able prepared to share based on the topics provided. Some participants enjoy having the group virtually in the comfort of their home, they feel safer and the hassle of commuting has been eliminated. People have felt more prepared during their shares and they enjoy the support they receive from their peers.

Program Challenges:
The Telling Your Story group challenges have been a lack of in-person connection and some people not having zoom are unable to see others on the screen.

SUICIDE PREVENTION PROGRAM

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

The City of Berkeley partners with the California Mental Health Services Authority to locally provide Suicide Prevention resources through the PEI Statewide Projects initiative:

California Mental Health Services Authority (CalMHSA) - PEI Statewide Projects

In 2009, California's counties formed the California Mental Health Services Authority (CalMHSA) as a Joint Powers Authority to implement PEI statewide program initiatives. With an approved combined funding level of $40 million per year for four years during the timeframe of 2011 through 2015, CalMHSA implemented statewide initiatives in the following areas: Suicide Prevention, Stigma and Discrimination Reduction, and Student Mental Health. Following 2015, funding for PEI Statewide projects was generated through pooled contributions from individual counties. Contributing counties are members of a CalMHSA board that provides direction into the types of initiatives that are implemented. In order to continue to sustain programming, CalMHSA previously asked counties to allocate 4% of their annual local PEI allocation each year to these statewide initiatives. In the City of Berkeley, this has varied from year to year between $42,000 - $66,000 depending on the amount of PEI revenue received. Through the previously approved Three Year Plan the City of Berkeley allocated PEI funds for one year towards this statewide initiative, and for the remaining two years, elected to assess on an annual basis whether or not to continue to allocate funds to this initiative. The Division allocated funding for services in FY22, and was required to execute a Participation Agreement with CalMHSA in order to provide the funding to participate in this initiative. In FY23 the Division is recommending to continue funding this initiative as in previous years at 4% of the projected PEI funding amount (approximately $70,907) and to amend the Participation Agreement with CalMHSA to allocate funds to participate in this project.

In FY21, through this initiative resources on Suicide Prevention, Student Mental Health and Stigma and Discrimination reached approximately 1,620 individuals. Additionally, resources were distributed via email to local schools, community agencies and community members.

INNOVATIONS (INN)

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

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

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**.** An update to this plan was subsequently approved by the MHSOAC in December 2018 which added funds to the project and switched the initial target population from BUSD students and staff to children, teachers and parents at YMCA Head Start sites in Berkeley.

In September 2018, the Division received approval from the MHSOAC for a third INN project to allocate funds to join the Technology Suite Multi-County Collaborative (later re-named Help@Hand Project) and in April 2022, the Division received approval for a fourth INN Project to allocate funds for an Encampment Based Mobile Wellness Center Project.

INN Reporting Requirements

Per MHSA INN regulations, all INN funded programs have to collect additional state identified outcome measures and detailed demographic information. Beginning in FY19, INN Evaluations were required to be included in each MHSA Annual Update or Three Year Plan. The Innovations (INN) Fiscal Year (FY) 2020/2021 Annual Evaluation Report is located in Appendix B of this Annual Update.

A description of current INN programs, and INN programs funded during the reporting timeframe as well as FY21 data are outlined below:

Early Childhood Trauma Resiliency (ECTR) - Trauma Informed Care Project

In May 2016, the City of Berkeley received approval from the MHSOAC to implement a Trauma Informed Care (TIC) for Educators project (which is posted on the MHSA webpage) into several BUSD schools to assess whether educators who are trained to become aware of their own trauma and trauma triggers (and how to address them), are better equipped to recognize

and make appropriate decisions on how to help students who are exhibiting trauma symptoms, and assist them in accessing the mental health services and supports they may need.

The project was implemented through the 20/20 Vision Program which is operated out of the City of Berkeley, City Manager's Office. After a year of the TIC Project being executed, there were two vacancies in the 20/20 Vision Program which impacted the ability to continue the implementation of the TIC Project. The project was only able to be implemented for one year in FY17 and during that timeframe an evaluation was conducted by Hatchuel Tabernik & Associates (HTA) on the project outcomes. The HTA Training Informed Systems Training Program 2016-17 Pilot Year Evaluation Report is located on the City of Berkeley MHSA webpage.

In FY18, due to staffing vacancies the TIC project was not able to be implemented. When staffing vacancies were filled in mid FY18, meetings were held with several BUSD principals who indicated that although their schools received a lot of positive benefits out of the TIC project, additional training requirements within the school system had been added for teachers and administrators that needed to be fulfilled over the next couple of years. As a result, the TIC Project would not be able to be prioritized within the school system at that time. In light of the changes in the school system, staff conducted outreach and found that area YMCA Head Start Centers were interested in executing the same TIC Project for their early childhood educators and staff, to impact the children and families who are served at the centers. As such, proposed changes to the population and funding amount of the original TIC Plan were vetted through community program planning, and an update to the TIC Plan underwent a 30 Day Public Review and Public Hearing process. The City of Berkeley Trauma Informed Care Plan Update (which is posted on the City of Berkeley MHSA webpage) was approved through City Council in October 2018 and by the MHSOAC in December 2018. The modified project implements TIC Training for Educators and interested parents in four local Head Start sites.

The TIC modified project, "Early Childhood Trauma and Resiliency" (ECTR) was implemented from January 2019 through June 2021 at four YMCA Head Start sites located in Berkeley: Ocean View. South YMCA, Vera Casey, and West YMCA. The project provided training and supports to enable Head Start staff to recognize trauma and its effects on themselves and the children and families they serve, and to integrate trauma and resiliency informed approaches into their work. The project provided training, coaching and peer support to staff and parents who have children enrolled in Head Start and advanced Berkeley's 2020 Vision priority, that all Berkeley children enter kindergarten ready to learn.

The learning objectives of this project were as follows:

- To create a change in the way Head Start educators and staff view and handle challenging student and parent behaviors (which often mask trauma);
- To create an increase in access to mental health services and supports for children/families in need;
- To promote better mental health outcomes by increasing child/family referrals to "appropriate' mental health services.

In FY21, 178 children received services through this program. For all program outcomes refer to the ECTR Final Three Year Evaluation Report which was developed by HTA during the reporting timeframe and is located on the MHSA webpage and in Appendix B of this Annual

Update. Below are demographics of individuals impacted by this program:

DEMOGRAPHICS N=178	
Age Groups	
0-15 (Children)	100%
Race	
Asian	9%
Black or African American	29%
White	9%
Other	28%
More than one Race	17%
Declined to Answer (or Unknown)	8%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Central American	2%
Mexican/Mexican-American/Chicano	32%
Puerto Rican	1%
South American	2%
Other	2%
More than one ethnicity	7%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	6%
Cambodian	<1%
Chinese	3%
Middle Eastern	<1%
Vietnamese	1%
Other	9%
More than one Ethnicity	2%
Declined to Answer (or Unknown)	20%
Primary Language	
English	67%
Spanish	23%
Urdu	<1%
Arabic	2%
French	1%
Berber	1%
Mongolian	<1%
Amharic	<1%

Tigrina	1%
Chinese/Mandarin	1%
Nepalese	<1%
Declined to Answer (or Unknown)	<1%
Disability	
Communication: other, speech/language impairment	39%
Physical domain	7%
Other	7%
No Disability	47%
Gender	
Female	41%
Male	59%

Help@Hand Project

In September 2018, following a four-month community planning process and approval from City Council, the City of Berkeley Technology Suite Project (which has since been renamed "Help@Hand) was approved by the MHSOAC. This project allocates a total of $462,916 to participate in a Statewide Collaborative with other California counties to pilot a Mental Health Technology Project that makes various technology-based mental health services and supports applications (Apps) locally available in Berkeley. The Help@Hand project seeks to learn whether the use of the Apps will increase access to mental health services and supports; and whether it will increase the quality of mental health services, including leading to better outcomes.

Since plan approval and through FY21, the City of Berkeley worked both internally and with the California Mental Health Services Authority (CalMHSA), the fiscal intermediary for this project to prepare for citywide implementation. Due to a need for additional community mental health supports as a result of the pandemic, the priority population for accessing Apps was changed from the original primary focus on TAY and Older Adults, to include anyone who lives, works and goes to school in Berkeley.

Per a competitive recruitment process, the Division contracted with Resource Development Associates (RDA), who conducted Project Coordination work through early FY22 on this project. Additionally, on behalf of the City and with locally designated Help@Hand project funds, CalMHSA executed a contract with Uptown Studios, a local Marketing company in early FY22 to conduct a marketing and social media campaign for this project. In November 2021, as a result of this project, free access to the HeadSpace and MyStrength Apps became locally available for a limited timeframe to anyone who lives, works or goes to school in Berkeley.

The City is currently participating in a State Evaluation with other counties in this project. The evaluation is being conducted by the University of California at Irvine (UCI). Additionally, following a competitive recruitment process, the City of Berkeley entered into a contract with Hatchuel, Tabernik & Associates to conduct a local evaluation of this project.

Encampment-Based Mobile Wellness Center

In FY20, the community program planning process for the next round of INN funded Projects was provided by Resource Development Associates (RDA), who was chosen through a competitive recruitment process to conduct this work. Based on community input received around the need for additional services and supports for individuals who are experiencing homelessness and mental health needs, including direct feedback from individuals who reside in homeless encampments, an Encampment-Based Mobile Wellness Center project was developed.

In April 2022, the Division received approval to implement the Encampment-Based Mobile Wellness Center Project (located on the City of Berkeley MHSA webpage) from the Berkeley City Council and the State Mental Health Oversight and Accountability Commission (MHSOAC). This new project will pilot a five year, 2.8 million dollar Mobile Wellness Center at Homeless encampments in Berkeley that will provide an on-site, customizable menu of services that are chosen by individuals who reside at the encampments. The project will be led by peers with lived experience of homelessness, and include partners from encampment communities to encourage participation, help define service needs, and support service provision at the site. The project will be implemented through a community partner who will be chosen through a competitive Request For Propoosal (RFP) process.

The project will seek 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. The project 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.

WORKFORCE, EDUCATION & TRAINING (WET)

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

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

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.

Greater Bay Area Workforce, Education & Training Regional Partnership

The Office of Statewide Health Planning and Development (OSHPD) allocated $40 million in Workforce, Education and Training funds through FY25 for Regional Partnerships across the state for various mental health workforce strategies. A total of 2.6 million of OSHPD was allocated to the Greater Bay Area (GBA) Workforce, Education & Training Regional Partnership. In order to participate in the GBA Regional Partnership, mental health jurisdictions were

required to contribute a portion of local funds towards this initiative. For the Berkeley contribution the amount was $40,127, which the Division allocated through the previously approved Three Year Plan.

Since the approval of the Three Year Plan, the Division has participated in meetings with representatives from other counties in the GBA Regional Partnership. All participating counties decided to allocate these funds for the Loan Repayment program. This program will enable funds to be made available to repay a portion of student loans for a given number of staff who are in hard-o-fill positions, in exchange for a number of years of service in the Public Mental Health system.

As some local counties have decided not to participate in this initiative, the GBA Regional Partnership was notified that each participating mental health jurisdiction will need to increase the amount of funds they are contributing to this initiative. The additional amount for Berkeley is $1,361. Per this Annual Update, the Division is proposing to transfer $1,361 of CSS System Development Funds to the Workforce, Education and Training (WET) funding 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 to participate in this initiative, which is being administered through a joint powers authority, the California Mental Health Services Authority (CalMHSA). Through this Annual Update the Division is requesting to enter into a Participation Agreement with CalMHSA to allocate the designated funds through FY25 to participate in this initiative.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

The original City of Berkeley CFTN Plan was approved in April 2011, with updates to the plan in May 2015, June 2016, 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. In its previous condition, use of the Adult Clinic space was inefficient and inadequately aligned with MHSA goals, including not having welcoming spaces for client and family centered wellness and recovery programs and services. In addition to electrical, HVAC and other environmental upgrades, CFTN funds were used to re-configure shared work spaces to increase safety; improve clinical, wellness/recovery, support services,

and administrative functions; and to support the implementation of electronic health records and other emerging technologies.

Construction on the Adult Clinic began in FY19, and in June 2021, the renovation was completed, staff moved back into the building, and the clinic was re-opened for services. There is approximately $199,572 in remaining CFTN funds. It is anticipated that approximately $35,000 of these funds will be utilized in FY23 to alleviate water damage at the Adult Clinic and $75,000 will be utilized to conduct a Renovation Study on the adjacent property to the Adult Clinic (2636 Martin Luther King Jr. Way) where some Adult Clinic staff offices are located.

FY21 AVERAGE COST PER CLIENT
*(Includes FY21 expenditures attributed to the MHSA Funding component)

COMMUNITY SERVICES & SUPPORTS			
Program Name	**Approx. # of Clients**	**Cost**	**Average Cost Per Client**
Children and Youth Intensive Support Services FSP	16	$119,135	$7,446
TAY, Adult & Older Adult FSP	79	$550,410.07	$6,967
Homeless FSP	1	$292,767	$292,767
TAY Support Services	129	$122,856	$952
System Development (includes: Wellness Recovery Services; Family Support Services; Benefits Advocacy; Employment/Educational Services; Housing Services and Supports; Crisis Services; TOT; FIT; TAY Case Management Services; Hearing Voices; Berkeley Wellness Center)	1,232	$2,742,199	$2,226
PREVENTION & EARLY INTERVENTION			
Be A Star	2,203	$61,154	$28
Supportive Schools Program	179	$55,000	$307
Living Well Project	25	$32,046	$1,282
LGBTQI Trauma Project	69	$32,046	$464
TAY Trauma Project	150	$32,046	$214
High School Youth Prevention Program	101	$339,900	$3,365
Homeless Outreach and Treatment Team	91	$52,416	$576
Child And Youth at Risk Project	49	$35,924	$733
Dynamic Mindfulness	Unknown	$95,000	Unknown
African American Success Project	63	$150,000	$2,381
INNOVATION			
Trauma Informed Care Project	178	$233,059.22	1,309

BUDGET NARRATIVE

The enclosed budget provides an update to the estimated revenue and expenditures that were projected for FY23 in the approved Three Year Plan. As with all MHSA Plans and Annual Updates, revenue and expenditures in this Annual Update are estimates.

The Division obtains financial projections from the state on the amount of MHSA revenue to be allocated in a given year. Previous FY23 projections received, which were utilized to calculate MHSA revenue the City would receive in the three-year timeframe, were included in the approved Three Year Plan. Financial projections for the Three Year Plan were provided at a time of great uncertainty of the amount of revenue that would be generated during the pandemic, and were based on a projected downturn of revenue in the MHSA Fund. As has been reflected nationally regarding the wealth divide, there was an increase of MHSA revenue in FY22, and funds are projected to increase in FY23 in the MHSA Fund. Additionally, the expenditure projections for FY22 in the approved Three Year Plan reflected the total costs of each program if it was fully operable. The actual expenditures in FY22 were less than what was projected, due to several factors including staff attrition and vacancies, and slower start-ups with new programs.

The savings from the FY22 expenditures, and the projected additional revenue in FY23, will provide increased monies to support MHSA programs and services over the next couple of years. Additionally, the budgets in this MHSA Annual Update reflect the following: a movement of some staff from being fully funded on the MHSA Fund, to being partially funded on Medi-Cal and partial MHSA; a 10% vacancy across all programs; and funding amounts for the proposed additional positions based on staff being hired by mid FY23 with 30% of the costs of the positions offset by Medi-Cal reimbursement. This funding projection more fully reflects the realities of spending amid vacancies, delays in hiring positions, and the movement of staff to blended funding streams.

The Division will continue to closely monitor the City of Berkeley MHSA allotments and expenditures to assess whether program changes are needed in the future. Any proposed program changes will be vetted for community input and reflected in the next Three Year Plan.

PROGRAM BUDGETS

FY 2022/23 Mental Health Services Act Annual Update
Funding Summary

County: City of Berkeley

Date: 5/23/22

	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 FY2022/23 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	5,002,253	1,897,440	1,730,975	41,248	199,572	
2. Estimated New FY2022/23 Funding	7,088,391	1,772,679	482,230			
3. Transfer in FY 2022/23[a/]				1,361		
4. Transfer Local Prudent Reserve in FY 2022/23						
5. Estimated Available Funding for FY 2022/23	12,090,644	3,670,119	2,213,205	42,609	199,572	
B. Estimated FY22/23 Expenditures	8,514,903	1,759,216	548,650	42,609	110,000	
G. Estimated FY22/23 Fund Balance	3,575,741	1,910,903	1,664,555	0	89,572	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Unspent Local Prudent Reserve on June 30, 2022	1,237,629
2. Contributions to the Local Prudent Reserve in FY2022/23	0
3. Distributions from the Local Prudent Reserve in FY2022/23	0
4. Estimated Local Prudent Reserve balance on June 30, 2023	1,237,629

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 2022/23 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: City of Berkeley

Date: 5/23/22

	Fiscal Year 2022/23					
	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	1,997,481	1,997,481				
2. Children's FSP	427,313	427,313				
3. Homeless FSP	1,542,847	1,542,847				
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	337,592	337,592				
2. System Development, Wellness & Recovery	3,564,591	3,564,591				
3. Crisis Services	261,794	261,794				
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	383,285	383,285				
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	8,514,903	8,514,903	0	0	0	0
FSP Programs as Percent of Total	46.6%					

FY 2022/23 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: City of Berkeley

Date: 5/23/22

	Fiscal Year 2022/23					
	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	188,930	188,930				
2. African American Success Project	37,500	37,500				
3. CalMHSA	70,907	70,907				
4. Dynamic Mindfulness	71,250	71,250				
5. Mental Health Promotion Campaign	100,000	100,000				
6.						
7.						
8.						
9.	0	0				
10.	0	0				
PEI Programs - Early Intervention						
11. High School Prevention Program	236,163	236,163				
12. African American Success Project	112,500	112,500				
13. BE A STAR	34,658	34,658				
14. Community Education & Supports	364,092	364,092				
15. Dynamic Mindfulness	23,750	23,750				
16. Supportive Schools	110,000	110,000				
17. Specialized Care Unit	68,000	68,000				
18.						
19.						
PEI Programs - Stigma & Discrimination						
20. Social Inclusion	9,000	9,000				
PEI Programs - Outreach for Incr. Recog. Of Mental Illness						
21. High School Prevention Program	47,233	47,233				
PEI Administration	285,233	285,233				
PEI Assigned Funds						
Total PEI Program Estimated Expenditures	1,759,216	1,759,216	0	0	0	0

FY 2022/23 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: City of Berkeley

Date: 5/23/22

	Fiscal Year 2022/23					
	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. Help@Hand - Technology Suite Project	21,900	21,900				
2. New INN Homeless Encampment Project	526,750	526,750				
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	548,650	548,650	0	0	0	0

FY 2022/23 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: City of Berkeley

Date: 5/23/22

	Fiscal Year 2022/23					
	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. Greater Bay Area Regional Partnership	42,609					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	42,609	0	0	0	0	0

FY 2022/23 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: City of Berkeley

Date: 5/23/22

	Fiscal Year 2022/23					
	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. Renovation Study of 2636 MLK	75,000	75,000				
2. Water Damage Repairs 2640 MLK	35,000	35,000				
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	110,000	110,000				

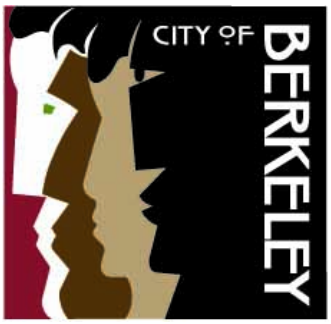
APPENDIX A

Prevention and Early Intervention

Fiscal Years 2019 – 2021

Three Year Evaluation Report

City of Berkeley
Mental Health Services Act



Prevention and Early Intervention
Fiscal Years 2019 - 2021
Three Year Evaluation Report

WELLNESS • RECOVERY • RESILIENCE

INTRODUCTION

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

- 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 individuals with mental health challenges or mental illness.
- Access and linkages to necessary medical care for individuals 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.

Beginning in 2017, 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, beginning December 2018, a Three Year PEI Evaluation Report is due to the MHSOAC every three years. Regulations also require mental health jurisdictions to submit either a Three Year Evaluation Report or an Annual Evaluation Report 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 Review period and approval from the local governing board. In FY22, the Prevention and Early Intervention (PEI) Fiscal Years 2018/2019 – 2020/2021 (FY18/19 –20/21) Three Year Evaluation Report is due.

This PEI FY18/19 – 2/021 Three Year Evaluation Report provides descriptions of currently funded MHSA services, and reports on program and demographic data during the reporting timeframe, to the extent possible. The main obstacles in collecting data for this PEI Three Year Evaluation Report continue be with limited staffing and resources both within the City and at Contractor sites to implement and oversee all the necessary data collection requirements. While, it may be a multi-year process before the City of Berkeley will be able to present a complete data set for each PEI Program on an Annual basis, ongoing efforts will continue towards accomplishing this goal.

Impact Berkeley Initiative

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. Since FY18 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. Results of the RBA Evaluation are captured in this report and will continue to be reported in future PEI Evaluation Reports.

BACKGROUND

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

Key Community Mental Health Needs:

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

PEI Priority Populations:

- Underserved Cultural Populations – Projects that address individuals who are unlikely to seek help from any traditional mental health services whether because of stigma, lack of knowledge, or other barriers (such as members of ethnically/racially diverse communities, members of gay, lesbian, bisexual, transgender communities, etc.) and would benefit from PEI programs and interventions.
- Individuals Experiencing Onset of Serious Psychiatric Illness – Individuals identified by providers, including but not limited to primary health care, as presenting signs of mental illness first break, including individuals who are unlikely to seek help from any traditional mental health service.
- Children and Youth in Stressed Families – Children and youth placed out-of-home or individuals in families where there is substance abuse or violence, depression or other mental illnesses or lack of caregiving adults (e.g., as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems.
- Trauma-Exposed – Individuals who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including individuals who are unlikely to seek help from any traditional mental health service.
- Children and Youth at Risk for School Failure – Due to unaddressed emotional and behavioral problems.
- Children and Youth at Risk of or Experiencing Juvenile Justice Involvement – Individuals with signs of behavioral/emotional problems who are at risk of or have had any contact with any part of the

juvenile justice system, and who cannot be appropriately served through MHSA Community services and Supports funded services.

In April 2009, following a nine-month long Community Planning Process, the original City of Berkeley Prevention and Early Intervention plan was approved. 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 Supportive Schools Program Community Based Child & Youth Risk Prevention Program	➢ At-Risk Children, Youth and Young Adult Populations	• Children and Youth in Stressed Families • Children and Youth at Risk for School Failure • Underserved Cultural Populations
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)	➢ 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

On October 6, 2015, updated PEI regulations designed by the Mental Health Services Oversight and Accountability Commission (MHSOAC) became effective. The updated regulations changed the PEI requirements. Per new PEI State Regulations, Mental Health jurisdictions are to utilize PEI funds to implement 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 applicable negative outcomes that may result from untreated mental illness.	➢ Provide services that do not exceed 18 months ➢ Program may include services to parents, caregivers, and other family members of the person with early onset of a mental illness. ➢ Program may be combined with a Prevention program ➢ Measure the impact of one or more of the negative outcomes listed in the MHSA (suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes). ➢ Demonstrate the use of an evidence-based or promising practice or a community or practice-based evidence standard* ➢ Collect all PEI demographic variables
Access and Linkage to Treatment	Connecting children who are seriously emotionally disturbed, and adults and seniors with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs.	➢ Collect # of unduplicated individuals served ➢ Collect # of unduplicated referrals made to a Treatment program (and type of program) ➢ Collect # of individuals who followed through (participated at least once in Treatment) ➢ Measure average time between referral and engagement in services per each individual ➢ Measure duration of untreated mental illness (interval between onset of symptoms and start of treatment)per each individual ➢ Collect all PEI demographic variables
Stigma and Discrimination Reduction	Direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being	➢ Collect the number of individuals reached by activity (e.g., # who participated in each service or activity)

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

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

PEI Demographic Reporting Requirements

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

(A) The following Age groups:

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

(B) Race by the following categories:

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

(C) Ethnicity by the following categories:
(i) Hispanic or Latino as follows

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

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

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

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

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

(E) Sexual orientation

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

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

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

(G) Veteran Status,

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

(H) Gender

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

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

Effective July 2018 amended PEI regulations 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 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, local PEI funded programs have been 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 • DMIND • MEET • African American Success • Supportive Schools • Child & Youth At Risk • 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 medically necessary care and treatment, including but not limited to care provided by county mental health programs.	• Homeless Outreach and Treatment* • High School Prevention • Specialized Care Unit
OPTIONAL Suicide Prevention	Activities to prevent suicide as a consequence of mental illness.	• CalMHSA PEI Statewide Project

*Prior project that was in operation during FY21, the reporting timeframe of this annual update)

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 MHSOAC 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 MHSOAC, "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)).

At the time of the writing of this Annual Update, the MHSOAC had not established additional priorities to the following specifically enumerated required priorities in WIC Section 5840.7 (a) for the use of PEI funding:

- 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;
- Culturally competent and linguistically appropriate prevention and intervention;
- 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 MHSOAC, 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:

CITY OF BERKELEY PEI PROGRAMS	PEI PRIORITIES
• Be A Star • 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 • African American Success Project • Specialized Care Unit	Youth Engagement and Outreach Strategies that target secondary school and transition age youth, Culturally competent and linguistically appropriate prevention and intervention Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis
• Mental Health Promotion Campaign • Social Inclusion • Community Education & Supports	Culturally competent and linguistically appropriate prevention and intervention Youth Engagement and Outreach Strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs Strategies targeting the mental health needs of older adults.

This PEI FY18/19 – 20/21 Three Year Evaluation Report documents program measures and demographic elements to the extent data was available. While, it may be a multi-year process before the City of Berkeley will be able to present a complete data set for each PEI Program on an Annual basis, ongoing efforts will continue towards accomplishing this goal.

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.

Currently, seven out of ten local PEI programs provide services for children and youth, 6 of which are in the Berkeley Unified School District (BUSD). Programs are as follows: Behavioral-Emotional Assessment, Screening, Treatment and Referral (BE A STAR); Supportive Schools Project; Mental Emotional Education Team (MEET); Dynamic Mindfulness (DMIND); African American Success Project; High School Youth Prevention Project, and the TAY Trauma Support Project. Additionally, from FY11 through FY20, the City of Berkeley utilized a portion of PEI funds to provide services for children, youth and TAY in the Albany Unified School District, through the Albany Trauma Project.

Programs and services funded with PEI funds, and FY18/19 – 20/21 data are outlined below by PEI Program type.

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 FY22 Annual Update the City of Berkeley funded the following Prevention initiative that will be implemented in FY23:

Mental Health Promotion Campaign

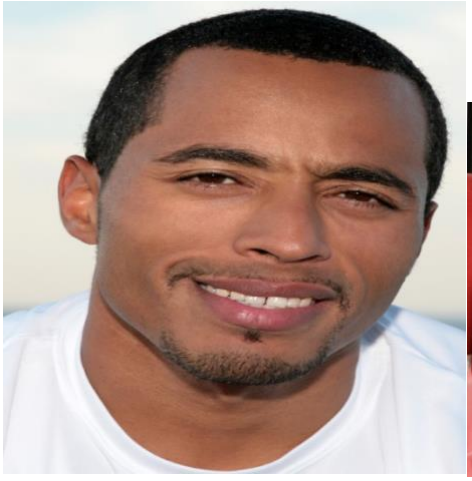
As a result of the impact of the pandemic, and public input around the overwhelming need for mental health supports in the community, a community Mental Health Promotion Campaign will be implemented to support the wellness and self-care of Berkeley residents. The Division will partner with the community 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.

It is envisioned that this campaign will be implemented in FY23 and the Division will continue to work with the community to determine how to best promote mental health and wellness in Berkeley.

EARLY INTERVENTION AND PREVENTION & EARLY INTERVENTION COMBINED PROGRAMS



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:

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

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

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

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

In FY19, there were vacancies in staff, as such program data for the reporting timeframe is unavailable.

In FY20, there were vacancies in staff, and shortly after a staff person was hired, they were deployed to work in the City's Emergency Operations Center as a result of the pandemic. A total of 1,538 children were able to be screened through community partners.

In FY21, a total of 2,203 children were screened through this program however data was not collected on all individuals screened. Only Race/Ethnicity data was collected on a subset of 141 children as follows:

DEMOGRAPHICS N=2,203	
Age Groups	
0-15 (Children/Youth)	100%
Race N=141	
Asian	30%

Black or African American	32%
White	8%
More than one Race	1%
Other	29%
Ethnicity: Hispanic or Latino/Latina/Latinx N=141	
Unspecified Hispanic or Latino/Latina/Latinx	29%
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:

- A total of 154 referrals to resources/services were made as a result of the developmental screenings conducted at BUSD preschools and pediatric sites.
- Overall, there was an increase in developmental screenings in pediatric settings. For example, when compared to data in FY20, two Berkeley pediatric sites increased their number of screenings by 211% and 76%.
- Sites demonstrated great adaptability due to the challenges that COVID-19 caused. Several sites were able to transition to doing developmental screenings online. Be A Star was able to provide training and Technical Assistance to help ensure a smooth transition.

Program Challenges:

- Although many pediatric sites and BUSD preschools were able to provide more services this year, there were still challenges caused by COVID-19, including delayed trainings for pediatric sites and decreases in available referral services.
- Be A Star staffing was impacted by the City of Berkeley's COVID-19 response. All Public Health nursing positions supported the emergency response in some capacity. A new Be A Star Public Health Nurse started in January 2021 and there has been a transition as this nurse has settled into the role.
- There were program challenges in being able to collect an accurate full data set as some of the Berkeley pediatric sites do not collect and report out on various demographic information and other screening sites only captured general demographic information.

Community-Based Child & Youth At Risk Program

This program targets children (aged 0-5) who are impacted by multiple risk factors including trauma, family or community violence, familial distress, and/or family substance abuse, (among other issues). A BMH clinician serves 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 have 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 are to reduce risk factors or other stressors, and promote positive cognitive, social, and emotional well-being. This program serves approximately 50 Children & Youth a year.

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

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

DEMOGRAPHICS N=54	
Age Groups	
0-15 (Children/Youth)	100%
Race	
Asian	6%
Black or African American	55%
White	4%
Other	33%
More than one Race	2%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American/Chicano	33%
Ethnicity: Non-Hispanic or Non-Latino	
Declined to Answer (or Unknown)	67%
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%

In FY19, the following services were provided:

- Fifteen Early Childhood Mental Health Reflective Case Consultation groups for five classrooms;

- General Classroom Consultations in five classrooms;
- Individual and group consultations to the Center Program Supervisor, 15-18 Childhood Teachers, and two Family Advocates;
- Coordination with the "Inclusion Program" which includes Inclusion Specialists and a Speech Pathologist to help observation and assessment efforts that facilitate early intervention screenings and referrals to BUSD and Regional Center;
- Planning and assistance with implementation of behavior plans for children with behavioral and social-emotional needs;
- Direct interventions including providing visuals and classroom tools to help teach children self-regulation skills, social skills, and skills to help with transitions and to improve the overall functioning of individual children in the classroom setting;
- Mental Health consultations to 15 parents which included a variety of direct psycho-education around developmental concerns, social-emotional issues/behavioral concerns, parenting issues, providing information regarding mental health services as well as information regarding community services such as: First 5 Alameda, Help Me Grow, Regional Center, BUSD, and Primary Care physicians; and
- Co-facilitation of monthly Resiliency Circles to promote self-care and trauma informed care principles with teaching staff.

According to the HeadStart Center Supervisor, the consistency with the current Mental Health Consultant allowed for relationship building and establishing rapport with teachers and their families, which are essential to providing successful and effective mental health consultations.

In FY20, 54 children were served through this program. Demographics on those served is as follows:

DEMOGRAPHICS N=54	
Age Groups	
0-15 (Children/Youth)	100%
Race	
Asian	5%
Black or African American	56%
White	4%
Other	19%
More than one Race	2%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican/Mexican-American/Chicano	33%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	67%
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%

FY20 services were as follows:

- Consultation meetings allowed teachers to develop clear plans and interventions in the classroom for individual children (and families) who had high risk factors including but not limited to complicated family dynamics, trauma, mental health and social-emotional needs as well as overall developmental needs of individual children
- General classroom consultations were held in five classrooms;
- Individual and group consultations to the Center Program Supervisor, 15-18 Childhood Teachers, and two Family Advocates;
- Coordination with the "Inclusion Program" which includes Inclusion Specialists and a Speech Pathologist to help observation and assessment efforts that facilitate early intervention screenings and referrals to BUSD and Regional Center;
- Planning and assistance with implementation of behavior plans for children with behavioral and social-emotional needs;
- Direct interventions including providing visuals and classroom tools to help teach children self-regulation skills, social skills, and skills to help with transitions and to improve the overall functioning of individual children in the classroom setting;
- Mental Health consultations to over 15 parents which included a variety of direct psycho-education around developmental concerns, social-emotional issues/behavioral concerns, parenting issues, providing information regarding mental health services as well as information regarding community services as as: First 5 Alameda, Help Me Grow, Regional Center, BUSD, and Primary Care physicians;
- Co-facilitation of monthly Resiliency Circles to promote self-care and trauma informed care principles with teaching staff; and
- Over 15 Early Childhood Mental Health Reflective Case Consultation groups for five classrooms. Case maintenance despite the impact of the pandemic.

In FY21, 49 children were served through this program. Demographics on those served were as follows:

DEMOGRAPHICS N=49	
Age Groups	
0-15 (Children/Youth)	100%
Race	
American Indian	2%
Asian	12%
Black or African American	45%

White	14%
More than one Race	5%
Declined to Answer (or Unknown)	22%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Declined to Answer or Unknown	100%
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 Unlknown)	100%

Program Successes:

All of the general mental health consultation duties outlined below continued to be provided remotely via tele-care/Zoom until they were transitioned to in-person services in early FY22:

- Facilitated weekly Early Childhood Mental Health Reflective Case Consultation group/meetings to five classrooms. Case consultation meetings allowed teachers to develop clear plans and interventions for individual children and families in their classroom that present with high risk factors including but not limited to: complicated family dynamics; trauma; mental health concerns; social-emotional needs; and/or overall developmental needs.
- Provided general classroom observation to five infant care, toddler care and pre-school classrooms, serving a total of 49 children.
- Provided individual and group consultation to the Center Program Supervisor, 15-20 Early Childhood Teachers, and two family advocates
- Coordinated with the Inclusion Program which includes Inclusion Specialists and a Speech Pathologist to help observation and assessment efforts that facilitate early intervention screenings and referrals to BUSD and the Regional Center.
- Provided planning and assistance with implementation of behavior plans for children with behavioral and social-emotional needs.
- Provided direct interventions around classroom interventions including providing visuals and classroom tools to help teach children self-regulation skills, social skills, and skills to help with transitions, and to improve the overall functioning of individual children in the classroom setting.
- Provided individual mental health consultations to parents, and provided direct psycho-education around developmental concerns, social-emotional issues/behavioral concerns, parenting issues, and information regarding mental health services as well as information regarding community services including First 5 Alameda, Help Me Grow, the Regional Center, primary care Doctors, and BUSD services.

Program Challenges:

- The downside of continuing services and not being on site was not having access to families. This posed some difficulties in being able to build relationships with children and families directly.
- There was an increased need to provide crisis interventions during the pandemic as staff managed the stress of returning to their work as essential workers in the middle of a pandemic.
- There was an increase of collective stress as a result of the pandemic.
- As the pandemic continued into FY21 the center continued to experience disruptions to care with staff and children being quarantined at times.
- It was a challenge to work off-site during the COVID-19 pandemic to observe the child and teacher interactions. With not being onsite in-person there were no continuous conversations, spontaneous consultations, nor in-vivo modeling interactions. The ability to demonstrate for staff by working with the children and practicing certain interventions with children in-person along with observing staff implementing the techniques was also limited.
- There was no ability to model in-person for the teachers, as these elements were a part of the challenge in working remotely via telehealth (Zoom).

In FY23, MHSA funding for this program will be discontinued as the YMCA Head Start program has created a staff position for an internal Mental Health Specialist.

Supportive Schools Program

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

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

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

In FY19, BUSD sub-contracted with the following local agencies to provide services: Bay Area Community Resources (BACR), Child Therapy Institute (CTI), and LifeLong Medical Care. Agency and district staff providers led social skills groups, provided early intervention social and emotional support services, playground social skills, "check in/check out," individual counseling, and support for parents and guardians from diverse backgrounds. As aligned with priority and focus on equity, providers participated in Coordination of Services Team (COST) meetings, and linked parents and guardians with resources at the school, within the school district, and in the community. A total of 1,065 elementary age students were served through this program.

Note: data provided by BUSD in FY19 combined the demographics for the Supportive Schools Project, the MEET Program, and DMind. Program data for all three projects is outlined below:

DEMOGRAPHICS N= 3,065	
Age Group	
0-15 (Children/Youth)	81%
16-25 (Transition Age Youth)	13%
26-59 (Adult)	6%
Ages 60+ (Older Adult)	<1%
Race	
American Indian or Alaska Native	1%
Asian	11%
Black or African American	19%
Native Hawaiian/Pacific Islander	<1%
White	41%
Other	1%
More than one race	4%
Declined to Answer (or Unknown)	9%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American/Chicano	14%
Primary Language Used	
English	86%
Spanish	7%
Mandarin	1%
Declined to Answer (or Unknown)	6%
Sexual Orientation	
Gay or Lesbian	7%
Heterosexual or Straight	49%
Bisexual	2%
Questioning or unsure of sexual orientation	<1%
Queer	<1%
Declined to Answer (or Unknown)	41%
Disability	
Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)	9%

Physical/mobility domain	<1%
Veteran Status	
Declined to Answer (or Unknown)	100%
Gender: Assigned sex at birth	
Male	58%
Female	42%
Current Gender Identity	
Male	54%
Female	39%
Transgender	<1%
Questioning or unsure of gender identity	<1%
Another gender identity (Non-Binary)	<1%
Declined to Answer (or Unknown)	6%

In FY20, Early Intervention Services were provided at all eleven BUSD elementary schools. Funding was allocated at each elementary school to provide early intervention services. 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. Additionally, a counselor was provided to support two elementary schools. As a result of the pandemic, schools finished the year in distance learning. During the academic year, supports were initially provided in-person, before shifting to online. It was reported that providing remote therapy sessions had its challenges. Supports for each school, per service provider, and numbers served in FY20 were as follows:

Elementary School	Agency/Provider	Number of Students Served
Cragmont Emerson Malcolm X Oxford Ruth Acty Thousand Oaks	Bay Area Community Resources BACR	229
Bay Area Arts Magnet (BAM) Washington	Child Therapy Institute	39
John Muir Sylvia Mendez	School Site Counselor	No Data Available
Rosa Parks	Child Therapy Institute	No Data Available
Total		**268**

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

In addition, other agency and district staff providers led social skills groups, early intervention social and emotional supports, playground social skills, "check in / check out," individual counseling, and supports for parents and guardians from diverse backgrounds. As aligned with the priority and focus on equity, providers participated in the COST team meetings, and linked parents and guardians with resources within the school district, and in the community.

Data provided by BUSD, on 248 students that were served from this project in FY20, is outlined below:

DEMOGRAPHICS N= 248	
Age Group	
0-15 (Children/Youth)	100%
Race	
American Indian or Alaska Native	7%
Asian	4%
Black or African American	34%
Native Hawaiian/Pacific Islander	1%
White	24%
More than one Race	19%
Declined to Answer (or Unknown)	11%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican/Mexican-American/Chicano	22%
Declined to Answer (or Unknown)	5%
Ethnicity: Non-**Hispanic or Non- Latino/Latina/Latinx**	
Asian Indian/South Asian	1%
Filipino	<1%
More than one Ethnicity	10%
Declined to Answer (or Unknown)	62%
Primary Language Used	
English	13%

Spanish	3%
Other	<1%
Declined to Answer (or Unknown)	84%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)	6%
No Disability	11%
Declined to Answer (or Unknown)	83%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	55%
Female	45%
Current Gender Identity	
Male	55%
Female	45%

In FY21 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. Additionally, a counselor provided support at two elementary schools. As a result of the pandemic, schools began the year in distance learning. BUSD then transitioned to small cohorts at each elementary school, before moving to in-person learning in the spring of 2021. During the academic year, supports were provided both virtually, and in-person.

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 consults with staff on many issues and provides trauma informed coaching for teachers, and referrals to outside providers, parenting classes/support groups, crisis hotlines, and other programs.

In addition, other agency and district staff providers led social skills groups, early intervention social and emotional support, playground social skills, “check in / check out,” individual counseling, and support for parents and guardians from diverse backgrounds. As aligned with priority and focus on equity, providers

participated in COST team meetings, and linked parents and guardians with resources within the school district, and in the community.

Supports for each school per each service provider, and numbers served in FY21 were as follows:

Elementary School	Agency/Provider	Number of Students Served
• Cragmont • Emerson • Malcolm X • Oxford • Ruth Acty • Thousand Oaks	Bay Area Community Resources (BACR)	115
• Bay Area Arts Magnet (BAM) • Washington	Child Therapy Institute	39
• John Muir • Sylvia Mendez	School Site Counselor	25
• Rosa Parks	Lifelong Medical Care	No Data Available
Total		**179**

Data provided by BUSD, on 179 students that were served through this project in FY21, is outlined below:

DEMOGRAPHICS N= 179	
Age Group	
0-15 (Children/Youth)	100%
Race	
American Indian or Alaska Native	1%
Asian	6%
Black or African American	25%
Native Hawaiian/Pacific Islander	1%
White	33%
More than one Race	19%
Declined to Answer (or Unknown)	11%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Central American	1%
Mexican/Mexican-American/Chicano	1%
South American	1%
Declined to Answer (or Unknown)	20%

Ethnicity: **Non-Hispanic or Non- Latino/Latina/Latinx**	
American Indian	1%
Asian Indian/South Asian	1%
Chinese	1%
Eastern European	1%
Filipino	1%
Korean	1%
More than one Ethnicity	3%
Declined to Answer (or Unknown)	68%
Primary Language Used	
English	30%
Spanish	4%
Other	1%
Declined to Answer (or Unknown)	65%
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)	11%
Declined to Answer (or Unknown)	88%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	53%
Female	43%
Declined to Answer (or Unknown)	4%
Current Gender Identity	
Male	52%
Female	43%
Non-binary	1%
Other Gender Identity	4%

Community Education & Supports Program

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

Since 2019 the Community Services & Supports projects have participated in the Health, Housing and Community Services Department "Impact Berkeley" Results Based Accountability (RBA) Evaluation. RBA seeks to answer the quantity of services provided, how well the program is providing services, and whether participants are better off as a result of participating in the services.

In FY19, RBA aggregated results across all Community Education & Supports projects were as follows:

How Much Did We Do?	How Well Did We Do It?	Is Anyone Better Off?
• 651 Support Groups/Workshops • 3,524 Support Groups/Workshop Encounters • 419 Outreach Activities • 6,938 Outreach Contacts • 1,308 Referrals	• 7 Support groups or workshop sessions attended on average per person • 96% Survey respondents were satisfied with services • Referrals by type: 251 Mental Health 240 Social Services 227 Physical Health 156 Housing 434 Other Services	• 92% of program participants reported an increase in social supports or trusted people they can turn to for help (3 of 5 projects reported in this measure). • 88% of program participants reported positive changes in terms of coping strategies, feeling anxious or overwhelmed (4 out of 5 programs reported on this measure).

In FY20 the aggregated results across all Community Education & Supports projects were as follows:

How Much Did We Do?	How Well Did We Do It?	Is Anyone Better Off?
• 555 Support Groups/Workshops • 5,183 Support Groups/Workshop Encounters • 188 Individual Contacts/Individuals • 3,342 Outreach Contacts • 1,245 Referrals	• 13 Support groups or workshop sessions attended on average per person (5 out of 7 programs reporting). • 98% Survey respondents were satisfied with services (4 out of 7 programs reporting) • Referrals by type: 277 Mental Health 252 Social Services 230 Physical Health 125 Housing 361 Other Services (6 out of 7 programs reporting)	• 90% of program participants reported an increase in social supports or trusted people they can turn to for help (2 out of 7 programs reporting). • 88% of program participants reported positive changes in terms of coping strategies, feeling anxious or overwhelmed (3 out of 7 programs reporting).

In FY21, the aggregated results across all Community Education & Supports projects were as follows:

How Much Did We Do?	How Well Did We Do It?	Is Anyone Better Off?
• 578 Support Groups/Workshops • 1,247 Support Groups/Workshop Encounters • 118 Individual Contacts (2 of 3 programs reporting) • 2,524 Outreach Activities • 225 Outreach Contacts • 1,179 Referrals	• 9 Support groups or workshop sessions attended on average per person • 85% Survey respondents reported satisfaction with services • Referrals by type: 223 Mental Health 200 Social Services 213 Physical Health 124 Housing 419 Other Services	• 86% of program participants reported an increase in social supports or trusted people they can turn to for help (2 of 3 programs reporting) • 90% of program participants reported positive changes in terms of coping strategies, feeling anxious or overwhelmed (2 of 3 programs reporting)

To ensure fair contracting practices in the City, the Division proposed in the approved FY20 MHSA Annual Update, to execute a new Request for Proposal (RFP) process for the Community Education & Supports Project contracts that have been in place for five or more years. It was anticipated that the RFP process would be executed in the Spring of FY20. Due to Covid-19 the Division decided it would be best to delay this RFP Process, and RFP's for each project were executed in the Spring of FY21. All Community Education & Supports contracts were continued through June 30, 2021. In FY22, the chosen bidders from the RFP processes, began providing services to each population.

Per the previously approved Three Year Plan, in an effort to ensure each unserved, underserved and inappropriately served population has an equitable amount of dedicated MHSA funds for programs and services, the Division made the following changes to this program, which began in FY22: Increased the amount up to $100,000 per each of the following populations, African Americans, Latinos/Latinas/Latinx and LGBTQIA+; and no longer funded the API population in this program, as the Division is providing $100,000 of dedicated CSS funds for services and supports for this community.

Outlined below are descriptions of services provided and numbers served through this program during the reporting timeframe:

Albany Trauma Project

Implemented through Albany Unified School District this project provides trauma support services to Latinx, Asian Pacific Islanders and African American TAY, and Adults. Through various supports the project: provides helpful information and coping strategies around the effects of trauma; offers interventions to keep at-risk individuals and families from developing serious mental health symptoms and behaviors; provides a forum for clinicians to monitor trauma-exposed individuals and families who may need more intensive mental health services; and creates a venue to explore trauma and stress management through symbols of healing, artwork, and alternative coping strategies. Services include one-on-one outreach and engagement for adults, and support groups in the Elementary and High School in Albany. Additional one time cultural activities to promote healing through reflection groups and art projects are also conducted throughout the year. This project annually serves approximately 40-55 children/youth and 25-45 adults.

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

Adult Support Groups: This project used to implement outreach and engagement activities and support groups to Latino/Latina/Latinx immigrant adults dealing with trauma issues, who live and work the backstretch of Golden Gate Field's race track as groomers; exercise jockeys and caretakers of the horses.

Over the years this project has migrated to more of a one-on-one engagement project to support individuals in need, with occasional cultural and strength building group activities.

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

PEI Priority: MHSOAC priorities were not required during the timeframe that this project was implemented.

In FY19, 24 individuals received supports through one-on-one engagement sessions. Eleven referrals were provided, 1 to Physical Health services, 3 for Legal services, 1 for Tax Preparation, and 6 to other unspecified supports.

Children/Youth Support Groups: Young children and high school youth experiencing trauma are unlikely to seek services at traditional mental health clinics. Schools are an essential vehicle of treatment for trauma exposed individuals and their families. By aiming psycho-educational interventions for elementary age children and high school youth, it is possible to introduce youth and their families to information about trauma, coping mechanisms, and to combat the isolation that trauma brings.

The purpose of the groups was to reduce at-risk behaviors, reduce a sense of alienation, and increase a sense of belonging among group members. Various psycho-educational techniques were used to achieve these goals, such as improving communication skills, using role modeling and feedback, increasing empathy by encouraging self-disclosure and emotional engagement in the group, and developing trust via positive interactions in the group. The support group program provided information about the effects of trauma, and helpful coping strategies; served a preventive function by offering interventions that will keep at-risk individuals and families from developing serious symptoms and behaviors; provided a forum for clinicians to monitor trauma-exposed individuals and families who may need more intensive mental health services; and created a venue to explore trauma and stress management through symbols of healing, artwork, and alternative coping strategies.

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

Elementary School Support Groups: Through this project, Support Groups were provided to Elementary aged students to reduce children's negative responses to trauma, correct maladaptive beliefs and attributions, and build resilience and reduce anxiety. Student participants were referred from parents, teachers or school staff. Students with experiences of community violence, physical assault, significant separations, witness to domestic or sexual violence, and lack of food, clothing, or shelter were invited to attend groups. As these experiences can lead to the child's regulatory capacity being overwhelmed, his or her daily life behaviors, school performance, attention, self-perception and emotional regulation may all be affected. Support Groups provided psycho-education, coping skills, and a safe environment in which to address and process traumatic experiences.

In FY19, 18 support groups were provided to a total of 10 participants. Each group met for 1-2 hours in duration. There were two referrals for additional mental health services. Fifty-one outreach activities were also conducted. From teacher, school staff, and parental report, outcomes for students participating in support groups were as follows: 60% took a more active role in learning; 90% received increased positive attention from peers; and 80% exhibited less anxiety in the classroom.

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

In FY19, three separate support groups were held at Albany high School. Each group met weekly for 1 hour and continued until the end of the school year. Students were assigned to three groups based on racial or ethnic identity: Latinx, African-American, and Asian-American. This was done in order to help promote connection, identification and group cohesion. Students that participated in the trauma groups at Albany High School were initially recommended by counselors, mental health coordinators, or administrators who believed that these selected students may have experienced trauma in their lives. These students were then interviewed individually to assess and determine if they wished to participate in the groups. Forty-five students were interviewed and assessed for all three groups. Of those 45 students, 32 students attended at least 1 group session, and 22 students continued in group for 6 or more sessions. The initial group meeting was set up specifically as a way to allow prospective members to experience group and to determine if they wanted to participate. After the initial group sessions, students were asked to either commit to attend group for 8 sessions or to opt out. As expected, some students who attended the initial group chose not to participate in the groups, while most students signed up for 8 initial sessions and then continued to attend groups through the remainder of the year. In aggregate, there were a total of 58 individual meetings with students and 63 group sessions. The 45 students served by this program received 422 total contacts, and there were 4 referrals for additional mental health services.

A pre-test questionnaire was administered at the 2nd group meeting, and a post-test questionnaire was administered at the last group meeting. The pre-test was completed by 25 students and the post-test was completed by 19 students. Several group members were unable to complete the post-test due to not being able to attend the final group session. Student responses on the pre-test questionnaire are outlined below:

QUESTIONNAIRE RESULTS N = 25	
QUESTIONS	**PARTICIPANT RESPONSES**
Have you lost someone close to you?	Yes – 64% No – 36%
Have you witnessed violence in your family?	Yes – 52% No – 48%
Have you witnessed violence in your home?	Yes – 7 – 28% No – 18 – 72%
Have you been a victim of violence or abuse?	Yes – 72% No – 28%
If yes, have you spoken to anyone about this?	Yes – 100% No – 0%
Do you feel that you've had the support in your life to cope effectively with the painful things you've experienced?	Rarely – 8% Sometimes – 48% Most of the Time – 44%

Do you use healthy ways to cope with stress in your life?	Never – 4% Rarely – 20% Sometimes – 32% Most of the Time – 44%
Do you use drugs or alcohol to help cope with your feelings, i.e. relax, calm down, quiet your mind, reduce anger, etc.?	Never – 48% Rarely – 20% Sometimes – 24% Most of the Time – 8%
Are there adults at your school who you can talk openly to about personal issues?	Yes – 76% No – 24%

Pre-test results indicated that many of the group members had experienced significant trauma in their lives. Other traumas experienced by group members that were discussed in group included institutionalized racism, unjust police practices, poverty, immigration, parental incarceration, death of a family member, parental substance abuse, mental illness of a parent, and physical/emotional abuse. Student responses on the post-test questionnaire were as follows:

QUESTIONNAIRE RESULTS N = 19	
QUESTIONS or STATEMENTS	**PARTICIPANT RESPONSES**
I felt welcomed into group.	Strongly Disagree – 0% Disagree – 0% Neutral – 0% Agree – 37% Strongly Agree – 63% N/A – 0%
I felt the group was a place I could express my feelings.	Strongly Disagree – 0% Disagree – 0% Neutral – 0% Agree – 53% Strongly Agree – 47% N/A – 0%
I felt supported by other group members.	Strongly Disagree – 0% Disagree – 0% Neutral – 0% Agree – 32% Strongly Agree – 68% N/A – 0%
As a direct result of participating in the group, I feel like I have more support to help me deal with challenges.	Strongly Disagree – 0% Disagree – 0% Neutral – 11% Agree – 63% Strongly Agree – 26% N/A – 0%
As a direct result of participating in the group, I cope with stress in healthier ways.	Strongly Disagree – 0% Disagree – 5% Neutral – 32% Agree – 32% Strongly Agree – 26% N/A – 5%

As a direct result of participating in the group, I have reduced the use of drugs and/or alcohol to cope with difficult feelings.	Strongly Disagree – 0% Disagree – 5% Neutral – 11% Agree – 21% Strongly Agree – 5% N/A – 58%
As a direct result of participating in the group, I would consider seeking help from a mental health professional in the future for a personal problem that was really bothering me.	Strongly Disagree – 0% Disagree – 5% Neutral – 32% Agree – 11% Strongly Agree – 26% N/A – 26%
Would you recommend this group to a friend?	Yes – 100% No – 0%

Post-test results suggested that all group members reported a positive experience in the support groups. All students who completed the post-test responded that they felt welcomed into the group, felt that the group was a place where they could express their feelings, and felt supported by the other group members. Additionally, all students who completed the post-test responded "Yes" to the question, "Would you recommend this group to a friend?" Group members also reported significant improvements in various metrics related to their coping skills as outlined below:

- 89% felt more supported in dealing with challenges;
- 72% indicated that they coped with stress in healthier ways;
- 63% reported a reduction in their use of drugs and alcohol to cope with difficult feelings;
- 71% expressed willingness to seek help from a mental health professional in the future.

The sole adverse finding from the post-test results was related to school truancy. Among the 19 students who participated in support group sessions, school truancy increased by 90% between the FY18 academic year (31 unexcused absences) to the FY19 academic year (59 unexcused absences). According to the AUSD program report, several factors may account for this surprising finding. First, the groups were disproportionally comprised of seniors (16 of the 19 students), many of whom spoke repeatedly in group about their "senioritis" and corresponding lack of motivation to attend school. Additionally, a small number of students (4) accounted for 31 of the 59 unexcused absences for the current school year. The truancy of these 4 students – which resulted from a complicated series of factors (e.g., adverse changes in one student's home environment; a bout of clinical depression for another student) – likely skewed the overall data. If the attendance numbers of these 4 students were removed from the analyses, the difference in school truancy between the FY18 academic year (20 unexcused absences) and the FY19 academic year (28 unexcused absences) would be much less pronounced.

Among all services conducted for children, youth and Adults through the Albany Trauma Project, a total of 79 individuals were served. Demographics on individuals served were as follows:

DEMOGRAPHICS N=79	
Age Group	
0-15	13%
16-25	58%

26-59	20%
60+	9%
Race	
Asian	20%
Black or African American	15%
Native Hawaiian or other Pacific Islander	1%
White	32%
Other	24%
More than one race	8%
Ethnicity: Hispanic or Latino	
Central American	6%
Mexican/Mexican-American/Chicano	44%
South American	3%
Ethnicity: Non-Hispanic or Non-Latino	
African	14%
Asian Indian/South Asian	5%
Chinese	4%
European	1%
Filipino	6%
Japanese	1%
More than one ethnicity	8%
Other	3%
Declined to Answer (or Unknown)	5%
Primary Language Used	
English	72%
Spanish	28%
Sexual Orientation	
Gay or Lesbian	3%
Heterosexual or Straight	57%
Bisexual	3%
Declined to Answer (or Unknown)	37%
Disability	
Difficulty Seeing	1%

Mental (not mental health)	1%
Physical/Mobility Disability	1%
No Disability	42%
Veterans Status	
No	100%
Gender: Assigned sex at birth	
Male	61%
Female	39%
Current Gender Identity	
Male	61%
Female	39%

In FY20, 18 individuals received supports through one-on-one engagement sessions. Services were not able to continue between March and June due to the pandemic. Nine Elementary School Support Groups served a total of 10 participants. Each group met for 1-2 hours in duration. There were seven referrals for additional mental health services, four for Social Services, and one referral to an unspecified service. Thirty-five outreach activities were also conducted. School ended abruptly in mid-March in response to the pandemic. Students who had participated in individual counseling continued to receive weekly services over Zoom. Twenty-nine support group sessions were held at Albany high School, and served a total of 29 students. Students were assigned to three groups based on racial or ethnic identity: Latinx, African-American, and Asian-American. This was done in order to help promote connection, identification and group cohesion. Students that participated in the trauma groups at Albany High School were initially recommended by counselors, mental health coordinators, or administrators who believed that these selected students may have experienced trauma in their lives. These students were then interviewed individually to assess and determine if they wished to participate in the groups. Each group met weekly for one hour, and were able to continue by Zoom when schools were abruptly closed in March due to the pandemic.

Among all services conducted for children, youth, adults and older adults through the Albany Trauma Project, a total of 65 individuals were served. Demographics on individuals served were as follows:

DEMOGRAPHICS N=65*			
Age Group	Golden Gate Fields Racetrack Supports	Elementary Support Groups	High School Support Groups
Percent of total participants served	28%	15%	57%
0-15		90%	
16-25	6%	10%	100%
26-59	56%		

60+	39%		
Race			
Asian	6%		24%
Black or African American		50%	27%
White	56%	20%	41%
Other	39%	30%	
More than one Race			8%
Ethnicity: Hispanic or Latino/Latina/Latinx	Golden Gate Fields Racetrack Supports	Elementary School Support Groups	High School Support Groups
Mexican/Mexican-American/Chicano	94%	10%	32%
Central American			3%
Puerto Rican		10%	5%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx			
Asian Indian/South Asian		10%	3%
Chinese			14%
Filipino	6%		5%
Japanese			3%
More than one Ethnicity			35%
Declined to Answer (or Unknown)		70%	
Primary Language Used			
English	17%	100%	100%
Spanish	83%		
Sexual Orientation			
Gay or Lesbian			3%
Heterosexual or Straight	100%	100%	95%
Bisexual			3%
Disability			
Other Disability	22%		
No Disability	78%	30%	100%
Declined to Answer (or Unknown)		70%	

Veterans Status			
No	100%	100%	100%
Gender: Assigned sex at birth			
Male	83%	50%	51%
Female	17%	50%	49%
Current Gender Identity			
Male	83%	50%	51%
Female	17%	50%	49%

*Percentages may not add up to 100% due to rounding.

In FY21 this project was discontinued as Albany services began to be funded through Alameda County MHSA Funds. Beginning in FY22, Trauma Support Services for the Latinx population in Berkeley began to be provided through the East Bay Sanctuary Covenant, who were chosen through a competitive Request For Proposal (RFP) process.

Latinx Trauma Support Project

In FY22, following a competitive Request For Proposal (RFP) process, East Bay Sanctuary Covenant began implementing the Latinx Trauma Support Project. This 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 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;
- Youth Engagement and Outreach Strategies that target secondary school and transition age youth.
- Strategies targeting the mental health needs of older adults.

As this project was not in operation in FY21, future MHSA Three Year Plans and Annual Updates will include a reporting on program data and activities.

Transition Age Youth Trauma Support Project

Implemented through the Covenant House, Youth Engagement Advocacy Housing (YEAH!) program through FY21, 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;
- Youth engagement and outreach strategies that target secondary school and transition age youth.

In FY19, 142 TAY participated in one or more project services over the year. Support Group sessions included: Harm Reduction and Substance Use; Mindfulness; Coping Skills; Creative Expression, among others. Twelve Youth Social Outings included 48 TAY participants, and 123 TAY, participated in 21 Youth Celebratory Events. Demographics on youth served were as follows:

DEMOGRAPHICS N = 142	
Age Group	
16-25 (Transition Age Youth)	100%
Race	
Asian	1%
Black or African American	46%
Native Hawaiian or Other Pacific Islander	1%
White	33%
Other	4%
More than one Race	13%
Decline to State (or Unknown)	2%
Latino Ethnicity	
Central American	16%
Mexican/Mexican-American	74%
South American	10%
Ethnicity: Non-Hispanic or Non-Latino	
African	34%
Asian Indian/South Asian	1%
Eastern European	6%

European	14%
Filipino	2%
More than one Ethnicity	14%
Other	1%
Declined to Answer (or Unknown)	28%
Primary Language Used	
English	91%
Spanish	8%
Other	1%
Sexual Orientation	
Gay or Lesbian	14%
Heterosexual or Straight	48%
Bisexual	8%
Questioning or Unsure	4%
Queer	1%
Decline to State	25%
Disability	
Difficulty Hearing or Having Speech Understood	1%
Mental (not mental health)	33%
Physical/Mobility Disability	5%
Chronic Health Condition	5%
Other Disability	44%
No Disability	11%
Decline to State	1%
Difficulty Hearing or Having Speech Understood	1%
Veteran Status	
No	100%
Gender: Assigned sex at Birth	
Male	58%
Female	42%
Gender Identity	
Male	50%
Female	36%

Transgender	9%
Genderqueer	1%
Other	4%

During the reporting timeframe 246 outreach activities were conducted, with 4,930 duplicated contacts. There were 405 referrals for additional services and supports. The number and type of referrals were as follows: 68 Mental Health; 71 Physical Health; 116 Social Services; 49 Housing; 101 other unspecified services. A total of 23% of project participants received individual counseling; 20% exited the project into stable housing; and 24% obtained employment or entered school during the project. Per participant feedback, 83% reported being satisfied with project services.

In FY20, 96 TAY participated in one or more project services. Services were continued during the pandemic through tele-health and tele-conferencing platforms. A total of 96 TAY participated in support groups over the year. Support Group sessions included: Harm Reduction and Substance Use; Mindfulness; Coping Skills; Creative Expression, among others. There was a total of 24 Youth Social Outings with 68 unduplicated TAY participants, and 82 unduplicated TAY, participated in 24 Youth Celebratory Events. Demographics on youth served were as follows:

DEMOGRAPHICS N = 96*	
Age Group	
16-25 (Transition Age Youth)	100%
Race	
American Indian or Alaska Native	5%
Asian	1%
Black or African American	46%
Native Hawaiian or Other Pacific Islander	4%
White	28%
More than one Race	15%
Decline to Answer (or Unknown)	1%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Central American	5%
Mexican/Mexican-American	15%
South American	1%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	35%

Asian Indian/South Asian	1%
Chinese	1%
Eastern European	5%
European	15%
Filipino	3%
More than one Ethnicity	17%
Declined to Answer (or Unknown)	2%
Primary Language Used	
English	86%
Spanish	14%
Sexual Orientation	
Gay or Lesbian	8%
Heterosexual or Straight	81%
Bisexual	10%
Disability	
Mental (not mental health)	50%
Chronic Health Condition	11%
Other Disability	20%
No Disability	16%
Decline to Answer (or Unknown)	3%
Veteran Status	
Yes	1%
No	99%
Gender: Assigned sex at Birth	
Male	33%
Female	26%
Decline to Answer (or Unknown)	41%
Gender Identity	
Male	59%
Female	36%
Transgender	2%
Other	2%

*Percentages may not add up to 100% due to rounding.

During the reporting timeframe 1,615 outreach activities were conducted, with 2,351 duplicated contacts. There were 423 referrals for additional services and supports. The number and type of referrals were as follows: 77 Mental Health; 102 Physical Health; 88 Social Services; 76 Housing; 80 other unspecified services. A total of 46% participants received individual counseling; 29% exited the project into stable housing; and 39% obtained employment or entered school during the project. Per participant feedback, 100% reported being satisfied with project services.

In FY21, 150 TAY participated in one or more project services. Services were continued during the pandemic through tele-health and tele-conferencing platforms. Support Group sessions included: Harm Reduction and Substance Use; Mindfulness; Coping Skills; Creative Expression, among others. There was a total of 9 Youth Social Outings with 37 unduplicated TAY participants, and 68 unduplicated TAY, participated in 18 Youth Celebratory Events. Demographics on youth served were as follows:

DEMOGRAPHICS N = 150	
Age Group	
16-25 (Transition Age Youth)	100%
Race	
American Indian or Alaska Native	3%
Asian	3%
Black or African American	57%
Native Hawaiian or Other Pacific Islander	1%
White	15%
More than one Race	15%
Other	3%
Decline to Answer (or Unknown)	3%
Ethnicity: Latino/Latina/Latinx	
Central American	14%
Mexican/Mexican-American	9%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	19%
Asian Indian/South Asian	1%
European	4%
Filipino	1%
Japanese	1%

More than one Ethnicity	21%
Other	29%
Declined to Answer (or Unknown)	1%
Primary Language Used	
English	89%
Spanish	11%
Sexual Orientation	
Gay or Lesbian	6%
Heterosexual or Straight	47%
Bisexual	12%
Questioning or unsure	4%
Other	20%
Declined to Answer (or Unknown)	11%
Disability Status	
Mental (not mental health)	15%
Physical/Mobility Disability	4%
Chronic Health Condition	3%
Other Disability	31%
No Disability	35%
Declined to Answer (or Unknown)	12%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	61%
Female	39%
Current Gender Identity	
Male	60%
Female	37%
Transgender	3%

During the reporting timeframe 2,510 outreach activities were conducted. There were 493 referrals for additional services and supports. The number and type of referrals were as follows: 112 Mental Health; 104 Physical Health; 87 Social Services; 76 Housing; 114 other unspecified services. A total of 25% of project participants received individual counseling; 24% exited the project into stable housing; and 53% obtained

employment or entered school during the project. Per participant feedback, 79% reported being satisfied with project services.

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;
- Strategies targeting the mental health needs of older adults.

In FY19, 52 Living Well workshops 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 118 Senior Citizens participated in the Living Well Workshops. Demographics of Workshop participants are outlined below:

DEMOGRAPHICS N=118	
Age Groups	
26-59 (Adult)	4%
Age 60+ (Older Adult)	94%
Declined to Answer (or Unknown)	4%
Race	
Asian	6%
Black or African American	46%
Native Hawaiian or Pacific Islander	1%
White	35%
Other	3%

Ethnicity: Hispanic or Latino/Latina/Latinx	
Caribbean	2%
Central American	2%
Mexican/Mexican-American/Chicano	7%
Declined to Answer (or Unknown)	89%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	20%
Chinese	3%
European	8%
Filipino	3%
Japanese	1%
Other	3%
Declined to Answer(or Unknown)	62%
Primary Language Used	
English	90%
Spanish	2%
Other	1%
Declined to Answer (or Unknown)	62%
Sexual Orientation	
Gay or Lesbian	3%
Heterosexual or Straight	75%
Other	1%
Declined to Answer (or Unknown)	21%
Disability	
Difficulty seeing	5%
Difficulty hearing or Having Speech Understood	10%
Mental (not mental health)	5%
Physical/mobility disability	12%
Chronic health condition	15%
No Disability	11%
Declined to Answer (or Unknown)	42%

Veteran Status	
Yes	2%
No	95%
Declined to Answer (or Unknown)	3%
Gender: Assigned Sex at Birth	
Male	20%
Female	77%
Declined to Answer (or Unknown)	3%
Current Gender Identity	
Male	20%
Female	76%
Transgender	1%
Declined to Answer (or Unknown)	4%

During the reporting timeframe 16 outreach and informational events were conducted reaching 317 individuals, with 249 individuals receiving further engagement services. There were 640 referrals for additional services and supports. The number and type of referrals were as follows: 121 Mental Health; 137 Physical Health; 109 Social Services; 101 Housing; 172 other unspecified services. A total of 39% of project participants completed a Living Well Workshop Series. The workshop series received very positive feedback per participant self-report. Project participants reported 100% on all of the measures outlined below: feeling satisfied with the workshops; improvement in feeling satisfied in general; increased feeling of social supports; preparedness to make positive changes; and feeling less overwhelmed and helpless.

In FY20, 63 Living Well workshops 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 59 Senior Citizens participated in the Living Well Workshops. Demographics of Workshop participants are outlined below:

DEMOGRAPHICS N=59*	
Age Groups	
26-59 (Adult)	2%
Age 60+ (Older Adult)	97%
Declined to Answer (or Unknown)	1%

Race	
American Indian or Alaska Native	2%
Asian	5%
Black or African American	54%
White	29%
Other	2%
More than one Race	5%
Declined to Answer (or Unknown)	3%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	32%
Asian Indian/South Asian	2%
Chinese	2%
European	19%
Filipino	2%
Middle Eastern	3%
More than one Ethnicity	2%
Other	12%
Declined to Answer(or Unknown)	27%
Primary Language Used	
English	92%
Other	3%
Declined to Answer (or Unknown)	5%
Sexual Orientation	
Gay or Lesbian	2%
Heterosexual or Straight	68%
Bisexual	2%
Declined to Answer (or Unknown)	29%
Disability	
Difficulty seeing	5%
Difficulty hearing or Having Speech Understood	8%
Mental (not mental health)	5%
Physical/mobility disability	14%

Chronic health condition	22%
No Disability	31%
Declined to Answer (or Unknown)	15%
Veteran Status	
Yes	2%
No	95%
Declined to Answer (or Unknown)	3%
Gender: Assigned Sex at Birth	
Male	14%
Female	83%
Declined to Answer (or Unknown)	3%
Current Gender Identity	
Male	14%
Female	71%
Declined to Answer (or Unknown)	15%

*Percentages may not add up to 100% due to rounding.

During the reporting timeframe 5 outreach and informational events were conducted reaching 84 individuals, with 235 individuals receiving further engagement services. Services were moved to virtual format providing tele-workshops and tele-support services to accommodate the pandemic. There were 653 referrals for additional services and supports. The number and type of referrals was as follows: 115 Mental Health; 147 Physical Health; 112 Social Services; 58 Housing; 221 other unspecified services. A total of 39% 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;
- 98% indicated an improvement in feeling satisfied in general;
- 98% had increased feelings of social supports;
- 100% felt prepared to make positive changes; and
- 88% reported they felt less overwhelmed and helpless.

In FY21, 49 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 25 Senior Citizens participated in the Living Well Workshops. Demographics of Workshop participants are outlined below:

DEMOGRAPHICS N=25	
Age Groups	
26-59 (Adult)	16%
Age 60+ (Older Adult)	84%
Race	
Asian	4%
Black or African American	56%
White	28%
Other	12%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Caribbean	4%
South American	4%
Other	8%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	36%
Eastern European	8%
European	20%
Filipino	4%
More than one Ethnicity	4%
Other	12%
Primary Language Used	
English	96%
Spanish	4%
Sexual Orientation	
Gay or Lesbian	4%
Heterosexual or Straight	76%
Bisexual	8%
Other	4%
Declined to Answer (or Unknown)	8%
Disability	

Physical/mobility disability	24%
Chronic health condition	24%
Other Disability	16%
No Disability	28%
Declined to Answer (or Unknown)	8%
Veteran Status	
Yes	4%
No	96%
Gender: Assigned Sex at Birth	
Male	16%
Female	84%
Current Gender Identity	
Male	16%
Female	80%
Other	4%

During the reporting timeframe 2 outreach and informational events were conducted reaching 12 individuals, with 93 unduplicated individuals receiving further engagement services. Services were moved to virtual format providing tele-workshops and tele-support services to accommodate the pandemic. There were 595 referrals for additional services and supports. The number and type of referrals was as follows: 60 Mental Health; 102 Physical Health; 106 Social Services; 48 Housing; 279 other unspecified services. A total of 88% of project participants completed a Living Well Workshop Series. Feedback per participant self-report was as follows:

- 91% reported they felt satisfied with the workshops;
- 91% indicated an improvement in feeling satisfied in general;
- 91% had increased feelings of social supports;
- 91% felt prepared to make positive changes; and
- 88% reported they felt less overwhelmed and helpless.

Projecct Successes**:**

To help seniors stay connected 96 tele-support group sessions were held. Living Well Project virtual/tele-workshops were offered every Monday and tele-support groups were held every Tuesday. In December, laptops and technical training were provided to previous participants and also in May to participants who completed The Living Well Workshop Series.

Project Challenges:

The workshops were well attended with lively engagement. Some Living Well participants gave painful testimonies of isolation, sadness and fear and others of loneliness. Many missed their families, their grandchildren, and friends. Some needed 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 seniors had difficulties connecting with others due to the technological gap. The Workshop Series facilitator also had to learn systems she never had to use before.

Harnessing Hope Project

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

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

PEI Priority: MHSOAC priorities were not required during the timeframe that this project was implemented.

In FY19, 29 individuals were served through this project. Demographics on individuals served were as follows:

DEMOGRAPHICS N=29	
Age Groups	
0-15 (Children/Youth)	3%
16-25 (Transition Age Youth)	17%
26-59 (Adult)	69%
Ages 60+ (Older Adult)	11%
Race	
American Indian or Alaska Native	3%
Black or African American	38%
White	7%
Other	14%
More than one Race	28%
Declined to Answer (or Unknown)	10%

Ethnicity: Hispanic or Latino	
Carribean	4%
Mexican/Mexican-American/Chicano	7%
Other	3%
Declined to Answer (or Unknown)	3%
Ethnicity: Non-Hispanic or Non-Latino	
African	3%
Asian Indian/South Asian	7%
More than one Ethnicity	10%
Other	10%
Declined to Answer (or Unknown)	52%
Primary Language Used	
English	86%
Spanish	10%
Other	4%
Sexual Orientation	
Heterosexual or Straight	62%
Queer	3%
Other	10%
Declined to Answer (or Unknown)	25%
Disability	
Chronic Heart Condition	7%
Other Disability	3%
No Disability	62%
Declined to Answer (or Unknown)	28%
Veteran Status	
No	55%
Declined to Answer (or Unknown)	45%
Gender: Assigned Sex at Birth	
Male	28%
Female	62%
Declined to Answer (or Unknown)	10%

Current Gender Identity	
Male	28%
Female	62%
Genderqueer	3%
Declined to Answer (or Unknown)	7%

During the reporting timeframe 8 outreach presentations were conducted reaching 58 individuals, 29 of whom received supportive engagement services. Five facilitators were also trained. Primary services included psycho-education and promotion of mental health through one-on-one and telephone engagement, networking supports, and referrals. One Just Like Sunday Dinner group was held for 15 participants. There were 25 referrals for additional services and supports. The number and type of referrals were as follows: 6 Mental Health; 1 Physical Health; 2 Social Services; 2 Housing; and 14 other unspecified services. Lower numbers this year were due to a variety of staffing, and unforeseen programmatic constraints.

On a Satisfaction Survey that was conducted, project participants reported 100% on all of the following measures: Felt respected; would return if they or their family member needed help; experienced increased awareness of community services and supports; and improved their skills in coping with challenges.

In FY20, 22 individuals were served through this project. Demographics on individuals served were as follows:

DEMOGRAPHICS N=22*	
Age Groups	
0-15 (Children/Youth)	4%
16-25 (Transition Age Youth)	18%
26-59 (Adult)	73%
Ages 60+ (Older Adult)	5%
Race	
Asian	14%
Black or African American	82%
Other	5%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	77%
Asian Indian/South Asian	9%
Vietnamese	5%

More than one Ethnicity	5%
Declined to Answer (or Unknown)	5%
Primary Language Used	
English	100%
Sexual Orientation	
Heterosexual or Straight	95%
Questioning or Unsure	5%
Disability	
Chronic Health Condition	18%
No Disability	82%
Veteran Status	
No	100%
Gender: Assigned Sex at Birth	
Female	100%
Current Gender Identity	
Female	100%

*Percentages may not add up to 100% due to rounding.

During the reporting timeframe 9 outreach presentations were conducted reaching 63 individuals, 16 of whom received supportive engagement services. Primary services included psycho-education and promotion of mental health through one-on-one and telephone engagement, networking supports, and referrals. Some services were able to continue during the pandemic, through phone and tele-conferencing. During the reporting timeframe the Training of Trainers and Just like Sunday Dinners were not able to be held. There were 20 referrals for additional services and supports. The number and type of referrals were as follows: 8 Mental Health; 4 Social Services; 3 Housing; 5 other unspecified services.

On a Satisfaction Survey that was conducted, program participants reported the following:

- 100% Felt respected;
- 95% indicated they would return if they or their family member needed help;
- 82% experienced increased awareness of community services and supports; and
- 95% improved their skills in coping with challenges.

In FY21, MHSA funded services did not continue with GOALS, as the program was no longer in operation. A Request For Proposal (RFP) process was executed in April 2021 for these services. In FY22, the SoulSpace project was implemented for African Americans in Berkeley.

SoulSpace Project

In FY22, following a competitive Request For Proposal (RFP) process, OnTrack Program Resources began implementing the SoulSpace Project for African Americans in Berkeley. This project assists African Americans in accessing culturally, ethnically, and linguistically responsive and trauma-informed prevention and early intervention services. Project services include: community education; outreach and engagement; assessment; coaching; 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;
- Youth Engagement and Outreach Strategies that target secondary school and transition age youth.
- Strategies targeting the mental health needs of older adults.

As this project was not in operation in FY21, future MHSA Three Year Plans and Annual Updates will include a reporting on the data and activities.

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;
- Youth Engagement and Outreach Strategies that target secondary school and transition age youth.
- Strategies targeting the mental health needs of older adults.

In FY19, 40 outreach activities reached approximately 1,572 duplicated individuals. Outreach was provided at various locations including Street Fairs, Community Agencies, and area events. Through 15 Peer Support groups, 446 weekly or bi-weekly sessions were conducted which were all led by a trained facilitator. Peer Support Groups were as follows: Female to Male; Women Coming Out of Straight Marriage; Married/Once Married Gay/Bisexual Men's Group; Queer Femmes; Transgender Support Group; Lesbian & Queer Women of Color; Partners of Trans and Gender Non-Conforming Folk; Middle Eastern Femmes; Senior Gay Men's Group; Bi-sexual Women; Primetime Men (40's-50's); LezBold (old lesbians); Wicked Transcendent Folk; R.E.A.L. Queer (TAY), and QPAD – for Queer Men in their 20's and 30's. A total of 168 individuals participated in support groups throughout the year. Demographics on individuals served include the following:

DEMOGRAPHICS N=168	
Age Groups	
16-25 (Transition Age Youth)	32%
26-59 (Adult)	54%
Ages 60+ (Older Adult)	13%
Declined to Answer (or Unknown)	1%
Race	
American Indian or Alaska Native	2%
Asian	8%
Black or African American	4%
Native Hawaiian or Other Pacific Islander	63%
White	1%
More than one race	16%
American Indian or Alaska Native	2%
Asian	8%
Black or African American	4%
Native Hawaiian or Other Pacific Islander	63%
Declined to Answer (or Unknown)	6%

Ethnicity: Hispanic or Latino	
Caribbean	8%
Central American	21%
Mexican/Mexican-American/Chicano	38%
Puerto Rican	13%
South American	8%
Other	8%
Declined to Answer (or Unknown)	4%
Caribbean	8%
Central American	21%
Ethnicity: Non-Hispanic or Non-Latino	
African	4%
Asian Indian/South Asian	3%
Chinese	3%
Eastern European	10%
European	26%
Filipino	3%
Japanese	1%
Korean	1%
Middle Eastern	4%
Vietnamese	1%
African	4%
Asian Indian/South Asian	3%
More than one Ethnicity	12%
Other	4%
Declined to Answer (or Unknown)	28%
Primary Language Used	
English	96%
Spanish	1%
Mandarin	1%
Other	1%
Declined to Answer (or Unknown)	1%
Sexual Orientation	
Gay or Lesbian	24%
Heterosexual or Straight	4%
Bisexual	20%
Questioning or Unsure	5%
Queer	27%

Other	15%
Declined to Answer (or Unknown)	5%
Disability	
Difficulty Hearing or Having Speech Understood	2%
Mental (not Mental Health)	6%
Physical/Mobility Disability	3%
Chronic Health Condition	6%
Other Disability	2%
No Disability	80%
Declined to Answer (or Unknown)	1%
Veteran Status	
Yes	5%
No	91%
Declined to Answer (or Unknown)	4%
Gender: Assigned Sex at Birth	
Male	24%
Female	36%
Declined to Answer (or Unknown)	40%
Current Gender Identity	
Male	18%
Female	32%
Transgender	9%
Genderqueer	11%
Questioning or Unsure	8%
Other	18%
Declined to Answer (or Unknown)	4%

During the reporting timeframe 16 new Peer Facilitators were trained, 98% of whom went on to facilitate peer group sessions. The offering of Skills Building Workshops was expanded to include trainings on: Nonviolent Communication; Crisis Intervention; and Implicit Bias as it Relates to Race and workshops were provided to 51 Peer Facilitator participants. There were 221 referrals for additional services and supports. The number and type of referrals was as follows: 50 Mental Health; 17 Physical Health; 13 Social Services; 4 Housing; 137 other unspecified services. To assess the project services, a self-administered Peer Support Group Survey was distributed to all peer group members. A total of 123 Peer Support Group members (or 72%) completed the survey. Survey results were as follows:

- 100% indicated they would recommend the organization to a friend or family member;
- 94% felt like staff and facilitators were sensitive to their cultural background;
- 81% reported they deal more effectively with daily problems;
- 84% indicated they have trusted people they can turn to for help;
- 87% felt like they belong in their community.

A vast majority of individuals who completed the survey reported having improved social connections and community-building, and a deep gratitude for a safe environment to freely express and explore their authentic self.

In FY20, 11 outreach activities reached approximately 835 duplicated individuals. Through 19 Peer Support groups, weekly or bi-weekly sessions were conducted which were all led by a trained facilitator. While some of the long time running Peer Support Groups continued, a few were discontinued and the following five new groups were added: Queer Crips United - for people who live at the intersection of LGBTQ!A+ and Disability; Thursday Night Men's Group for gay, bisexual, transgender and cisgender men; Parents and Caregivers of Trans Tweens; Parents and Caregivers of Trans Youth of all ages; and Love Letter- for Black Indigenous and People of Color (BIPOC) Women of Color. A total of 151 individuals participated in support groups throughout the year. Demographics on individuals served include the following:

DEMOGRAPHICS N=151*	
Age Groups	
16-25 (Transition Age Youth)	28%
26-59 (Adult)	41%
Ages 60+ (Older Adult)	26%
Declined to Answer (or Unknown)	4%
Race	
American Indian or Alaska Native	1%
Asian	11%
Black or African American	6%
White	57%
Other	3%
More than one Race	12%
Declined to Answer (or Unknown)	11%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Caribbean	1%
Central American	2%
Mexican/Mexican-American/Chicano	5%
Puerto Rican	1%
South American	1%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	3%
Asian Indian/South Asian	3%

Chinese	6%
Eastern European	10%
European	27%
Filipino	1%
Japanese	1%
Korean	1%
Middle Eastern	4%
Vietnamese	1%
More than one Ethnicity	7%
Other	2%
Declined to Answer (or Unknown)	24%
Primary Language Used	
English	98%
Spanish	1%
Mandarin	1%
Sexual Orientation	
Gay or Lesbian	23%
Heterosexual or Straight	7%
Bisexual	25%
Questioning or Unsure	2%
Queer	25%
Other	17%
Declined to Answer (or Unknown)	3%
Disability	
Difficulty Seeing	2%
Difficulty Hearing or Having Speech Understood	6%
Mental (not Mental Health)	8%
Physical/Mobility Disability	6%
Chronic Health Condition	9%
Other Disability	1%
No Disability	64%
Declined to Answer (or Unknown)	4%

Veteran Status	
Yes	1%
No	99%
Gender: Assigned Sex at Birth	
Male	26%
Female	50%
Declined to Answer (or Unknown)	24%
Current Gender Identity	
Male	12%
Female	34%
Transgender	27%
Genderqueer	8%
Questioning or Unsure	3%
Other	13%
Declined to Answer (or Unknown)	4%

*Percentages may not add up to 100% due to rounding.

During the reporting timeframe 25 new Peer Facilitators were trained. The offering of Skills Building Workshops that included trainings on: Nonviolent Communication; Crisis Intervention; and Implicit Bias as it Relates to Race and workshops were provided to 57 Peer Facilitator participants. Services were adjusted to accommodate for the pandemic and support group and other services were able to continue virtually on the Zoom platform. There were 93 referrals for additional services and supports. The number and type of referrals was as follows: 45 Mental Health; 11 Physical Health; 3 Housing; 34 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;
- 88% felt like staff and facilitators were sensitive to their cultural background;
- 84% reported they deal more effectively with daily problems;
- 76% indicated they have trusted people they can turn to for help;
- 76% felt like they belong in their community.

Per contractor report, they received complaints from Queer and Trans, Black, Indigenous and People of Color (QTBIPOC) group members regarding their difficulties bringing their full selves (all of their identity markers, including race, ethnicity) to groups, citing examples of micro-aggressions. To mitigate this lack of safety, listening sessions were held. Plans were put in place to train new QTBIPOC facilitators, develop new required group agreements and trainings, and implement a QTBIPOC Support Group.

In FY21, 12 outreach activities reached approximately 155 individuals. A total of 480 support groups were conducted. Through 20 Peer Support groups, weekly or bi-weekly sessions were conducted which were all led by a trained facilitator on Zoom. All of the long time running peer groups were offered and one new

group was added. A total of 69 individuals participated in support groups throughout the year. Demographics on individuals served included the following:

DEMOGRAPHICS N=151*	
Age Groups	
16-25 (Transition Age Youth)	26%
26-59 (Adult)	46%
Ages 60+ (Older Adult)	20%
Declined to Answer (or Unknown)	8%
Race	
American Indian or Alaska Native	4%
Asian	13%
Black or African American	6%
Native Hawaiian or Pacific Islander	1%
White	41%
More than one Race	14%
Declined to Answer (or Unknown)	21%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Caribbean	1%
Central American	1%
Mexican/Mexican-American/Chicano	1%
South American	1%
Declined to Answer (or Unknown)	4%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	4%
Asian Indian/South Asian	3%
Chinese	7%
Eastern European	6%
European	43%
Filipino	1%
Korean	1%
Vietnamese	1%
More than one Ethnicity	16%

Other	1%
Declined to Answer (or Unknown)	9%
Primary Language Used	
English	100%
Sexual Orientation	
Gay or Lesbian	25%
Heterosexual or Straight	6%
Bisexual	12%
Questioning or Unsure	3%
Queer	22%
Other	29%
Declined to Answer (or Unknown)	3%
Disability	
Difficulty Seeing	1%
Difficulty Hearing or Having Speech Understood	3%
Mental (not Mental Health)	4%
Physical/Mobility Disability	6%
Chronic Health Condition	14%
No Disability	36%
Declined to Answer (or Unknown)	36%
Veteran Status	
Yes	1%
No	99%
Gender: Assigned Sex at Birth	
Male	30%
Female	36%
Declined to Answer (or Unknown)	34%
Current Gender Identity	
Male	6%
Female	23%
Transgender	33%
Genderqueer	9%
Questioning or Unsure	4%

Other	23%
Declined to Answer (or Unknown)	2%

During the reporting timeframe 38 Peer Facilitators were trained. The offering of Skills Building Workshops that included trainings on Intersectionality; Disability, Justice and Accessibility; and Micro-aggressions were provided to 38 Peer Facilitator participants. Services were adjusted to accommodate for the pandemic and support group and other services were able to continue virtually on the Zoom platform. There were 91 referrals for additional services and supports. The number and type of referrals was as follows: 51 Mental Health; 7 Physical Health; 7 Social Services; 26 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:

- 93% indicated they would recommend the organization to a friend or family member;
- 79% felt like staff and facilitators were sensitive to their cultural background;
- 93% reported they deal more effectively with daily problems;
- 71% indicated they have trusted people they can turn to for help;
- 86% felt like they belong in their community.

Project Successes:

- Of the 20 peer support groups that were running prior to Shelter-In-Place, 19 groups successfully transitioned to Zoom and flourished on the virtual platform and in addition, 1 new group was launched.
- Staff increased consultation meeting frequency to support the facilitators for a portion of the fiscal year.
- Peer groups gained returning attendees who had moved out of town and who, for a variety of reasons, ie, disability, transportation barriers and child-care and other caregiving needs, were able to attend due to online access.
- Three 6-hour Facilitator Orientation and Trainings were provided to community members welcoming them as trained peer group facilitators.
- Three Diversity, Equity and Inclusion trainings were offered: Intersectionality; Disability, Justice and Accessibility; and Micro-aggressions.
- A Social Work student provided case management and wellness checks to older adults.
- A handful of peer groups requested to hold their meetings throughout the winter break when the agency is typically closed for all services.
- Peer group facilitators were invited to join the white accountability group or the Black, Indigenous and People of Color (BIPOC) affinity group (spaces to discuss various challenges, explore and examine topics relating to privilege and oppression, dynamics of power, etc.) to explore how they show up in relationships for added accountability and support.
- Virtual/online outreach started to pick up by the end of the fiscal year. To make up for the reduction in outreach opportunities, email lists were utilized with community partners and networks and social media platforms, such as Meet-up, Instagram, and Facebook to inform and engage the community.
- A new pilot clinical consultation ‘on-call’ system was offered for facilitators to access a clinician to be invited to their virtual group space as needed should a group member bring mental health concerns and/or behaviors outside of the peer group scope of service. This was utilized twice during the reporting timeframe.

Project Challenges:

- Continual adjustment to being in the virtual space. There was a learning curve for peer group facilitators in navigating the virtual space, for which program staff and fellow peer group facilitators provided support and guidance. Zoom safety tips and guidelines were created to assist the facilitators.
- Some community members, including a few peer group facilitators, were no longer able to attend their peer group when it moved to a virtual space due to a lack of privacy in their home, anxiety when in virtual spaces, or the lack of the necessary equipment and/or sufficient internet connection.
- Since paper forms were adapted to be received digitally, many group members had serious challenges completing and submitting the demographic forms.
- Due to COVID-19, the typical in-person outreach opportunities drastically declined.
- Peer group facilitators expressed concern for their group members' stress level in regards to the anxiety-producing November Presidential election, and the aftermath of the January 6th violent events in Washington DC.

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

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

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

In FY19, a Berkeley High School (BHS) Counselor, led and facilitated weekly MEET trainings throughout the school year for thirteen high school students for the purpose of establishing and implementing a peer-led mental health education curriculum. Weekly trainings prepared MEET students to provide classroom presentations. Seven pairs of MEET students provided a total of twenty-eight psycho-educational

presentations in 9th grade classes. The presentations aimed to reduce mental health stigma, teach coping skills, create awareness about depression and anxiety, and demonstrate to students how to access mental health resources on campus and in the community. A total of 882 students were served. Four encore follow-up presentations were provided to 108 students in the 10th grade. Additional MEET student accomplishments were as follows:

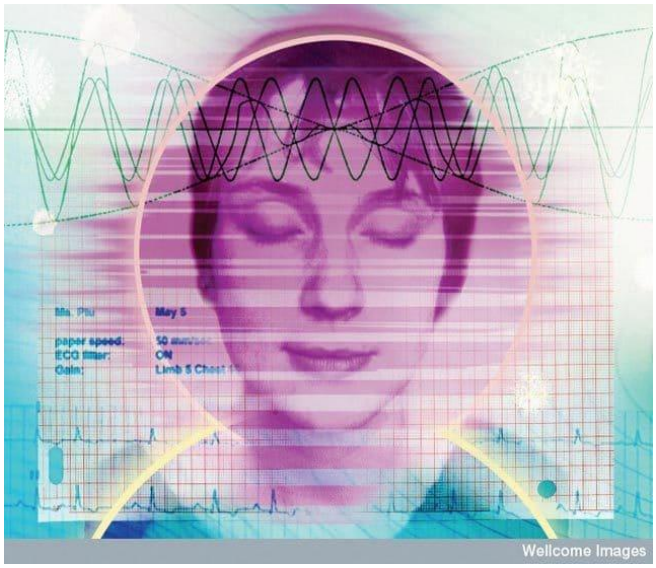
- Provided stress management tips through interactive presentations in ten classrooms, before the 1st semester exams to assist 271 students in increasing stress reduction strategies;
- Assisted in designing surveys to measure students' knowledge before and after the classroom presentations;
- Conducted lunch-time meetings to assist 11 students through peer-to-peer services and supports;
- Distributed 1000 bookmarks with Crisis Services on them to 9th graders and other high school students;
- Assisted in designing mental health survey questions that were used in the school-wide Berkeley High School Student (BHS) Survey;
- Created videos to promote mental health awareness: "MEET Members Speak Out", "Mental Health and Homeless Youth", and "Welcome to the Health Center";
- Assisted in designing a MEET Website with a resources page;
- Created a MEET Instagram account, promoting mental health awareness;
- Participated in the school-run podcast, "The BHS Jacket";
- Attended the BMH MHSA Advisory Committee meeting to voice the need and advocate for increased funding for mental health resources at Berkeley public schools; and
- Hosted a panel discussion to help incoming seniors manage stress.

MEET conducted two surveys to measure learning outcomes of the 9th grade classroom presentations. A pre and post test was conducted. A majority of the 9th graders surveyed improved their scores from pre to post-test. Areas measured were as follows:

1. Knowledge of mental health resources – where to find them
2. Identifying symptoms of anxiety and depression
3. Mental health stigma – willingness to talk about mental health
4. Learning mental health coping strategies
5. How to respond to a mental health crisis, especially suicidal ideation

Program outcomes showed that numerous 9th grade student participants as well as 100% of 9th grade teachers, verbally reported being satisfied with MEET's classroom presentations. The BHS Health Center also reported a correlative increase in student self-referrals after MEET's presentations. Students often arrived at the Health Center holding a Crisis Resource Bookmark, of which MEET distributed. Demographics on the 13 students who were in the MEET program were as follows: 31% Male; 69% Female; 15% African American; 15% Asian; 46% Caucasian; 8% Latinx; 16% mixed race. A total of 1,285 students participated in prevention services offered by MEET. Demographics on student participants were as follows: 16% African American; 19% Asian; 29% Caucasian; 18% Latinx; and 18% were of mixed race or did not specify race or ethnicity. Additional demographics on PEI funded programs at BUSD were provided in aggregate format for the following programs: MEET, Dynamic Mindfulness (DMind), African America Success Project and Supportive Schools. These aggregated demographics for FY19 are provided following the DMind program. In FY20 and FY21 this program was not in operation.

Dynamic Mindfulness Program (DMind)



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

PEI Goals: The goal of this program is to bring about mental health, including the reduction of school failure or dropout 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.
- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

In FY19, planning, design and customization of DMind for each school site was conducted. DMind training for staff was provided, as well as post-training follow-up supports. Niroga Instructors provided in-

classroom DMind instruction. DMind curriculum supports, including the DMind video library was also made available.

According to the DMind program report, specific program outcomes were as follows:

- School Administrators and staff, as well as students, enthusiastically embraced the DMind program;
- Special Education students seemed to especially take to DMind. In addition to other classrooms, 13 Special Education classes were provided with the DMind program:
- The DMind program for chronic absentees led to a 1.8% increase in attendance.

A total of 520 students and 117 staff were served through this program in FY19, as follows:

School	Number of Students Served	Number of Staff Served
Berkeley High School	125	75
Berkeley Technology Academy	28	25
Martin Luther King Middle School	215	6
Williard Middle School	152	11
TOTAL	520	117

Data provided by BUSD for FY19, which combined demographics for the Supportive Schools Project, the MEET Program, and DMind, is outlined below:

DEMOGRAPHICS N= 3,065	
Age Group	
0-15 (Children/Youth)	81%
16-25 (Transition Age Youth)	13%
26-59 (Adult)	6%
Ages 60+ (Older Adult)	<1%
Race	
American Indian or Alaska Native	1%
Asian	11%
Black or African American	19%
Native Hawaiian/Pacific Islander	<1%
White	41%
Other	1%
More than one race	4%
Declined to Answer (or Unknown)	9%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American/Chicano	14%

Primary Language Used	
English	86%
Spanish	7%
Mandarin	1%
Declined to Answer (or Unknown)	6%
Sexual Orientation	
Gay or Lesbian	7%
Heterosexual or Straight	49%
Bisexual	2%
Questioning or unsure of sexual orientation	<1%
Queer	<1%
Declined to Answer (or Unknown)	41%
Disability	
Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)	9%
Physical/mobility domain	<1%
Veteran Status	
Declined to Answer (or Unknown)	100%
Gender: Assigned Sex at Birth	
Male	58%
Female	42%
Current Gender Identity	
Male	54%
Female	39%
Transgender	<1%
Questioning or unsure of gender identity	<1%
Another gender identity (Non-Binary)	<1%
Declined to Answer (or Unknown)	6%

Due to the pandemic, in FY20, all supports were shifted to online in the second half of the school year. 380 students participated in DMind during the reporting timeframe. Demographics on individuals served were not provided by BUSD. In FY21, all supports remained online. Data on individuals served were not provided by BUSD. Per anecdotal evidence from site leadership, the program presents positive use.

African American Success Project

The African American Success Project (AASP) was first implemented in FY19 in four Berkeley Unified School District Schools (King, Longfellow, Willard and Berkeley High School). Closely aligned with the work of Berkeley's 2020 Vision, the AASP works with African American youth and their families to actively engage students in the classroom and school life while creating a pathway for their long-term success. The project implements a three-pronged approach that includes case management and mentorship (which are individualized and tailored to meet each student's needs), community building, and family engagement. Through this approach a case manager engages and works with each student on school success planning. This work includes establishing student check-ins, family connections, teacher and staff collaborations, advocacy, and community building sessions. The project supports students who have disproportionately faced barriers in Berkeley public schools to promote an individual's learning, mental, and socio-emotional well-being. During the first year the project team worked with 84 students and their families while assessing the effectiveness of the project and identifying ways to strengthen the service model. One key finding was that the project could only have limited impact when staff were spread across four school sites.

Following FY19, the project was only going to be implemented at Longfellow. A second key learning was that services could be strengthened if they were integrated into the school day through a class that African American students could elect to take that would provide a safe space to focus on ongoing social and emotional development, skill-building, habits and mindsets that enable self-regulation, interpersonal skills, and perseverance and resilience. The class would be facilitated by a Counselor/Instructor who would follow-up with students in one-on-one counseling sessions on issues of concern that are raised in class and

would provide referrals to mental health services and supports as needed. To support the implementation of this additional component, through the FY20 Annual Update the Division allocated PEI funds to BUSD to support this project.

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

During the FY20 school year students participated/were enrolled in Umoja- a daily elective class offered through the African American Success Project (AASP), 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.

In addition to the opportunities identified above, Umoja provides a unique chance to expose learners to content traditionally overlooked by educational institutions. Umoja course lessons are touted in African and African American cultural percepts, 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:

Umoja seeks to increase entry points for caregivers to be informed and involved in their child's learning. Highlights in this area include:

- Community meetings/engagements (monthly typically).
- Coordinating and hosting Parent teacher conferences.
- Individual parent meetings/contacts, including advising, problem-solving, and updates regarding student progress.
- Coordinating and hosting community events: Kwanzaa Celebration, Black History Month events and activities.

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.

In FY20, 23 students were provided services through this program. Outlined below are demographics on individuals served:

DEMOGRAPHICS N=23	
Age Groups	
Children/Youth (0-15)	100%
Race	
Black or African American	74%
More than one Race	26%
Ethnicity: Hispanic or Latino/Latina/Latinx	
More than one Ethnicity	17%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Black/African American	74%
More than one ethnicity	4%
Other	4%
Declined to Answer (or Unknown)	1%
Primary Language	
English	99%
Other	1%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Other	43%
Veteran Status	
No	100%
Gender: Assigned Sex at Birth	
Male	70%
Female	30%
Current Gender Identity	
Male	70%
Female	30%

In FY21, 63 students participated in this project. Outlined below are demographics on individuals served through this project:

DEMOGRAPHICS N=63	
Age Group	
Children/Youth (0-15)	100%
Race	
Black or African American	68%
More than one Race	11%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Hispanic/Latino/Latina/Latinx	21%
Primary Language	
English	98%
Other	2%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Other	8%
Veteran Status	
No	100%
Gender: Assigned Sex at Birth	
Male	56%
Female	44%
Current Gender Identity	
Male	56%
Female	44%

ACCESS AND LINKAGE TO TREATMENT PROGRAM and COMBINED PROGRAMS

ACCESS & LINKAGE TO TREATMENT PROGRAMS

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.

The City of Berkeley Access & Linkage to Treatment program that was in operation during this reporting timeframe was as follows:

Homeless Outreach and Treatment Team (HOTT)

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

PEI Goals: The goal of this program was 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 Priorities:

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

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

- HOTT was serving as an important resource for the local community and homeless service continuum;
- The program had been very effective in persistent and consistent outreach, especially for chronically homeless individuals with a history of refusing services;
- HOTT met individual where they were, in parks, encampments, motels;
- The program had successfully connected homeless individuals to critical resources and service linkages.

In FY19, 147 individuals were served through this program. Demographics on individuals that received services through this pilot project were as follows:

DEMOGRAPHICS N= 147	
Age Groups	
16-25 (Transition Age Youth)	4%
26-59 (Adult)	41%
Ages 60+ (Older Adult)	14%
Declined to Answer (or Unknown)	41%

Race	
Asian	3%
Black or African American	42%
White	40%
Other	15%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American/Chicano	7%
Ethnicity: Non-Hispanic or Non-Latino	
Non-Hispanic or Non-Latino	8%
Primary Language Used	
Declined to Answer (or Unknown)	100%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
Declined to Answer (or Unknown)	100%
Gender: Assigned Sex at Birth	
Declined to Answer (or Unknown)	100%
Current Gender Identity	
Male	57%
Female	42%
Declined to Answer (or Unknown)	1%

Due to the nature of the many brief interactions attempting to engage with individuals, as well as trying to not put up barriers to bringing them into services, some data wasn't able to be collected in order to best support effective service provision.

The RDA Homeless Outreach and Treatment Team Final Evaluation Report (posted on the City of Berkeley MHSA webpage) covered the timeframe from January 2018 – February 2020, showed the following outcomes:

- A total of 4,435 total encounters were conducted with individuals who were either enrolled or non-enrolled in the program, averaging 171 encounters per month;
- The number of contacts provided in-person in the field was 73%, while 26% were provided by phone;
- A total of 81% of HOTT encounters were with individuals who were enrolled in the program;
- Enrolled individuals had an average of 20 total encounters with HOTT staff, with an average of 4 encounters per month;

- During encounters, HOTT staff provided at least 1,845 material supports and services (including food, transportation or BART or bus passes, Hygiene Kits, Emergency Housing Vouchers, Blankets, etc.); to respond to an individuals immediate and longer-term needs;
- During 488 encounters, HOTT provided emergency or temporary housing vouchers (e.g., for a motel) to individuals who required immediate shelter;
- Approximately three-quarters of enrolled individuals (75%) and over a third of non-enrolled individuals (38%) were referred or connected to housing support services;
- In addition to connecting individuals to housing services, HOTT also connected individuals to other supportive services to help reduce or address initial barriers to obtaining housing;
- Approximately 27% of HOTT participants and 6% of non-enrolled individuals successfully enrolled in social service benefits. In comparison, only 9% of HOTT participants and 1% of non-enrolled individuals ultimately enrolled in mental health services;
- Over 58% of all HOTT participants, and 9% of non-enrolled individuals obtained emergency or temporary housing (e.g., motel or shelter) at some point during their engagement with HOTT. In comparison, 12% of HOTT participants and 1% of non-enrolled individuals obtained permanent housing;
- To assess changes in self-sufficiency, HOTT staff completed a Client Self-Sufficiency Matrix (SSM) on enrolled participants at program intake, on a quarterly basis after program enrollment, and/or at program discharge. Overall, HOTT participants SSM scores remained relatively unchanged from baseline to follow-up.

During interviews that were conducted with several HOTT existing and previous participants regarding their experience with the program, interviewees reported the following:

- "They help people, not just me. I introduce people on the street to them, and I say you can talk to the HOTT team and they will help you."
- "I really didn't expect anything, but when I called the City, they said someone [from HOTT] would meet me right then. They got me a hotel room that day. I wasn't expecting the City to help."
- "They were so helpful. I felt like if I didn't get the hotel room, they would have let me stay at their personal house."

In addition to these interviews, RDA conducted focus groups with HOTT participants during a previous year of the evaluation, and developed brief impact stories based on participant experiences. In one of the impact stories, the individual self-report was as follows:

"I would still be on the streets and probably dead if it wasn't for HOTT. I could have died and no one would have cared. Doctors told me I had months to live and I gave up on living. I gave up on everything for help. No one cared but the HOTT team did care. I'm the type of person that never asks for help, and here they were offering to help and they never gave up on me. I lived on the same spot for six years and never got medical care. They checked up on me and came back multiple times, even though I was turning them away in the beginning. I figured HOTT team was just like the other programs where they would just disappear after the first meeting. But I know the HOTT team is there. And everything the HOTT team said they would do came true. Now I am in hospice care getting the care that I need. I don't know how much longer I have to live, but it's a hell of a lot longer than a couple months which is what the doctors said. This gives me the opportunity to live my life with dignity. The HOTT team provided me with the positive energy just like hospice care that is so needed for people like me."

In FY20, 616 individuals were served through this project. Demographics on individuals that received services through this pilot project were as follows:

DEMOGRAPHICS N= 616	
Age Groups	
16-25 (Transition Age Youth)	2%
26-59 (Adult)	36%
Ages 60+ (Older Adult)	16%
Declined to Answer (or Unknown)	46%
Race	
Asian	4%
Black or African American	36%
White	45%
More than one Race	1%
Other	7%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Hispanic	7%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	100%
Primary Language Used	
Declined to Answer (or Unknown)	100%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
Declined to Answer (or Unknown)	100%
Gender: Assigned Sex at Birth	
Male	61%
Female	37%
Declined to Answer (or Unknown)	2%
Current Gender Identity	
Male	61%

Female	37%
Declined to Answer (or Unknown)	2%

Flex funds were used to provide various supports for HOTT program participants. In FY20, 57 participants were provided hotel stays, and 142 flex funds were used for 46 individuals on the following: 113 food and groceries; 15 transportation; 9 clothing/hygiene; 4 household items; 1 housing.

HOTT, planned as a short term pilot project, was initially slated to wrap up in April of 2020. During the last four months of FY20, the duties of the HOTT team were redirected due to the pandemic and focused on encampment support and response. As discussed in the HOTT final report, the HOTT team provided important community functions: providing flexible and broadly available service to community requests, relatively quick response to unhoused individuals experiencing mental health issues, and broad services to a large number of individuals. The HOTT team linked a large number of individuals to resources, housing, service providers, and short term housing during their pilot.

A result of the COVID-19 pandemic was a shift from many in-person services to telephonic or tele-health. The incidence of the pandemic changed the face of services and resources throughout the landscape, including systems of care and access to them. The data used for the final HOTT report, for example, was truncated due to the unavailability of consistent information and the redirection of services as dictated by the City of Berkeley and its Emergency Operations Center. Similarly, data gathered after February 2020 is likely less reflective of the services as planned, but more in the emergency response and shift of focus to emergency support of vulnerable communities and individuals. Maintaining regular staffing was also difficult in this pilot. Since the positions were temporary project based appointments, any staff who were hired for this team did not have job security with the City of Berkeley unless they transferred with a pre-existing permanent career status. This resulted in the exit of two staff during this time period who found other employment.

HOTT continued to be in operation until March 2021, when the Homeless Full Service Partnership was fully operational. As the program continued past the original projected end-date and final evaluation timeline, data, successes and challenges in FY21 are outlined below. In FY21, 91 individuals were served. Demographics on individuals served were as follows:

DEMOGRAPHICS N= 91	
Age Groups	
25-44 years	21%
45-64	25%
65 years and older	8%
Declined to Answer (or Unknown)	46%
Race	
Black or African American	37%
Latino/a/x	5%
White	43%

Other	15%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Declined to State (or Unknown)	100%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
Declined to Answer (or Unknown)	100%
Gender: Assigned Sex at Birth	
Declined to Answer (or Unknown)	100%
Current Gender Identity	
Male	58%
Female	40%
Transgender	2%
Sexual Orientation	
Declined to Answer (or Unknown)	100%

In FY21 Flex funds were used to provide various supports for HOTT program participants including: Hotel stays/rental or housing assistance for 42 participants; food/groceries for 26 participants; bus passes or transportation for 3 participants; and on Pparmacy needs for 1 participant.

Program Successes:

The HOTT pilot demonstrated that a dedicated team of workers could effectively engage and work with a large number of unhoused residents providing short term services and connections to longer term treatment and care. It also demonstrated that the team could be flexible in redirecting its efforts to support the needs of the unhoused community during the pandemic:

- HOTT was responsive to both enrolled and unenrolled individuals when providing outreach and engagement: responding to community referrals, providing direct in-person outreach, and responding to immediate service calls and needs.
- The project provided an array of material supports, including but not limited to basic necessities, transportation (direct and voucher), hygiene kits, emergency housing/respite support, COVID-related supplies (masks, testing, resource information, sanitizer, etc.).
- HOTT facilitated linkages and referrals to treatment, housing, primary care, material support, and other community resources.
- Community needs were supported by encampment outreach by the HOTT, including outreach, material support, and other COVID related needs.

Program Challenges:
With the change in HOTT's mission and staffing, it became increasingly difficult to effectively serve the community. The needs and resources in the community, especially due to COVID-19, drastically changed:

- Staff left the team steadily over this time period from a supervisor and 4 staff until only one staff was left, and then the program ended.
- With the pandemic, many of the resources to which the HOTT team would normally link clients had either: changed their hours, gone to only remote service, changed their services available, or closed their doors.
- The directions from the Emergency Operations Center (EOC) during the pandemic were not consistent due to the changing nature of the COVID-19 response. This also made consistent services difficult to maintain.
- Since most of the services HOTT was directed to perform during this time period were COVID-19 encampment outreach related, the previous linkage services were no longer the focus of the team and its work.

ACCESS AND LINKAGE TO TREATMENT AND PREVENTION & EARLY INTERVENTION COMBINED PROGRAM

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.

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.

The City of Berkeley has one combined Prevention, Early Intervention, and Access and Linkage to Treatment combined program:

High School Youth Prevention Program

This program operates in conjunction with other health related services offered at Berkeley High School (BHS) and Berkeley Technology Academy (BTA) to provide young people with the information and individual support they need to make positive and healthy decisions in their lives. The program includes: outreach activities designed to provide students with basic information around the risks of certain behaviors, and ways to protect themselves and make positive and safer decisions; classroom presentations to enable students to receive more in-depth information around a variety of health topics and available resources, and provide the opportunity for students to do a personal assessment of risk and current lifestyle choices; drop-in crisis and counseling services; individual appointments to identify young people who may need more intensive intervention; and short-term treatment. The individual appointments, held at the school-based health center, provide young people with the opportunity to hold very in-depth discussions around the choices they are making and the risks that are involved in their choices. They receive guidance about

changes they can make to reduce or eliminate their risks, and are given the opportunity to identify barriers that might exist for them that prevent them from making healthier choices. In addition, they complete a 40 question, in-depth HEADSSS (Home, Education, Activities, Drugs/Alcohol, Sexuality, Safety, Suicidality) assessment. Based on the outcome of the individual appointment and/or assessment, a young person may be referred to either a medical or mental health professional for follow-up care and intervention and/or treatment. Approximately 2,600 Berkeley High School Students and 100 B-Tech students receive some level of services through this program each year.

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

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

PEI Priorities:

- Youth engagement and outreach strategies that target secondary school and transition age youth.
- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

In FY19, approximately 1,059 students at BHS and BTA received services at the school's Student Health Center, with 1,511 visits for Behavioral Health Individual sessions, and 321 visits for Behavioral Health Group sessions. Demographics on youth served are outlined below:

DEMOGRAPHICS N=1,059	
Age Groups	
0-15 (Children/Adult)	6%
16-25 (Transition Age Youth)	13%
Declined to Answer (or Unknown)	81%
Race	
Asian	7%
Black or African American	20%
White	33%
More than one Race	17%
Declined to Answer (or Unknown)	7%
Ethnicity: Hispanic or Latino	
Mexican/Mexican-American/Chicano	16%

Ethnicity: Non-Hispanic or Non-Latino	
Declined to Answer (or Unknown)	84%
Primary Language	
Declined to Answer (or Unknown)	100%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Assigned Sex at Birth	
Male	66%
Female	34%
Current Gender Identity	
Male	66%
Female	34%

In FY20, approximately 801 students at BHS and B-Tech received services at the school's Student Health Center. A total of 325 individuals received Behavioral Health services with 1,206 visits for Behavioral Health Individual sessions, and 169 visits for Behavioral Health Group sessions. Demographics on youth served are outlined below:

DEMOGRAPHICS N=801	
Age Groups	
14-18 (Youth)	100%
Race	
Asian	6%
Black or African American	19%
White	36%
More than one Race	20%
Declined to Answer (or Unknown)	3%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican/Mexican-American/Chicano	16%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	84%

Primary Language	
Declined to Answer (or Unknown)	100%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Assigned Sex at Birth	
Male	30%
Female	70%
Current Gender Identity	
Male	30%
Female	68%
Students who identified as either transgender, gender queer, or gender non-conforming	2%

The last day of in-person classes was on March 12th due to the pandemic and related school closure. Mental Health in-person and group services were suspended the following day and on April 28th a Warm Line was implemented to support student's mental health needs.

Results on a survey from the Alameda County School Health Center Evaluation for BHS and BTA students was as follows:

- 100% reported that the people who work at the Health Center "treat me with respect" and "keep my information private";
- 100% reported that the Health Center "helped me to feel like there is an adult at school who cares about me";
- 100% reported that the Health Center "is easy to get help from when I need it", "is a good place to go if I have a problem", and "helps me to meet many of my health needs";
- 98% reported that the people who work at the Health Center "listen carefully to what I have to say";
- 98% of students surveyed reported that the Health Center "helps me to miss less school or class time than going somewhere else for help";
- 97% reported that "the Health Center helped me to deal with stress/anxiety better".

Program Successes:

- Applied for and was awarded the SB-82 Crisis Triage Grant in order to fund 1.0 FTE Behavioral Health Clinician II position, which enabled more consistent and reliable provision of assessment and crisis assessment services;

- In response to COVID-19, shelter in place restrictions, and transition to virtual learning, the Mental Health team developed and implemented a "Mental Health Warm Line" for students, parents, and school staff;
- Provided ongoing individual Mental Health remote tele-health services from March through June 2020 for all existing Health Center clients;
- Increased awareness and the de-stigmatization of services;
- Increased access to services for historically marginalized student communities;
- Increased BHS campus presence through several tabling events, presentations, and gatherings with students, families, and school staff;
- Successful internal/external linkages to ongoing care;
- Ongoing collaborative partnerships with school administration, teachers, and school-based programs;
- Diverse/eclectic staff backgrounds supported embedding foundational framework of cultural humility across clinical practice; and
- Maintained a 100% staff retention.

Program Challenges:

- Student need continued to exceed clinician/team capacity during the months where in-person learning took place (August 2019 through mid-March 2020);
- Difficulties with external linkages due to fractured nature of larger Mental Health healthcare systems, insurance barriers, etc.;
- Limited staff time to promote prevention and early intervention services due to high volume of Tier 3 therapy services;
- Transition of in-person services and workflows to remote tele-health services and workflows due to the pandemic;
- Utilization of new technology to support remote tele-health services;
- Decline in accessibility and utilization of Mental Health services due to the pandemic;
- Impact of the pandemic on staff;
- Vicarious trauma for staff due to the nature and content of the therapeutic work, high volume, and impact of the pandemic; and
- Limited staff time for team meetings to discuss/plan/review administrative and programmatic considerations.

In FY21, approximately 101 students received services through this project. Demographics on youth served are outlined below:

DEMOGRAPHICS N=101	
Age Groups	
0-15 Years	27%
16-25 Years	73%
Race	
Asian	16%
Black or African American	15%

White	32%
More than one Race	19%
Other	10%
Declined to Answer (or Unknown)	8%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Other	32%
Declined to Answer (or Unknown)	9%
Primary Language	
English	87%
Spanish	13%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Assigned Sex at Birth	
Male	40%
Female	60%
Current Gender Identity	
Male	37%
Female	52%
Transgender	3%
Genderqueer	8%

Program Successes:

- In spite of the numerous and multi-faceted challenges associated with COVID-19 and distance learning, the Health Center was still able to provide mental health counseling services to over 100 students and was able to provide longer-term support to more students due to the lower than typical number of unduplicated clients. The Health Center was able to host a small, diverse, and talented graduate-level MFT trainee cohort.
- Adapted care provision to utilize these new platforms and was able to flexibly provide services while also mitigating potential safety risks associated with COVID-19.
- During the course of the school year, the Health Center's MH team was able to develop and implement use of a JotForm application in order to digitize referral processes, make referrals accessible online, and

thereby improve overall accessibility. Transition to this HIPAA-compliant online referral process has been maintained into the FY22 school year and is now being more broadly used by all Health Center programs.

- The online referral process was implemented in January 2021 and promoted across student/parent bulletins, emails to the school community from BHS and BTA principals, and presentations to teacher leads and other school staff. Upon successfully implementing this new method for referrals, the Health Center phased out use of its phone-based Mental Health Warm Line, which was initially utilized in Spring 2020 shortly after the COVID-19 pandemic began. The Warm Line was phased out in order to simplify the referral pathway for accessing mental health services from the Health Center.
- Throughout the COVID-19 pandemic and for the duration of the FY21 school year, the Health Center's MH team maintained a positive and collaborative relationship with school administration, the BHS and BTA COST teams, and the school-based Intervention and IEP counselors. Collaboration and coordination with school-based stakeholders enabled program staff to effectively triage and refer students/families to EPSDT/ERMHS services in addition to short-term Health Center services.

Program Challenges:

- During the FY21 school year, BUSD provided all educational instruction via remote "distance learning" using platforms like Zoom and Google Meet due to COVID-19-related safety concerns. Students were not present on campus from the start of the school year in August 2020 through spring break in April 2021. From mid-April through early June of 2021, a small percentage of the student body was on campus two hours per day, 2-3 days per week. Health Center counseling rooms were not usable for in-person services due to spatial limitations, inadequate social distancing, and inadequate ventilation. An alternative physical space on the BHS campus was identified for crisis-only use during this timeframe.
- For the duration of the FY21 school year, one Health Center clinician was on parental leave. The Health Center's graduate-level trainee cohort was also downsized by 50%, from four to two, due to COVID-19-related constraints.
- Up until COVID-19, the Health Center relied upon a paper-based referral process where referrals needed to be submitted in person to staff. Accessing services remotely was not feasible until workflow adjustments were made, which required technological advancements and collaboration with the City's IT department. The planning and implementation of a digital, online, HIPAA-compliant referral portal took approximately five months.

ACCESS & LINKAGE TO TREATMENT AND EARLY INTERVENTION COMBINED PROGRAM

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.

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.

Through the FY22 Annual Update the City of Berkeley provided a one-time amount of CSS and PEI funding to support a pilot program. Per PEI program type definitions, this program would be considered as an Access to Treatment and Early Intervention combined program. The program is as follow:

Specialized Care Unit

On July 14, 2020 City Council passed Resolution No, 69,501-N.S.; a package of items providing direction for the development of a new paradigm of public safety in Berkeley. One of the items adopted by City Council directed the City Manager to analyze and develop a pilot program to re-assign non-criminal police service calls to a Specialized Care Unit (SCU). The SCU will consist of trained crisis-response field workers who will respond to behavioral health occurrences that do not pose an imminent threat to safety without the involvement of law enforcement. The SCU will be implemented as a pilot model and lessons-learned will inform the long-term implementation. Through the approved FY22 Annual Update, the Division proposed to allocate a small portion of CSS and PEI funds to be leveraged with other City funds for this pilot program. This allocation was a one-time MHSA funding amount, while the City determines how to best fund this initiative.

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.

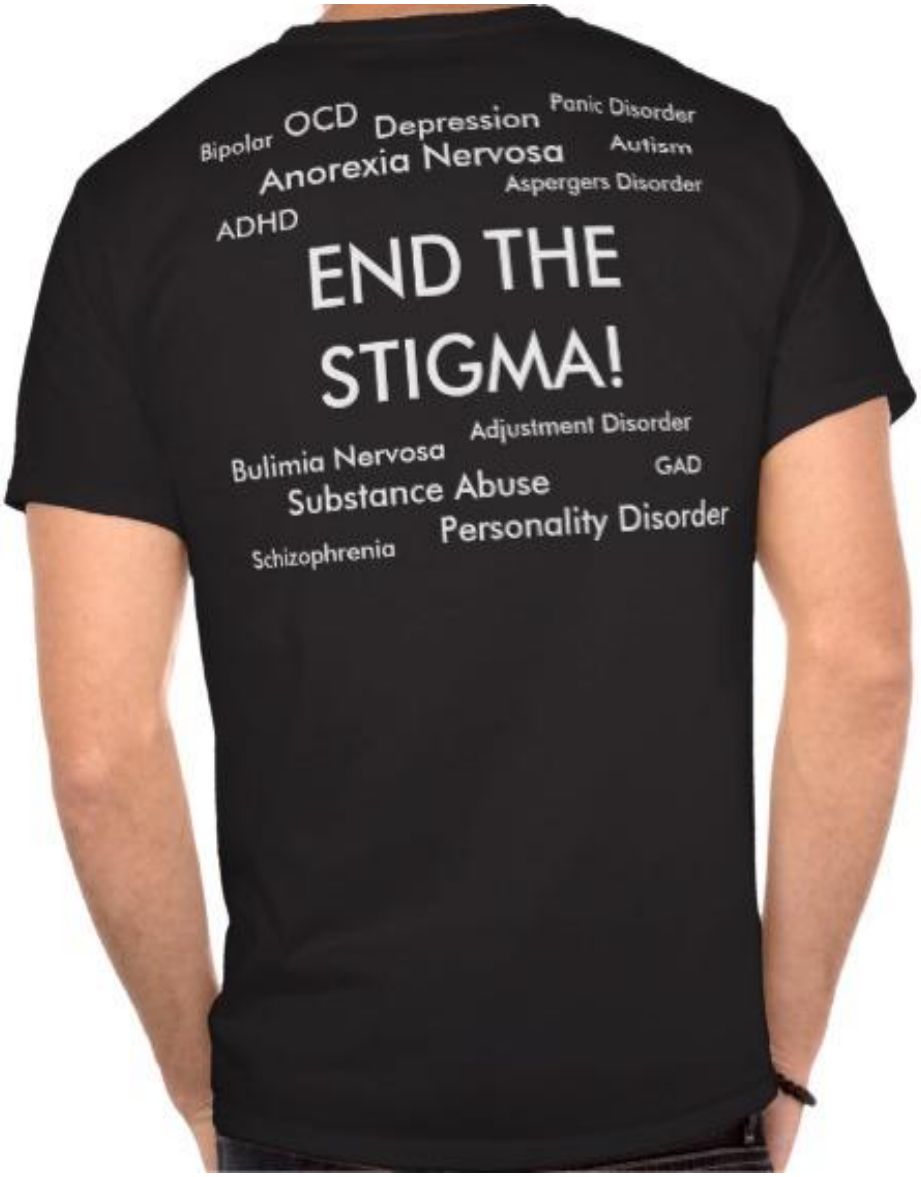
PEI Priority:

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

In FY22, Resource Development Associates (RDA), chosen through a competitive Request for Proposal (RFP) process to evaluate the current crisis system in Berkeley, received an expanded scope of work to provide recommendations on the implementation of the SCU. To oversee and advise RDA in their work, the City formed an SCU Steering Committee consisting of Health, Housing and Community Services Department and Fire Department staff, and community representatives from the Mental Health Commission and the Berkeley Community Safety Commission. The Steering Committee met from January 2021 through January 2022 and advised on RDA's completion of three critical reports. The first two reports summarized crisis response programs in the United States and internationally as well as gathered perspectives from community and City stakeholders regarding the crisis response system. This included gathering input from City of Berkeley and Alameda County agencies, local community-based organizations (CBOs), local community leaders, and utilizers of Berkeley's crisis response services. These reports laid the foundation for the twenty-five recommendations that were the subject of the third and final report to inform the SCU model. Each recommendation put forth in the final report is deeply rooted in the stakeholder feedback included in the two previous reports.

The work of the SCU Steering Committee has now transitioned from planning to implementation. It is envisioned that the SCU will begin operations in late FY22 or early FY23 through a community partner that will be chosen through a competitive Request for Proposal process.

STIGMA AND DISCRIMINATION REDUCTION PROGRAM



Stigma and Discrimination Program - 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.

In FY19, the "Telling Your Story" group met 24 times with 20 unduplicated persons attending for a total of 144 visits. Groups averaged 6 attendees. Due to a vacancy in the Consumer Liaison position until February 2019, demographic data for this program during FY19 is not available.

In FY20, the "Telling Your Story" group met 19 times with 22 unduplicated persons attending for a total of 119 visits. There were 4 virtual zoom groups included in the total meetings. On average there were 6.2 attendees. Program participants spent time discussing and practicing what makes a good story based on the topics given by the instructors. Demographics on individuals served were as follows:

DEMOGRAPHICS N= 22*	
Age Groups	
26-59 (Adult)	18%
Ages 60+ (Older Adult)	36%
Declined to Answer (or Unknown)	46%
Race	
American Indian or Alaska Native	9%
Asian	14%
Black or African American	14%
Native Hawaiian or other Pacific Islander	9%
White	32%
Other	9%
Declined to Answer (or Unknown)	13%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican	4%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	96%
Primary Language Used	
English	41%
Declined to Answer (or Unknown)	59%
Sexual Orientation	
Gay or Lesbian	4%
Heterosexual or Straight	27%
Bisexual	4%
Queer	4%
Questioning	9%
Declined to Answer (or Unknown)	52%

Disability	
Difficulty Seeing	9%
Communication (other)	9%
Mental Domain not including a mental illness	9%
Physical Mobility domain	18%
Chronic Health Condition	9%
Declined to Answer (or Unknown)	46%
Veteran Status	
Declined to Answer (or Unknown)	100%
Gender: Assigned Sex at Birth	
Female	41%
Declined to Answer (or Unknown)	59%
Current Gender Identity	
Female	41%
Declined to Answer (or Unknown)	59%

*Demographics were based on a survey that was mailed back and returned. Not all participants responded to the survey.

Staff changed the formation of the group to better prepare the participants before coming to the meeting. Topics were mailed out or people were called to help them prepare for the group. The staff also created more guidelines to help participants tell their story within a given timeframe, focusing on the topic and give effective feedback to their peers. This format will help prepare the story tellers when there are opportunities for panels to break stigma about Mental Health.

Staff then assessed participant's involvement within the group by sending out surveys to capture how they feel about the group. The "Telling Your Story" group brainstormed and discussed criteria on what makes a good story. The list of criteria that was generated was re-visited at many meetings and each criteria were discussed by the group. The group then practiced giving feedback to each person based on the criteria. A survey that included the criteria, with emphasis on participants understanding and awareness of turning points in their stories was then developed. The survey was then administered towards the end of the fiscal year and the results were tallied. The results indicated that the highest rated question pertained to participants' confidence in telling a story that would change negative perceptions of mental health challenges. The results also guided the group to work on effectively using pauses and timing in telling a story, catchy first lines, and descriptive use of language to describe recovery to others.

In FY21, the "Telling Your Story" group held 25 meetings with 21 unduplicated persons attending for a total of 168 visits. This group met through the virtual platform "Zoom". On average there were 6.72% attendees. Program participants spent time discussing and practicing what makes a good story based on the topics given by the instructors. Demographics on individuals served were as follows:

DEMOGRAPHICS N= 21	
Age Groups	
26-59 (Adult)	52%
Ages 60+ (Older Adult)	48%
Race	
Asian	5%
Black or African American	9%
Native Hawaiian or other Pacific Islander	5%
White	71%
Other	5%
More than one Race	5%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	14%
Asian Indian/South Asian	5%
European	14%
Filipino	9%
Japanese	5%
Middle Eastern	5%
Declined to Answer (or Unknown)	48%
Primary Language Used	
English	100%
Sexual Orientation	
Gay or Lesbian	5%
Heterosexual or Straight	52%
Bisexual	9%
Another Sexual Orientation	5%
Declined to Answer (or Unknown)	29%
Disability	
Difficulty Hearing	14%
Mental Domain not including a mental illness	14%
Physical Mobility domain	14%
Chronic Health Condition	14%

Other (Specify): PTSD	10%
Declined to Answer (or Unknown)	34%
Veteran Status	
No	48%
Declined to Answer (or Unknown)	52%
Gender: Assigned Sex at Birth	
Declined to Answer (or Unknown)	100%
Current Gender Identity	
Male	14%
Female	67%
Declined to Answer (or Unknown)	19%

Program Successes:
The Telling Your Story group has grown to having more consistent attendees and participants being prepared to share based on the topics provided. 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 they enjoyed the support they received from their peers.

Program Challenges:
The Telling Your Story group challenges have been a lack of in-person connection and some individuals not having Zoom were unable to see others on the screen.

OUTREACH FOR INCREASING RECOGNITION OF 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.

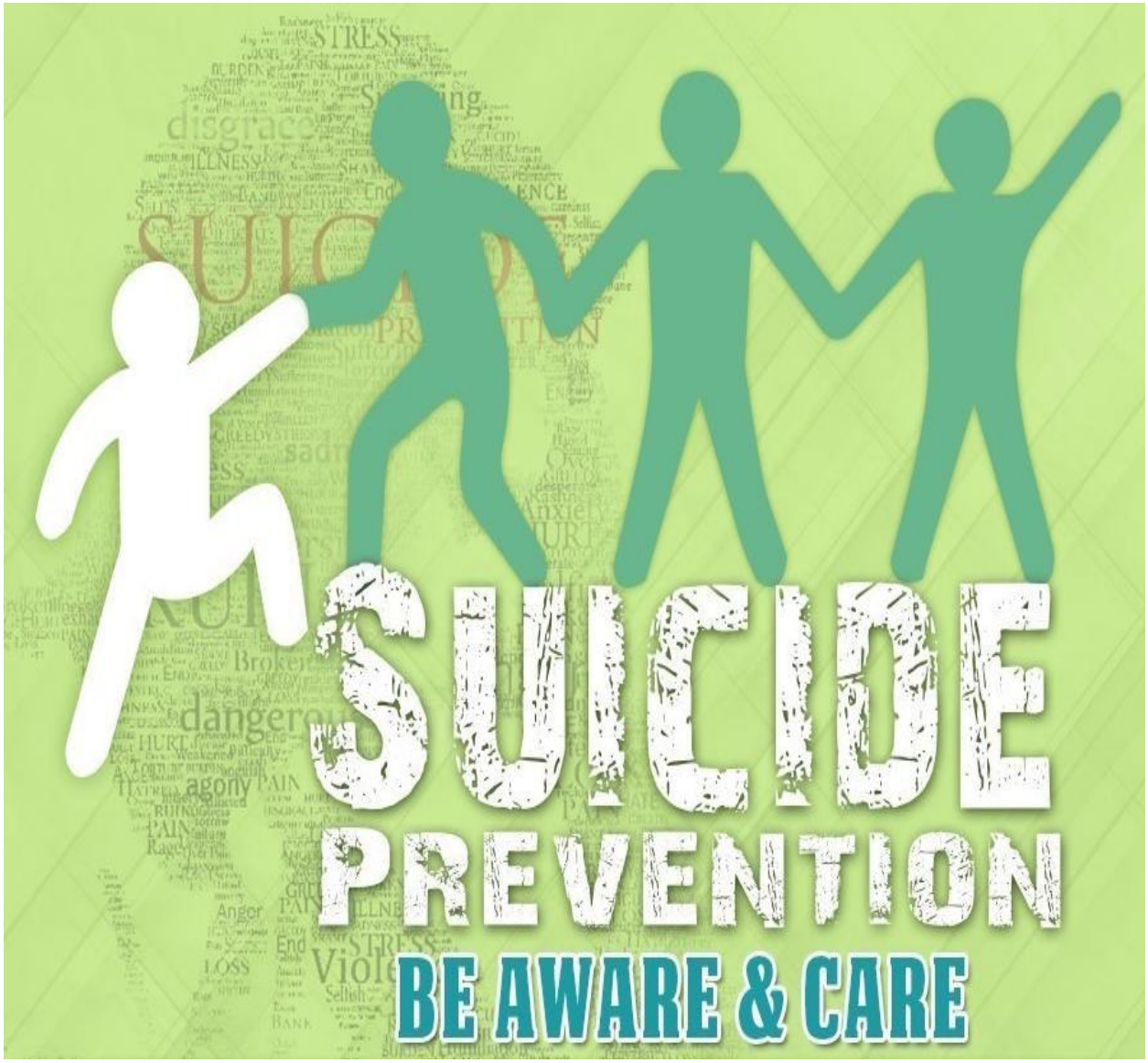
Per PEI State Regulations in addition to having the required "Outreach for Increasing Recognition of Early Signs of Mental Illness Program", mental health jurisdictions may also offer required Outreach for Increasing Recognition of Early Signs of Mental Illness as: a strategy within a Prevention program,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

Mental Health First Aid

City of Berkeley Mental Health staff have 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. Due to the pandemic and vacancies in staff, Mental Health First Aid trainings have not been provided in the past several years.

SUICIDE PREVENTION

(OPTIONAL PEI PROGRAM)



Suicide Prevention Program (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 BMH began contributing funding to the California Mental Health Services Authority (CalMHSA) PEI Statewide Projects in order to obtain State resources locally on Suicide Prevention, Student Mental Health, and Stigma and Discrimination.

In FY19, through the CalMHSA Statewide Projects initiative, resources on Suicide Prevention, Student Mental Health and Stigma and Discrimination reached an excess amount of 1,546 individuals. Additionally, an excess of 1,315 pamphlets and resources on Suicide Prevention, Student Mental Health and Stigma and Discrimination were distributed in local schools and the community. BMH also participated in the CalMHSA "Each Mind Matters" campaign and distributed materials and giveaways at the local "May is Mental Health Month" event.

In FY20, resources from this initiative reached an excess amount of 1,680 individuals. Additionally, an excess of 1,225 pamphlets and resources on Suicide Prevention, Student Mental Health and Stigma and Discrimination were distributed in local schools and the community.

In FY21, through this initiative resources on Suicide Prevention, Student Mental Health and Stigma and Discrimination reached approximately 1,620 individuals. Additionally, resources were distributed via email to local schools, community agencies and community members.

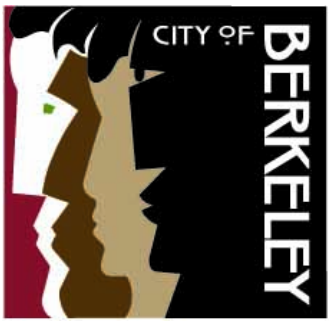
APPENDIX B

Innovation

Fiscal Year 2020/2021

Annual Evaluation Report

City of Berkeley
Mental Health Services Act



Innovation
Fiscal Year 2020/2021
Annual Evaluation Report

WELLNESS • RECOVERY • RESILIENCE

INTRODUCTION

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

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

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

Per MHSA State requirements, Mental Health jurisdictions are to submit an INN Evaluation Report to the Mental Health Services Oversight and Accountability Commission (MHSOAC) on an annual basis. INN Regulations released in 2018 also require mental health jurisdictions to submit an Annual Evaluation Report to the State each fiscal year. The Evaluation Report should be included with the MHSA Annual Update or Three Year Program and Expenditure Plan and undergo a 30 Day Public Review period and approval from the local governing board. Per state regulations in 2022, the MHSA INN Fiscal Year 2020/2021 (FY21) Annual Evaluation Report that covers data from FY21 is due.

This INN FY21 Annual Evaluation Report provides descriptions of currently funded MHSA INN services, and reports on FY21 program and demographic data.

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

INN Demographic Reporting Requirements

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

(A) The following Age groups:

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

(B) Race by the following categories:

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

(C) Ethnicity by the following categories:
(i) Hispanic or Latino as follows

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

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

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

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

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

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

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

(E) Sexual orientation

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

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

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

(G) Veteran Status,

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

(H) Gender

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

Effective July 2018 amended INN regulations specified the following:

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

CITY OF BERKELEY INN PROGRAMS

A description of the currently funded INN programs and FY21 data are outlined below:

Early Childhood Trauma Resiliency (ECTR) - Trauma Informed Care Project

In May 2016, the City of Berkeley received approval from the MHSOAC to implement a Trauma Informed Care (TIC) for Educators project (which is posted on the City of Berkeley MHSA webpage) into several BUSD schools to assess whether educators who are trained to become aware of their own trauma and trauma triggers (and how to address them), are better equipped to recognize and make appropriate decisions on how to help students who are exhibiting trauma symptoms, and assist them in accessing the mental health services and supports they may need.

The project was implemented through the 20/20 Vision Program which at the time was operated out of the City of Berkeley, City Manager's Office. After a year of the TIC Project being executed, there were two vacancies in the 20/20 Vision Program which impacted the ability to continue the implementation of the TIC Project. The project was only able to be implemented for one year in FY17 and during that timeframe an evaluation was conducted by Hatchuel Tabernik & Associates (HTA) on the project outcomes. The HTA Training Informed Systems Training Program 2016-17 Pilot Year Evaluation Report is located on the City of Berkeley MHSA webpage.

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

planning, and an update to the TIC Plan underwent a 30 Day Public Review and Public Hearing process. The City of Berkeley Trauma Informed Care Plan Update (which is posted on the City of Berkeley MHSA webpage) was approved through City Council in October 2018 and by the MHSOAC in December 2018. This modified project implemented TIC Training for Educators and interested parents in four local Head Start sites.

The TIC modified project, "Early Childhood Trauma and Resiliency" (ECTR) was implemented from January 2019 through June 2021 at four YMCA Head Start sites located in Berkeley: Ocean View. South YMCA, Vera Casey, and West YMCA. The project provided training and supports to enable Head Start staff to recognize trauma and its effects on themselves and the children and families they serve, and to integrate trauma and resiliency informed approaches into their work. The project provided training, coaching and peer support to staff and parents who have children enrolled in Head Start and advanced Berkeley's 2020 Vision priority, that all Berkeley children enter kindergarten ready to learn.

The learning objectives of this project were as follows:

- To create a change in the way Head Start educators and staff view and handle challenging student and parent behaviors (which often mask trauma);
- To create an increase in access to mental health services and supports for children/families in need;
- To promote better mental health outcomes by increasing child/family referrals to "appropriate' mental health services.

In FY21, 178 children received services through this program. Below are demographics of individuals impacted in FY21 by this program. The final evaluation conducted during the reporting timeframe by HTA, is attached to this report.

PARTICIPANT DEMOGRAPHICS N=178	
Age Groups	
0-15 (Children)	100%
Race	
Asian	9%
Black or African American	29%
White	9%
Other	28%
More than one Race	17%
Declined to Answer (or Unknown)	8%

Ethnicity: Hispanic or Latino/Latina/Latinx	
Central American	2%
Mexican/Mexican-American/Chicano	32%
Puerto Rican	1%
South American	2%
Other	2%
More than one ethnicity	7%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	6%
Cambodian	<1%
Chinese	3%
Middle Eastern	<1%
Vietnamese	1%
Other	9%
More than one Ethnicity	2%
Declined to Answer (or Unknown)	20%
Primary Language	
English	67%
Spanish	23%
Urdu	<1%
Arabic	2%
French	1%
Berber	1%
Mongolian	<1%
Amharic	<1%
Tigrina	1%
Chinese/Mandarin	1%
Nepalese	<1%
Declined to Answer (or Unknown)	<1%

Disability	
Communication: other, speech/language impairment	39%
Physical domain	7%
Other	7%
No Disability	47%
Gender	
Female	41%
Male	59%

Help@Hand - Technology Suite Project

In September 2018, following a four-month community planning process and approval from City Council, the City of Berkeley Technology Suite Project (which has since been renamed "Help@Hand) was approved by the MHSOAC. This project allocates a total of $462,916 to participate in a Statewide Collaborative with other California counties to pilot a Mental Health Technology Project that makes various technology-based mental health services and supports applications (Apps) locally available in Berkeley. The Help@Hand project seeks to learn whether the use of the Apps will increase access to mental health services and supports; and whether it will increase the quality of mental health services, including leading to better outcomes.

Since plan approval and through FY21, the City of Berkeley worked both internally and with the California Mental Health Services Authority (CalMHSA), the fiscal intermediary for this project, to prepare for citywide implementation. Due to a need for additional community mental health supports as a result of the pandemic, the priority population for accessing Apps was changed from the original primary focus on TAY and Older Adults, to include anyone who lives, works and goes to school in Berkeley.

Per a competitive recruitment process, the Division contracted with Resource Development Associates (RDA), who conducted Project Coordination work through early FY22 on this project. Additionally, on behalf of the City, and with locally designated Help@Hand project funds, CalMHSA executed a contract with Uptown Studios, a local Marketing company in early FY22 to conduct a marketing and social media campaign for this project. In November 2021, as a result of this project, free access to the HeadSpace and MyStrength Apps became locally available for a limited timeframe to anyone who lives, works or goes to school in Berkeley.

The City is currently participating in a State Evaluation with other counties in this project. The evaluation is being conducted by the University of California at Irvine (UCI). Additionally,

following a competitive recruitment process, the City of Berkeley entered into a contract with Hatchuel, Tabernik & Associates to conduct a local evaluation of this project. Outcomes of this project will be outlined in future reports.

Early Childhood Trauma and Resiliency Project (ECTR)

City of Berkeley, Berkeley's 2020 Vision

Final 3-Year Evaluation Report, August 2021

Prepared by
Ruthie Chang, EdM
Hatchuel Tabernik and Associates

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Project Description

Berkeley's 2020 Vision is a citywide partnership that strives to eliminate racial disparities in Berkeley's public education system, with a primary focus on African American and Latinx children and their families. Berkeley's 2020 Vision advances the following City of Berkeley's strategic plan goal: to champion and demonstrate social and racial equity.

In December 2019, Berkeley's 2020 Vision was awarded $336,825 in Mental Health Services Act (MHSA) funding through June 30th, 2021, to implement the Early Childhood Trauma and Resiliency (ECTR) Project in partnership with the YMCA of the East Bay. The ECTR project advances Berkeley's 2020 Vision priority that all Berkeley children enter kindergarten ready to learn.

The ECTR Project provides training, coaching, and peer support to staff and parents with children enrolled in YMCA's four Head Start sites located in Berkeley: Ocean View, South YMCA, Vera Casey, and West YMCA. This project's core strategy is to build the capacity of YMCA Head Start staff to recognize trauma and its effects on themselves, children, and families, and integrate a trauma- and resiliency-informed approach into their work with children and families. The ultimate goal of this project is to improve mental health care access and outcomes for children, ages 0 through 5 years old who are enrolled at each of the YMCA's four sites.

Key Partners

Nina Goldman of Berkeley's 2020 Vision is managing this project on behalf of the City of Berkeley. Anita Smith, Psy.D., who oversees the work of Head Start's mental health services, is the Project Coordinator of the ECTR Project on behalf of the YMCA of the East Bay. Dr. Smith works closely with Melanie Mueller, Executive Director, who is responsible for early childhood development programs at YMCA of the East Bay, replacing Pamm Shaw as of Winter/Spring 2020. Head Start has contracted with Julie Kurtz, MS, LMFT, to conduct trauma training, coaching, and guidance to the ECTR Project. Ms. Kurtz is a private consultant and author with extensive expertise in trauma, early childhood development, training, and curriculum development. She co-authored the book, **Trauma-Informed Practices for Early Childhood Educators**, published in 2019. Before opening her consulting practice, Ms. Kurtz served as Co-Director of Trauma-Informed Practices in Early Childhood Education at WestEd's Center for Child & Family Studies. Berkeley's 2020 Vision has also contracted with Hatchuel Tabernik and Associates (HTA) to lead the evaluation of the ECTR project.

Theory of Change

The underlying theory of change creates a chain of reasoning from resources to outcomes that is used to test assumptions and inform the evaluation. ECTR's theory of change is as follows:

- Trauma has a significant impact on the mental health of Head Start students, parents/guardians, educators and staff.
- Introducing a trauma-informed approach and strategies to Head Start educators and staff will enable them to better recognize their own trauma and triggers.
- This knowledge will help educators and staff approach students and parents/guardians from a trauma-informed perspective (including shifting from "What's wrong with you?" to "What happened to you?").

- Supported by agency-wide trainings, peer support learning circles, and in-class coaching, teachers and staff will develop more positive, empathic relationships with students and their parents/guardians, helping them to better identify trauma in the children/families they serve.
- Equipped with trauma-informed tools and stronger relationships with students and parents, educators will make more successful and "appropriate" mental health referrals.
- This project will build Head Start's in-house capacity to lead trainings, facilitate peer support circles, and onboard new staff to ensure sustainability beyond the current funding term.

"It is easier to build strong children than to repair broken men."

-Frederick Douglass

Methodology

The overall purpose of this evaluation is to determine the impact of the ECTR model implementation on the way that Head Start educators and staff view trauma, how they handle challenging behavior, and their capacity to provide "appropriate" mental health referrals. Through a mixed-methods, collaborative, and client-centered approach, HTA uses a **utilization-focused approach** for the ECTR evaluation, combining surveys, focus groups/interviews, and archival data to address the impact of the program on participants and mental health referrals. Utilization-based evaluation is an approach whereby the evaluation activities from beginning to end are focused on the intended use by the intended users.[1] HTA also attempts to account for the developmental nature of the program as it is designed and continues to evolve while the evaluation is underway.

The following research questions (RQs) were developed to guide the evaluation activities:

Project Goal 1: To create a change in the way Head Start educators and staff view and handle challenging student and parent behaviors (which often mask trauma)

RQ1: What is the impact of the ECTR model on participants (Head Start staff and educators, resiliency champions, peer support learning circle participants)?

Specifically, do they view themselves, the parents, and children they work with differently? Do they view student behavior issues differently? When parents attend trainings, what is the impact on them?

Project Goal 2: To create an increase in access to mental health services and supports for children/families in need

RQ2: What is the impact on Head Start families' and children's access to mental health services?

[1] Patton, M.Q. (2012). *Essentials of Utilization-Focused Evaluation*. Thousand Oaks, CA: SAGE Publications, Inc.

Specifically, are Head Start educators and staff more comfortable talking about mental health with families, both before and after referrals are made? Do they see themselves as allies in helping families access mental health services? Do Head Start educators and staff feel better equipped to utilize the mental health referral process? Is there a change in the number of mental health referrals?

Project Goal 3: To promote better mental health outcomes by increasing child/family referrals to "appropriate" mental health services

RQ3: Is there an increase in the number of "appropriate" mental health referrals from Head Start educators and staff?

In order to answer the evaluation questions, HTA is collecting the following data from ECTR program staff and developing instruments (e.g., staff survey, focus group protocols) as needed.

Table 1. ECTR Data Sources

Data Source	Description of Data Source
Training attendance sheets	Collected by YMCA at each training, these attendance sheets indicate all YMCA staff who attended the training. Attendance sheets include training date, training location, names, job titles, and sites.
Annual participant survey	Online survey completed by YMCA staff annually. The survey was developed by HTA in collaboration with ECTR program leaders adapting some questions from existing surveys from the City of Berkeley's 2016-17 Trauma-Informed Systems pilot program and a trauma-informed practices self-assessment from *defendingchildhoodoregon.org*. Topics covered include how staff better understand how their own past trauma impacts their work, how staff view students and families who have experienced trauma that impacts their behavior, and how staff approach behavioral issues. The same survey will be completed each year to see change over time.
YMCA Child Plus	YMCA database with demographics of children for MHSA reporting requirements.
YMCA supplemental demographics survey	YMCA survey administered at the door to families to collect missing demographic data for MHSA that is missing from ChildPlus.
Program Information Reports (PIR)	YMCA Mental Health Consultants complete this worksheet on a monthly basis for submission to the Program Manager. This worksheet reports mental health referrals to agencies outside of the YMCA Head Start program.
Mental health referral follow-up form	HTA helped YMCA develop this form. Mental Health Consultants complete this form to document "appropriateness" of referral, in other words, whether they contacted referral agencies before the referral, whether families utilized the referral, and whether it met their needs.
Focus group	A focus group was conducted with staff from each site in the second year. Focus groups gather information about how educators and staff view themselves, children, and parents, how they handle challenging behaviors, and changes to their capacity to make referrals.
Staff Interviews	Four staff and leadership interviews were conducted in the third and final year of the project to understand the long-term impacts of the trauma trainings.
Post-training surveys	Surveys developed by trainers and administered post-training via paper surveys to measure understanding and satisfaction.

Implementation

Implementation Activities to Date

This report covers program activities and outcomes cumulatively over the past 30 months of program implementation from January 1st 2019 through June 30th, 2021.

Year 1

Head Start kicked off the ECTR project in February 15th, 2019 with its first all-staff (e.g., teachers, counselors, administrators) training, **"Understanding Trauma Informed Practices for Early Childhood Programs: Creating Strength-Based Environments to Support Children's Health and Healing"** (also referred to as "Trauma Informed Care 101"). See Table 3 below for training dates and attendance counts.

The subsequent training was designed for Head Start's leadership team to begin preparing management staff to effectively guide their teams/supervisees through organizational culture change. This session, **"Kick-off and Leadership Reflective Practices,"** was held on June 10th, 2019. It specifically focused on how to create a safe and strong supervisor-supervisee relationship through a reflective practice.

The Resiliency Champion component of this project was designed to help establish and maintain a trauma-informed care environment at the Head Start Centers by developing staff leadership and putting in place a mechanism to onboard new staff to trauma-informed practices quickly and effectively. In early summer 2019, Dr. Smith recruited and selected a group of 15 "Resiliency Champions" to serve as internal leaders and future trainers of the trauma-informed curriculum to new staff. Resiliency Champions include program managers, area managers, workforce development staff, health specialists, family advocates, a center director, and a lead teacher.

The **Resiliency Champion trainings and Learning Circles** launched on June 10th, 2019. Champions attended ten three-hour training sessions through November 1st, 2019. Training sessions were co-facilitated by Julie Kurtz and Dr. Smith. Training handouts describe the purpose of the Resiliency Champions sessions as: "to reflect and go deeper in discussion about how to practically apply social-emotional and trauma sensitive strategies to the work we do with each other, families and children every day. To seek to understand human behavior so that we can grow in our awareness and help make our own lives, others and the planet a more humane place to live in. To take an inquiry stance where we are eager to learn and seek to understand. Growth comes from self-reflection and self-awareness."

Resiliency Champion sessions covered topics including: **Understanding the Neurobiology of Trauma, Foundations of Trauma-Informed Practices for Early Childhood Education** and **Trauma Sensitive Early Childhood Programs**. Participants discussed case studies, including those of an infant and mother in a homeless shelter, a toddler with a history of neglect and three foster care placements, a preschooler with an undocumented father who has been deported, and a child who witnessed a drive-by shooting while at school. The text for these sessions is a book co-authored by Julie Kurtz, Trauma Informed Practices for Early Childhood Educators: Relationship-

Based Approaches that Support Healing and Build Resilience in Young Children. The Resiliency Champions also learned and practiced delivering three new staff trainings developed by Ms. Kurtz for this project, each with its own PowerPoint slide deck. A later session covered: **The Importance of Self-Care: Taking Care of Yourself in Order to Prevent Burnout, Compassion Fatigue and Secondary Traumatic Stress.**

> **"We were always gardening, but now we can be better gardeners because we can name the plants."**
>
> **-May 2020 Trauma Training Attendee**

Year 2

Four all-staff trainings were held during this second year of the program. The first, a four-hour training, was held on August 22nd, 2019 and covered the topic, **Self-Care: Getting a PhD in You**, focused on provider self-care while doing trauma-informed work and was facilitated by Julie Kurtz. Attendees had positive feedback in post-training evaluations, sharing that they learned techniques regarding internal dialogue and self-talk. One participant expressed that "when we care for ourselves in a great way, meeting all of our needs, we can better care for others." The next all-staff training on October 14th discussed the topic of **Trauma Informed Practices: Classroom Strategies** and was also facilitated by Julie Kurtz. This 6-hour training was attended by 67 staff and covered strategies such as supporting relationship practices and environments that promote safety, predictability, empowerment, and control as well as direct skill-building of social-emotional skills.

After these trainings, staff provided feedback about them to ECTR leaders, as well as to HTA, in a focus group held on November 27th. Focus group participants expressed thoughts and opinions about the training and the trainer that program leaders felt would be addressed by bringing on additional trainers to provide a wider variety of perspectives, strategies, and cultural vantage points. On January 27th, 2020, Valentina Torrez, a trainer through Optimal Brain Integration, along with Julie Kurtz, facilitated a follow-up to the Self-Care training for all staff entitled **Self-Care Part 2**. Training evaluations reflect staff's appreciation of having Ms. Torrez's expertise to build upon Ms. Kurtz's knowledge base.

In February 2020, Dr. Smith, the Project Coordinator, began leading **Resiliency/Learning Circles** with staff at each site. In sessions with staff at the South Y and Vera Casey Head Start sites, Dr. Smith facilitated two-hour discussions around **Expectations and Self-Care**.

As part of this project's effort to ensure the long-term sustainability of the trauma-informed approach throughout the organization, Dr. Smith also conducted two 1.5-hour training sessions on **Intro to Trauma-Informed Care** for twelve new staff onboarded on January 8th and February 6th. Staff included a center director, program assistants, family advocates, teachers and kitchen staff. Because of the challenges of conducting trainings remotely, Dr. Smith led the onboarding processes by herself without participation from the Resiliency Champions. Moving into the next school next year, part of the introduction to trauma trainings will be delivered through webinars produced by

YMCA staff. Resiliency Champions will be an integral part of delivering the training materials with support and oversight by Dr. Smith.

Pivots to Programming During COVID-19

On March 16th, 2020, Alameda County issued stay-at-home orders in response to Covid-19, the novel coronavirus. Head Start had to close its doors without notice and shift its services to reach out to and support families and children in this new reality. Staff who work directly with children conducted outreach to families once or twice weekly, depending on the family's needs and circumstances. Parents were most responsive through phone calls (audio only) and primarily communicated with staff this way. About half of our families engaged either over video (e.g., Zoom) or over email. As indicated in Table 2 (below), nearly three-quarters of Head Start teachers and outreach staff created and shared activities remotely with children and families, 40% referred families to resources, and 37% developed resources and media such as recording story time on YouTube. Nearly a third distributed diapers and emergency supplies to families, and one in five distributed gift cards to families for emergency needs. Other staff were involved in crisis management issues or managed Head Start hiring and administrative tasks as they transitioned online.

Table 2. Ways Staff Worked with Children and Families as a Result of the COVID-19 Pandemic

	%
Providing activities for children/families	73%
Diaper/supply distribution	31%
Referring families to resources	40%
Crisis management	12%
Learning kits for each family	14%
Gift card distribution for emergency support	20%
Developing resources and media	37%
Not working with children/families	6%
Other • *Call families once or twice a week to meet their needs and know about children learning and development at home* • *Call parents once a week and check on children.* • *More managerial tasks--putting much of the work we do online, hiring, supporting Family Advocates, etc.* • *Other management task* • *referring to our mental health* • *Take trainings*	11%

Source: ECTR Evaluation Staff Survey, May/June 2020 (N=52)

In the midst of this upheaval, the ECTR program continued its work. Julie Kurtz and Lawanda Wesley (of Optimal Brain Integration) were scheduled to lead an in-person **Family Engagement Trauma Training** on May 18th, 2020. In response to the pandemic, the Head Start team transitioned this planned training into a two-part virtual training over three hours on May 18th and three hours on the 28th. In addition to discussing strategies to engage families from a trauma-based lens, the trainers adjusted the topics to meet the immediate needs of staff, including: anxiety as a result of Covid-19, coping strategies, wellness, and self-care. Staff also discussed what would make them feel safe when Head Start re-opened. Feedback from these trainings was extremely positive based on post-training evaluations. Attendees wanted even more training for staff "to better handle

families that are dealing with trauma as they [staff] may be dealing with trauma themselves" and others recommended that families take the training as well. Another attendee reportedly expressed how the training helped her to name the issues she sees with children, "We were always gardening but now we can be better gardeners because we can name the plants."

The ECTR team also reconvened staff in online, monthly **Resiliency/Learning Circles** starting the week of April 9th, 2020. These forums provided a critical space for teachers and staff to come together, by site, and talk through their own apprehensions and fears amidst the pandemic, and those being experienced by the children and families they serve. The ECTR Project Coordinator, Dr. Smith, led the Resiliency Circles and invited all site staff, except for the Center Director (by design), to join on their lunch break. This was an opportunity to have time to reflect together on the current challenges, wellness during Covid-19, and also how to re-open sites safely.

According to Dr. Smith, the Circles were sometimes emotional, teachers were in distress, and many attendees were in tears but "feeling uplifted and challenged together." It became clear to Dr. Smith that Covid-19 is a traumatic event and "if we teach the strategies about trauma, we have to be about it." The manner in which she led the Resiliency Circles with teachers and staff was critical in reinforcing and modeling how staff need to work with children. She acknowledged all feelings, fears, and anxiety and allowed them to name it. She acknowledged that they were in a safe place and normalized their tears without judgment, just as they do with the children.

A **Leadership Team Peer Support Learning Circle** for managers on May 21st, 2020 , led by Kriss Sulka, LCSW, an Oakland-based early childhood mental health expert, allowed leaders to come together and learn, receive support, and troubleshoot issues associated with the impacts of the pandemic, implementing ECTR and adopting a trauma-centered organizational approach. Kriss Sulka also led a similar one-hour training on June 4th, 2020 for the Head Start Inclusion Team to discuss the impacts of the pandemic on their work specifically.

While these activities continued, YMCA was also making plans to re-open on July 6th, 2020. While also managing staff anxiety about re-opening, YMCA staff and leaders plan to conduct a reorientation with families to make their return as smooth and safe as possible and to ensure that everyone knows what to expect. An important element of this re-opening plan will involve building on the knowledge and expertise that Head Start staff has learned about trauma-informed care. The students, their families and many of the Head Start staff have experienced trauma as a result of the Covid-19 outbreak. The ECTR project has positioned Head Start to better support children, families and out own staff through this traumatic time.

Year 3

In the third and final year, the program leaders continued to listen to staff feedback that trainers should have relatable lived experience and that they would like new faces and perspectives. Several of this year's all-staff trainings were led by DB Bedford, a trainer and speaker on the topics of emotional intelligence based on his own life experience in his youth in the criminal justice system. Program leaders also expanded the audiences of the trainings to offer them to parents as well.

On August 13, 2020, all staff attended the training on **Emotional Intelligence**. Through personal stories from his early life in Oakland, Bedford described how he lost several of his childhood friends

to murder over emotionally charged incidents and struggled with his own emotional outbursts and violent behavior. His behavior consequently landed him in jail facing serious time for losing his temper and attempting to take another man's life. Staff were able to apply prior learning from trauma-informed training as well as see an undesirable path for some of the children in their classrooms if their emotions and trauma were not addressed properly.

The last all-staff training was held on June 4, 2021 during Wellness Day on the topic of **Belief Theory.** The trainer, Steve Bacon, led a training on the topic of one's self-image related to trauma and traumatic experiences. He discussed strategies for shifting one's mindset about trauma.

"We are the ones that hold power and we can learn a lot from children by listening and watching them, their verbal and physical reactions and using that to support them." – Health and Family Service Specialist, 2021

Bedford returned on October 23, 2020 to conduct the same **Emotional Intelligence** training with parents and again on January 25, 2021 to conduct an **Emotional Detox** training with all staff. The trainings were well-received by staff who appreciated his relatable style and approach.

In the fall and into the following summer, Dr. Anita Smith continued to lead **Resiliency Circles** at each of the four sites on the topics of **Self Care Strategies and Wellness during Covid-19**. These circles allowed staff a space to reflect on and apply the self-care strategies learned in the prior year and to share their personal stresses and challenges as well as those related to the children and families they work with. Dr. Smith also led a training for Resiliency Champions to continue the "train the trainer" model for Champions to hold these spaces for staff at each site.

"My emotional well-being was affected [by Covid-19]. Meditation was the biggest thing that helped me. Tuning into my body and understanding what was happening. I used to have lots of panic attacks –tingling, breathing signs. I started meditation. I would think about families and kids… I used these concepts at work and at home." — Health and Family Service Specialist, 2021

In addition to the **Emotional Intelligence** training for parents, other trainings for parents included **Resiliency and Trauma** on September 25, 2020 and **Surviving Covid** on December 16, 2020. This was a critical component of the program's trauma-informed design to ensure everyone involved at the YMCA sites, from teachers, staff, leadership to parents, were able to use the same language and call upon the same concepts learned in trainings around trauma.

Table 3. Training Sessions and Attendance

Training Name	Date	Length	# Attendees
Year One Trainings			
Understanding Trauma Informed Practices for Early Childhood Programs (All Staff)	Feb 15, 2019	8 hours	62
Kick-off and Leadership Reflective Practices	June 10, 2019	3 hours	17
Resiliency Champion Meeting 1	June 10, 2019	3 hours	15
Resiliency Champion Meeting 2	June 24, 2019	3 hours	15
Year Two Trainings			
Resiliency Champion Meeting 3	July 1, 2019	3 hours	13
Resiliency Champion Meeting 4	July 15, 2019	3 hours	13
Resiliency Champion Meeting 5	Aug 19, 2019	3 hours	11
Trauma-Informed Practices: Self-Care for Early Childhood Providers (All Staff)	Aug 22, 2019	3 hours	86
Resiliency Champion Meeting 6	Sept 9, 2019	3 hours	11
Resiliency Champion Meeting 7	Sept 23, 2019	3 hours	10
Resiliency Champion Meeting 8	Oct 7, 2019	3 hours	10
Resiliency Champion Meeting 9	Oct 21, 2019	3 hours	8
Trauma-Informed Practices: Classroom Strategies (All Staff)	Oct 14, 2019	6 hours	67
Resiliency Champion Meeting 10	Nov 1, 2019	3 hours	7
Self-Care Part 2 (All Staff)	Jan 27, 2020	3 hours	85
Resiliency Circles (site-based)			
South Y	Feb 19, 2020	2 hours	12
Vera Casey	Mar 10, 2020	2 hours	8
Resiliency Circles-virtual (site-based)			
South Y (Self-Care and Wellness During Covid-19)	Apr 9, 2020	1 hour	15
West Y (Self-Care and Wellness During Covid-19)	Apr 15, 2020	1 hour	15
Vera Casey (Self-Care and Wellness During Covid-19)	Apr 23, 2020	1 hour	15
Oceanview (Self-Care and Wellness During Covid-19)	Apr 29, 2020	1 hour	15
South Y (Prioritizing to Minimize Stress & New Normal)	May 13, 2020	1 hour	15
Vera Casey (Prioritizing to Minimize Stress & New Normal)	May 14, 2020	1 hour	15
West Y (Prioritizing to Minimize Stress & New Normal)	Jun 12, 2020	1 hour	15
Oceanview (Prioritizing to Minimize Stress & New Normal)	Jun 19, 2020	1 hour	15
Family Engagement Part 1 -virtual (All Staff)	May 18, 2020	3 hours	65
Leadership Team Peer Support Learning Circle (leadership)	May 21, 2020	1 hour	9
Family Engagement Part 2 -virtual (All Staff)	May 28, 2020	3 hours	65
Peer Support Learning Circle (Inclusion Team)	Jun 4, 2020	1 hour	4
Year Three Trainings			
Emotional Intelligence (All Staff)	Aug 13, 2020	90 min	85
Resiliency Circles (site based)			
South Y	Jul 11, 2020	1 hour	15
West Y	Sept 11, 2020	1 hour	15
West Y (Self-Care and Wellness During Covid-19)	Oct 28, 2020	2 hours	13
Oceanview (Self-Care and Wellness During Covid-19)	Nov 18, 2020	2 hours	10
Vera Casey (Self-Care and Wellness During Covid-19)	Dec 10, 2020	1 hour	5
West Y	Jun 24, 2021	1 hour	15
South Y	Jun 25, 2021	1 hour	15
Oceanview	Jun 28, 2021	1 hour	10
Vera Casey	Jun 29, 2021	1 hour	5
Resiliency and Trauma (Parents)	Sept 25, 2020	1 hour	35
Resiliency Champions Training	Nov 20, 2020	1 hour	3
Emotional Intelligence (Parents)	Oct 23, 2020	90 min	35
Surviving Covid (Parents)	Dec 16, 2020	90 min	6
Emotional Detox (All Staff)	Jan 25, 2021	1 hour	85
Wellness Day: Belief Theory	Jun 4, 2021	1 hour	85

Source: ECTR program documents

Findings

Demographic Data

While the ECTR program activities are aimed at teachers and staff, the ultimate long-term goal of the program is to improve the lives of the children they serve. We, therefore, consider children the primary participants of the program and provide their demographics below. Demographic data was collected from Head Start's ChildPlus system as well as a supplemental parent/guardian survey for demographics not collected in ChildPlus (e.g., MHSA ethnicity categories). The program's Theory of Change posits that more immediate changes will first occur in teachers and staff, as described in Figure 1 later in the report.

Child (Participant) Demographics

The ECTR program served 197 children at the four program sites in 2018-19, 197 in 2019-20, and 178 in 2020-21 (see Table 4). The majority of children's primary language is English (67%), and 23% primarily speak Spanish. There are more male (59%) than female (41%) children. All children are in the 0-5 age group. The most common disability among the children is a speech/language impairment (39%).

Table 4. ECTR Child Demographics[2]

	n	Year 1 (N=197) %	n	Year 2 (N=197) %	n	Year 3 (N=178) %
Site						
Oceanview	49	25%	48	24%	42	24%
South YMCA	69	35%	63	32%	56	31%
Vera Casey	16	8%	19	10%	18	10%
West YMCA	63	32%	67	34%	62	35%
Total	*197*	*100%*	*197*	*100%*	*178*	*100%*
Gender (assigned at birth)						
Female	97	49%	93	47%	73	41%
Male	100	51%	104	53%	105	59%
Total	*197*	*100%*	*197*	*100%*	178	100%
Age						
0-5	197	100%	197	100%	178	100%
Primary Language						
English	130	66%	119	60%	120	67%
Spanish	41	21%	43	22%	41	23%
Urdu	5	3%	2	1%	1	<1%
Arabic	4	2%	4	2%	4	2%
French	4	2%	2	1%	2	1%
American Sign Language	2	1%	0	0%	0	0%
Berber	2	1%	2	1%	2	1%
Mongolian	2	1%	0	0%	1	<1%
Punjabi	2	1%	1	<1%	0	0%
Tigrina	2	1%	1	<1%	2	1%
Amharic	0	0%	1	<1%	1	<1%
Chinese/Mandarin	1	1%	1	<1%	2	1%
Laotian	1	1%	0	0%	0	0%
Nepalese	0	0%	1	<1%	1	<1%
Russian	1	1%	0	0%	0	0%
Korean	0	0	0	0	0	0%
Missing	0	0%	20	10%	1	<1%
Total	*197*	*100%*	*197*	*100%*	*178*	100%
Disability						
Communication: difficulty seeing	0	0%	0	0%	0	0%
Communication: difficulty hearing	0	0%	0	0%	0	0%
Communication: other, speech/language impairment	39	20%	20	10%	70	39%
Mental domain	4	2%	2	1%	0	0%
Physical/mobility domain	3	2%	0	0%	12	7%
Chronic health condition	11	6%	1	<1%	0	0%
Other	11	6%	3	2%	13	7%
[No Disability]	129	65%	171	87%	83	47%
Total	*197*	*100%*	*197*	*100%*	178	100%

Source: YMCA ChildPlus

[2] The MHSA categories of sexual orientation, veteran status, and current gender identity are excluded as instructed.

A supplemental survey asking only the following race and ethnicity questions was administered to families in May 2021. Black/African American children are the largest ethnic/racial group served (29%) followed by children reporting "Other" (28%) (See Table 5).

Table 5. ECTR Child Race and Ethnicity Demographics[3]

	Year 1 (N=154)		Year 2 (N=158)		Year 3 (N=109)	
	n	%	n	%	n	%
Race						
American Indian or Alaska Native	3	2%	4	3%	0	0%
Asian	8	5%	6	4%	10	9%
Black or African American	64	42%	75	47%	32	29%
Native Hawaiian or other Pacific Islander	0	0%	0	0%	0	0%
White	17	11%	36	23%	10	9%
Other	42	27%	15	9%	30	28%
More than one race	18	12%	20	13%	18	17%
Declined to answer/Unspecified	2	1%	2	1%	9	8%
Total	*154*	*100%*	*158*	*100%*	*109*	*100%*
Ethnicity: Hispanic or Latino						
Caribbean	0	<1%	1	<1%	0	0%
Central American	2	1%	1	<1%	2	2%
Mexican/Mexican-American/Chicano	37	30%	42	27%	35	32%
Puerto Rican	0	<1%	1	<1%	1	1%
South American	1	<1%	2	3%	2	2%
Other	1	<1%	0	0%	2	2%
More than one ethnicity	5	4%	15	9%	8	7%
Declined to specify	0	3%	1	<1%	0	0%
Total Hispanic or Latino	46	*30%*	*63*	*40%*	*50*	*49%*
Ethnicity: Non-Hispanic or Non-Latino						
African	53	34%	59	37%	7	6%
Asian Indian/ South Asian	2	1%	3	2%	0	0%
Cambodian	1	1%	2	1%	1	<1%
Chinese	1	1%	2	1%	3	3%
Eastern European	0	0%	1	<1%	0	0%
European	1	1%	2	1%	0	0%
Filipino	0	0%	0	0%	0	0%
Japanese	0	0%	1	<1%	0	0%
Korean	3	2%	0	0%	0	0%
Middle Eastern	6	4%	2	1%	2	2%
Vietnamese	0	0%	0	0%	1	<1%
Other	4	3%	11	7%	10	9%
More than one ethnicity	4	3%	0	0%	2	2%
Declined to specify	5	3%	12	8%	21	20%
Total Non-Hispanic or Non-Latino	*80*	*52%*	*95*	*60%*	*50*	*45%*
Ethnicity: Both Hispanic/Latino and Non-Hispanic Latino	*16*	*10%*	*0*	*0%*	*3*	*3%*
Ethnicity: Declined to answer	*12*	*8%*	*0*	*0%*	*9*	*8%*

Source: ECTR Supplemental MHSA Race/Ethnicity Survey

[3] The MHSA categories of sexual orientation, veteran status, and current gender identity are excluded as instructed.

Staff Demographics

In this third year of the program, a total of 41 staff who work at the four Berkeley YMCA Head Start sites responded to an online survey in the summer of 2021 for the evaluation. The survey was sent to 61 YMCA Head Start staff, including teachers and assistant teachers, managers, directors, coaches, family advocates, mental health consultants, and program assistants. The response rate was 67%.

Survey respondents in this third year of the ECTR program reflect the general breakdown of respondents over the past three years. They work at West YMCA (37%), South YMCA (32%), Oceanview (17%), and Vera Casey (12%) (See Table 6 below). Over half of survey participants have worked at the YMCA for greater than six years (52%), with 39% who have worked for Head Start for over 9 years. About a quarter of respondents have worked at YMCA for 3-5 years (27%) and about one in five have worked there for two years or fewer (22%). Participants include teachers (44%) and teacher assistants (24%), family advocates (12%), and administrative staff such as center directors (7%), and other staff (10%). The great majority are female (83%), and nearly half identified as either Hispanic/Latinx (34%) or Black/African-American (17%). Just under half of respondents were also Resiliency Champions (42%).

Table 6. Demographics of ECTR Staff Surveyed

	Year 1 %	Year 2 %	Year 3 %
Site			
Oceanview	17%	21%	17%
South YMCA	30%	31%	32%
Vera Casey	8%	12%	12%
West YMCA	43%	35%	37%
Other (responses: all sites, admin office)	2%	2%	2%
Length of time at YMCA			
Less than one year	12%	8%	5%
1-2 years	22%	14%	17%
3-5 years	20%	27%	27%
6-8 years	12%	10%	12%
More than 9 years	35%	42%	39%
Job Title/Role			
Teacher Assistant	30%	25%	24%
Teacher/Head Teacher	37%	48%	44%
Area Manager	5%	6%	0%
Center Director	5%	6%	7%
Coach	2%	0%	0%
Family Advocate	5%	8%	12%
Mental Health Consultant	5%	0%	0%
Program Assistant	3%	0%	0%
Other Manager	7%	0%	0%
Other (responses: floater, inclusion manager, kitchen)	2%	6%	10%
Missing	0%	2%	2%
Sex			
Female	77%	85%	83%
Male	5%	0%	0%
Missing/Declined to answer	18%	15%	17%
Race			
American Indian or Alaska Native	2%	0%	0%
Asian	7%	10%	12%
Black or African American	18%	17%	17%
Native Hawaiian or other Pacific Islander	0%	0%	0%
White	5%	8%	12%
Hispanic or Latinx	30%	37%	34%
Other	5%	2%	5%
More than one race	3%	0%	0%
Missing/Declined to answer	30%	27%	12%
Staff is a Resiliency Champion			
Yes	N/A	35%	42%
No		50%	51%
Missing		15%	7%

Source: ECTR Evaluation Staff Survey, June/July 2019 (N=60), May/June 2020 (N=52), May/June 2021 (N=41)

HTA developed and administered a 39-item online survey to teachers and staff at the four sites in May and June 2020. The survey was developed by HTA in collaboration with ECTR program leaders adapting some questions from the Year 1 survey as well as existing surveys from the City of Berkeley's 2016-17 Trauma-Informed Systems pilot program and a 2016 trauma-informed practices self-assessment from defendingchildhoodoregon.org. The survey is administered annually to assess change in how staff understand how their own past trauma impacts their work, how staff view children and families who have experienced trauma and how that impacts their behavior, and changes in how staff approach the children and families with whom they work. In the first year, the survey was administered in the summer of 2019 and designed slightly differently as a post-retrospective survey. It asked staff how they would have answered questions prior to ECTR trainings began and then how they would answer in the past 30 days. A few questions were added over the next two years in response to Covid-19 and other programmatic changes.

ECTR's Theory of Change posits that as staff attend trainings and learn about recognizing trauma, their own triggers, and strategies to working with children and families struggling with trauma, staff will change their own perceptions and feelings about trauma through reflections on their own lives and how that affects the way they work with children. Subsequently, they will begin to approach students and parents/guardians from a trauma-informed perspective (including shifting their framing from "What's wrong with you?" to "What happened to you?") and develop more positive, empathic relationships with students and their parents/guardians helping them to better identify trauma in the children/families they serve. Ultimately, staff will then change their actions and behaviors as it relates to children and families, and make more successful and "appropriate" mental health referrals. (See Figure 1 below).

Figure 1. ECTR Theory of Change for Staff

Source: Adapted from the ECTR Theory of Change

While there was incremental growth in the Year 1 survey results across staff views, their perceptions of children and their parents, as well as their behavior working with children and families there is limited growth in this second year. The YMCA and its ECTR project entered unchartered territory as a result of the stay-at-home orders resulting from the Covid-19 pandemic. While the ECTR trainings continued online and staff remained engaged with families, the ECTR project model is built on the premise that staff have day-to-day, intensive, in-person interactions with children throughout the school day, five days a week. Once the Head Start program shifted to virtual, children were no longer in the care of YMCA staff and YMCA staff did not have many opportunities to employ the strategies they continued to learn in trainings and Resiliency Circles. Their work with families was frequently limited to quick phone calls to check in. Likewise, the survey was not designed to measure the impact of a program that is shifting and pivoting to such a degree but rather for a structured and set program. This is important to highlight in order to contextualize those findings in that very unique year of ECTR programming.

Staff's familiarity with trauma-informed approaches continues to grow every year of this ECTR project. Over a third (39%) of participants expressed that they were "very" familiar with trauma-informed approaches this year which is an increase from 29% who expressed this last year, and 18% who expressed it in the first year (See Table 7 below).

Table 7. Staff Familiarity with Trauma Trainings

How familiar are you with trauma-informed approaches to support children/families?	Pre		Post Year 2		Post Year 3	
	n	%	n	%	n	%
Very familiar	11	18%	15	29%	16	39%
Somewhat familiar	39	65%	36	69%	23	56%
Not at all familiar	7	12%	1	2%	0	0%
Not Sure	1	2%	0	0%	2	5%
No response	2	3%	0	0%	0	0%

Source: ECTR Evaluation Staff Survey, June/July 2019 (N=60), May/June 2020 (N=52), May/June 2021 (N=41)

On average, survey respondents attended more trainings (3.42) than the year prior (2.25) through the ECTR project. See Table 8 below.

Table 8. Number of Trauma Trainings Attended by Staff

	Post Year 2		Post Year 3	
	n	%	n	%
0 trainings	7	14%	3	7%
1 training	13	25%	9	22%
2 trainings	8	15%	3	7%
3 trainings	10	19%	7	17%
4 trainings	12	23%	5	12%
5 trainings	2	4%	5	12%
6 trainings	n/a		6	15%
7 trainings	n/a		7	2%
8 trainings	n/a		8	5%
Mean # of trainings attended	***2.25***		***3.42***	

Source: ECTR Evaluation Staff Survey, May/June 2020 (N=52) Month 2021 (N=41)

Staff Views and Perceptions

In the survey, staff were asked about their views and perceptions of their own trauma and triggers, as well as their perceptions of children and families. In this third year of the program, staff felt most confident "that my actions had the ability to help a child who has been exposed to trauma" (76%) and "in using trauma informed strategies" (69%). These results are reflective of those in Year 2 (See Table 9 below). In questions pertaining to triggers, there was an increased awareness by staff of what their triggers were both in terms of their own trauma (49% compared to 29% in Year 2), and that of the behavior of a child (56% up from 49% in Year 2).

We see two years in a row recently where very few staff report they had difficulty maintaining a positive learning environment because of challenging classroom behavior (3% in Year 2 and 7% in Year 3). This may be related to the fact that staff were not regularly working directly with children at the time of the survey as a result of closures for Covid-19.

Table 9. Staff Self-Perception

	Pre % "Often" or "Always"	Post Y1 % "Often" or "Always"	Post Y2 % "Often" or "Always"	Post Y3 % "Often" or "Always"
I felt I could handle every serious behavioral issue by myself	38%	43%	38%	38%
I reflected on my own trauma and triggers	38%	67%	29%	49%
I noticed when I felt triggered by a child's behavior	51%	70%	49%	56%
I felt confident in using trauma informed strategies	69%	74%	67%	69%
I had difficulty maintaining a positive learning environment because of challenging classroom behavior	21%	26%	3%	7%
I felt confident that my actions had the ability to help a child who has been exposed to trauma	76%	81%	72%	76%

Source: ECTR Evaluation Staff Survey, June/July 2019 (N=60), May/June 2020 (N=52) May/June 2021 (N=41)
Note: Percentages are valid (i.e. exclude missing and N/A responses). Pre and Post Y1 results are among staff who responded to the item for both the Pre and Post time periods. Percentage of missing or N/A responses for perception, behavior, and morale items in the Pre/Post Year 1 survey ranged from 20-36%, and from 15%-44% in the Post Year 2 survey and 12%-27% in Post-Year 3 Survey.

For the survey items regarding staff perceptions of students and parents, staff sentiment about children and their future demonstrated a generally positive trend over the duration of this project that are increasingly seen and understood family and child trauma and the benefit of their using trauma-informed strategies in their work. (See Table 10 below). None of the staff "felt that a child's actions/behavior made me irritated" (from 14% in post-Year 1 to 6% in post-Year 2 and 0% in Post Year 3) and most continued to feel generally hopeful about the lives of the children" (78% in Year 2 and Year 3) and "saw" how "class disruptions" or "behavior problems" could be related to trauma the child has experienced" (74% compared to 38% in Year 2). In Post Year 3, there was an increase in how staff 'saw' how children (from 56% to 62%) and parents (from 46% to 56%) were impacted by trauma and also how staff saw "improvements in a child's behavior after I used trauma-informed strategies" (from 33% in Year 2 to 63% in Year 3).

Staff understanding "why families may not seek out or accept mental health services/programs they need" dropped from 78% in Year 2 to 56% in Year 3. This may be an area worth investigating, whether staff need to revisit training topics or whether this is just a symptom of their frustration working with certain families they feel would benefit from services.

"I have learned a lot, especially a few years ago with the anger issues. Parents are not getting help. We have to treat the parent as a child when trying to tell them what is going on. Explain it slow. I understand where parents are coming from too." – Pre-school Teacher, 2021

As staff described in a Year One focus group, participants described the challenges of getting parents to see the issues with their child and to get them to agree to seek services.

- "It's difficult if families don't agree that there are behavioral issues, they don't want to see it."
- "At the end of the day it's the family's choice to get extra services, and it is frustrating when they decline."
- "Parents don't want their kids labeled"
- "We will put in referrals for extra services, but it's up to the parents to accept."
- "We need to educate the parents."

An extra question was added in Post Year 3 that reflected on the impact of the trauma training taken by staff on ability to see strengths in families. Just over half (56%) of the staff felt that they were better able to recognize this than before the training.

Table 10. Changes in Perceptions of Students and Parents

	Pre % "Often" or "Always"	Post Y1 % "Often" or "Always"	Post Y2 % "Often" or "Always"	Post Y3 % "Often" or "Always"
A child's actions/behavior irritated me	11%	14%	6%	0%
I saw how children at my site have been impacted by trauma	67%	69%	56%	62%
I saw how parents/families have been impacted by trauma	66%	66%	46%	56%
I saw how "class disruptions" or "behavior problems" could be related to trauma the child has experienced	67%	74%	38%	74%
I saw improvements in a child's behavior after I used trauma-informed strategies	46%	59%	33%	63%
I felt hopeful about the lives of the children at my site	81%	84%	78%	78%
I understood why families may not seek out or accept mental health services/programs they need	70%	70%	78%	56%
I see strengths in families I would not have recognized before the trauma trainings	--	--	--	56%

Source: ECTR Evaluation Staff Survey, June/July 2019 (N=60), May/June 2020 (N=52), May/June 2021 (N=41)
Note: Percentages are valid (i.e. exclude missing and N/A responses). Pre and Post Y1 results are among staff who responded to the item for both the Pre and Post time periods. Percentage of missing or N/A responses for perception, behavior, and morale items in the Pre/Post Year 1 survey ranged from 20-36%, and from 15%-44% in the Post Year 2 survey, and from 17%-22% in Post Year 3.

Staff Behaviors

Nearly all staff (91%) reported that they kept themselves "calm and regulated in moments working with a student who is challenging." As with Year 2, about one in five respondents (21%) still "felt hesitant to refer students to mental health resources." (See Table 11 below.) A high percentage of staff emphasized teamwork in their role with 80% "working with other co-worker to support a child with emotional or behavior issues related to trauma" (from 68% in Post Year 2).

The percentage of staff who "knew where or to whom to go when I had questions about a child's or parent's mental health", while still high, had dropped from 85% in Post Year 2 to 80% in Post Year 3. However, **the percentage of staff who "used strategies rooted in trauma informed practices" dropped more dramatically from 74% in Post Year 2 to 58%, a proportion below those at Year One of 67%. It would seem that although staff still knew where and who to turn to with questions about a child or parents mental health, their ability to draw on their trauma informed training and use the tools they had learned to cope with their responses to challenging behaviors had dropped.**

With a return to in-school teaching, the results remained stable or showed a slight increase to "pre pandemic" percentages on questions about relationship-building with families like "I felt comfortable talking to parents about their child's emotional, developmental, or behavioral issues" (68% to 71%),"I worked with a child's parent/family to support a child's emotional or behavior issues related to trauma" (53% to 61%), "I was able to build rapport with most parents/families" (66% to 65%). However, while 71% of staff "felt comfortable talking to parents/families about their child's emotional, developmental, or behavioral issues related to trauma", an increase from 68% in Post Year 2, there was a drop from Post Year 2 in sharing information on trauma and its effects on child's behavior with families (53% to 38%) as well as sharing ways to "manage challenging trauma-related

behavior" (50% to 38%). Three quarters (77%) of the staff reported feeling "more compassion for the families/children I work with."

Table 11. Changes in Staff Behaviors

	Pre % "Often" or "Always"	Post Y1 % "Often" or "Always"	Post Y2 % "Often" or "Always"	Post Y3 % "Often" or "Always"
I was able to build rapport with most parents/families	79%	81%	66%	65%
I felt comfortable talking to parents/families about their child's emotional, developmental, or behavioral issues related to trauma	67%	79%	68%	71%
I worked with a co-worker to support a child with emotional or behavior issues related to trauma	80%	84%	64%	80%
I worked with a child's parent/family to support a child who had emotional or behavior issues related to trauma	63%	75%	53%	61%
I shared information about trauma and its effects on behavior with parents/families	50%	67%	53%	38%
I used strategies rooted in trauma informed practices	67%	79%	74%	58%
I shared ways that I manage challenging trauma-related behavior with parents/families	51%	63%	50%	38%
I felt hesitant to refer a child to mental health resources (e.g., mental health specialist, outside mental health services)	21%	28%	21%	12%
I knew where or to whom to go when I had questions about a child's or parent's mental health	79%	81%	85%	80%
I kept myself calm and regulated when working with a child with challenging behavior	87%	93%	94%	91%
I feel more compassion for the families/children I work with	--	--	--	77%

Source: ECTR Evaluation Staff Survey, June/July 2019 (N=60), May/June 2020 (N=52), May/June 2021(N=41)
Note: Percentages are valid (i.e. exclude missing and N/A responses). Pre and Post Y1 results are among staff who responded to the item for both the Pre and Post time periods. Percentage of missing or N/A responses for perception, behavior, and morale items in the Pre/Post Year 1 survey ranged from 20-36%, and from 15%-44% in the Post Year 2 survey, and from 15% -22% in Post Year 3 of the Survey.

In open-ended survey responses, staff described how the trauma trainings and/or resiliency circles impacted their awareness of how trauma impacts families and children:

> **"The trauma training to me brought about an awareness of some of the after effects trauma have on children and families. It taught sensitivity, empathy, and compassion."**
>
> **"I am much more empathetic and understanding towards the struggles families are facing, and how they might project those struggles."**
>
> **"Just to understand their emotions and be a good listener about families emotional needs, look for mental support when family need it, and the most important support our children emotionally in the classroom."**

Some were more specific in how the training had given them a new perspective and greater understanding of the impact of trauma on children and families:

"I learn that [it] depend[s] on us if we want to keep a negative thought all the time with us or we can move on to a positive way."

"The circles help me to stop and think carefully before responding to a situation."

"More compassionate and understanding. More reflective about behaviors I see as associated to trauma."

"I understand that how we feel, this will be the environment in which those around us will be. So we have to know how to control our emotions and have a positive mind."

"The trainings have helped remind me of the signs of trauma in young children and how challenging behaviors can sometimes be connected to trauma experiences as well."

Others appreciated the training and how it enabled them to do their job better:

"I appreciate the opportunity to received quality trauma trainings, which help me to provide support to the families and myself."

Or helped them at home or in their world outside YMCA:

"After having trauma training, I think about what type of trauma a child may be going thru at home. It also helps me with my grandchildren that I am raising."

Staff also reflected on how the resiliency circles helped them to understand how trauma impacted themselves and the importance of self-care:

"The training helped me to understand first myself and then understand others."

"The resiliency circles have been a good reminder that self-care and a supportive environment is crucial to reduce stress levels which have been higher than normal with the impact of the pandemic on staff, families and children."

"I am thoughtful instead of reactive."

"I let out my inner want[s] and hopes."

"Learn to always take care of myself. Self-care is important for me. If I don't maintain myself strong and healthy no one will."

One respondent referred to the context of the last two years and the impact it has had on everyone:

"**We all had experienced a hard time for this pandemic, and we all need help for support this feelings. I believe that we need to help each other**."

Staff Morale

The evaluation also asked five questions, 2 from Post Y1 and Y2 and 3 new questions for Post Y3 to assess staff morale at the YMCA Head Start sites. Although the positive responses to these questions were higher in Year 2, the two questions reveal that a high proportion of staff continue to enjoy working at the school (89%), and staff

relationships are overall positive and supportive (80%). For the three extra questions added in Year 3, responses for two were at the same level for other items in this category, with 80% of staff feeling "more compassion for my fellow staff member" and "I take care of myself" (81%). However, a comparatively lower proportion of the staff (62%) felt "seen and heard at YMCA, as a full human" (See Table 12 below).

As the program evolves post-grant funding and staff are expected to work together to address children's mental health issues, we anticipate that staff morale and the quality of staff relationships will remain high or even increase. This is also important to monitor as staff morale could help reveal whether there are other issues impeding the program's successful implementation.

Table 12. Staff Morale

	Pre % "Often" or "Always"	Post Y1 % "Often" or "Always"	Post Y2 % "Often" or "Always"	Post Y3 % "Often" or "Always"
The relationships among the staff at this school were generally positive and supportive	85%	85%	91%	80%
I enjoyed working at this school	98%	94%	93%	89%
I feel seen and heard at YMCA, as a full human	--	--	--	62%
I feel more compassion for my fellow staff members	--	--	--	80%
I take care of myself	--	--	--	81%

Source: ECTR Evaluation Staff Survey, June/July 2019 (N=60), May/June 2020 (N=52), May/June 2021 (N=41)
Note: Percentages are valid (i.e. exclude missing and N/A responses). Pre and Post Y1 results are among staff who responded to the item for both the Pre and Post time periods. Percentage of missing or N/A responses for perception, behavior, and morale items in the Pre/Post Year 1 survey ranged from 20-36%, and from 15%-44% in the Post Year 2 survey and from 12% to 17% in Post Year 3.

"Our teaching staff have exhibited a level of empathy towards the children and families whereas they have purposed themselves to see them differently with the intention to better understand rather than labeling or pathologizing. Another layer to this shift has been their own awareness of their past historical trauma and how close their adverse childhood experiences are to the children and families we serve. With the heightened awareness and knowledge, they too have begun the work towards healing and restoration within their own lives." -Dr. Anita Smith, ECTR Project Coordinator, 2020

Mental Health Referrals

Number of Mental Health Referrals

As a critical component of the MHSA grant, mental health referrals were to be tracked every year of the evaluation in order to measure change over time. Based on Program Information Reports (PIR) completed by the Mental Health Consultants and submitted to the Program Manager over the past three years, the number of mental health referrals slightly increased to five referrals last year and then decreased to 0 in this third year (Table 13). In theory, the number of referrals, a longer-term outcome, is expected to increase as more staff understand their role in identifying and supporting access to children's mental health services.

Table 13. Number of Mental Health Referrals

School Year	# Children Referred
2017-18 (baseline)	9
2018-19	4
2019-20	5
2020-21	0

Source: YMCA Program Information Reports (PIR) forms

The reality of this outcome measure however is that ECTR leaders have since concluded that connecting children via Mental Health Referrals to an external service may not be the best or most appropriate method of serving children who need services, especially now that site-based staff are holding children and their needs differently.

Referrals to "Appropriate" Mental Health Services

Originally, ECTR project leaders established a mental health consultation process where the teachers start their own early observations of children in collaboration with the observations of Mental Health Consultants/Specialists. They also complete forms that show patterns of behavior which allows for questions, rather than complaints, about a child for whom they would previously have no tangible behavioral examples. These forms provide an opportunity to discuss and initiate Trauma Informed Care strategies within the consultation meetings and classrooms.

Additionally, a new Mental Health Referral form, implemented in the fall of 2019, was initiated to be intentional about outside referrals and determine if they were "appropriate." In other words, documenting whether staff contacted referral agencies before the referral, whether the agency was a thoughtful match for the child, whether families utilized the referral, and whether it met families' needs. These are used by the Mental Health Consultants/Specialist during the parent meetings with their approval, to refer children out for mental health services to appropriate organizations that are trauma-trained and informed. Our Mental Health Consultants/Specialists initiate the connection with organizations and the parents to begin the intake process with the purpose of building rapport with the organization as a secondary contact if they have challenges connecting with the parents afterwards. Mental Health Consultants/Specialists do a 15- to 30-day follow-up with the parents to inquire about the follow through on acquiring services. If the parents have not followed through, then the Mental Health Consultants/Specialist inquires to see if they can help facilitate any further. If it is decided collaboratively with the parents that a therapeutic preschool setting would be a better fit for their child, then a Mental Health Consultant/Specialist would support them by accompanying them on a tour/visit of the new preschool. This initiates the intake process and move.

Four children received five referrals between December 2019 and July 2020. All (5 of 5) referrals were appropriate, in other words, the referral agency had availability to take new clients, is located somewhere accessible to the client, has experience with children age 0-5, is a cultural match for the child, and was given information about the child's needs. Three of the four families utilized the services of the referral, and all families who utilized the services expressed that it met the families' needs. One child/family was referred to the same agency twice but did not utilize the service the first time (February 2020) because of the stay-at-home orders. The second time (July 2020) the family did not utilize the service because the child's mom indicated that she had not been contacted.

The ECTR project leaders have expanded their categorization to include mental health as well as behavioral health referrals. When designing the project, the project team initially thought referring more families to external mental health specialists would be the ideal scenario. As the project team has come to learn, that may not be the best option in terms of getting the right support to the children who need it. Additionally, getting families to agree that their child requires services and to agree to see a specialist is an ongoing challenge. Based on these learnings, the ECTR project has pivoted to support children who need a higher level of care in a much more appropriate and expeditious manner by bringing specialists directly into the classroom. As described by the project coordinator in 2020:

"Due to the early establishment of the new procedure which encourages early observations and inquiries, we have been able to have several children placed at two therapeutic preschools in the Bay Area being Maya Angelou Academy in Oakland and EBAC (East Bay Agency for Children) here in Berkeley. This can be seen as a rarity; due to classroom room size being considerably smaller than our classrooms, they fill up very fast. The collaboration with teachers and parents helps consider the wellbeing of the child and do not allow for things to be overlooked, ignored or dismissed. We have also had the benefit of working in collaboration with our Inclusion Team to coordinate having Behavioral Aides through Juvo (Autism and Behavioral Health Services) come into our classrooms to work with children who have both behavioral, developmental, and trauma concerns. We have been fortunate to witness the effectiveness of this support for current children within our program that would have otherwise been unmanageable within the classroom setting. These children's parents were not able to benefit from mental health services due to many personal and systemic issues, so to provide these services has been a true turn around for these children."

In this third year of the program and definitely since the pandemic began, leaders also see many outside referral agencies (e.g., therapeutic preschools) are no longer accepting new referrals for safety reasons. Outside referrals that were accepting new children were for virtual meetings that are not as effectively for children of this age, especially when they are with someone with whom children are unfamiliar. Program leaders describe that the need also changed as a result of trauma trainings because staff engagement with children changed. There was also the added benefit that when classrooms re-opened, spaces were limited initially to children of essential workers. These small class sizes were one of the benefits of the therapeutic preschools to begin with. The YMCA also increased the number of ADA aides available for one-on-one support for behavior and emotional issues in the classroom. This staff person was allowed into the classroom during the pandemic which allowed them to stay at the YMCA rather than be referred out. An unintended benefit was that all the other children in the classroom also learned to think differently about that child in terms of how to interact and play with them, rather than seeing them as "bad."

As program leaders see it, building the YMCA sites' internal capacity was always central to the design of the grant. When it comes to mental health referrals, "the action is where the kids are" and periodic pull outs takes a long time. If they are able to bring in aid to the classroom for a child, that is more efficient than sending the child out twice a week. They plan to prioritize funding to internal specialists because external mental health referrals are only a small part of the picture. Having the internal capacity to support children builds staff confidence and what sets this program apart. They want the YMCA classroom to be the place for daily habit making, emotional development, learning how to work productively with others, and how to manage having a hard time. "We saw that investment in the last three years. We saw this lead to fewer mental health referrals. There was no outside capacity for referrals anyway but there was also less need."

Conclusion

In this final year of the ECTR program, staff have demonstrated a commitment to trauma-informed and resiliency strategies and applying these strategies and others from trainings on topics such as Self Care and Emotional Intelligence in their day-to-day work with children and families as well as in their personal lives. Program leaders and staff describe in interviews how integrated these concepts have become in the culture of the YMCA sites and they are "rippling outward" to other sites based on the success other sites are seeing at the Berkeley YMCA sites.

ECTR leaders reflected on what would have happened over the past three years, especially during Covid closures, without the ECTR program:

"People would have been withdrawn, the resiliency wouldn't have been there. If we were not prepared for the overload of emotional tension, we could do more harm than good… But because [foundation was] put in place, the rain boots were on when it's storming, the majority of your body has been protected. You were affected by the pandemic but had the padding to bounce off stresses. We were always in community in sites –big community and

small community at each site. I saw how they banded together. You can feel like a teenager, so dysregulated. You can't leave the house. We'd get on zoom and get together with your colleagues. No staff ended up in a corner in the fetal position. They can't say they don't know about trauma. They have a common language… I would go to staff meetings during the closure and noticed a different type of capacity among staff. Center directors had some words to acknowledge people. There was consistency around empathy, appreciation, and sharing feelings. People were crying during staff meetings –sharing 'this is so hard for me.' People felt comfortable having these outpourings and knowing how to respond. And setting up that positive experience was remarkable. We would not have had that without the foundation [we built three years ago]… Some county sites were also able to ask for help –management was a part of our meetings even though they weren't part of grant. They knew they needed something although they couldn't name it. They knew we existed but they didn't have a mental health specialist. They implemented what we told them –I was floored. I hadn't worked with them but they received [my recommendations] and put it onto action. It trickled down."

We did see an unexpected finding in this third year of the staff survey where the percentage of staff who "used strategies rooted in trauma informed practices" dropped from 74% in Year 2 to 58% in Year 3, a proportion below those at Year One of 67%. While newly onboarded staff receive training on trauma-informed strategies, it may be beneficial for all staff to have a "refresher" training on the topic, either by an outside trainer or the Resiliency Champions.

As the grant funding ends, ECTR program leaders plan to continue, sustain, and evolve this trauma-informed work with the Berkeley sites and across other YMCA sites.

1. Systems change:
    a. While work still needs to be done to implement trauma-informed systems, trauma-informed language has been incorporated into the program. The CEO now talks about trauma-informed systems. The seeds have been planting for program leaders to carry this work forward and enact system-level changes.
    b. Providing more mental health support has become a priority, and there is a desire to increase the number of mental health staff rather than outsourcing mental health services to outside providers. ECTR program leaders have also committed to integrating mental health employees into teams and have provided teachers with additional mental health training and support.
2. Funding and Fundraising Priorities:
    a. ECTR leaders are looking into additional grant funding after the current grant expires. There are also potential sources of federal funding.
    b. One priority area will be securing funding to ensure that every site eventually has its own mental health and behavioral specialists (mental health staff are currently split across three local sites). Program leaders anticipate that, following the pandemic, there will be an increased interest in funding opportunities for mental health programming.
    c. Training for teachers around trauma-informed care and emotional intelligence will also be prioritized.
    d. ECTR leaders will also seek out additional funding to address early Head Start wellness goals. Wellness goals are usually centered around physical health (e.g., asthma and obesity), but ECTR leaders hope to find funding to implement a multi-faceted approach to wellness.
3. Developing Wellness Policy:
    a. ECTR leaders are in the process of developing a wellness policy that pulls together themes of wellness, self-care, coping, and emotional intelligence. There has been a programmatic and cultural shift to a growth mindset, and goals have shifted from surviving to thriving. One way that this reframing has been put into practice has been the implementation of Wellness Day, which used to be Staff Appreciation Day. Now, the day is spent on addressing different components of wellness through activities like yoga, a trip to the park, music and dance, games, and socializing with peers.
4. Incorporation of PEARLS:

a. ECTR has begun incorporating the Pediatric ACEs and Related Life-events Screener (PEARLS) into programming. Additionally, ECTR staff have worked to improve parental awareness of PEARLS through parent trainings, though not all components of PEARLS have yet been covered.

Appendix

Interview Summary

ECTR Staff Interview Analysis

1. Please tell me your role at YMCA and how long you've been in that role. Are you also a Resiliency Champion?

   Nutrition Specialist: Has been in YMCA Nutrition Spec. Nutrition Ed for about a year and a half. Prior to this role, was a family advocate for about 2 years as part of Resiliency Champions.

   Health and Family Service Specialist: Has been working as Health and Family Service Specialist for about 2 years now and at the YMCA almost 6 years. Family advocate before and shifted to more health aspects.

   Pre-school Teacher: Pre-school teacher, 3-5 for 7 years now. Started with infants and toddlers. Pre-schoolers last 4 years. Not a Resiliency Champion.

2. What, if anything, have you taken from the trainings in your work with children, their parents, your colleagues or your personal life?

   Overall, all interviewed staff described the trainings as helpful both professionally and personally. One common theme across interviewed staff was that staff have been able to apply what they learned through these trainings in their day-to-day interactions with children, their colleagues and with their own children. For instance, one staff member relayed that deep breathing is a common practice that she uses every day with her students. These trainings have also helped staff better communicate with students.

   What follows is a high-level summary of staff feedback by training type:

   Brain training:

   - All staff found this training helpful and reinforce what they knew before the training.
   - Staff have applied what they have taken from the trainings in their work and personal lives.
   - One staff member noted that this training provided tools that were realistic for staff use.
   - One staff member shared that the training introduced her to different terminology and approaches to support her students. Additionally, the training helped her reflect on her own triggers and sparked an interest in mental health.

   Self-care trainings (Emotional intelligence and Emotional Detox):

   - One staff member appreciated that all staff were in the same space and that the speaker was someone staff could relate to.
   - Another interview staff relayed that these trainings were helpful to shared and hear what others were doing to cope with pandemic-related stress.
   - Interviewed staff learned skills that they have applied while at work and/or at school. For instance, one staff member noted that it helped her frame how she might approach or process someone else's behavior (i.e., pausing intentionally before reacting to something). Another staff member shared one practice she took from the training is going on walks and taking breaks so that she is able to present and fully engaged with her students or with her own children at home.

     "When I go home, set work aside to focus on kids. This was hard to do before but with self-care training and experience it has gotten easier." – Health and Family Service Specialist

"I talked with other staff about these trainings about what's going on and/or give approaches and suggestions to take care of ourselves. We're all feeling this way so became a great way to accept that and it's ok to take time." – Health and Family Service Specialist

"We are the ones that hold power and we can learn a lot from children by listening and watching them, their verbal and physical reactions and using that to support them." – Health and Family Service Specialist

- Only one of the three interviewed staff members participated in a resiliency circle. This staff member said that while she likes the idea of these circles, she had some reservations about sharing what she felt. She added that maybe with more time she would warm up to being more open during the conversations.

Resiliency Champion Trainings:

- All interviewed staff appreciated that staff from different sites and roles within the organization participated in these trainings.
- One staff member noted that these trainings reinforced what she already knew and that the case studies examined during the training provided a framework for this work.
- Trainer (Julie) taught them how to share this information with colleagues and parents.

"The Resiliency Champion Trainings helped reinforce what I already knew. We as childcare providers, I was looking at it as helpful for staff. Not everything is peaches and cream. There are issues that come with staff. I could see this as something they could use." – Nutrition Specialist

"I really appreciated coming together. We all hold the same values. The resiliency circles helped us support those conversations without making it burdensome to talk about things that are hard. I was able to confide in them." – Health and Family Service Specialist

3. MH referrals to therapeutic schools/places outside YMCA etc now shifted to behavior aides in classrooms. How is that different? Better? Worse?

   Interviewed staff believe that staff who participated in the recent trainings are more aware of mental health needs of children before referring them out than before receiving the trainings. One staff member noted that she refers children to their mental health consultant but that only a few students have required a referral.

4. Work during Covid? Self-care, self-regulation, trauma lens? In what ways are you using these skills if at all during covid?

   Two of the three staff members reported using skills they learned from the self-care and stress management training during the pandemic. One staff member shared that meditation was very helpful to check-in with herself. She added that she not only shared meditation exercises with her mom, but also told her parents about it.

Nutrition Specialist:
Yes, hard, distance learning. Self-care and stress management were most useful. The strategies mentioned before were probably most useful.

Health and Family Service Specialist:
Helpful, had a lot of personal situations. Families past away. My emotional well-being was affected. Meditation was the biggest thing that helped me. Tuning into my body and understanding what was happening. Used to

have lots of panic attacks –tingling, breathing signs. Started meditation. Would think about family and kids. Mom is a teacher at West Y. Shared these with her too. Used these concepts at work and at home. Supported staff –being at home, Zoom meetings. Having them talk to teachers and staff -kids are stuck at home they need more activities. At home, you can meditate, read books together. Tell parents they need time to support child at home but also take care of themselves.

Pre-school Teacher:
Did help. Reminder you're stuck in house you can only do a couple things. Reminder of what is occurring in other people's homes maybe not your own home. Trauma doesn't end just bc it's not in your home and we're not at work. Still happening.

5. Anything else you'd like to share about these trainings, your work with colleagues, families or children?

- One staff member would've wanted to see the Resiliency Circles continue past the sunset of the grant.
- A staff member would like to see more support for staff/adults to reduce staff burnout.
- Two staff members shared that the trainings provided tools to better support parents

"They may feel like not great parents –this gives us support that there are diff parenting styles and it's ok if you don't have all the tools. But we're here to support you with what you do have." – Health and Family Service Specialist

Nutrition Specialist:
Something that came up during trainings, didn't cover physical touch re: trauma. Know that has come up in prior work. Thought I had.

Since grant is sunsetting, this is a great start to make everyone more aware of work. Would have loved to see R Circles to continue w staff. Education staff on trauma informed practices is important for providing care to children, but staff burnout and lack of support for adults when there are challenges. Not sure what has been going on. Want that more visible and strengthened. Would be really impactful. For entire program.

What have you heard about end of grant activities?
Haven't had good pulse on activities since stopped R Champions. Large trainings are one and done. Haven't had sense this is ending or closing. With such a big program. Want to make work visible –can be challenge to get everyone up speed.

Health and Family Service Specialist:
Trauma and resiliency trainings, really enjoyed it. Sparked my interest in this work. Excited to start with field work w Dr. Anita. Now w staffing support. Will be able in Sept to be able to do it more differently with families. Is this effective and maybe change it. Even though I do hear needs, want to apply it with parents. Trust, if we can be emotionally tuned in with them they will be more communicative w us. They may feel like not great parents –this gives us support that there are diff parenting styles and it's ok if you don't have all the tools. But we're here to support you with what you do have.

Pre-school Teacher:
I have learned a lot, esp a few years ago with the anger issues. Parents not getting help. Have to treat parent as a child when trying to tell them what is going on. Explain it slow. Understand where parents are coming from too. Self-care recently –trying to help morale improvement. Could apply to personal lives. If you deal with that on outside. Can leave it at door when you come in.

Her strategy: Changing the environment. Same mess but diff toilet. Can't moving and changing jobs bc have to do work on inside. Not something I've always done but now I see it. Others are like me, hear that too.

Also DB example relationship w mother –have seen relationship with mother and kids. Could offer help who is having same struggles.

Focus Group Notes

Date of Focus Group: 11/27/2019
Facilitator: Sophie Lyons, HTA

Participants:

- Family advocate
- Teacher
- Teacher
- Enrollment and childcare
- Teacher
- Teacher
- Teacher

6. **Tell me about your work with children. What are one or two examples of the MOST challenging behaviors for you and how do you typically handle them?**

- Sometimes kids have not been identified as having or needing an individual family service plan; teachers and staff do not know their diagnosis
    - Teachers are not always equipped to deal with behavior issues, causes strain
    - Need to work with kid one on one to address their individual needs – discipline and positive reinforcement
- Parents are low income, affects the social life of families
    - Some kids are in single parent households
    - Often behavioral issues are physical in the classroom– fighting, pushing, biting
    - Teachers have years of experience and can recognize
- It's the undiagnosed children or kids who have family issues who have behavior issues
    - Children are physical towards the adults, not always towards other kids
    - Teachers take a child development classes, and learn a little bit about how to handle issues, but is it not always enough
    - Personal experience as parent with a child at Head Start - she had a child with behavioral issues, so has learned from that and understands the parent perspective, but it is still very challenging to work with some parents
    - Parents are not as educated (about child development) and are in denial; they also pass down generational trauma
- Difficult if families don't agree that there are behavioral issues, they don't want to see it
    - At the end of the day it's the family's choice to get extra services, and it is frustrating when they decline
    - Parents don't want their kids labeled
- Staff/teachers will put in referrals for extra services, but it's up to the parents to accept
    - Need to educate the parents
- In past 5 years, has seen/experienced more aggression from the kids, but not sure why
    - Kids are impulsive and quick to anger, short tempers, quick to react

Steps teachers and staff take to address issues

- Not allowed to call a parent for pick up, so they have to manage the behavior at school

- Teachers rely on each other to take over when they need a break – They are often able to recognize when they need to be separated from the child because they are getting overwhelmed/tired/too frustrated
    - They use a team approach in the classroom
- Document using ABC charts and they call parents to talk about their child when they complete these forms
    - Teachers try to focus on the positive with the parent when they come pick up the child, but also talk about the challenges with the parent
    - Use parent teacher conferences to talk about the challenges and the help kids need
- Teachers and staff try to drive home the point of safety to parents – help parents understand that they have a goal of keeping classrooms safe, so when one child is having behavioral issues, it means that one teacher has to work individually with them, which can decrease safety in the classroom
- When they talk to parents who blame other kids, they need to help parents see the good and the bad – they try to help parents see that all kids need to and deserve to be here
- Some parents are in denial – say the kid is fine with them and behaviors only happen in school
    - Have to try and get parents to see why that might be the case, that kids behave differently in different environments
- Try to give the kids all the love they can, but there is still a lot of stress
    - Even one challenging behavior kid can be a lot as they need the one on one time with teachers and staff

7. **Tell me about your relationships with parents. How do you handle difficult conversations around their child's behavior/needs? What is your process like when working with parents around their child's challenging behavior/needs?**

- A lot of times parent issues take priority over the child's issues
    - Talking about the child turns into a conversation about the parents' issues and needs
    - Parents get this help from family advocates, but cannot get out the mindset when they talk to teachers as well
    - The teachers are focused on the child's needs, while the FA is focused more on working with the whole family
- Many parents are in denial – "they don't do this at home…"
    - Or the challenging behavior is normal at home, so parent doesn't see it as an issue
    - Or parents who say they will be involved in finding a solution, but then they avoid the conversation with teachers
- If a parent does come to school to discuss the child during the day, a teacher has to leave the classroom to talk to a parent who is upset and could cause another safety issue
    - Parents say hurtful things to the teachers, sometimes they are discriminatory and disrespectful
    - Parent treat teachers like they are their employees sometimes

What could help the conversations with parents:

- Need a more strictly enforced code of conduct for anyone who comes in – parents need to stick to it, there is no consequence when parents do not follow it
    - At most there is a conversation
    - They just want parents to understand that they are trying to help the child in a school setting, trying to get them ready for bigger schools – teachers need help getting parents to understand what school is, that it's not just childcare
- Parents also experience a lot of trauma – teachers and staff know and recognize this

    - It's important to think about who is talking to the parents, a white staff member telling a parent of color what to do may not be effective

8. **What has been your experience with working with colleagues to help a child/family who has challenging behavior issues? What role do you see for yourself in helping families access mental health services? (Have you tried to help a child or family get mental health support? Why or why not?)**
   - Sometimes there is a misunderstanding – teachers know they are supposed to serve families
     - But sometimes teachers don't feel that they have the support they need from administration – there's a lot of turnover
   - Have mental health consultation meetings to talk about development of children
     - When families meet with different people who are telling them the same thing, this can help the family get on board
   - Try and learn the personality of the family, who is the best person/teacher to approach them
   - Case consultation is important, it's when you get to sit down with families
   - Inclusion specialists and speech consultants are very helpful, teachers feel like they can go to them for help with a kid
   - If you're a new teacher, you'll get walked over by the parents, need to have a veteran teacher in the room with you
   - Staff have to be on the same page, need to have good working relationships
     - Teachers will talk to parents and then they will go to FA, the FA needs to know what's going on before they talk to the parent
     - Some parents would rather talk to the FA, so all teachers and staff need to be aware and on the same page, FAs sometimes know more about what is going on with the family
     - But sometimes it is challenging when parents feel more comfortable talking to the FA (rather than the teacher) – raises a red flag for the teacher, they feel as if families should be comfortable talking to the teacher
   - Line of support exists, but sometimes the inclusion/mental health consultants are not available enough or you are too busy to do the one on one with them
   - When you do a referral form, but then the ball gets dropped or there is no follow up, this can be very frustrating

9. **Some of you may have taken an online survey from us a few months ago. We have some results that we want to share. Are these numbers surprising? Do they sound accurate? Why or why not?**
   a. **The percentage of staff who reflected on their own trauma and triggers increased from before to after the program started: 38% to 67%.**
   b. **The percentage of staff who could identify when they felt triggered by a child's behavior or actions increased from before to after the program started: 51% to 70%.**

- First statistic is accurate likely – Julie's training could have helped staff see their own trauma and triggers, her introduction about herself was the best thing she presented
  - Not sure about the second stat – may not be accurate

10. **Have you attended any of the recent trauma trainings (Understanding Trauma Informed Practices for Early Childhood Programs with Julie Kurtz; Self Care: Getting a PhD in You! with Julie Kurtz; Resiliency Champion trainings)?**

- Didn't find the trainings helpful – not agreeable to Julie's approach (*agreement from one other person in the group*)
- Initial story that Julie told about her own background was interesting and helpful, but then the rest of the presentations were not as helpful
    - Would be more helpful to have this person be able to show what they can do in the classroom, not just tell them what might work
- Every situation in the classroom is different, so what they are being trained on will not be the same or work for everyone
    - Training needs to be tweaked for different situations
- The "if you do x, then y will happen" way of training doesn't help as staff knows that kids have differences in what they need
    - Training is too "basic" teachers are more aware of trauma, they know more than the trainers expected
- The trainings are way too long – a multi hour training is hard to pay attention to (*group agreement on this*)
- Maybe the trainings should be done in smaller groups (*group agreement on this*)
    - Not everyone is paying attention, therefore they won't bring what they learned back to the classroom
    - Center by center would be better, smaller group trainings would be more effective
- Some teachers are not ready because they have their own traumas
    - Teachers have to deal with their own traumas
    - Trainings may heighten some people's awareness of traumas
- Anita provides more individualized care for teachers, which has helped
    - Teachers love working with Anita
- There has been progress in getting teachers to understand and recognize trauma, but there is still work to do
- It's the person, not the trainings themselves, that might be the problem
    - Didn't vibe with the style, too lecture based, too long
    - Interactive activities were better, need movement activities

11. **Has anything you learned in trainings changed or helped with your relationships with children? Parents? Colleagues? In your personal life?**

- Learning the physicality of what happens when they are triggered by a child's behavior
    - Smell reminders, etc.
- Talking about the importance of self-care was helpful, now they think about the self-care when a child is exhibiting challenging behavior
- There is a line that parents cross, we can't blame the teachers for reacting poorly sometimes
    - How do you "train" teachers to not have their own reactions, to not take things personally
- Need concrete strategies for how to work with parents
- Teachers are champions for each other, they feel protective of each other
- But parents also need actual consequences when they break the code of conduct, it can't just be
    - Bargaining team with the union is working on the importance of the code of conduct and holding parents accountable

Full Narrative Transcript, ECTR Project Coordinator

1. How did Head Start address trauma in children/families before the ECTR program?

Previous to the City of Berkeley Trauma grant the YMCA of the East Bay had established Mental Health Consulting whereas monthly classroom consultation meetings were conducted with teachers, Center Directors, Family Advocates and Mental Health Consultants/Specialists. Within these meetings, classroom dynamics were discussed which includes those children with what was considered "challenging behaviors" as well as resources that could be utilized to support them. This collaboration meeting would yield mental health consultation strategies and plans that would include social and emotional strategies to support the children on the radar and the classrooms as a whole.

In addition to these meetings individual child consultation meetings would be held with parents in order to gain more developmental and historical information that would help to better understand what was going on with their child and any family dynamics that were attributing to their child's presentation within the classroom. Additionally, within these parent meetings, a Positive Behavioral Support Plan would be established with strategies for the classroom and for the parents to utilize at home. Within these meeting outside resources were discussed like mental health services for the child and family as well as the possibility of a new small therapeutic preschool placement and possible psychological assessments needed to diagnosis with the intention of effective interventions. Parents would sign this document as an indication of acknowledgement and acceptance of their role and the steps that are necessary to support their child. This was to ensure the parental role in promoting their child's developmental and academic advances not only within the classroom setting but, in their child's, everyday life. This is seen as preventative care rather than intervention. Frederick Douglass stated that "it is easier to build strong children then to repair broken men."

2. What did you change with the ECTR grant? How? Why?

Our intention as The YMCA of the East Bay in applying for and accepting the City of Berkeley Trauma grant, is to empower or teaching staff, administration and management with evidenced based knowledge that is trauma informed with the purpose of changing the lens from what is wrong with this child to what has happened to this child. We believe that this knowledge would empower those within these classroom settings to change their individual understanding, mindset and heart set towards the children and families we serve. Therefore, since the onset of Trauma Informed trainings on the foundations of trauma which include the developmental and neurological effects of trauma, Trauma Informed care strategies, self-care strategies and engaging with families an allowed for a systemic anticipated shift to occur. Our teaching staff have exhibited a level of empathy towards the children and families whereas they have purposed themselves to see them differently with the intention to better understand rather than labeling or pathologizing. Another layer to this shift has been their own awareness of their past historical trauma and how close their adverse childhood experiences are to the children and families we serve. With the heightened awareness and knowledge, they too have begun the work towards healing and restoration within their own lives.

3. What systems, policies, procedures have you put in place in order to better address the mental health and behavioral needs of children?

At the onset of this City of Berkeley Trauma grant, we established a Mental Health consultation procedure whereas the teachers start their own early observations in collaboration with Mental Health Consultants/Specialists observations. They also keep behavioral forms that show patterns of behavior which allows for questions, rather than complaints about a child that they would previously have no tangible behavioral examples of. These forms provide an opportunity to discuss and initiate Trauma Informed Care strategies within the consultation meetings and classrooms.

Newly established Mental Health Referral forms were also initiated to be intentional about outside referrals. These are used by the Mental Health Consultants/Specialist during the parent meetings with their approval, to refer children out for mental health services to appropriate organizations who are Trauma trained and informed. Our Mental Health Consultants/Specialists initiate the connection with organizations and the parents to begin the intake process with the purpose of building rapport with the organization as a secondary contact if they have challenges connecting with the parents afterwards. Our Mental Health Consultants/Specialists do a 15-30 day follow up with the parents to inquire about the follow through on acquiring services. If the parents have not followed through, then the Mental Health Consultants/Specialist inquire to see if they can help facilitate any further. If it is decided collaboratively with the parents that a therapeutic preschool setting would be a better fit for their child, then a Mental Health Consultant/Specialist would support them by accompanying them on a tour/visit of the new preschool which initiates the intake process and move.

4. When did you put these in place and why? What are some examples of children/families these have worked for?

Due to the early establishment of the new procedure which encourages early observations and inquiries, we have been able to have several children placed at two therapeutic preschools in the Bay Area being Maya Angelou Academy in Oakland and EBAC (East Bay Agency for Children) here in Berkeley. This is can been seen as a rarity due to classroom room size begin considerably smaller than our classrooms, they fill up very fast. The collaboration with teachers and parents help consider the wellbeing of the child and not allow for things to be overlooked, ignored or dismissed. We have also had the benefit of working in collaboration with our Inclusion Team to coordinate having Behavioral Aids through JUVO come into our classrooms to work with children who have both behavioral, developmental and trauma concerns. We have been fortunate to witness the effectiveness of this support for current children within our program that would have others wise been unmanageable within the classroom setting. These children's parents were not able to benefit from mental health services due to many personal and systemic issues, so to provide these services has been a true turn around for these children.

We continue to look forward to the work ahead of us with empowering the parents in our program with the same trainings that we have provided for our staff. This is with the hope that it will not only allow them to have a better understanding of their children but to connect the dots on their own adverse childhood experiences along with historical and cultural trauma that has been in the way of their own healing and the work that needs to be done to shift the trajectory of their family with hope leading the way.

Open-Ended Responses from Staff Survey (May/June 2020)

How have the trauma trainings or Resiliency Circles changed how you work with families/children?

- As in apprentice I have learned a lot. The YMCA has taught me a lot in this horrible times of the pandemic the trainings I have taken and how it's preparing me for any guide the children and families will need as a resource or activities children can do for trauma the way they need to be treated to help them to learn and have a healthy and happy growth.
- Channels your inner thought process
- Help me more to get more knowledge to support to families may needed by using different strategies and referred to our mental health supported as well out of the agency mental health supported.
- I can see the difference Corona has impacted families. Some people show how much it effected them and others don't show it. From the training, I get to hear other peoples stories
- I didn't have this experience yet
- I don't work directly with families and children.
- I feel that I understand better how trauma impact children and families
- I got a more detailed understanding of how trauma effects children's learning in the classroom environment.
- I have a better understanding of my own trauma and how I am impacted by others, ie triggers, etc
- I have good relationship with the families

- I have realized that some of the trauma that our children and families have suffered is a lot deeper than what we may be able to handle and that we need to make sure that we have resources for our families.
- I talked to the family weekly and have zoom meeting with kids and families Give one on one time Read book to the kids do so interactive activities through video and zoom
- I understand my own trauma triggers and I can manage them appropriately.
- I will more confident more knowledge and have more resource to handle the traumatize kids or families
- It has made me more understanding of why some families may react to things different and has given me an opportunity to address these families in a more understanding way.
- it really break down the difference between behavior and trauma, and what is really trauma.
- It's easier to communicate with families and support them
- My perspective on impact of trauma has changed and deepened. I see TIC as ongoing tool when supporting all children, families and staff.
- No change, just reassurance
- Teach me more strategies to use.
- teaches me a lot
- The training have been a good review of past trainings I've attended during my years at HS or trainings from the masters credential program. Some things are refreshers and others have built upon previous concepts.
- The trauma add more knowledge to the little experience I have before and I will be confident to help and support a traumatic child.
- The trauma training has changed the way I work with families and children because it gave me a better understanding.
- The Trauma Trainings have helped me to understand the many characteristics of a child's behavior, and of the parent's as well. It also made me realize that it's important for teachers to try to remain calm when dealing with parent's because sometimes parents can be overwhelmed.
- to always support parents with their needs. referring them to specialists
- Trauma trainings during this time have helped understand more the resiliency circles. Also gave me more tools in order to be able to help and support my families and children.
- Understanding a child's behavior in the classroom.
- Using positive strategy that we learn in the training
- We can use strategies we get on training

In what ways has your relationship with families changed since you attended the trauma trainings or resiliency circles, if at all?

- At first I was nervous about building relationships with parents, because I didn't know what the outcome would be, and I was worried that parents would not like me. Now I have built relationships with parents, and it's easier for me to communicate with them.
- Better communication with them
- Better communication with them
- Better understand the families because we all have trauma especially at this time
- depend on the behavior of the child
- Didn’t have this experience yet
- I am more compassionate towards myself.
- I feel like my relationships with parents have gotten a lot better.
- I feel more confident.
- I feel more confident talking to families about strategies to cope with trauma
- I have a better understanding of why families sometimes do not accept mental health support. I can also see more clearly generational impact of trauma.

- I Having been trained I can now better handle the kids. With the shelter in place, I proactively guide the parents to be patient with the kids. This help the parents to have an easy happy time at home while the shelter in place is active.
- I'm learning to step back when triggers arise and remain calm until I develop a plan of action.
- it did not change much but i have a better understand on how parents do not share.
- Keep calm and listen to parents and give them positive environment To open up more
- More understanding of the children's situation at home.
- My relationships have changed because I am more knowledgeable of trauma and it gives me the tools to better help the families.
- My relationships with families has not changed science the trauma training.
- My relationships with my parents are positive.
- n/a for now. I will hear and listen to their problems and try to give them suggestions on what to do
- Offering activities to work with kids.
- parents are willing to help child and their needs
- still same
- The families and I have been more connected, even when this has happened remotely.
- The relationships are still good but a little strained by the COVID - 19.
- The training are reminder to remember that experienced shape a person. Not to take a response personally because words, actions, expression can be triggering. Remember to remain calm.
- Understanding more about emotions personal things that can trigger them. Feelings can burst for any reason because trauma can live within them at all times. We must be strong to thrive forward and keep the families healthy and strong.

Additional thoughts and comments

- Am glad to do the trauma trainings on the 18th May and the 28th of May 2020
- I am very grateful with the organization because they have always provided the tools and trainings to grow professionally and improve my practices. THANK YOU for this opportunity!
- I answered questions personally, what I'm experiencing in my own household in this time. As I have not been present in a classroom since 3/16/2020
- I do not have additional thoughts, comments and responses.
- Thank you for provide us those training to reinforce my knowledge and get a new information or resources to support the families as well to us.
- Trauma is harmful and difficult. Only the strong survive.