Health, Housing & Community Services
Mental Health Commission

To: Mental Health Commissioners
From: Jamie Works-Wright, Commission Secretary
Date: July 15, 2024

Documents Pertaining to 7/25/24 Agenda items:

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Email Correspondence	**Memo:** Mental Health Advisory Board Meeting (July 15, 2024) **Attachment:** MHAB Main Board Agenda (July 2024) _.pdf **Attachment:** MHAB Main Board Meeting UNAPPROVED Minutes (June 2024)_.pdf **Attachment:** Draft Letter to BOS re MHSA FY24-25 Annual Plan Update_.pdf **Attachment:** Housing as HealthCare Presentation (July 2024).pdf **Memo:** MHC agenda items for July	339 341 342 346 350 386

Health, Housing & Community Service Department
Mental Health Commission

Berkeley/ Albany Mental Health Commission

AGENDA

Regular Meeting
Thursday, July 25, 2024

All Agenda Items are for Discussion and Possible Action

Public Comment Policy: *Members of the public may speak on any items on the Agenda and items not on the Agenda during the initial Public Comment period. Members of the public may also comment on any item listed on the agenda as the item is taken up. Members of the public may not speak more than once on any given item. The Chair may limit public comment to 3 minutes or less.*

Time: 7:00 p.m. - 9:00 p.m.

Location: North Berkeley Senior Center
1901 Hearst Ave. Berkeley, Poppy Room

1. **Roll Call (1 min)**

2. **Preliminary Matters**
   a. Action Item: Approval of the July 25, 2024 meeting agenda
   b. Public Comment (non-agenda items)
   c. Action Item: to Approve the June 27, 2024 minutes

3. **Public Hearing - MHSA Fiscal Year 2025 Annual Update – Karen Klatt**

4. **Review, edit and vote for approval of the letters written to the City Auditor by Edward Opton**

5. **Discussion and review of Berkeley Side article about "Berkeley returns $400,000 in housing funds meant for homeless hotel". Write and vote on an opinion to be sent to the city manager, city council and/or Berk MH division – Glenn Turner**

6. **Mental Health Manager's Report and Caseload Statistics – provided by Jeff Buell**
   a. MHC Manager Report July
   b. Caseload Statistic July 2024

7. **Subcommittee Reports**
   a. **Membership Subcommittee**
   b. **Evaluation Subcommittee**
   c. **Berkeley's participant in reorganization and, potentially, to make recommendations concerning Berkeley's implementation of the reorganization**

Health, Housing & Community Service Department
Mental Health Commission

8. Adjournment

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Contact person: Jamie Works-Wright, Mental Health Commission Secretary (510) 981-7721 or Jworks-wright@berkeleyca.gov

Communication Access Information: This meeting is being held in a wheelchair accessible location. To request a disability-related accommodation(s) to participate in the meeting, including auxiliary aids or services, please contact the Disability Services specialist at 981-6418 (V) or 981-6347 (TDD) at least three business days before the meeting date. ***Please refrain from wearing scented products to this meeting. Attendees at trainings are reminded that other attendees may be sensitive to various scents, whether natural or manufactured, in products and materials. Please help the City respect these needs.*** *Thank you.*

SB 343 Disclaimer

Any writings or documents provided to a majority of the Commission regarding any item on this agenda will be made available for public inspection in the SB 343 Communications Binder located at the Adult Clinic at 2640 MLK Jr. Way, Berkeley, CA 9470

Department of Health,
Housing & Community Services
Mental Health Commission

Berkeley/Albany Mental Health Commission
Draft Minutes – Regular Meeting

7:00 pm
North Berkeley SC 1901 Hearst

Regular Meeting
June 27, 2024

Members of the Public Present: Shirley Posey

Staff Present: Jeff Buell**,** Jamie Works-Wright

1) **Call to Order at 7:11 pm**
   Commissioners Present: Ajay Krishnan, Monica Jones (Chair), Edward Opton (7:10)
   Absent: Cecilia Lunaparra **Excused Absent:** Andrea Prichett, Glenn Turner (Vice Chair)

2) **Preliminary Matters**
   a) **Approval of the June 27, 2024 agenda**
      M/S/C (Opton, Jones) Move to approve the June 27 agenda
      PASSED
      Ayes: Krishnan, Jones, Opton, **Noes:** None; **Abstentions:** None; **Absent:** Lunaparra

   b) **Public Comment-** 1 public comments

   c) **Approval of the May 23, 2024 Minutes**
      M/S/C (Opton, Krishnan) Motion that we move to approve the May 23, 2024 minutes
      PASSED
      Ayes: Krishnan, Jones, Opton, **Noes:** None; **Abstentions:** None; **Absent:** Lunaparra

   d) **Approval of the April 25, 2024 Minutes**
      M/S/C (Jones, Opton) Moved that we approve the April minutes
      PASSED
      Ayes: Krishnan, Jones, Opton, **Noes:** None; **Abstentions:** None; **Absent:** Lunaparra

3) **Response by Police Department to Mental Health Crisis calls Presentation - Police Captain Schofield** – Presenter was not present but an email was read to the commission answering questions.

4) **SCU update – provided by Katie Hawn –** No motion made

5) **Review, edit and vote for approval of the letters written to the City Auditor.**
M/S/C (Opton, Jones) Motion to have commissioner Opton review and edit the auditor letter and will review at the next mental health commission meeting.
PASSED
Ayes: Krishnan, Jones, Opton**, Noes:** None; **Abstentions:** None; **Absent:** Lunaparra

6) **Discussion and review of Berkeley Side article about "Berkeley returns $400,000 in housing funds meant for homeless hotel". Write and vote on an opinion to be sent to the city manager, city council and/or Berk MH division – Glenn Turner –** Bring this agenda item for July commission meeting.

7) **Mental Health Manager's Report and Caseload Statistics – provided by Jeff Buell**
   a) MHC Manager Report June – No motion made
   b) Caseload Statistic June 2024 – No motion made

8) **Subcommittee Reports (20 min)**
   a) Youth Subcommittee –
   M/S/C (Jones, Opton) Motion to disband the youth subcommittee.
   PASSED
   Ayes: Krishnan, Jones, Opton**, Noes:** None; **Abstentions:** None; **Absent:** Lunaparra

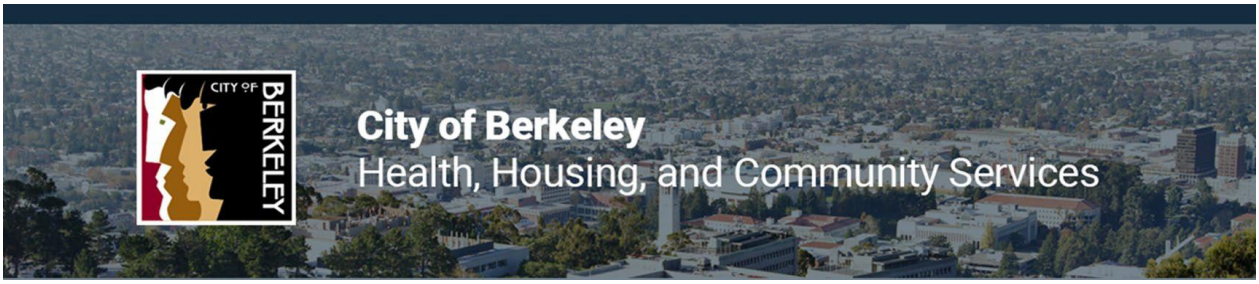
   b) Membership Subcommittee –
      i) Review, edit and vote for draft MHC recruitment email template

      M/S/C (Jones, Opton) Motion to accept Commissioner Opton's revisions and once corrected, it's approved to be sent out.
      PASSED
      Ayes: Krishnan, Jones, Opton**, Noes:** None; **Abstentions:** None; **Absent:** Lunaparra

   c) Evaluation Subcommittee – No Motion Made
   d) Berkeley's participant in reorganization and, potentially, to make recommendations concerning Berkeley's implementation of the reorganization – No Motion Made

9) **Adjournment – 8:35 PM**
M/S/C (Jones, Opton) Motion to adjourn the meeting
PASSED
Ayes: Krishnan, Jones, Opton**, Noes:** None; **Abstentions:** None; **Absent:** Lunaparra

Minutes submitted by: _____
Jamie Works-Wright, Commission Secretary



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

Fiscal Year 2025

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.
- Innovation (INN): For short-term pilot projects designed to increase new learning in the mental health field.
- Workforce, Education & Training (WET): Primarily for strategies to identify and remedy mental health occupational shortages, promote cultural competency and the employment of mental health peers and family members in the workplace.
- Capital Facilities and Technological Needs (CFTN): For capital projects on owned buildings and on mental health technology projects.

Among other things, the MHSA was designed to provide enhanced services and supports for seriously emotionally disturbed children, youth and Transition Age Youth (TAY), adults, and older adults suffering from severe mental illness through a “no wrong door” approach and aims to move public mental health service delivery from a “disease oriented” system to one that is culturally responsive, consumer informed, and wellness recovery oriented. This is accomplished through implementing programs that focus on the following major components:

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

The MHSA also strives to improve and increase services and supports for individuals and families from cultural and ethnic populations that are traditionally unserved and underserved in the mental health system. In Berkeley these have included: Asian Pacific Islanders (API); Latinos/Latinas/Latinx (Latino/a/x); Lesbian, Gay, Bi-Sexual, Transgender, Queer/Questioning, Inter-Sexed, Agender, Plus others (LGBTQIA+); Older Adults; and Transition Age Youth (TAY). African Americans have been an additional population of focus as data indicates they are overrepresented in the mental health system and hence "inappropriately served", which could be due to being provided services that are not culturally responsive and/or appropriate.

In order to access MHSA funds, a stakeholder informed plan outlining how funds will be utilized must be developed and locally approved. Development of an MHSA Plan includes: community program planning with the involvement of area stakeholders, writing a draft plan, initiating a 30-day public review, conducting a public hearing at a Mental Health Commission meeting, and obtaining approval on the plan from City Council.

The Community Services & Supports, Prevention & Early Intervention, and Innovation funding components are the only re-occurring MHSA monies that are allocated annually and may be spent over a five-year period. Workforce, Education & Training and Capital Facilities and Technological Needs funds had initial expenditure time periods of 10 years each, and were to be utilized by the end of Fiscal Year 2018 or 2019. Per the City Council approved MHSA AB114 Reversion Expenditure Plan (which is posted on the City of Berkeley MHSA webpage), some CFTN and WET projects were continued past the original timeframes.

MHSA legislation requires mental health jurisdictions to provide updates on MHSA Plans on an annual basis, and an integrated Program and Expenditure Plan must also be developed every three years. Currently, the City of Berkeley Mental Health (BMH) Division has a City Council approved MHSA Fiscal Years 2023/2024 - 2025/2026 Three Year Program and Expenditure Plan in place.

City of Berkeley MHSA Services

Since 2006, MHSA funding has been utilized to provide mental health services and supports in Berkeley. Additionally, from Fiscal Year 2011 (FY11) through FY20, the City of Berkeley also utilized a portion of MHSA funds to provide services in the City of Albany, although Albany is a part of the Alameda County total population. Beginning in FY21, per agreement with Alameda County Behavioral Health Care Services (BHCS), the Division transitioned to only using MHSA funds for services and supports in Berkeley, and BHCS now provides MHSA funded services in Albany.

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

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

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

Additionally, an outcome of the implementation of the MHSA is that mental health peers, family members and other stakeholders now regularly serve on several of the BMH internal decision-making committees. These individuals share their "lived experience" and provide valuable input which has become an integral component that informs the Division on the implementation of MHSA services and supports. Even prior to the passage of Proposition 63, BMH convened (and has since maintained) an MHSA Advisory Committee which serves in an advisory role on MHSA programs and is comprised of mental health peers, family members, and community stakeholders.

This City of Berkeley MHSA Fiscal Year 2025 (FY25) Annual Update is a stakeholder informed plan that provides an update to the previously approved FY2024-2026 Three Year Program and Expenditure Plan (Three Year Plan). This Annual Update summarizes proposed program changes that will begin during the FY25 timeframe. Descriptions of MHSA services that will be continued in FY25, through the approved FY24-26 Three Year Plan, and a reporting of FY23 program data are also provided.

Proposition 1 – The Behavioral Health Services Act

In 2023 Senate Bill 326 (SB326), the Modernization of the Mental Health Services Act (MHSA) and Assembly Bill 531, a Behavioral Health Infrastructure Bond for treatment facilities and supportive housing were linked and signed by the Governor. On March 5, 2024 the linked bill was on the ballot as one measure, Proposition 1, which was narrowly passed by the voters. This legislation renames the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA) as it includes an allowance to utilize funding for services for individuals who have Substance Use Disorders.

Beginning 7/1/26, through the BHSA, the current five MHSA funding allocations will change to the following three components:

- Housing: For children and families, youth, adults and older adults living with severe mental illness or serious emotional disturbance and/or Substance Use Disorders who are experiencing homelessness or are at risk of homelessness, with 50% being prioritized for interventions for the chronically homeless.

- Full Service Partnership (FSP): Includes the use of funds for mental health, supportive services, and substance use disorder treatment services for Severely Mentally Ill Adults, Seriously Emotionally Disturbed Children and Youth, and individuals who experiences Substance Use Disorders.

- Behavioral Health Services and Supports: Includes early intervention, outreach and engagement, workforce education and training, capital facilities, technological needs, and innovative pilots and projects. A majority (51%) of funds must be used for Early Intervention services to assist in the early signs of mental illness or substance misuse, and 51% of the Early Intervention services and supports must be for individuals who are 25 years and younger.

Among other things, the BHSA will also make changes to the planning process and Three Year Plans and Annual Updates. These changes will require the demonstration of coordinated behavioral health planning around all behavioral health funding received, and an integrated plan that includes all local behavioral health funding, services, and program outcomes. It is anticipated that the Department of Health Care Services (DHCS) will release regulations for the new BHSA in early 2025. In preparation, the City has started pre-planning around the changes to MHSA and will begin engaging the community in the upcoming months to share information on the BHSA requirements and obtain input on local mental health needs.

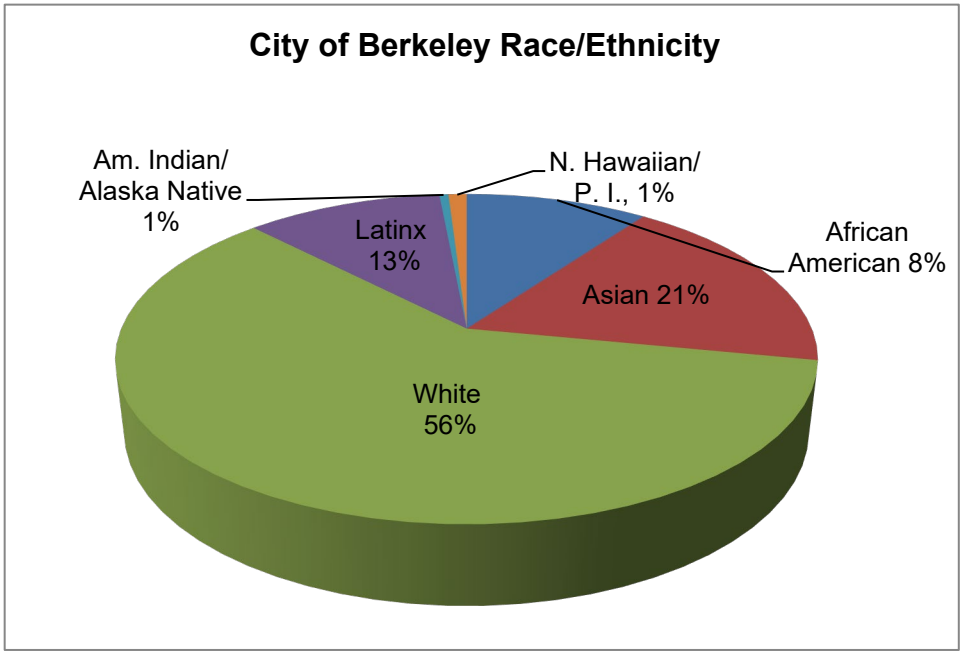
DEMOGRAPHICS

Description

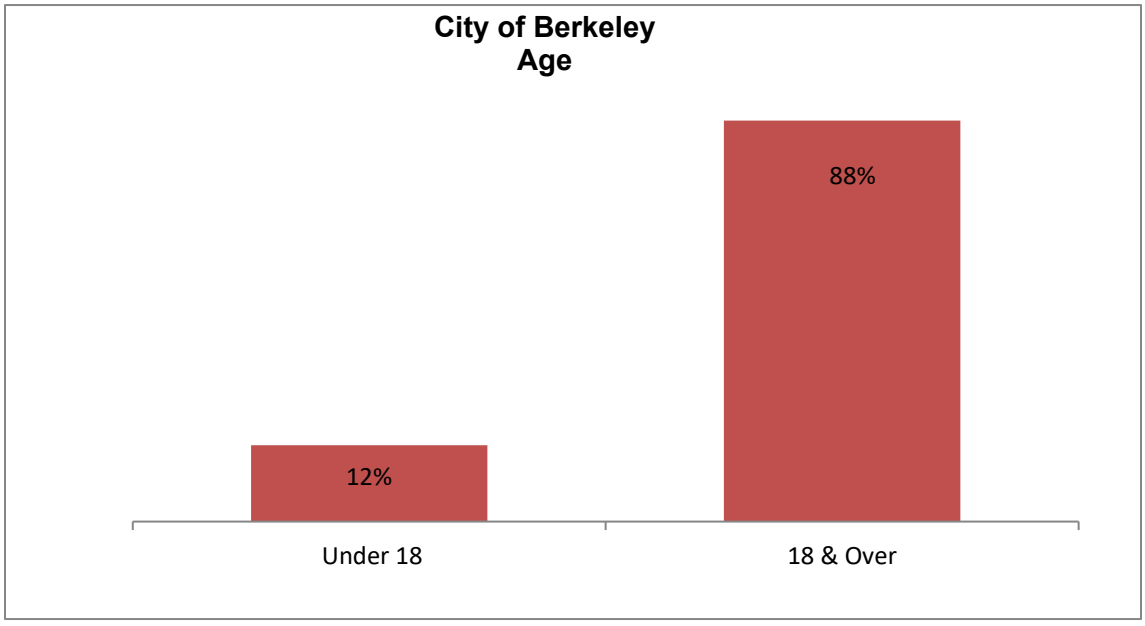
Situated in the heart of the San Francisco Bay area, and home to the University of California, Berkeley is an urban city, located in northern Alameda County. With a combined land mass of around 12.2 miles and a total population of approximately 118,962 (updated estimates since the 2020 census), the City of Berkeley is densely populated and larger than 23 of California's small counties.

Race/Ethnicity

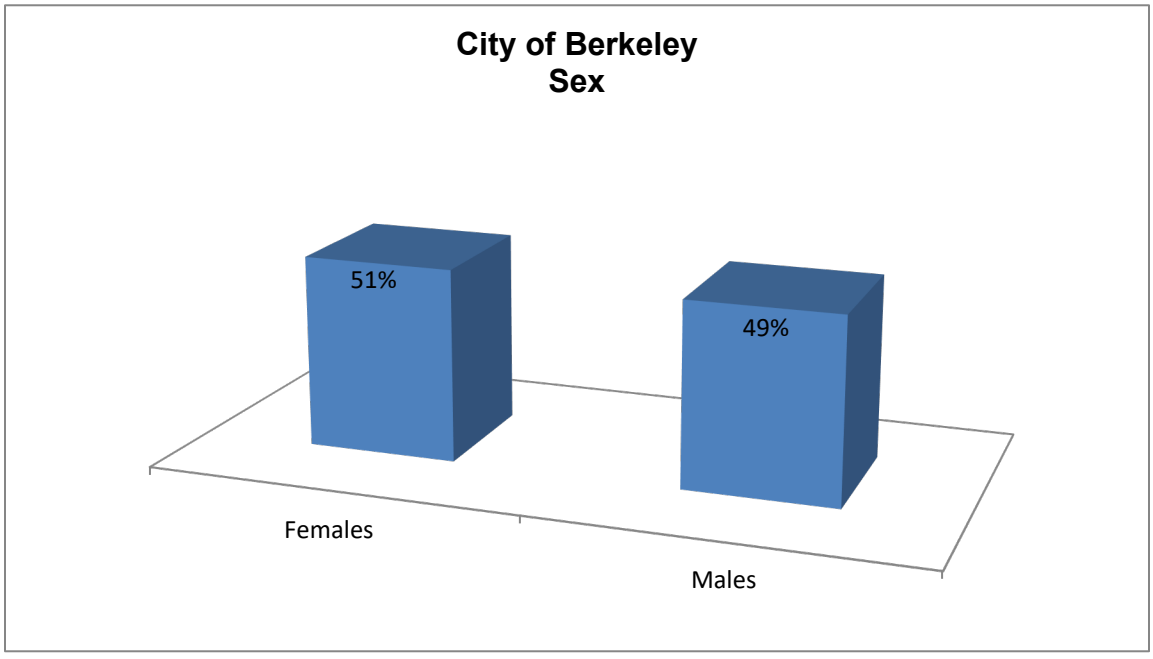
Berkeley is a diverse community with changing demographics. The African American population has decreased in recent years while the Latinx and Asian populations have both increased. Berkeley has a large student population, which provides housing for many of University of California's foreign students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



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



Sex demographics are as follows:



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

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

Income/Housing

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

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

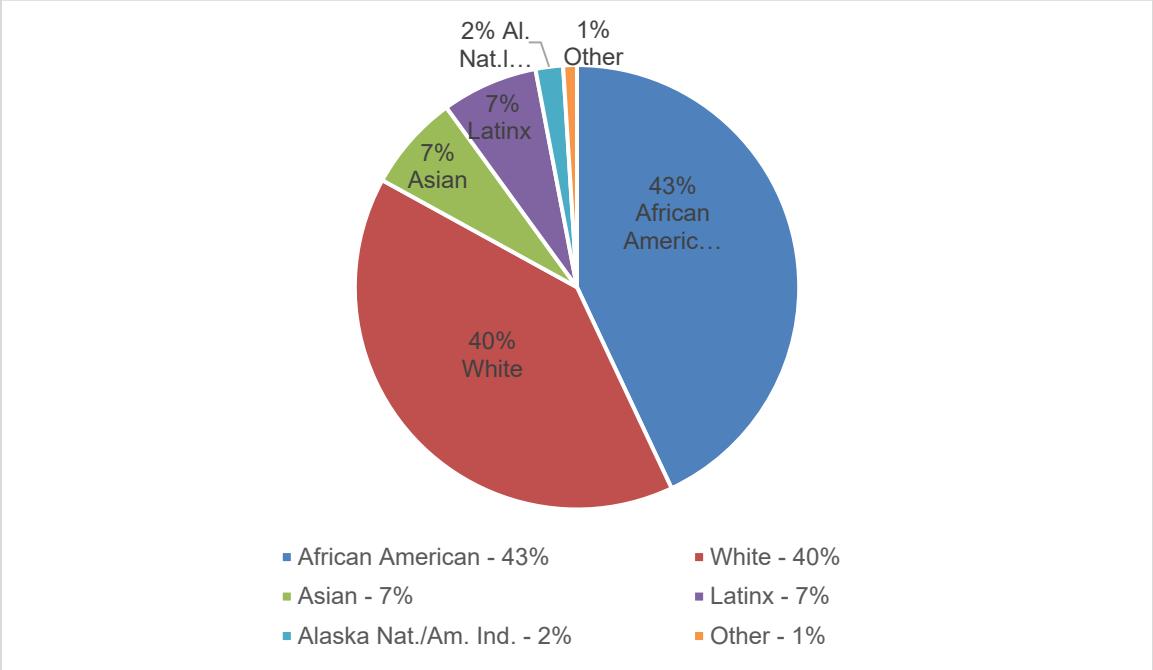
Education

Berkeley has a highly educated population: 97% of individuals aged 25 or older are high school graduates; and approximately 74% 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 programs providing services: Crisis; Family, Youth & Children; High School Mental Health, Full Service Partnership Services, and Adult Services.

Services include: assessment, assertive community treatment, individual and group therapy, case management, and crisis intervention. In addition to offering treatment, outreach, and support, some services are provided through a variety of community-based agencies and at school sites. As part of the Crisis unit, a Mobile Crisis Team operates seven days a week when fully staffed. The majority of mental health services provided by BMH are aimed towards the Medi-Cal and uninsured population; as such it is important to note the ways in which the Medi-Cal population demographics differ from the overall demographics in Berkeley. Using data available from Alameda County, the Medi-Cal population in Berkeley in 2023 was as follows:



COMMUNITY PROGRAM PLANNING

During the Community Program Planning (CPP) process one MHSA Advisory Committee meeting was held on Thursday, May 30th, and six Community Input Meetings were held on the following dates/times:

- Thursday, June 6th: 11:00am-12:30pm
- Monday, June 10th: 1:00pm-2:30pm
- Wednesday, June 12th: 6:00pm-7:30pm
- Thursday, June 13th: 6:00-7:30pm
- Tuesday, June 18th: 6:00-7:30pm
- Wednesday, June 19th: 6:00pm-7:30pm

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

During the MHSA Advisory and Community Input Meetings a presentation was conducted to provide information on MHSA background, funding, program requirements, the CPP process, and on upcoming changes to the funding requirements as a result of Proposition 1. The presentation also covered detailed information on the proposed MHSA FY25 Annual Update and provided opportunities for input from the community.

An anonymous voluntary 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 individuals who participated in the CPP Process through meetings or provided input by phone were as follows:

DEMOGRAPHICS N = 41	
Age Category	
Age Category	*% of total*
Transition Age Youth	*
Adult	*
Older Adult	37%
Declined to Answer (or unknown)	*
Gender Identity	
Gender Identity	*% of total*
Male	*
Female	37%
Declined to Answer (or Unknown)	*
Race/Ethnicity	
Race/Ethnicity	*% of total*
Black or African American	27%
White	28%
Latino/a/x	*

Declined to Answer (or Unknown)	*
Sexual Orientation	
Sexual Orientation	*% of total*
Heterosexual	44%
Gay/Lesbian	*
Queer	*
Declined to Answer (or Unknown)	*
Veteran Status	
Veteran Status	*% of total*
Non-Veteran	46%
Declined to Answer (or Unknown)	44%
Disability Status	
Disability Status	*% of total*
Disabled	27%
Not Disabled	29%
Declined to Answer (or Unknown)	44%
Representative Categories**	
Representative Status	*% of total*
Consumer	*
Family Member of Consumer	*
Community Member or MHSA Stakeholder	27%
Representative of City of Berkeley Commission	*
Parent, Student or Representative of UC Berkeley or City College	*
Representative of Mental Health or Social Services Agency	*
Representative of Health Care Organization	*
City of Berkeley Staff	*
Other	41%
Declined to Answer (or Unknown)	17%

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.
**Many 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, Community members and other MHSA stakeholders. Development of this Annual Update began with an internal examination of existing programs, unaddressed needs, and available funding which included a review of input received over the prior year and during previous MHSA planning processes. Following an internal review, proposed new additions were vetted through the MHSA Advisory Committee prior to engaging community members and other MHSA stakeholders.

Proposed program changes in this Annual Update include the following:

- Move an Assistant Management Analyst position that was previously approved for the Adult Full Services Partnership, to the Children's Full Services Partnership;
- Eliminate the PEI funded Mental Health Promotion Campaign;
- Eliminate the PEI funded Early Child Health and Wellness Program;
- Eliminate the allocation of local PEI funding for the PEI Statewide Projects initiative.

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

Outlined in the following categories below are the input and questions received during this process:

Data and Evaluation

- We see individuals still struggling and don't have any way of judging outcomes and whether the Specialized Care Unit and other mental health services are working or not.
- We need top to bottom evaluations of staff and funded programs that is conducted bi-annually or quarterly, not results based accountability evaluations.
- Program data should be provided in a way that meets accessibility needs for individuals who are disabled, and dispersed to the community on a regular basis so that the disabled community can provide informed input on funded programs.
- Programs shouldn't just be evaluated when they receive funding, but regularly throughout the year by a panel of reviewers that includes individuals who receive the program services.
- Data for all programs should be easily accessible at any point in time to the community.

Housing

- Need licensed Board and Care facilities, and high-quality supportive housing
- Utilize the Land Trust to increase housing and improve the quality of services.
- Who provides services and oversees staff at hotels?
- You can't put people in Single Room Occupancies (SROs) as they will be traumatized. The bathrooms are locked; there's drug use; the people who work there seem hostile; and there is no monitoring of the facilities.
- People are afraid to complain about bad housing conditions because of the shortage of housing.
- What is the complaint process for hotels?
- In regards to housing community "Block Fund Trust", there needs to be evaluation to the validity of applications. When giving money, there should be a body of City people to evaluate these contractors.
- There needs to be different kinds of housing with different levels of care and have peer support services for individuals experiencing homelessness.
- Address the shortage of housing for people experiencing mental illness and address the traumatized individuals experiencing homelessness by providing stable, welcoming environments.
- There is a need for more affordable housing for veterans.

- All Resources for Community Development (RCD) properties should have supportive services. University Avenue does not have adequate supportive services. Concerned that there is not a plan with RCD on how people will get into housing, and limited to no supportive housing.

Mental Health Services:

- Interns dealing with individuals in need are not culturally diverse. Need more community outreach with culturally diverse, trained, skill people.
- Don't separate mental health and substance abuse.
- A meeting with community-based organizations should occur to obtain information on services provided and to ask questions of providers,
- What modes of technology are being used by the Mobile Crisis Team and by clinicians who provide services in the field for individuals who have disabilities to meet their accessibility needs?
- Individuals who are disabled may not know how to access services or even what questions to ask regarding services unless they are being advertised in a way that meets accessibility needs.
- Do Contracts include the requirements for accommodations for individuals with disabilities?
- There is a disconnect between policy makers and the needs in the community. Policy makers need to be out there seeing what is happening.
- What is currently happening at the Berkeley Daytime Drop In Center? It is not running the way it used to, when people got the services they need.
- Do the FSP's have 24/7 services?
- Don't forget funding for services for children.
- Individuals who are affected are not engaged in mental health policy and they need to be engaged in the process.
- Don't see any services for white straight males, who are in need and may be suicidal.
- As a white person my mental health issues are not addressed.
- The vacancies and freezing of positions in the Mental Health Division is concerning and support should be provided by City Council.

MHSA FY25 Annual Update Community Input Meetings:

- Paper fliers for the meetings should have been posted widely.
- There should be more attendees at the community meetings.
- What is happening with the unspent funds?

Specialized Care Unit

- What's going on with the Specialized Care Unit (SCU) services, are these services working?
- Is the Berkeley Specialized Care Unit (SCU) phone number publicly posted?
- The City should stencil the Specialized Care Unit's phone number on the sidewalk.
- My individual experience with the SCU was not good. The SCU program was engaged by a family member who was concerned about me and although the program is not supposed to

include the use of Law Enforcement, the Police showed up at my door. I was not connected to resources following my release from John George and was released without shoes or a cell phone I had just purchased so I had no way to call my doctor to give permission to release my medical history to a mental healthcare provider. I didn't have a good experience with the FSP either and my trust is shaken.

Additional written input that was submitted by the Friends of Adeline (some of which are also represented above and were stated by individuals from this community group who attended an MHSA Community Input meeting) were as follows:

- Develop more community owned or non-profit owned housing for those highly affected by mental illness so housing can't be sold or go out of business.
- A fully functioning Drop-In Center is needed for our un-housed neighbors.
- Quality supportive services are necessary in housing for those living with mental illness (residents at two Berkeley housing developments complain about poor maintenance and support services in their buildings).
- Increase high quality outreach and treatment services for those suffering from substance abuse and mental illness.
- Create a public education campaign about the services available in Berkeley so people know where to find them.
- Make the Specialized Care Unit, SCU (Crisis Services) well-functioning and well publicized.

As a result of public comments received during this process, the Division will not be eliminating the Mental Health Promotion Campaign, and will be utilizing the campaign to educate the community on available services.

A 30-Day Public Review is currently being held from Tuesday, June 25th through Wednesday, July 24th to invite input on this Annual Update. A copy of the Annual Update has been posted on the BMH MHSA website, and announcements of the 30-Day Public Review were mailed and/or emailed to community stakeholders and City staff. Individuals interested in providing input on this Annual Update can also attend one of the following four community meetings that will be held during the 30-Day Public Review:

- Tuesday, July 9th: 6:00pm-7:30pm
- Thursday, July 11th: 6:00pm-7:30pm
- Tuesday, July 16th: 6:00pm-7:30pm
- Thursday, July 18th: 6:00-7:30pm

The Community Input Meetings have 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. A Public Hearing on the Annual Update will be held at 7:00pm on Thursday, July 25th, during the Mental Health Commission meeting which will be held at the North Berkeley Senior Center on 1901 Hearst Avenue. If you would like to provide input on this MHSA Annual Update, or need information regarding the Community Input Meetings or the Public Hearing, contact Karen Klatt, by phone (510) 981-7644, or email at: KKlatt@berkeleyca.gov

MHSA Fiscal Year 2024/2025 Annual Update

This City of Berkeley MHSA Fiscal Year 2024/2025 (FY25) Annual Update is a stakeholder informed plan that provides an update to the previously approved MHSA FY2023/2024 – 2025/2026 Three Year Program and Expenditure Plan. This Annual Update summarizes proposed program changes, includes descriptions and updates of currently funded MHSA services that will be continued in FY25 through the previously approved Three Year Plan, and provides a reporting on FY23 program data. Additionally, per state regulations, this Annual Update includes the Prevention and Early Intervention (PEI) Fiscal Year 2022/2023 (FY23) Annual Evaluation Report (Appendix C), and the Innovations (INN) Fiscal Year 2022/2023 (FY23) Annual Evaluation Report (Appendix D).

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

- Impact Berkeley: In 2018, the Health Housing and Community Services (HHCS) Department implemented "Impact Berkeley". Central to this initiative is using a highly regarded framework called Results Based Accountability (RBA) to account for the work of the Department. RBA provides a new way of understanding the quality and impact of services provided by collecting data that answer three basic questions:
  1. How much did you do?
  2. How well did you do it?
  3. Is anyone better off?

  RBA has been incorporated into selected programs within the Department. This has included community agency programs funded through the MHSA Prevention & Early Intervention (PEI) Community Education & Supports program. Through this initiative the Department worked with each contractor to envision, clarify and develop measures on the outcomes and results each program is seeking to achieve, and used a rigorous framework to measure and enhance progress towards these results. The results of this initiative are outlined in the PEI Community Education & Supports program section of this Annual Update.

- Results Based Accountability Evaluation for all BMH Programs: Through a previously approved MHSA Annual Update the Division hired Resource Development Associates (RDA) to conduct a Results Based Accountability (RBA) Evaluation for all programs across the Division. Since FY21 RDA has been working with the Division to implement the RBA research methodology. An update of the activity's RDA conducted in FY23 on this evaluation is included in this Annual Update.

  RBA outcomes in FY23 are outlined throughout this Annual Update for the following MHSA funded internal programs: Children/Youth FSP; TAY, Adult and Older Adult FSP; Homeless FSP; Wellness Recovery Services; Crisis Services; Transitional Outreach Team; Social Inclusion Project; and the High School Prevention Project. The complete set of RBA outcomes for all BMH programs is located in Appendix C.

- Program Evaluator: Per the approved FY23 Annual Update, in order to build internal capacity for data collection and reporting, the Division hired a Program Evaluator who will be collecting and reporting on RBA Outcomes and future evaluations.

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

Per State requirements, Evaluation Reports for PEI and INN programs are also included in the Appendix of this Annual Update as follows:

- PEI Data Outcomes: Per MHSA PEI regulations, all PEI funded programs are required to collect state identified outcome measures (specific to the category of services provided) as well as detailed demographic information. PEI Evaluations are required to be included in each MHSA Annual Update or Three-Year Plan. See Appendix C for the Prevention & Early Intervention Fiscal Year 2022/2023 (FY23) Annual Evaluation Report.

- INN Data Outcomes: Per MHSA INN regulations, all INN funded programs are required to collect state identified outcome measures and detailed demographic information. INN Evaluations are required to be included in each MHSA Annual Update or Three-Year Plan. See Appendix D for the Innovation (INN) Fiscal Year 2022/2023 (FY23) Annual Evaluation Report.

PROPOSED PROGRAM CHANGES

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

- Move Assistant Management Analyst position to Children's Full Services Partnership (FSP): Through the previously approved FY23 Annual Update, the Division received approval to hire an Assistant Management Analyst for the Adult Clinic Programs. In an effort to support the need for administrative support, the Division is proposing to move this position to the Children's FSP.

- Eliminate MHSA funding for the Early Child Health and Wellness Program:
  The Early Childhood Health and Wellness program (formerly named the Be A Star Project) has been a collaboration with the City of Berkeley's Public Health Department since the initial MHSA PEI Plan. It provides a coordinated system in Berkeley that identifies children birth to age five and their parents, who are at risk of childhood development challenges including developmental, social, emotional, and/or behavioral concerns and provides linkages to services and supports for individuals in need. Services include triage, assessment, treatment and referrals to appropriate community-based or specialist services as needed.

  Beginning in FY25, the MHSA PEI funding for this program will be discontinued, as the Public Health Division will be transitioning these program activities to be funded and housed programmatically under their Maternal, Child and Adolescent (MCAH) Program:

- The MCAH Program is a California Department of Public Health (CDPH) funded program committed to serving women, children, teens and their families by improving access to comprehensive, quality health care, and focusing on prevention and early intervention strategies.

- Within MCAH, there are program requirements which align with the focus of early identification, assessment, treatment, and referral for children (ages 0-5) and their families that provides rationale for the shift to MCAH.

- As part of the MCAH scope of work, the focus on supporting early childhood development screenings will be able to be integrated with other programs that reside within the MCAH scope, such as the Berkeley Black Infant Health Program and Fatherhood Initiative.

Going forward, the Early Childhood Health and Wellness Program (ECHW) move under the MCAH Program will address the MCAH Child priority need to optimize the healthy development of all children so they can flourish and reach their full potential with a child focus area to expand and support developmental screening.

- Eliminate funding for the Prevention/Early Intervention (PEI) Statewide Projects Initiative:
  In 2009, California's counties formed the California Mental Health Services Authority (CalMHSA) as a Joint Powers Authority. Contributing jurisdictions are members of a CalMHSA board that provides direction into various types of initiatives that are implemented. One of the initiatives that was implemented is the PEI Statewide Projects. With an approved combined funding level of $40 million per year for four years during the timeframe of 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 mental health jurisdictions. In order to continue to sustain programming, CalMHSA previously requested jurisdictions to allocate 4% of their annual local PEI allocation each year to these statewide initiatives.

  The Division has provided the requested 4% of PEI funds on an annual basis since 2015, to participate in this initiative. At present, the City has approximately $153,901 of unspent funds that were previously allocated to CalMHSA for this initiative. As a result, through this Annual Update, the Division is proposing to eliminate the allocation of local annual PEI funding for this initiative. Additionally, the Division will either utilize the previously allocated funds that are remaining at CalMHSA, to continue this initiative for a short-time, or to have the funds returned to the City for local use.

PROGRAM DESCRIPTIONS AND FY23 DATA BY FUNDING COMPONENT

Outlined in this section per each funding component are descriptions of current City of Berkeley MHSA services that were continued through the previously approved Three Year Plan and FY23 program data. In FY23, across all MHSA funded programs, approximately 4,717

individuals participated in some level of services and supports. Some of the FY23 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 family members; increased services for individuals who are experiencing homelessness; Wellness Center services; community-based support group services; consumer driven wellness recovery activities; housing and benefits advocacy services; augmented prevention and early intervention services for children and youth in the schools and community; outreach, supportive services for TAY, Adults and Older Adults in unserved, underserved and inappropriately served cultural and ethnic populations; and free access to the HeadSpace Mental Health App for anyone who lives, works or goes to school in Berkeley.

COMMUNITY SERVICES & SUPPORTS (CSS)

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

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

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

Descriptions of each CSS funded program that were continued through the previously approved Three-Year Plan, and FY23 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 FY25 by each age category is as follows: 6-12 years = 9 individuals; 13-17 years = 9 individuals; 18-21 years = 2 individuals.

In FY23, a total of 13 children/youth and their families were served through this program. Demographics on those served were as follows:

DEMOGRAPHICS N = 13	
Age Category	
Age Category	*% of total*
6-12 years	*
13-17 years	*
18-21 years	*
Declined to Answer (or Unknown)	*
Gender Identity	
Gender Identity	*% of total*
Male	*
Female	*
Declined to Answer (or Unknown)	*

Race/Ethnicity	
Race/Ethnicity	*% of total*
Black or African American	*
Multi-racial	*
Sexual Orientation	
Sexual Orientation	*% of total*
Heterosexual	*
Gay or Lesbian	*
Queer	*
Declined to Answer (or Unknown)	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

Flex funds are used to provide various supports for FSP program participants and/or the families of program participants. In FY23, flex funds were utilized as follows: 1 individuals/families received funding for housing assistance; 6 individuals/families received funding for food/groceries; 6 individuals/families received funds for clothing/hygiene; 2 individuals/families received funding for Bus Passes or transportation; and 7 individuals/family members received funding for other various needs including school supplies, birthday and Holiday gifts, and pro-social activities.

Program Successes:

- Successfully worked with all CFSP clients in-person, as the pandemic continued to subside.
- Increased access to psychiatric medication services within the clinic and the provision of individual/family therapy.
- Transitioned one CFSP client who was over 18 to community-based services to support their housing and behavioral health needs.
- Continued to reduce psychiatric hospitalizations and the usage of crisis services.
- Services continued to be provided by clinicians who mirror the racial/ethnic identity of the populations served and was able to provide care to families who are monolingual Spanish.
- Continued to provide flex funding to support the felt needs of clients; this was extremely important as there was an increase in needs due to parent's loss of employment, the increased cost of goods and services, and parents continued to struggle with employment. These purchases supported the purchase of birthday/holiday gifts, food, household items, fun activities for clients and their siblings, and clothing. The team was able to pay for a family to stay in a hotel in order to reduce the likelihood they would become unhoused.
- Successfully on-boarded a temporary staff member to fulfill the Social Services Specialist role until the position could be filled.
- Successfully supported three families to use the After-Hours service to reduce the need for emergency/crisis services.

Program Challenges:

- There we a reduction in referrals that were accepted due to staff transitions resulting in clients having to be placed on wait lists or referred to other FSP programs.

In FY23, the RBA Measures that were established for this FSP were as follows:

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

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

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

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients	Clients who were not served by the program in the previous fiscal year	Yellowfin
Average # of days in FSP per client	Average length of stay for primary program episodes which have closed since the beginning of the reporting period	Yellowfin
Average # of service hours per client per month	Average of hours of service in a month divided by clients served in a month. Includes all services recorded for clients. Does not include MAA	Yellowfin
Average # of service hours per client per month	Average of hours of service in a month divided by clients served in a month. Includes all services recorded for clients. Does not include MAA	Yellowfin
Average # of services per client per month	Average services in a month divided by clients served in a month. Includes all services recorded for clients. Note: more than one service can be provided during a single contact. Does not include MAA	Yellowfin
% of clients who have at	Of clients with a completed CANS/ANSA,	

Measure	Definition	Data Source
least one completed CANS/ANSA for each six month period that they are in the program	what percentage of them had an assessment at least every six months?	Objective Arts
% of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month	Clients must be been open to a provider for at least 30 days in order to be included in this metric. Phone contacts are included during the pandemic. Days in subacute or jail not counted, but services are counted.	Yellowfin
% of clients with no service gap of over 30 days	Maximum days each Level 1 client went without service during their episode(s) in the reporting period. Only considered clients open to a provider for at least a total of three months during the reporting fiscal year.	Yellowfin
% of discharges from hospitalization or subacute who had a follow up visit with FSP staff within 7 business days	Follow-up rates for individuals open to Level 1 providers at the time of MH hospital discharge.	Yellowfin
#/% of clients closed, by reason closed	Discharge reason for clients discharged during the reporting period	Yellowfin

Data Development Agenda – measures the team is interested in reporting on but for which reliable data was not available:

- Spending: # of Flex Funds spent on a family per year, based on tenure in program;
- Service provision: % of clients who received unscheduled service contacts due to low engagement or necessity/acuity of family needs;
- Staff training:
  -% of staff trained in WRAP;
  -% of staff who are skilled to implement trauma-informed interventions;
- Staff satisfaction: % of staff who report that they have the tools/resources necessary to do their jobs;
- Client satisfaction, specifically in regards to measuring racially responsive care;
- #/% of clients/families who report high quality, racially responsive care on the annual Consumer Perception Survey;
- Client/family outcomes:
  -# of clients/families who can navigate systems better to address their needs;
  -# of clients with improved school attendance and increased engagement in class/school;
  -% of clients with improved family relations (communication and stability, problem solving, support);
- Client-to-staff ratio;

- % staff retention year-to-year;
- % of clients who schedule a meeting with FSP team within 14 calendar days of referral;
- % of clients who are referred to other primary services (therapy, TBS, etc.,) within 5 calendar days of agreement in a family team or a provider meeting;
- % of new clients who receive a face-to-face visit within 7 calendar days of the episode opening date;
- % of clients/families discharged from services within 9-12 months because of improved life circumstances.

For context around the RBA Outcomes, throughout FY23 the Children/Youth Full Service Partnership (CFSP) team operated below full staffing levels. This shortfall impacted the program's capacity, limiting the number of clients the program could accommodate and reducing the extent of services that could be delivered each month.

RBA Outcomes in FY23 for this FSP are outlined on the following pages.

BMH RBA Report FY 2023

Reporting Period July 2022 - June 2023

Child Full Service Partnership (CFSP)

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

13

Clients Served

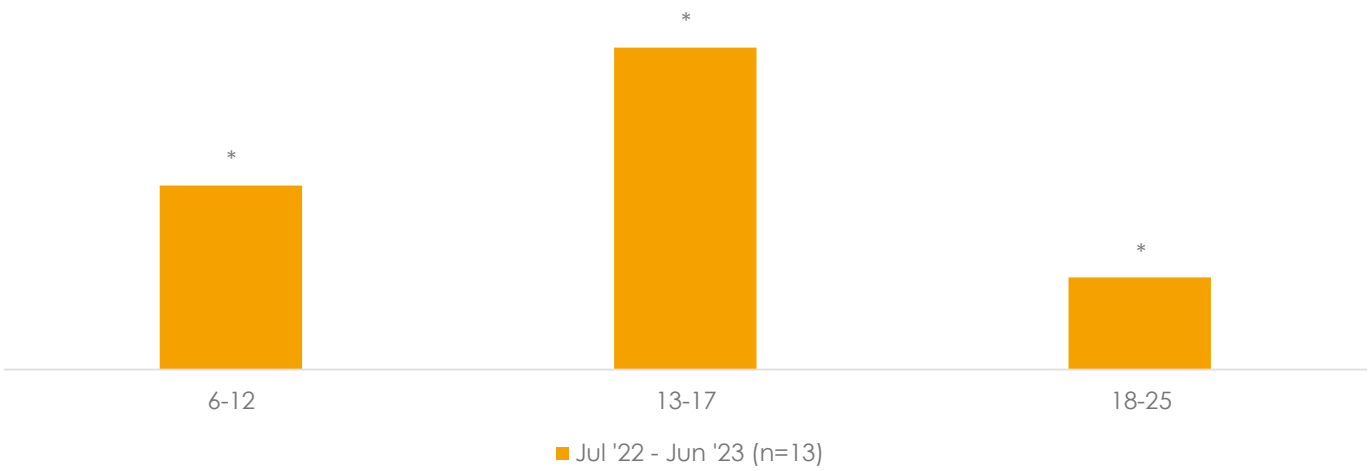
9

New Clients

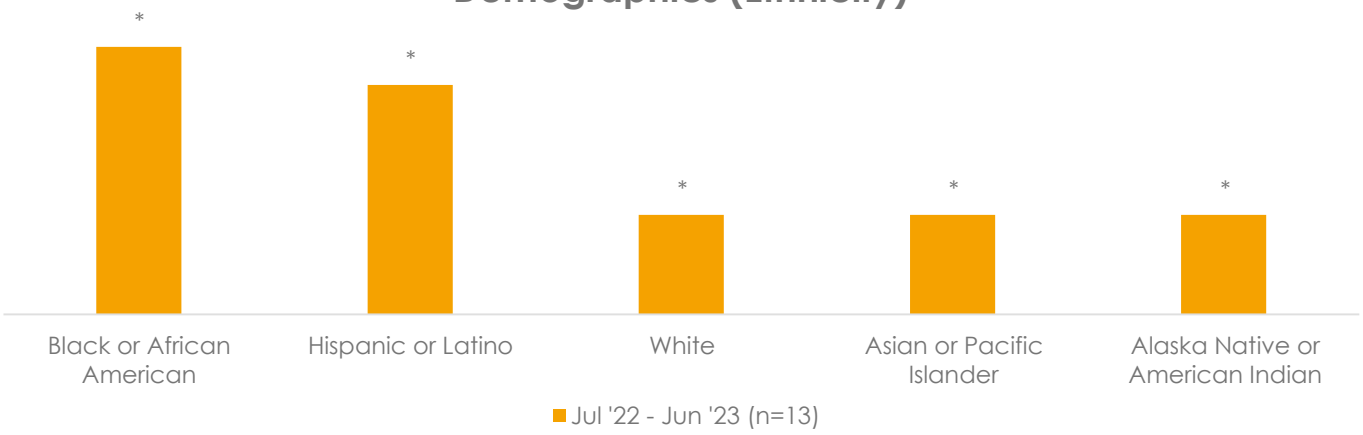
Program Description: This team provides wrap around services to children and families with acute needs, who meet the following criteria: child is at risk of/has been removed from their parent/guardian; child is involved with the Juvenile Justice System or at risk of that; has been recently had a psychiatric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

Program Updates: For all time periods in this report, the CFSP team was not fully staffed. This affected both the total number of clients that the program was able to serve, as well as the monthly services provided.

Demographics (Age)

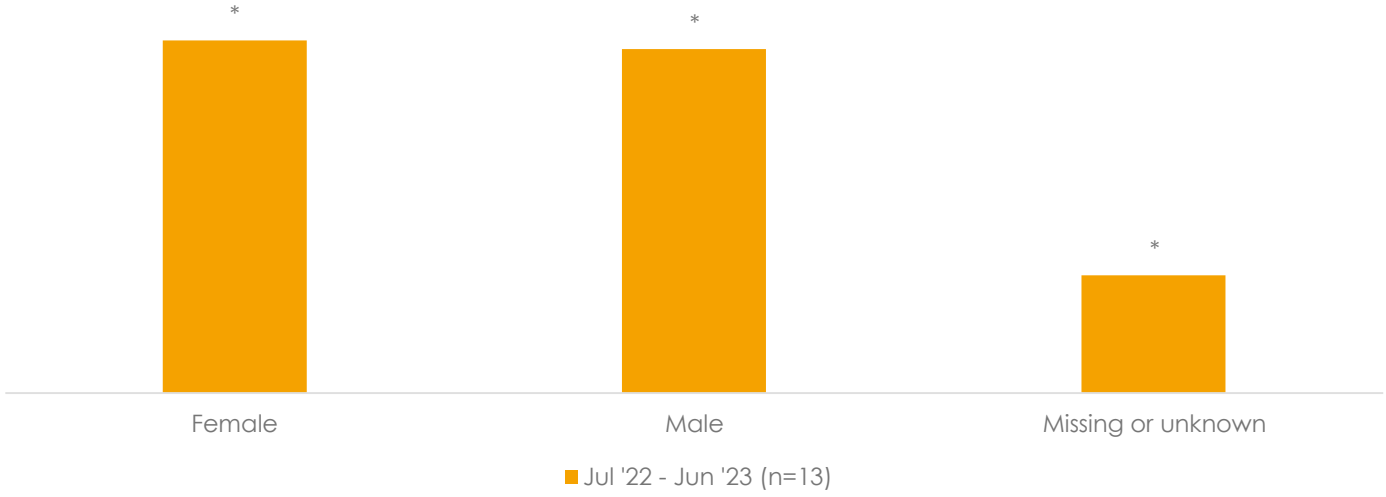


Demographics (Ethnicity)

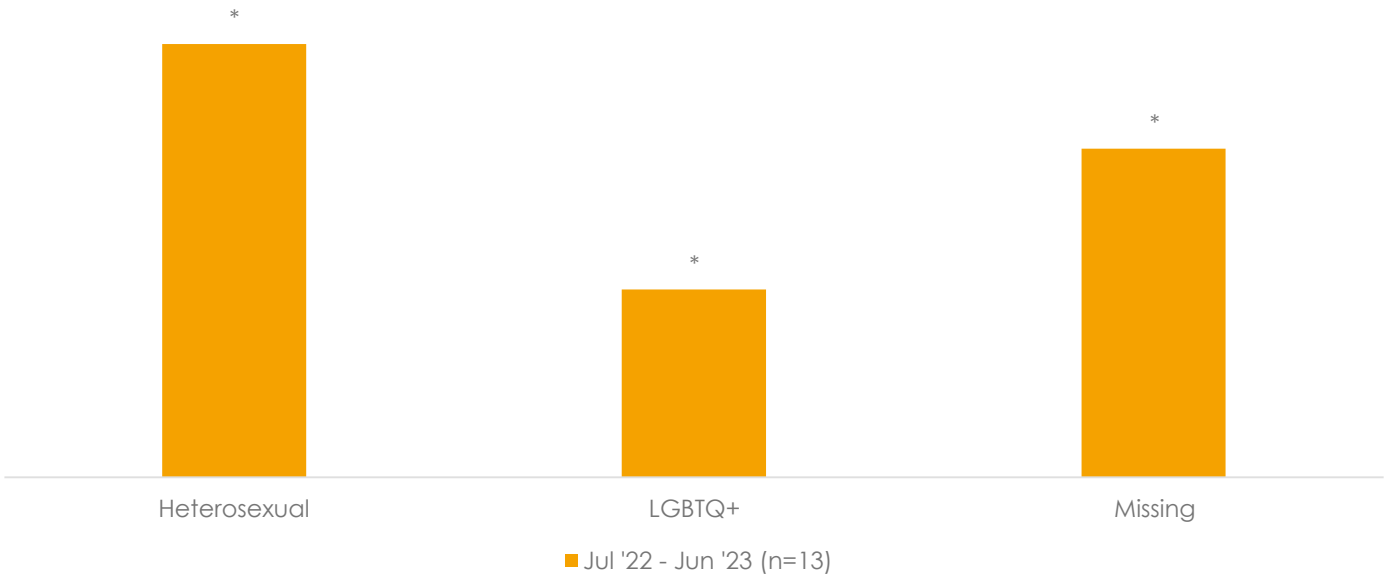


NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Demographics (Gender Identity)



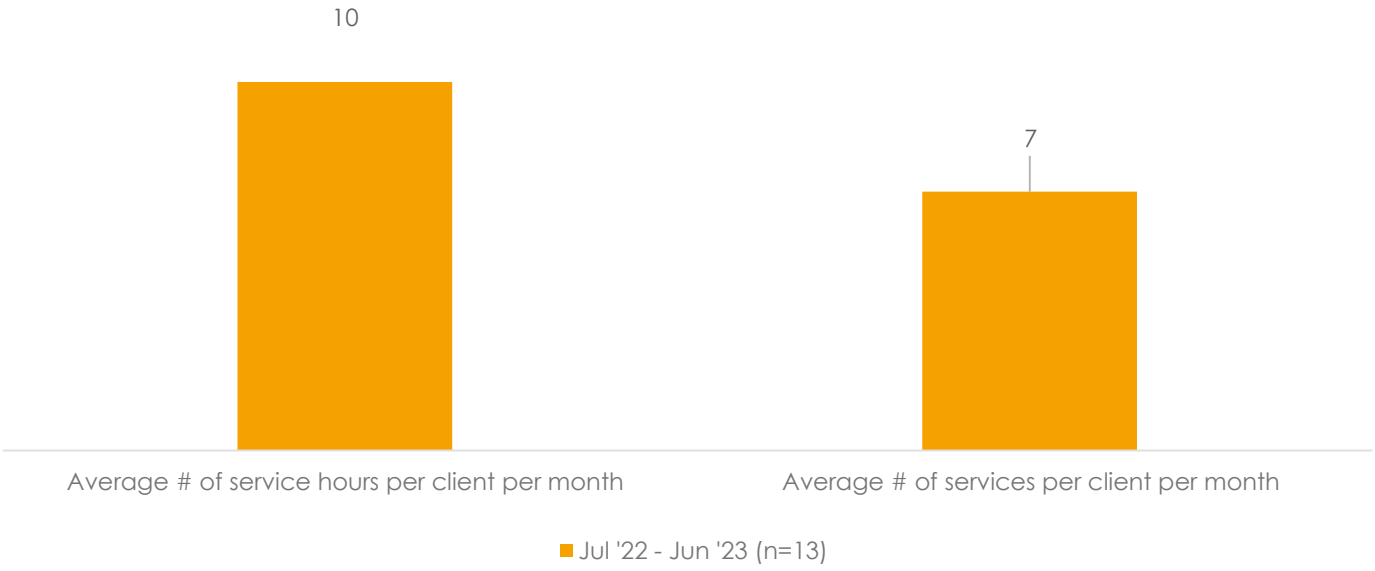
Demographics (Sexual Orientation)



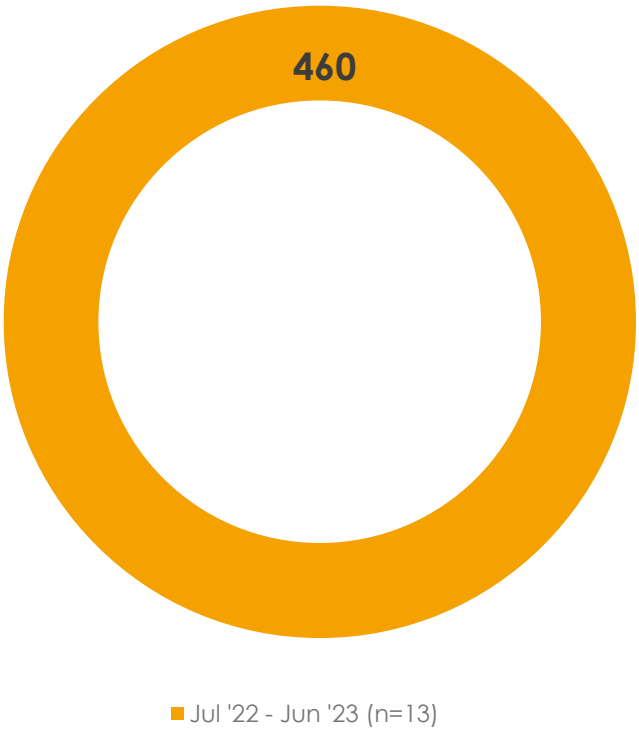
*LGBTQ+ includes gay, questioning, and other.

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Average Monthly Services per Client



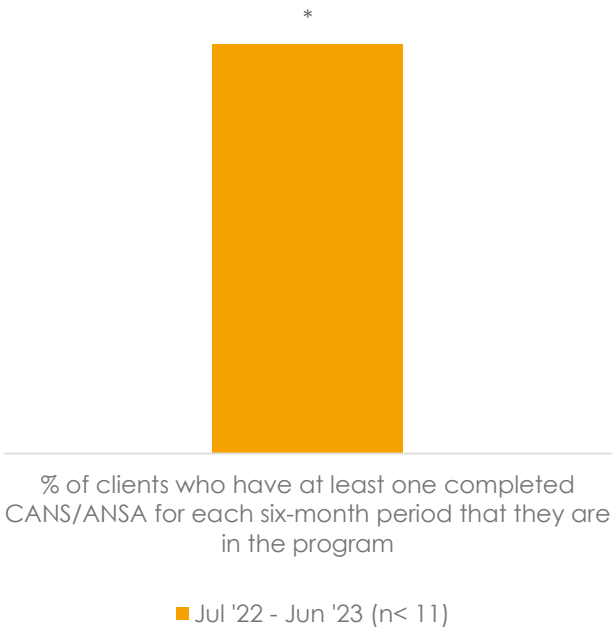
Average # of days in FSP per client

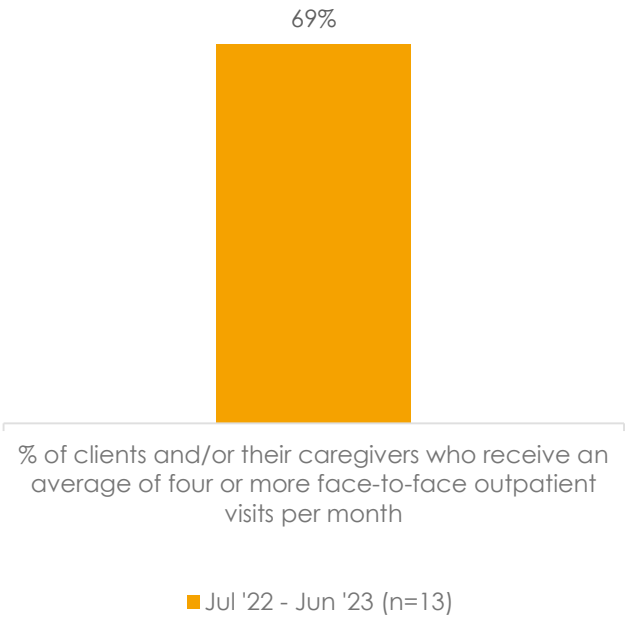


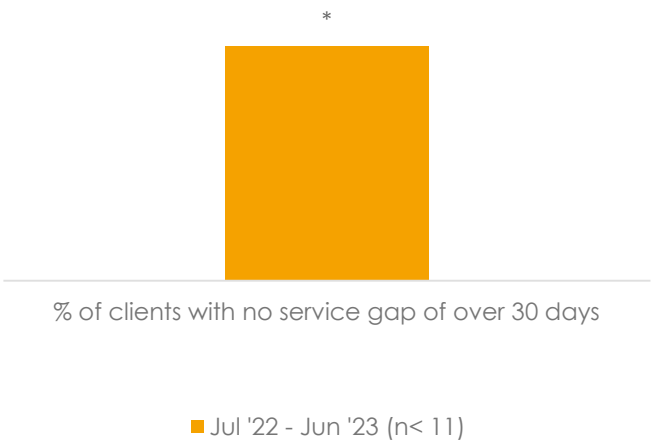
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

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

Service Consistency

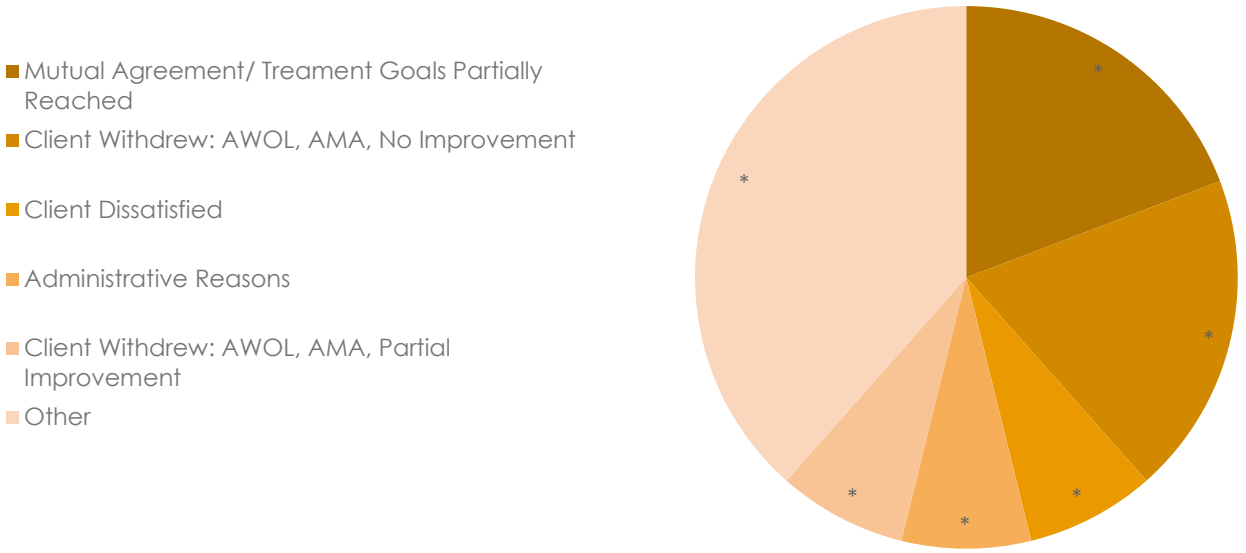




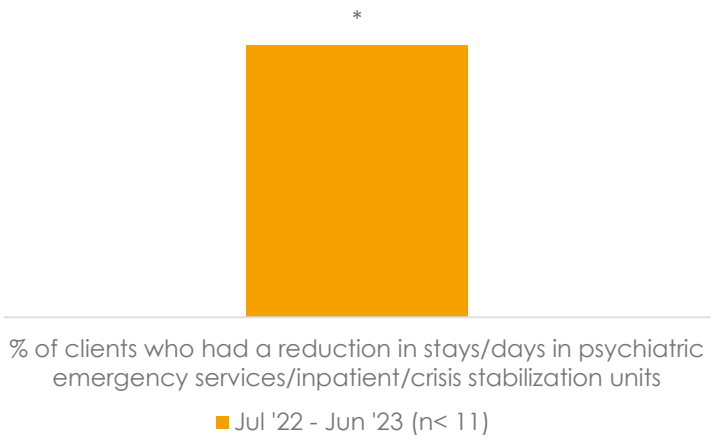


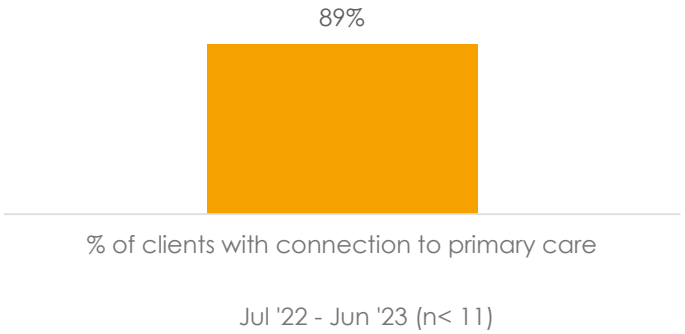
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Impact Outcomes ("Is anyone better off?")

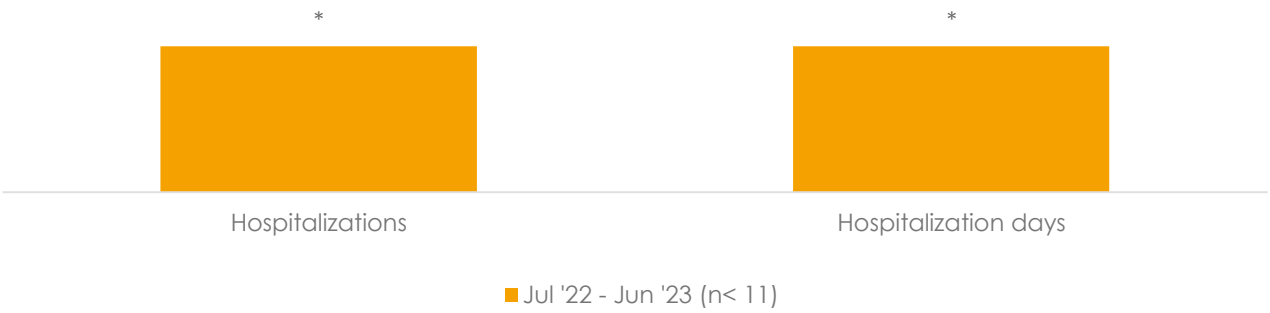


Client Outcome Improvements





% of clients with a decrease in hospitalizations/hospital days



NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

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

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

% of clients with a decrease in hospitalization days/admissions	Decrease in hospital days/admissions in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital day in the 12 months prior to admission and remained in the program for at least 1 year. Only available for fiscal years.	Yellowfin

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Adult Full Service Partnership

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

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

In FY23 a total of 63 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 = 63	
Age Category	
Age Category	*% of total*
Transition Age Youth	*
Adult	71%
Older Adult	21%
Declined to Answer (or Unknown)	*
Gender Identity	
Gender Identity	*% of total*
Male	57%
Female	41%
Declined to Answer (or Unknown)	*
Race/Ethnicity	
Race/Ethnicity	*% of total*
Asian or Pacific Islander	*
Black or African American	54%
White	41%
Latino/a/x	*
Sexual Orientation	
Sexual Orientation	*% of total*
Heterosexual	81%
Bisexual	*
Queer	*
Questionning	*

Multiple Sexual Orientations	*
Declined to Answer (or Unknown)	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

Flex funds are used to provide supports for FSP program participants. In FY23, 41 partners received rental and housing assistance; 20 received food and groceries; 6 received In-Home Assistance (cleaning, activities of daily living); and 32 partners were provided with miscellaneous assistance with bills, clothing, clothing, transit, medical supplies, storage, etc.

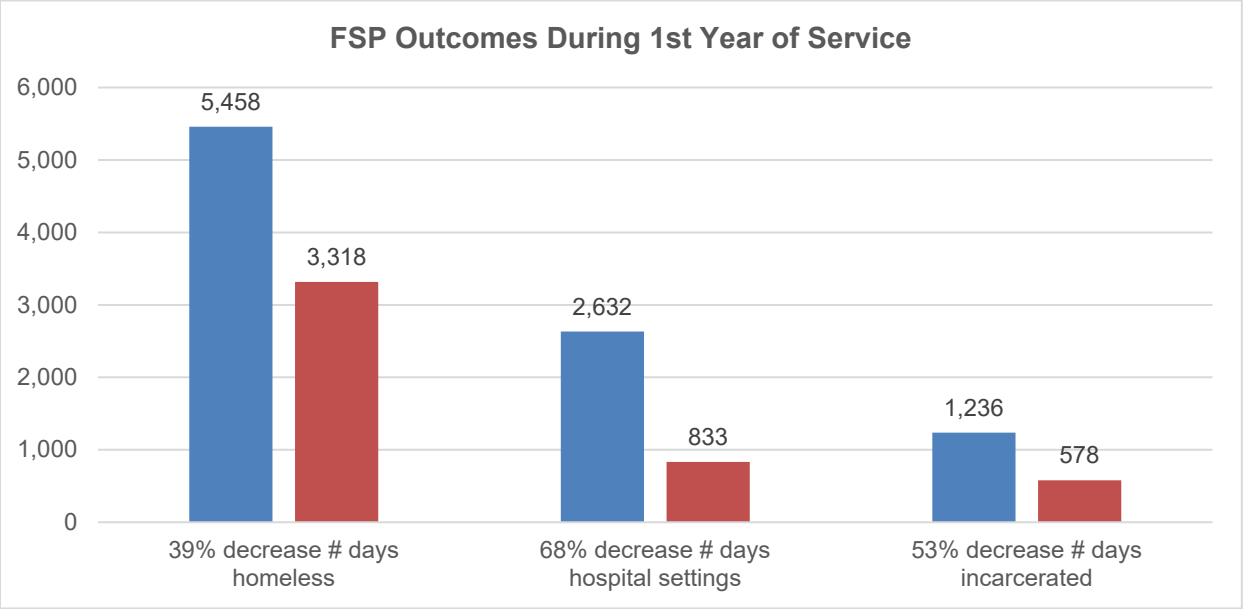
Program Successes:
In FY23, the Adult Full Service Partnership (FSP) program engaged 63 individuals actively, with 54 successfully completing at least one full year of service. The outcomes discussed below are derived from the state's Full Service Partnership Data Collection & Reporting (DCR) system, offering a comprehensive insight into the achievements of these 54 participants.

Program Enrollment and Disenrollment: Throughout the fiscal year, the program welcomed 12 new partners, with 9 of these participants completing a full year of service. In contrast, 11 partners were disenrolled from the program during FY 23. Disenrollment reasons include partners meeting treatment goals and transitioning to lower levels of care (27%), partners transferring to specialized Full Service Partnership teams for chronically homeless individuals (18%), partners sadly passing away (18%), partners becoming unlocatable (9%), partners being institutionalized in psychiatric settings (9%), and partners no longer meeting program criteria (9%).

Comparative Analysis - 54 Individuals Completing 1 Full Year of Service: For the 54 individuals completing a full year of service, a thorough comparison between the 12 months before program enrollment and the first 12 months in treatment revealed significant positive outcomes:

- A notable 39% reduction in days spent homeless, with partners experiencing 5,458 days of homelessness in the year prior to program enrollment and 3,318 days during the first year of program participation.
- A substantial 68% reduction in days spent in various hospital settings, including Psychiatric Emergency, acute psychiatric inpatient, IMDs, MHRCs, state psychiatric hospitals, medical hospitals, and SNFs. Partners spent 2,632 days in hospital settings the year before program enrollment and 833 days during the first year of program participation.
- A significant 53% reduction in days spent incarcerated during the first year of program participation. Partners spent 1,236 days incarcerated (jail and prison) in the year prior to program enrollment, compared to 578 days during the first year of program participation.

These outcomes underscore the program's positive impact in addressing homelessness, hospitalization, and incarceration among its participants, reflecting the effectiveness of the Adult FSP program during FY23, as tracked and reported through the DCR system.



Comparative Analysis - Alameda County Database Source (YellowFin) - FY23 vs. Most Recent 12 Months: In contrast to the state DCR, the Alameda County database, facilitated through the YellowFin system, draws information from a diverse set of over thirty external reporting sources. This data allows for a focused comparison of FY23 data to the most recent prior 12 months. The findings highlight significant positive outcomes for participants in the current fiscal year:

- Reduction in Psychiatric Emergency Services/Inpatient/Crisis Stabilization:
  A noteworthy 77% of participants experienced a decrease in psychiatric emergency services, inpatient care, and crisis stabilization compared to the preceding 12 months (n=13).
- Reduced Jail Days:
  A substantial 69% of clients witnessed a reduction in jail days when comparing the current fiscal year to the most recent 12 months (n=16).

This shift in data source offers a nuanced perspective, providing additional insights into the program's impact on participant outcomes, and aligns with the evaluation data from the state database (DCR).

Program Challenges:

- *Bay Area Housing Crisis* – In FY23 the Bay Area continued to be entrenched in a formidable housing crisis, characterized by the daunting challenge of securing safe and affordable housing. Housing prices, among the highest in the country, contribute to the extreme difficulty faced by individuals in finding suitable accommodations. Adding to this, Licensed Board & Cares, offering 24/7 support and medication monitoring, increasingly demanded additional funding from the city or county to sustain operations. The rent for these facilities surpasses the social security disability income received by our participants. Moreover,

Single Room Occupancy Hotels have raised their monthly rates to the extent that clients find it unaffordable without housing subsidies.

- *Coordinated Entry System* - The Coordinated Entry System in Alameda County, aimed at addressing homelessness more efficiently and equitably, introduces its own set of challenges. While standardizing the assessment process and prioritizing resources for individuals with the highest need, guiding these individuals through the assessment process proves challenging. Some individuals we serve are hesitant to acknowledge their mental health and substance use issues, resulting in lower "needs" assessment scores and diminished chances of obtaining permanent supported housing resources.
- *Staffing Challenges* - Retaining and hiring staff has been exceptionally challenging in FY23. The departure of several team members has left numerous vacancies, exacerbated by a substantial decline in applicants over the past several years. The scarcity of mental health workers in the public sector, coupled with the ongoing challenges posed by the Covid-19 pandemic, likely contributes to this hiring crisis. The nature of Full Service Partnership work, involving engagement with individuals deemed the highest need within our service system, presents inherent challenges. Burnout, cited by departing staff, underscores the demanding nature of the work. Despite these challenges, we remain optimistic about filling the current vacancies in the coming fiscal year.

The Division is committed to enhancing the Adult FSP Teams staff expertise in treating co-occurring substance abuse disorders through ongoing training in Motivational Interviewing. Concurrently, efforts will persist in refining adherence to the ACT model, reflecting the Divisions dedication to delivering effective and compassionate care to the community.

The projected number of individuals to be served in each age category in FY25 is as follows: 18-24 years – 3 individuals; 25-44 years - 23 individuals; 45-64 years - 14 individuals; 65 years and older - 11 individuals.

In FY23, the RBA measures that were established for this FSP were as follows:

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

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is Anyone Better off?
	who had a follow up visit with FSP staff within 7 and within 30 calendar days • #/% of clients closed, by reason closed • #/% of clients transferred to another level of care • % of clients who were satisfied with services**	• % of clients with a decrease in hospitalizations and hospitalization days • % of clients with a primary care visit in the last 12 months • % of clients who moved out of homelessness**

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

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients	Clients who were not served by the program in the previous fiscal year	Yellowfin
Average # of days in FSP per client	Average length of stay for primary program episodes which have closed since the beginning of the reporting period	Yellowfin
Average # of service hours per client per month	Average of hours of service in a month divided by clients served in a month. Includes all services recorded for clients. Does not include MAA	Yellowfin
Average # of services per client per month	Average services in a month divided by clients served in a month. Includes all services recorded for clients. Note: more than one service can be provided during a single contact. Does not include MAA	Yellowfin
% of clients who have at least one completed CANS/ANSA for each six month period that they are in the program	Of clients with a completed CANS/ANSA, what percentage of them had an assessment at least every six months?	Objective Arts
% of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month	Clients must be been open to a provider for at least 30 days in order to be included in this metric. Phone contacts are included during the pandemic. Days in subacute or jail not counted, but services are counted.	Yellowfin
% of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month	Clients must be been open to a provider for at least 30 days in order to be included in this metric. Phone contacts are included during the pandemic. Days in subacute or jail not counted, but services are counted.	Yellowfin

Measure	Definition	Data Source
% of clients with no service gap of over 30 days	Maximum days each Level 1 client went without service during their episode(s) in the reporting period. Only considered clients open to a provider for at least a total of three months during the reporting fiscal year.	Yellowfin
% of discharges from hospitalization or subacute who had a follow up visit with FSP staff within 7 and within 30 calendar days	Follow-up rates for individuals open to Level 1 providers at the time of MH hospital discharge.	Yellowfin

Data Development Agenda – measures the team is interested in reporting on but for which reliable data was not available:

- % of clients who have a billable contact with FSP staff within 7 calendar days:
  -Following discharge (from a hospital, crisis residential or release from jail);
  -After assignment to the team;
- Client-to-staff ratio;
- % staff retention year-to-year;
- Average # of contacts per month per client.

To provide context around the FY23 RBA Outcomes for this FSP, during FY22 and FY23 the Adult Full Service Partnership experienced a notable rate of staff changes. Additionally, there was a general decrease in productivity, which can be attributed to the ongoing impacts of the pandemic. Efforts are currently underway to enhance staff retention strategies.

RBA Outcomes in FY23 for this FSP are outlined on the following pages.

BMH RBA Report FY 2023

Reporting Period July 2022 - June 2023

Adult Full Service Partnership (AFSP)

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

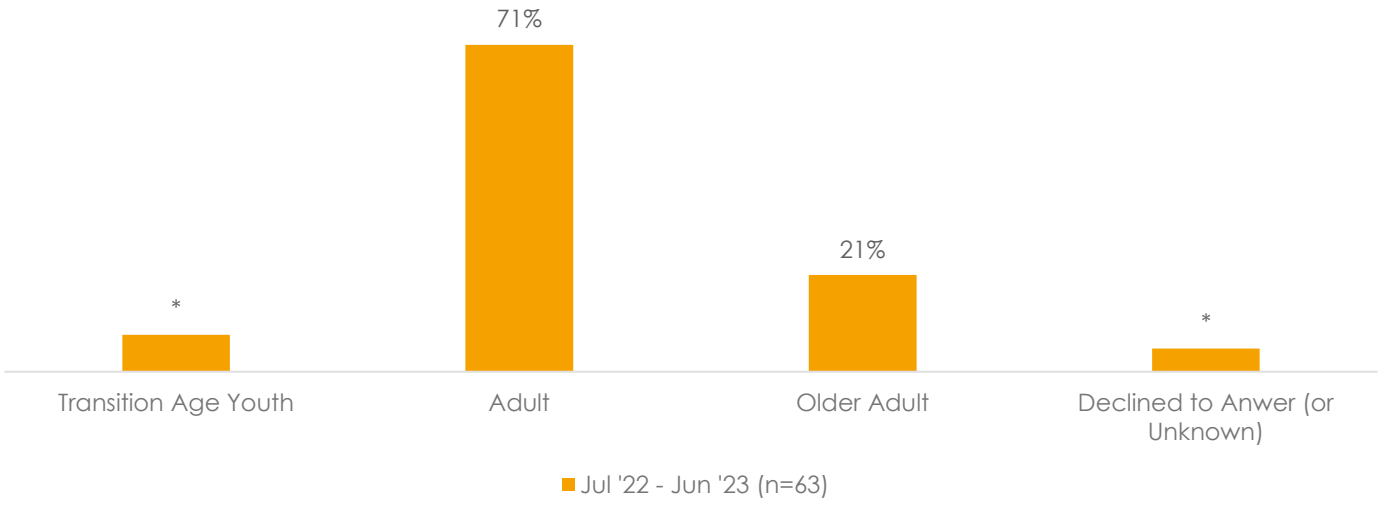
63
Clients Served

11
New Clients

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

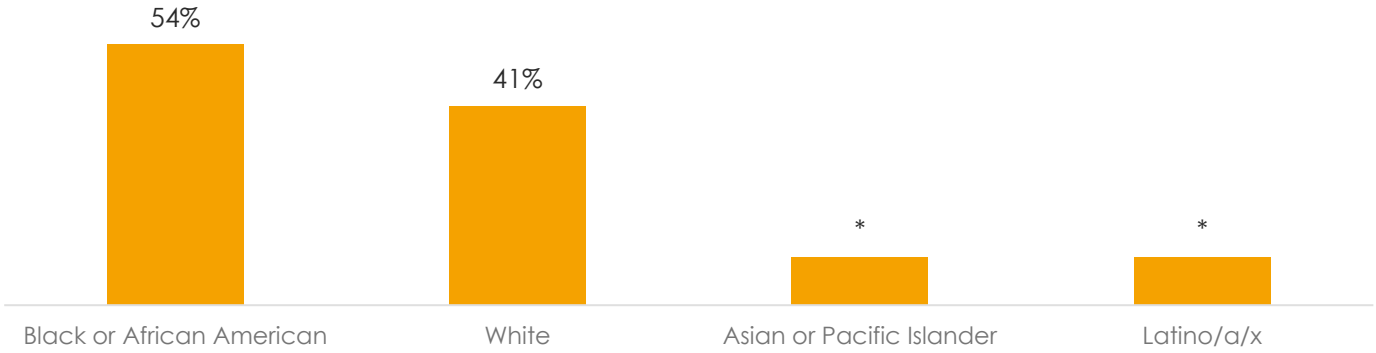
Program Updates: In Fiscal Year 2021-2022, the Adult Full Service Partnership was not fully staffed, this has been remedied in FY 2022-23.

Demographics (Age)



Demographics (Ethnicity)

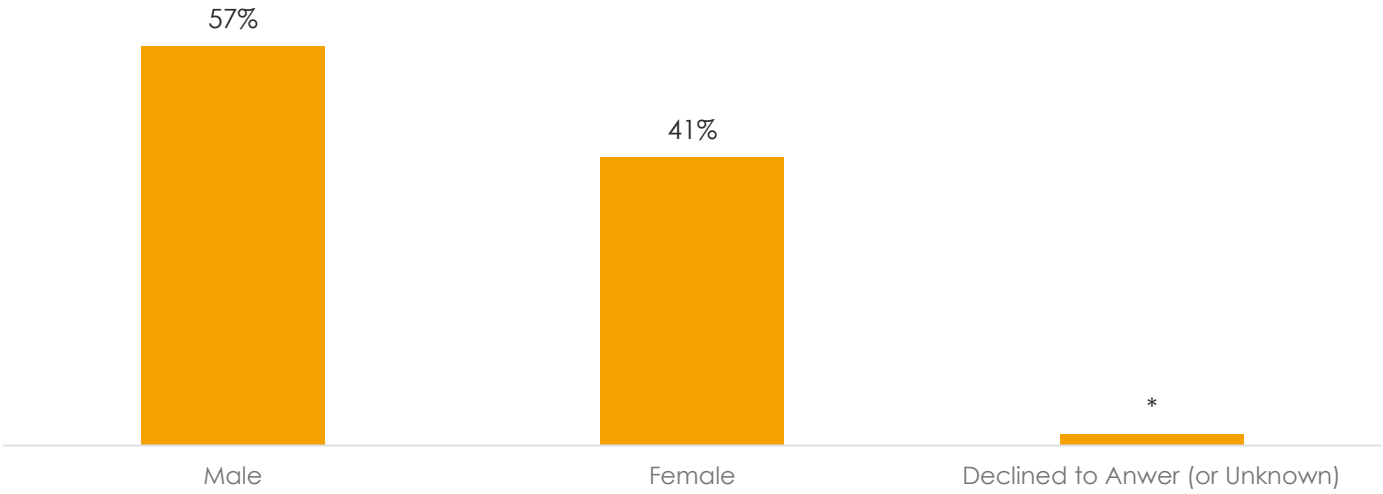
Jul '22 - Jun '23 (n=63)



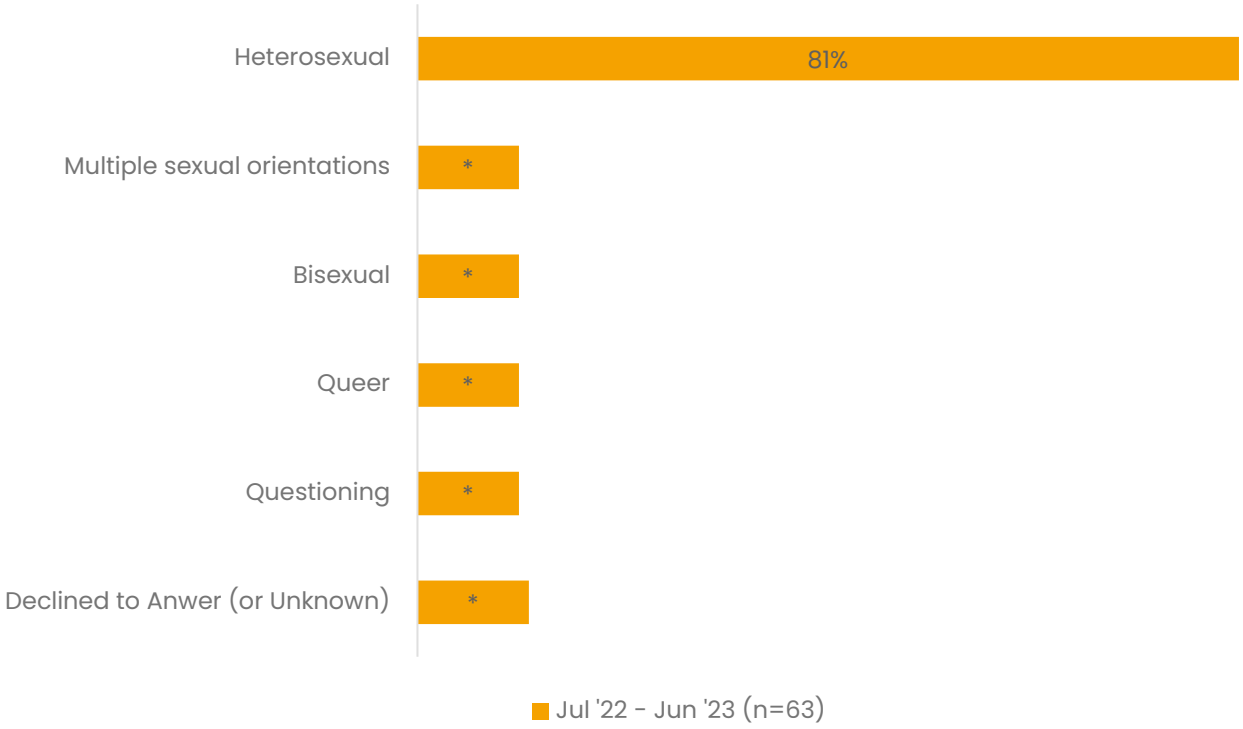
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Demographics (Gender Identity)

Jul '22 - Jun '23 (n=63)

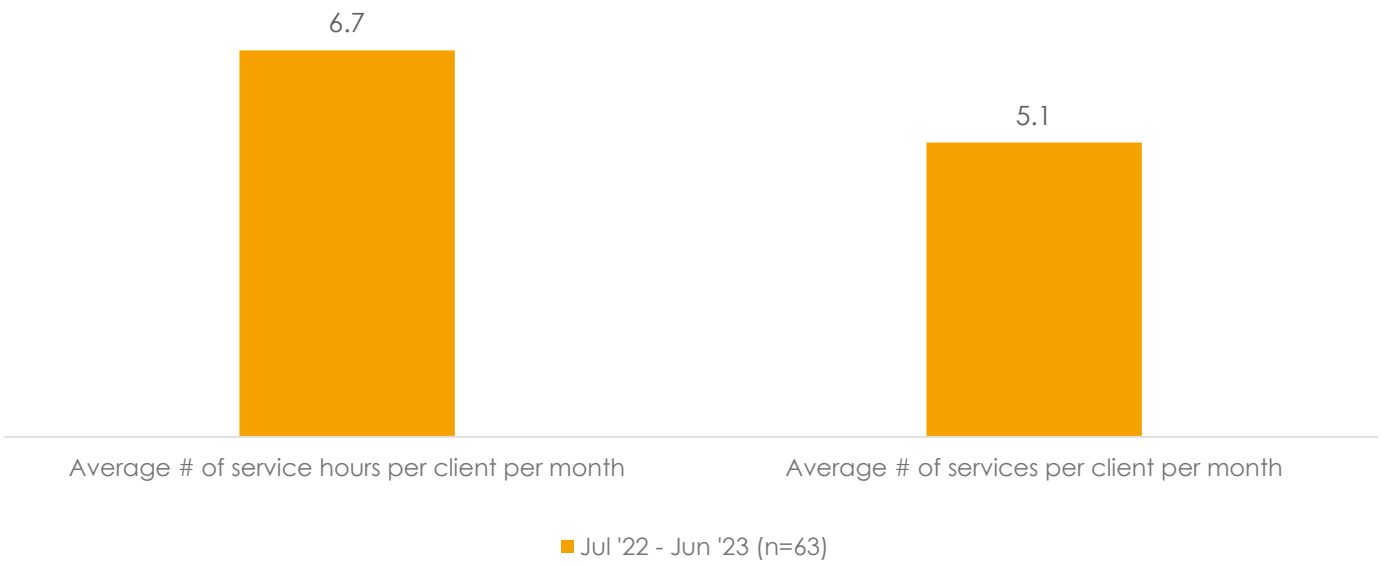


Demographic (Sexual Orientation)

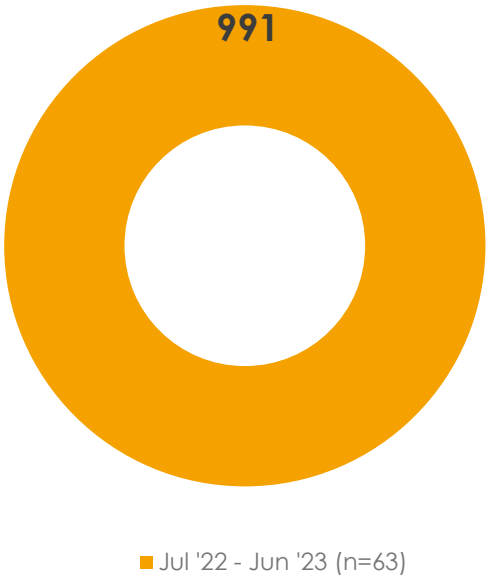


NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Average Monthly Services per Client



Average Number of Days in FSP

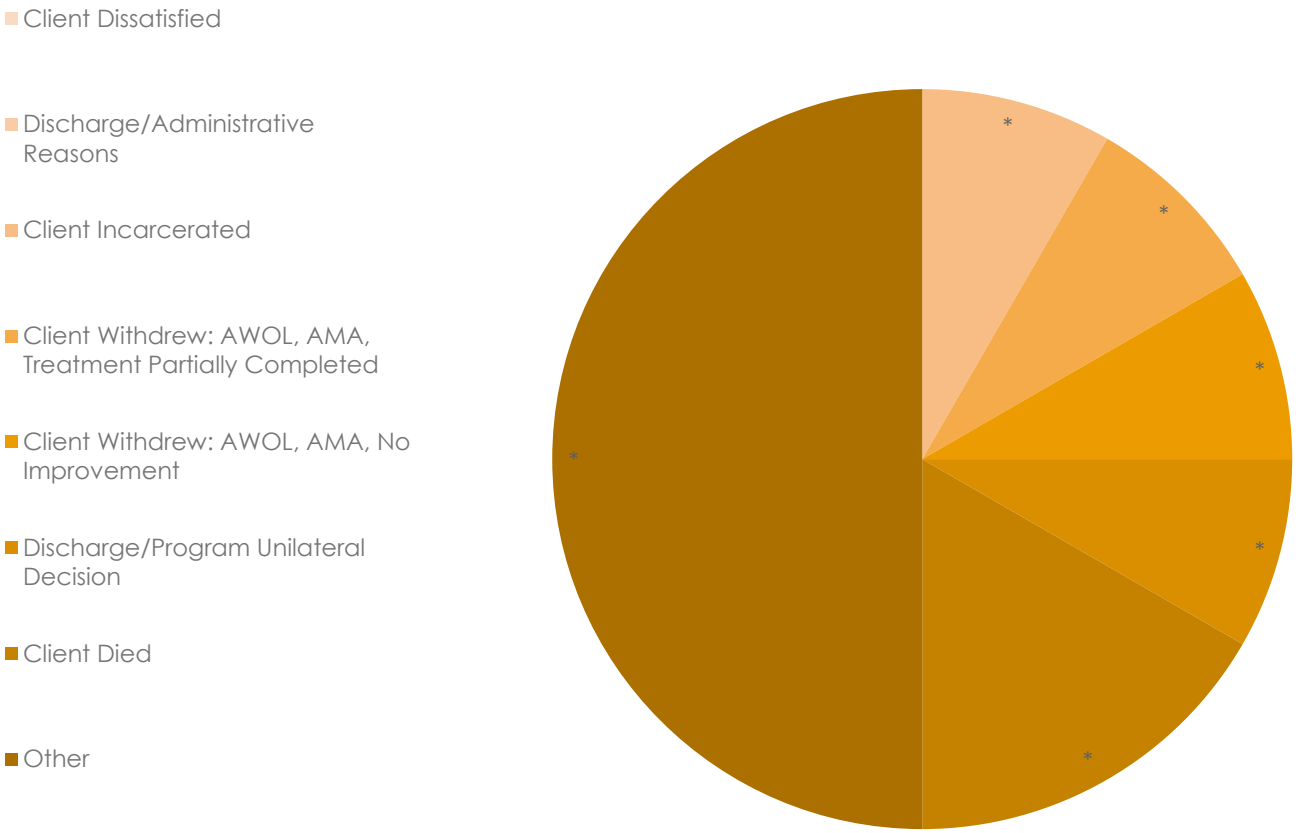


NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

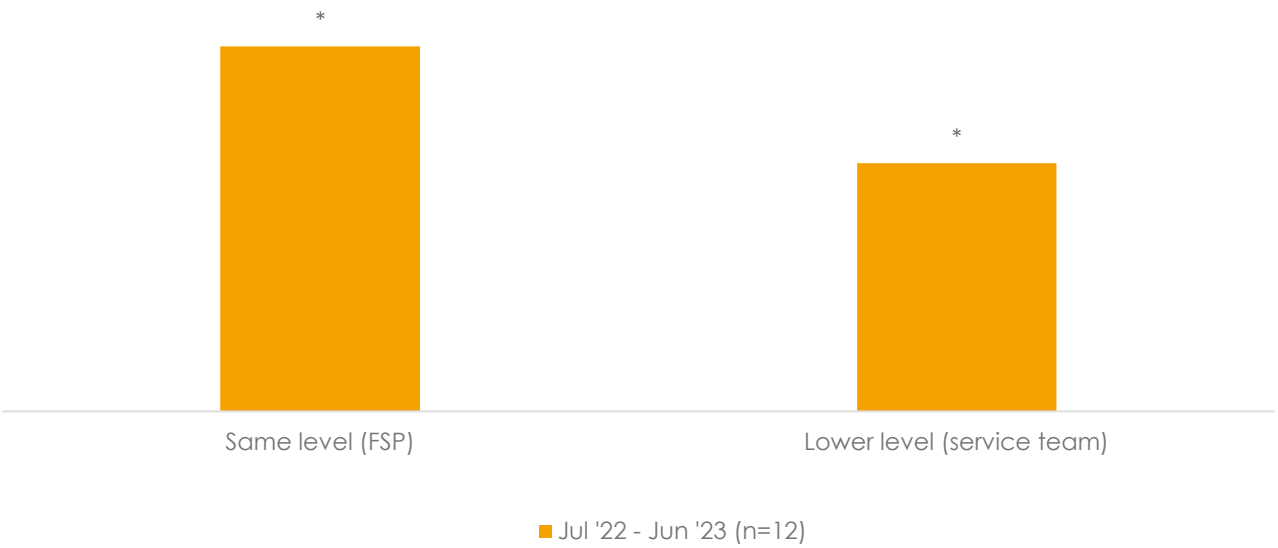
Quality Outcomes ("How well did we do it?")

Clients Closed, by Reason Closed

Jul '22 - Jun '23 (n=12)

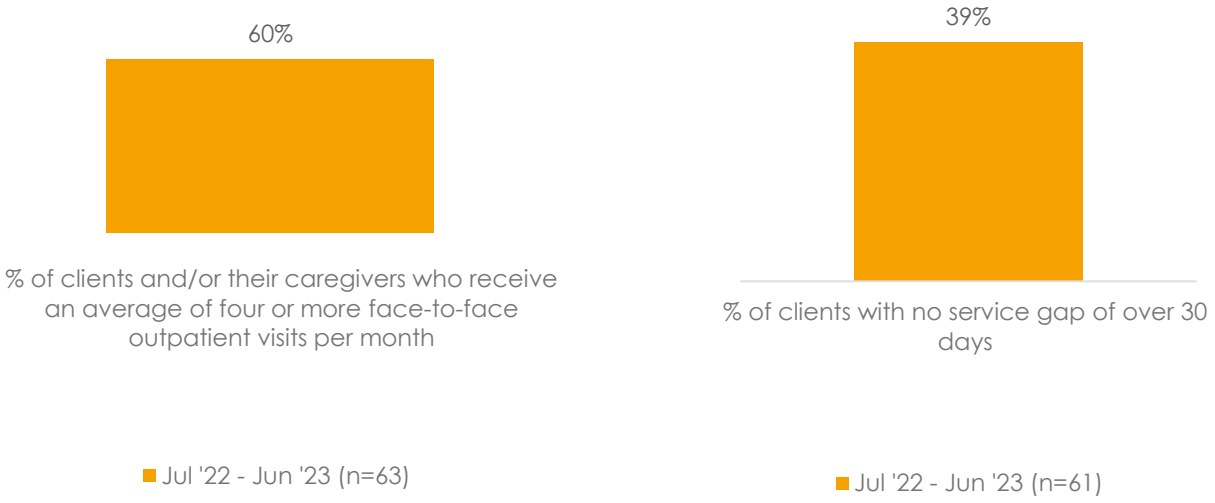


Clients Transferred to Another Program, by Level of Care



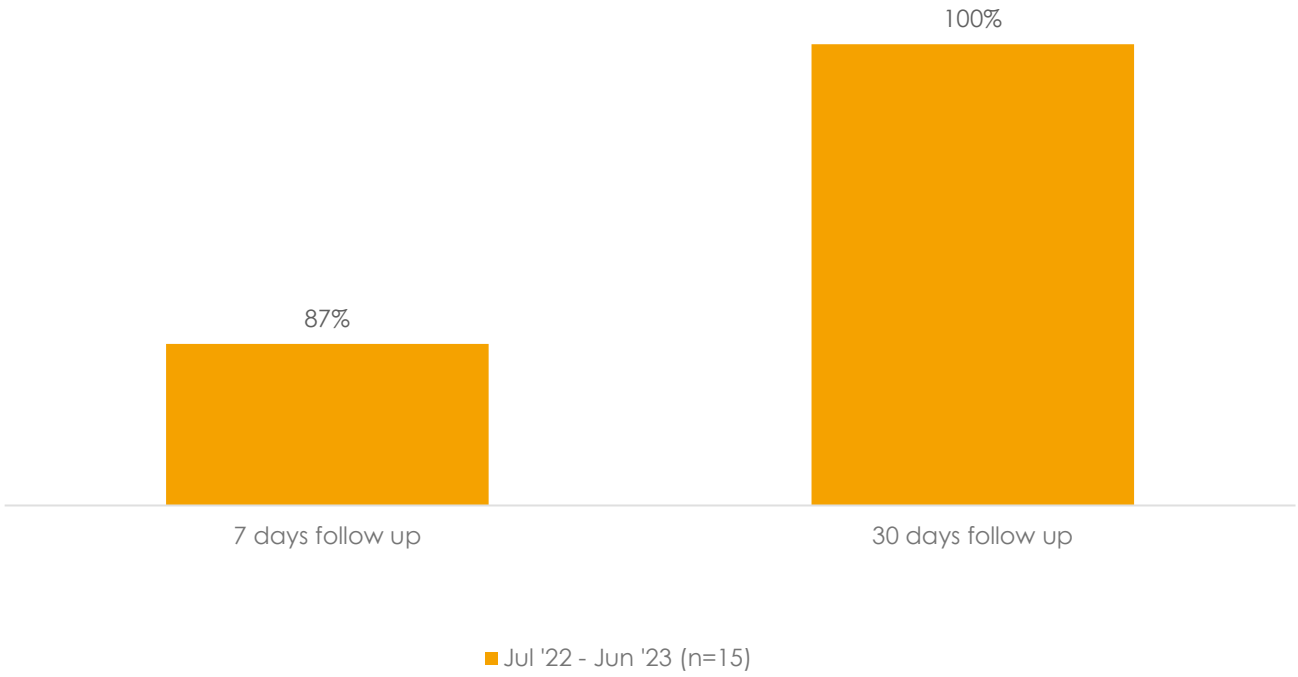
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Service Consistency



Hospital Follow Up Consistency

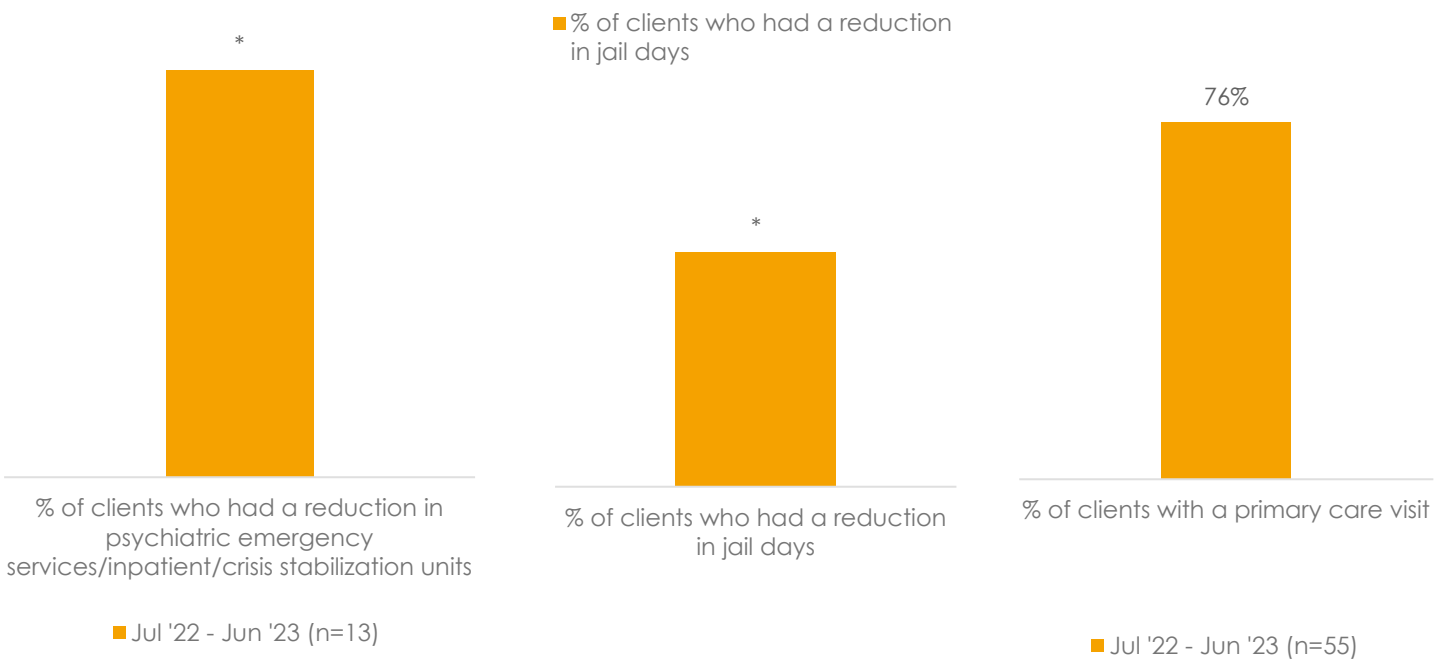
% of discharges from hospitalization or subacute who received FSP follow up within 7 and 30 days



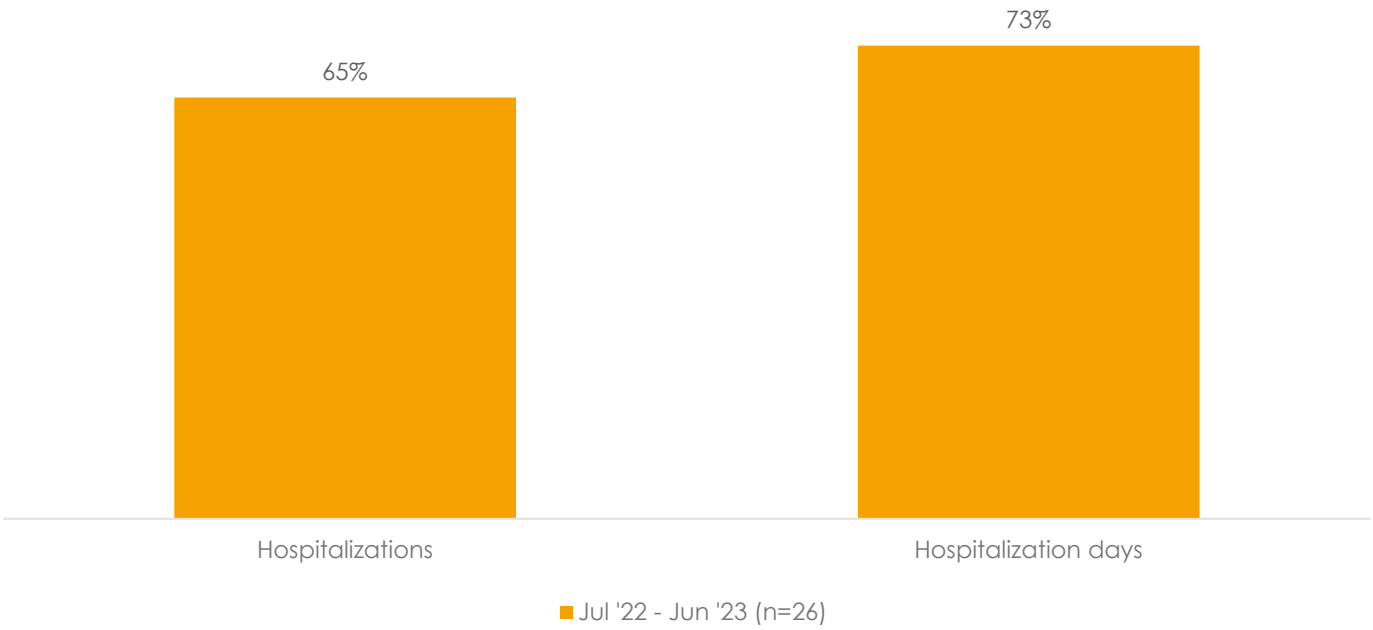
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Impact Outcomes ("Is anyone better off?")

Client Outcome Improvements



% of clients with a decrease in hospitalizations/hospital days



NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

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

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

% of clients who had a reduction in psychiatric emergency services/inpatient/crisis stabilization units	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in psychiatric emergency services, inpatient or crisis stabilization unit other than Amber House, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in jail and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients who had a reduction in jail days	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in jail days, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in hospital and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients with a primary care visit	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/Community Health Center Network (CHCN) primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).	Yellowfin
% of clients with a decrease in hospitalizations/hospitalization days	Decrease in hospital days/admissions in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital day in the 12 months prior to admission and remained in the program for at least 1 year. Only available for fiscal years.	Yellowfin

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

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 individuals experiencing homelessness following the ending of the Homeless Outreach and Treatment Team (HOTT) Pilot Program, a Homeless Full Services Partnership (HFSP) was developed. The HFSP provides services to individuals primarily in the community, and in any temporary housing placement (e.g. shelter, unhoused encampment) who meet the following criteria:

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

The HFSP utilizes a team model for providing intensive treatment, meeting people up to several times per week.

In FY23, 47 individuals were served. Demographics on individuals served are as follows:

DEMOGRAPHICS N = 47	
Age Category	
Age Category	*% of total*
Adult (26-59)	89%
Older Adult (60+)	11%
Gender Identity	
Gender Identity	*% of total*
Male	70%
Female	30%
Race/Ethnicity	
Race/Ethnicity	*% of total*
Black or African American	62%
Asian Pacific Islander	*
Latino/a/x	*
White	28%
Declined to Answer (or Unknown)	*
Sexual Orientation	
Sexual Orientation	*% of total*
Heterosexual	64%
Bisexual	*
Gay	*
Declined to Answer (or Unknown)	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

Flex funds are used to provide supports for FSP program participants. During FY23, 2 partners received rental and housing assistance; 16 received food and groceries; 5 partners received

bus passes or transportation; 4 partners were provided with assistance with clothing/hygiene; and 8 partners were provided with assistance with cell phones, bills, or obtaining a mail box.

Program Successes:
The most significant success for the team in FY23 was the hiring of the Mental Health Clinical Supervisor to lead the team and two Case Managers. The Team was able to enroll additional participants, continue to serve the unhoused community, and support individuals making the transition into housing.

Program Challenges:
The ongoing challenge for the team has been difficulties in locating and consistently meeting with clients who are unhoused and who's mental health symptoms make it difficult for them to attend scheduled appointments, keep and maintain cell phones to stay connected to service providers, etc. The team continued to make attempts to outreach and engage clients in the community by going out to look for them at various locations in the community when they missed meetings. Another challenge was the difficulty the team had when attempting to link clients to crisis services, including crisis stabilization units. The HFSP was provided with feedback that the behaviors the individual's exhibited were too challenging and/or that there were too many risk factors for the client to be at that level of care. The main purpose of the team was to support individuals with their mental health symptoms. However, the Team begun to function as housing navigators by supporting clients in locating housing, even though the team and clinic are not a housing program. If the team and client were able to locate housing, there were also insufficient resources and supports within the housing community to help the client maintain that placement, leading to the increased likelihood of recidivism to homelessness.

The projected number of individuals to be served through this program in FY25 by age category is as follows: 18-24 years - 2 individuals; 25-44 years - 16 individuals; 45-64 years - 23 individuals; 65 years and older - 5 individuals.

In FY23, the RBA Measures that were established for this FSP were as follows:

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

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

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

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients	Clients who were not served by the program in the previous fiscal year	Yellowfin
Average # of days in FSP per client	Average length of stay for primary program episodes which have closed since the beginning of the reporting period	Yellowfin
Average # of service hours per client per month	Average of hours of service in a month divided by clients served in a month. Includes all services recorded for clients. Does not include MAA	Yellowfin
Average # of services per client per month	Average services in a month divided by clients served in a month. Includes all services recorded for clients. Note: more than one service can be provided during a single contact. Does not include MAA	Yellowfin

Measure	Definition	Data Source
% of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program	Of clients with a completed CANS/ANSA, what percentage of them had an assessment at least every six months?	Objective Arts
% of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month	Clients must be been open to a provider for at least 30 days in order to be included in this metric. Phone contacts are included during the pandemic. Days in subacute or jail not counted, but services are counted.	Yellowfin
% of clients with no service gap of over 30 days	Maximum days each Level 1 client went without service during their episode(s) in the reporting period. Only considered clients open to a provider for at least a total of three months during the reporting fiscal year.	Yellowfin
% of discharges from hospitalization or subacute who had a follow up visit with FSP staff within 7 and within 30 calendar days	Follow-up rates for individuals open to Level 1 providers at the time of MH hospital discharge.	Yellowfin
#/% of clients closed, by reason closed	Discharge reason for clients discharged during the reporting period	Yellowfin
% of clients who had a reduction in days in psychiatric emergency services/inpatient/crisis stabilization units	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in psychiatric emergency services, inpatient or crisis stabilization unit other than Amber House, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in jail and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients with a decrease in hospitalization	Decrease in hospital admits and hospitalization days in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital admit in the 12 months prior to admission and remained in the program for at least 1 year	Yellowfin
% of clients who had a reduction in jail days	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in jail days, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in	Yellowfin

Measure	Definition	Data Source
	hospital and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	
% of clients with a primary care visit in the last 12 months	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/CHCN primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).	Yellowfin

Data Development Agenda: measures the team is interested in reporting on but for which reliable data was not available:

- Client satisfaction with services;
- Client engagement in interpersonal activities;
- Client income (incl. entitlements);
- Change in violence (e.g. # of violent interactions reported) experienced by the client;
- Change in educational or workforce training status of client;
- Client-to-staff ratio;
- % staff retention year-to-year;
- % of clients and/or their caregivers who have consented to participate in services and have received one or more face-to-face visits within 7 calendar days of their HFSP referral;
- #/% of clients who maintained housing at 6 months from housing placement date.

To provide context for the FY22 RBA outcomes, the HFSP initiated service in FY22 leading to an expansion of their client base. Throughout the latter part of FY23, the team underwent staffing changes but has since achieved full staffing capacity. The workforce was augmented by two new members, enhancing the follow-up capabilities of the program. Staff maintained a high frequency of interaction with clients, ensuring robust support. Although the HFSP lacked a Clinical Supervisor from August 2022 to April 2023, the gap was bridged by interim personnel to assist clients in progressing towards their treatment objectives.

RBA Outcomes in FY23 for this FSP are outlined on the following pages.

BMH RBA Report FY 2023

Reporting Period July 2022 - June 2023

Homeless Full Service Partnership (HFSP)

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

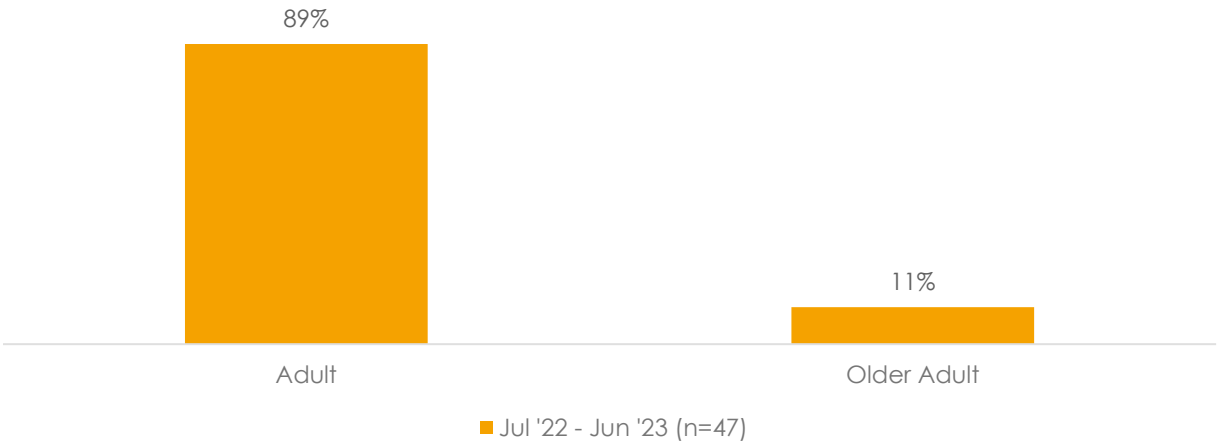
47
Clients Served

11
New Clients

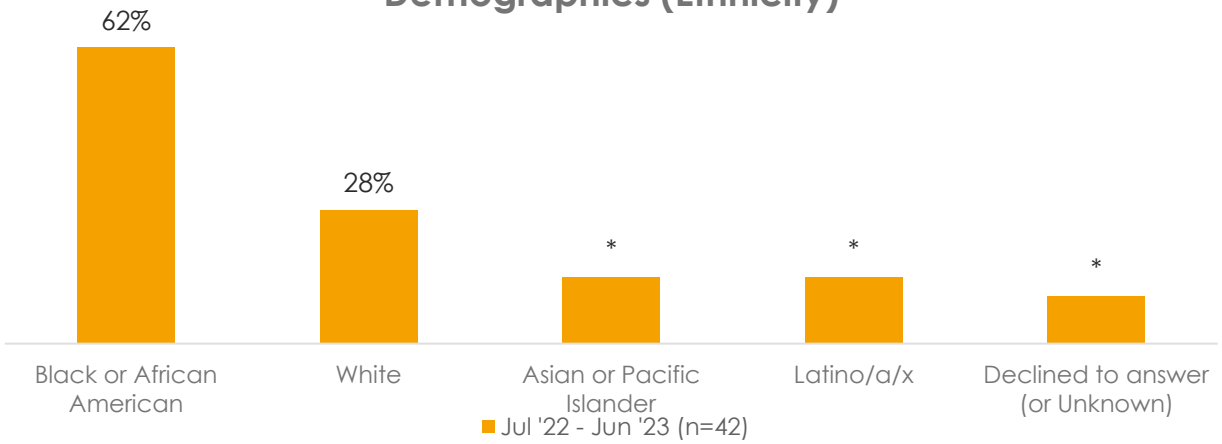
Program Description: HFSP serves unhoused residents of Berkeley in an Assertive Community Treatment (ACT) model at high staff to client ratios, providing intensive case management and mental health services in a multi-disciplinary team approach. This team serves those with the highest level of need,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

Program Updates: HFSP began offering services during Fiscal Year 2021-22, and therefore was growing their caseload. They additionally had some staffing transitions in the second half of FY 2022-23 but are now fully staffed.

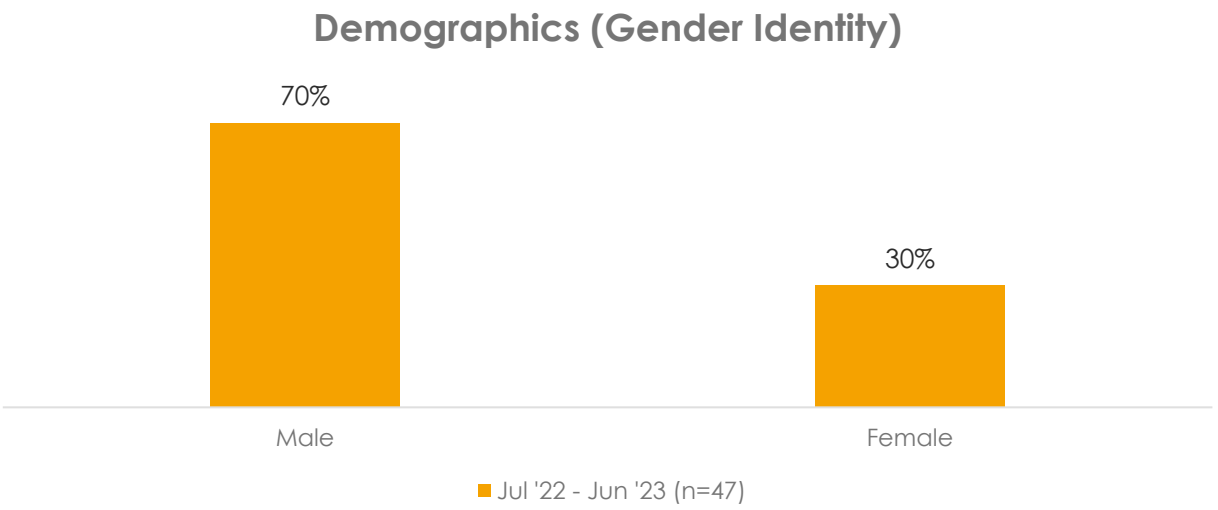
Demographics (Age)

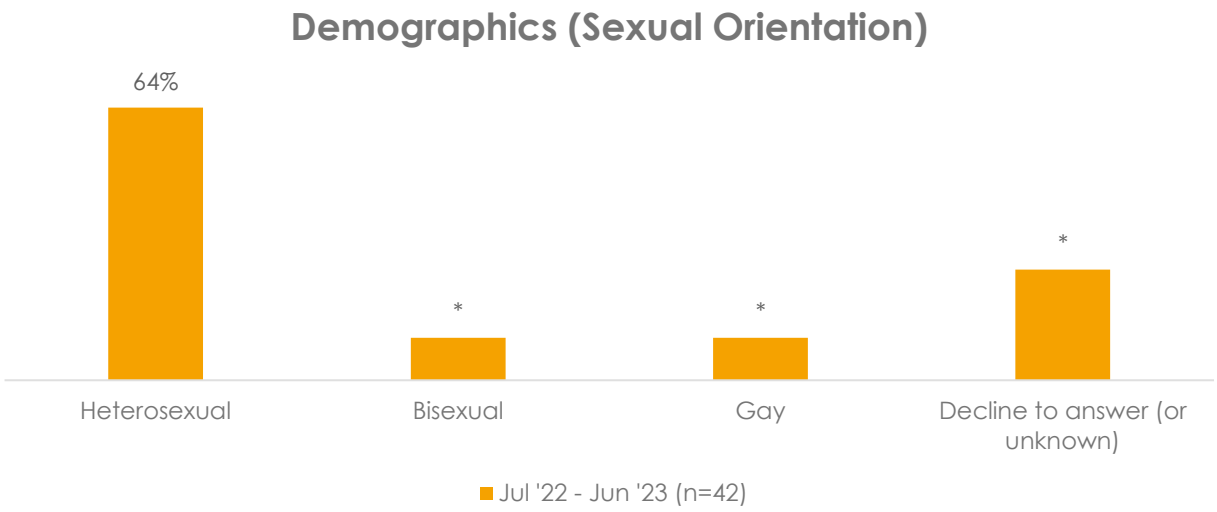


Demographics (Ethnicity)



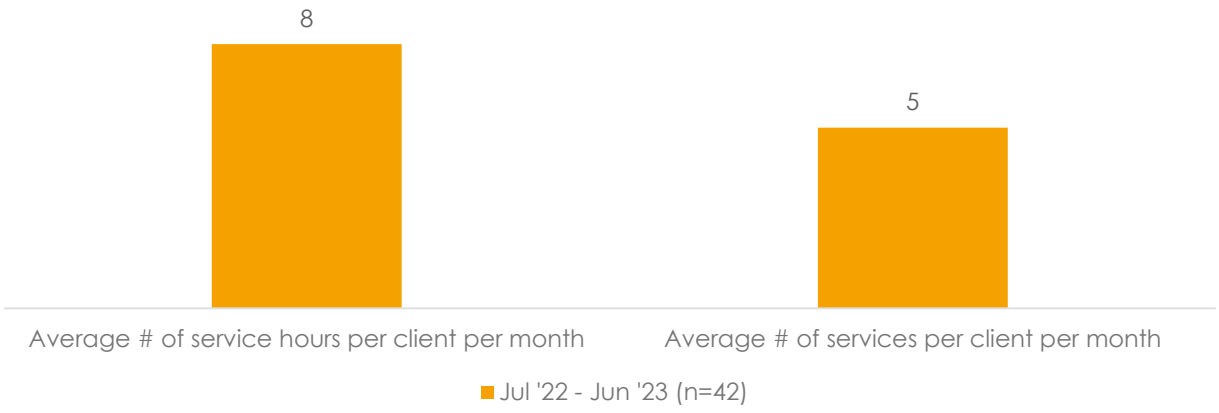
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.





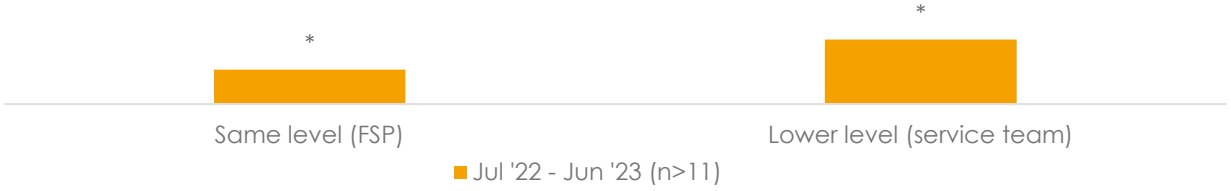
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Average Monthly Services per Client



Average Number of Days in FSP

Clients Transferred to Another Program, by Level of Care

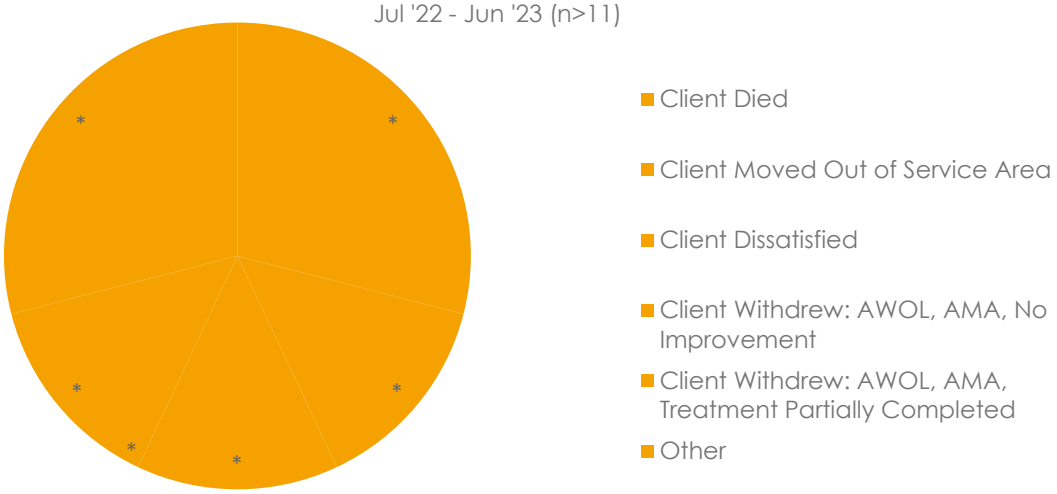


NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

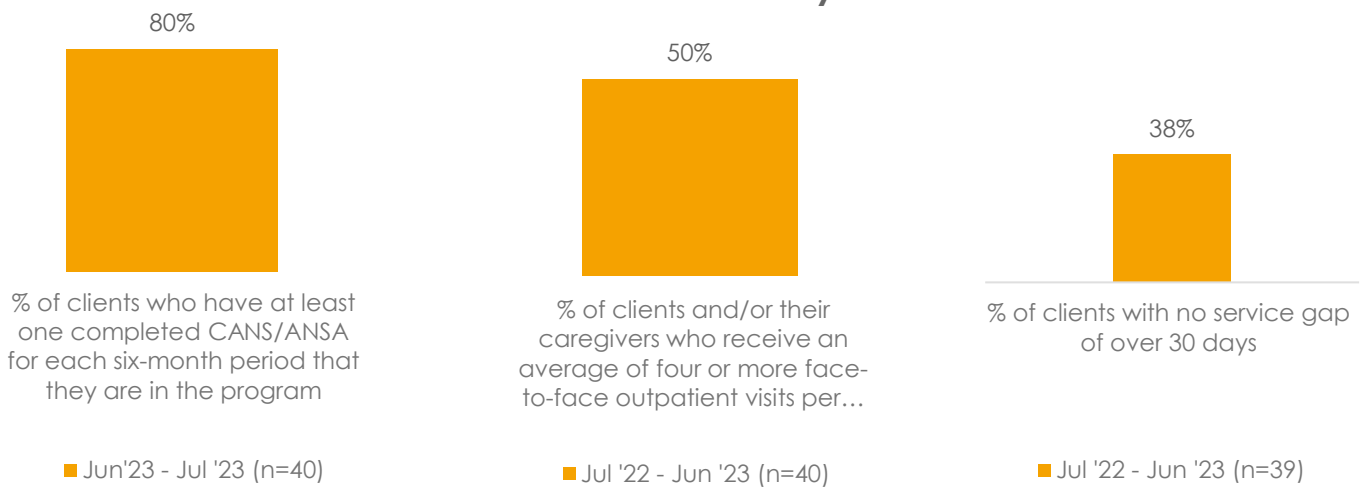
Quality Outcomes ("How well did we do it?")

Clients Closed, by Reason Closed

Jul '22 - Jun '23 (n>11)

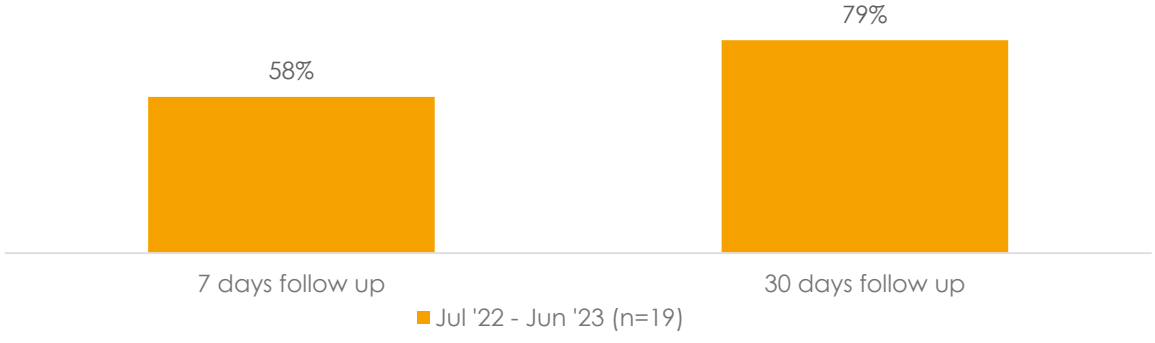


Service Consistency



Hospital Follow Up Consistency

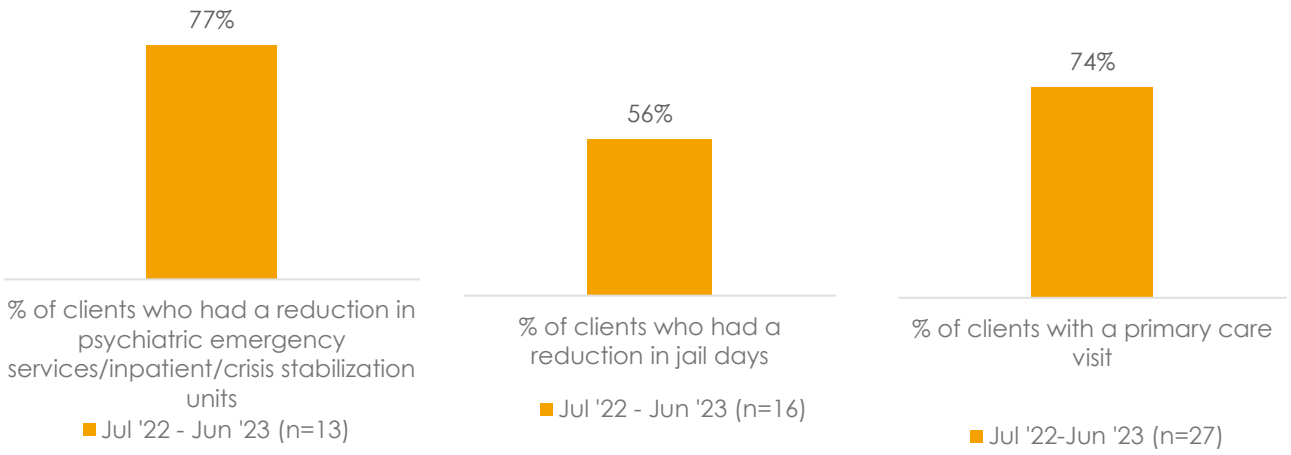
% of discharges from hospitalization or subacute who received FSP follow up within 7 and 30 days



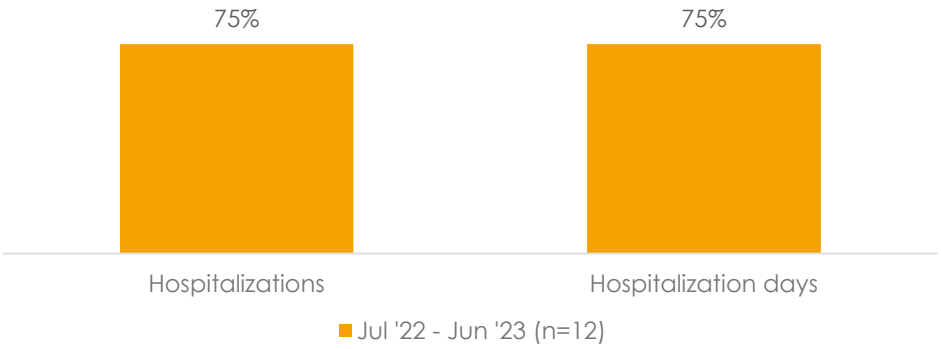
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Impact Outcomes ("Is anyone better off?")

Client Outcome



% of clients with a decrease in hospitalizations/hospital days



NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

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

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

% of clients who had a reduction in psychiatric emergency services/inpatient/crisis stabilization units	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in psychiatric emergency services, inpatient or crisis stabilization unit other than Amber House, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in jail and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients who had a reduction in jail days	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in jail days, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in hospital and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients with a primary care visit	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/Community Health Center Network (CHCN) primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).	Yellowfin
% of clients with a decrease in hospitalizations/hospitalization days	Decrease in hospital days/admissions in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital day in the 12 months prior to admission and remained in the program for at least 1 year. Only available for fiscal years.	Yellowfin

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

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 humility competency training to all behavioral health, community partners, and all stakeholders in Berkeley and other geographic locations in the region as a collaborative partner;
- Performing outreach and engagement to unserved, underserved, inappropriately served and emerging communities and populations;
- Developing long and short-term goals and objectives to promote cultural/ethnic and linguistic competency within the system of care;
- Developing an annual training plan and budget;
- Chairing the agency's Diversity and Multicultural Committee;
- Attending continuous trainings in the areas of cultural competency;
- Monitoring Interpreter and Translation Services for the agency;
- Collaborating with State, Regional, County, and local groups and organizations, and
- Developing and updating BMH's Cultural Humility Competency Plan as needed.

In FY23, there was a vacancy in this position.

Transition Age Youth (TAY) Support Services

The Transition Age Youth (TAY) Support Services program provides outreach, services, supports, and/or referrals to TAY with serious mental health issues who are homeless or marginally housed and not currently receiving services. Priority is given to youth coming out of foster care and/or the juvenile justice system and particular outreach strategies are utilized to engage youth from various ethnic communities, including African Americans, Asian and Latino/a/x populations, among others. Program services include: Culturally appropriate outreach and engagement; peer counseling and support; assessment; individual and group therapy; family education; case management, coaching, ancillary program referrals and linkages. Also provided are services in housing attainment and retention, financial management, employment, schooling, and community involvement. Services are designed to be culturally relevant, tailored to each individual's needs, and delivered in multiple, flexible environments. The main goals of the program are to increase outreach, treatment services, and supports for mentally ill TAY in need, and to promote self-sufficiency, resiliency and wellness. This program serves 15-20 youth at a time. This program has not been implemented over the past couple of years, it will not be implemented in FY25.

SYSTEM DEVELOPMENT

System Development includes Wellness Recovery Support Services that are intended to expand collaboration with stakeholders, promote the values of wellness, recovery and resilience, and move the Division towards a more consumer and family member driven system. Services are comprised of the following main components: Wellness/Recovery System Integration and Family Advocacy Services. Together, both ensures that mental health peers and family members are informed of, and able to be involved in, opportunities to provide input and direction in the service delivery system and/or to participate in recovery-oriented or other supportive services of their choosing. Strategies designed to reach program goals include: developing policies that facilitate the Division in becoming more Wellness & Recovery oriented and consumer/family member driven; outreach to, and inclusion of, mental health peers and family members on Division committees; provision of family support & education; supported employment and vocational services; wellness activities; peer supportive services; and client advocacy. Some of the additional services and supports that CSS System Development provides funding for are as follows: Housing Services and Supports; Benefits Advocacy; Employment/Educational Services; Wellness Recovery Center; Counseling Services for Senior Citizens; Youth Case Management Services; Hearing Voices Groups; Transitional Outreach Team; Flex Funds and Sub-Representative Payee Services for clients, etc.

Wellness Recovery Services

The BMH Wellness Recovery Team works with staff, stakeholders, community members and clients to advance the goals of Wellness and Recovery on a system wide level. In order to accomplish these goals, some of the various tasks include: Recruiting peers for Division committees; convening committees around Wellness Recovery system initiatives; oversight/administration of peer stipends; convening and conducting meetings for the Berkeley “Peers Organizing Community Change (POCC)”; working with staff to develop various Wellness and Recovery related policy and procedures; and oversight of the Division’s “Wellness Recovery Activities”. The Consumer Liaison is also a resource person around “Mental Health Advance Directives” for individuals desiring to express their treatment preferences in advance of a crisis, and is a participant on a number of local MHSA initiatives. The combination of individual services and system-level initiatives impact all clients and their family members across the system in a given year. In FY23, there were approximately 397 clients in the BMH system.

Three positions were added in FY23, to the Wellness Recovery Program. The vacant Assistant Mental Health Clinician position was filled and two Social Service Specialist positions, or Wellness Community Specialists, were hired to make the clinic more welcoming and provide peer support to individuals waiting to be seen at the clinic. Adding these positions made more individuals aware of the wellness groups, community resources and support that the clinic has to offer.

Being fully staffed, The Wellness Recovery Team was able to bring some groups back in-person such as the WRA- Wellness Recovery Activities and to start engaging with people in the waiting room, offering resources, peer support, light refreshments and warm connections. All of

the group flyers received a facelift and were re-vamped and the Monthly Wellness Recovery Activities Newsletter was brought back for the peer community.

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:

Wellness Recovery Groups

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

Wellness Recovery Activities

The Wellness Recovery Activities (WRA) group highlights consumer facilitation and creativity skills. In FY23, there were 11 group sessions with a total of 9 attendees. The projected numbers to be served in FY25 per each age group is as follows: 18-25 years – 1 individual; 26-59 years – 5 individuals; 60 years or older – 5 individuals.

Walking Groups

The Wellness Recovery Team provides walking groups to help with isolation, promote physical activities and socialization. The walks take place at local Berkeley parks and neighborhoods and they varied in physical intensity. The walks are advertised in the Wellness Recovery monthly calendar. In FY23, 20 walks were scheduled throughout the year. During the month of January walks were not scheduled due to rainy weather. The parks visited were Ohlone, Grove Park, Cedar Rose, 4th street, Aquatic Park, Berkeley Marina, San Pablo Park and the University of California at Berkeley campus. A total of 9 unduplicated individuals participated in the Walking Groups. The projected numbers to be served in FY25 per each age group is as follows: 18-25 years – 1 individual; 26-59 years – 5 individuals; 60 years or older – 2 individuals.

Field Trips

In FY23 the Wellness Recovery Team did not schedule any field trips due to staff shortage.

Card Party Groups

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 Peer Wellness Collective formally known as “Alameda Network of Mental Health Clients” Reach-Out Program to distribute the cards that were created from the Card Party groups when they visit the hospitals throughout the County.

In FY23 a total of 24 Card making groups were offered to inspire peers to write inspirational messages in cards as well as design cards with arts and crafts for individuals in psychiatric hospitals and Board & Cares. Peers can choose the card they want to receive. Through this program 50 cards were created and given to the Reach-Out Program. The number of cards made this year was significantly lower due to a loss of attendees or connecting to pick up cards from attendee’s homes. This program has been operating in-person and on the Zoom platform. A total of 4 unduplicated individuals participated in the Card Party Groups. The projected

numbers to be served in FY25 per each age group is as follows: 18-25 years – 1 individual; 26-59 years – 6 individuals; 60 years or older – 3 individuals.

Mood Group

The Mood Group is designed for people to share their thoughts and feelings in a safe place where support is also offered. In FY23 the group met mostly twice a month but a few months the group only met once due to staff shortage and events. The group focused on reviewing a Mood Scale to help people identify their emotions and address the impacts of their choices among non-judgmental peers. The group was hosted for a total of 20 times during the reporting timeframe with a total of 3 unduplicated participants. The projected numbers to be served in FY25 per each age group is as follows: 18-25 years – 2 individuals; 26-59 years – 4 individuals; 60 years or older – 4 individuals.

Peers Organizing Community Change

Peers Organizing for Community Change (POCC) which was formerly known as Pool of Consumer Champions is a community activism group designed to educate, advocate and lead and it is open to any community member who identifies as a peer, a person with lived mental health conditions. The committee meets once a month and focuses on the needs and concerns of Berkeley residents as well and provides input on the Mental Health Service Act. In FY23, the group met 10 times, with 7 regular attendees, 5 of whom assumed positions within the committee. Each year the committee is tasked with identifying and coordinating a community event to educate on a popular topic. For the FY23 the topic was “Standing proudly with Berkeley Resources” and 30 community members attended the event. The projected numbers to be served in FY25 per each age group is as follows: 26-59 years – 3 individuals; 60 years or older – 3 individuals.

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 and calendar, in FY23 there weren’t any requests for this service. The projected numbers to be served in FY25 per each age group is as follows: 18-25 years – 1 individual; 26-59 years – 2 individuals; 60 years or older – 3 individuals.

In FY23, a total of 49 individuals participated in Wellness Recovery services. Demographics on 30 of the individuals served are as follows:

DEMOGRAPHICS N = 30	
Age Category	
Age Category	*% of total*
25-44 years	*
45-64 years	*
65 years and older	*
Declined to Answer (or Unknown)	*

Gender Identity	
Gender Identity	*% of total*
Male	*
Female	*
Declined to Answer (or Unknown)	*
Race/Ethnicity	
Race/Ethnicity	*% of total*
Asian or Pacific Islander	*
Black or African American	*
White	*
Multi-racial	*
Other	*
Declined to Answer (or Unknown)	*
Sexual Orientation	
Sexual Orientation	*% of total*
Heterosexual	*
Bisexual	*
Questioning	*
Multiple Sexual Orientations	*
Declined to Answer (or Unknown)	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

Program Successes:
In the third quarter of FY23, the Wellness Recovery Team added two Social Services Specialist positions to the program. These positions titles are designed to make the clinic more welcoming and provide peer support to individuals in the clinic waiting room. Adding these positions made more people aware of the wellness groups, events and support that the clinic has to offer. In the fourth quarter an Assistant Mental Health Clinician position was filled to provide full staffing capacity on the team.

Being fully staffed, some of the groups such as the Wellness Recovery Activities were able to be conducted in-person, and more individuals were engaged and began participating in groups. Staff has been able to do one on one support in the waiting room and offer resources to people in crisis. Some groups continued to meet on Zoom and a hybrid option was available as well and there was a consistent number of individuals who benefitted from the groups. Staff also engaged with individuals in the waiting room offering light refreshments and connections, one on one supports, and resources for individuals in crisis. In June, all of the group flyers received a facelift and were re-vamped.

Program Challenges:
There were still some members of the groups only wanted to attend group activities online or through dial-in even after the option was provided to meet in the office. It was challenging to manage the groups with the hybrid option. Engaging individuals to fill out the demographic form

was challenging as well, when individuals participated online, or either came after group had started or left prior to the ending of a group activity.

In FY23, the RBA measures for this program (which were combined with the Social Inclusion, Telling Your Story Project measures, as both are conducted by the same staff) were as follows:

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

Measure	Definition	Data Source
# participants served	Total # of participants served	Wellness Recovery Group Attendance Tracker
# of different group convened	Number of different types of groups (i.e. walking group, mood group, Telling Your Story group) convened	Wellness Recovery Group Attendance Tracker
Group events	Total number of meetings held	Wellness Recovery Group Attendance Tracker
# of participants who meet the requirements for "Telling Your Story"	Total number of participants in all "Telling Your Story" meetings	Wellness Recovery Group Attendance Tracker
# of participants who return for group events	Of total number of participants, % who returned for more than one event or meeting	Wellness Recovery Group Attendance Tracker
% of participants who reported feeling less shame about their experiences and challenges	Of participants who took the survey, percent who responded "agree" or "strongly agree" to the question.	Telling Your Story Survey
% of participants who reported recognizing progress in their recovery	Of participants who took the survey, percent who responded "agree" or "strongly agree" to the question.	Telling Your Story Survey

Data Development Agenda: measures the team is interested in reporting on but for which reliable data was not available:

- Advance Directives Data:
  -#/% of participants with an Advance Directive completed;

-#/% of participants able to advocate for themselves with service providers;

- Equity of services (e.g. client demographics compared to Medi-Cal population);
- % of clients who were satisfied with services.

To provide context for the FY23 RBA outcomes, the Wellness Recovery Services experienced notable growth in FY23, expanding its team and broadening the scope of its services. Subsequent reports will be refined to comprehensively reflect the program's extensive services and its overall influence.

RBA Outcomes in FY23 for this program are outlined on the following pages.

BMH RBA Report FY 2023

Reporting Period July 2022 - June 2023

Wellness & Recovery Services

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

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

Program Updates The Wellness Recovery Team added two Social Services Specialist positions to the program. Adding these positions made more people aware of the wellness groups, events and support that the clinic has to offer.

49

Participants served

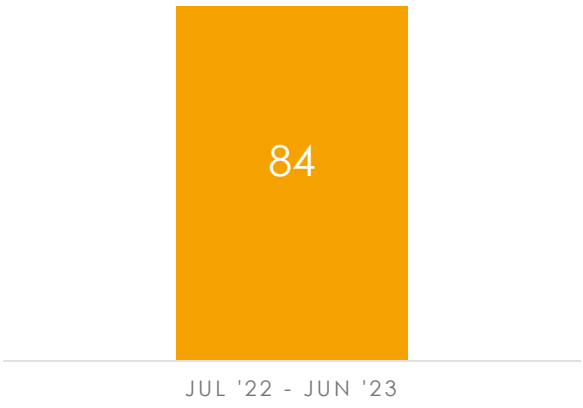
10

Participants who meet requirements for "Telling Your Story"

7

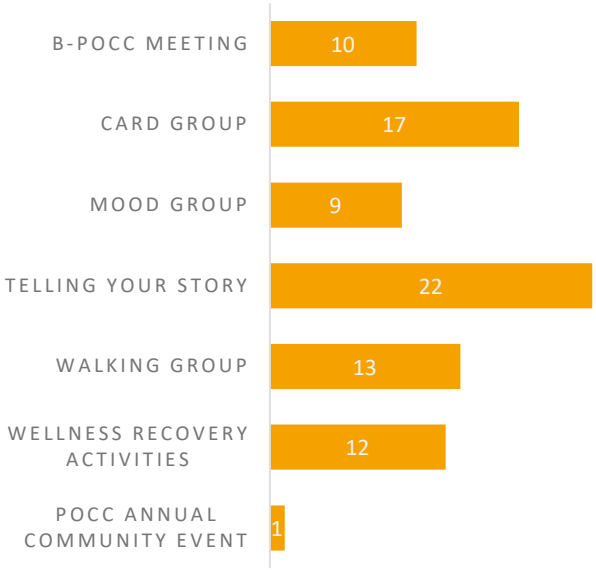
Different groups convened

WELLNESS GROUP MEETINGS ACROSS 7 DISTINCT GROUPS

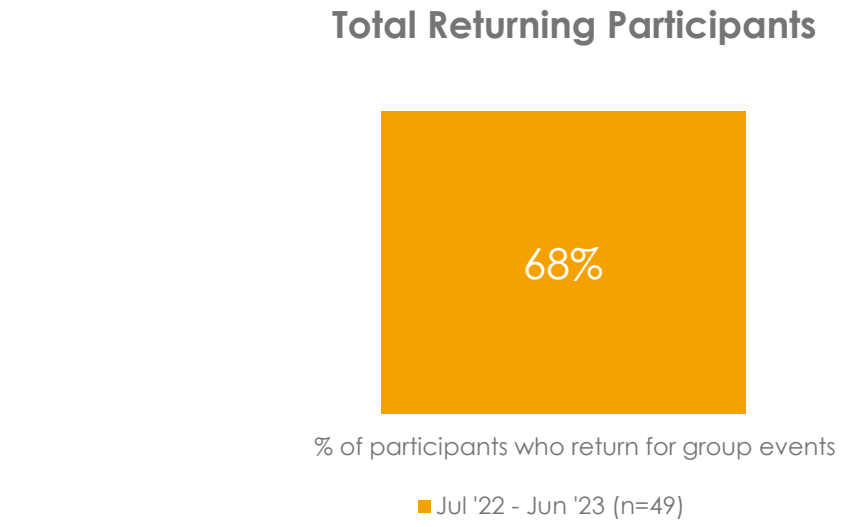


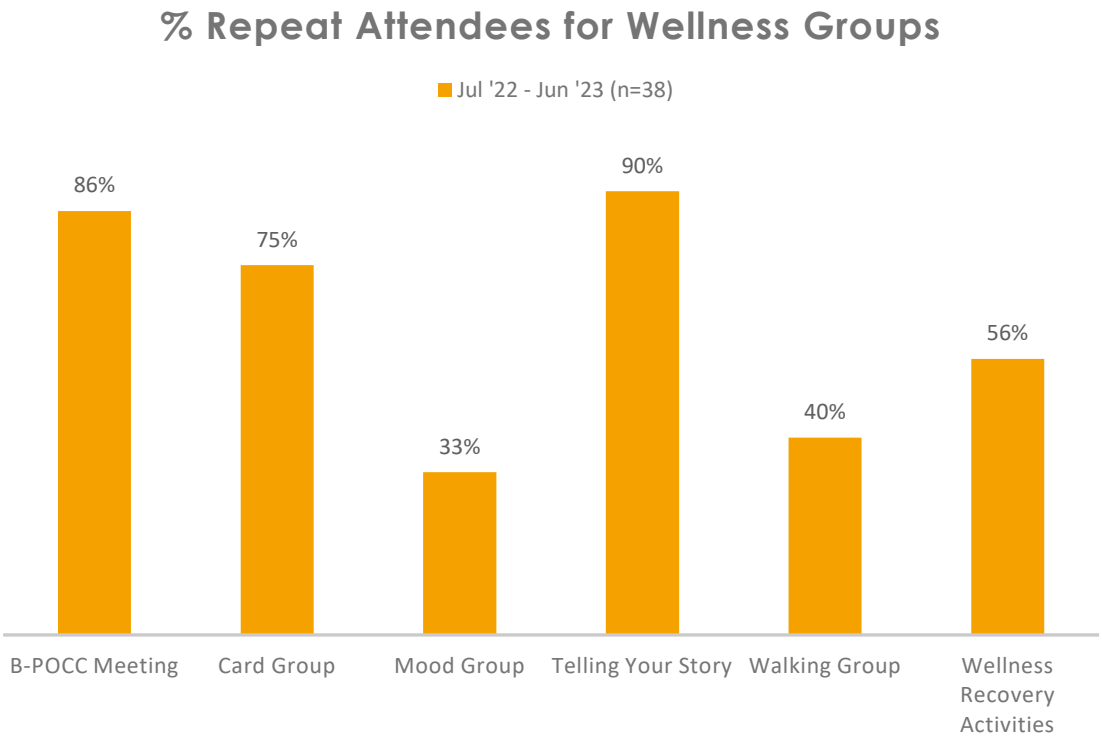
WELLNESS GROUP MEETINGS

JUL '22 - JUN '23 (N=84)



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





Measure	Definition	Data Source
# participants served	Total # of participants served	Wellness Recovery Group Attendance Tracker
# of different groups convened	Number of different types of groups (i.e. walking group, mood group, Telling Your Story group) convened	Wellness Recovery Group Attendance Tracker
Average # of group events held per 6 months	Total number of meetings held	Wellness Recovery Group Attendance Tracker
# of participants who meet the requirements for "Telling Your Story"	Total number of participants in all "Telling Your Story" meetings	Wellness Recovery Group Attendance Tracker
% of participants who return for group events	Of total number of participants, % who returned for more than one event or meeting	Wellness Recovery Group Attendance Tracker
% of participants reporting feeling less shame about their experiences and challenges	Percentage of survey respondents who agree or strongly agree that they feel less shame about their experiences and challenges	Telling Your Story Survey
% of participants reporting recognizing progress in their recovery	Percentage of survey respondents who agree or strongly agree that they recognize progress in their recovery	Telling Your Story Survey

Family Support Services

A Family Service Specialist works with family members, staff, community-based organizations etc. to improve services and supports for BMH clients and their family members on a system-wide level. 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 FY23, there were approximately 397 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: Provided supports for parents, children, siblings, spouses, significant others or caregivers. The group met once a month for two hours.

During FY23 a total of 19 family members were served. Demographics of individuals served are outlined below:

DEMOGRAPHICS N = 19	
Age Category	
Age Category	*% of total*
25-44 years	*
45-64 years	*
65+ years	*
Declined to Answer (or Unknown)	*

Gender Identity	
Gender Identity	*% of total*
Male	*
Female	*
Race/Ethnicity	
Race/Ethnicity	*% of total*
Asian or Pacific Islander	*
Black or African American	*
White	*
Multi-racial	*
Sexual Orientation	
Sexual Orientation	*% of total*
Declined to Answer (or Unknown)	100%

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

As the Family Services Specialist position was vacant from April 2019 to May 2023, the previous position holder continued the Family Support Group and occasional Warm Line Phone support, until the position was filled.

The projected numbers of individuals to be served in FY25 by each age group are as follows: 18-24 years - 2 individuals; 25-44 years - 10 individuals; 45-64 years - 15 individuals; 65 years and older - 38 individuals. There are approximately 5 additional individuals of an unknown age at this time that are projected to be served.

Employment Services

Previously, a BMH Employment Specialist provided services to support individuals in job readiness and accessing employment opportunities. It was envisioned that these services would at a minimum, create and nurture supported vocational, educational and volunteer "try-out" opportunities in the community; build employment and educational readiness; and increase the numbers of individuals who are gainfully employed and/or engaging in other meaningful activities such as school or volunteer work. Different strategies were implemented over time including utilizing the Dartmouth model of supported employment. The Dartmouth model helps to promote wellness and recovery by enabling clients to work alongside other non-mentally ill workers in a competitive environment in their community.

Up until there was a vacancy in the position, the Employment Specialist provided supports to clients who were interested in starting their own business by guiding them through the necessary steps of getting a license, advertising, etc.; assisted clients who weren't quite ready to obtain employment, in becoming involved in volunteer opportunities; connected clients with the Department of Rehabilitation for computer skills training; worked with staff to ensure clients were adhering to their medication regimen; and supported clients in filling out job applications and or practicing their interview skills. Although various strategies were implemented over the years, client participation and employment outcomes remained low.

Low client outcomes coupled with the vacancy in the Employment Specialist position prompted the Division to evaluate 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.

It was envisioned that once the Employment Specialist position was filled, work would be focused on utilizing an evidenced based model for supporting individuals with serious mental illness in obtaining and retaining competitive employment. The hiring process for this position has not occurred yet, as the City of Berkeley has spent time assessing whether the best use of funds would be to hire the full-time position, or to contract the services out to a local organization that focuses on employment services and supports for mental health consumers.

Housing Services and Supports

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 works 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 FY23, 10 clients were served through this program. Demographics on those served were as follows:

DEMOGRAPHICS N = 10	
Age Category	
Age Category	*% of total*
18-24 years	*
25-44 years	*
Gender Identity	
Gender Identity	*% of total*
Male	*
Female	*
Race/Ethnicity	
Race/Ethnicity	*% of total*
Black or African American	*
White	*

Latinx	*
Other	*
Declined to Answer (or Unknown)	*
Sexual Orientation	
Sexual Orientation	*% of total*
Declined to Answer (or Unknown)	100%

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

Program Successes:
In FY23, 80% (4 out of the 5 cases closed) resulted in the individuals receiving SSI Benefits. All but one of the cases were approved at the initial or reconsideration stage. The fifth case was closed when the individual moved out of the area.

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

The projected numbers of individuals to be served in FY25 per each age category is as follows: 18-24 years = 3 individuals; 25-44 years of age: 7 individuals.

Flexible Funds for Level One Clients

A contract with the community-based organization, Berkeley Food & Housing Project (now known as Insight Housing), enables flexible funds to be used with clients across the system for supports such as housing, clothing assistance, food, transportation, etc. This use of flexible funds aids individuals in achieving better stability in areas where they are less capable of addressing their daily living needs. This program is set up to aid any clients in need across the system in a given year. In FY23, there were a total of 397 clients in the BMH system.

Mobile Crisis Team (MCT) Expansion

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

- Increase in staff to expand the Mobile Crisis Team (MCT) capacity and hours of operation;
- Mental Health First Aid Trainings to teach community members how to assist individuals who are in crisis or are showing signs and symptoms of a mental illness;
- A Consumer/Family Member Satisfaction Survey for Crisis services.

In FY23, the RBA Measures that were established for this program were as follows:

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is Anyone Better off?
• # of clients served • # of documented contacts	• % of clients who receive a visit (phone contact with client or hospital provider) in the 24 hours after	• None available at this time

	hospitalization • % of Mobile Crisis Team who had a Crisis, Assessment Team staff attempt to contact • % of clients who were satisfied with services**	

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

Measure	Definition	Data Source
# clients served	Total unique clients served	MCT Contact Log
Client contact types	# of client contacts made, by a. Field contacts b. Phone contacts c. Other	MCT Contact Log
Total referrals, by referring party	# of crisis services referrals made to the MCT, by referring party (i.e. BPD, BFD, BMH, community, etc.)	MCT Contact Log
# of 5150 evaluations conducted	Total number of incidents with 5150 Evaluations of any sort	MCT Contact Log
Results of 5150 Evaluations	% of 5150 evaluations that did or did not result in transportation to a receiving facility for further evaluation	MCT Contact Log
Number of interventions per client	% of clients who had one, two, or more than two interventions	MCT Contact Log

Data Development Agenda: measures the team is interested in reporting on but for which reliable data was not available:

- #/% of calls to CAT line that receive crisis intervention support that does not involve the police: crisis referral to non-MCT, crisis support, de-escalation support;
- % of clients who receive a follow-up call for a no-show screening, intake or appointment;
- #/% of no-show clients for whom there is inter-system coordination to engage;
- #/% of clients and families who receive connection to grief counseling and other services;
- % of clients connected to a service team within 7 calendar days;
- % of clients assessed or referred on the same day as inquiry.

For context around the FY23 RBA outcomes, since 2019, the Mobile Crisis Team (MCT) has been functioning with a limited core of just two full-time clinicians and without a supervisory lead. To address this shortfall, the team has relied on supplemental staffing through overtime and part-time hourly personnel. Despite these efforts, the MCT has faced challenges in operating at its intended full capacity.

RBA Outcomes in FY23 for this program are outlined on the following pages.

BMH RBA Report FY 2023

Reporting Period: June 2022 - July 2023

Mobile Crisis Team (MCT)

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

700

Clients Served

978

Incidents Responded To

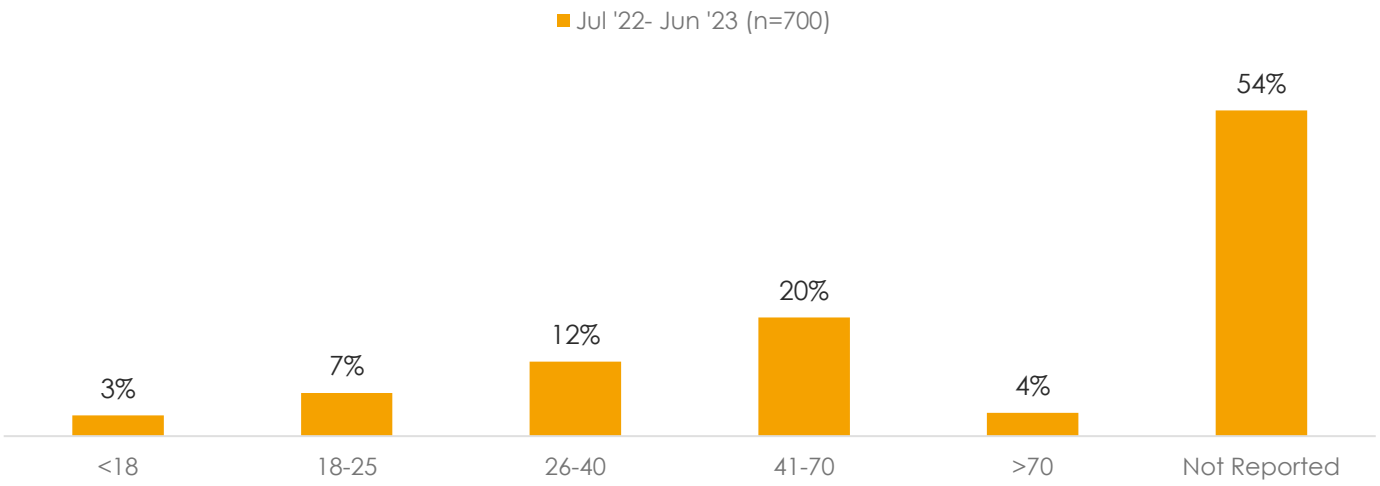
Program Description

The Mobile Crisis Team (MCT) serves residents of Berkeley, from 11:30am-10pm each day of the week when fully staffed (1 Supervisor + 3 Full Time Clinicians). It provides crisis interventions, including but not limited to 5150 evaluations, consultations, and referrals/linkages.

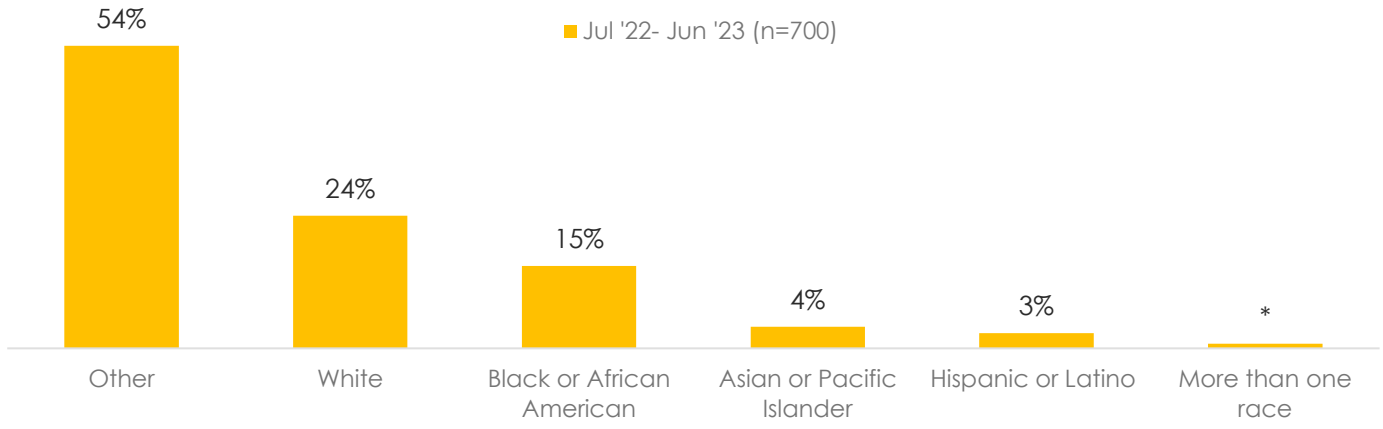
Program Updates

Since 2019, the MCT has had only 2 FT clinicians and no supervisor. As a result, the program has not been able to operate at full capacity.

Demographics (Age)



Demographics (Ethnicity)

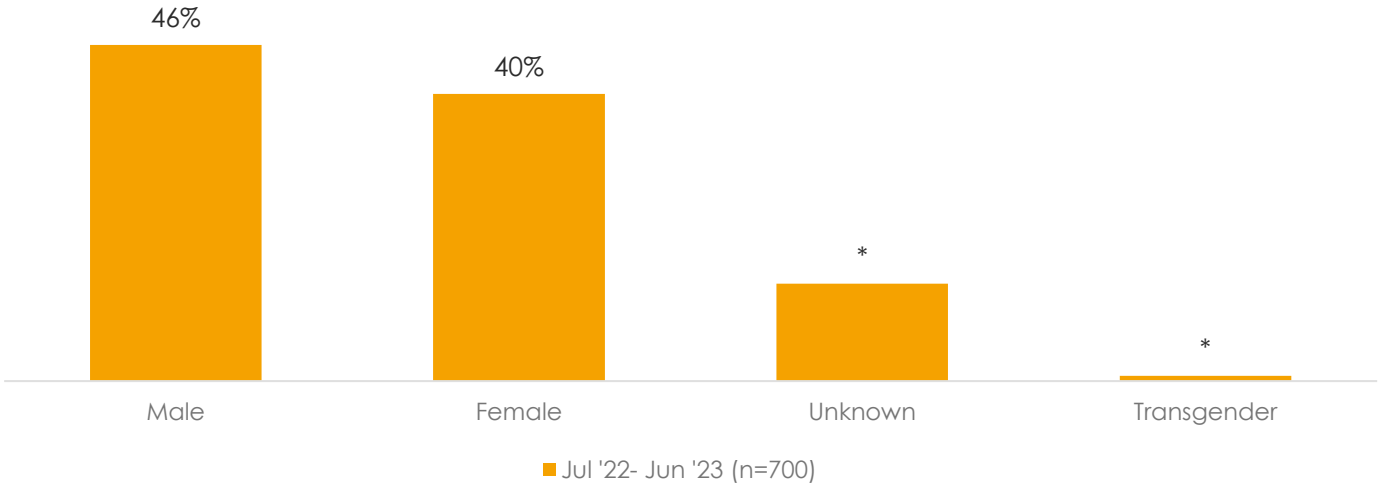


NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

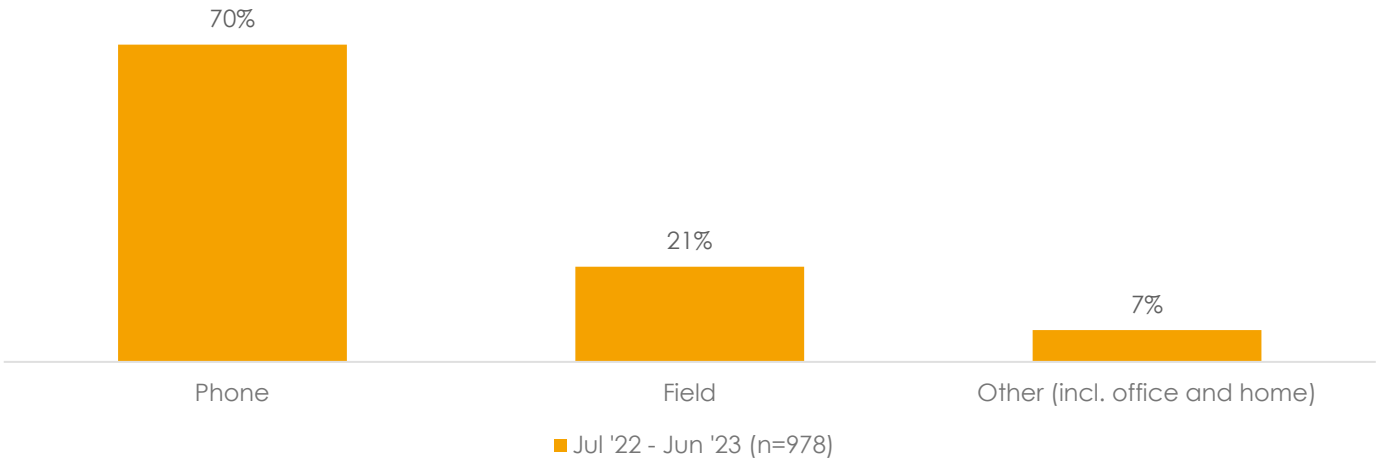
BMH RBA Report FY 2023

Reporting Period: June 2022 - July 2023

Demographics (Gender Identity)



Client Contacts Made by Contact Type



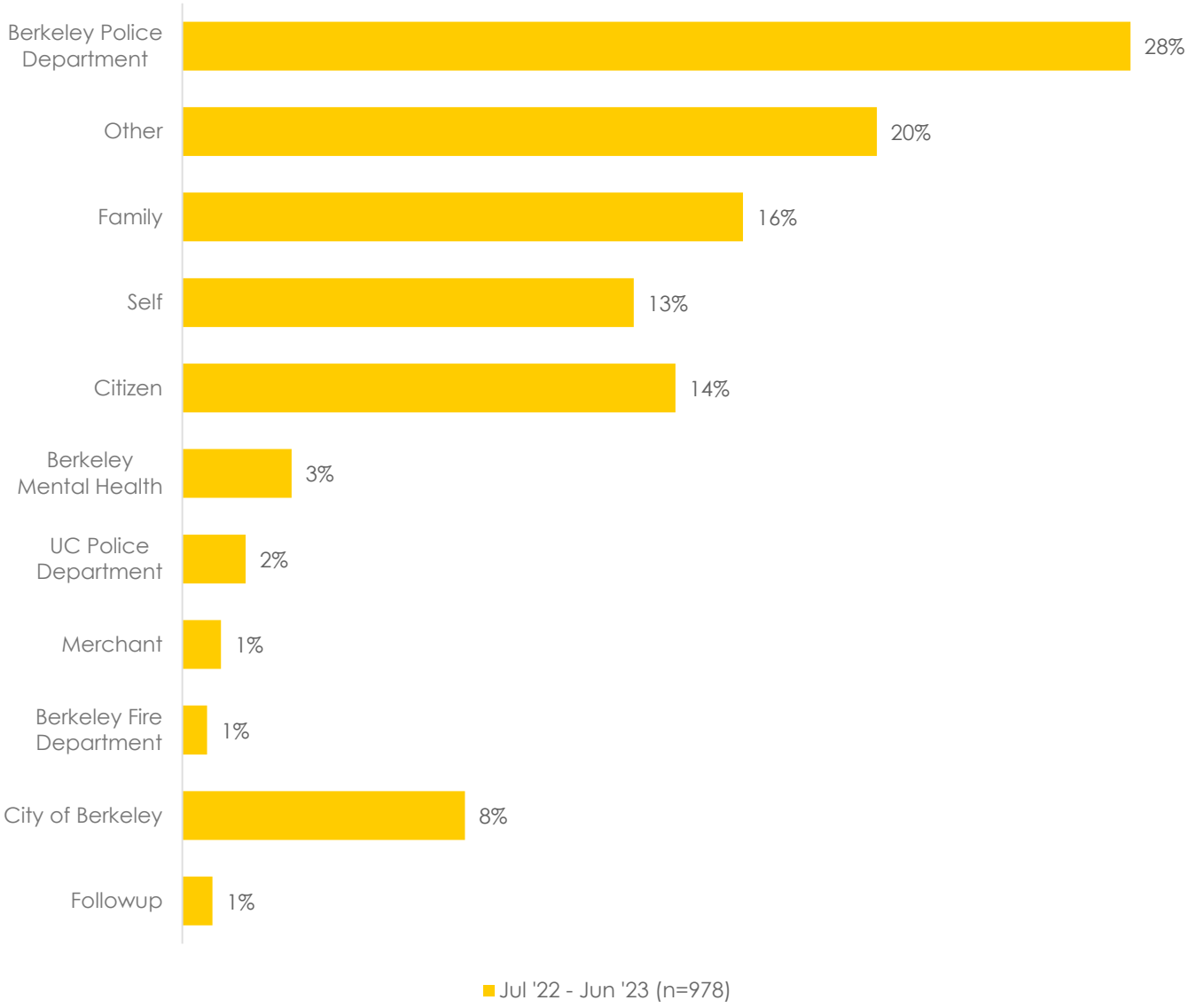
From June 2022 - July 2023, the MCT program performed **189** 5150 Evaluations

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

BMH RBA Report FY 2023

Reporting Period: June 2022 - July 2023

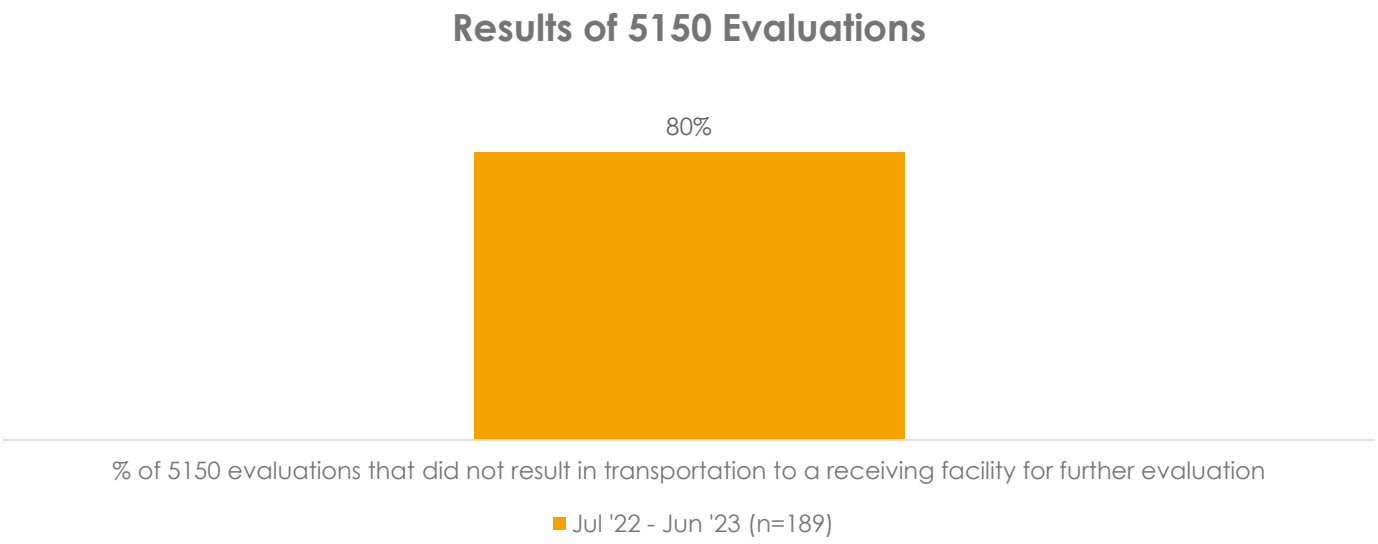
Referrals by Referring Party



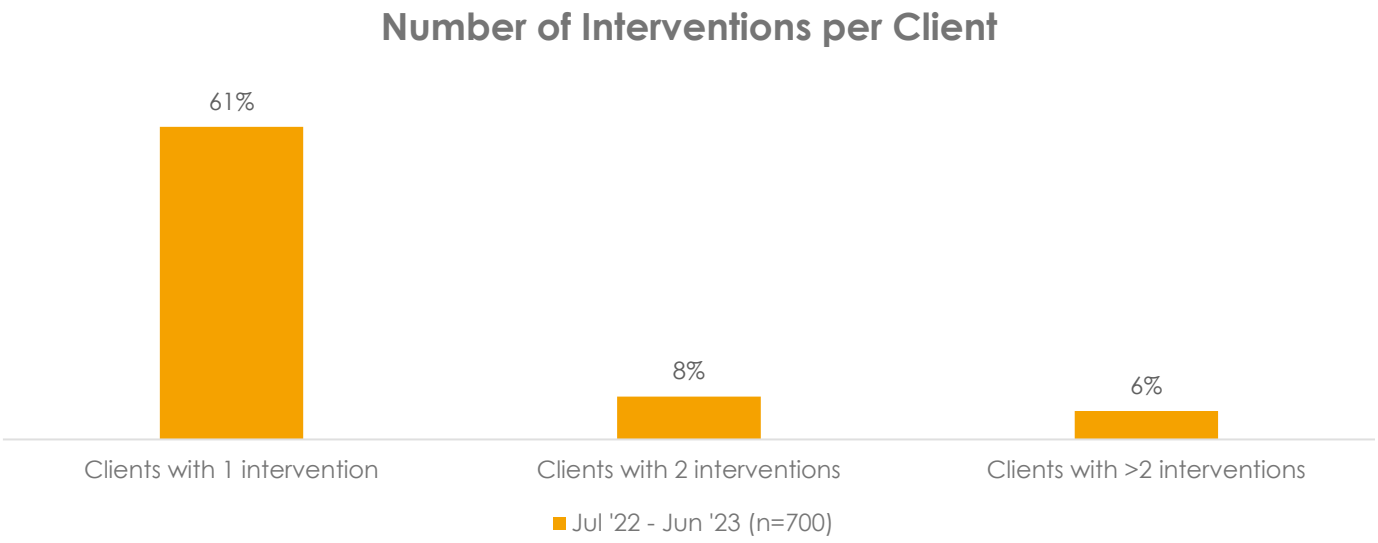
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

BMH RBA Report FY 2023

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



Impact Outcomes ("Is anyone better off?")



NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

BMH RBA Report FY 2023

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

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Transitional Outreach Team (TOT)

The Transitional Outreach Team (TOT) was added thru the previously approved MHSA FY16 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 FY23, 50 individuals were served through this project. Demographics on those served were as follows**:**

DEMOGRAPHICS N = 50	
Age Category	
Age Category	*% of total*
0-18 years	*
18-25 years	*
25-44 years	*
45-64 years	*
65 years or older	*
Declined to Answer (or Unknown)	*
Gender Identity	
Gender Identity	*% of total*
Male	30%
Female	60%
Transgender	*
Declined to Answer (or Unknown)	*
Race/Ethnicity	
Race/Ethnicity	*% of total*
Asian or Pacific Islander	*
Black or African American	22%
Latinx	*
White	46%
Multi-racial	*
Declined to Answer (or Unknown)	*
Sexual Orientation	
Sexual Orientation	*% of total*
Declined to Answer (or Unknown)	100%

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

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

Program Successes:

- Continued successful follow-up with residents who had contact with Mobile Crisis by phone and/or in person.
- Connected individuals and families to needed and wanted mental health, housing, family, and other social services.
- Offered intensive short-term support to individuals and families who experienced a mental health crisis, including referrals, linkage, psychoeducation, and active support in connecting with needed service in Berkeley or elsewhere in the Alameda County system of care.
- Provided in person outreach and engagement to individuals receiving homeless services and staff at homeless service provider agencies, including Dorothy Day, BOSS, BFHP, and others.
- Coordinated with other programs within the City's Mental Health Division, including the Crisis/Assessment/Triage (CAT) On Duty staff and field-based services such as Mobile Crisis (MCT).
- Continues to follow-up on hospital referrals and coordinating with individuals and hospital staff after a MCT contact.

Program Challenges:

- TOT appears to have served fewer individual people during FY23 than during FY22. One possible reason may be due to how contacts were categorized in the database system.
- Data collection system does not capture all necessary information that would support accurate outcome reporting. This remains an ongoing difficulty due to the limitations of the current system.

In a prior year, TOT was merged with the Crisis Assessment and Triage (CAT) Team due to staffing limitations and to increase flexibility of staffing capacity.

The projected numbers of individuals to be served in FY25 by each age group are as follows: 0-15 years - 4 individuals; 16-25 years - 7 individuals; 26-59 years - 27 individuals; 60 years or older - 5 individuals. There are approximately 6 additional individuals of an unknown age at this time that are projected to be served.

In FY23, the RBA measures that were established for TOT/CAT were measures as follows:

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

	• % of clients who were satisfied with services**	

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

Measure	Definition	Data Source
# clients served	Total unique clients served	Mobile Crisis Team (MCT) & Crisis Assessment (CAT) Contact Log
# of documented contacts	Total number of documented incidents	MCT & CAT Contact Log
Follow-up after hospitalization	% of clients who receive a visit (phone contact with client or hospital service provider) in the 24 hours after hospitalization	MCT & CAT Contact Log
% of MCT contacts who had a CAT attempt to contact	Of Client IDs in MCT contact log, % which also have record in CAT contact log	MCT & CAT Contact Log

Data Development Agenda: measures the team is interested in reporting on but for which reliable data was not available:

- #/% of calls to CAT line that receive crisis intervention support that does not involve the police: crisis referral to non-MCT, crisis support, de-escalation support.
- % of clients who receive a follow-up call for a no-show screening, intake or appointment.
- #/% of no-show clients for whom there is inter-system coordination to engage.
- #/% of clients and families who receive connection to grief counseling and other services
- % of clients connected to a service team within 7 calendar days
- % of clients assessed or referred on the same day as inquiry

For context around the FY23 RBA outcomes, in June 2023, the Crisis, Assessment, Triage (CAT)/Transitional Outreach Team (TOT) lengthened its walk-in availability from 3 to 5 hours. This change, while accommodating more immediate client needs, constrained the team's ability to conduct follow-up services, given the surge of new clients. Balancing the increased walk-in service hours with the imperative of crisis response made it challenging to allocate sufficient time for follow-ups.

RBA Outcomes in FY23 for this program are outlined on the following pages.

BMH RBA Report FY 2023

Reporting Period July 2022 - June 2023

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

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

645
Clients Served

1425
Contacts

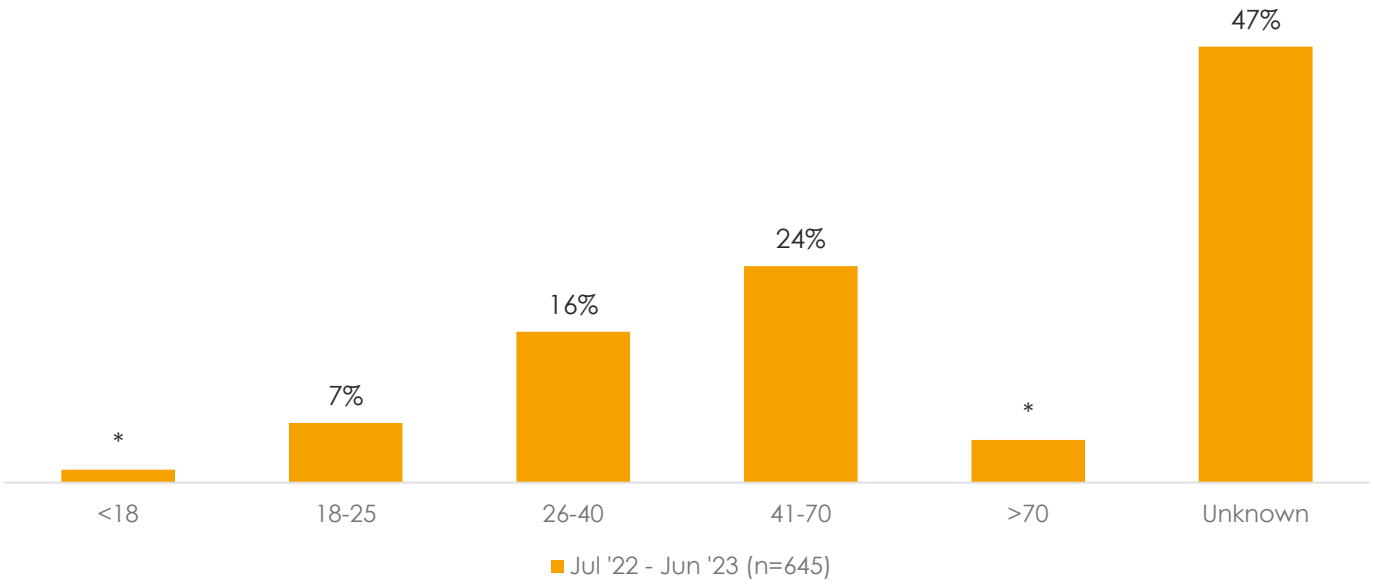
Program Description

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

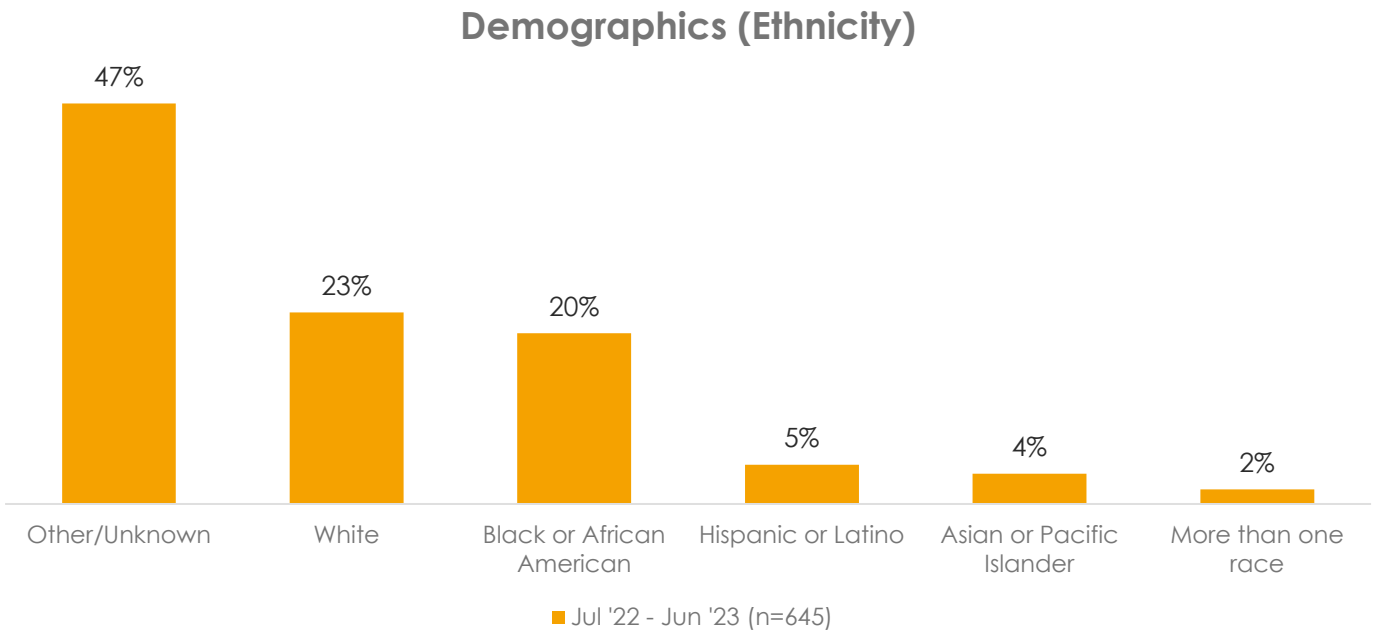
Program Updates

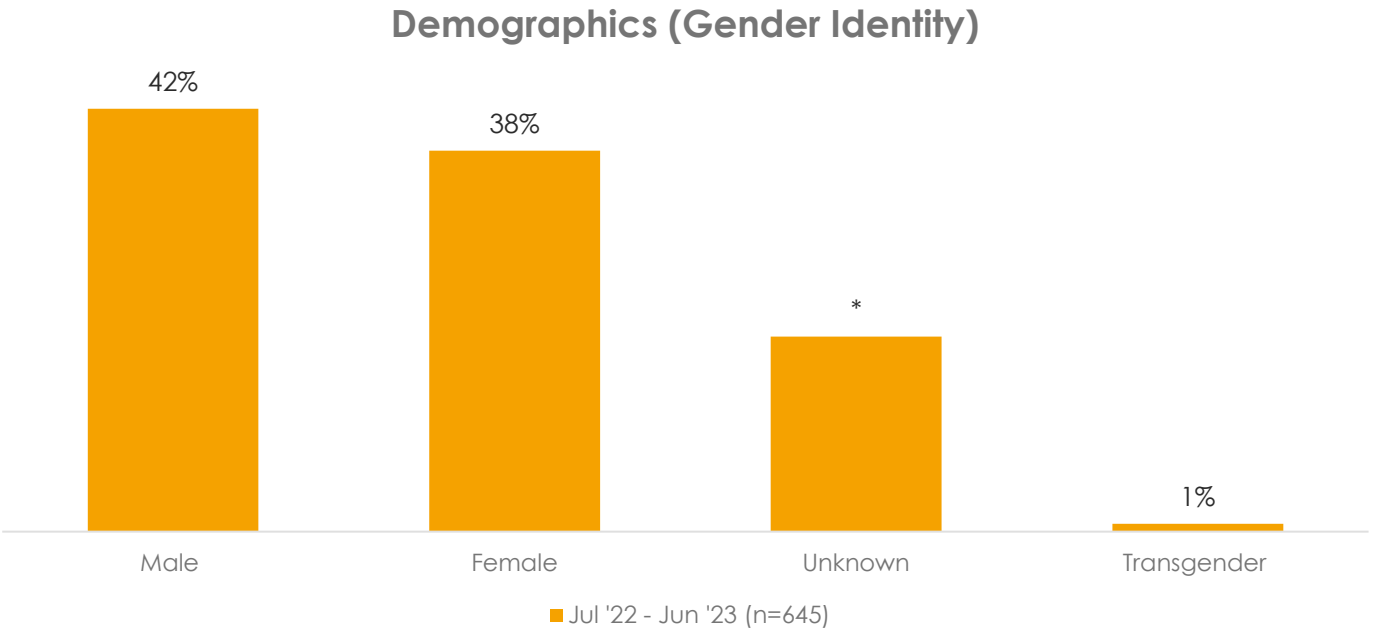
The program expanded their walk-in hours from 3 hours to 5 hours in June 2023. Due to the increase in new clients, there has been limited staff capacity for follow up services.

Demographics (Age)



NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.



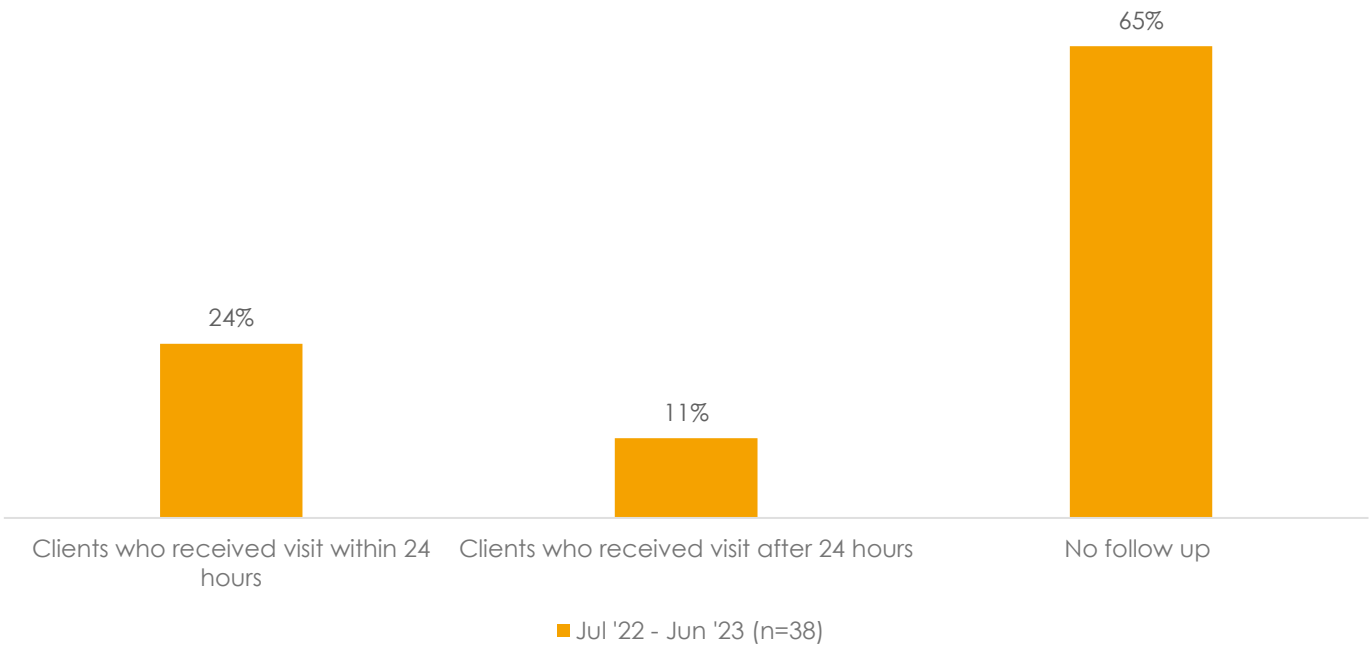


Note: "Other" includes those marked as "Other." Unknown includes those marked as "Unknown" or missing due to clients not disclosing, clinician unable to make the determination, or a crisis situation not allowing for more comprehensive data collection. Sexual orientation data not available.

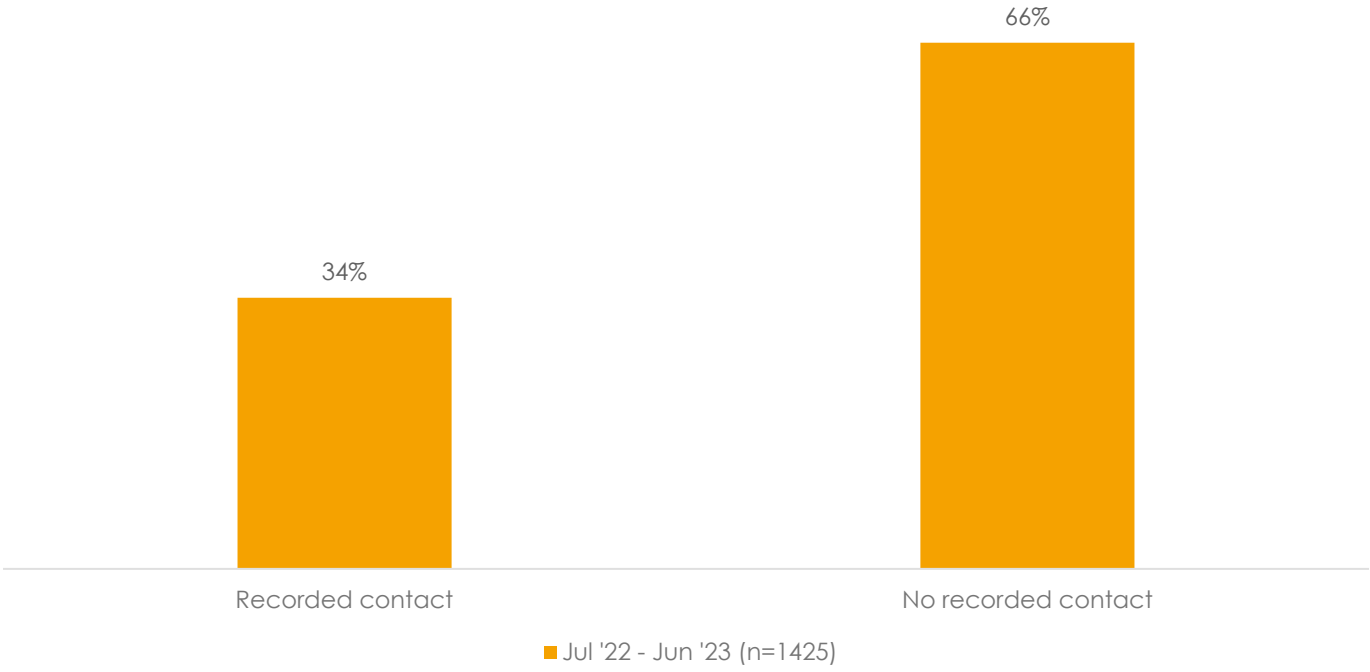
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

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

Follow-up after hospitalization



MCT contacts who had a CAT attempt to contact



NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

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

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Sub-Representative Payee Program

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

In FY23, 76 individuals were served. Demographics on individuals served were as follows:

DEMOGRAPHICS N = 76	
Age Category	
Age Category	*% of total*
18-24 years	*
25-44 years	17%
45-64 years	*
Declined to Answer (or Unknown)	*
Gender Identity	
Gender Identity	*% of total*
Male	71%
Female	29%
Race/Ethnicity	
Race/Ethnicity	*% of total*
Black or African American	62%
Asian Pacific Islander	*
Native American	*
White	*
Other	*
Sexual Orientation	
Sexual Orientation	*% of total*
Declined to Answer (or Unknown)	100%

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

Program Successes:
A part-time receptionist was hired in FY23 to support the program. All new clients were paired with a case manager, which enhanced staff ability to provide more effective assistance to each individual.

Program Challenges:
The Social Security Office was persistently understaffed which led to delays in processing new representative payee applications, instances of receiving incorrect funds, and various other issues related to the clients Social Security Income (SSI) and Social Security Disability Income (SSDI) funds.

The projected numbers of individuals to be served in FY25 by each age group are as follows: 16-25 years = 5 individuals; 26-59 years = 25 individuals; 60+ years = 45 individuals.

Hearing Voices Support Groups

The Hearing Voices Support Groups are offered through a contract with the Bay Area Hearing Voices Network. A free weekly drop-in Support Group is provided for adults who experience voices, visions, special messages, unusual beliefs or extreme states of consciousness. The support group is co-facilitated by trained group facilitators whom have lived experience in the mental health system. A separate support group for Family Members of individual participants is also provided.

In FY23, a total of 1,308 individuals were served through weekly online support groups. Demographics on individuals served were as follows:

DEMOGRAPHICS N = 1,308	
Age Category	
Age Category	*% of total*
25-44 years	28%
45-64 years	40%
65 years or older	32%
Gender Identity	
Gender Identity	*% of total*
Male	60%
Female	40%
Race/Ethnicity	
Race/Ethnicity	*% of total*
African American	16%
Asian or Asian Pacific Islander	*
Latino/a/x	8%
Multi-Racial	*
Native American	*
White	65%
Other	*
Declined to Answer (or Unknown)	*
Sexual Orientation	
Sexual Orientation	*% of total*
Heterosexual or Straight	75%
Bisexual	*
Gay	10%
Other Sexual Orientation	*
Declined to Answer (or Unknown)	10%

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

In FY23, three more hearing voices groups (two adult groups and a family member's group) were added. A successful Community workshop for family members, clinicians, and family members was also held at the North Berkeley Senior Center. An Instagram app was launched, and there are approximately one hundred followers on this social media platform. The on-line newsletter was also redesigned and sent out every month.

Program Successes:

- BAHVN is the only community organization which offers on line peer-led groups for adults who hear voices and have other unusual experiences. Participants who attend groups regularly express that the continuity helps them to stay out of mental hospitals, deal with stigma as well as stress and difficult experiences associated with the voice hearing experiences.
- On-line groups continued to expand in numbers of attendees.
- New facilitators were added and the monthly facilitator trainings were well attended.
- Successfully reached out to NAMI East Bay to co-host an annual community workshop.
- Started to use social media and other media sources to get the word out about groups and to help offset stigma.

Program Challenges:

- Would like to expand outreach and education to community mental health organizations, clinics, and schools.
- Would like to offer a Transitional Age hearing voices groups.
- BAHVN is seeking an organization to sponsor a new Sunday Hearing Voices group.
- Would also like to expand the BAHVN network to include other mental health agencies like Kaiser and are looking for grants to help fund the education outreach program.

Results from a survey questionnaire of 216 group participants on the impact of the groups were as follows:

How have the groups helped you?

- "It has given me a forum to share my experiences, thoughts, and symptoms."
- "This group has helped me to stay connected and find people with similarities to myself. I really enjoy coming."
- "Social connectivity and emotional support. It helped me find safety when I needed it and allowed me to be the validating accepting person anchoring someone else down when they needed it. It increased my vocabulary."
- "It has helped me to not feel alone, find resources, gain clarity, and learn about myself."
- "This group has helped me have an open mind towards all people with differences. Most importantly, it has given me hope for a more positive future for my daughter and other loved ones who might be in a similar situation. It has also helped me maintain my relationship with my daughter."
- "It has helped me feel deeply in a safe place, it has helped me to break my isolation, learn new things about my loved one's situation."

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

- "The facilitators are sometimes the best listeners and help the group discussions move forward."
- "They treat me kindly and offer validating words and qualifiers so that I feel like I belong."
- "They are very kind and compassionate people."

- “Welcoming.”
- “Good leadership.”
- “They want to hear from me and address my concerns.”
- “Group agreements.”
- “Empathetic and helpful answers. Sometimes I think its hard for everyone (me included) to remember to ask if people want advice or feedback but I want to work on a well.”
- “They are expert listeners, their presentations hit home each time, and they validate what people say. They also provide suggestions for many helpful resources.”
- “They try to let everyone speak.”

Describe your overall experience in the Group.

- “I still think about some of the interactions and things said from groups that were 5 or more years ago. These are positive impacts and memories.”
- “Good, though I think on occasion some people get a lot more time to speak in group, at the expense of others getting to share.”
- “It is very positive.”
- “Life changing to know that I am not alone.”
- “This is the only time that I fill I have for myself to express my true feelings.”
- “Our group meetings last two hours. The facilitators give us a brief introduction to the Hearing Voices Movement. We may have up to twelve members participating on Zoom each week. What I like most is the diversity of the group, some who live in other parts of the country--New York, Cincinnati, Auston, and Los Angeles for example, but most from Berkeley and the Bay Area. It is rare that anyone leaves the group before the two hours are up. We always have a lot to share with each other.”
- “Positive.”
- “This group has become as important to me as my fringe house church. Without referencing a higher power, we are essentially in a school of love every Monday night.”
- “I feel comfortable talking about my voice experiences.”

The projected numbers of individuals to be served in FY25 by each age group are as follows: 16-25 years = 18 individuals; 26-59 years = 1,287 individuals; 60+ years = 645 individuals.

Berkeley Wellness Center

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

In FY23, 48 individuals participated in this program. Demographics on individuals served were as follows:

DEMOGRAPHICS N = 48	
Age Category	
Age Category	*% of total*
18-24 years	*
25-44 years	25%
46-64 years	*
65 years and older	25%
Declined to Answer (or Unknown)	*
Gender Identity	
Gender Identity	*% of total*
Male	42%
Female	58%
Race/Ethnicity	
Race/Ethnicity	*% of total*
Black or African American	*
Asian or Asian Pacific Islander	*
Latinx	*
White	*
Other	*
Unknown	*
Sexual Orientation	
Sexual Orientation	*% of total*
Heterosexual or Straight	33%
Declined to Answer (or Unknown)	67%

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

In FY23, the Berkeley Wellness Center's former director resigned, and the program was led by an interim program manager for four months. In September, a new program manager was hired and programs were expanded. Navigation provisions and resource information was also consolidated and offered a greeting and entrance program. Outreach plans were created and implemented ranging from on the ground, to coordination with fellow service programs.

Program Successes:
Since the creation and implementation of outreach plans, the numbers of clientele increased daily, and new clients invariably became repeat visitors to the center. Individuals responses to new programming was enthusiastic. Navigation services were easier to access, which resulted in clients inquiring more often about various service needs, and staff being better equipped to provide supports.

Program Challenges**:**
The various program challenges were as follows: The building needs to be made more visible to community members; creating public awareness of services, and particularly making meaningful connections with Board and Care facilities; reintegration of previous clients that have stalled use of services; balancing the social issues arising in the meeting of various levels of cognition, emotional stability, sobriety, and class among the clients.

The projected numbers of individuals to be served in FY25 by each age group are as follows: 16-24 years = 7 individuals; 25-44 years = 11 individuals; 46-64 – 20 individuals; 65+ years = 11 individuals.

BMH Peer and Family Member Positions

Since the first MHSA Plan, BMH has included positions for peers and family members with lived experience to be added to various programs throughout the Division. The Division utilizes existing City job classifications for an employment track for peer or family member providers. The entry level position is Community Health Worker, the mid-level is Assistant Mental Health Clinician, and the top-level is Social Services Specialist. All of these classifications are also used broadly for differing purposes throughout the City. For the specific positions where the MHSA Plan envisioned utilizing peer or family providers, BMH has had success in establishing employment lists where there are applicants who describe themselves as having "lived experience" and as peer or family member providers. In 2018, a peer provider was hired to support the Wellness Recovery services work. This position became vacant in December 2021 and it wasn't filled until the third quarter of FY23.

Two additional positions were added through the FY22 Annual Update, to increase the Wellness Recovery work and enable a greater ability to provide a variety of peer led services, and the provision of activities and supports to individuals in the waiting room. These positions were hired in the third quarter of FY23.

Case Management for Youth and Transition Age Youth

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

In 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 FY23, 62 youth were served through this project. Demographic data on youth participants is outlined below:

DEMOGRAPHICS N = 62	
Age Category	
Age Category	*% of total*
16-25 years	100%
Gender Identity	
Gender Identity	*% of total*
Male	*
Female	37%
Transgender	*

Genderqueer	*
Another Gender Identity	*
Declined to Answer (or Unknown)	*
Race/Ethnicity	
Race/Ethnicity	*% of total*
American Indian or Alaska Native	*
Asian or Asian Pacific Islander	*
Black or African American	*
Latinx	*
White	*
More than one Race	29%
Declined to Answer (or Unknown)	*
Sexual Orientation	
Sexual Orientation	*% of total*
Heterosexual or Straight	21%
Gay or Lesbian	*
Bisexual	30%
Questioning or Unsure	*
Declined to Answer (or Unknown)	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

In FY23 YSA went through many changes. A new program model was crafted and implemented with the intention of redesigning and refining the organization's programs and theory of change. Staff received training on theory of change, program development, ACES Science, trauma informed practices, the politics of trauma, facilitation skills, positive youth development, strength-based model, community resilience model, somatic awareness, individual coaching, housing navigation skills and curriculum and evaluation introduction. This change and shift in culture expanded the program offerings. The components and activities were designed with specific outcomes in mind and with the intention to increase intervention, engagement, and opportunities for the young people being served.

The Case Management program also went through significant changes to support the transitional experiences of youth. YSA referred several youth to mental health services and communities, while also assisting individuals in establishing housing through their transitional journey's.

Program Successes:

Youth participated and were engaged in the program changes. They were also trained in the Theory of Change Model and understood the feedback loop and how YSA would access them to help evaluate program effectiveness, satisfaction, and facilitator engagement. In addition, youth engaged in leadership development through facilitation, curriculum, and event planning training to assist in their future developments in leading peers and community.

Case management was conducted by the lead case manager and UC Berkeley Masters of

Social Work students. YSA made it a requirement for youth participating in youth leadership activities to also participate in case management services. Some of the youth enjoyed having wellness support with the interns, as they were able to meet specific needs they were facing. Some needs included getting a State ID to get a bank account, Mental Health Services and crisis intervention, as well as housing.

The following linkages and referrals were provided:

Mental Health: 15

Physical Health: 3

Employment: 7

Education: 2

Housing Assistance: 3

SSI/Legal Aid Assistance: 3

Education Linkage:1

Financial Resources:1

Program Challenges:

A big program challenge was dealing with staff training and buy-in. Many of YSAs staff were former youth participants and many struggled with similar challenges as the youth that were being served. During this time YSA was challenged with staff understanding the importance of data collection and evaluation. Staff were not trained on using data to drive programmatic changes, which at times led to resistance and eventually the loss of some staff.

The projected numbers of individuals to be served in FY25 by each age group are as follows: 16-25 years = 75 individuals; 26-59 years = 20 individuals; 60+ years = 20 individuals.

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 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. At present, the Division is currently in the process of assessing how best to partner with a local community agency to implement these services.

Results Based Accountability Evaluation

Per the previously approved MHSA FY19 Annual Update, the Division allocated CSS System Development funds for a Consultant who would conduct an evaluation on all BMH programs across the system utilizing the “Results Based Accountability” (RBA) framework. The RBA

framework measures how much was done, how well it was done, and whether individuals are better off as a result of the services they received. A competitive RFP process was executed, and Resource Development Associates (RDA) was the chosen consultant.

RDA has been working with the Division since FY21 to execute this evaluation. This has included training the Division on the RBA framework, including assisting staff in developing a common language that can be used to communicate program results; working with designated staff to establish and embed RBA measures into each program; developing and implementing standardized data collection tools; collecting data and reporting out on program outcomes; and assisting the Division in implementing strategies that will build and sustain the RBA evaluation efforts.

In FY23, RDA facilitated meetings with staff and community members; collected, evaluated and reported on program data; and provided Technical Assistance. Activities are outlined detailed below:

- Conducted 24 meetings with BMH Staff and Stakeholders including the following: 12 monthly check-in meetings between RDA and BMH; 2 Community Advisory Group meetings to review dashboards; 7 individual meetings with program managers to provide technical assistance on data collection or to review data for the dashboard.
- Finalized the Data Collection and Reporting Plan using updated data sources and measures.
- Requested data from program staff and ran reports in Yellowfin.
- Cleaned and analyzed raw data from program staff and Yellowfin.
- Input RBA measures into program and division dashboards.
- Conducted two rounds of Data Reporting.
- Provided Technical Assistance for data collection and reporting.
- Began the process of recording 48 Training Videos to walk through the process of analyzing and reporting each RBA measure and completed the creation of 18 of the videos.
- Finalized dashboard template, measures list, and tracking sheet in preparation for the onboarding of Program Evaluator.
- Created an initial Technical Assistance Plan.

In FY24, RDA collected, analyzed and reported on FY23 RBA Division-wide data. The RBA outcomes for FY23 are outlined throughout this Annual Update for the following MHSA funded internal programs: Children/Youth FSP; TAY, Adult and Older Adult; Homeless FSP; Wellness Recovery Services; Crisis Services; Transitional Outreach Team; Social Inclusion Project; and the High School Prevention Project. The complete set of RBA outcomes for all BMH programs is located in Appendix B.

Counseling Services for Older Adults

Older Adults who only have Medicare insurance currently have great difficulty accessing mental health services, despite consistent input on the need for support for this population. In an effort to increase mental health services and supports for older adults, the Division allocated 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 the Wright Institute was the chosen contractor.

A total of 89 individuals received services in FY23, demographics on individuals served are outlined below:

DEMOGRAPHICS N = 89	
Age Category	
Age Category	*% of total*
65 years and older	94%
Declined to Answer (or Unknown)	*
Gender Identity	
Gender Identity	*% of total*
Male	22%
Female	78%
Race/Ethnicity	
Race/Ethnicity	*% of total*
Asian or Asian Pacific Islander	*
Black or African American	*
Latinx	*
White	*
More than one Race	*
Other	*
Declined to Answer (or Unknown)	*
Sexual Orientation	
Sexual Orientation	*% of total*
Heterosexual or Straight	75%
Gay or Lesbian	*
Bisexual	*
Queer	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

Program Successes:
According to the Aging Division that oversees this program, the Wright Institute continues to be a very reliable and collaborative partner. The clinicians and group facilitators have adopted a rhythm and regular schedule at both Senior Centers. They continue to communicate openly and willingly with Aging Services staff to discuss needs of older adult community, and to brainstorm best ways to promote therapeutic groups and workshops. Their promotional flyers for the groups and workshops are clear and easy to read and are included in the monthly Senior Center Nugget newsletter, as well as posted around the Senior Centers, to maximize attendance. They have provided a valuable service, as many older adults have expressed appreciation anecdotally.

Program Challenges:
In FY23, there were no program challenges reported.

The projected numbers of individuals to be served in FY25 by each age group are as follows: 26-59 years = 5 individuals; 60+ years = 85 individuals.

Substance Use Disorder Services

A large portion of individuals who currently receive services at BMH are also experiencing co-occurring disorders, having both mental health issues and substance use disorders (SUD). In an effort to increase the capacity to serve individuals with SUD, funds were previously allocated through the MHSA FY22 Annual Update for the Division to work with a local SUD provider to co-locate SUD services at the Mental Health Adult clinic. In FY23 a contract was executed with Options Recovery Services. This collaboration has increased the provision of SUD services for BMH clients, provides an opportunity for staff to obtain consultations on SUD services, and makes referrals into SUD services outside of BMH an easier process for individuals.

In FY23, 34 individuals received services. Demographics on individuals served are outlined below:

DEMOGRAPHICS N = 34	
Age Category	
Age Category	*% of total*
18-24 years	*
25-44 years	*
46-64 years	*
65 years and older	*
Declined to State (or Unknown)	*
Gender Identity	
Gender Identity	*% of total*
Male	*
Female	*
Declined to Answer (or Unknown)	*
Race/Ethnicity	
Race/Ethnicity	*% of total*
Black or African American	*
Asian or Asian Pacific Islander	*
Latinx	*
White	*
Multi-racial	*
Declined to Answer (or Unknown)	*
Sexual Orientation	
Sexual Orientation	*% of total*
Heterosexual or Straight	38%
Gay or Lesbian	*
Declined to Answer (or Unknown)	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

In FY23, there were significant staffing changes between February 2023-May 2023 and lack data during those months. There was a 50% decrease in group participation between May 2023

and June 2023. Group participation was dependent on available transportation. If a BMH Staff member was able to bring their client to group it increased the likelihood that the individual would attend. There were 17 individual sessions between the months of August 2022-June 2023. The staff at Options consists of a coordinator and a peer mentor. The peer mentor typically assists with BMH Staff with outreach and providing peer-support services to clients. The coordinator is responsible for collecting client data, providing supervision to the peer mentor, conducting groups, reaching out to high-risk clients and collaborating with BMH case workers and other community partners. From February 2023 to April 2023 staffing changes, impacted the collaborative peer-driven approach to individual services. Options Recovery Services is currently working on boosting the number of individual and group sessions.

Program Successes:
Between August 2022 and June 2023, Options Recovery Services developed a weekly substance use support group, and gained a peer mentor. Clients were integrated into Options outpatient program with supportive housing. Individuals were also referred to residential programs through Center Point. Options utilized a collaborative approach with BMH to reach individuals who have significant mental health and substance use concerns. There were clients who were mandated by the court system and worked collaboratively with the courts, and BMH to help those individuals stay out of hospitals, jails, and other institutions. One client had exhausted their resources in Alameda County but was able to participate in the Options Co-occurring group and receiving that was provided. Options also made community connections with other agencies to help clients get services at BMH. It is predicted that fixing transportation issues and adding the peer mentor will increase the numbers of individuals reached, and result in overall growth in the program.

Program Challenges:
Transportation was a major challenge for many clients. Group participation was dependent on having transportation for the clients. Options does not have a designated driver for clients so it was up to BMH staff to drive the individuals to the group or to their appointments. When a BMH Staff was unavailable there was a high chance that the client would not make it to the group. Another barrier was the availability of co-occurring substance use treatment programs. There were difficulties referring high-level mental health clients to residential programs. There were also difficulties when a client had high-level medical concerns that were not stabilized for mental health or medical. This could be an issue when the individual was homeless and needed a stable living environment. Clients are often hospitalized and then discharged back to the community unhoused. The challenge for the Options co-occurring program was reaching the client when they are unhoused. These barriers could be addressed by having a designated staff driver and housing resources for clients with serious mental illness and or medical concerns that place them out-of-scope for traditional substance use residential programs.

The projected numbers of individuals to be served in FY25 by each age group are as follows:

0-15 years = 4; 16-25 years = 8; 26-59 years = 9 individuals; 60+ years = 1 individuals. There are approximately 11 additional individuals of an unknown age at this time that are projected to be reached through outreach.

Specialized Care Unit

Through the approved FY22 Annual Update, the Division allocated a portion of one-time CSS and PEI funds to be leveraged with other City funds to support the Specialized Care Unit (SCU). Implemented through Bonita House, the SCU is Berkeley's new behavioral health crisis response team without the involvement of law enforcement. The SCU consists of trained crisis-response field workers who respond to behavioral health occurrences that do not pose an imminent threat to safety.

In FY23, MHSA funds directly supported start-up costs of the program including recruitment, hiring, and training of Bonita House staff. Training included crisis support training through Bonita House's Crisis Training Academy as well as the design and training of Berkeley-specific procedures for the SCU program. Additionally, this funding supported the salaries of the SCU program management staff as additional team members were hired. During this time, program management staff worked closely with the City of Berkeley to create the policies and procedures for a SCU that aligned with the implementation recommendations from the Berkeley community. The SCU began providing services in early FY24, and continues to operate daily from 6am to 4pm, eventually building toward a 24/7 crisis response service without involvement of law enforcement.

On-site management at Martin Luther King Jr. House

The Martin Luther King Jr. House is a 12-unit single room occupancy (SRO) complex with shared living spaces that serves the disabled community in Berkeley. Per the approved FY23 Annual Update, the Division allocated a portion of CSS System Development funds to provide on-site property management at this SRO. A contract was executed through the Housing and Community Services Division of HHCS, to provide management and oversight of this SRO.

Short-term housing for individuals on the Homeless FSP

Through the approved FY23 Annual Update the Division allocated a portion of MHSA FSP Funds to support short-term housing for individuals receiving services on the Homeless FSP. It was envisioned that the funding would be utilized to provide housing in trailers located at 701 Harrison Street, and daily living supports for four individuals. Since the approval of the FY23 Annual Update, the Division learned that it will not be possible to utilize the Harrison Street trailers for this purpose. Going forward it is anticipated that funding allocated for this purpose, will be expended on other short-term housing sites for individuals in need.

PREVENTION & EARLY INTERVENTION (PEI)

The Prevention & Early Intervention (PEI) funding component is for strategies to recognize the early signs of mental illness and to improve early access to services and programs, including the reduction of stigma and discrimination, and for strategies to prevent mental illness from becoming severe and disabling.

The original City of Berkeley PEI was approved in April 2009. Since the approval of the original plan, Three Year Plans or Annual Updates outlining proposed PEI funding and programming have been approved on an annual basis. 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 peers and family members; and
- Intervention services for at-risk children.

PEI Reporting Requirements

Per MHSA PEI regulations, all PEI funded programs are require to collect specified state identified outcome measures and detailed demographic information. MHSA also requires Evaluation Reports for PEI funded programs. PEI Evaluations are required to be included in each MHSA Annual Update or Three-Year Plan. Included in Appendix C of this Annual Update is the Prevention & Early Intervention (PEI) Fiscal Year (FY) 2022/2023 Annual 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. The results of this initiative are outlined in each of the projects funded through the PEI Community Education & Supports program.

Results Based Accountability Evaluation for all BMH Programs

Through the approved FY19 Annual Update the Division executed a Request for Proposal (RFP) process to hire a consultant to conduct a Results Based Accountability Evaluation (RBA) for all programs across the Division, and Resource Development Associates (RDA) was the chosen vendor. In FY21 RDA began working with the Division to implement the RBA research methodology. An update of the activities conducted by RDA in FY22 on this evaluation is included in the CSS Section of this Three-Year Plan.

RBA outcomes in FY23 are outlined in this Annual Update for the following MHSA PEI funded internal programs: Social Inclusion Project, and the High School Prevention Project. The complete set of RBA outcomes for all BMH programs is located in Appendix B.

PEI Regulations

Per PEI State Regulations, Mental Health jurisdictions are to utilize PEI funds to implement the following programs: Prevention, Early Intervention, Access and Linkage to Treatment, Stigma and Discrimination Reduction, and Outreach for Increasing Recognition of Early Signs of Mental Illness. Programs and/or strategies within programs can also be combined. Jurisdictions may also opt to utilize some PEI funds to implement a Suicide Prevention program. The definitions of each program that have been funded through FY24 are outlined below along with the City of Berkeley corresponding program:

PEI Program Type	Program Definition	City of Berkeley PEI Program(s)
Prevention	A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors.	• Mental Health Promotion Campaign • High School Prevention • DMIND • MEET • African American Success
Early Intervention	Treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that may result from untreated mental illness.	• High School Prevention • Be A Star • DMIND • MEET • African American Success • Supportive Schools • Community Education and Supports
Outreach for Increasing Recognition of Early Signs of Mental Illness	A process of engaging, encouraging, educating, and/or training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.	• Mental Health First Aid (non-PEI funded program)

PEI Program Type	Program Definition	City of Berkeley PEI Program(s)
Stigma and Discrimination	Direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.	• Social Inclusion
Access and Linkage to Treatment	Connecting children who are seriously emotionally disturbed, and adults and seniors with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs.	• High School Prevention
OPTIONAL Suicide Prevention	Activities to prevent suicide as a consequence of mental illness.	• CalMHSA PEI Statewide Project

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

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

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

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

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

All MHSA programs and projected funding amounts were vetted through the Community Program Planning process for this Annual Update. Many PEI projects meet multiple established priorities. Per PEI regulations, outlined below are the City of Berkeley PEI programs, priorities, and FY25 projected funding amounts:

CITY OF BERKELEY PEI PROGRAMS	PEI PRIORITIES	FY25 Projected Funding Per Priority
• Supportive Schools	Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.	$110,000
• High School Youth Prevention Project	Youth Engagement and Outreach Strategies that target secondary school and transition age youth	$900,560
• Mental Health Peer Mentor Program	Culturally competent and linguistically appropriate prevention and intervention including community defined evidence practices (CDEPs)	$46,389
• Dynamic Mindfulness Program		$95,000
• African American Success Project		$150,000
• Social Inclusion • Community Education & Supports	Culturally competent and linguistically appropriate prevention and intervention, including community defined evidence practices (CDEPs)	$310,000
	Youth Engagement and Outreach Strategies that target secondary school and transition age youth not in college.	$32,046
	Strategies targeting the mental health needs of older adults.	$32,046

PEI Funded Children and Youth and TAY Services

Per MHSA regulations 51% of PEI funds are to be used on services and supports for Children, Youth, and TAY. Small counties, of which the City of Berkeley is considered, may elect to forego this regulation as long as a community vetted, locally approved justification is provided as to why children and youth services are funded at a lower level. Since the initial PEI Plan, the City of Berkeley has allocated more than 51% of PEI funds to services and supports for children, youth and TAY as the majority of PEI funds has been utilized to serving these populations. All City of Berkeley PEI programs in FY25 will provide services for children and youth and/or Transition Age Youth. Five programs are in the Berkeley Unified School District (BUSD).

Programs and services funded with PEI funds that were approved to be continued in FY25 through the previously approved Three Year Plan, are outlined below by PEI Program type, along with FY23 data.

PREVENTION PROGRAMS

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

Mental Health Promotion Campaign

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

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

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

It is anticipated that this campaign will be implemented in FY25.

EARLY INTERVENTION PROGRAMS

Early Intervention Program – Provides treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that may result from untreated mental illness.

The City of Berkeley Early Intervention programs are as follows:

Early Childhood Health and Wellness Program

The Early Childhood Health and Wellness program (formerly named the Be A Star Project) has been a collaboration with the City of Berkeley's Public Health Department since the initial MHSA PEI Plan. It has provided a coordinated system in Berkeley that identifies children birth to age five and their parents, who are at risk of childhood development challenges including developmental, social, emotional, and/or behavioral concerns. The program specifically targets low income families, including those with teen parents, who are experiencing homelessness, substance use disorders, or are 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 FY23, a total of 2,339 children were screened through this program (255 at BUSD, and 2,084 at the Help Me Grow sites) however data was not collected on all individuals screened. Although all 2,339 of the individuals that were either screened or were screened and received services, were aged 0-15, the other data elements were only collected on the 255 children screened at BUSD as follows:

DEMOGRAPHICS N=255	
Age Groups	
0-15 (Children/Youth)	100%
Race	
American Indian or Alaska Native	*
Asian	17%
Black or African American	30%

White	19%
More than one Race	*
Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican/Mexican-American/Chicano	25%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	100%
Primary Language	
English	51%
Spanish	18%
Declined to Answer (or Unknown)	31%
Disability	
Declined to Answer (or Unknown)	100%
Gender: Assigned Sex at Birth	
Male	44%
Female	56%

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

Program Successes:

- On-site technical assistance visits to all Berkeley Help Me Grow providers continued and went well.
- 2,339 ASQ developmental screenings were conducted in Berkeley, BUSD preschools and Berkeley Help Me Grow pediatric provider sites combined.
- Berkeley Help Me Grow sites conducted a total of 2,084 screenings, across all sites averaging a 20% increase in children screened from the previous year.
- Referrals to resources & follow-up: BUSD referred a total of 64 preschool students and Help Me Grow providers referred 94 infants/children.
- Approximately 72% of all Help Me Grow referrals had their goals met.

Program Challenges:

- The Early Childhood Health and Wellness Public Health Nurse vacancy occurring in May 2023 and staffing vacancies/turnovers at the Berkeley Help Me Grow provider sites impacted the continuity of services, with the need to introduce/train/orient provider sites to ASQ implementation, tracking, and resource referrals to clients;
- Help Me Grow sites did not collect race/ethnicity, language spoken data, or gender; BUSD does not collect specific ethnicity data, gender, sexual orientation for this age group. BUSD does collect language spoken students that are not reflected on this PEI Report, for

example, data reflected Arabic, Vietnamese, Russian, Mandarin, Cantonese, Urdu, and other languages not on this report form.
- There were delays in receiving the annual infographic data for Help Me Grow sites. The Help Me Grow Collaborative collects and analyzes the data from all Help Me Grow sites in Alameda County so it takes time to collect and synthesize the data and to receive the Berkeley specific data.

Beginning in FY25, the MHSA-PEI funding for this program will be discontinued, as the Public Health Division will be transitioning these program activities to be funded and housed programmatically under their Maternal, Child and Adolescent (MCAH) Program.

- The MCAH Program is a California Department of Public Health (CDPH) funded program committed to serving women, children, teens and their families by improving access to comprehensive, quality health care, and focusing on prevention and early intervention strategies.

- Within MCAH, there are program requirements which align with the focus of early identification, assessment, treatment, and referral for children (ages 0-5) and their families that provides rationale for the shift to MCAH.

- As part of the MCAH scope of work, the focus on supporting early childhood development screenings will be able to be integrated with other programs that reside within the MCAH scope, such as the Berkeley Black Infant Health Program and Fatherhood Initiative.

Going forward, the Early Childhood Health and Wellness Program (ECHW) moved under the MCAH Program will address the MCAH Child Priority Need: To optimize the healthy development of all children so they can flourish and reach their full potential with a child focus area to expand and support developmental screening.

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 FY23 Early Intervention Services were provided at each of the BUSD elementary schools. BUSD sub-contracted with local agencies to provide early intervention services based upon the standard of evidence-based practices. Bay Area Community Resources (BACR), Child Therapy Institute (CTI), and Lifelong Medical (Lifelong) were subcontracted to provide services at BUSD elementary schools.

Supports for each school per each service provider, and numbers served in FY23 were as follows:

Elementary School	Agency/Provider	Number of Students Served
• Cragmont • Emerson • John Muir • Malcolm X • Oxford • Ruth Acty • Sylvia Mendez • Thousand Oaks	Bay Area Community Resources (BACR)	644
• Bay Area Arts Magnet (BAM) • Washington	Child Therapy Institute	37
• Rosa Parks	Lifelong Medical Care	133
Total		**814**

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

Bay Area Community Resources (BACR): Provided services to improve emotional functioning and success in school and life, including individual and group therapy, family consultation, conflict resolution/restorative justice, suicide prevention, check-in/check-out, crisis intervention, and classroom presentations. BACR used many different therapy modalities as well as classroom support to develop skills and health. Additionally, the BACR Counselor participated in weekly Coordination of Services (COST), Student Success Team (SST), and Individualized Education Program (IEP) meetings for students, providing mental health and trauma informed perspectives. BACR consulted with school staff on many issues and provided trauma informed coaching for teachers needing support. BACR also made referrals to outside providers, parenting classes/support groups, crisis hotlines, and other programs.

Program Successes:

- A total of 644 individuals were served.
- 90% of youth in therapy showed improved emotional functioning and resiliency through the CANS and/or Stages of Change scale.
- 85% of students receiving classroom education reported gaining skills or knowledge.
- 95% of Caregivers reported that they are satisfied with the services their children/family received.
- 100% of school personnel reported that BACR is a great partner and supports their goals.

Program Challenges:

The biggest challenge was the increase in cost to fund the program. These increases required the district to make cuts in other programming areas, as well as moving resources around to be able to continue providing ongoing services at the same rate as in the previous year. An additional challenge was ensuring that each school site had an equivalent 1.0 FTE BACR

counselor at all BUSD elementary schools, as there was a shortage of credentialed therapist and counselors and BACR had to compete with other agencies for employees.

Child Therapy Institute (CTI): Continued providing services at Bay Area Arts Magnet and Washington Schools.

Program Successes:
CTI staff met with 37 students individually and in groups.

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

Lifelong Medical: A Licensed Clinical Social Worker (LCSW) and interns provided individual counseling to students, family counseling, and mental health consultation to caregivers and school staff. Full-class support was provided in several classrooms. The full class support was tailored to the needs of the teacher and class and consisted of community building, regulation strategies such as Zones of Regulation, and social emotional learning.

Program Successes:
A total of 52 students received individual counseling and 81 students participated in group services. The Family Resource Center (FRC) was a valuable resource and support to children, families, and school staff during the reporting timeframe. Through individual counseling, groups, and as-needed support, the FRC staff worked hard to help make Rosa Parks a place of healing and joy. The Rosa Parks community experienced the ripple effects of global pandemic and many losses in the community. FRC created spaces for students to experience a sense of belonging and connection. FRC helped children develop regulation and coping strategies to help them manage their emotions so that they could be more present in the classroom for learning. FRC developed deep relationships with students in order to help guide them in the process of making sense of the many scary and sad experiences they have had over the past few years. Additionally, FRC provided consultation and referrals to mental health services in the community.

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

Demographic data provided by BUSD on 814 students that were served through this project in FY23, is outlined below:

DEMOGRAPHICS N= 814	
Age Group	
0-15 (Children/Youth)	100%
Race	
American Indian or Alaska Native	*
Asian	*
Black or African American	26%
Native Hawaiian/Pacific Islander	*
White	35%
More than one Race	26%
Declined to Answer (or Unknown)	*
Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican/Mexican American - Chicano	*
Other	29%
Declined to Answer (or Unknown)	*
Ethnicity: Non-Hispanic or Non- Latino/Latina/Latinx	
African	*
Asian Indian/South Asian	*
Chinese	*
Eastern European	*
European	*
Middle Eastern	*
Other	13%
More than one Ethnicity	*
Declined to Answer (or Unknown)	55%
Primary Language Used	
English	*
Spanish	*
Other language	*
Declined to Answer (or Unknown)	81%

Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
No Disability	*
Declined to Answer (or Unknown)	96%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	50%
Female	40%
Declined to Answer (or Unknown)	10%
Current Gender Identity	
Male	44%
Female	37%
Another Gender Identity	*
Declined to Answer (or Unknown)	17%

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

The projected numbers of individuals to be served in FY25 per age groups are as follows:
0-15 years = 820 individuals.

Community Education & Supports

Through five community-based organizations, the Community Education & Supports program implements culturally-responsive psycho-educational trauma support services for individuals (18 and above) in various cultural, ethnic, and age specific populations that are unserved, underserved and inappropriately served in Berkeley including: African Americans; Latino/a/x; LGBTQIA+; TAY; and Senior Citizens.

In FY23 the Community Education & Supports program participated in the HHCS Results-Based Accountability (RBA) Evaluation. In an aggregated summary across the five projects within this program the following work was conducted: 549 Support Groups/Workshops; 2,693 Support Group/Workshop encounters; 476 Outreach activities; 4,001 Outreach Contacts; and 393 Referrals.

Descriptions of the five projects within the Community Education & Supports program along with FY23 data and RBA evaluation results, are outlined below:

➢ Transition Age Youth Trauma Support Project

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

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

PEI Priorities:

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

In FY23, YSA went through many changes. A new program model was crafted and implemented with the intention of redesigning and refining the organization's programs and theory of change. Staff received training on theory of change, program development, ACES Science, trauma informed practices, the politics of trauma, facilitation skills, positive youth development, strength-based model, community resilience model, somatic awareness, individual coaching, housing navigation skills and curriculum and evaluation introduction. This change and shift in culture expanded the program offerings. The components and activities were designed with specific outcomes in mind and with the intention to increase intervention, engagement, and opportunities for the young people being served.

In FY23, 83 youth participated in one or more program services. Demographics on youth served were as follows:

DEMOGRAPHICS N = 83	
Age Group	
16-25 (Transition Age Youth)	100%
Race	
American Indian or Alaska Native	*
Asian	*

Black or African American	48%
White	*
More than one Race	28%
Declined to Answer (or Unknown)	*
Ethnicity: Latino/Latina/Latinx	
Mexican/Mexican American-Chicano	18%
Declined to Answer (or Unknown)	15%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	*
Declined to Answer (or Unknown)	66%
Primary Language Used	
English	100%
Sexual Orientation	
Gay or Lesbian	*
Heterosexual or Straight	27%
Bisexual	33%
Questioning or Unsure of sexual orientation	*
Another sexual orientation	*
Declined to Answer (or Unknown)	26%
Disability Status	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	21%
Female	28%
Declined to Answer (or Unknown)	51%

Current Gender Identity	
Male	25%
Female	28%
Transgender	*
Genderqueer	*
Another Gender Identity	*
Declined to Answer (or Unknown)	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

RBA Outcomes during the reporting timeframe were as follows: 6 Behavioral Health Education Groups were conducted reaching 99 individuals; 100 Peer Mentoring sessions were conducted reaching 75 individuals; 108 Art Therapy sessions were conducted reaching 107 individuals; and 32 individuals participated in 6 events.

Feedback per participant self-report was as follows:

- 84% reported that groups were helpful;
- 70% of Art as Therapy participants reported that they feel their Behavioral Health is improved or very improved.

Program Successes:
Youth participated and were engaged in the program changes. Youth engaged in being trained in theory of change and understood the feedback loop and how YSA would assess them to help evaluate program effectiveness, satisfaction, facilitator engagement. In addition, youth engaged in leadership development through facilitation, curriculum, and event planning training to assist in their future developments in leading peers and community.

Youth within the village were also connected to youth leadership opportunities, and were engaged in life skills development such as financial wellness, and cooking workshops. Both workshops were created to assist youth in being financially independent and well, while redirecting learned survival skills into resilience building opportunities that create building blocks for growth. Youth led and organized a fashion show “Out Of The Binary” where they created all of the fashion pieces for the runway. Youth also planned, organized, advertised, and facilitated the entire event using skills that they acquired through youth leadership meetings, and youth leadership training spaces. A total of 30 referrals & Linkages were provided to youth in Berkeley.

YSA was able to gain a deep understanding on how to shape the Art as Therapy workshops, the Peer to Peer led Pathways with practical, experiential engagement and opportunity to lead as well as the Behavioral Health support given to participants through relationship workshops offered out of our Youth Empowerment Meetings.

Project Challenges:
A big program challenge was dealing with staff training and buy-in. Many of YSAs staff were former youth participants and many struggled with similar challenges as the youth that were being served. During this time YSA was challenged with staff understanding the importance of data collection and evaluation. Staff were not trained on using data to drive programmatic changes, which at times led to resistance and eventually the loss of some staff.

The projected numbers of individuals to be served in FY25 per age groups are as follows:
16-25 years = 85 individuals.

- **Trauma Support Project for LGBTQIA+ Population**

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

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

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

In FY23, a total of 275 individuals were served. Demographics on individuals served include the following:

DEMOGRAPHICS N=275	
Age Groups	
16-25 (Transitional Age Youth)	13%
26-59 (Adult)	67%
Ages 60+ (Older Adult)	17%

Declined to Answer (or Unknown)	*
Race	
American Indian or Alaska Native	*
Asian	*
Black or African American	*
White	58%
More than one Race	*
Other	*
Declined to Answer (or Unknown)	*
Ethnicity: Hispanic or Latino/Latina/Latinx	
Carribbean	*
Mexican/Mexican-American Chicano	*
Puerto Rican	*
South American	*
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	*
Asian Indian/South Asian	*
Chinese	5%
Eastern European	*
European	26%
Filipino	*
Korean	*
Middle Eastern	*
Vietnamese	*
More than one Ethnicity	14%
Other	*
Declined to Answer (or Unknown)	29%

Primary Language Used	
English	97%
Spanish	*
Declined to Answer (or Unknown)	*
Sexual Orientation	
Gay or Lesbian	19%
Heterosexual or Straight	*
Bisexual	10%
Questioning or Unsure	*
Queer	12%
Another Sexual Orientation	49%
Declined to Answer (or Unknown)	*
Disability	
Difficulty Hearing or Having Speech Understood	*
Mental Domain not including a mental illness (including but not limited to a learning disability, developmental disability or dementia)	8%
Physical/mobility domain	*
Chronic health condition (including but not limited to chronic pain)	8%
Other (Specify)	17%
No Disability	64%
Veteran Status	
Yes	*
No	95%
Declined to Answer (or Unknown)	*
Gender: Assigned Sex at Birth	
Declined to Answer (or Unknown)	100%

Current Gender Identity	
Male	15%
Female	12%
Transgender	29%
Genderqueer	*
Questioning or Unsure	*
Another gender identity	37%
Declined to Answer (or Unknown)	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

RBA Outcomes during the reporting timeframe were as follows: 427 Support Groups were conducted reaching 275 individuals; 55 Outreach activities were conducted; 21 individuals attended Train the Trainer sessions to become Peer Support Group Facilitators; and 52 Peer Support Group Facilitators attended Skill Building Workshops. There were 88 referrals for additional services and supports. The number and type of referrals included: 47 Mental Health; 20 Physical Health; 12 Social Services; 3 Housing; 6 Other unspecified services. To assess the project services, a self-administered Peer Support Group Survey was distributed to all peer group members. Survey results were as follows:

- 98% indicated they would recommend the organization to a friend or family member;
- 95% felt like staff and facilitators were sensitive to their cultural background;
- 88% reported they deal more effectively with daily problems;
- 84% indicated they have trusted people they can turn to for help;
- 85% felt like they belong in their community.

Program Successes:

- Peer groups continued to run uninterrupted and to be a vital support to the LGBTQIA+ community during the reporting timeframe.
- 92.4% of participants reported that the peer support group(s) they attended helped them to feel safe talking about their gender.
- 88% reported that the peer support group(s) they attended helped them to feel safe in talking about their sexuality.
- The primary goal in FY23 was to increase capacity and reduce burnout for the group facilitators. To that end,16 new facilitators were on-boarded and an additional 3 facilitators were re-trained at their request.
- A full set of Diversity Equity and Inclusion trainings were also offered including one that was co-facilitated by a peer facilitator and our Community Programs Director.

Program Challenges:

- During quarter three facilitators were struggling with the Diversity Equity and Inclusion trainings offered and felt they were ready to move beyond the basics of inclusion and wanted more tools to interact with group members around issues of race, privilege, neurodivergence etc.
- In quarter four, the Diversity Equity and Inclusion training was co-facilitated by the Community Programs Director and a peer group facilitator and focused on lowering barriers to access and creating a more inclusive and welcoming space.

The projected numbers of individuals to be served in FY25 are as follows: 16-25 years = 40 individuals; 26-59 years = 176 individuals; 60+ years = 52 individuals.

- **Living Well Project**

Implemented through Center for Independent Living, this project provides services for Senior Citizens (aged 50 and over) who are coping with trauma and/or mental health issues associated with acquired disabilities. Senior Citizens with acquired disabilities are one of the most difficult groups to reach with disability services. It is similarly difficult to intervene with this group's developing mental health issues related to aging and the traumatic impact of acquiring one or more disabilities (such as loss of mobility, vision, hearing, et al). The core of the project is a wellness workshop series entitled "Living Well with a Disability". Through a combination of education, goal setting, group and peer counseling, the workshop series is designed to promote positive attitudinal shifts in a population who, despite the tremendous need for care, are often typically not responsive to mental health intervention. The workshop series includes a 10 week, one to two-hour class conducted by Peer Facilitators, and an optional 30-minute counseling session. Counseling sessions are designed to monitor curriculum impact and continually assess individual goals and resource needs. This project serves up to 80 Older Adults a year.

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

PEI Priorities:

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

In FY23, 89 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 FY23, a total of 73 individuals participated in the Living Well Workshop Series program. Demographics of Workshop participants are outlined below:

DEMOGRAPHICS N=73	
Age Groups	
Age 60+ (Older Adult)	88%
Declined to Answer (or Unknown)	*
Race	
Asian	23%
Black or African American	22%
White	34%
Other	*
Declined to Answer (or Unknown)	*
Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican/Mexican-American-Chicano	*
Other	*
Declined to Answer (or Unknown)	*
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Asian Indian/South Asian	*
Chinese	*
European	19%
Middle Eastern	*
Other	25%
Declined to Answer (or Unknown)	*
Primary Language Used	
English	79%
Other	*
Declined to Answer (or Unknown)	*
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Difficulty Seeing	*
Difficulty Hearing or Having Speech Understood	22%

Mental (not mental health)	*
Physical/mobility disability	*
Chronic health condition	22%
Other Disability	*
No Disability	*
Declined to Answer (or Unknown)	*
Veteran Status	
Yes	*
No	71%
Declined to Answer (or Unknown)	*
Gender: Assigned Sex at birth	
Male	*
Female	69%
Declined to Answer (or Unknown)	*
Current Gender Identity	
Male	*
Female	71%
Declined to Answer (or Unknown)	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

RBA Outcomes during the reporting timeframe were as follows: 4 outreach and informational events were conducted reaching 51 individuals. A total of 99 individuals participated in the Living Well Workshop series and 72 received engagement services. There were 149 referrals for additional services and supports. The number and type of referrals included: 46 Mental Health; 27 Physical Health; 38 Social Services; 26 Housing; 12 other unspecified services. Project participants completed a Living Well Workshop Series. Feedback per participant self-report was as follows:

- 93% reported they felt satisfied with the workshops;
- 93% indicated an improvement in feeling satisfied in general;
- 93% had increased feelings of social supports;
- 93% felt prepared to make positive changes; and
- 93% reported they felt less overwhelmed and helpless.

Project Successes**:**

- The Living Well with a Disability programming continued to be well attended, especially the PEERS group, which is a peer-based support and discussion group focused on mental and emotional health for seniors.
- New seniors attended every quarter, and participant survey's demonstrated positive outcomes.
- Due to the success of the program, the Senior and Aging Engagement Specialist received numerous requests to host Living Well workshops at additional locations.

Project Challenges:

- The Living Well program continued to experience the impacts of the ongoing pandemic; older adults are still at higher risk for complications from Covid-19. Some staff also got COVID/experienced long COVID, which impacted the program.
- A majority of participants expressed that they did not feel comfortable answering all of the demographic and life situation questions required by the MHSA reporting. The Management Team is continuing to work with the Senior and Aging Engagement Specialist to devise strategies to support getting the required information, and also to ensure that trust, confidentiality, and person-centered services remain at the core of the work.
- The Center for Independent Living transferred to a new customer relationship management (CRM) software called MiCil, and the shift between the two CRMs, as well as the on-ramp period to get Living Well staff familiar with the new system and ensure it was accessible to them, created challenges in getting numbers and reports in in a timely manner.
- There was also some transition in Senior Management staff, which led to a delay in invoicing and financial reports on a couple of occasions.
- The agency had an Interim Executive Director during the reporting timeframe and has continued search for a new Executive Director.
- The program structure shifted to include more managers, which will hopefully alleviate some of the challenges, particularly around data management.
- A Data and Reporting Specialist was hired, who works closely with the Senior and Aging Engagement Specialist to ensure Living Well data is tracked in an accurate and comprehensive manner.

It is anticipated that these issues will be ameliorated within the current fiscal year, as the Living Well program systems, policies, and procedures are being revised and revitalized.

A majority of participants expressed that they did not feel comfortable answering all of the demographic and life situation questions required by the MHSA reporting. The Management Team is continuing to work with the Senior and Aging Engagement Specialist to devise strategies to support getting the required information, and also to ensure that trust, confidentiality, and person-centered services remain at the core of the work.

The projected numbers of individuals to be served in FY25 per age groups are as follows: 26-59 = 10 individuals; 60+ = 70 individuals.

- **Soul Space Project**

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

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

PEI Priorities:

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

In FY23, 35 individuals were served. Demographics on individuals served are as follows:

DEMOGRAPHICS N=35	
Age Groups	
Transition Age Youth (16-25)	*
Adults (26-59)	69%
Older Adults (60+)	*
Race	
Black or African American	86%
Declined to Answer (or Unknown)	14%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	*
Primary Language	
English	100%
Sexual Orientation	
Heterosexual or Straight	*
Bisexual	*
Another sexual orientation	*
Declined to Answer (or Unknown)	*

Disability	
Mental (not mental health)	*
Physical/Mobility Disability	*
No Disability	*
Declined to Answer (or Unknown)	*
Veteran Status	
Declined to Answer (or Unknown)	100%
Gender: Assigned Sex at Birth	
Male	37%
Female	63%
Current Gender Identity	
Male	37%
Female	63%

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

RBA Outcomes during the reporting timeframe were as follows: 20 Community Education Trainings were conducted and 417 individuals were reached through outreach and engagement services. A total of 19 individuals received case management and 20 participated in Support Groups. There were 4 referrals for additional services and supports.

Project Successes**:**

- *Community Engagement***:** Soul Space Berkeley successfully integrated itself into the Berkeley community and has become a recognized and trusted resource for individuals seeking wellness and support services. Partnerships with community agencies, Building Opportunities for Self Sufficiency (BOSS) and Options for Recovery, yielded a reciprocal referral stream that has been beneficial.
- *Expanded Services*: One of the major accomplishments was the ability to serve individuals in the community effectively. The case management services proved to be highly beneficial assisting individuals in finding mental health resources; adjusting to life after the pandemic; offering financial education; and offering a safe place where individuals could openly express their needs and employment assistance.
- *Family Support*: Entire families the Soul Space services, reflecting the broad impact of the programs on the community. This demonstrates programs ability to address holistic well-being at both the individual and family levels. Soul Space will continue to offer family services given the need.
- *Successful Women's Group*: The establishment and success of the women's group “Crown Never Off” was a testament to the value of the services provided. This group provided a supportive and empowering space for women within the community.

- *Community Recognition*: Soul Space established meaningful connections with community organizations, enhancing the presence and reputation within the Berkeley community. The commitment to building community relationships yielded positive results.

Project Challenges:

- *Staffing*: Soul Space experienced staff turnover amid growth and an increased demand for services. Recruitment for new staff to ensure the right team is in place to meet the needs of the expanding program is an ongoing challenge given the program budget. In FY24, two new staff were hired. Soul Space is seeking additional funding to support the current staffing arrangement.
- *Location Accessibility*: In FY23, OnTrack, the provider of the SoulSpace project, was relocated to a space within Inter-City Services. However, due to various building issues, this space was temporary and OnTrack had to relocate again to it's current space in South Berkeley.

The projected numbers of individuals to be served in FY25 are as follows: 16-25 years = 27 individuals; 26-59 years = 39 individuals; 60+ years = 7 individuals.

- **Latinx Trauma Support Project**

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

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

PEI Priorities:

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

In FY23, this project served 339 individuals. Demographics on individuals served were as follows:

DEMOGRAPHICS N=339	
Age Groups	
Children and Youth (0-15)	*
Transition Age Youth (16-25)	*
Adults (26-59)	84%
Older Adults (60+)	*
Declined to Answer (or Unknown)	*
Race	
American Indian or Alaska Native	*
Asian	*
Black or African American	*
White	*
Other	85%
Declined to Answer (or Unknown)	*
Ethnicity: Hispanic or Latino/Latina/Latinx	
Central American	47%
Mexican/Mexican-American/Chicano	35%
South American	*
Other	*
Declined to Answer (or Unknown)	*
Ethnicity: Non-Hispanic or Latino/Latina/Latinx	
African	*
Asian Indian/South Asian	*
Cambodian	*
Eastern European	*
European	*
Japanese	*
Korean	*
Other	*

Primary Language	
English	*
Spanish	87%
Declined to Answer (or Unknown)	*
Sexual Orientation	
Gay or Lesbian	36%
Heterosexual or Straight	43%
Bisexual	*
Queer	*
Another sexual orientation	*
Declined to Answer (or Unknown)	*
Disability	
Other	*
No Disability	93%
Declined to Answer (or Unknown)	*
Veteran Status	
No	100%
Gender: Assigned Sex at Birth	
Male	44%
Female	55%
Declined to Answer (or Unknown)	*
Current Gender Identity	
Male	41%
Female	55%
Another Gender Identity	*
Declined to Answer (or Unknown)	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

RBA Outcomes during the reporting timeframe were as follows: 7 Support Group sessions were conducted reaching 132 individuals, and 94 individuals received One-on-One Supports. A total of 8 Trainings were conducted, reaching 30 individuals. There were 152 warm referrals for additional services and supports. The number and type of referrals included: 32 Mental Health; 8 Physical Health; 44 Social Services; 68 other unspecified services.

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

- 100% reported they liked participating in the Support Group;

- 98% indicated they would recommend the organization to a friend or family member;
- 100% indicated they felt safe, included and respected;
- 95% reported that they were able to deal more effectively with daily problems;
- 98% reported increased feelings of supports after participating in the support group.

Training feedback per participant self-report was as follows:

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

Project Successes**:**

- Continued to provide integrated support to low-income Latinx immigrants through case management, warm referrals, trilingual hotline, support groups, mental health support, and trainings, as well as quarterly retreats for LGBTQ asylum seekers and Mam women.
- Due to growth in the Support Services program an additional caseworker was hired, which helped clients connect to more public benefits, including Medi-Cal and CalFresh.
- In addition to 1x1 support, a support group was offered reaching 24 LGBTQ asylum seekers and a storytelling workshop reaching 17 people.
- Utilized undergraduate interns for 16-24 hours a week to provide direct service to individuals, and to assist with administrative tasks.
- Hosted four Trauma-Informed trainings for staff and partner organizations providing legal and mental health services to asylum seekers. Staff trainings on Wellness and Domestic Violence Prevention were also conducted. The Support Services team attended a training on Motivational Interviewing and participated in a convening of Bay Area nonprofits serving unaccompanied immigrant youth.
- Provided a training on Mental Health First Aid and suicide prevention, one for law student volunteers, and one in Spanish for outreach workers.
- Partnered with “No Separate Survival”, a participatory documentary project, to offer asylees a chance to get behind the camera and share their perspectives as storytellers, and hosted a film screening for asylum seekers and their families in a single-day support group event.
- The OLAS LGBT Sanctuary Project held a retreat on the theme, “The Pride of Being,” to empower participants to be proud of their unique identities, and to build community with each other.
- Connected clients to services such as rental assistance, state-funded medical services, mental health services, and more.
- Planned an integrated wellness workshop for clients, which took place in the Fall of 2023. The workshop covered topics such as sleep and stress, and offered a range of culturally appropriate approaches including Talk Therapy and traditional Mayan herbal remedies.
- The Community Education Manager and Amplifying Sanctuary Voices Team led two “Tell Your Story” workshop training sessions to help community members learn how to share their immigration stories with legislators and the public. These workshops helped community members find power and confidence in sharing their lived experiences to advocate for a greater cause.

- The OLAS LGBTQ Asylum Program Coordinator, led a support group retreat for new and returning members focused on the immigrant identity. Activities allowed participants to safely share their migration stories and discuss the dynamics of acculturation and chosen family.

Project Challenges:
It continued to be a challenge to connect clients with mental health services in a timely fashion, as the shortage of mental health workers seemingly only deepened. We stayed in close touch with groups like “Partnerships for Trauma Recovery” to make sure we had up-to-date information on which providers are accepting new patients and what wait times our clients could expect. A Team Member who specializes in working with teenagers and transition-aged youth, offered a support group for her clients, however it proved to be difficult to recruit for the group, as the need to earn money often overwhelmed all other needs of the potential participants.

The projected numbers of individuals to be served in FY25 per each age group are as follows: 0-15 years = 4 individuals; 16-25 years = 86 individuals; 26-59 years = 295 individuals; 60+ = 23 individuals.

PREVENTION & EARLY INTERVENTION COMBINED PROGRAMS

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

Early Intervention Program – Provides treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that may result from untreated mental illness.

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

Dynamic Mindfulness Program (DMind)

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

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

PEI Priorities:

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

In FY23, services were directly provided to 550 students and 66 staff. An additional 2,000 unduplicated students were reached through knowledge and skills shared by individuals who received direct services. Additionally, there were many more students who practiced along with the online curricular supports by accessing the DMind video library (containing over 300 brief DMind practices), and the "Mood Shifter" for emotion regulation in the programs InPower Mobile App. The big post-COVID change was going from online to in-person services/programs, including in-class sessions by Niroga instructors, as well as staff (teachers, counselors, administrators) training and coaching sessions.

The only demographic data provided by BUSD on individuals who were served in FY23, was as follows: 0-15 years = 84%; 16-25 years = 5%; 26-59 years = 11%.

Program Successes:

- Successfully pivoted from online to in-person programming after the COVID lockdown ended.
- Staff (teachers and counselors) reported that there was a substantial increase in student mental health issues, leading to challenging student behaviors, e.g. disruptive, distracted, disengaged (fight/flight/freeze), saying they were seeing a certain 'feral quality' to many students (as they re-learned socializing after the long period of social isolation because of COVID), Even so, staff and students responded very positively to the in-person movement-based mindfulness program.

In addition to engaging students, this program also works with school staff to (a) enhance their own personal sustainability (self-care, stress resilience and healing from vicarious trauma) as well as (b) professional application with their students (emotion regulation, de-escalation, focus/attention/engagement). This not only built staff capacity and ensured adequate DMind 'dosage' for enabling neuroplasticity and neurogenesis to rewire their brains and change behavior, but also provided a multiplier factor of ~30-40 (typical class size in middle and high schools, and nominal caseload for counselors), significantly increasing the reach and scope of programming, serving a much larger group of unduplicated students than would have been otherwise possible given budgetary limitations.

Program Challenges:
Program staff witnessed significant levels of overwhelmed school staff which limited their ability to participate in the capacity-building training and coaching offerings.

The projected numbers of individuals to be served in FY25 per each age group are as follows: 0-15 years = 517 individuals; 16-25 years = 31 individuals; 26-59 years = 68 individuals.

Mental and Emotional Education Team (MEET)

The Mental and Emotional Education Team (MEET) program implements a peer-to-peer mental health education curriculum to 9th graders, and an internship program for a cohort of high school students to serve as peers to their fellow students. The goals of the program are to increase student awareness of common mental health difficulties, resources, and healthy coping and intervention skills. Through this program, students are trained by a licensed BUSD clinician to conduct class presentations covering common mental health disorders, on and off campus resources, and basic coping and intervention skills. This model of peer-to-peer education can contribute to reducing mental health stigma, increasing students' understanding and use of coping skills, and increasing students' awareness and use of school-based mental health support services.

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

PEI Priorities:

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

In FY23, the MEET program was relaunched after having been discontinued for a couple of years. During this reporting timeframe,15 MEET Peer Educators participated in weekly trainings and in a 1 full day training for the purposes of developing leadership skills, learning about mental health needs and resources, and providing mental health education for their peers. The trained Peer Educators then presented in eight U-9 Freshman Seminar Classes.

Five of the MEET students participated in the City of Berkeley Health Justice (HJI) Internships with MEET as their internship site. The HJI interns participated in an additional weekly meeting and acted as leaders within MEET by developing the PowerPoint presentation and leading practice sessions with other MEET peer educators to prepare for their classroom presentations.

In FY23, 15 individuals were served through this program. Demographics on individuals served were as follows:

DEMOGRAPHICS N=15	
Age Groups	
Children and Youth (0-15)	100%
Race	
Asian	*
Black or African American	*
White	*
More than one Race	*
Declined to Answer (or Unknown)	*
Ethnicity: Hispanic or Latino/Latina/Latinx	
Other	*
Declined to Answer (or Unknown)	*
Ethnicity: Non-Hispanic or Latino/Latina/Latinx	
African	*
Asian Indian/South Asian	*
Other	*
Declined to Answer (or Unknown)	*
Primary Language	
Declined to Answer (or Unknown)	100%
Sexual Orientation	
Gay or Lesbian	*
Heterosexual or Straight	*
Bisexual	*
Questioning or unsure of sexual orientation	*
Queer	*
Declined to Answer (or Unknown)	*
Disability	
Difficulty Seeing	*
Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability or dementia)	*
Other	*

No Disability	*
Declined to Answer (or Unknown)	*
Veteran Status	
No	100%
Gender: Assigned Sex at Birth	
Declined to Answer (or Unknown)	100%
Current Gender Identity	
Male	*
Female	*
Genderqueer	*
Questioning or unsure of gender identity	*
Declined to Answer (or Unknown)	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

Program Successes:

- Developed informational PowerPoint and presentation for U-9 Freshman Seminar classes.
- Completed 8 educational presentations to U-9 Freshman Seminar classes.
- Presentations reached over 200 students and aimed to foster greater comfort in discussing mental health, provide information about common mental health issues, reduce mental health stigma, teach coping skills, and show students how to access mental health resources in and outside of Berkeley High School.
- Five MEET students participated in the City of Berkeley Health Justice (HJI) Internships with MEET as their internship site. The HJI interns acted as leaders within MEET by developing the PowerPoint presentation and leading practice sessions to prepare for their classroom presentations.
- Created informational posters about depression, anxiety, coping skills, and selfcare to be posted across campus.
- Helped design mental health survey questions that were used in the district-wide Mental Health Needs Assessment.
- Conducted over 40 interviews of Berkeley High Students for the district-wide Mental Health Needs Assessment.
- Assisted in designing a BHS Wellness Website.
- Nine weekly trainings and one full day training was facilitated for MEET students to foster community, learn about common mental health concerns and prepare to facilitate presentations to U-9 freshmen.
- HJI MEET interns met with the training facilitator an additional 5 times to support their development of the PowerPoint presentation, foster their leadership within MEET, and provide feedback and assistance in creating mental health informational posters.

- Each MEET participant co-facilitated at least 2 classroom presentations.
- MEET students taught over 200 students (all U-9 freshmen) in their classrooms by facilitating the PowerPoint presentation and interactive activities focusing on mental health and coping skills.
- Feedback from MEET peer educators, U-9 students, and teachers was overall positive. 93% of MEET Peer Educators reported that they learned more about mental health and 100% reported that they felt comfortable or very comfortable expressing themselves within the group.

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

The projected numbers of individuals to be served in FY25 per each age group are as follows: 0-15 years = 15 individuals.

African American Success Project

The African American Success Project (AASP) implements “Umoja” - a daily elective class offered at Longfellow Middle School. Umoja provides African American students a safe affinity space to explore their cultural heritage and identity, while building positive peer relationships and establishing relational trust with adults. Umoja provides an ongoing focus on social and emotional development, including building skills, habits and mindsets that enable self-regulation, interpersonal skills, perseverance and resilience. This project aligns with stated needs found in key BUSD initiatives, and strategic actions, including but not limited to the: Black Lives Matter Resolution, Local Control & Accountability Plan (LCAP), the African American Success Framework (AASF), and the Comprehensive Coordinated Early Intervention Services (CCEIS) Plan.

This project provides a unique chance to expose learners to content traditionally overlooked by educational institutions. Umoja course lessons are rooted in African and African American cultural precepts, and are composed to guide African American learners through:

- An exploration of their identities;
- An interrogation (questioning or query) of their ancestral history.
- Development of a positive sense of purpose and cultural pride.
- Envisioning their futures and outlining a path for fulfillment.
- Developing an awareness of their communal role.

Direct services for parents and guardians**:**
The project seeks to increase entry points for caregivers to be informed and involved in their child’s learning. Highlights in this area include:

- Providing digital newsletters, and updates using email marketing.
- Coordinating and hosting parent teacher conferences.

- Individual parent meetings/contacts, including advising, problem-solving, and updates regarding student progress.
- Hosting events including the Annual Kwanzaa celebration, and an end of the year meeting to gather qualitative program feedback.

Direct services for students (academic, social, behavioral):

- School-day cultural enrichment designed to uplift and empower African American learners using African centered pedagogical approaches.
- Equity centered support sessions (weekly).
- Structured class check-in sessions.

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

PEI Priorities:

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

In FY23, 53 students participated in this project. Outlined below are demographics on individuals served through this project:

DEMOGRAPHICS N=53	
Age Groups	
Children/Youth (0-15)	100%
Race	
Black or African American	66%
Declined to Answer (or Unknown)	34%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Other	*
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Other	*
Primary Language	
English	100%
Sexual Orientation	
Declined to Answer (or Unknown)	100%

Disability	
No	72%
Declined to Answer (or Unknown)	28%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	45%
Female	55%
Current Gender Identity	
Declined to Answer (or Unknown)	100%

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

Program Successes:

- *Learning Outcomes*: 6th-grade participants demonstrated significant growth in Literacy on the BUSD STAR Assessment.
- *Learning Experiences*: Participants were exposed to a variety of learning experiences, including field trips, STEM enrichment, and guest speakers
- 6th-grade participants visited the Ramses the Great exhibit at the DeYoung Museum.
- *School Yard Raps*: All participants had the opportunity to attend the Ourstory: The Black History musical. The musical aligned with the program curriculum, and many students reported increased interest and engagement with the performance since they had prior knowledge of the content. Additionally, this learning experience uplifted the significance of Black History Month and allowed students to be affirmed.
- *College Trips*: Umoja 7th graders visited Cal Berkeley and California State University, East Bay.
- *Berkeley Historical Society*: Participants were visited by members of the Berkeley Historical Society, who provided a guest lecture about local Black History that students learned in class.
- *STEM Enrichment Club*: 6th-grade boys gained access to a STEM Enrichment Club provided by Bay Area Sigmas. Four monthly Saturday sessions were held during the second semester. STEM Enrichment Club participants built STEM competencies using science-related activities.
- *BUSD Black History Oratorical Festival*: Umoja participants had a strong showing at the 2023 BUSD Black History Oratorical Festival and, for the third year in a row, placed as finalists for the secondary division. The winner of the 2022 and 2023 secondary division was an Umoja participant. An Umoja participant also placed third in the secondary division for 2023.
- *Community Engagement*: For the fourth consecutive year, Umoja held an annual Kwanzaa recognition. The 2022 Kwanzaa event was a great success and brought together many

families and staff for an evening of celebration and shared learning.

- *Professional Development:* The Umoja team provided professional learning opportunities for Longfellow staff, including an annual presentation to support them in preparing for Black History Month.
- The Umoja team joined professional learning efforts provided under the BUSD African American Success Framework, which provided a year-long cultural competence training series for Longfellow staff.
- *Collaboration*: The Umoja instructor actively collaborated with the Longfellow team to create a safe, welcoming, and inclusive school environment by helping to organize and host community engagements like the annual Rites of Passage Ceremony. They also attended Grade Level Team meetings, Content/Department Team meetings, IEP meetings, etc., to support Umoja participants. Their voices and perspectives about best supporting African-American students should be highlighted as a valuable resource to the school community.
- *Partnerships*: The Umoja team strategically partnered with organizations to meet program needs, including The City of Berkeley, The Mind of Milan LLC, AM1 Media, Freedom Soul Media Education Initiatives, Jason Seals and Associates, Bay Area Sigmas, Marcus Books, RT Fisher Educational Enterprises, and the Berkeley Public School Fund. These organizations provided financial support, subject matter expertise, services, and resources to keep the program running.

Program Challenges:
During the fiscal year, the program did not serve 8th-grade students as in past years. This caused a slight reduction in the number of participants served. Confusion regarding the course selection process and available options likely contributed to this circumstance.

The projected numbers of individuals to be served in FY25 per each age group are as follows:
0-15 years = 55 individuals.

ACCESS AND LINKAGE TO TREATMENT

Access and Linkage to Treatment Program – Connects children who are seriously emotionally disturbed, and adults and seniors with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs.

PREVENTION & EARLY INTERVENTION COMBINED PROGRAM WITH ACCESS AND LINKAGE TO TREATMENT COMPONENT STRATEGY

Access and Linkage to Treatment Program or Strategy – Connects children who are seriously emotionally disturbed, and adults and seniors with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs.

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

Early Intervention Program – Provides treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that may result from untreated mental illness.

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

High School Youth Prevention Program

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

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

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

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

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

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

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

PEI Priorities:

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

During the reporting timeframe, The Health Center resumed hosting a cohort of three graduate-level trainees (0.6 FTE each) due to stabilization of full-time staff capacity, which contributed to increased service capacity for the duration of the 22-23 school year. One full-time (1.0 FTE) Behavioral Health Clinician II obtained a promotional opportunity outside of the City of Berkeley and transitioned out of his role in early August 2022. This position was temporarily vacant and eventually backfilled by a new Behavioral Health Clinician II in late November 2022. One additional full-time (1.0 FTE) Behavioral Health Clinician I position was added to the High School Mental Health team in late October 2022, and this staff was based across multiple sites (0.4 FTE at Berkeley High School; 0.4 FTE at Berkeley Technology Academy; and 0.2 FTE at K-8 School-Based).

In April 2023, as a result of a Division-wide structural reorganization, High School Mental Health became a standalone program separate from Family, Youth & Children's Services. As part of this reorganization, a new full-time (1.0 FTE) Mental Health Program Supervisor position was created. The team's existing full-time (1.0 FTE) Mental Health Clinical Supervisor was promoted into this new position in April 2023, and the Mental Health Clinical Supervisor position has since remained vacant.

In FY23, approximately 244 students received services through this project. Demographics on youth served are outlined below:

DEMOGRAPHICS N=244	
Age Groups	
0-15 Years	24%
16-25 Years	76%
Race	
American Indian or Alaska Native	*
Asian	11%
Black or African American	20%
White	22%
More than one Race	18%
Other	22%

Declined to Answer (or Unknown)	*
Ethnicity: Hispanic or Latino/Latina/Latinx	
Other	32%
Declined to Answer (or Unknown)	*
Primary Language	
English	83%
Spanish	14%
Other	*
Declined to Answer (or Unknown)	*
Sexual Orientation	
Gay or Lesbian	*
Heterosexual or Straight	49%
Bisexual	13%
Questioning or Unsure of Sexual Orientation	*
Queer	*
Another Sexual Orientation	*
Declined to Answer (or Unknown)	21%
Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	34%
Female	65%
Declined to Answer (or Unknown)	*
Current Gender Identity	
Male	31%
Female	55%
Transgender	*
Genderqueer	*
Another gender identity	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

Program Successes:

- Continued to provide the full suite of in-person mental health, reproductive & sexual health, and first aid services for the duration of the school year.
- The Mental Health (MH) team was able to resume its graduate-level training program and provide a wider array of multi-tiered services with the resumption of support groups.
- Substantially increase service utilization year-over-year compared to 21-22 school year.
- Continued to use the Jotform application for referrals in order to streamline accessibility and minimize barriers to care.
- Maintained a collaborative and productive relationship with BHS's Coordination of Services Team (COST) throughout the school year in order to ensure that appropriate referrals were made to the Health Center and other programs.
- Due to a vacancy and new position, the Health Center was able to recruit two diverse, experienced, highly skilled clinicians, one of whom is a native bilingual Spanish speaker. Both new clinicians quickly became part of a cohesive and collaborative mental health team and integrated well into the larger Health Center team.
- Provided an array of crisis support services following the tragic deaths of two BHS students in October 2022.
- Health Center leadership continued to develop strong working relationships with BHS admin, especially the BHS Principal, new Vice Principal of Climate & Wellness, and 504/COST Program Supervisor. Health Center leadership, City of Berkeley HHCS Departmental leadership, and the BHS VP of Climate & Wellness also developed a plan to open a differentiated Wellness Center space at BHS along with a continuum of tiered wellness support services, to be implemented in the 23-24 school year by BHS staff with additional funding support and partnership from City of Berkeley.
- Continued to build upon and improve existing relationships and partnerships with other BHS stakeholders. To this end, the MH team collaborated with several different on-campus programs throughout the year such as the Multilingual Program, McKinney Vento Program, Special Education Program, and Intervention Counselors.

Program Challenges:

- From August through November 2022, one full-time bilingual Behavioral Health Clinician II position was vacant. This vacancy negatively impacted individual and group service provision as well as On Call crisis coverage. Nevertheless, the resumption of a graduate-level training program helped to offset some of these negative impacts.
- Staffing shortages across the Health Center's Public Health team, both administrative and clinical, contributed to less consistently available First Aid and Reproductive & Sexual Health services. This, in turn, negatively impacted students' ability to access integrated services. As a result of reduced administrative capacity, the MH Clinical Supervisor and MH team were also responsible for additional, sometimes time-consuming administrative tasks.
- Quality Assurance (QA)/Quality Improvement (QI) and related encounter data extraction/analysis were constrained for the duration of the 22-23 school year due the to an abrupt resignation of the City IT staff person who managed the Health Center's EHR, NextGen. As a result of this, other City IT staff were not sufficiently cross-trained to provide

technical support. Furthermore, NextGen vendor staff were often unresponsive to the needs and requests of the Health Center program. This contributed to significant delays with data analysis and reporting, which contributed to additional challenges with data collection across demographic categories and also constrained supervisory decision-making that could have improved efficiencies and improvements in service provision.

- The MH team also continued to use multiple EHRs and applications that are not integrated with one another. This made clinical documentation more cumbersome and time-consuming for all staff and also made data collection and analysis more laborious.

The projected numbers of individuals to be served in FY25 per each age group are as follows: 0-15 years = 67 individuals; 16-25 years = 201 individuals**.**

In FY23, the RBA Measures that were established for this program were as follows:

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

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

Measure	**Definition**	**Data Source**
# clients served	Total clients served	ETO/RedCap
# services provided by service type	# of services coded as behavioral_service with codes BHSV1-8. Key code accompanies Redcap data. Each incident could include more than one service provided.	ETO/RedCap
% clients screened for	Percent of total clients that were	ETO/RedCap

Measure	Definition	Data Source
depression, trauma, and substance use	recorded as having been screened for depression, trauma, and/or substance abuse at least one-time during reporting period.	
% referrals to HSHC followed up within one week	Percentage of referrals that had 7 days or less between referral date and response date. Calculation reflects % of total referrals, not % of total clients.	Referral Log
% of school population served	Unique clients served by HSHC divided by total student population	ETO/RedCap; BHS data
% of clients satisfied with services, as measured by % of clients who agree with various statements	% of responses marked as "agree" or "strongly agree" for various survey questions. Note: these responses are from all students who accessed the health center and answered the survey, not just those who received mental health services.	Berkeley SBHC Client Survey
% of clients able to receive needed care, as measured by % of clients who agree with various statements	% of responses marked as "agree" or "strongly agree" for various survey questions. Note: these responses are from all students who accessed the health center and answered the survey, not just those who received mental health services.	Berkeley SBHC Client Survey

Data Development Agenda: measures the team is interested in reporting on but for which reliable data was not available:

- Responsiveness of service (e.g. x days following qualifying event);
- % of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program.

To provide a context for the FY23 RBA outcomes, the High School Health Center expanded its team for the 2022-2023 academic year by hiring two additional full-time employees and welcoming three master's-level interns. These new team members increased the client service capacity as well as reinitiated, group sessions. Significant challenges were with the Electronic Health Records (EHR) system, which impeded the Center’s quality control efforts.

RBA Outcomes in FY23 for this program are outlined on the following pages.

BMH RBA Report FY 2023

Reporting Period: July 2022 - June 2023

High School Health Center (HSHC)

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

244

Clients Served

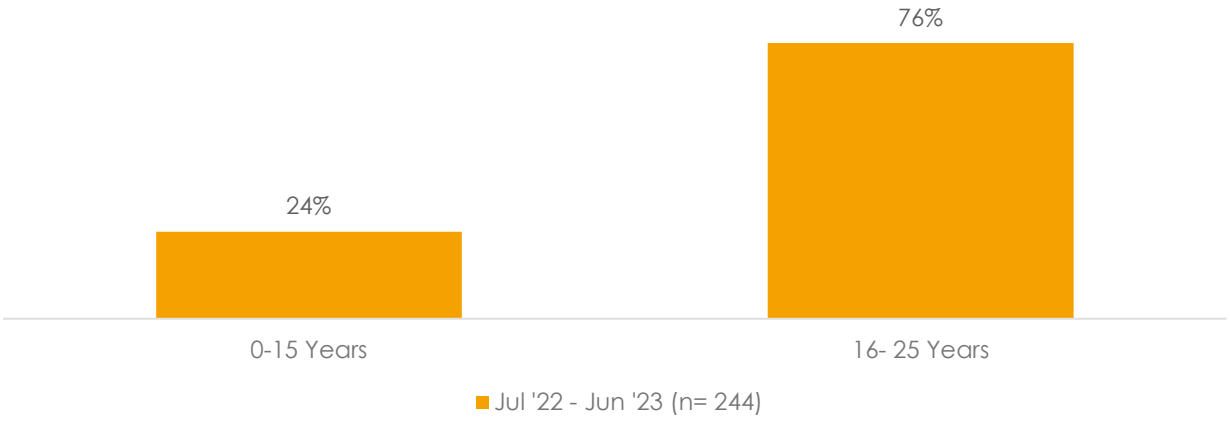
Program Description

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

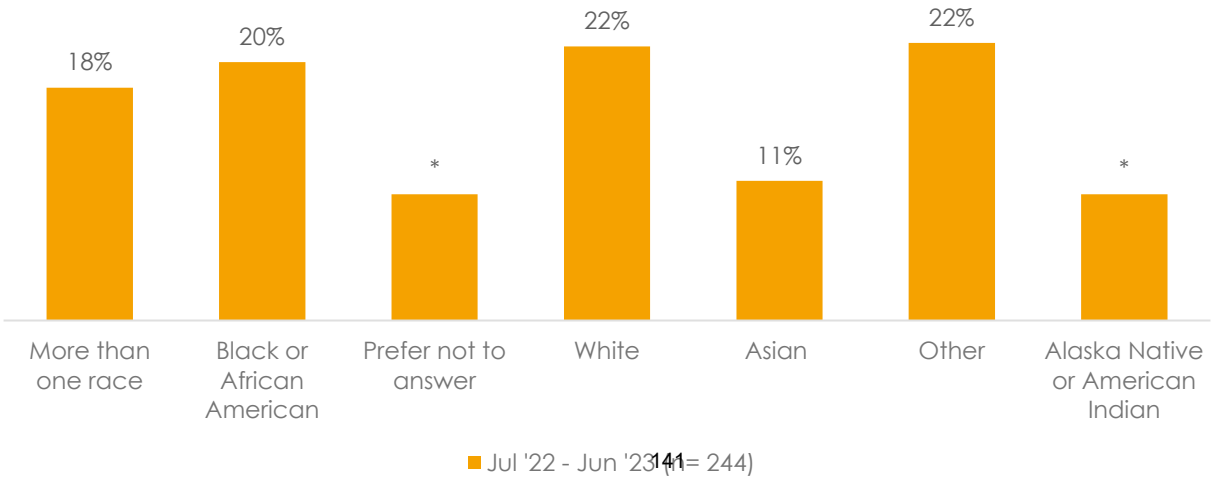
Program Updates

HSHC hired two new full time staff and onboarded 3 master's-level interns in the 2022-2023 school year. This allowed the team to serve more clients and restart groups. HSHC had significant challenges with their EHR, resulting in barriers to quality control.

Demographics (Age)

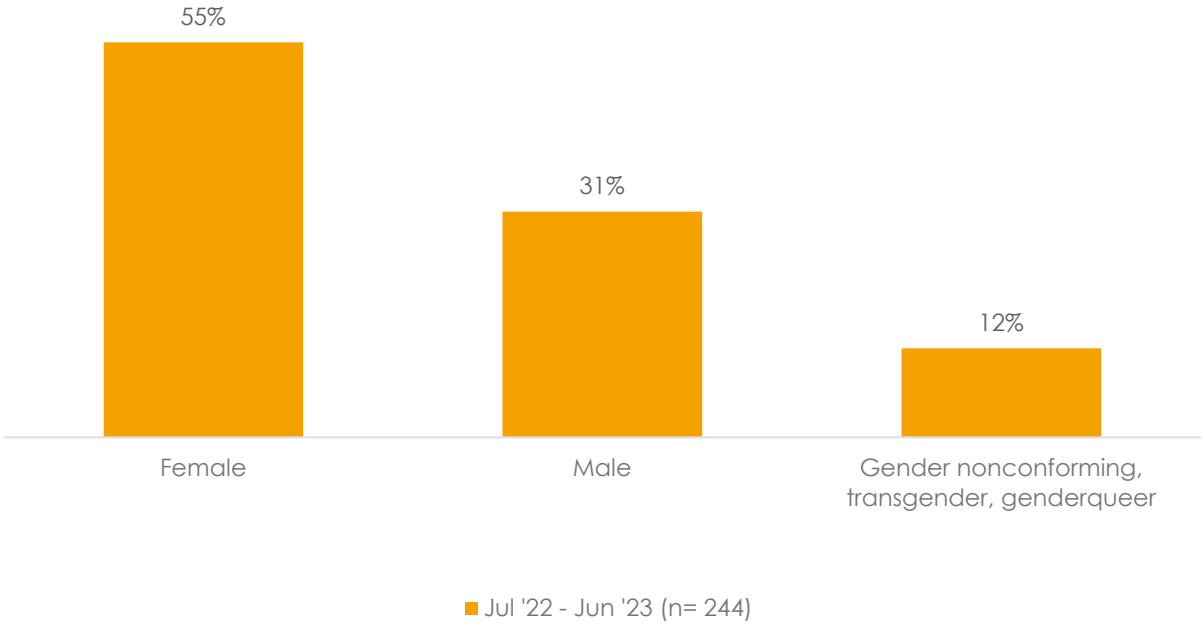


Demographics (Ethnicity)

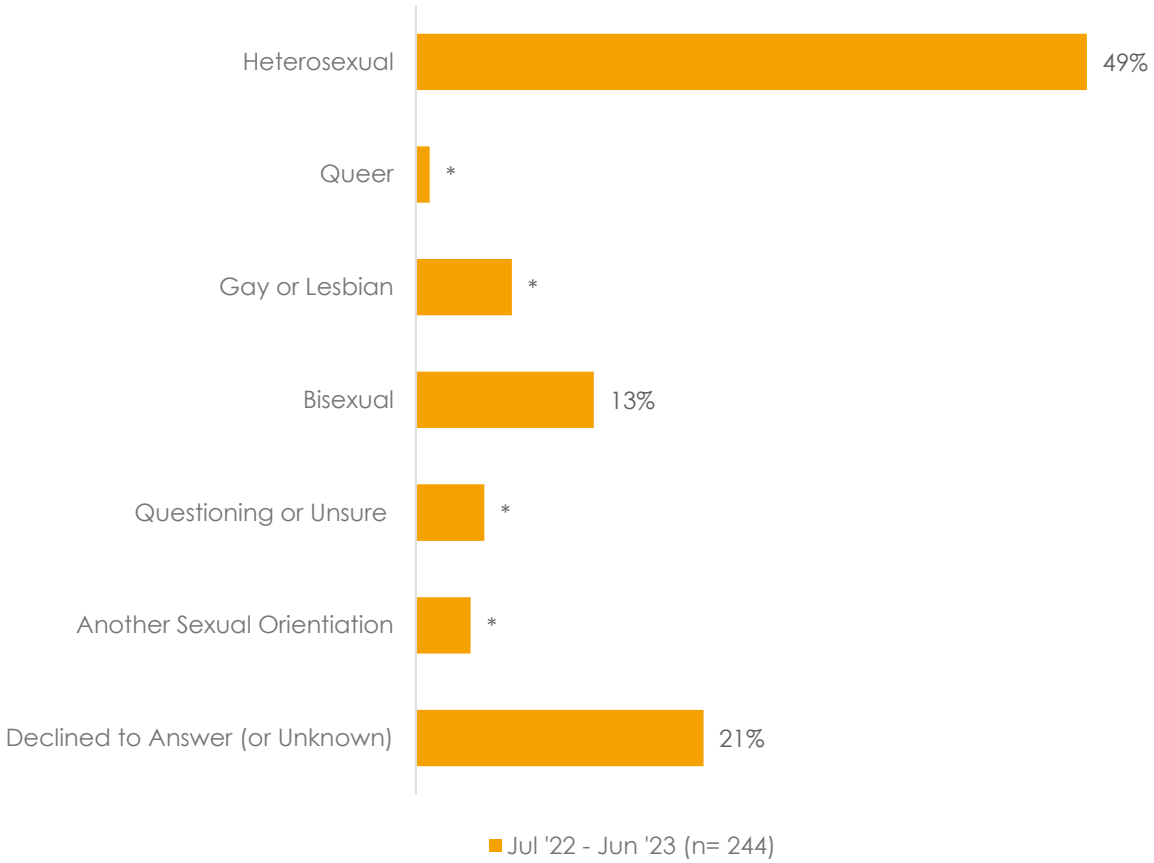


NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Demographics (Gender Identity)

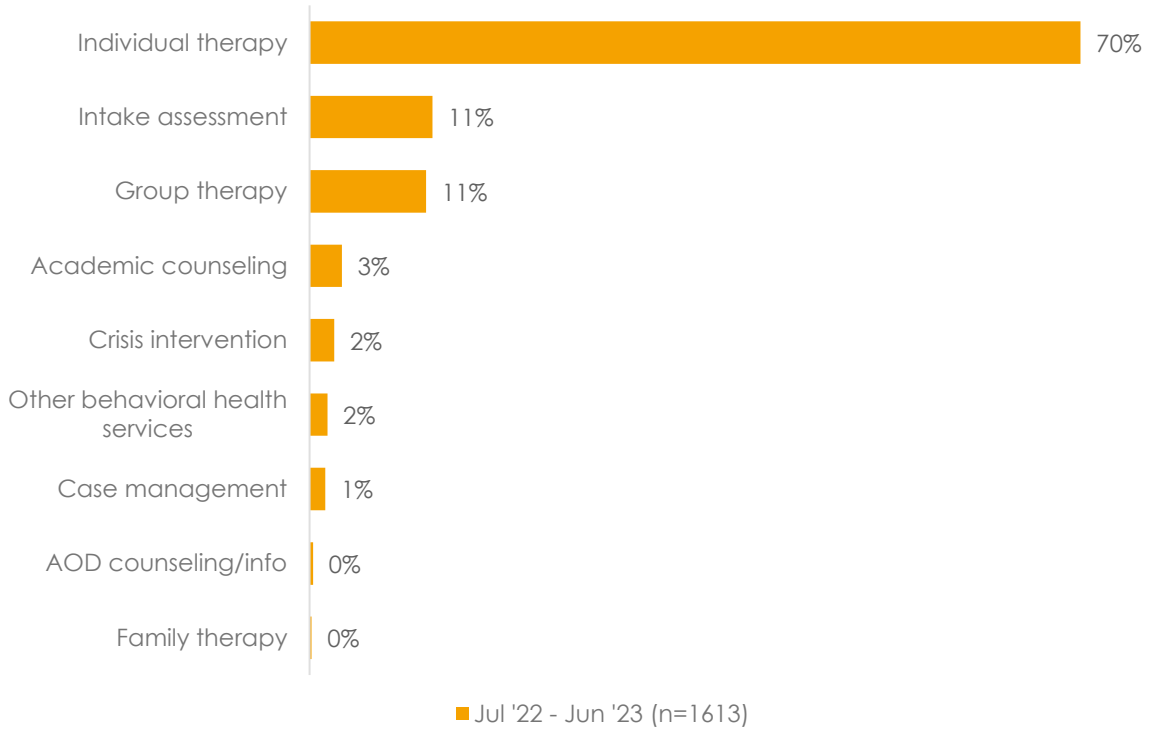


Demographics (Sexual Orientation)



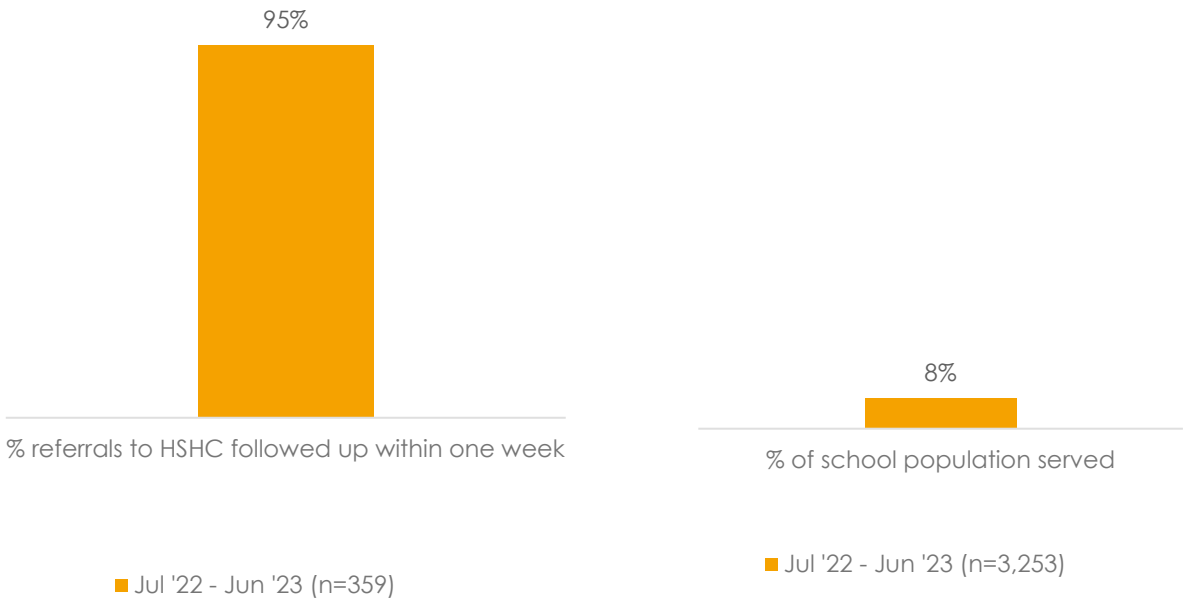
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Services Provided by Service Type

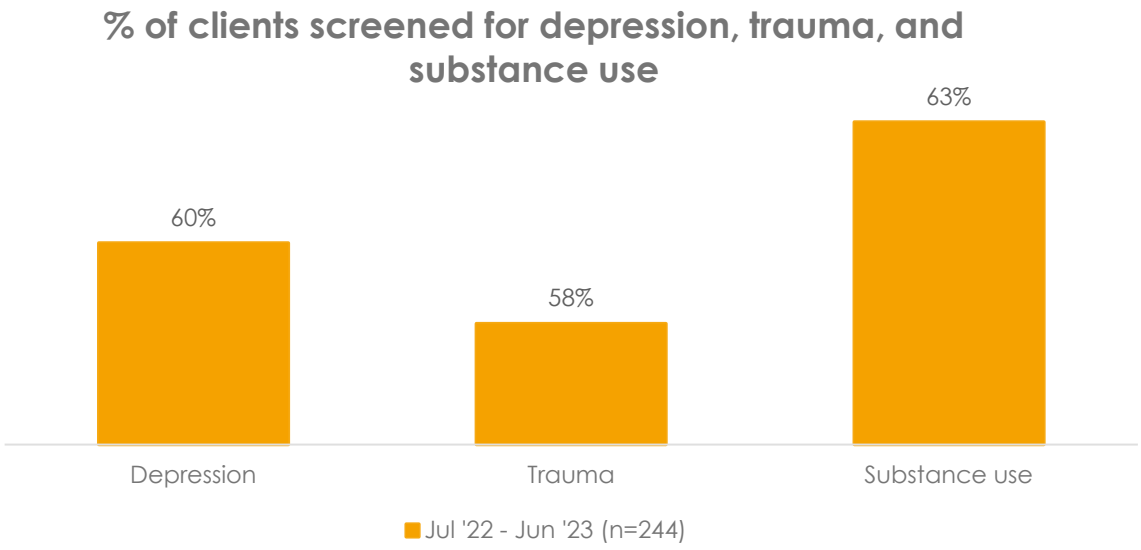


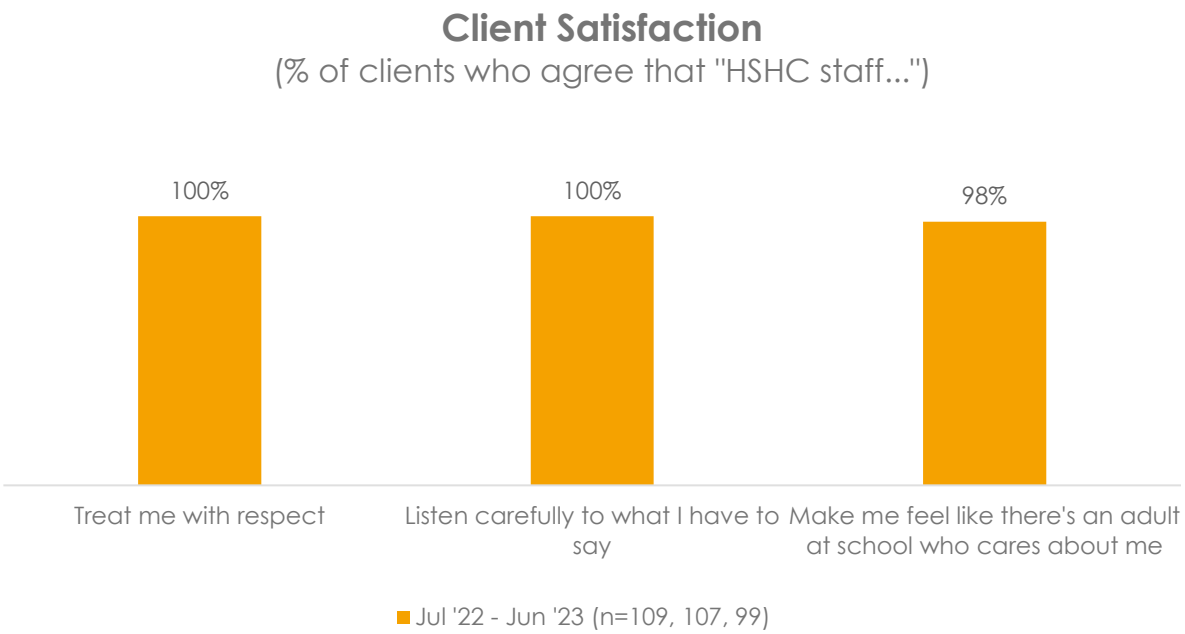
Note that multiple services could be provided in one visit (e.g. crisis assessment and referral) so total services by type is greater than total encounters.

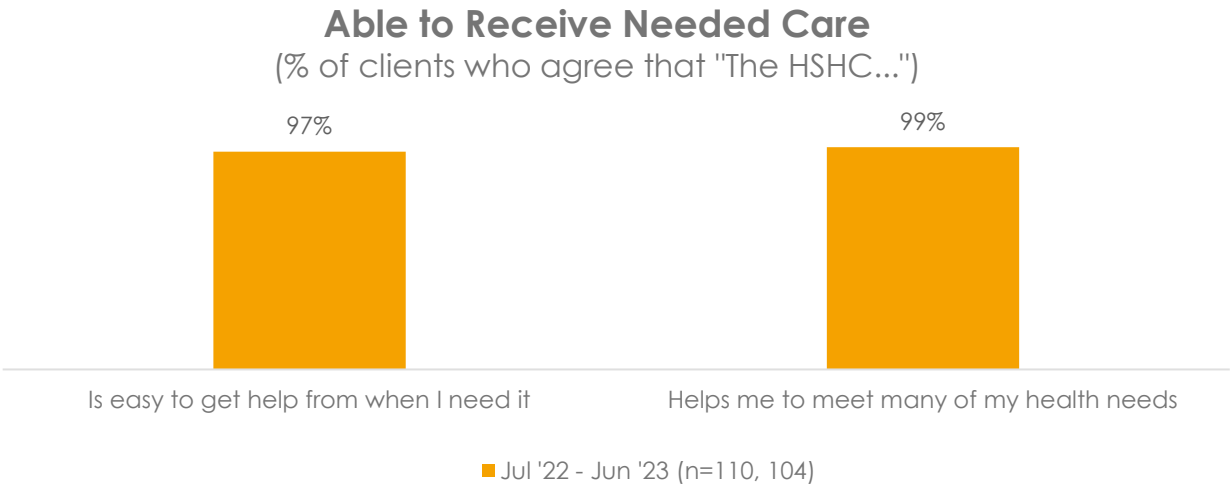
Quality Outcomes ("How well did we do it?")



NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.







NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

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

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

EARLY INTERVENTION PROGRAM
WITH ACCESS AND LINKAGE TO TREATMENT COMPONENT

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.

The City of Berkeley provided one-time PEI funding for a new program that is an Early Intervention program that also has an Access to Treatment component. The program is as follows:

Specialized Care Unit

As outlined in the CSS section of this Annual Update, through the approved FY22 Annual Update, the Division allocated a portion of one-time CSS and PEI funds to be leveraged with other City funds to support the Specialized Care Unit (SCU). Implemented through Bonita House, the SCU is Berkeley's new behavioral health crisis response team without the involvement of law enforcement. The SCU consists of trained crisis-response field workers who respond to behavioral health occurrences that do not pose an imminent threat to safety.

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

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

In FY23, MHSA funds directly supported start-up costs of the program including recruitment, hiring, and training of Bonita House staff. Training included crisis support training through Bonita House's Crisis Training Academy as well as the design and training of Berkeley-specific procedures for the SCU program. Additionally, this funding supported the salaries of the SCU program management staff as additional team members were hired. During this time, program management staff worked closely with the City of Berkeley to create the policies and procedures for a SCU that aligned with the implementation recommendations from the Berkeley community. The SCU began providing services in early FY24, and continues to operate daily from 6am to 4pm, eventually building toward a 24/7 crisis response service without involvement of law enforcement.

STIGMA AND DISCRIMINATION PROGRAM

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

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

Social Inclusion Program

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

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

The Social Inclusion program was created to combat stigma, attitudes and discrimination around individuals with mental health issues. Through this program, a “Telling Your Story” group provides mental health peers with opportunities to be trained, compensated and empowered to share their stories of healing in a supportive peer environment. When they feel ready, individuals can elect to be community presenters, sharing their inspirational stories at pre-arranged local public venues to dispel myths and educate others. This program serves approximately 10-20 individuals a year.

In FY23, 10 unduplicated individuals participated in the program. Demographics on program participants served were as follows:

DEMOGRAPHICS N= 10	
Age Groups	
26-59 (Adult)	*
Ages 60+ (Older Adult)	*
Race	
Black or African American	*
White	*
Other	*

Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican/Mexican-American Chicano	*
Puerto Rican	*
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	*
Eastern European	*
Other	*
Declined to Answer (or Unknown)	*
Primary Language Used	
English	100%
Sexual Orientation	
Heterosexual or Straight	*
Bisexual	*
Declined to Answer (or Unknown)	*
Disability	
Difficulty Seeing	*
Difficulty Hearing	*
Mental Domain not including a mental illness	*
Physical Mobility domain	*
Chronic Health Condition	*
Other (Specify):	*
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	*
Female	*
Current Gender Identity	
Male	*
Female	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

Program Successes:
In FY23, the Telling Your Story group has grown to having more consistent attendees in person and on the zoom platform. Some participants enjoyed having the group virtually in the comfort of their home, they felt safer, and the hassle of commuting was eliminated. Other individuals enjoyed connecting in-person with participants who, joined the group in the same way. The group continued to be conducted through the structure of a brainstorming session and a sharing component. The topics of discussion were focused on the Eight Dimensions of Wellness. Per staff report, many participants benefitted from listening to answers to questions that staff developed based on the topics of discussions, as well as through staff assistance with formulating their story. Per staff report, participants felt more prepared during their shares and enjoyed the support they received from their peers.

Program Challenges:
In FY23, the Telling Your Story group had a few challenges, which provided the staff have been working to improve to make the group more enjoyable for all participants. Over the course of the last two years, staff hosted the group online and in-person and at times, this caused some delays to the start of the group due to individuals arriving at different times and having to update all participants. Managing and making sure everyone engaged was difficult as individuals who joined by Zoom, called in so staff were unable to see participants faces. For individuals who primarily come to the group on Zoom, the questionnaire that required their feedback went unanswered, therefore staff wasn't able to obtain a full report of how the group was helping individuals to feel confident with sharing their story. Managing both platforms can be complicated and it lacks the in-person connection. This group was held twice a month and even though there was a brainstorming session of topics to discuss, some members didn't seem to come prepared to share based on the topic at the next group and this may be due to memory or not fully being engaged in the group when people are calling in on Zoom. The last challenge was the number of participants, a very consistent group of individuals participated, however staff would like to do more outreach to engage potential group participants, in an effort make a positive impact for more individuals in the community.

The projected numbers of individuals to be served in FY25 per each age group are as follows: 18-25 years = 2 individuals; 26-59 years = 6 individuals; 60+ = 4 individuals.

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

SUICIDE PREVENTION PROGRAM

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

The City of Berkeley has one Suicide Prevention Program through a partnership with the California Mental Health Services Authority as follows:

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

In 2009, California's counties formed the California Mental Health Services Authority (CalMHSA) as a Joint Powers Authority. Contributing jurisdictions are members of a CalMHSA board that provides direction into the types of initiatives that are implemented. One of the initiatives that was implemented is the PEI Statewide Projects. With an approved combined funding level of $40 million per year for four years during the timeframe of 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 mental health jurisdictions. In order to continue to sustain programming, CalMHSA previously asked jurisdictions to allocate 4% of their annual local PEI allocation each year to these statewide initiatives. In the City of Berkeley, this has varied from year to year depending on the amount of PEI revenue received.

In FY23, through this initiative resources on Suicide Prevention, Student Mental Health and Stigma and Discrimination reached approximately 1,624 individuals. Additionally, resources were distributed via email to local schools, community agencies and community members.

At present, the City has approximately $153,901 of unspent funds that were previously allocated to CalMHSA for this initiative. As a result, through this Annual Update, the Division is proposing to eliminate the allocation of local annual PEI funding for this initiative. Additionally, the Division will either utilize the previously allocated funds that are remaining at CalMHSA, to continue this initiative for a short-time, or to have the funds returned to the City for local use.

INNOVATION (INN)

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

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

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

- Mental Health services and supports for LGBTQI located in community agencies.

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 state identified outcome measures and detailed demographic information. INN Evaluations are required to be included in each MHSA Annual Update or Three-Year Plan. The Innovation (INN) Fiscal Year (FY) 2021/2022 (FY22) Annual Evaluation Report is located in Appendix E of this Three-Year Plan.

A description of INN Programs and FY23 data are outlined below:

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 allocated INN funding to participate in a Statewide Collaborative with other California counties to pilot a Mental Health Technology Project that made various technology-based mental health services and supports applications (Apps) locally available in Berkeley.

The Help@Hand Project was implemented to learn whether the use of Apps would increase access to mental health services and supports; and whether it would lead to better outcomes. The Division worked both internally and with the California Mental Health Services Authority (CalMHSA), the fiscal intermediary for this project, to prepare for citywide implementation of this project. 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 either lived, worked or attended 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. Following that time frame the BMH MHSA Coordinator has served as the Project Coordinator for this project. On behalf of the City and with locally designated Help@Hand project funds, CalMHSA

executed a contract with Uptown Studios, 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 in Berkeley for a limited timeframe. The MyStrength App was available through October 2022 and the HeadSpace App was available through September 2023. During the duration of the project there were 1,720 enrollees in MyStrength and 7,328 enrollees in HeadSpace.

The Division 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 Division entered into a contract with Hatchuel, Tabernik & Associates to conduct a local evaluation of this project. The evaluations are currently underway and will be reported on in future MHSA Plans and Annual Updates.

Each App company collected and provided reporting on various user data measures. Local usage data provided by each App is outlined on the following pages.

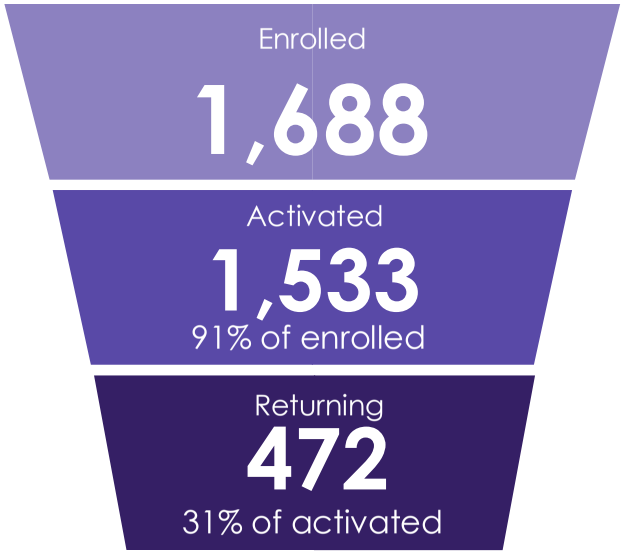
myStrength scorecard

City of Berkeley

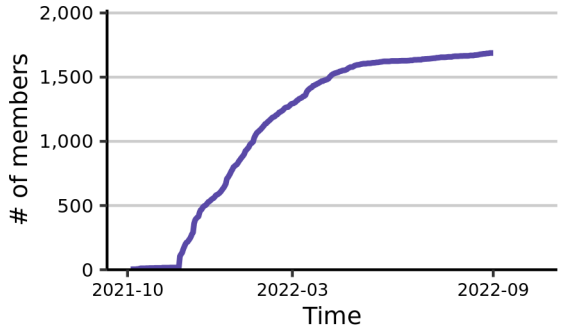
159

Program launch: 2021-09-20 Data thru: 2022-08-31

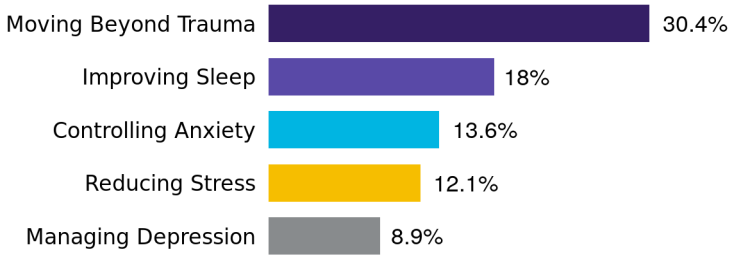
Members enrolled



Enrollment trends



Top 5 digital recommendations



Program engagement

Average 90 day member engagement rates (% of returning)

153

14%
65/472
Logged in

4%
20/472
Completed activity

NA%
NA/472
Used engagement guidance

3 average logins/member

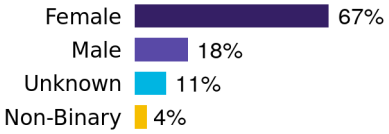
4 average activities completed/member

NA average messages sent to guide/member

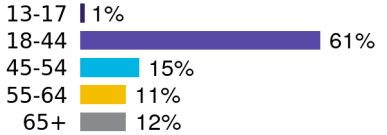
Member demographics

(% of enrolled)

Gender



Age Group



myStrength scorecard

City of Berkeley

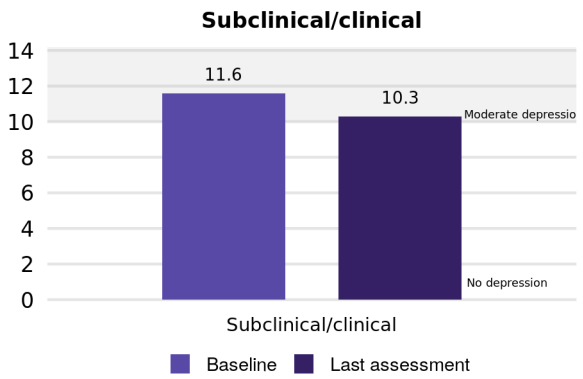
160

Program launch: 2021-09-20 Data thru: 2022-08-31

Depression outcomes

Clinical and subclinical population

Scored 5 or more in the PHQ-9 assessment



68.1%

Maintained or improved

40.5%

Clinically Improved

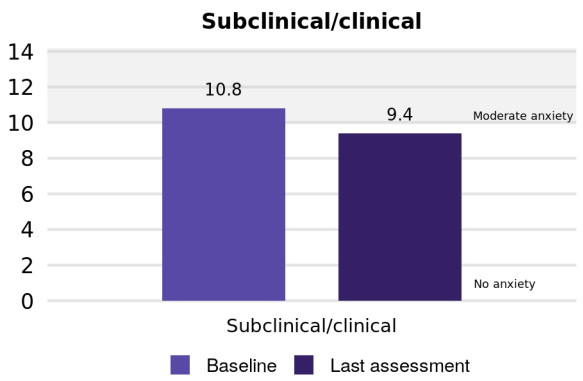
Started with scores ≥15 and decreased their score by at least 5 points

A PHQ-9 score indicates the severity level of a member's symptoms, where a score of 0-4 is nonclinical, 5-14 is subclinical, and 15+ is clinical.

Anxiety outcomes

Clinical and subclinical population

Scored 5 or more in the GAD-7 assessment



72.4%

Maintained or improved

25.8%

Clinically Improved

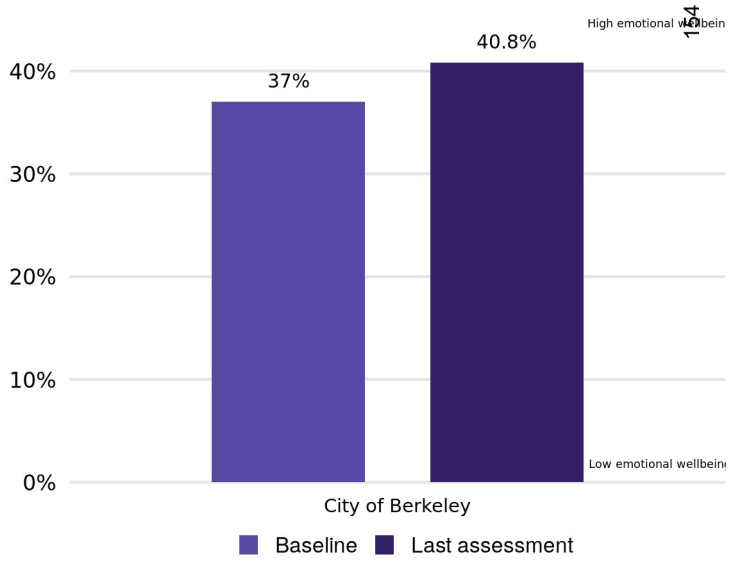
Started with scores ≥15 and decreased their score by at least 5 points

A GAD-7 score indicates the severity level of a member's symptoms, where a score of 0-4 is nonclinical, 5-14 is subclinical, and 15+ is clinical.

Wellbeing outcomes

28.4%

Of members' wellbeing improved at least 10% (Clinical definition of improvement)



A WHO-5 score below 52% (13 points) indicates poor well-being.

161

DATA DEFINITIONS

Members enrolled

Enrolled: Number of members who registered and successfully enrolled

Activated: Number of members who completed the onboarding assessment

Returning: Number of activated members who have logged into the myStrength program at least once after onboarding assessment completion

Enrollment trends: Number of members who have enrolled (current enrolled) over time since the program launch date

Top 5 digital recommendations

The percentage of returning members that were recommended "Just for You" content or digital courses and programs.

Program engagement

Logged in: The percentage of returning members that logged into the myStrength application via the mobile app or the myStrength website at least once in the last 90 days.

Completed activity: The percentage of returning members that completed at least one activity in the last 90 days. Members must click the "Finish" button after going through all the steps in order to be counted.

Engagement guidance: The percentage of returning members that have sent at least one message to a guide in the last 90 days.

*N/A will display if engagement guidance is not a part of the program that was purchased

155

Clinical outcomes

PHQ-9 is a validated depression screening tool. Total score is between 0 and 27 with higher scores meaning more symptoms. Metrics show % of members who have taken the PHQ-9 assessment at least twice – once at baseline and at least once more after baseline.

GAD-7 is a validated anxiety screening tool. Total score is between 0 and 21 with higher scores meaning more symptoms. Metrics show % of members who have taken the GAD-7 assessment at least twice – once at baseline and at least once more after baseline.

WHO-5 is a validated measure of general wellbeing (not a specific diagnosis or problem). Total score is between 0 and 25 with lower scores showing lower quality of life and higher scores showing higher quality of life. Raw scores are multiplied by 4 to get a percentage score. Metrics show % of members who have taken the WHO-5 assessment at least twice – once at baseline and at least once more after baseline.

*For each clinical outcome, the reported population has at least 10 members in the program and completed at least two assessments.

headspace

City of Berkeley

Enrollment

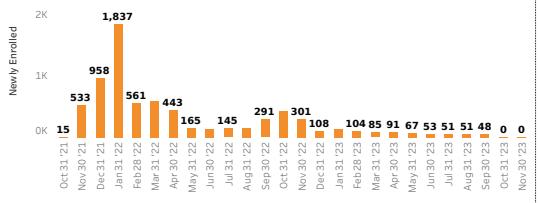
Current Members

Number of people (employees) from my organization enrolled to Headspace

New Enrollments

Number of new member enrollments by Month

For week view, weeks may include enrollments from prior/future month if these dates are in the chosen period; Week start is on Sunday and week end is on Saturday



Employee

Engagement

Headspace Minutes in None

Total minutes using ALL Headspace content within calendar year

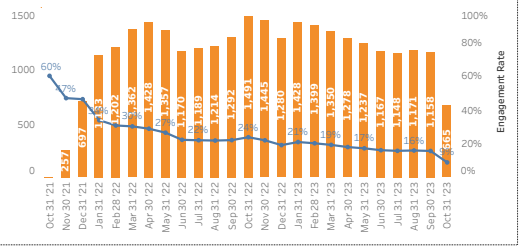
Minutes Meditated in None

Total minutes using meditation content within calendar year

Monthly Active Users

MAU: Number of enrolled members who have engaged with at least 1 piece of content in Headspace in the previous 30 days

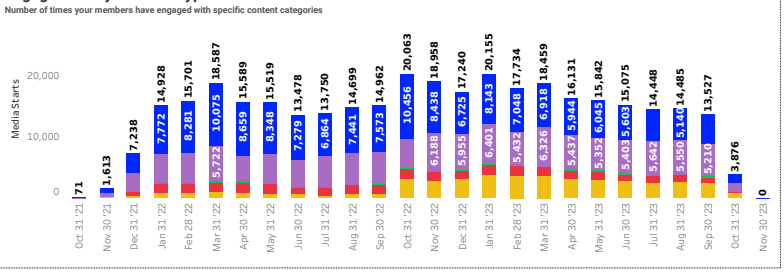
Engagement Rate: Percentage of total enrolled members who have engaged with at least 1 piece of content in Headspace in the previous 30 days



Engagement Rate MAU

Engagement by Content Type

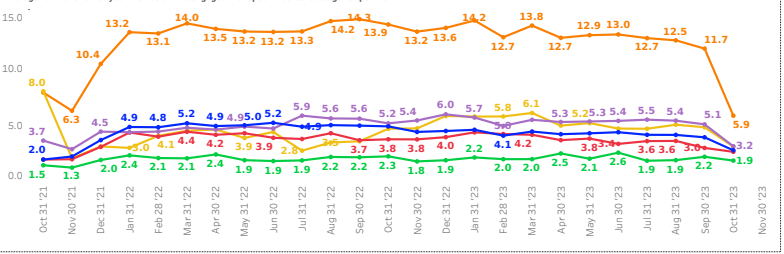
Number of times your members have engaged with specific content categories



Meditation Sleep Move Wakeup Focus

Depth of Engagement per Active User

Average number of times your members have engaged with specific content categories per month



Meditation Sleep Move Wakeup Focus ALL

Top 15 Courses

Percentage of sessions from courses over choosen period

Managing Anxiety	14.1%
Basics	10.8%
Letting Go of Stress	9.3%
Basics 2	5.3%
Sleep	4.2%
Basics 3	3.8%
Finding Focus	3.4%
Pro | Level 1	2.5%
Self-Esteem	2.4%
Headspace 365	2.4%
Acceptance	2.4%
Balance	2.3%
Handling Sadness	1.6%
Navigating Change	1.6%
Creativity	1.4%

Top 15 Non-Courses

Percentage of sessions from non-course content over choosen period

The Wake Up	9.3%
Goodnight	3.0%
Sleeping	2.4%
Everyday Headspace	2.1%
Doze	1.8%
Falling Back to Sleep	1.2%
Switching Off	1.2%
Unguided	1.0%
Rain on Rocks	0.9%
Take 5 Cleansing Breaths	0.9%
60 Seconds of Mindful Bre..	0.8%
Treat Yourself to 5 Gentle..	0.8%
Feel the Benefits of 5 Dee..	0.8%
1-Minute Breathing Exerc..	0.8%
Enjoy 5 Deep Breaths	0.8%

If you have issues or questions on your organization's report, please reach out to your customer success manager or contact teamsupport@headspace.com.

Encampment-based Mobile Wellness Center Project

In April 2022, the Division received approval to implement an Encampment-Based Mobile Wellness Center Project from the Berkeley City Council and the State Mental Health Oversight and Accountability Commission (MHSOAC). This new project will pilot a Mobile Wellness Center at Homeless encampments in Berkeley. The Mobile Wellness Center project 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 Options Recovery Services who was chosen through a competitive Request For Proposal (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. The program will include an evaluation which will be reported on in future MHSA Plans and Annual Updates. It is envisioned that the program will be implemented in early FY25.

WORKFORCE, EDUCATION & TRAINING (WET)

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

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

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

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

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

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

The Department of Health Care Access and Information (HCAI) (formerly the Office of Statewide Health Planning and Development) allocated $40 million in Workforce, Education and Training funds through FY25 for Regional Partnerships across the state for various mental health workforce strategies. A total of 2.6 million of funds was allocated to the Greater Bay Area (GBA) Workforce, Education & Training Regional Partnership. In order to participate in the GBA Regional Partnership, and receive a portion of funds to implement workforce development strategies, mental health jurisdictions were required to contribute a portion of local funds towards this initiative. The Division allocated funds for this program through previously approved MHSA Plans and Annual Updates.

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

In FY23, the first round of applications for this program were executed. The results of this program will be included in future Annual Updates and Three Year Plans.

Workforce Development Coordinator

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

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

This position that was hired in early FY24, supports staff recruitment and retention for the Division; oversees Intern recruitment; and coordinates training and support for graduate level interns.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

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

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

Clinic. The Adult Clinic serves Berkeley's most at-risk and fragile population through crisis intervention, case management, individual/or group supports, psychiatric medication support, Full Services Partnership Intensive Case Management Teams, Clinical services, Mobile Crisis, and Transitional Outreach Services. Construction on the Adult Clinic began in FY19, and in June 2021, the renovation was completed, staff moved back into the building, and the clinic was re-opened for services.

FY23 AVERAGE COST PER CLIENT*

*(Includes FY23 expenditures attributed to the MHSA Funding component)

COMMUNITY SERVICES & SUPPORTS			
Program Name	**Approx. # of Clients**	**Cost**	**Average Cost Per Client**
Children's FSP	12	$270,371**	$22,531
Adult FSP	63	$738,190***	$11,717
Homeless FSP	47	$708,147	$15,066
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; Case Management for Older Adults)	1,914	$2,211,958	$1,156
PREVENTION & EARLY INTERVENTION			
Early Child Health and Wellness Program (formerly Be A Star)	255	$33,871	$133
Supportive Schools Program	814	$93,676	$115
Living Well Project	73	$32,046	$439
LGBTQI Trauma Project	261	$100,000	$383
TAY Trauma Project	83	$32,046	$386
SoulSpace Project	35	$100,000	$2,857
Trauma Project for Latinx	339	$100,000	$295
High School Youth Prevention Program	244	$447,887	$1,836
Dynamic Mindfulness (DMIND)	616	$95,000	$154
African American Success Project	53	$141,475	$2,669

**Children's FSP also incurred $115,873 in MediCal expenditures

***Adult FSP also incurred $534,552 in MediCal expenditures

BUDGET NARRATIVE

The enclosed budget provides estimated revenue and expenditures for this Annual Update. The Division obtains financial projections from the state on the amount of MHSA revenue to be allocated in a given year. Financial projections for this FY25 Annual Update reflect an increase in MHSA funds, to what was previously estimated in the approved FY24-26 Three Year Plan.

The projected additional revenue in FY25, and savings from previous years (due to staff vacancies, slower start-ups with new programs, etc.), will assist in providing funding to support MHSA programs and services over the next couple of years should the MHSA fund begin to decrease.

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 FY26 Annual Update.

APPENDIX A

PROGRAM BUDGETS

FY 2024/25 Mental Health Services Act Annual Update
Funding Summary

County: City of Berkeley

Date: 6/24/24

	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 FY24/25 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	13,247,388	4,154,447	2,413,336	42,609	0	
2. Estimated New FY2024/25 Funding	6,414,353	1,603,588	421,997			
3. Transfer in FY 2024/25	(208,654)			208,654		
4. Transfer Local Prudent Reserve in FY 2024/25						
5. Estimated Available Funding for FY 2024/25	19,854,171	5,806,142	2,847,993	251,263	0	
B. Estimated FY24/25 Expenditures	8,608,952	2,165,302	600,000	208,654	0	
G. Estimated FY24/25 Unspent Fund Balance	11,245,219	3,640,840	2,247,993	42,609	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Unspent Local Prudent Reserve on June 30, 2024	1,233,738
2. Contributions to the Local Prudent Reserve in FY2024/25	0
3. Distributions from the Local Prudent Reserve in FY2024/25	0
4. Estimated Local Prudent Reserve balance on June 30, 2025	1,233,738

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

FY 2024/25 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: City of Berkeley Date: 6/24/24

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. TAY, Adult & Older Adult FSP	2,173,000	2,173,000				
2. Children's FSP	717,159	717,159				
3. Homeless FSP	1,453,532	1,453,532				
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	111,923	111,923				
2. CSS System Development	2,786,471	2,786,471				
3.						
4.						
5.						
6.						
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	1,158,212	1,158,212				
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	8,400,298	8,400,298	0	0	0	0
FSP Programs as Percent of Total	51.7%					

FY 2024/25 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: City of Berkeley Date: 6/24/24

	Fiscal Year 2024/25					
	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	450,280	450,280				
2. Social Inclusion	10,000	10,000				
3. African American Success Project	37,500	37,500				
4. Dynamic Mindfullness	71,250	71,250				
5. Mental Health Peer Education Program (MEET)	34,792	34,792				
6. Mental Health Promotion Campaign	100,000	100,000				
7.						
8.						
9.	0	0				
10.	0	0				
PEI Programs - Early Intervention						
11. Community Education & Supports	364,092	364,092				
12. High School Prevention Program	450,280	450,280				
13. African American Success Project	112,500	112,500				
14. Dynamic Mindfullness	23,750	23,750				
15. Mental Health Peer Education Program (MEET)	11,597	11,597				
16. Supportive Schools	110,000	110,000				
17.						
18.						
19.						
PEI Programs - Stigma & Discrimination						
20.						
PEI Programs - Outreach for Incr. Recog. Of Mental Illness						
21.						
PEI Administration	389,262	389,262				
PEI Assigned Funds						
Total PEI Program Estimated Expenditures	2,165,302	2,165,302	0	0	0	0

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

County: City of Berkeley Date: 6/24/24

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. MHSA INN Encampment	600,000	600,000				
2.						
3.						
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration						
Total INN Program Estimated Expenditures	600,000	600,000	0	0	0	0

FY 2024/25 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: City of Berkeley Date: 6/24/24

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce Development Coordinator	208,654	208,654				
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	208,654	208,654	0	0	0	0

FY 2024/25 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: City of Berkeley Date: 6/24/24

	Fiscal Year 2024/25					
	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.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
CFTN Programs - Technological Needs Projects						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
CFTN Administration						
Total CFTN Program Estimated Expenditures	0	0				

APPENDIX B

RESULTS BASED ACCOUNTABILITY (RBA)
FY23 BERKELEY MENTAL HEALTH DIVISION
MEASURES AND OUTCOMES

BMH RBA Report FY 2023

Reporting Period July 2022 - June 2023

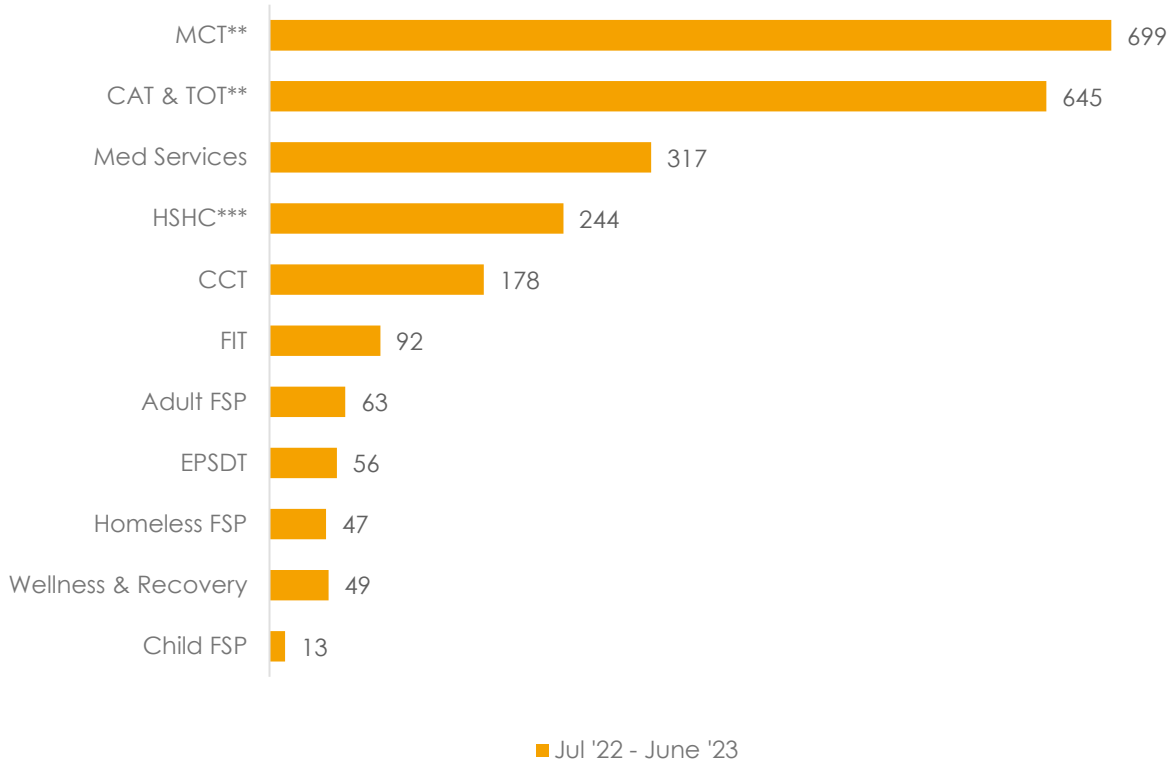
Berkeley Mental Health - Division-Level

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

Description Berkeley Mental Health provides mental health services to eligible adults, children, youth, and their families. Services focus on low-income residents and unhoused people with severe mental illnesses. Staff provide counseling and case management services with the goal of helping people to better manage their mental health symptoms, obtain and maintain housing and other community resources, and move forward in their recovery.

701 **Unduplicated Clients Served (includes FSPs, CCT, FIT, ERMHS, EPSDT, HSHC, Medical Services, and Wellness)**

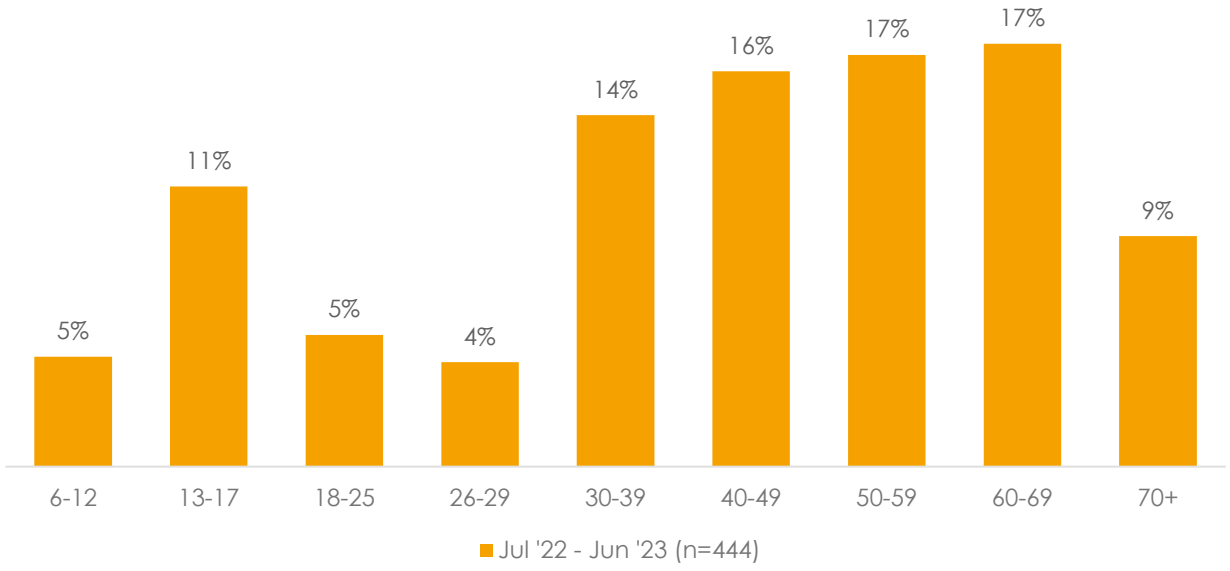
Clients Served, by Program*



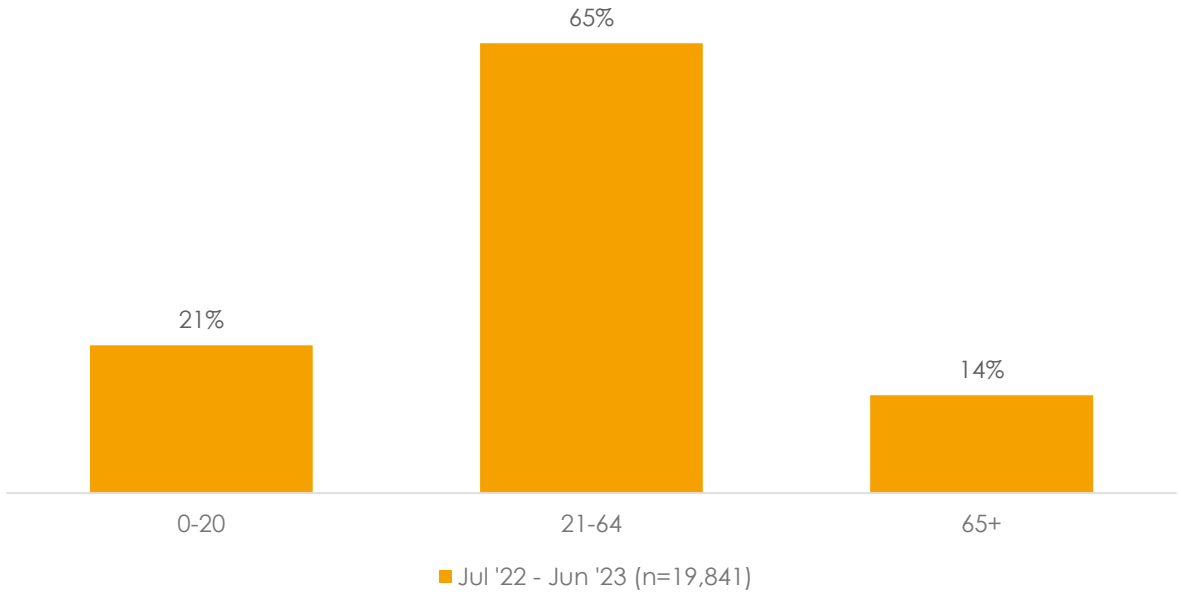
*A single client may be served by multiple programs, but these are unduplicated numbers within each program
**All but MCT and CAT & TOT include only clients who have gone through a service enrollment process
***HSHC reports data on the school year, so does not have data for Jul '22 - Dec '22

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

BMH Demographics (Age)

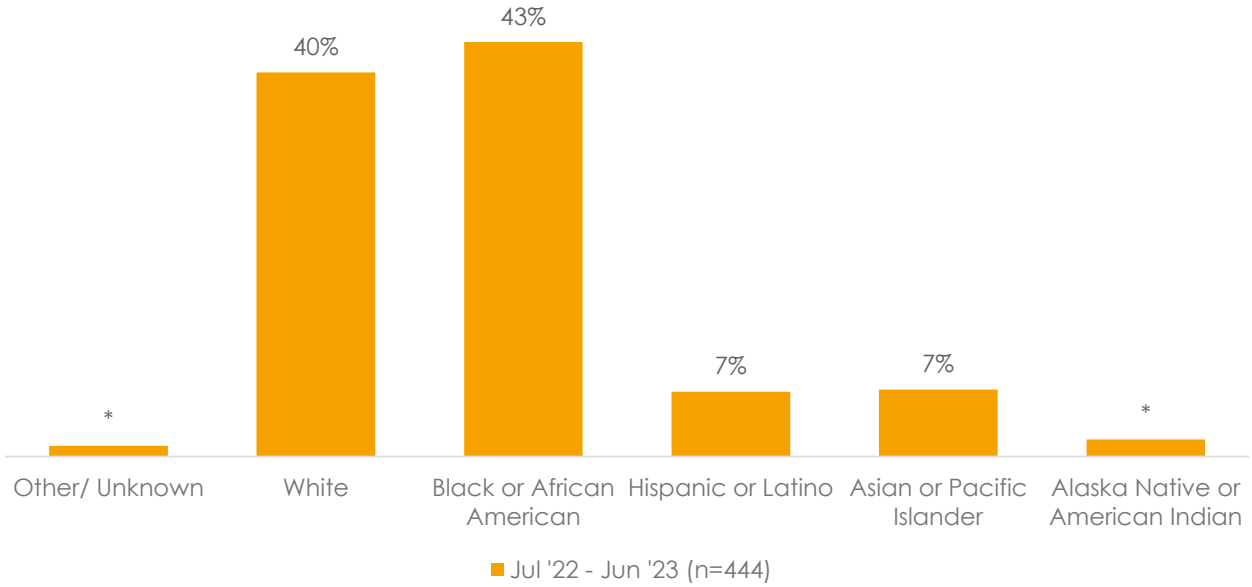


Medi-Cal Demographics (Age)

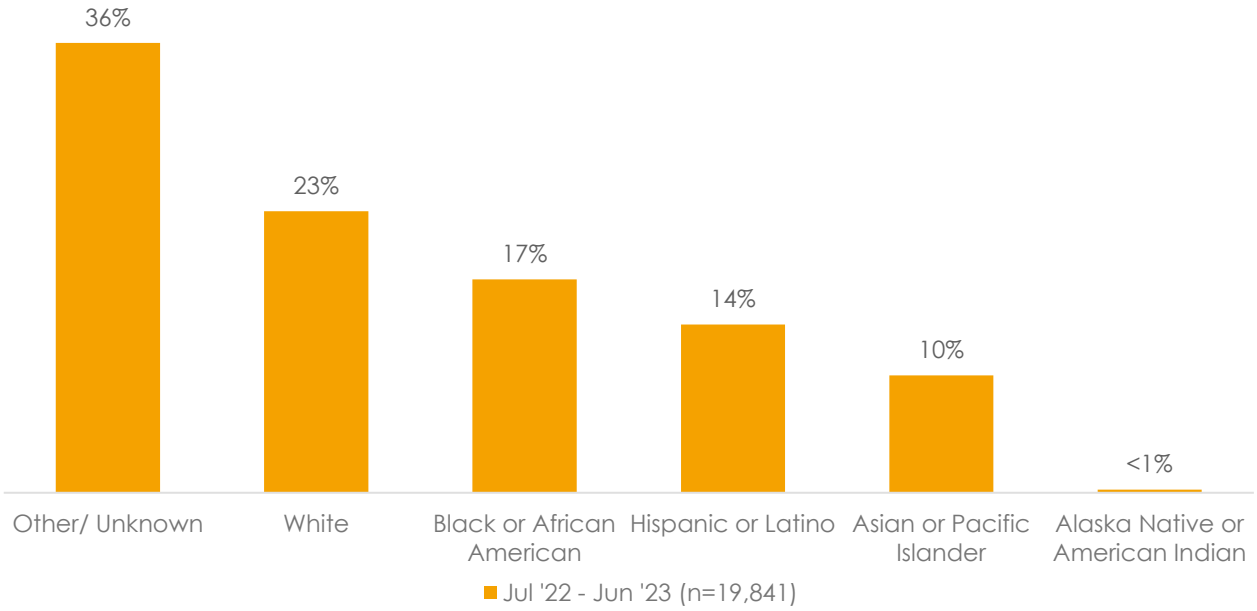


NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

BMH Demographics (Ethnicity)

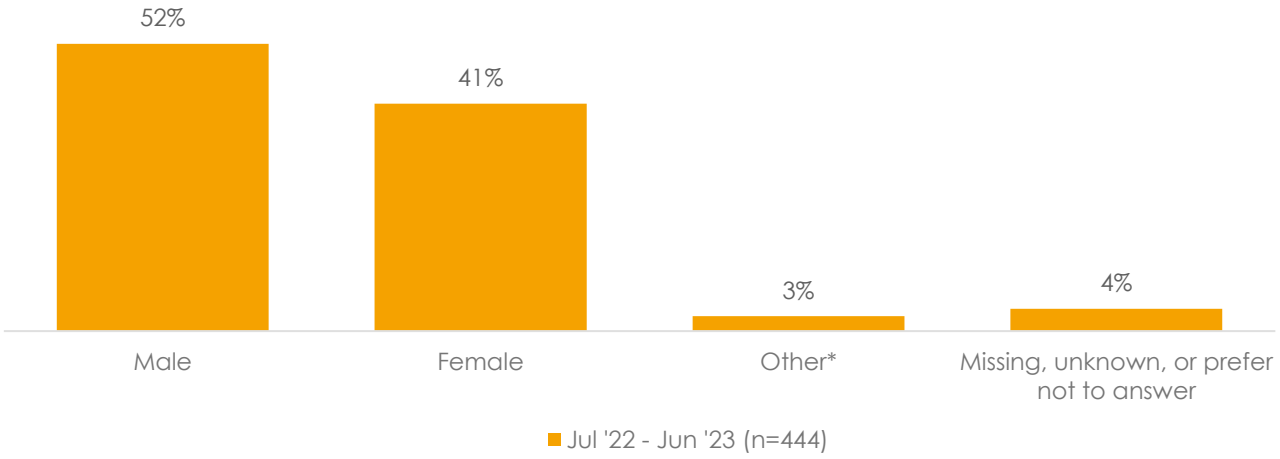


Medi-Cal Demographics (Ethnicity)



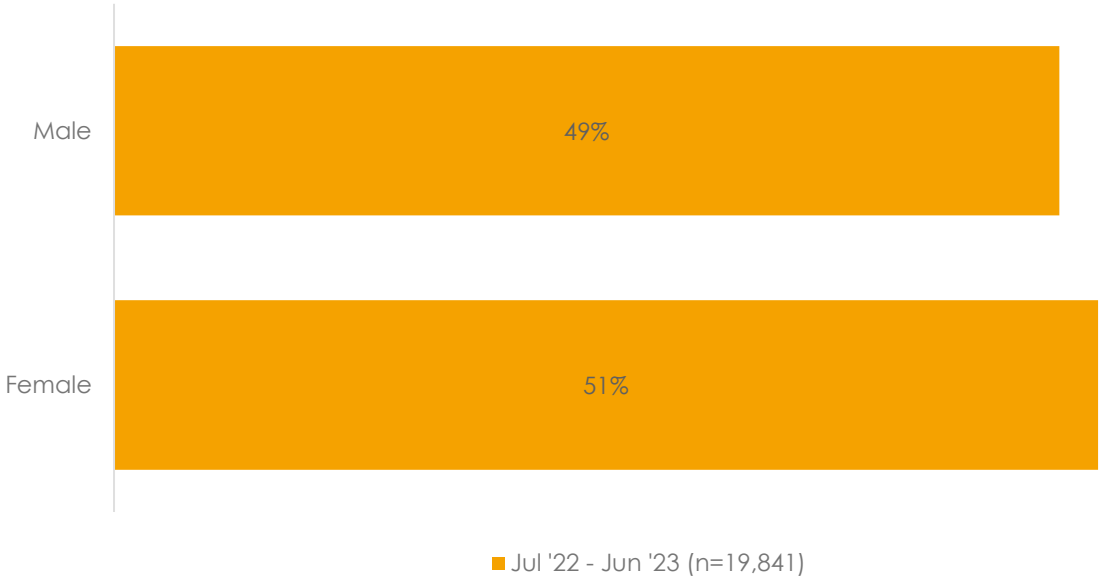
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

BMH Demographics (Gender Identity)



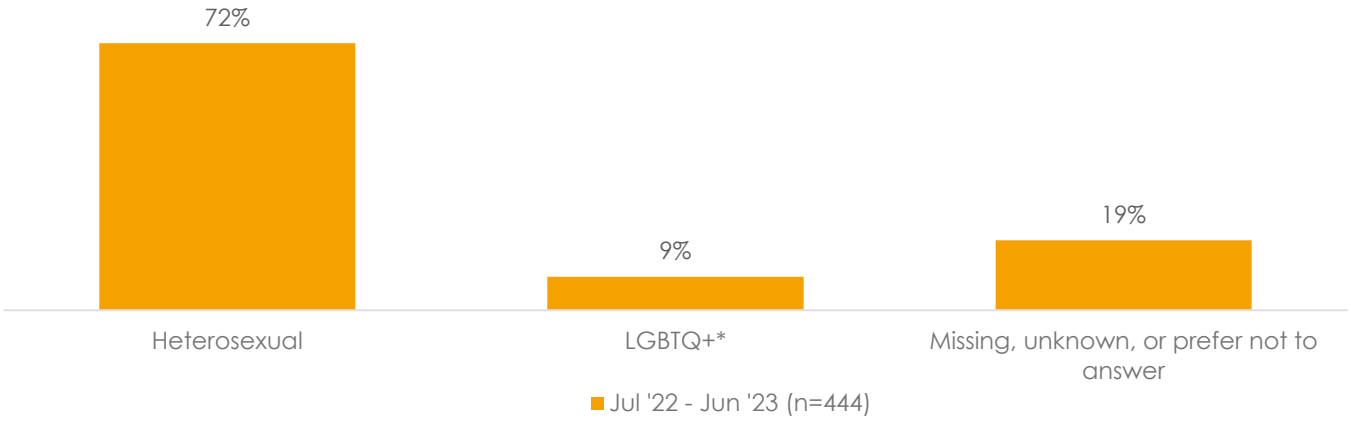
*Other includes multiple gender identities, non-conforming, female to male, intersex, queer, and other. Smaller categories (n<11) combined to represent collective size.

Medi-Cal Demographics (Gender Identity)



NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

BMH Demographics (Sexual Orientation)



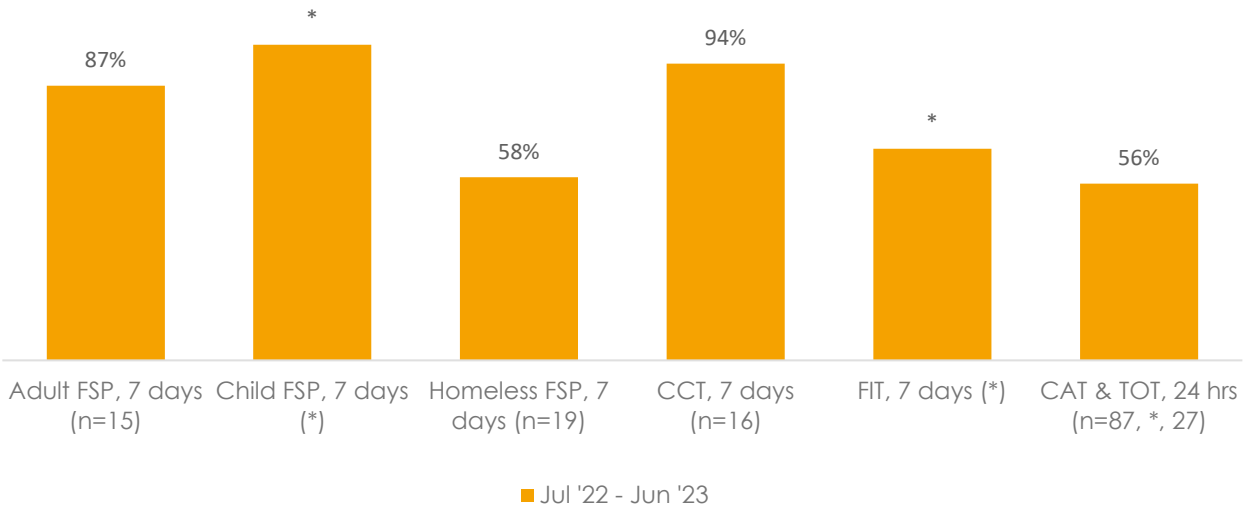
*LGBTQ+ includes lesbian, gay, bisexual, queer, multiple sexual orientations, questioning, and other. Smaller categories (n<11) combined to represent collective size.

Sexual orientation data is not available for Medi-Cal beneficiaries in Berkeley

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

Responsiveness of Service

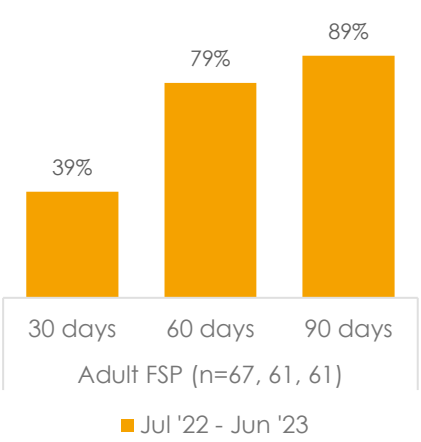
% of discharges from hospitalization or subacute who had a follow up visit within 7 calendar days

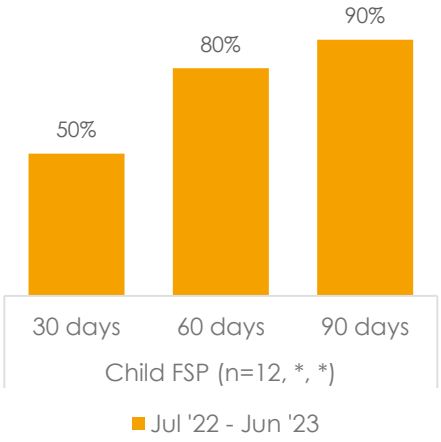


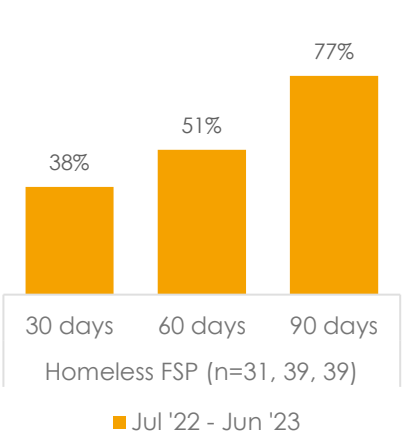
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

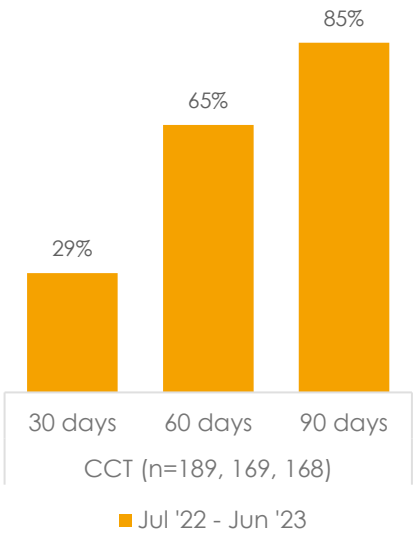
Consistency of Service

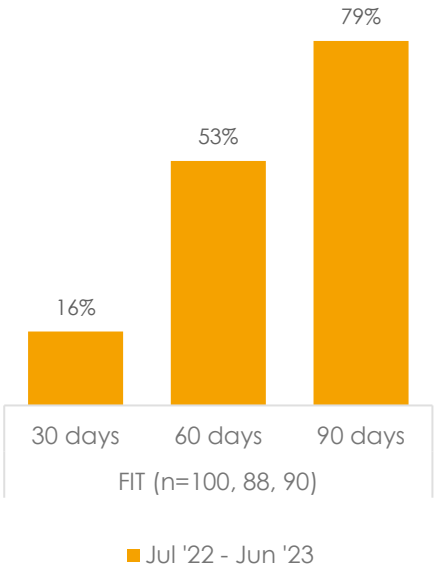
% of clients with no service gap over 30/60/90





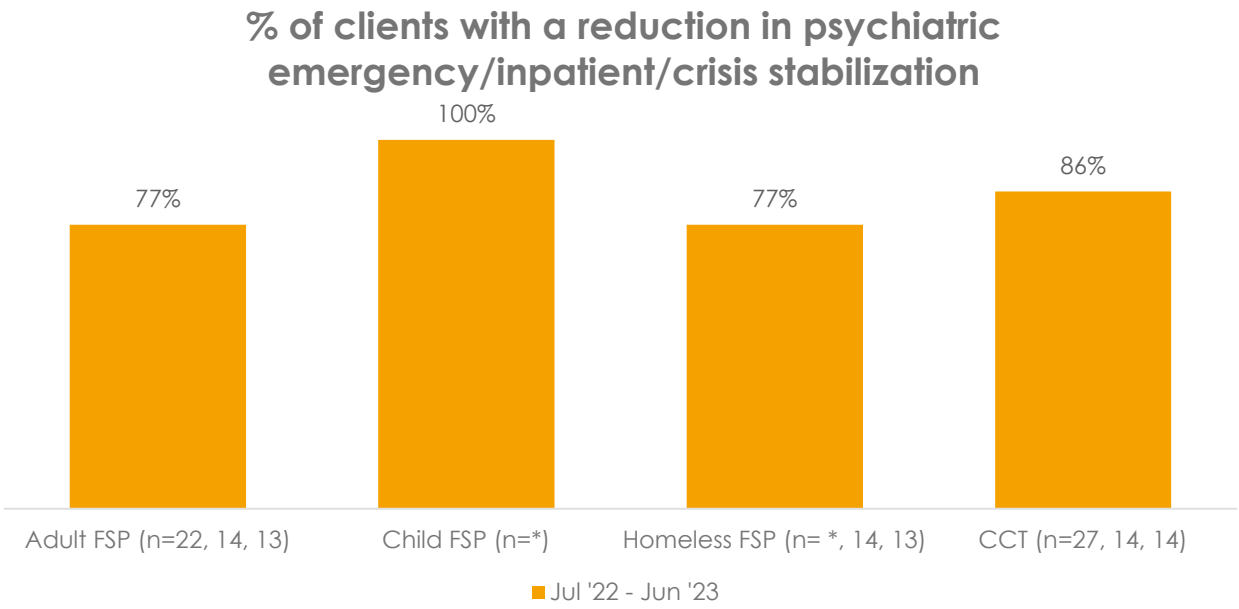


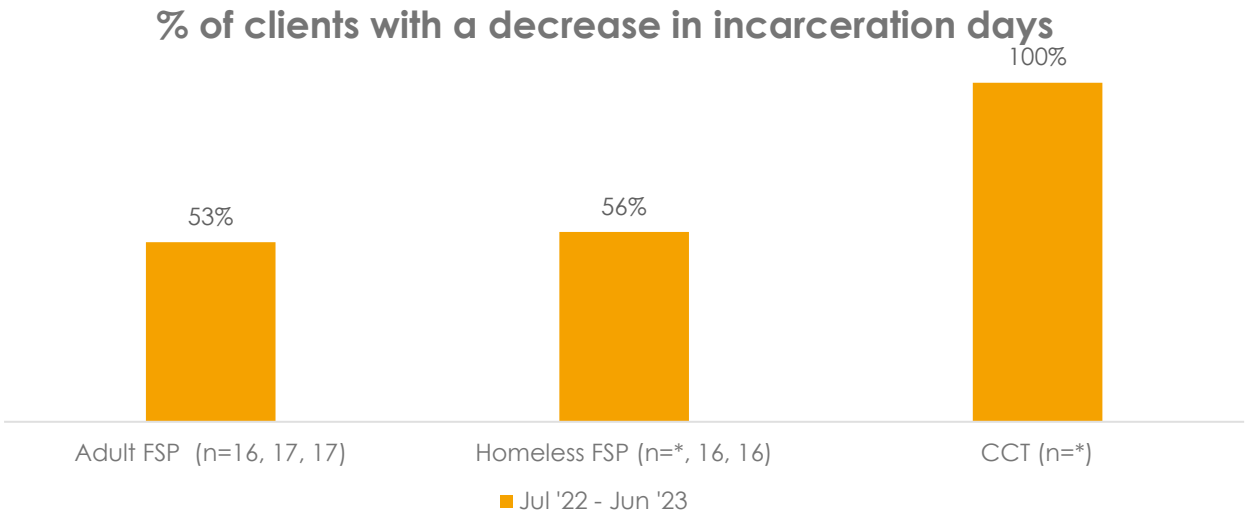


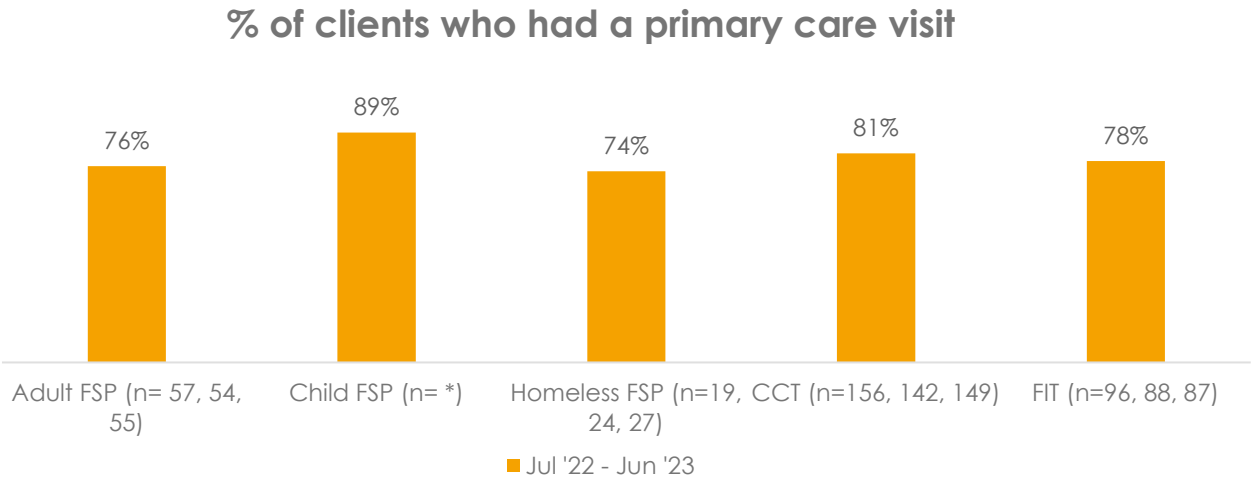


NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Impact Outcomes ("Is anyone better off?")







NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Measure	Definition	Data Source
# clients served	Total number of clients served during the reporting period. Available for: all clients served for Adult FSP, Children's FSP, Homeless FSP, CCT, FIT, ERMHS, EPSDT, High School Health Center, Medical Services, and Wellness & Recovery Services. Does not include clients from MCT, CAT/TOT (may be duplicated)	Yellowfin, ETO, Wellness Recovery Group Attendance
Responsiveness of service (% of discharges from hospitalization or subacute who had a follow up visit within specified time period)	Follow-up rates for individuals open to providers at the time of MH hospital discharge. Expected follow-up time period set by programs. Available for: Adult FSP, Children's FSP, Homeless FSP, CCT, FIT, CAT & TOT. *note: clients used to calculate follow up rates include those who didn't receive outreach and	Yellowfin, CAT Contact Log
Consistency of service (% of clients with no service gap over 30/60/90 days)	% of clients with less than 30/60/90 days maximum without service during their episode(s) in the fiscal year. Only includes clients open to a provider for at least a total of 1/2/3 months during the reporting fiscal year. Available for: Adult FSP, Children's FSP, Homeless FSP, CCT, FIT.	Yellowfin
% of clients who had a reduction in days in psychiatric emergency services/inpatient/crisis stabilization units	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in psychiatric emergency services, inpatient or crisis stabilization unit other than Amber House, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in jail and/or subacute) for six or more months during the current fiscal year or the prior fiscal year. Available for: Adult FSP, Children's FSP, Homeless FSP, CCT, FIT	Yellowfin
% of clients with a decrease in incarcerations	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in jail days, when comparing	Yellowfin
% clients who had a primary care	Of clients who completed 6 consecutive months	Yellowfin

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

BMH RBA Report FY 2023

Reporting Period July 2022 - June 2023

Adult Full Service Partnership (AFSP)

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

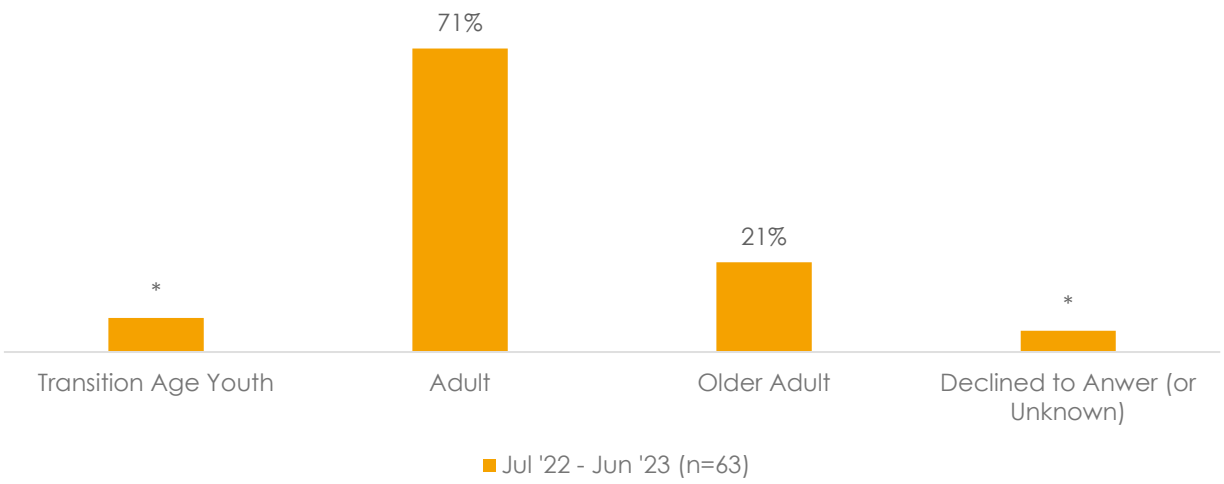
63
Clients Served

11
New Clients

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

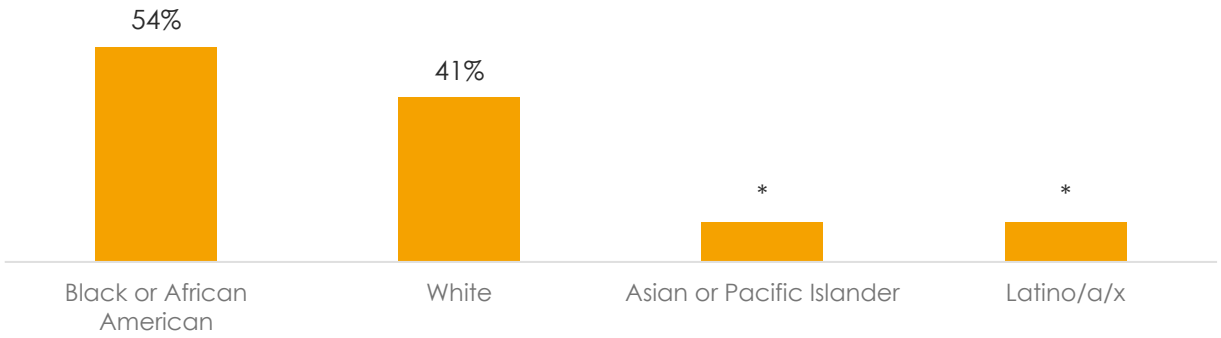
Program Updates: In Fiscal Year 2021-2022, the Adult Full Service Partnership was not fully staffed, this has been remedied in FY 2022-23.

Demographics (Age)

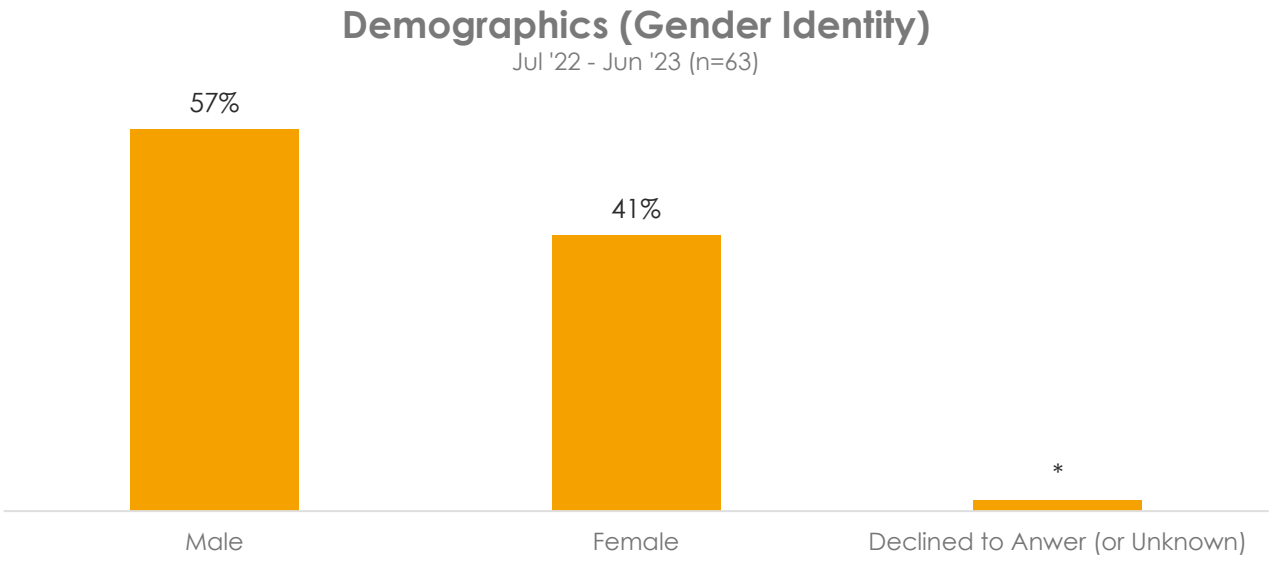


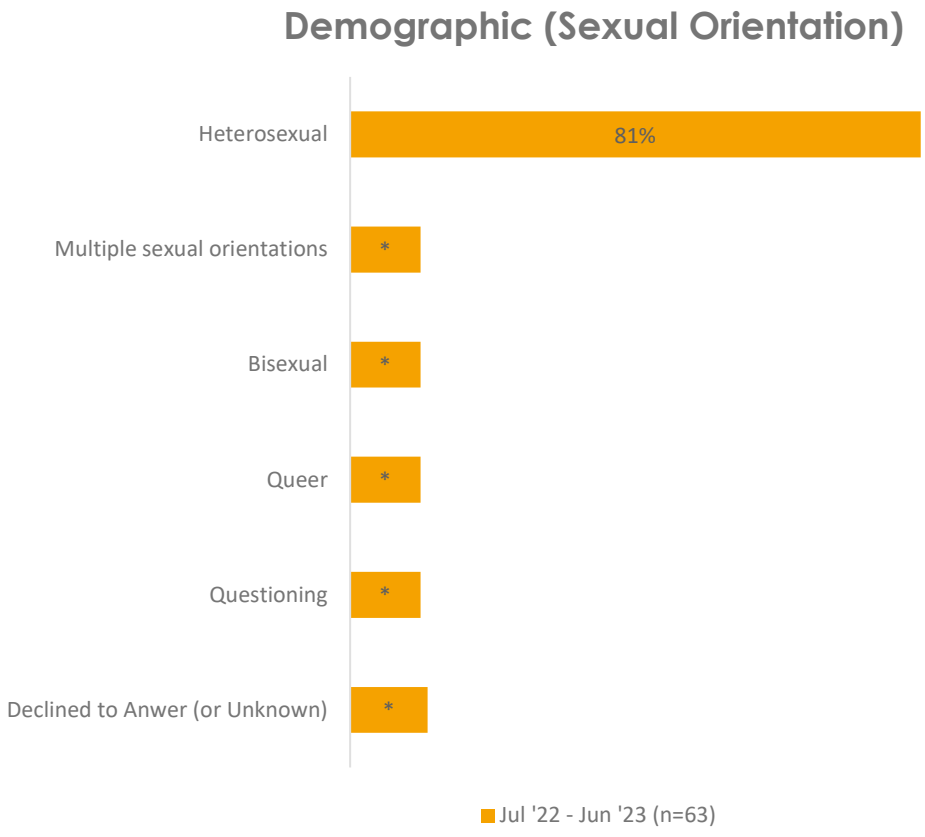
Demographics (Ethnicity)

Jul '22 - Jun '23 (n=63)



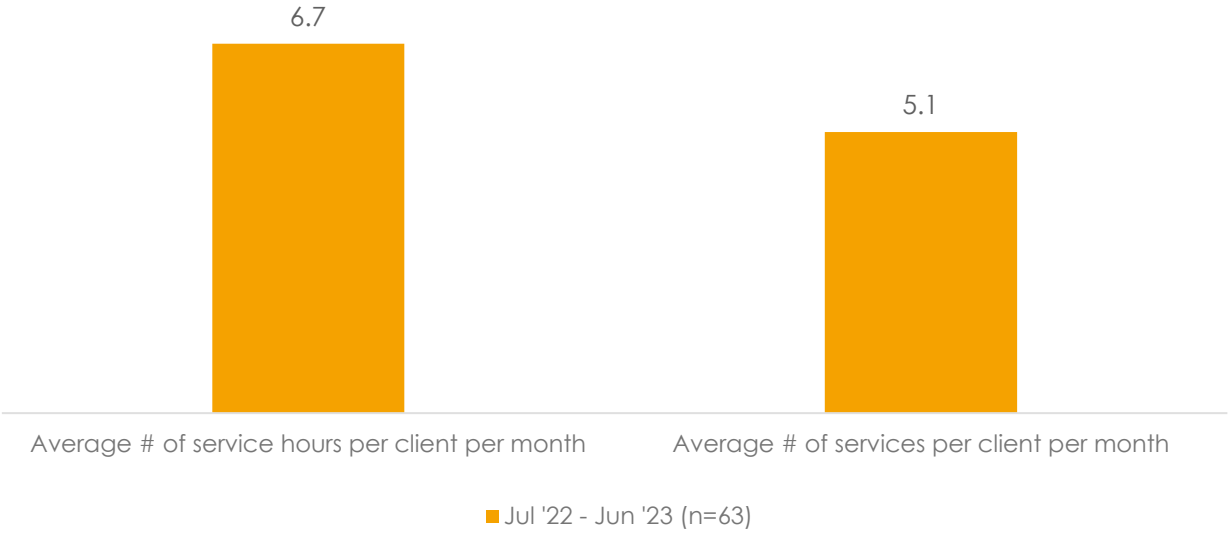
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.



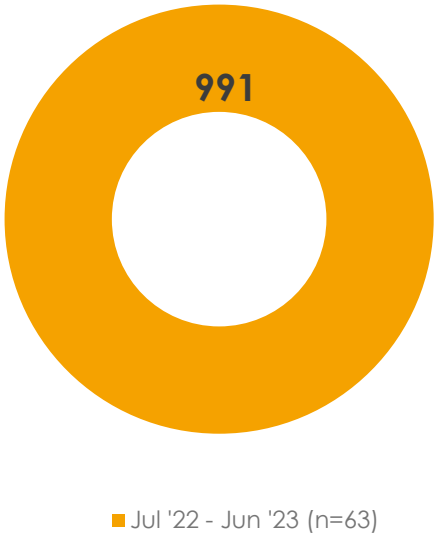


NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Average Monthly Services per Client



Average Number of Days in FSP

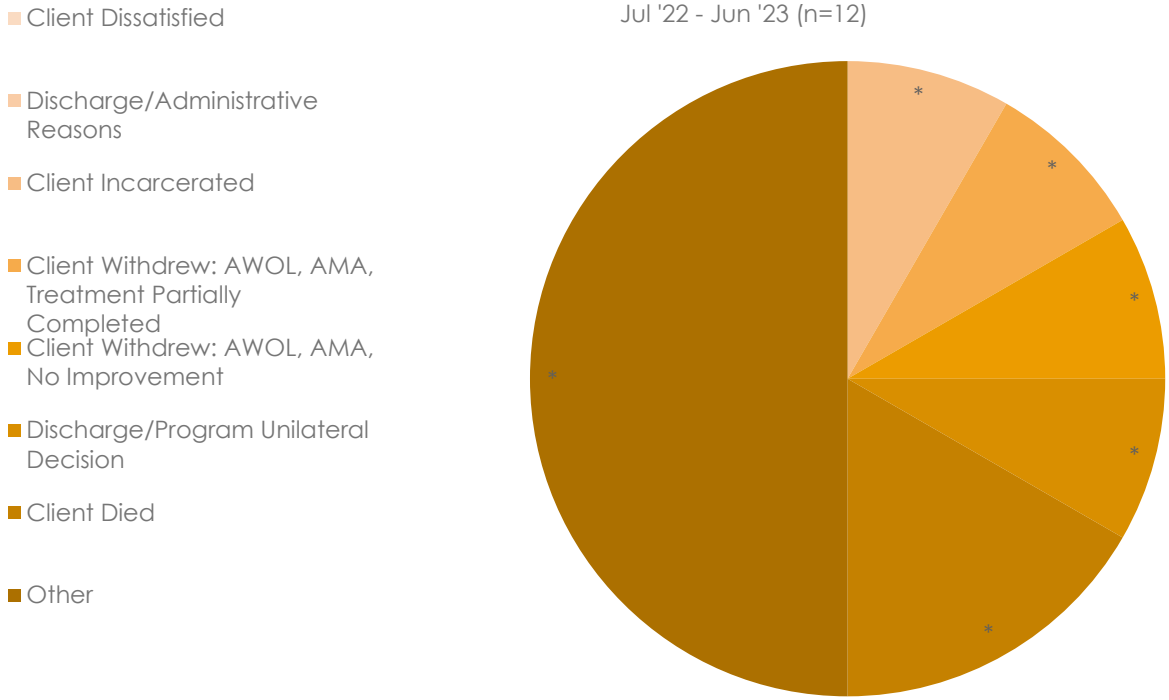


NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

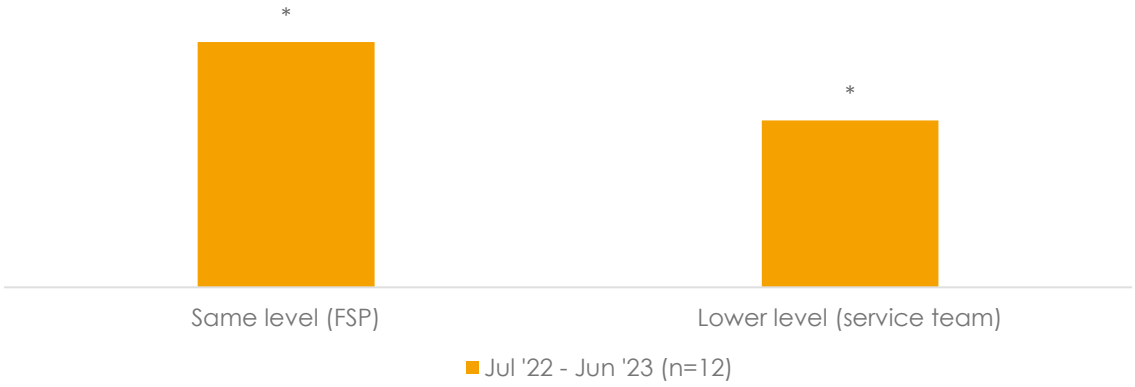
Quality Outcomes ("How well did we do it?")

Clients Closed, by Reason Closed

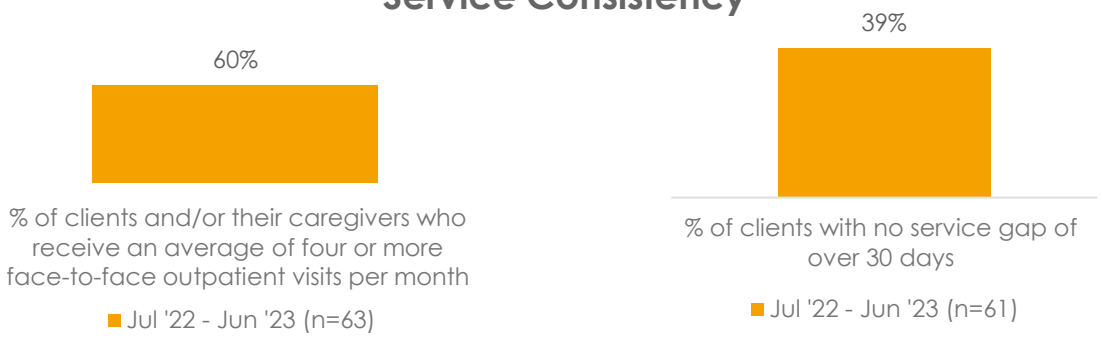
Jul '22 - Jun '23 (n=12)



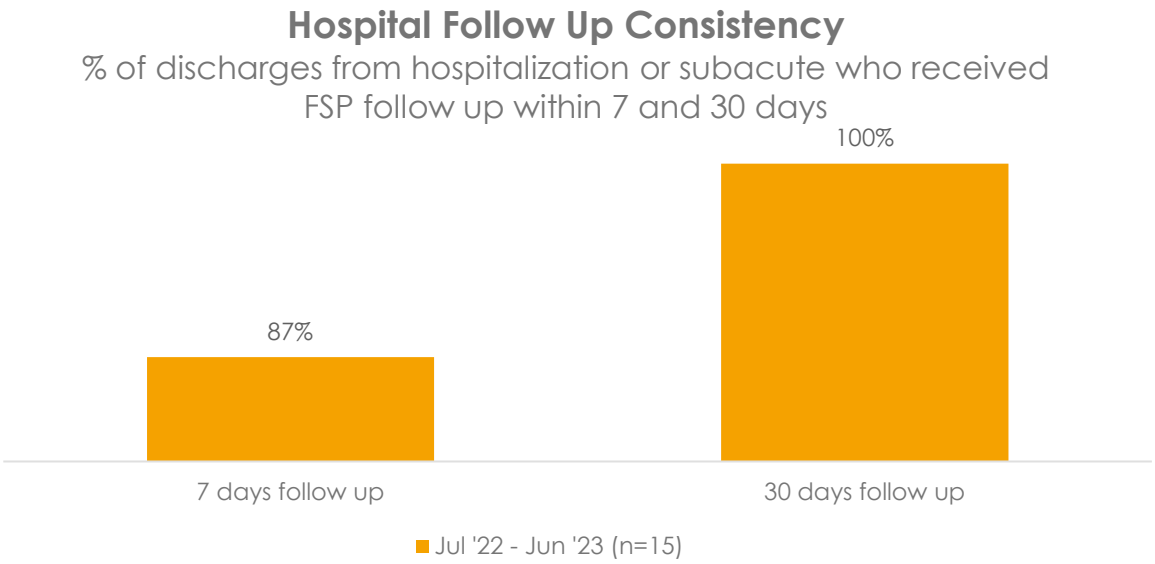
Clients Transferred to Another Program, by Level of Care



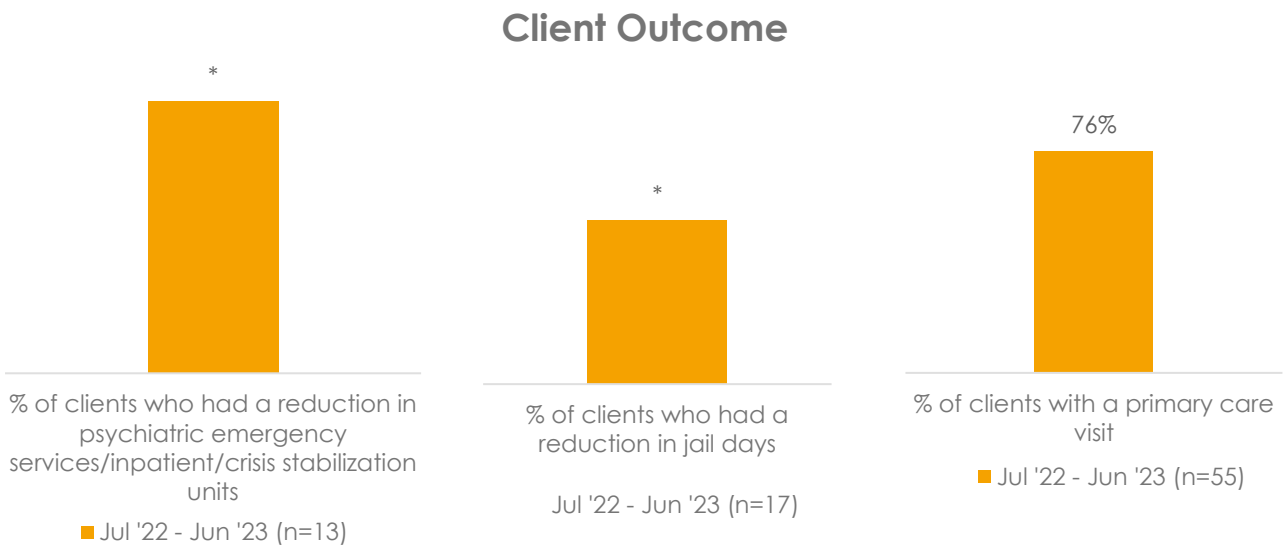
Service Consistency

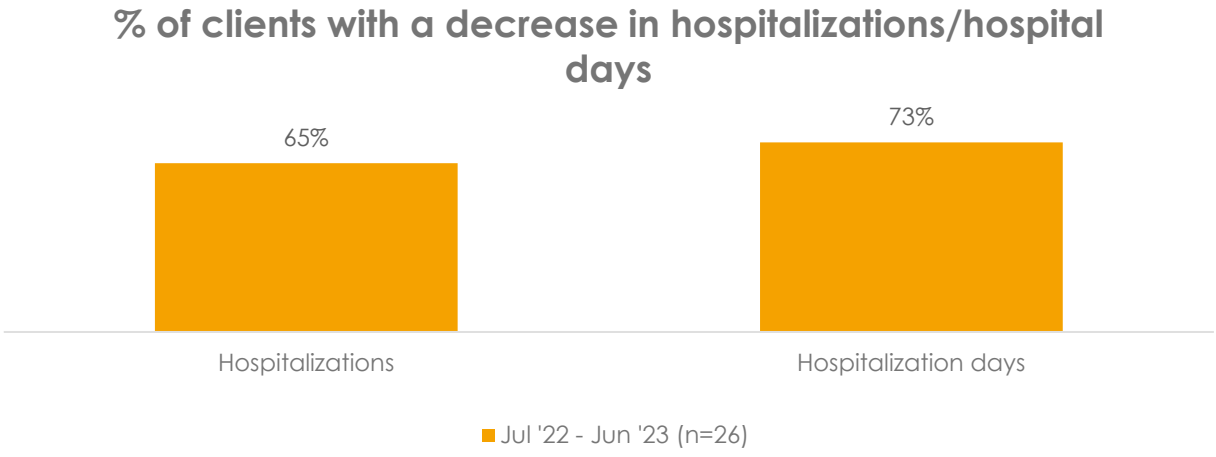


NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.



Impact Outcomes ("Is anyone better off?")





NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

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

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

% of clients who had a reduction in psychiatric emergency services/inpatient/crisis stabilization units	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in psychiatric emergency services, inpatient or crisis stabilization unit other than Amber House, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in jail and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients who had a reduction in jail days	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in jail days, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in hospital and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients with a primary care visit	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/Community Health Center Network (CHCN) primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).	Yellowfin
% of clients with a decrease in hospitalizations/hospitalization days	Decrease in hospital days/admissions in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital day in the 12 months prior to admission and remained in the program for at least 1 year. Only available for fiscal years.	Yellowfin

BMH RBA Report FY 2023

Reporting Period: July 2022 - June 2023

Comprehensive Community Treatment Team (CCT)

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

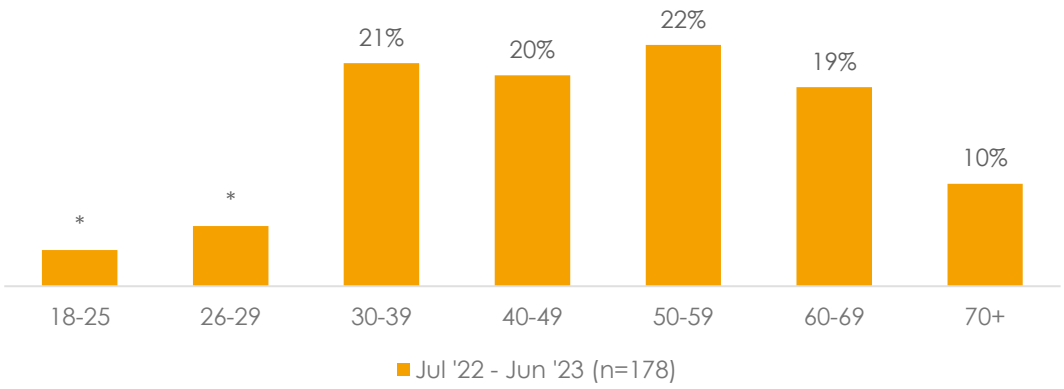
178
Clients Served

23
New Clients

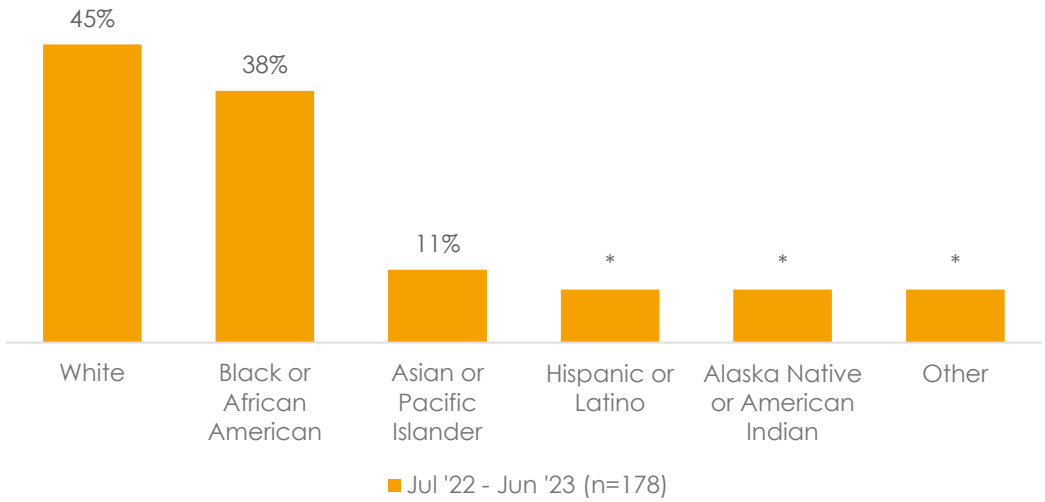
Program Description: The CCT team is responsible for providing services to adults with severe and persistent mental illness who require specialty mental health services. Staff provide case management, therapeutic services, and group services both in the field and in the clinic.

Program Update:
The CCT program experienced a lot of staffing and supervision changes in 2023, and was not fully staffed during this reporting period CCT team.

Demographics (Age)

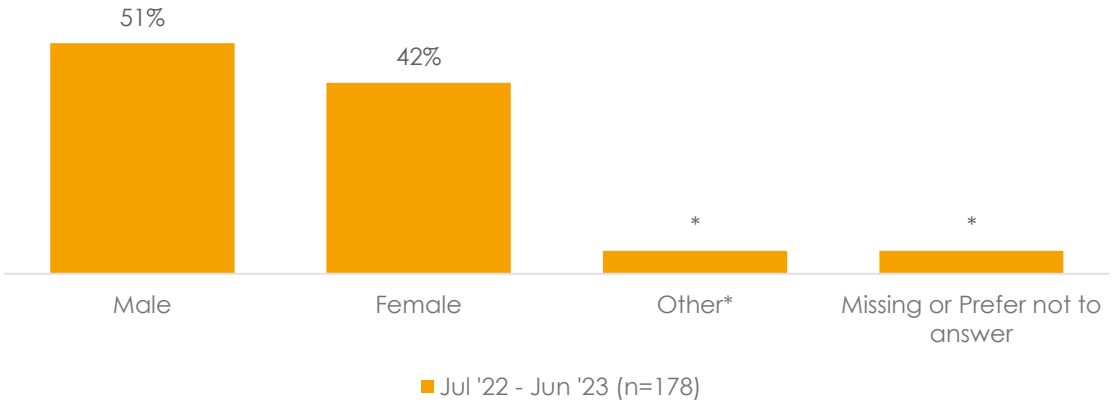


Demographics (Ethnicity)



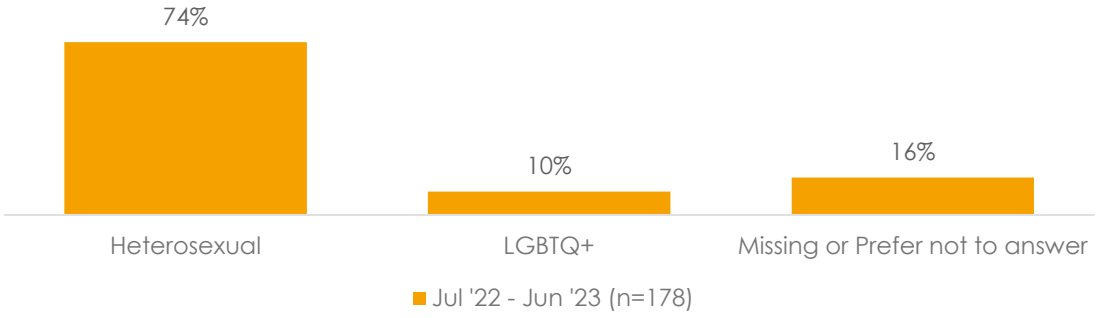
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Demographics (Gender Identity)



*Other includes female to male, multiple gender identities, non-conforming, and other.

Demographics (Sexual Orientation)



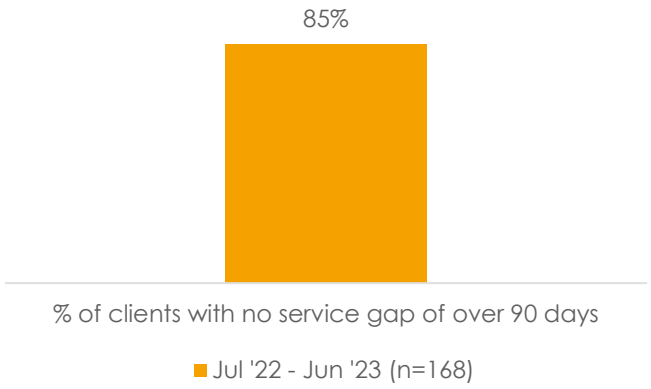
*LGBTQ+ includes lesbian,gay, bisexual,queer, multiple sexual orientations, and other.

Average Monthly Services per Client

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

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

Service Consistency

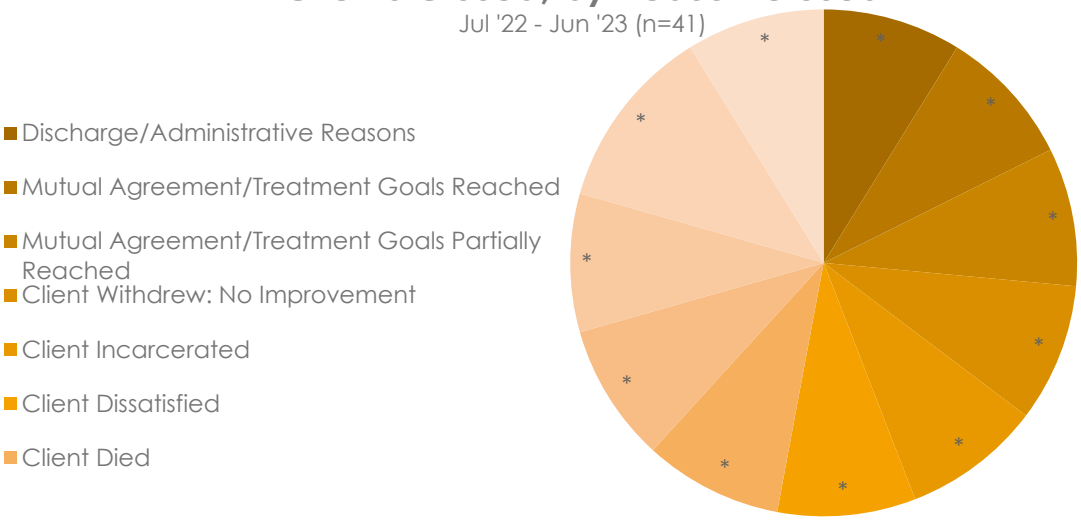


Hospital Follow Up Consistency

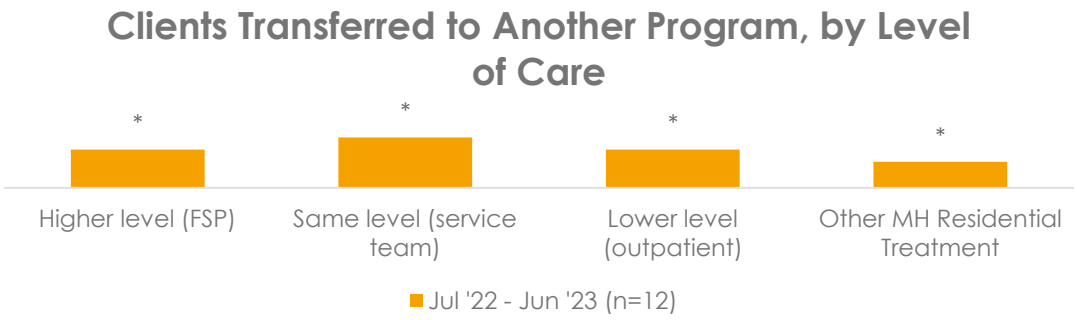
% of discharges from hospitalization or subacute who received follow up within 7 and 30 days

Clients Closed, by Reason closed

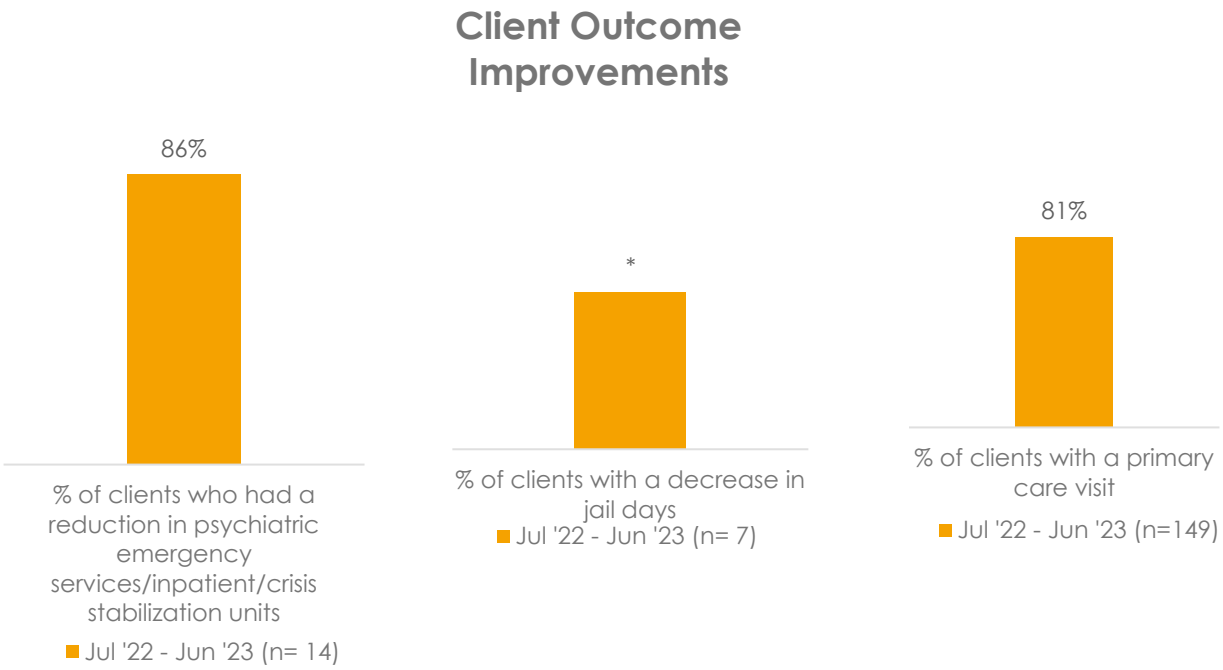
Jul '22 - Jun '23 (n=41)

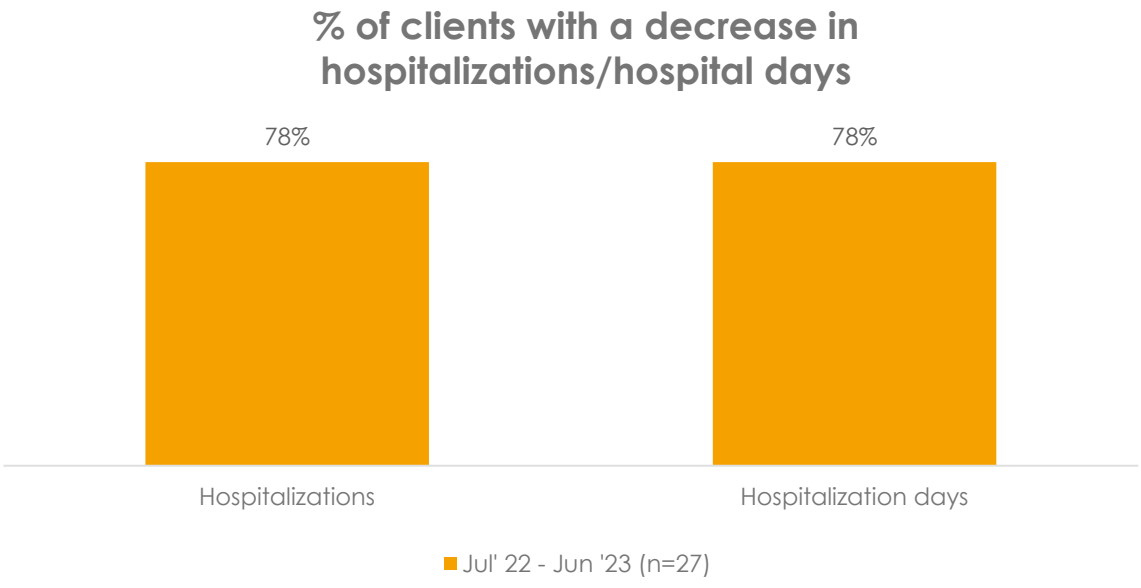


NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.



Impact Outcomes ("Is anyone better off?")





NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients	Clients who were not served by the program in the previous fiscal year	Yellowfin
Average # of service hours per client per month	Average of hours of service in a month divided by clients served in a month. Includes all services recorded for clients. Does not include medical services (MAA)	Yellowfin
Average # of services per client per month	Average services in a month divided by clients served in a month. Includes all services recorded for clients. Note: more than one service can be provided during a single contact. Does not include MAA	Yellowfin
% of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program	Of clients with a completed Child or Adult Needs and Strengths Assessment (CANS/ANSA), what percentage of them had an assessment at least every six months?	Objective Arts
% of clients with no service gap of over 90 days	% of clients with less than 90 days maximum without service during their episode(s) in the fiscal year. Only includes clients open to a provider for at least a total of three months during the reporting fiscal year.	Yellowfin
% of discharges from hospitalization or subacute who had a follow up visit with staff within 7 and within 30 calendar days	Follow-up rates for individuals open to Level 1 providers at the time of mental health hospital discharge. *note: clients used to calculate follow up rates include those who didn't receive outreach and	Yellowfin
#/% of clients closed, by reason closed	Discharge reason for clients discharged during the reporting period	Yellowfin
#/% of clients transferred to another level of care	Of clients discharged in the reporting period, # who were transferred to a full service partnership program, service team, or outpatient services in Alameda County within 90 days of discharge	Yellowfin

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

% of clients who had a reduction in psychiatric emergency services/inpatient/crisis stabilization units	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in psychiatric emergency services, inpatient or crisis stabilization unit other than Amber House, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in jail and/or subacute) for six or more months during the current fiscal year or the	Yellowfin
% of clients with a decrease in hospitalizations/hospitalization days	Decrease in hospital days/admissions in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital day in the 12 months prior to admission and remained in the program for at least 1 year. Only available for fiscal years.	Yellowfin
% of clients with a decrease in jail days	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in jail days, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in hospital and/or subacute) for six or more months during the current fiscal year or	Yellowfin
% of clients with a primary care visit	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/Community Health Center Network (CHCN) primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).	Yellowfin

BMH RBA Report FY 2023

Reporting Period: July 2022 - June 2023

Focus on Independence Team (FIT)

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

92

Clients Served

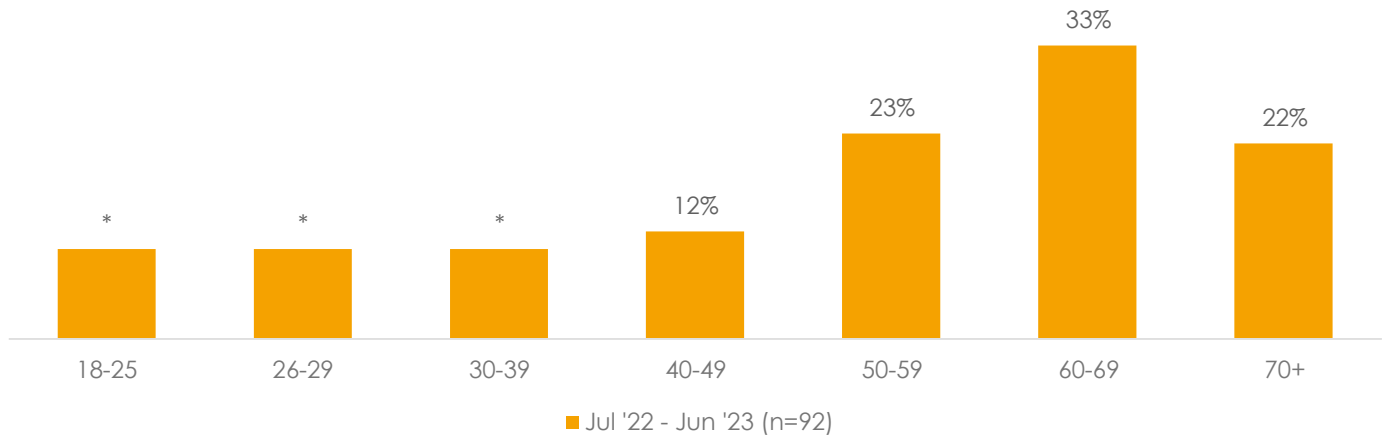
2

New Clients

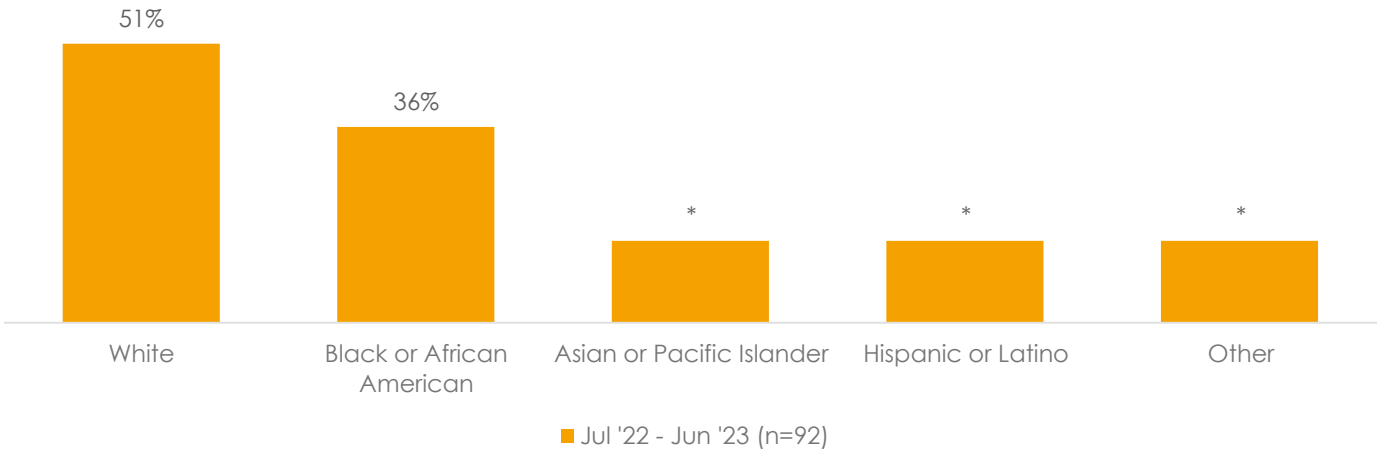
Program Description The Focus on Independence Team is responsible for providing services to clients who have graduated from higher levels of care within the clinic. Services are provided both in the field and in the clinic depending on client needs.

Program Updates The FIT program experienced a Manager transition, with the new Manager joining the staff in February 2023.

Demographics (Age)

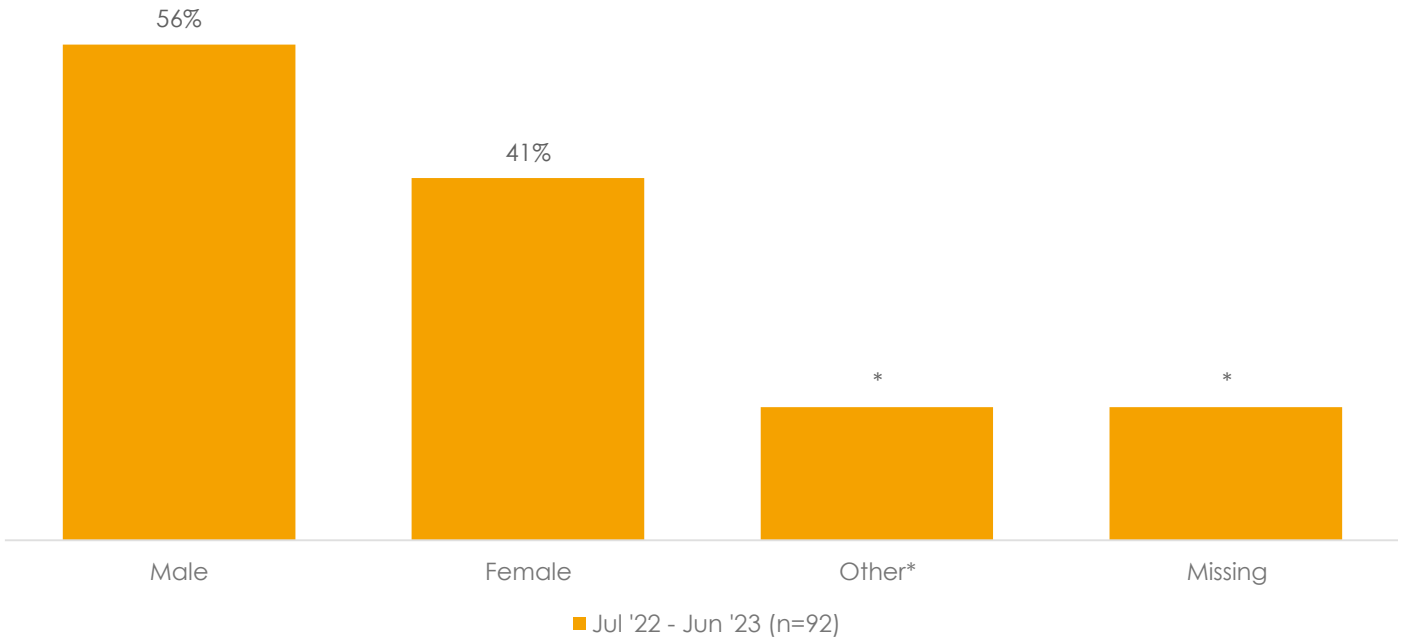


Demographics (Ethnicity)



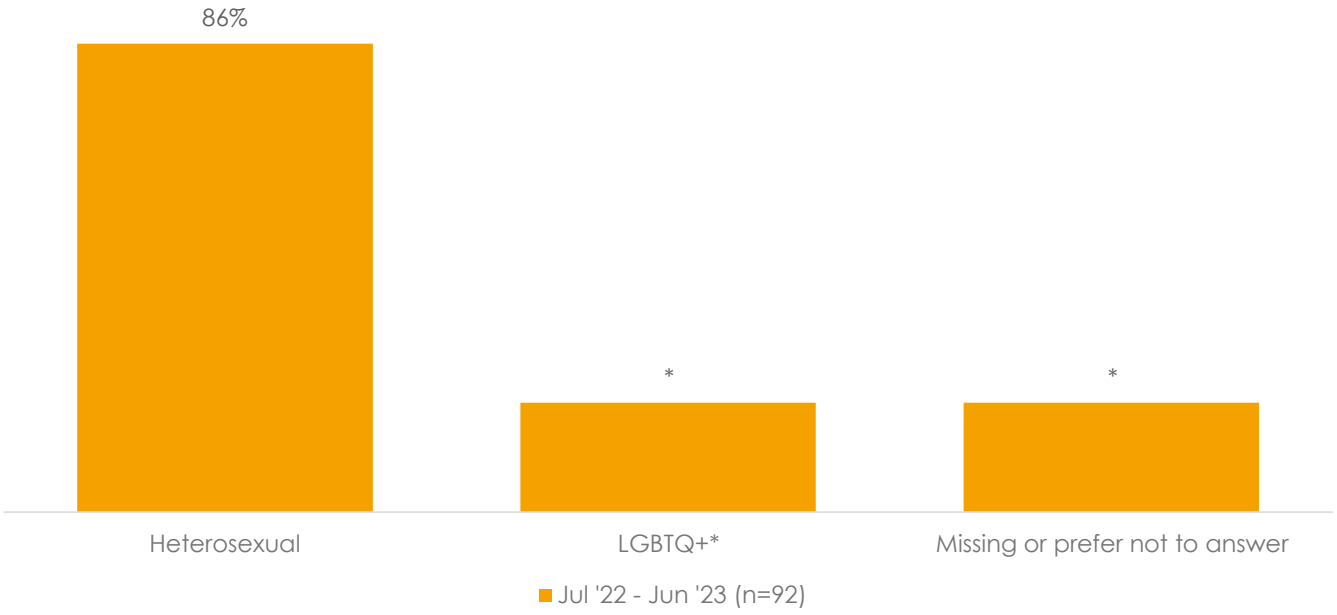
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Demographics (Gender Identity)



*Other includes intersex and other.

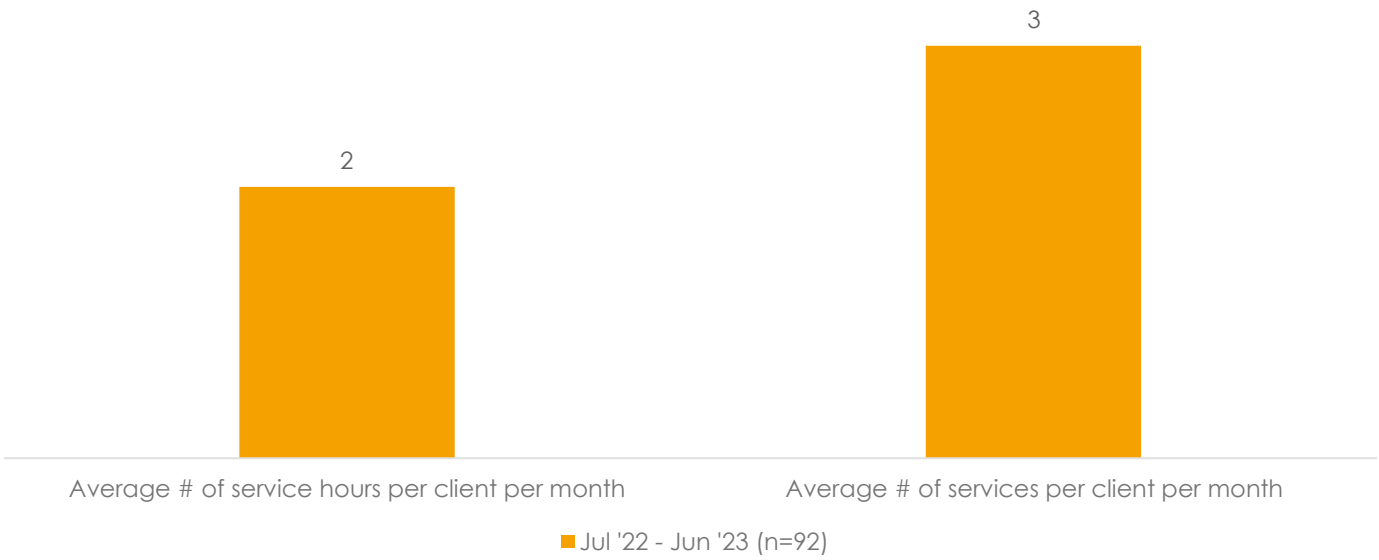
Demographics (Sexual Orientation)



*LGBTQ+ includes gay, questioning, and multiple sexual orientations.

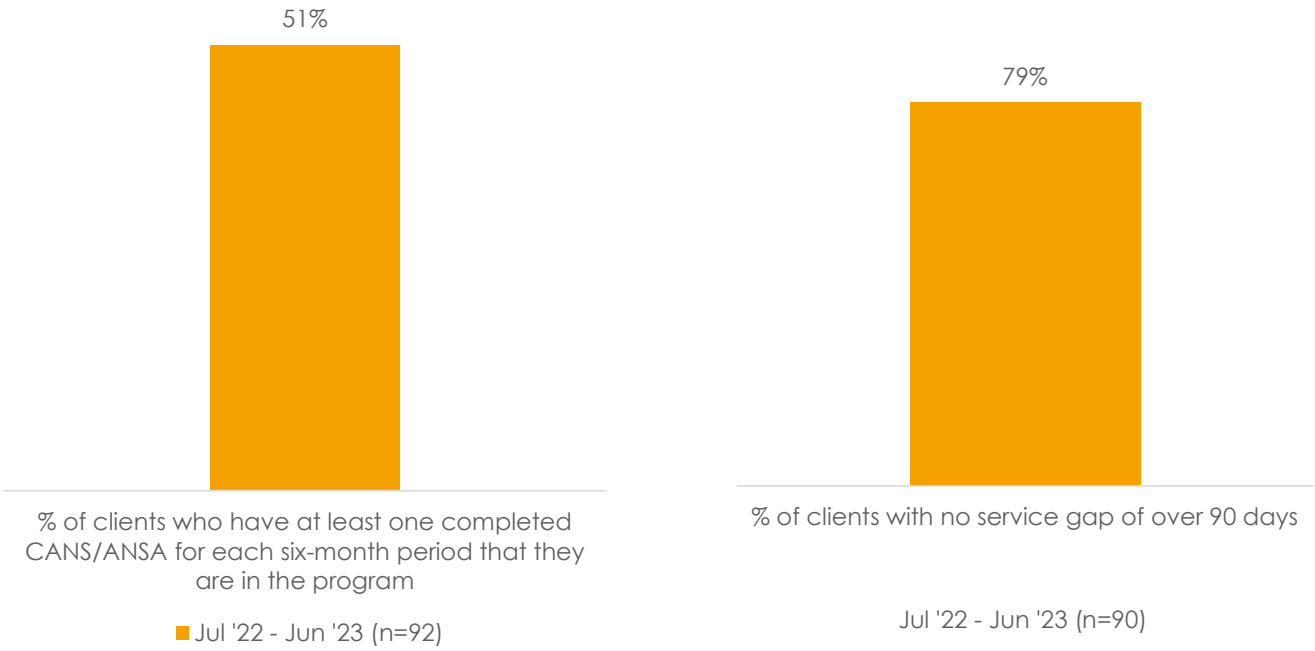
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Average Monthly Services per Client



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

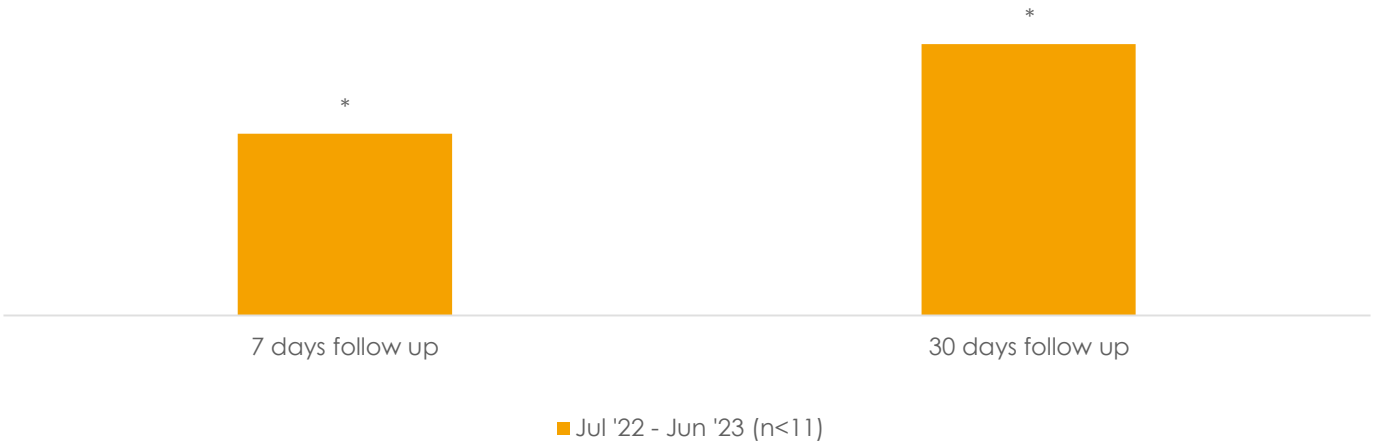
Service Consistency



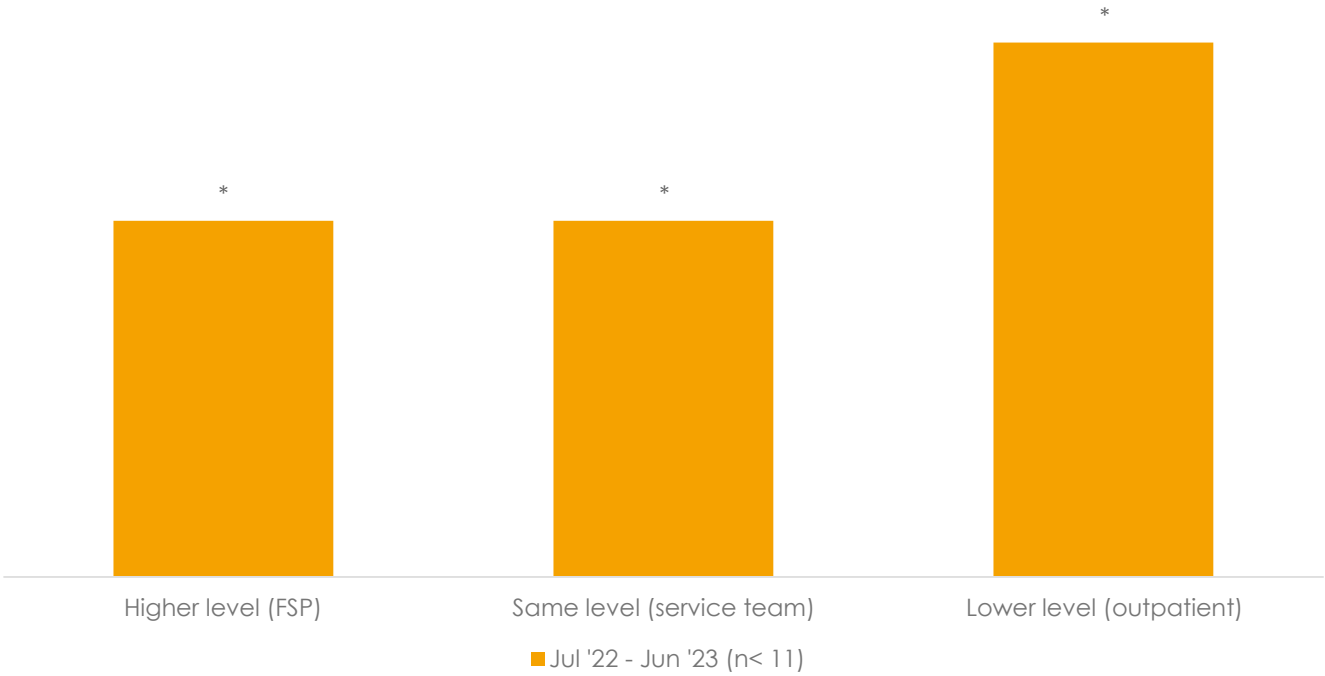
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Hospital Follow Up Consistency

% of discharges from hospitalization or subacute who received follow up within 7 and 30 days



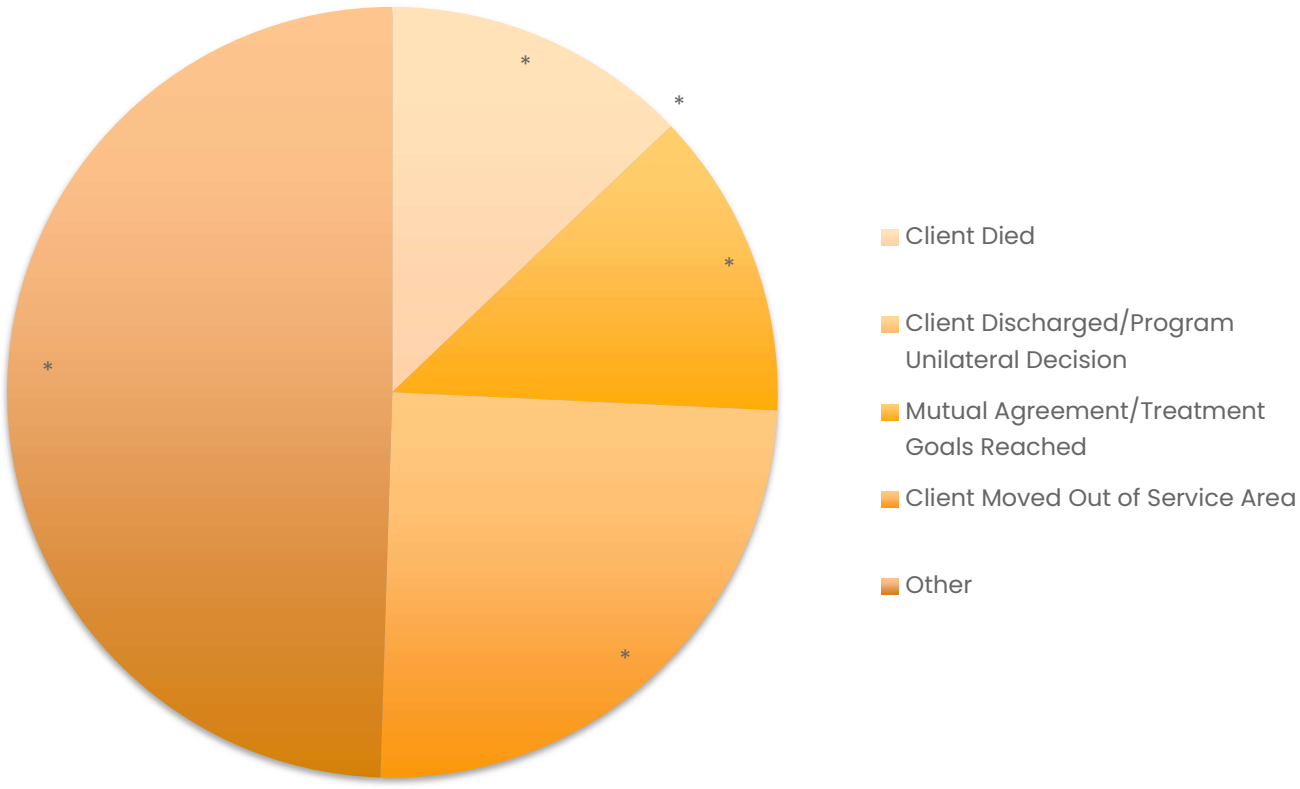
Clients Transferred to Another Program, by Level of Care



NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Clients Closed, by Reason Closed

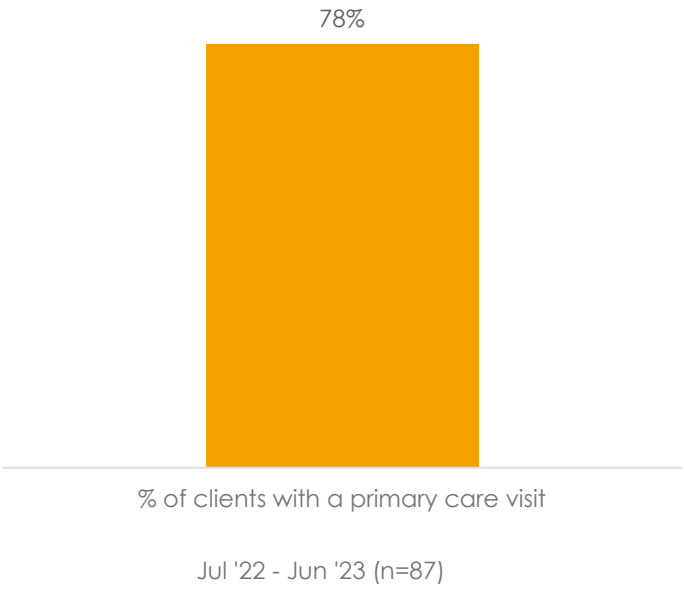
Jul '22 - Jun '23 (n>11)



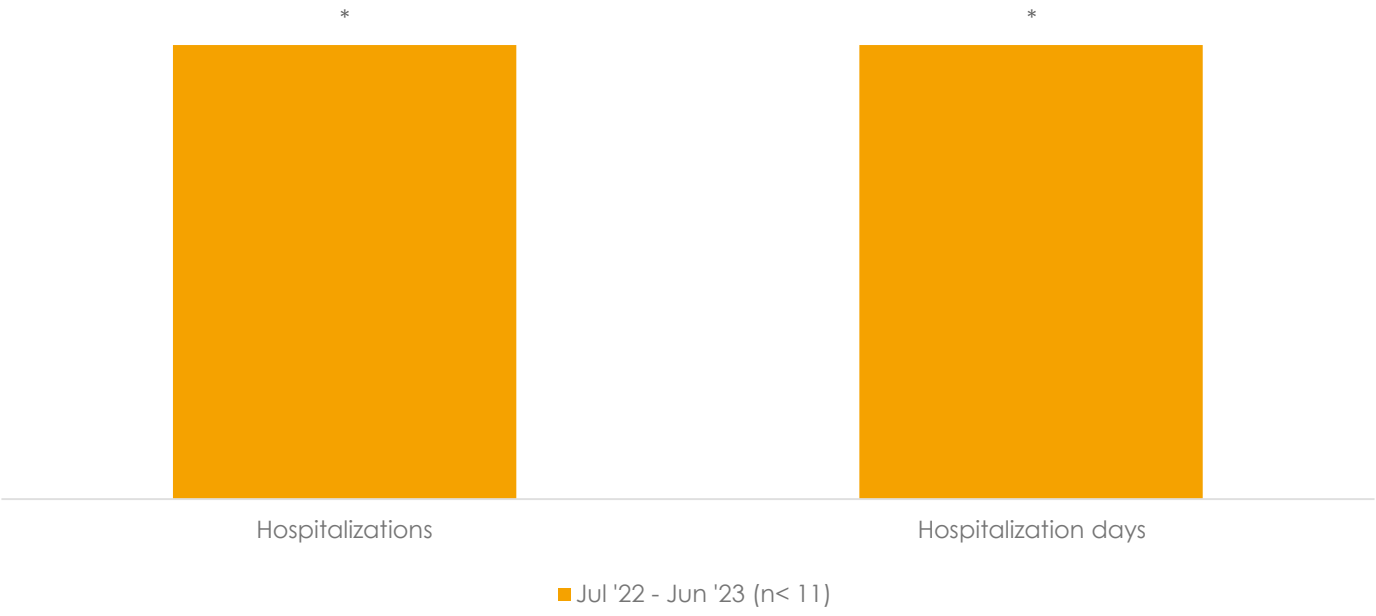
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Impact Outcomes ("Is anyone better off?")

Client Outcome Improvements



% of clients with a decrease in hospitalizations/hospital days



NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients	Clients who were not served by the program in the previous fiscal year	Yellowfin
Average # of service hours per client per month	Average of hours of service in a month divided by clients served in a month. Includes all services recorded for clients. Does not include medical services (MAA)	Yellowfin
Average # of services per client per month	Average services in a month divided by clients served in a month. Includes all services recorded for clients. Note: more than one service can be provided during a single contact. Does not include MAA	Yellowfin
% of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program	Of clients with a completed Child or Adult Needs and Strengths Assessment (CANS/ANSA), what percentage of them had an assessment at least every six months?	Objective Arts
% of clients with no service gap of over 90 days	% of clients with less than 90 days maximum without service during their episode(s) in the fiscal year. Only includes clients open to a provider for at least a total of three months during the reporting fiscal year.	Yellowfin
% of discharges from hospitalization or subacute who had a follow up visit with staff within 7 and within 30 calendar days	Follow-up rates for individuals open to Level 1 providers at the time of mental health hospital discharge. *note: clients used to calculate follow up rates include those who didn't receive outreach and those	Yellowfin
#/% of clients closed, by reason closed	Discharge reason for clients discharged during the reporting period	Yellowfin
#/% of clients transferred to another level of care	Of clients discharged in the reporting period, # who were transferred to a full service partnership program, service team, or outpatient services in Alameda County within 90 days of discharge	Yellowfin

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

% of clients who had a reduction in psychiatric emergency services/inpatient/crisis stabilization units	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in psychiatric emergency services, inpatient or crisis stabilization unit other than Amber House, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in jail and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients with a decrease in hospitalizations/hospitalization days	Decrease in hospital days/admissions in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital day in the 12 months prior to admission and remained in the program for at least 1 year. Only available for fiscal years.	Yellowfin
% of clients with a primary care visit	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/Community Health Center Network (CHCN) primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).	Yellowfin

BMH RBA Report FY 2023

Reporting Period: July 2022 - June 2023

High School Health Center (HSHC)

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

244

Clients Served

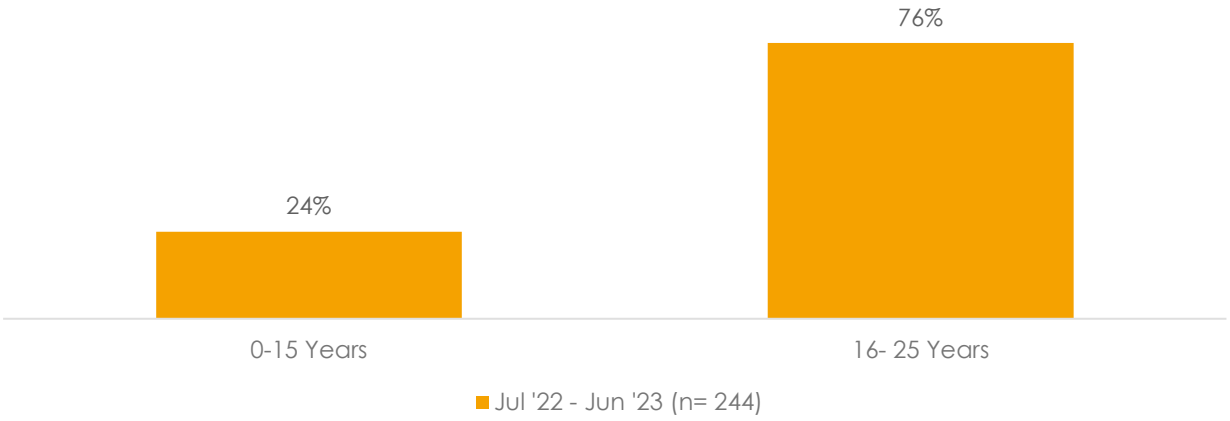
Program Description

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

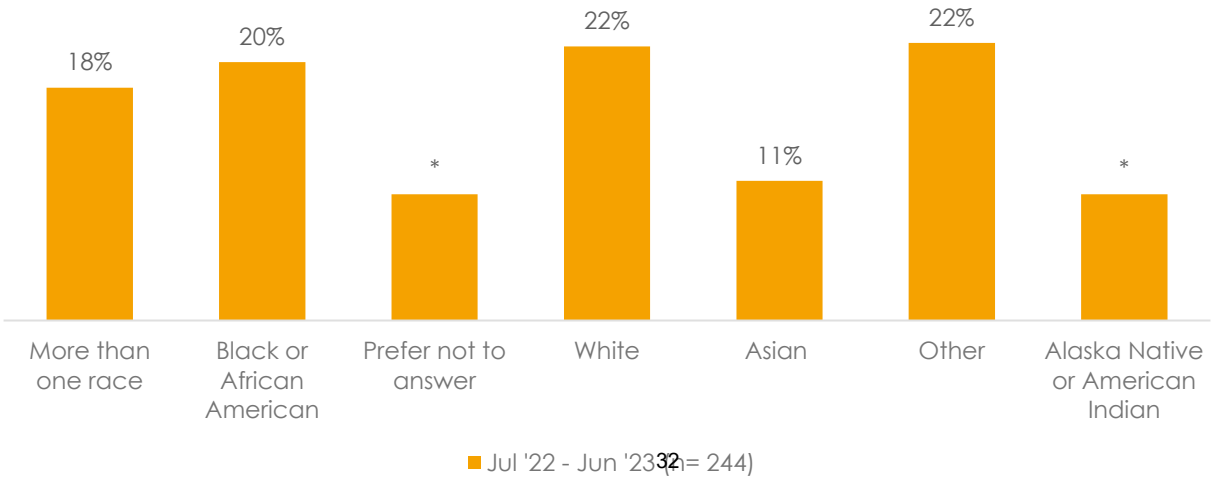
Program Updates

HSHC hired two new full time staff and onboarded 3 master's-level interns in the 2022-2023 school year. This allowed the team to serve more clients and restart groups. HSHC had significant challenges with their EHR, resulting in barriers to quality control.

Demographics (Age)

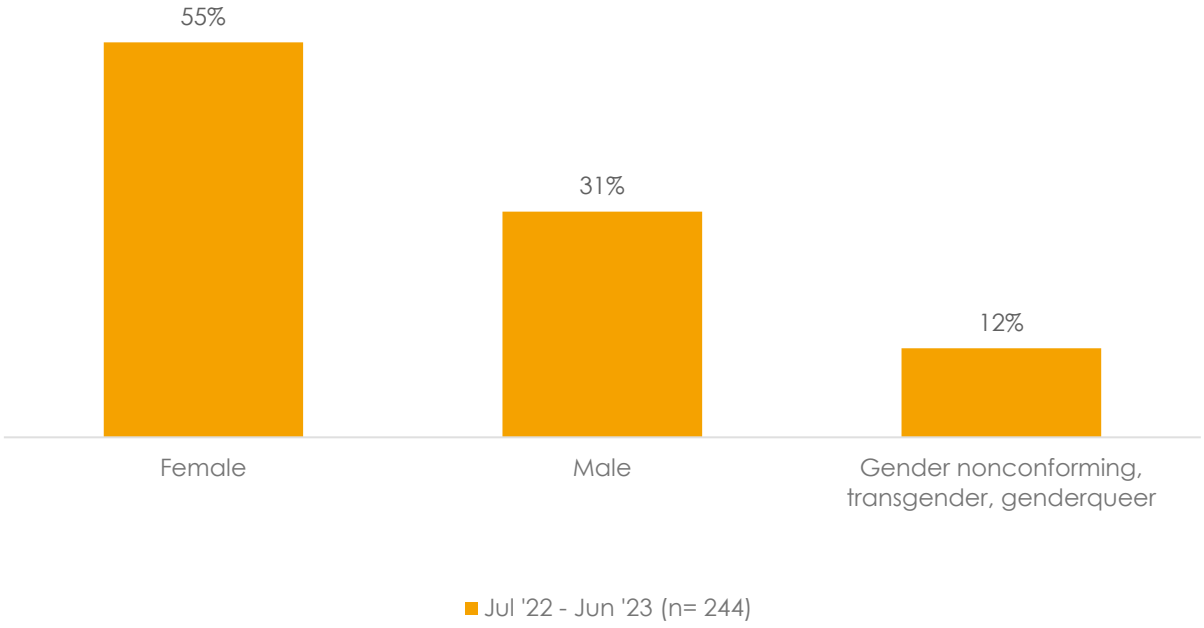


Demographics (Ethnicity)

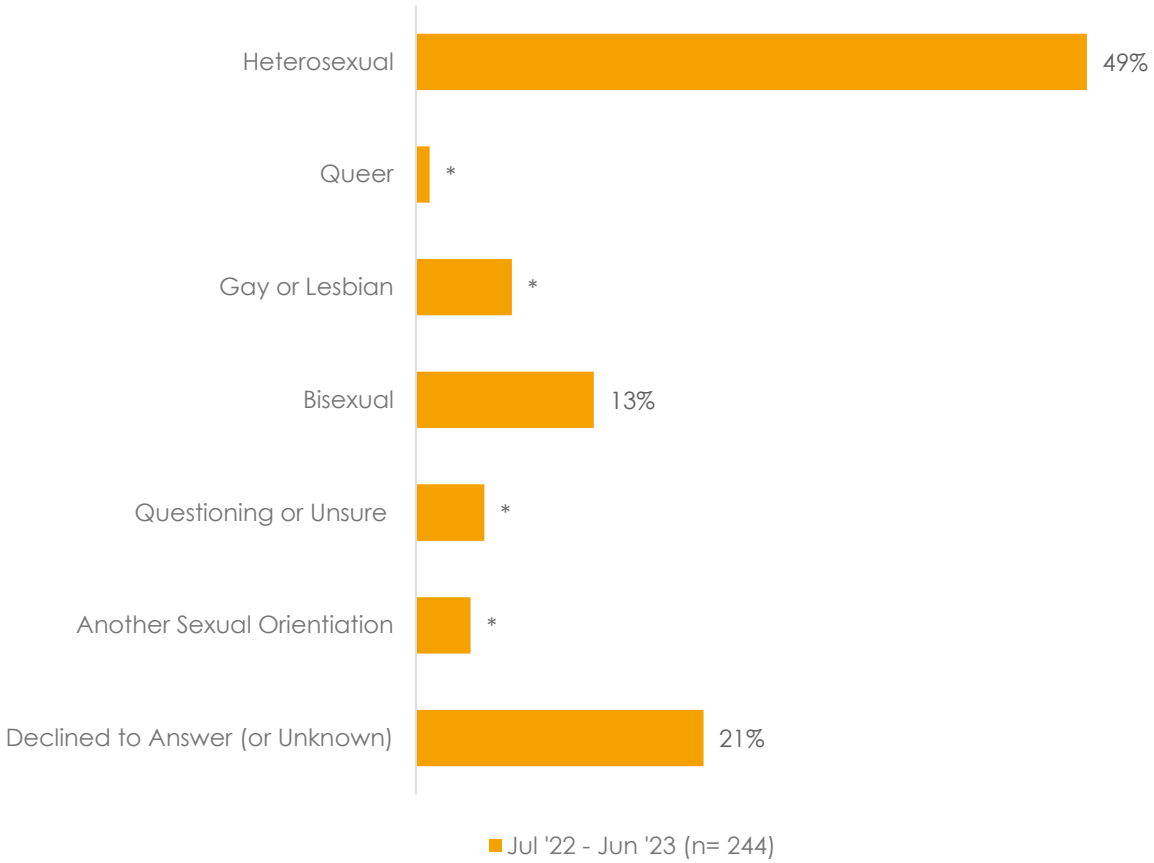


NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Demographics (Gender Identity)

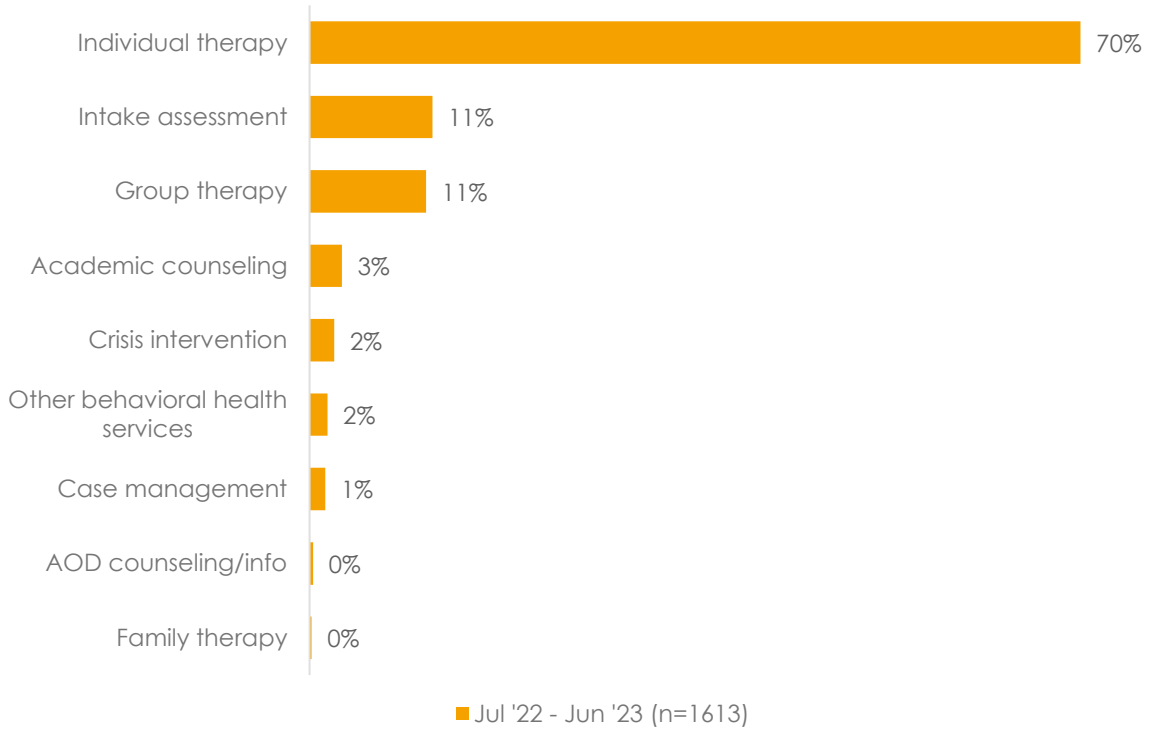


Demographics (Sexual Orientation)



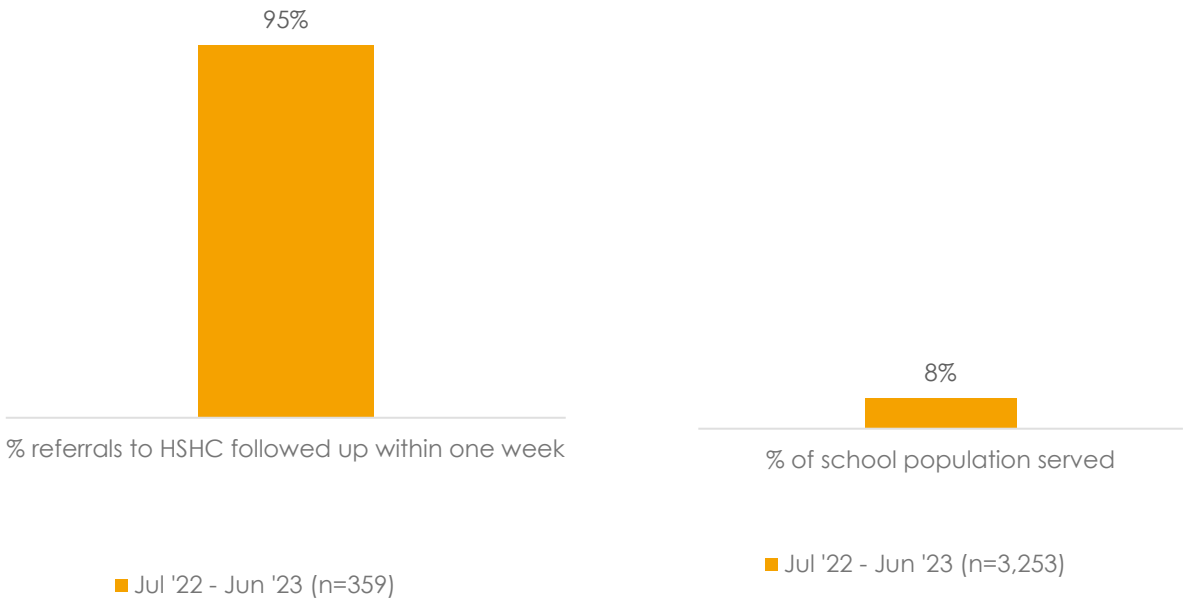
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Services Provided by Service Type



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

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



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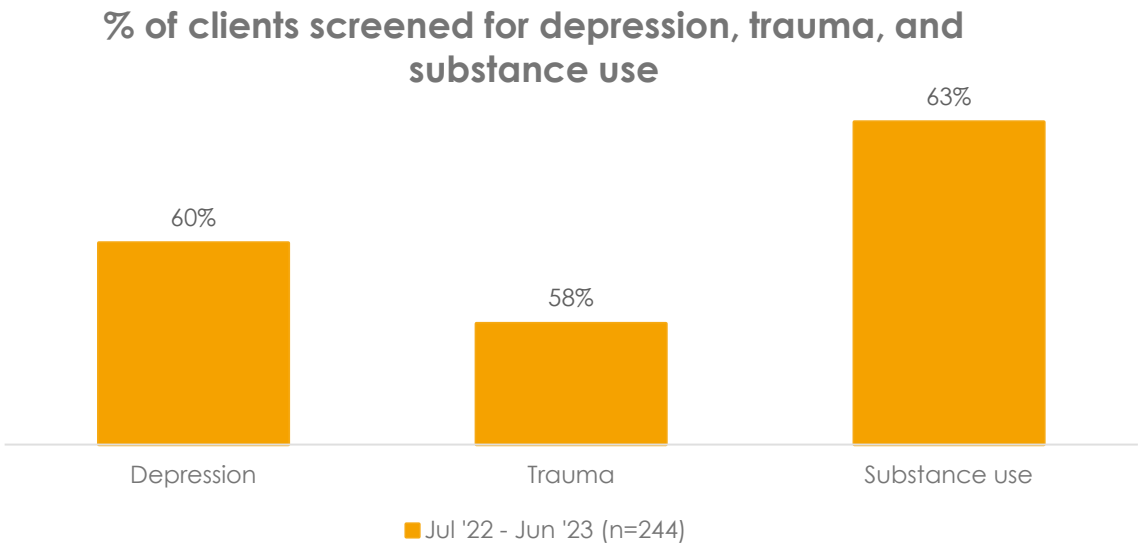
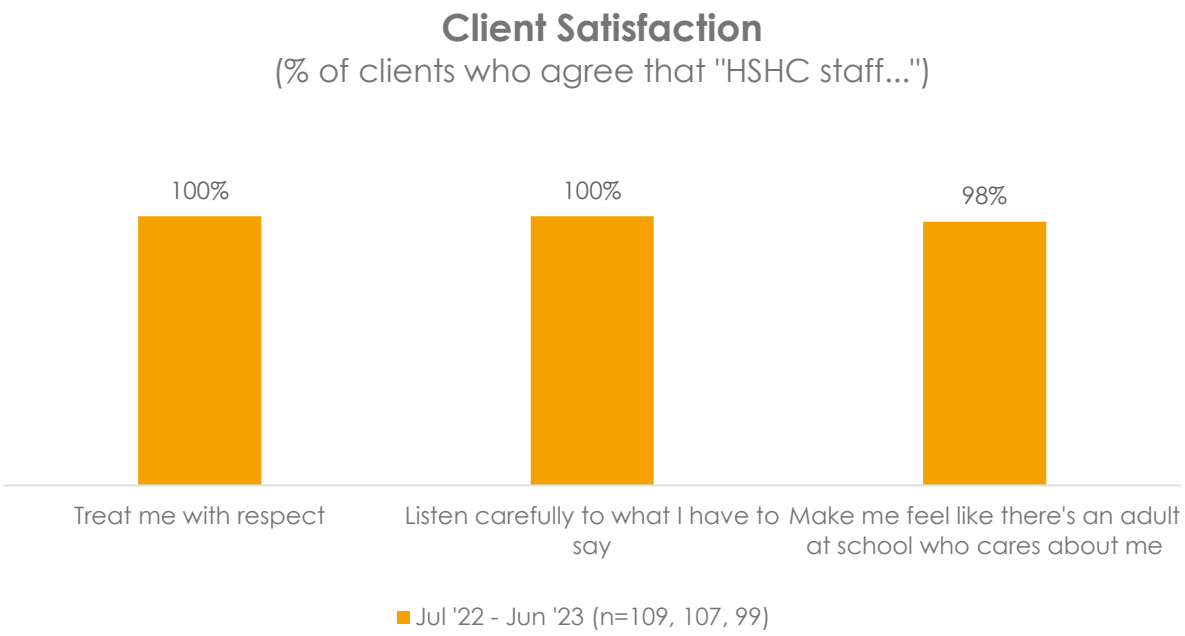
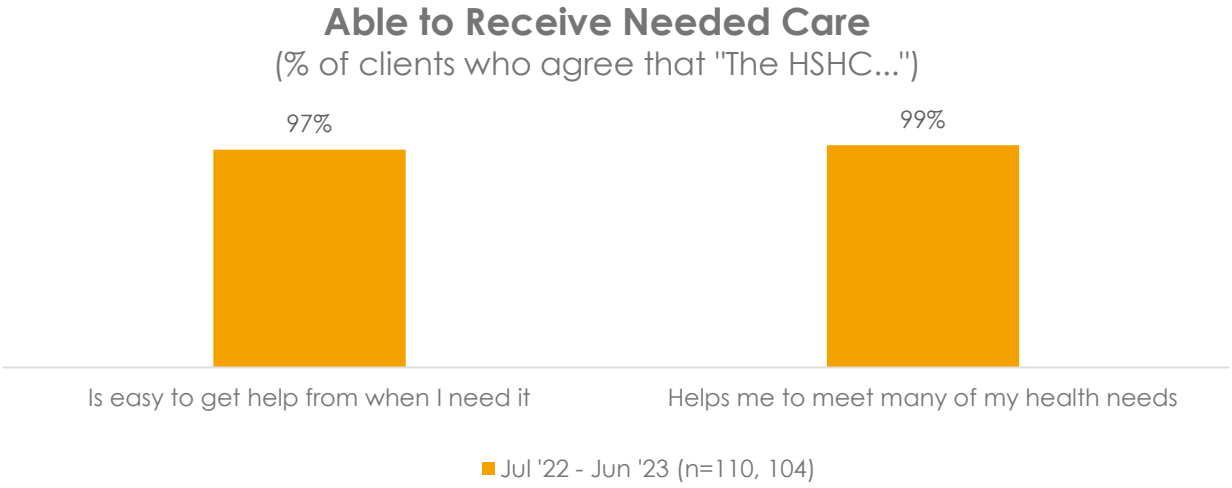






NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

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

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

BMH RBA Report FY 2023

Reporting Period July 2022 - June 2023

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

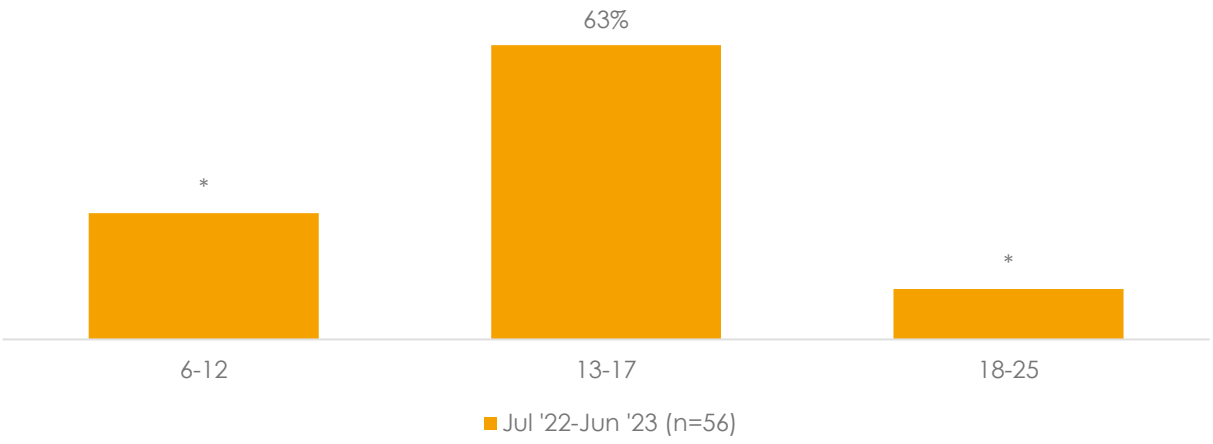
Process Outcomes ("How much did we do?")

56
Clients Served

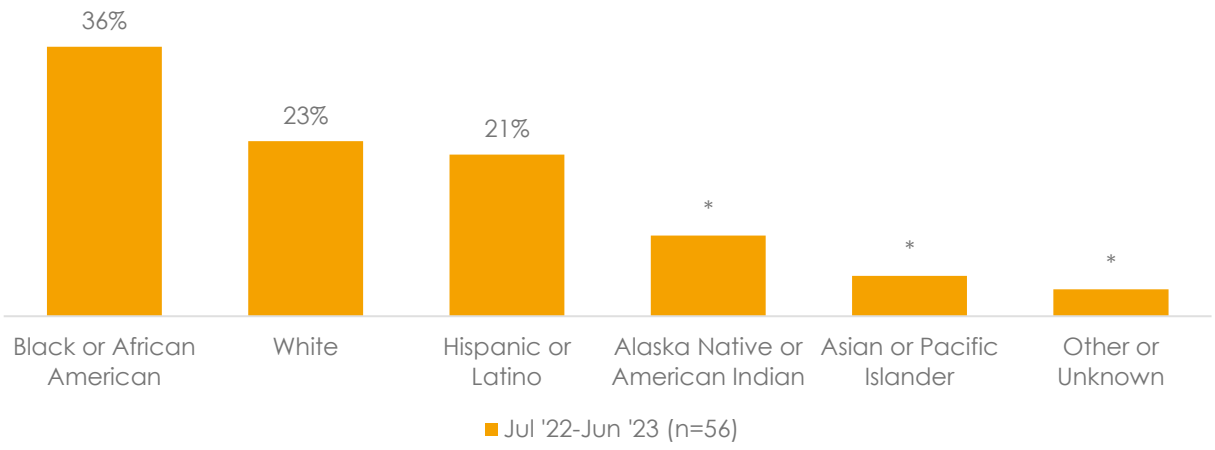
25
New Clients

Program Description: The EPSDT team provides comprehensive and preventive child health services which include assessment, plan development, individual/family/group therapy, rehabilitation, collateral, case management, and medication referrals.

Demographics (Age)

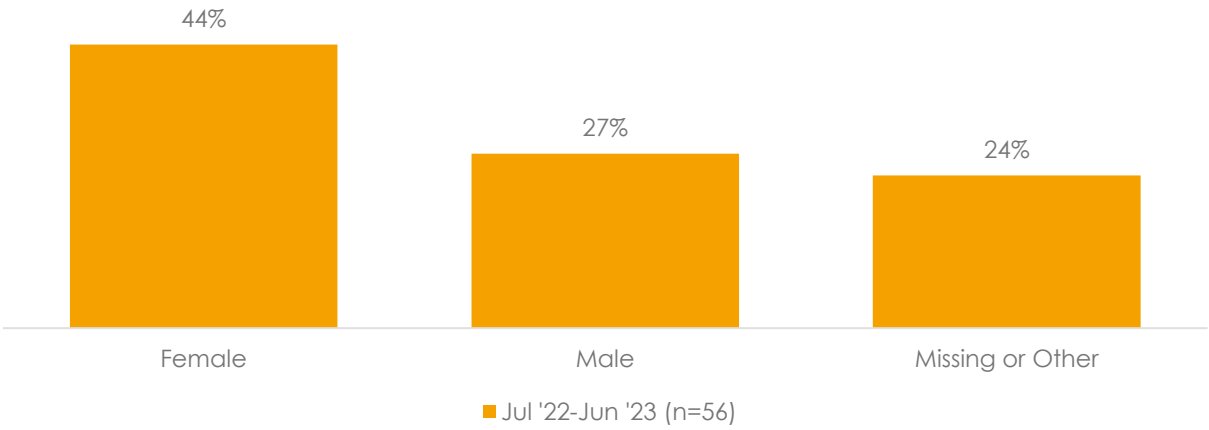


Demographics (Ethnicity)



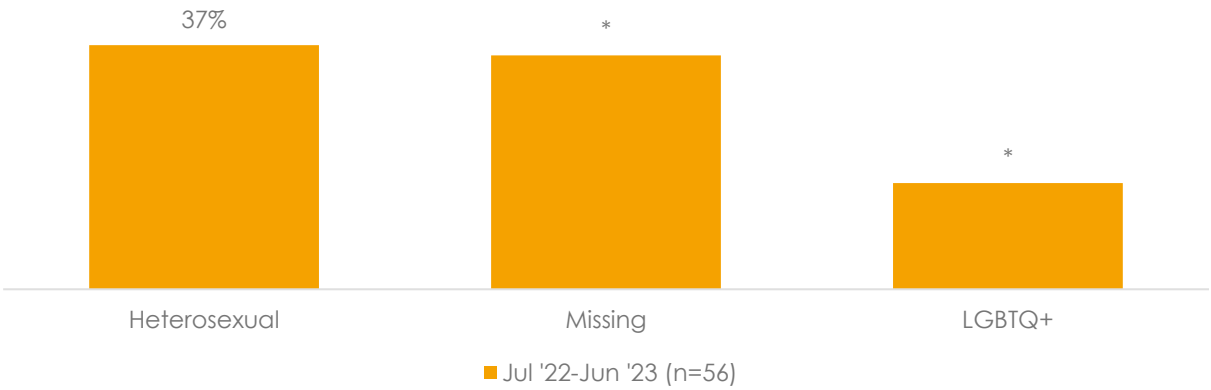
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Demographics (Gender Identity)



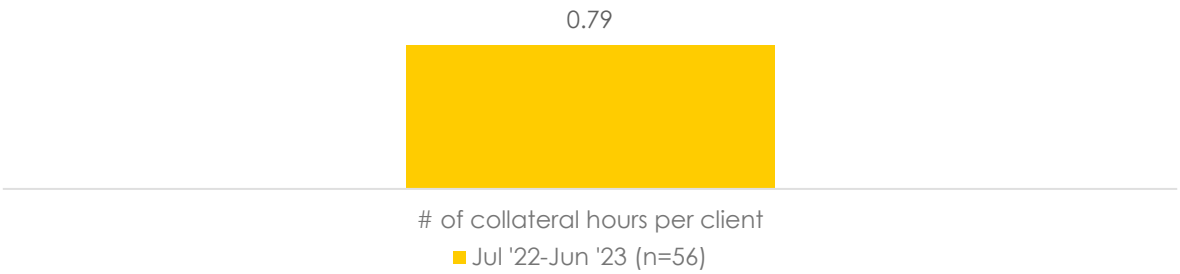
Note: Other includes Multiple gender identities and Non-conforming

Demographics (Sexual Orientation)



Note: *LGBTQ+ includes gay, questioning, and other.

Collateral Services

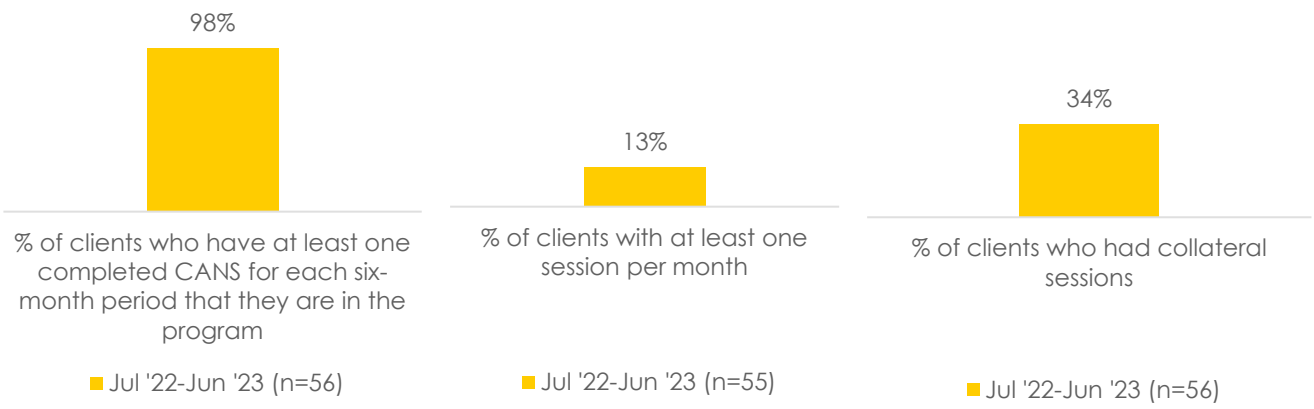


From July 2022 - June 2023, the EPSDT program provided **711.6 hours** of individual therapy

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

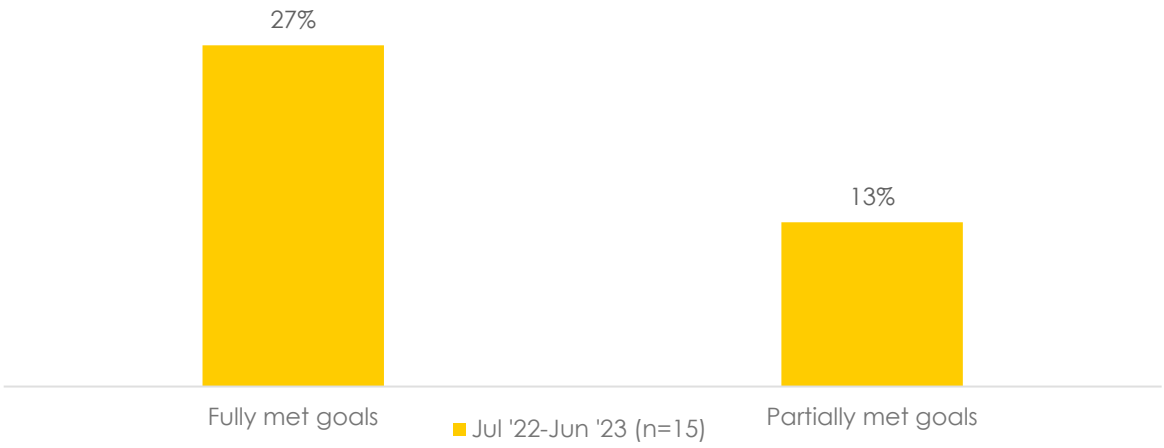
Quality Outcomes ("How well did we do it?")

Service Consistency



Impact Outcomes ("Is anyone better off?")

Discharged Clients Who Met Their Mental Health Goals



NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients	Clients who were not served by the program in the previous fiscal year	Yellowfin
# of individual therapy hours provided	Total individual therapy hours recorded for clients. Includes all procedures in the "ind therapy" service catergory.	Yellowfin
# of collateral hours per client	Total collateral hours recorded for clients divided by all clients. Includes all procedures in the "Collateral" category.	Yellowfin
% of clients who have at least one completed CANS for each six-month period that they are in the program	Of clients with a completed Child or Adult Needs and Strengths Assessment (CANS/ANSA), what percentage of them had an assessment at least every six months?	Objective Arts
% of clients with at least one session per month	Of clients with a recorded visit, what percentage of them had at least three visits for each full month they were enrolled in the program? Does not include months when clients enrolled or exited the program. Visits include all service categories except medical services (MAA).	Yellowfin
% of clients who had collateral sessions	Total clients who received collateral sessions divided by all clients. Includes all clients with recorded procedures in the "Collateral" category.	Yellowfin
Of clients who were discharged from the program, #/% who met mental health goals	Percent of discharged clients who had a discharge reason of either "Mutual Agreement/Treatment Goals Reached" or "Mutual Agreement/Treatment Goals Partially Reached"	Yellowfin

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

BMH RBA Report FY 2023

Reporting Period July 2022 - June 2023

Child Full Service Partnership (CFSP)

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

13

Clients Served

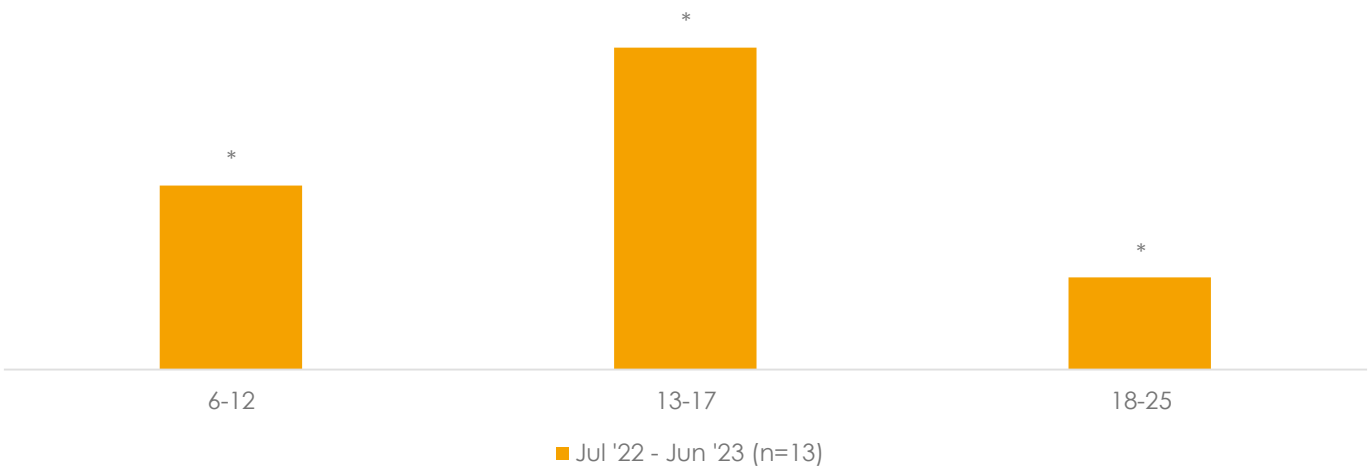
9

New Clients

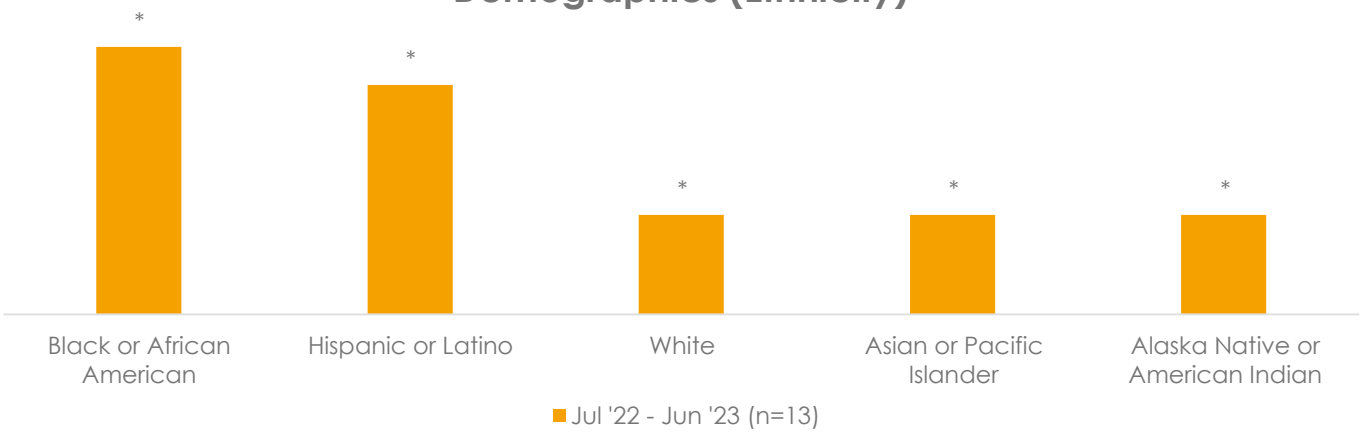
Program Description: This team provides wrap around services to children and families with acute needs, who meet the following criteria: child is at risk of/has been removed from their parent/guardian; child is involved with the Juvenile Justice System or at risk of that; has been recently had a psychiatric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

Program Updates: For all time periods in this report, the CFSP team was not fully staffed. This affected both the total number of clients that the program was able to serve, as well as the monthly services provided.

Demographics (Age)

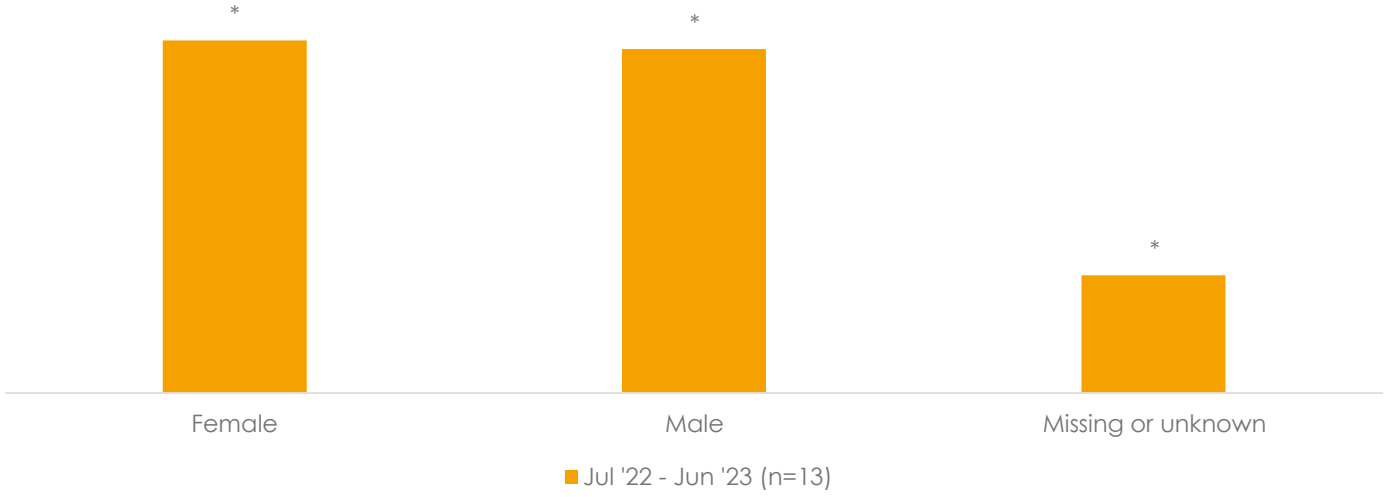


Demographics (Ethnicity)

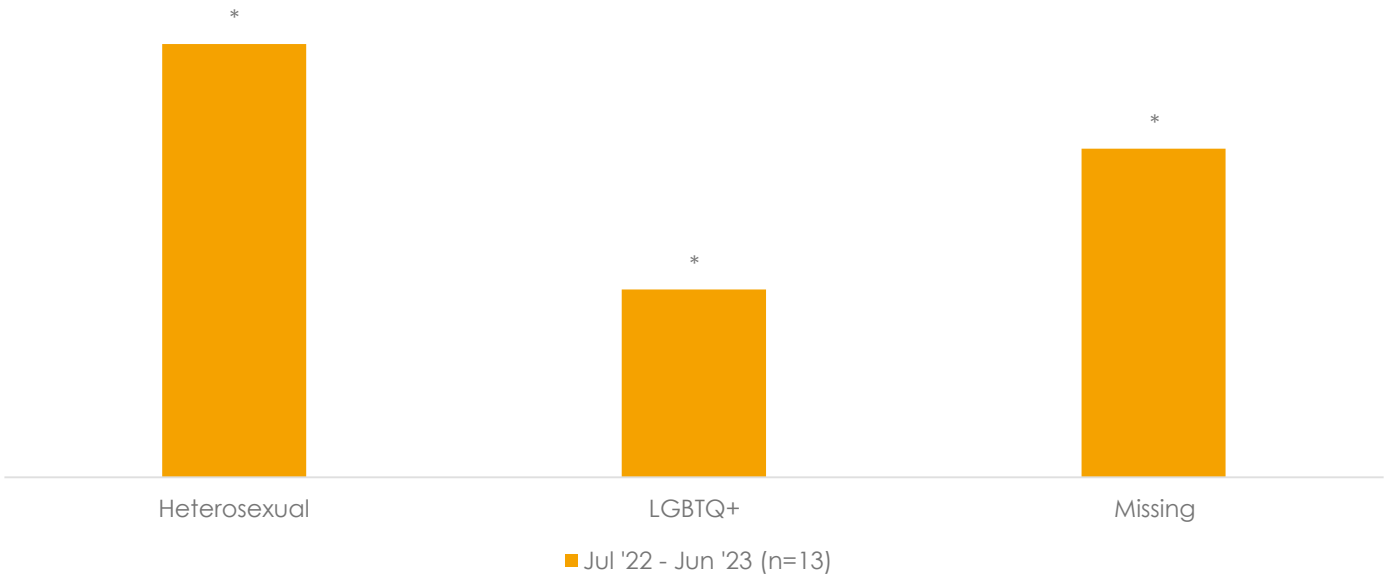


NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Demographics (Gender Identity)



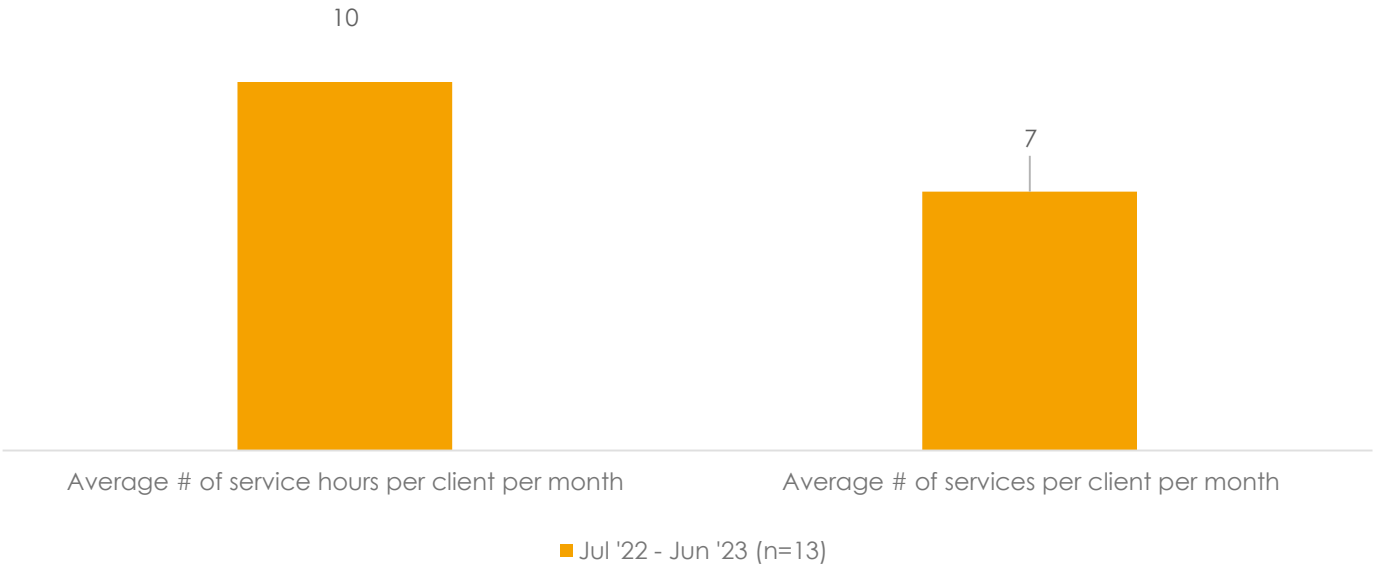
Demographics (Sexual Orientation)



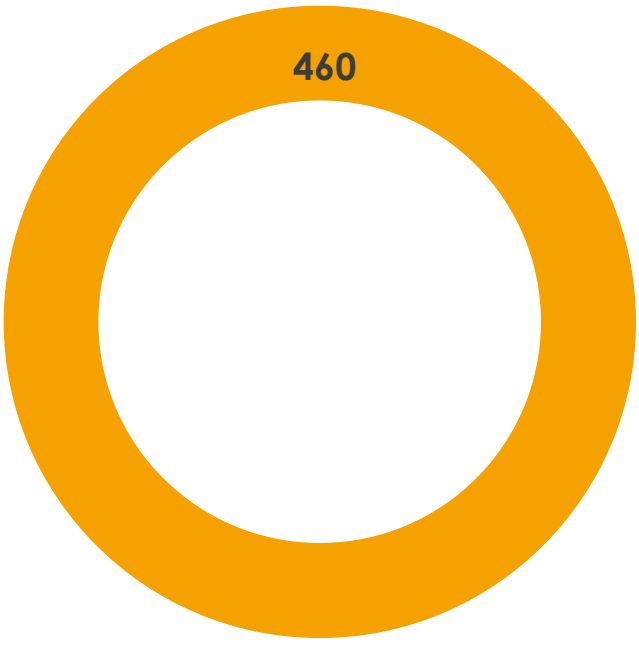
*LGBTQ+ includes gay, questioning, and other.

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Average Monthly Services per Client



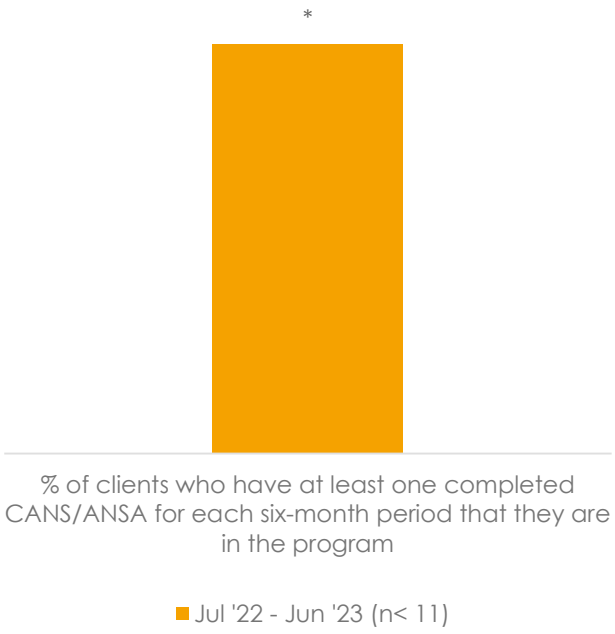
Average # of days in FSP per client

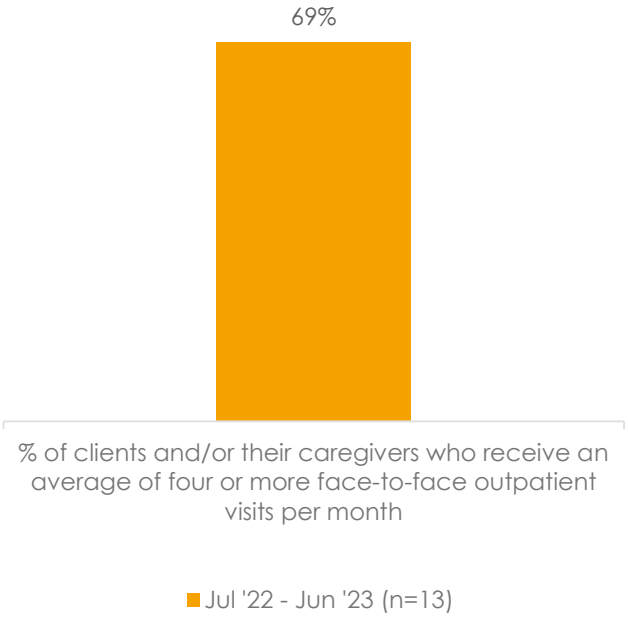


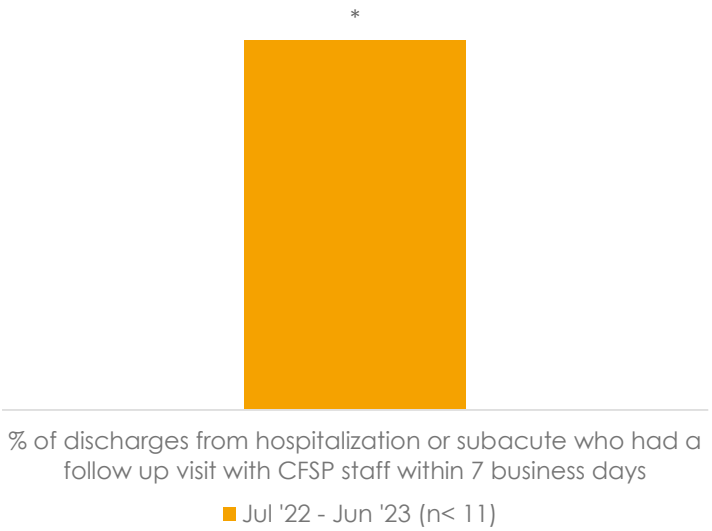
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

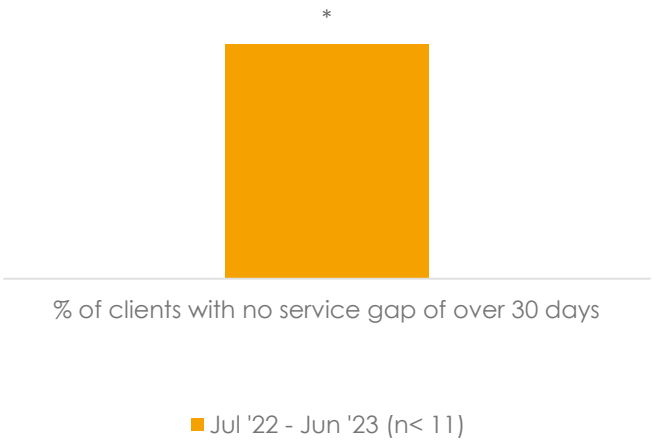
Quality Outcomes ("How well did we do it?")

Service Consistency



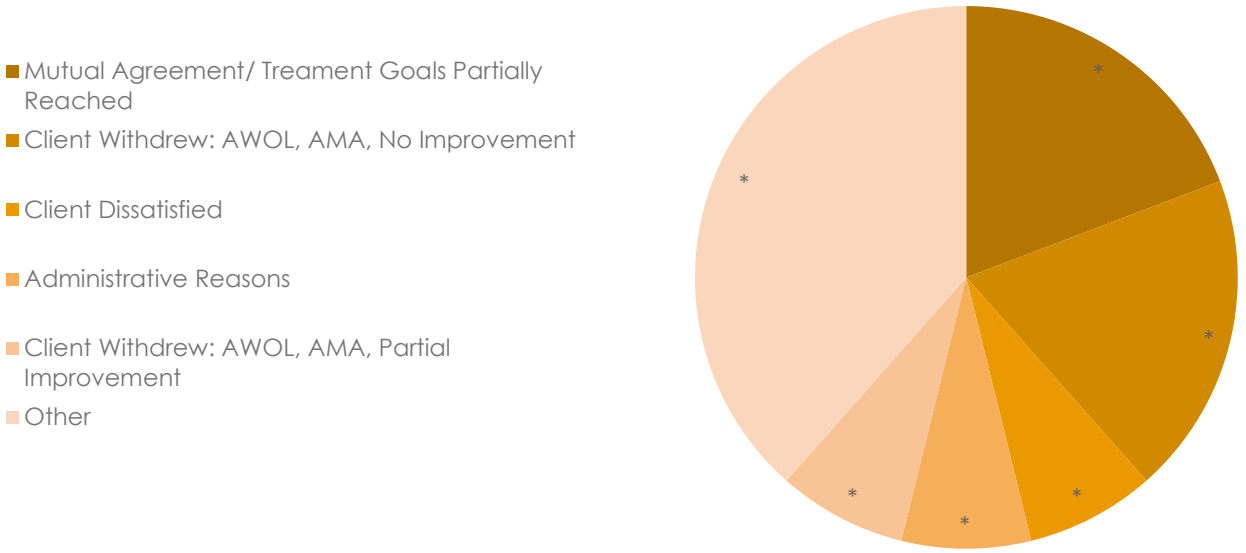






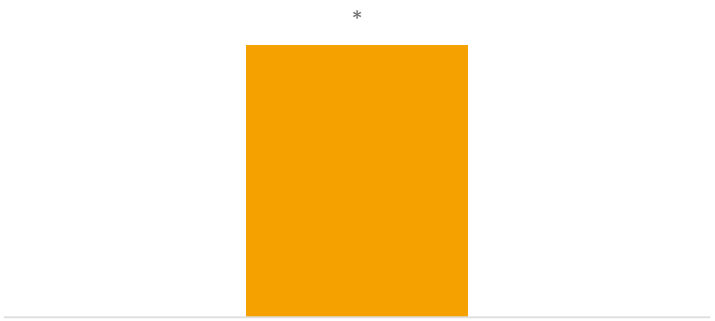
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Impact Outcomes ("Is anyone better off?")



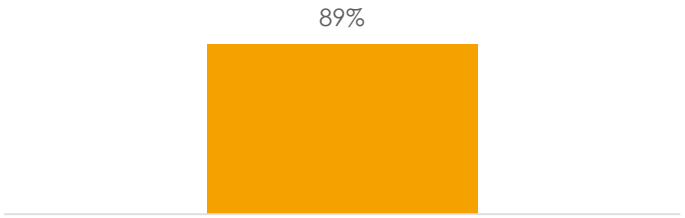
Jul '22 - Jun '23 (n< 11)

Client Outcome Improvements



% of clients who had a reduction in stays/days in psychiatric emergency services/inpatient/crisis stabilization units

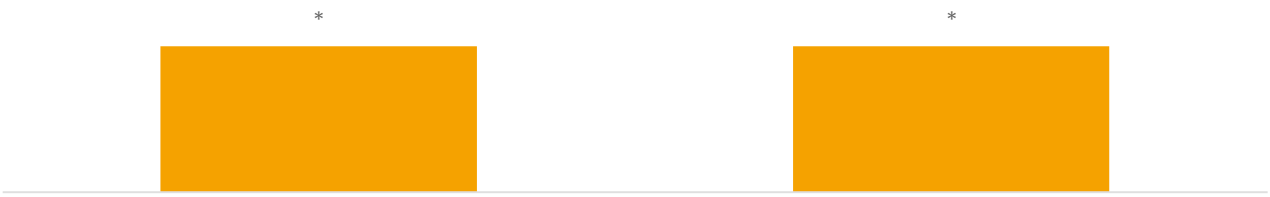
Jul '22 - Jun '23 (n< 11)



% of clients with connection to primary care

Jul '22 - Jun '23 (n< 11)

% of clients with a decrease in hospitalizations/hospital days



Jul '22 - Jun '23 (n< 11)

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

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

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

% of clients with a decrease in hospitalization days/admissions	Decrease in hospital days/admissions in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital day in the 12 months prior to admission and remained in the program for at least 1 year. Only available for fiscal years.	Yellowfin

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

BMH RBA Report FY 2023

Reporting Period: June 2022 - July 2023

Mobile Crisis Team (MCT)

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

700

Clients Served

978

Incidents Responded To

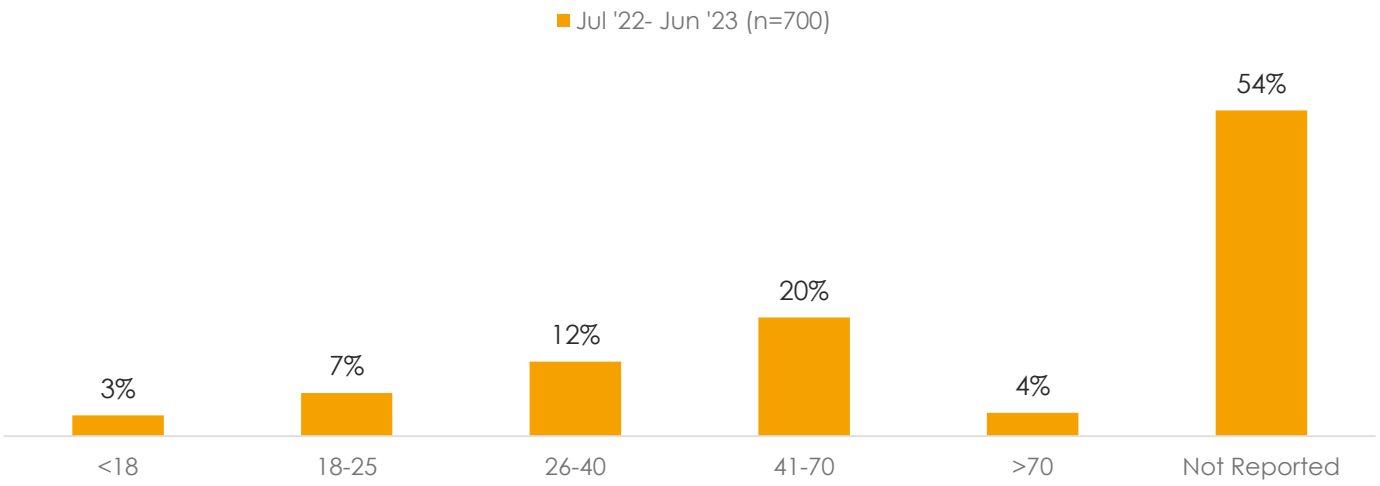
Program Description

The Mobile Crisis Team (MCT) serves residents of Berkeley, from 11:30am-10pm each day of the week when fully staffed (1 Supervisor + 3 Full Time Clinicians). It provides crisis interventions, including but not limited to 5150 evaluations, consultations, and referrals/linkages.

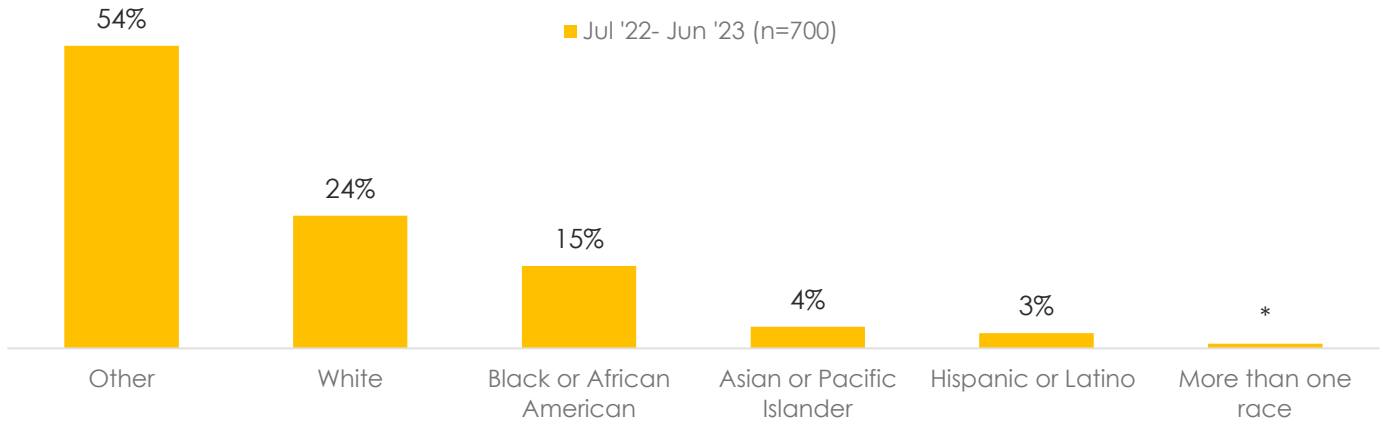
Program Updates

Since 2019, the MCT has had only 2 FT clinicians and no supervisor. As a result, the program has not been able to operate at full capacity.

Demographics (Age)



Demographics (Ethnicity)

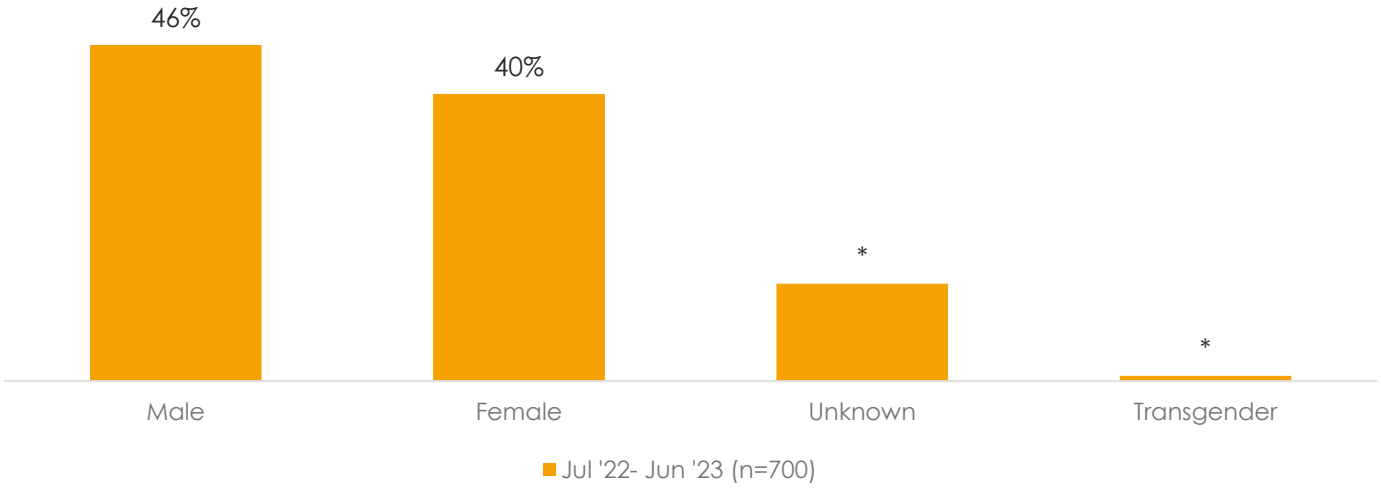


NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

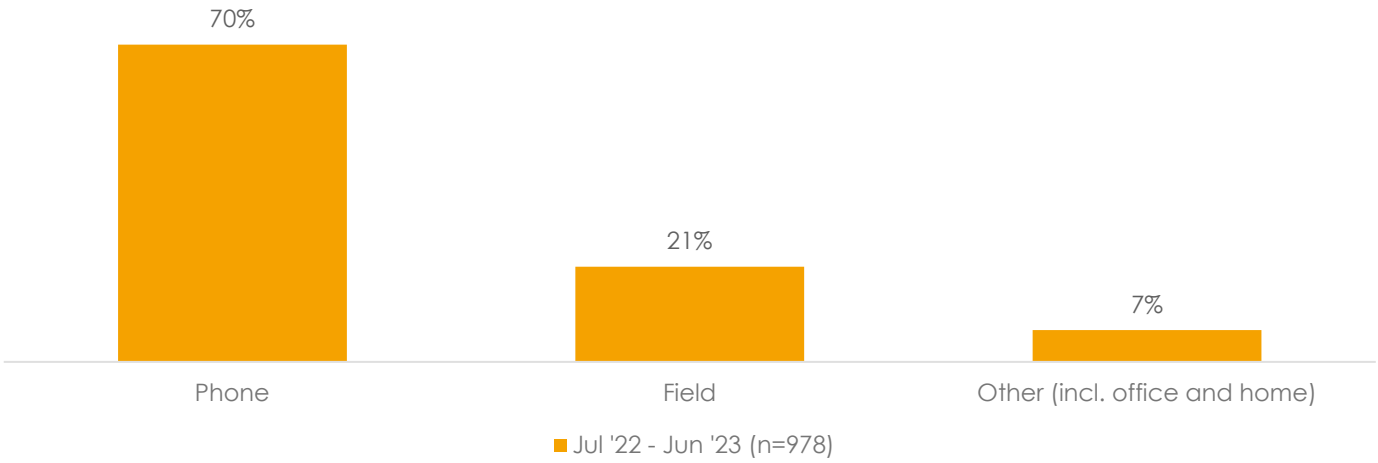
BMH RBA Report FY 2023

Reporting Period: June 2022 - July 2023

Demographics (Gender Identity)



Client Contacts Made by Contact Type



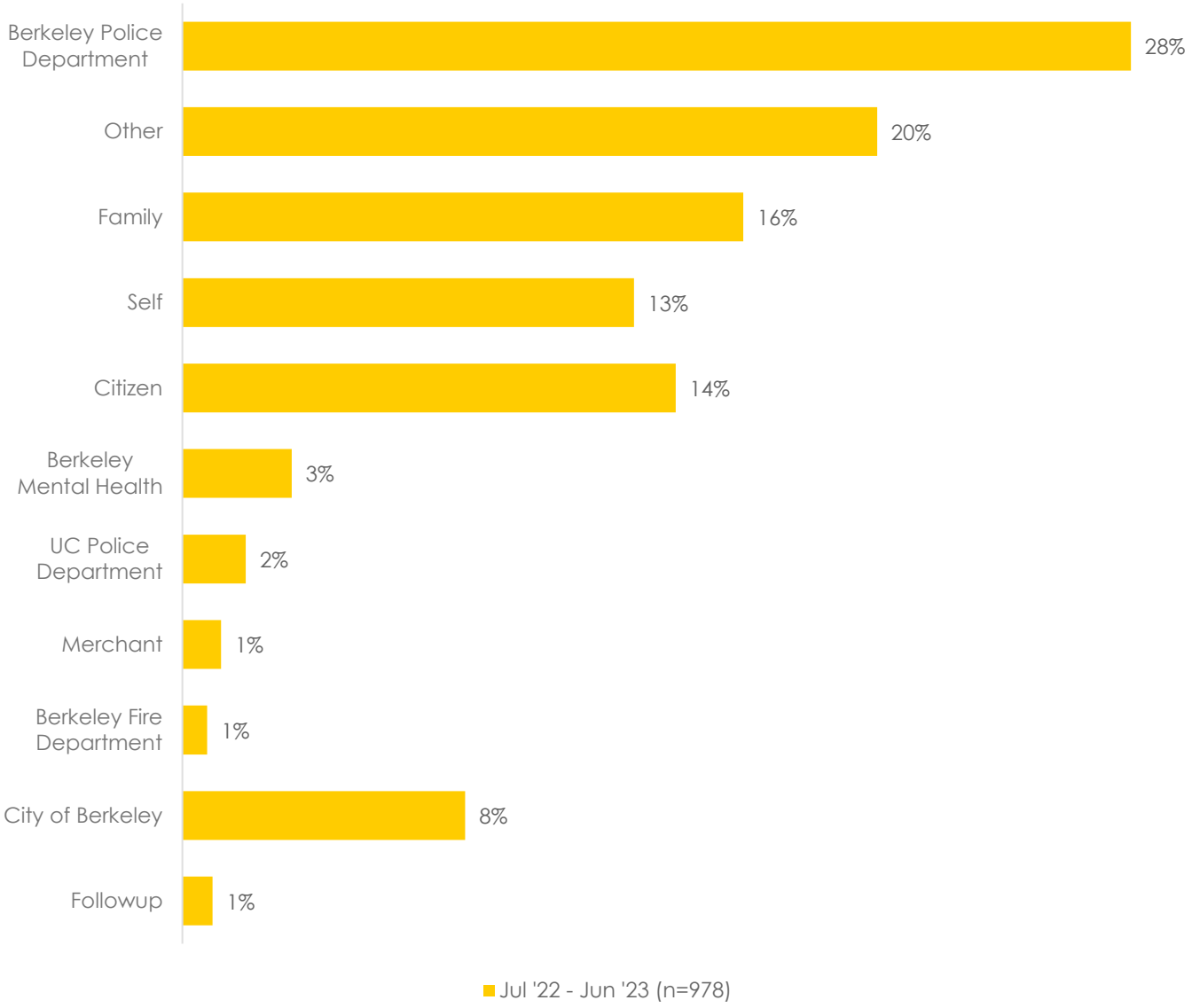
From June 2022 - July 2023, the MCT program performed **189** 5150 Evaluations

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

BMH RBA Report FY 2023

Reporting Period: June 2022 - July 2023

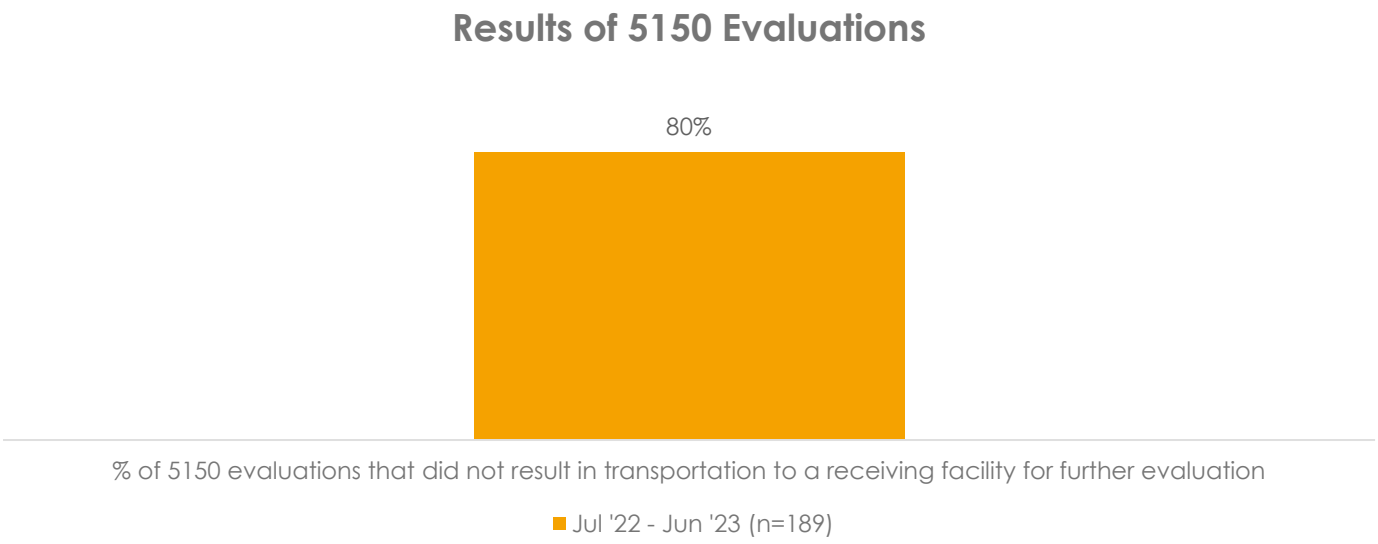
Referrals by Referring Party



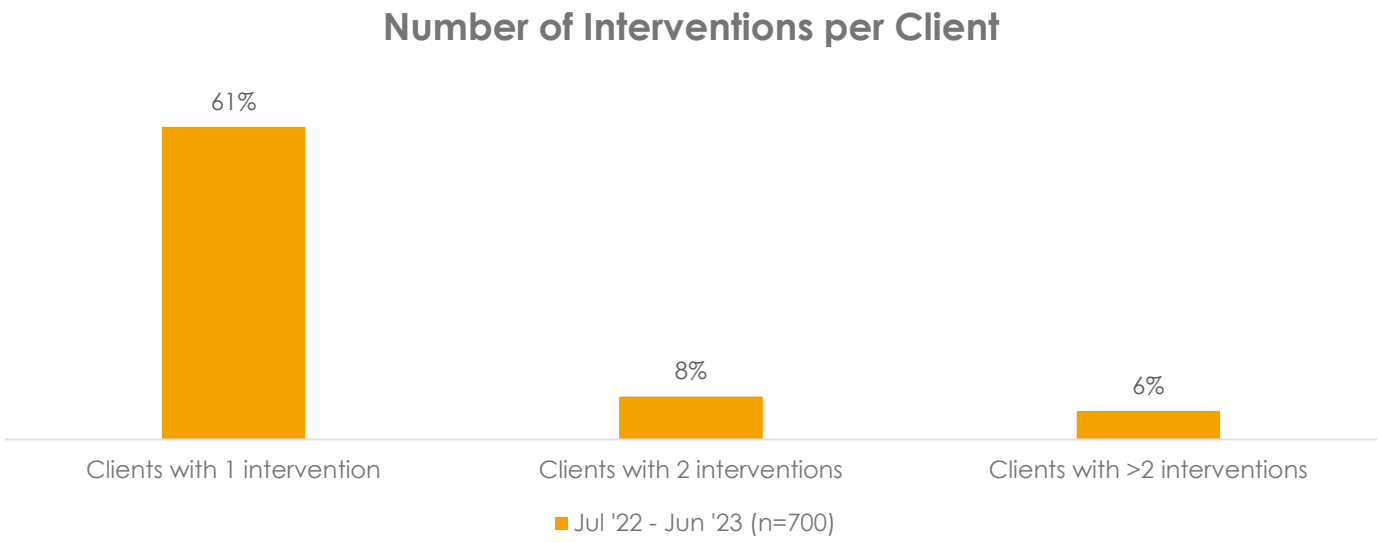
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

BMH RBA Report FY 2023

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



Impact Outcomes ("Is anyone better off?")



NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

BMH RBA Report FY 2023

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

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

BMH RBA Report FY 2023

Reporting Period July 2022 - June 2023

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

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

645
Clients Served

1425
Contacts

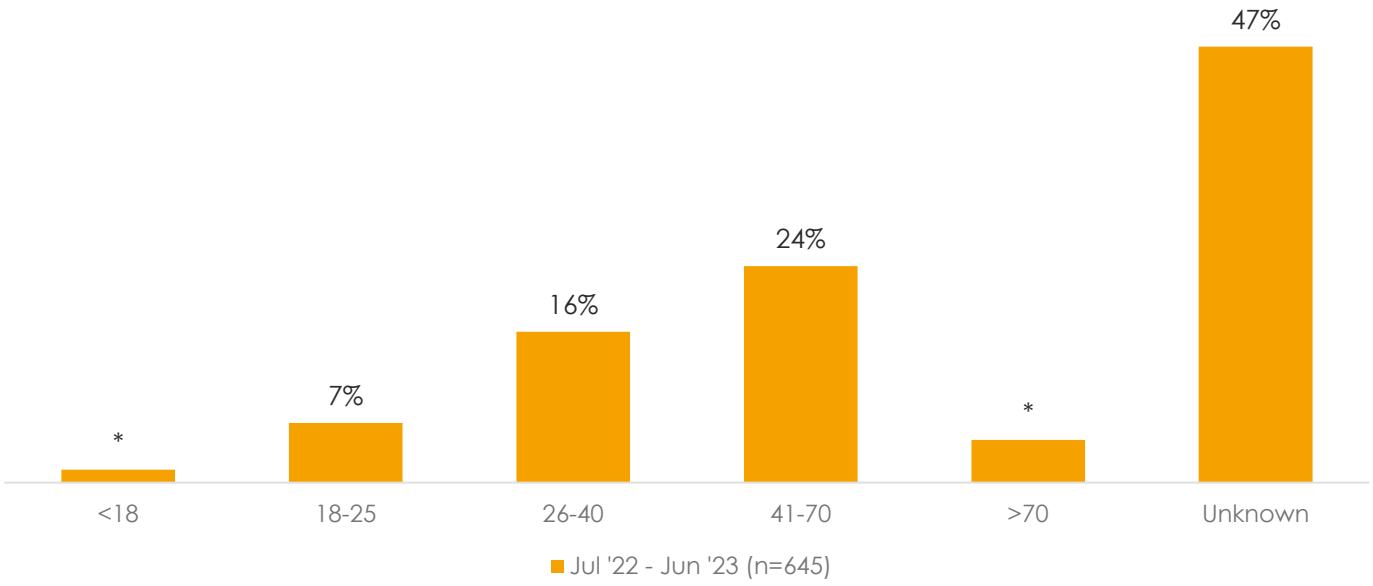
Program Description

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

Program Updates

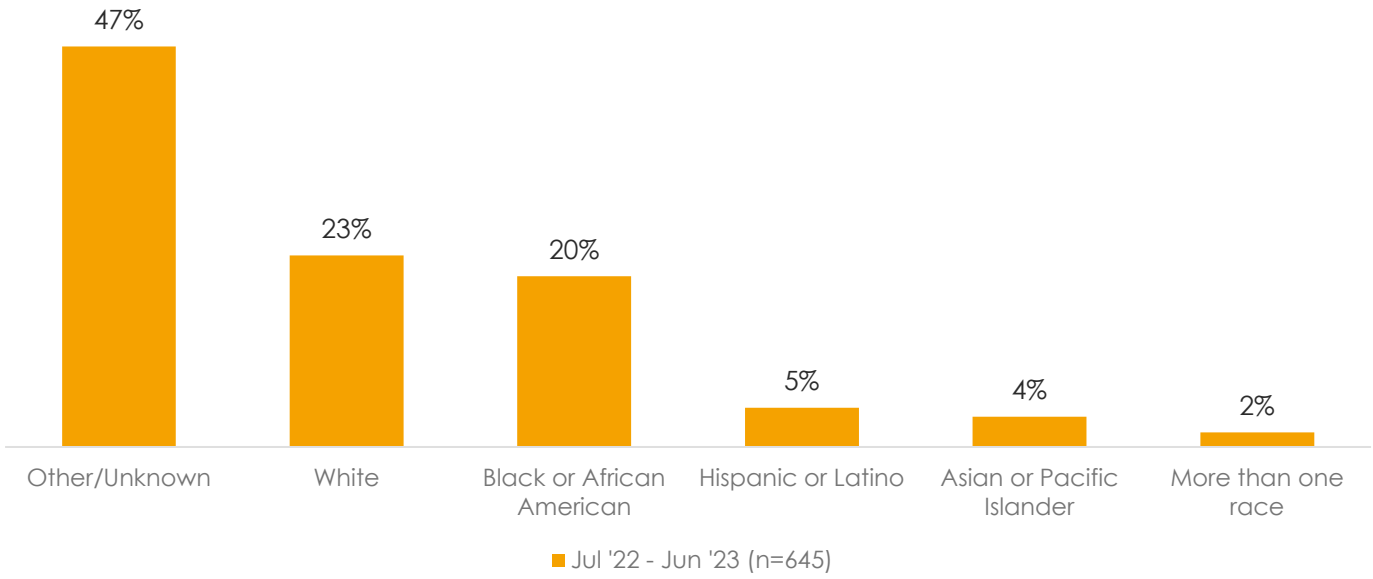
The program expanded their walk-in hours from 3 hours to 5 hours in June 2023. Due to the increase in new clients, there has been limited staff capacity for follow up services.

Demographics (Age)

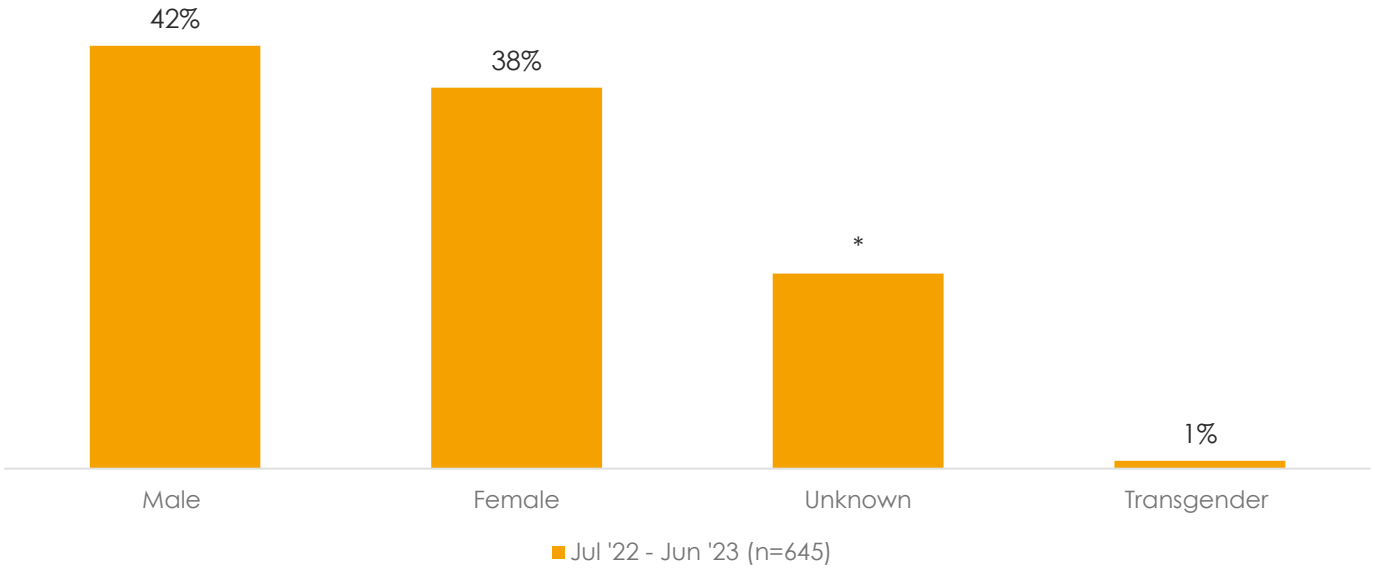


NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Demographics (Ethnicity)



Demographics (Gender Identity)

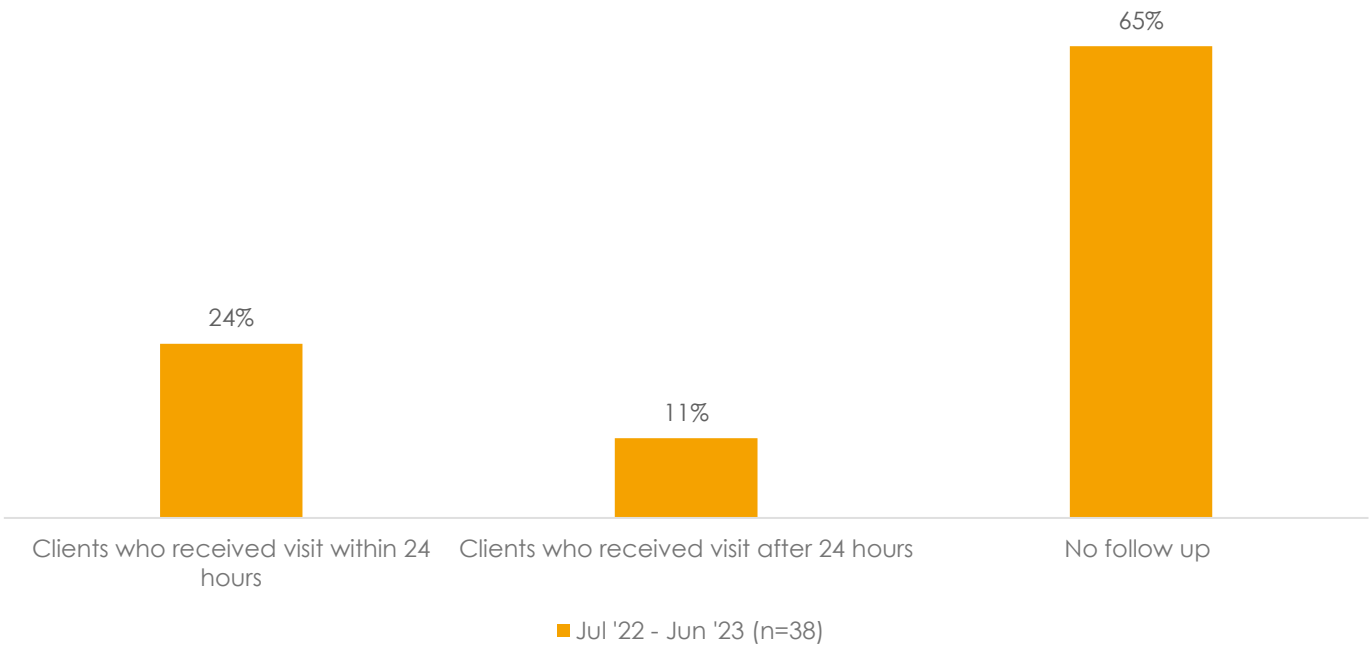


Note: "Other" includes those marked as "Other." Unknown includes those marked as "Unknown" or missing due to clients not disclosing, clinician unable to make the determination, or a crisis situation not allowing for more comprehensive data collection. Sexual orientation data not available.

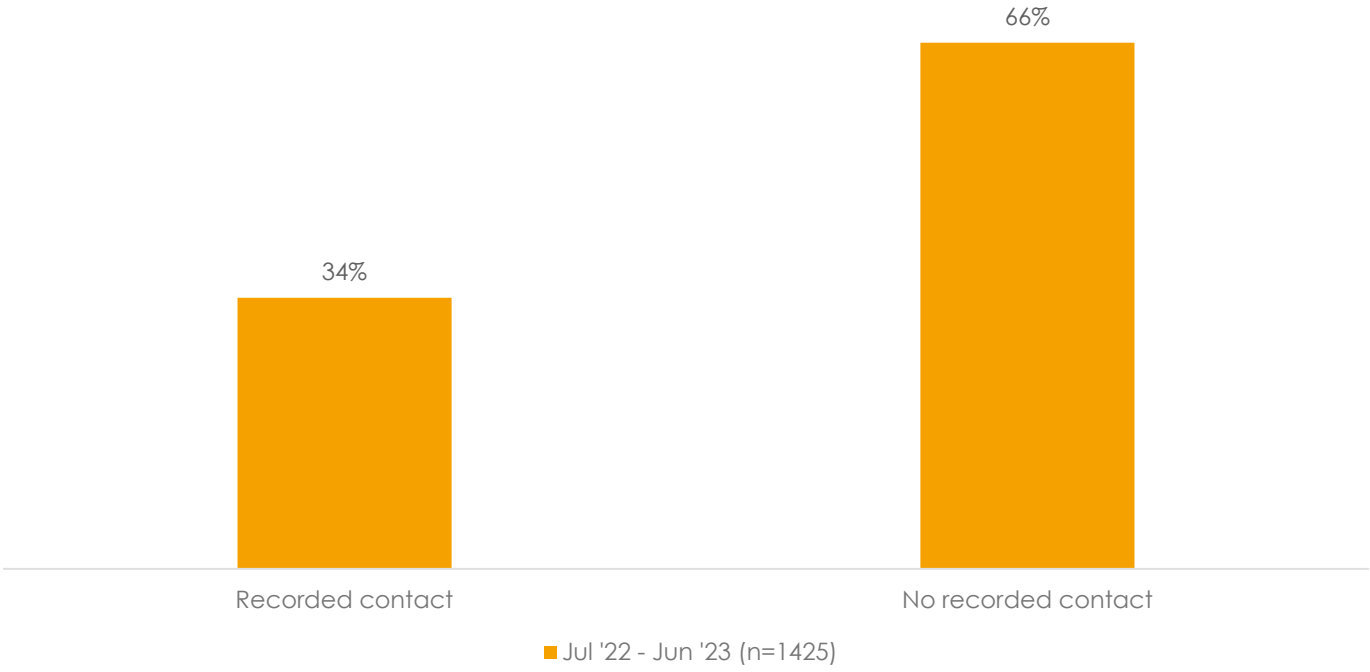
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

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

Follow-up after hospitalization



MCT contacts who had a CAT attempt to contact



NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

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

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

BMH RBA Report FY 2023

Reporting Period July 2022 - June 2023

Homeless Full Service Partnership (HFSP)

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

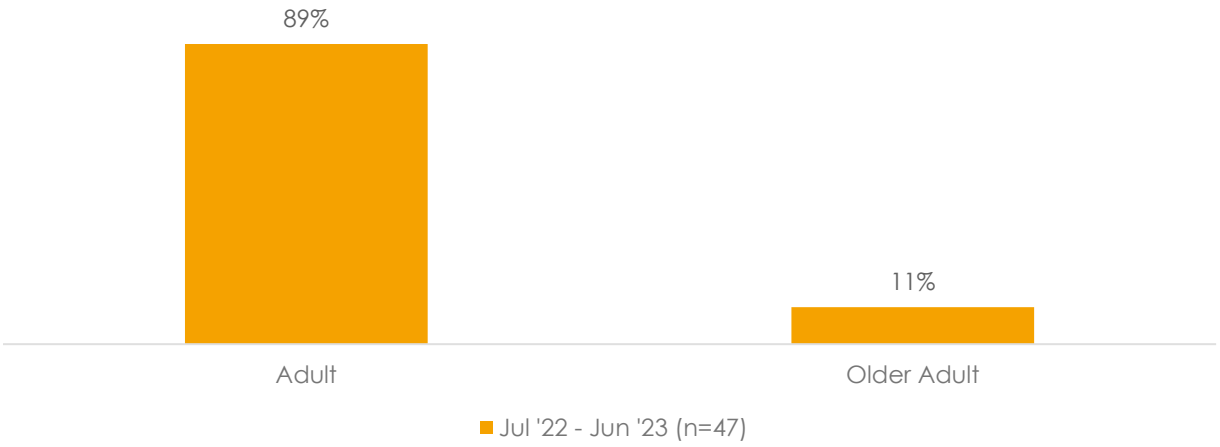
47
Clients Served

11
New Clients

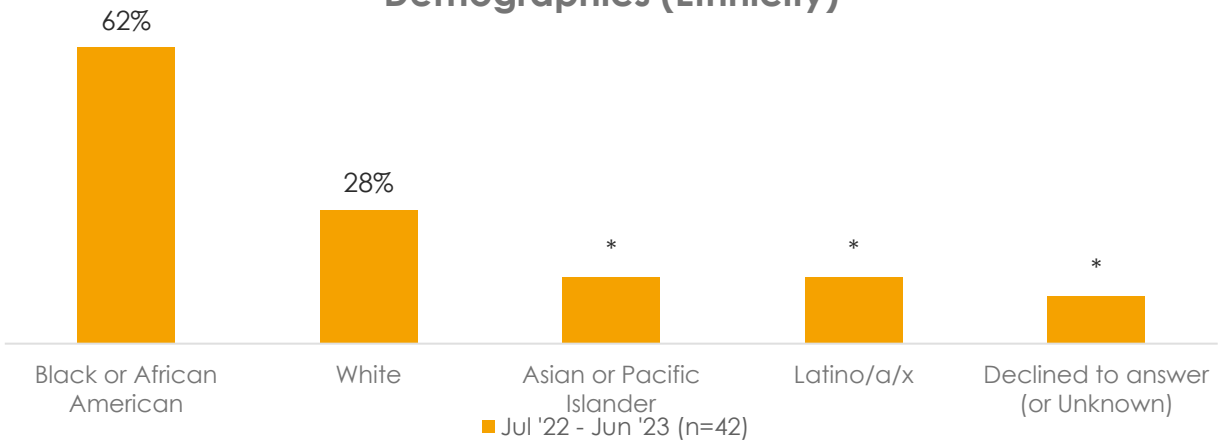
Program Description: HFSP serves unhoused residents of Berkeley in an Assertive Community Treatment (ACT) model at high staff to client ratios, providing intensive case management and mental health services in a multi-disciplinary team approach. This team serves those with the highest level of need,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

Program Updates: HFSP began offering services during Fiscal Year 2021-22, and therefore was growing their caseload. They additionally had some staffing transitions in the second half of FY 2022-23 but are now fully staffed.

Demographics (Age)



Demographics (Ethnicity)



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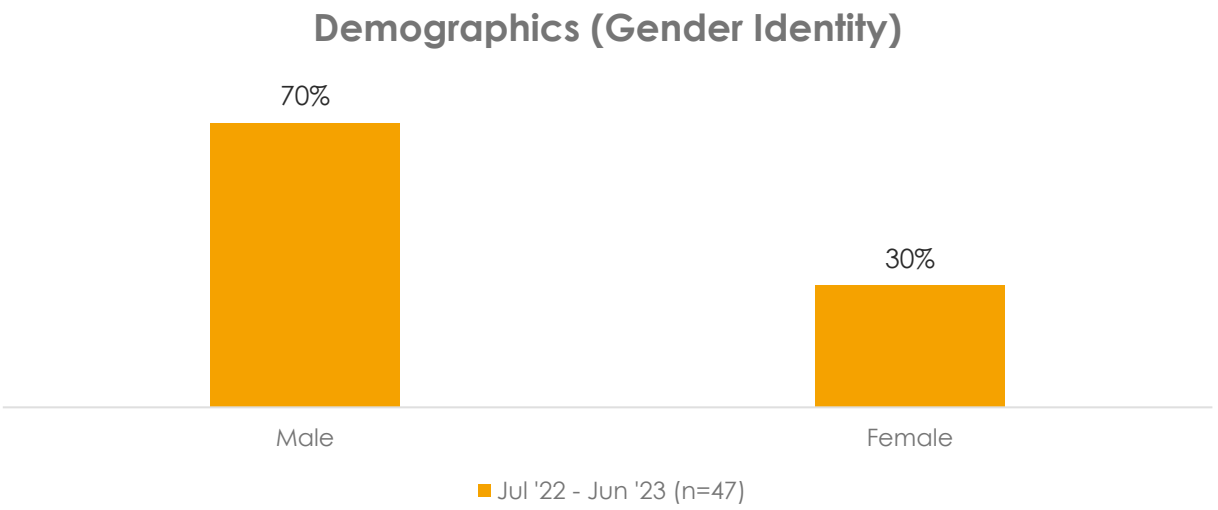
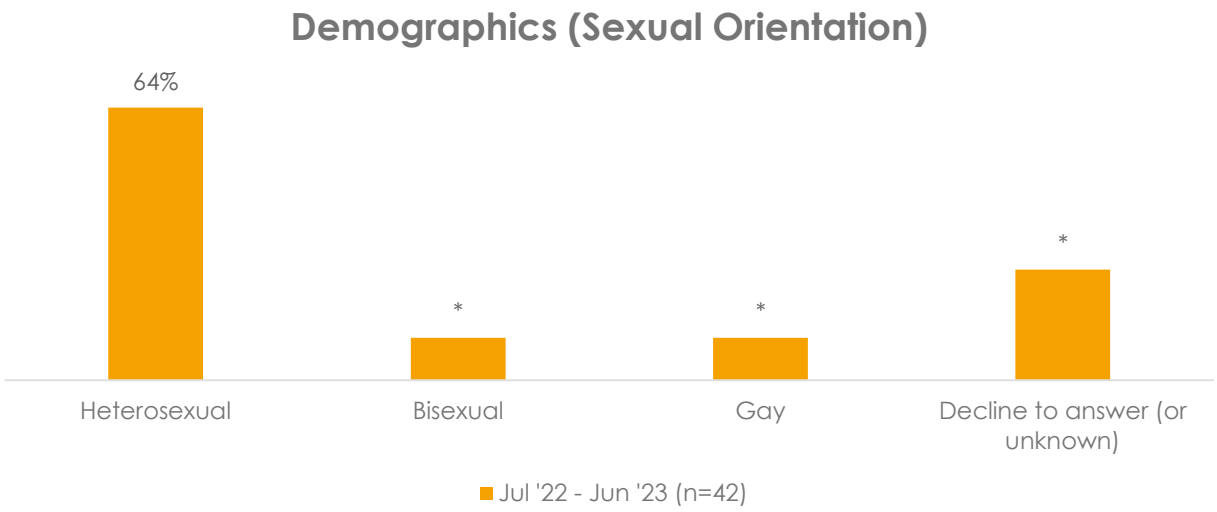
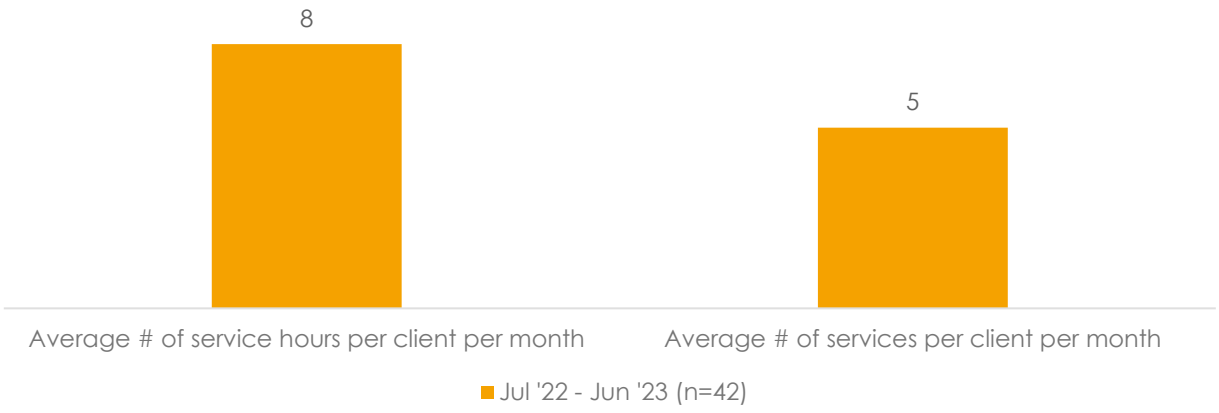




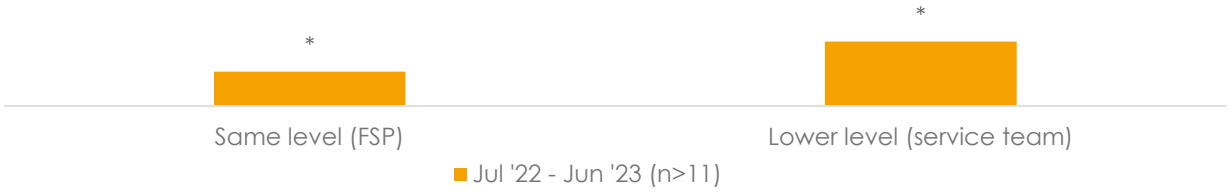
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Average Monthly Services per Client



Average Number of Days in FSP

Clients Transferred to Another Program, by Level of Care

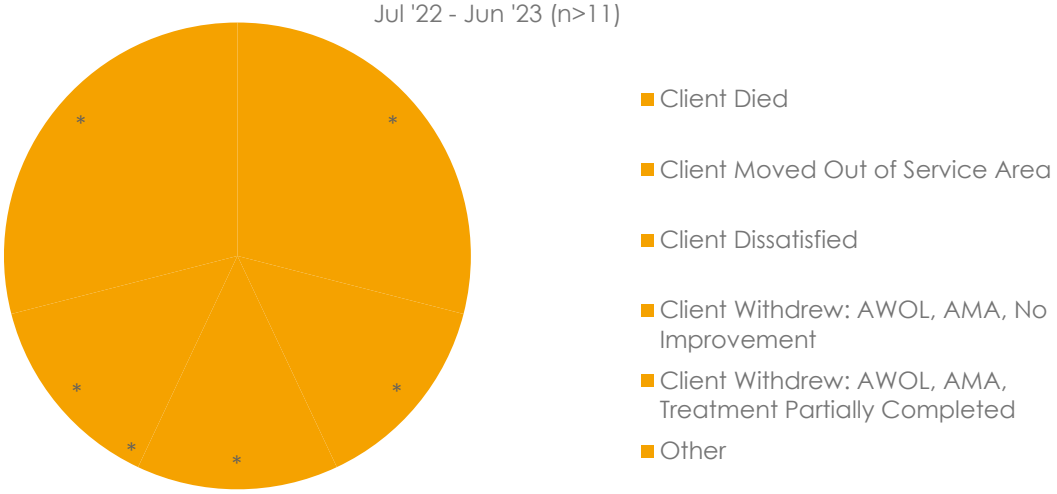


NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

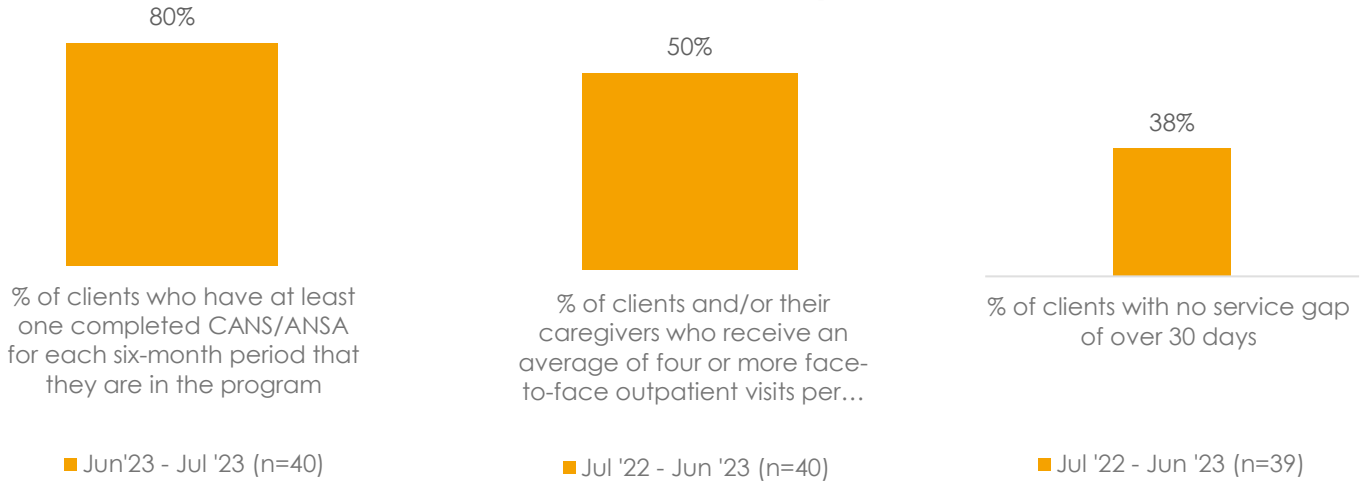
Quality Outcomes ("How well did we do it?")

Clients Closed, by Reason Closed

Jul '22 - Jun '23 (n>11)

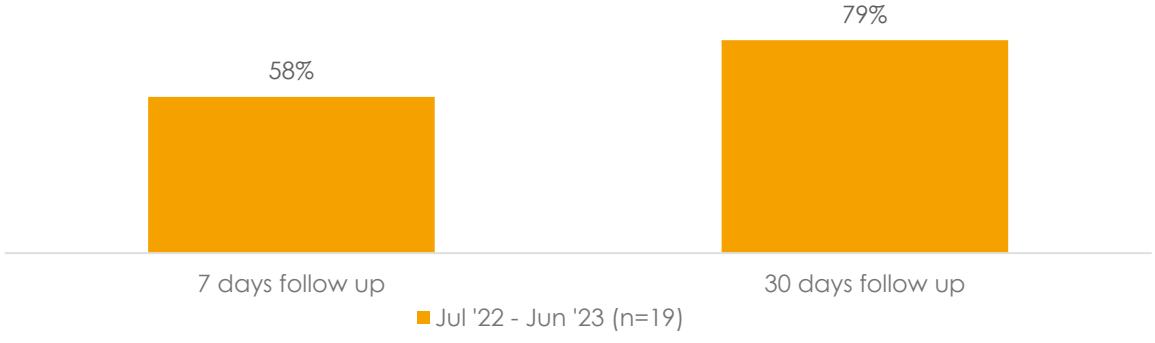


Service Consistency



Hospital Follow Up Consistency

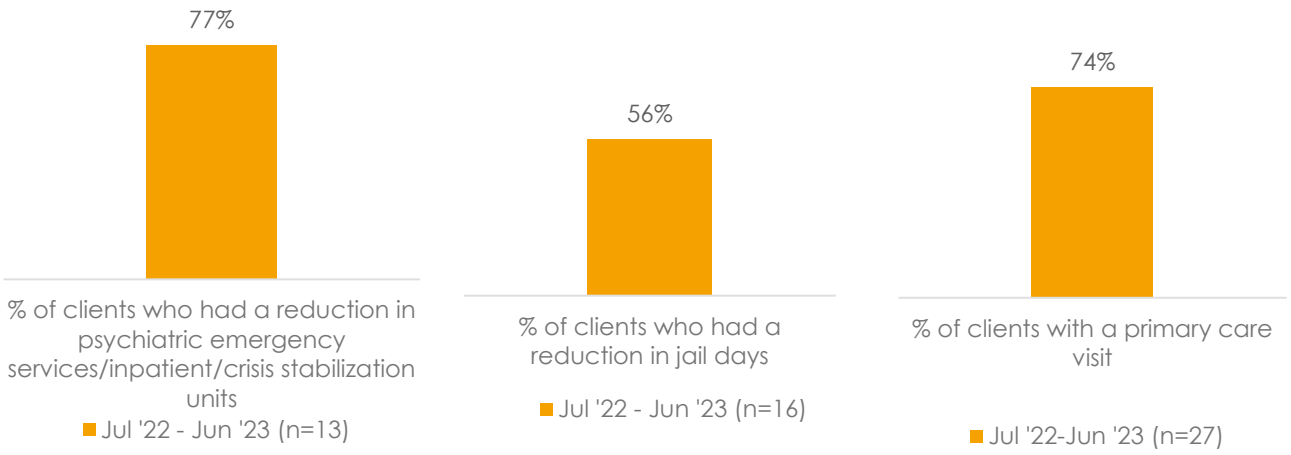
% of discharges from hospitalization or subacute who received FSP follow up within 7 and 30 days



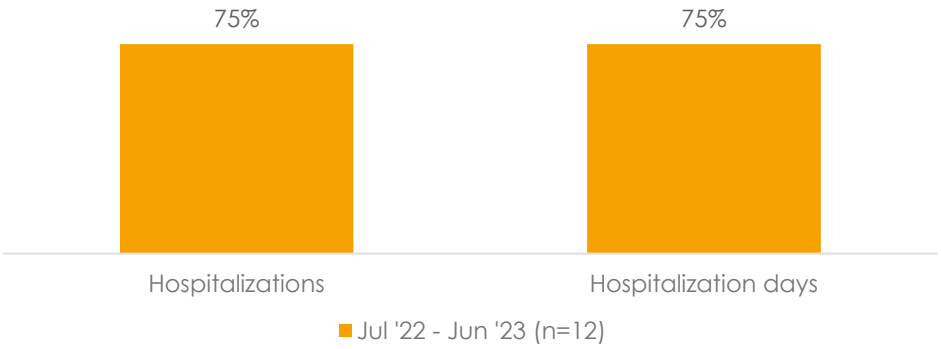
NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Impact Outcomes ("Is anyone better off?")

Client Outcome



% of clients with a decrease in hospitalizations/hospital days



NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

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

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

% of clients who had a reduction in psychiatric emergency services/inpatient/crisis stabilization units	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in psychiatric emergency services, inpatient or crisis stabilization unit other than Amber House, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in jail and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients who had a reduction in jail days	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in jail days, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in hospital and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients with a primary care visit	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/Community Health Center Network (CHCN) primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).	Yellowfin
% of clients with a decrease in hospitalizations/hospitalization days	Decrease in hospital days/admissions in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital day in the 12 months prior to admission and remained in the program for at least 1 year. Only available for fiscal years.	Yellowfin

BMH RBA Report FY 2023

Reporting Period: June 2023 - July 2023

Medical Services

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

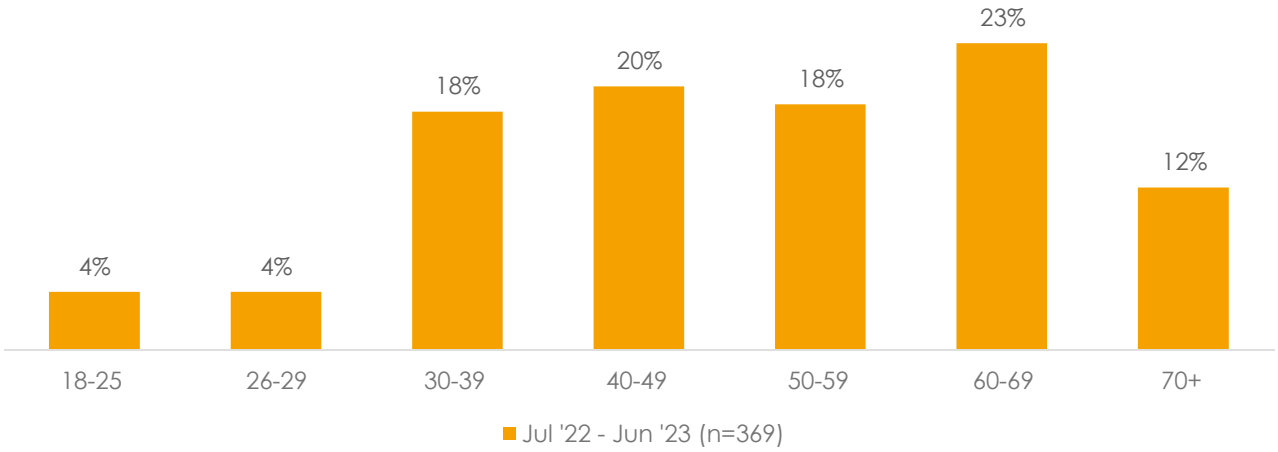
317

Clients Served

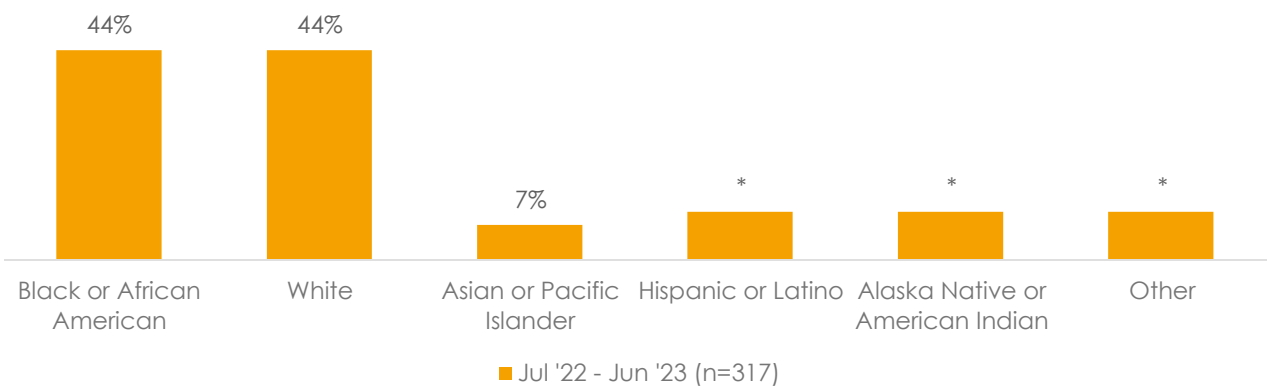
Program Description The Medical Services Team provides psychiatric and nursing services to patients on Adult Services (FIT, CCT, & FSP), Crisis Services, and Family, Youth, and Children's Services.

Program Updates The team has experienced staffing changes, with only 1 of 5 nursing positions currently filled. Nurses are the primary staff person who connects clients to PCPs. Office staff have been working hard to support clients in attending appointments, including reminders, coordinating with case managers to schedule appointments at times that work for the client, and offering phone visits.

Demographics (Age)

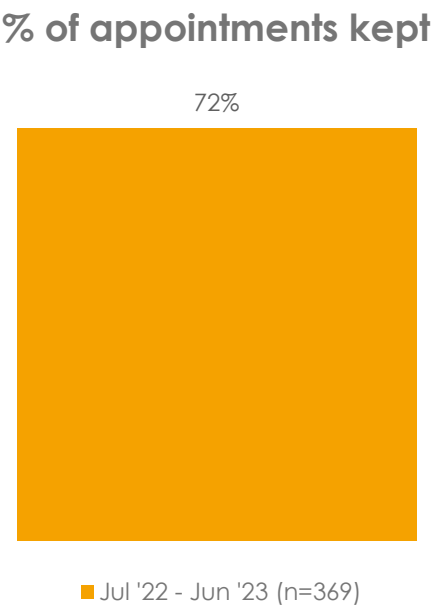


Demographics (Ethnicity)

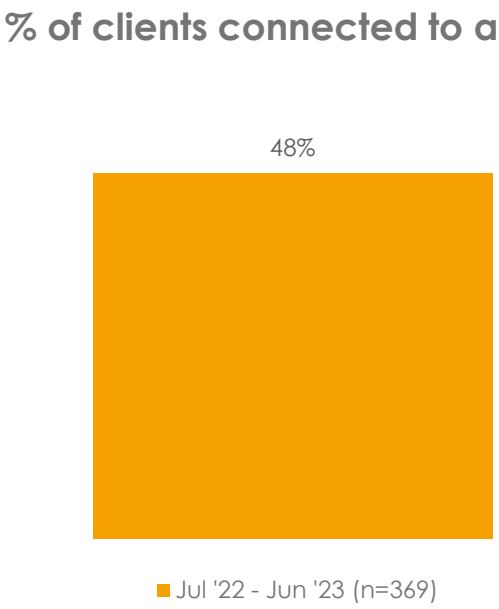


NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

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



Impact Outcomes ("Is anyone better off?")



NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Measure	Definition	Data Source
# clients served	Total clients served. Due to the discrepancy between client counts in Yellowfin and internal documents, Yellowfin is used for overall client count while internal totals are used for specific measures.	Yellowfin
% of appointments kept	Of scheduled appointments, % which were kept during the reporting period	MD Attendance Tracker
% of clients connected to a primary care provider	Of total clients, % who had Primary Care Practitioner (PCP) listed in Primary Care Tracker at least one month during the reporting period.	Primary Care Provider Tracker

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

BMH RBA Report FY 2023

Reporting Period July 2022 - June 2023

Wellness & Recovery Services

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

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

Program Updates The Wellness Recovery Team added two Social Services Specialist positions to the program. Adding these positions made more people aware of the wellness groups, events and support that the clinic has to offer.

49

Participants served

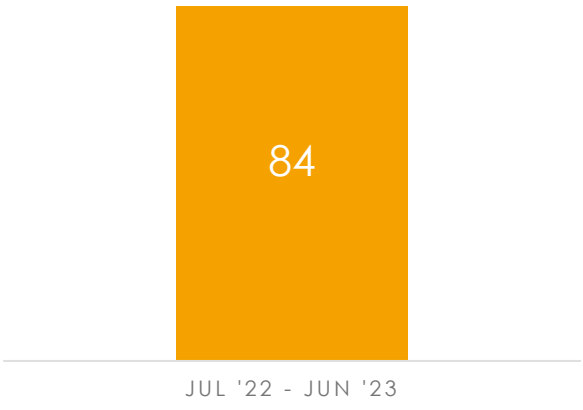
10

Participants who meet requirements for "Telling Your Story"

7

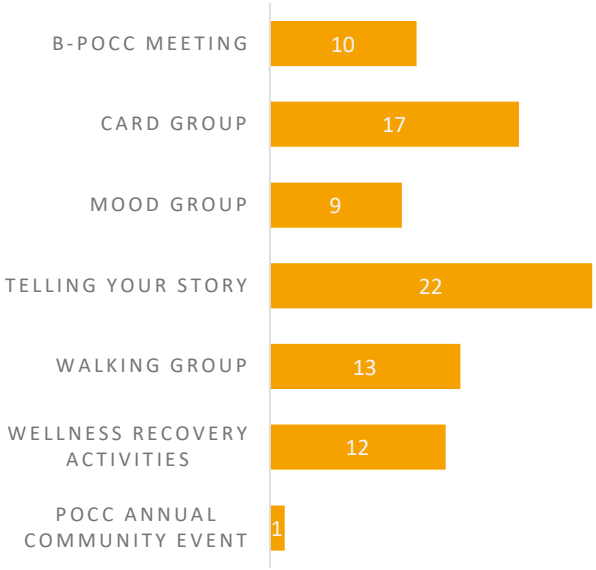
Different groups convened

WELLNESS GROUP MEETINGS ACROSS 7 DISTINCT GROUPS



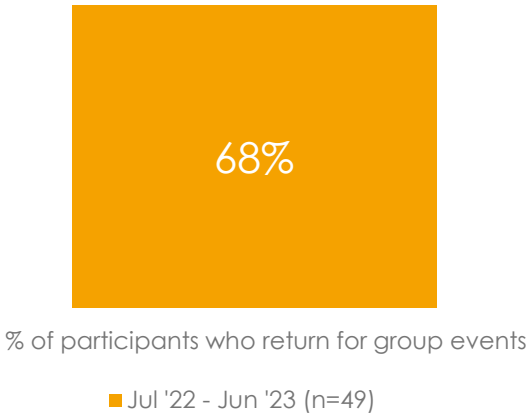
WELLNESS GROUP MEETINGS

JUL '22 - JUN '23 (N=84)

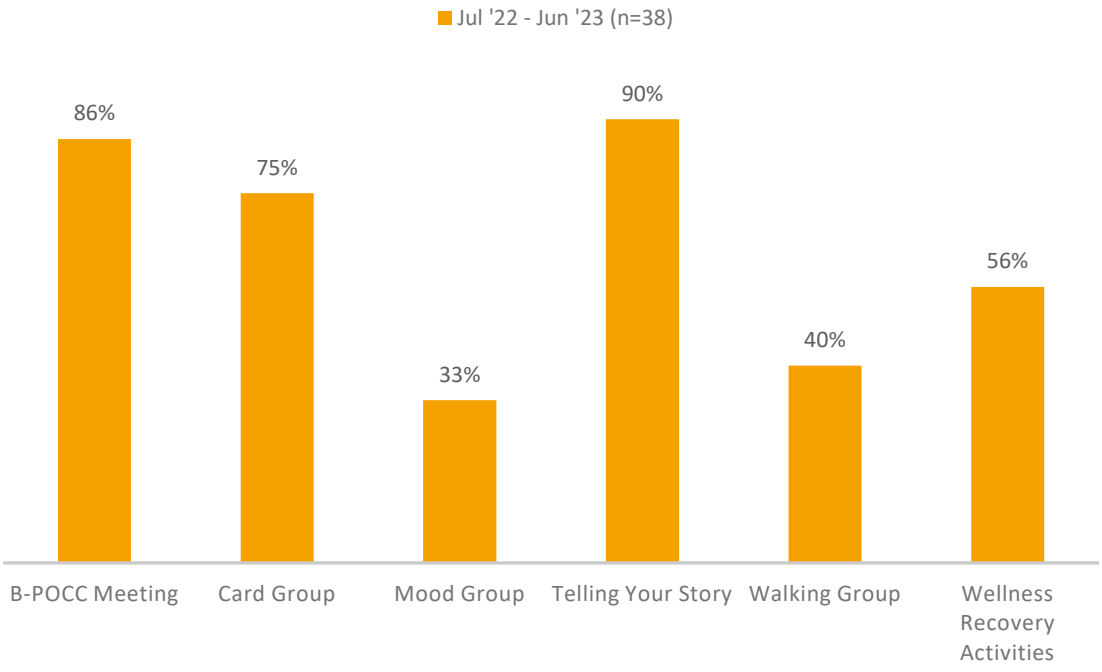


Quality Outcomes ("How well did we do it?")

Total Returning Participants



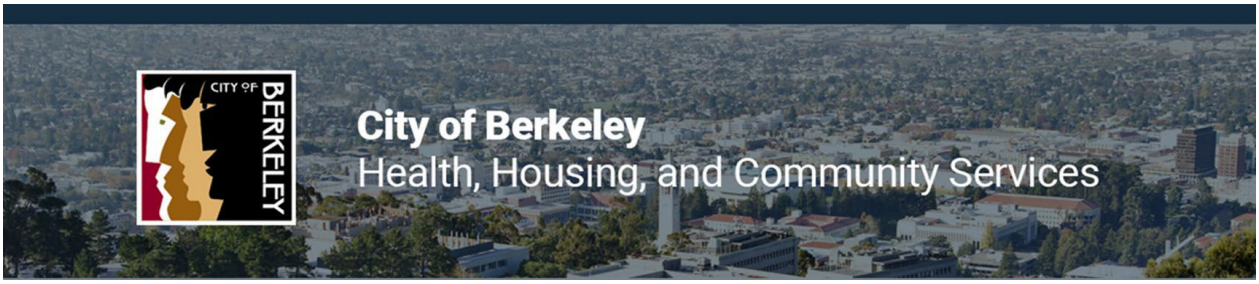
% Repeat Attendees for Wellness Groups



Measure	Definition	Data Source
# participants served	Total # of participants served	Wellness Recovery Group Attendance Tracker
# of different groups convened	Number of different types of groups (i.e. walking group, mood group, Telling Your Story group) convened	Wellness Recovery Group Attendance Tracker
Average # of group events held per 6 months	Total number of meetings held	Wellness Recovery Group Attendance Tracker
# of participants who meet the requirements for "Telling Your Story"	Total number of participants in all "Telling Your Story" meetings	Wellness Recovery Group Attendance Tracker
% of participants who return for group events	Of total number of participants, % who returned for more than one event or meeting	Wellness Recovery Group Attendance Tracker
% of participants reporting feeling less shame about their experiences and challenges	Percentage of survey respondents who agree or strongly agree that they feel less shame about their experiences and challenges	Telling Your Story Survey
% of participants reporting recognizing progress in their recovery	Percentage of survey respondents who agree or strongly agree that they recognize progress in their recovery	Telling Your Story Survey

APPENDIX C

PREVENTION AND EARLY INTERVENTION
FY23 ANNUAL EVALUATION REPORT



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

Prevention and Early Intervention (PEI)

FY22/23

Annual Evaluation Report

INTRODUCTION

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

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

Per MHSA State requirements, mental health jurisdictions are required to submit a PEI Evaluation Report to the Mental Health Services Oversight and Accountability Commission (MHSOAC) on an annual basis. Additionally, a Three-Year PEI Evaluation Report is due to the MHSOAC every three years. Regulations also require mental health jurisdictions to submit PEI Evaluation Reports to the State Department of Healthcare Services (DHCS). The PEI Evaluation Report is to be included with the MHSA Annual Update or Three-Year Program and Expenditure Plan and undergo a 30-Day Public Comment period and approval from the local governing board. In the MHSA FY25 Annual Update, the Prevention and Early Intervention (PEI) Fiscal Years 2022/2023 (FY23) Annual Evaluation Report is due.

This PEI FY23 Annual 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 Annual 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.

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. 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 Based Accountability Evaluation for all BMH Programs

Through the approved MHSA FY19 Annual Update the Division executed a Request for Proposal (RFP) process to hire a consultant to conduct a Results Based Accountability Evaluation for all programs across the Division, and Resource Development Associates (RDA) was the chosen vendor. In FY21 and FY22 RDA worked with the Division to implement the RBA research methodology and to identify data measures. Through this evaluation, RBA outcomes in FY23 are outlined in this report for the following MHSA PEI funded BMH programs: Social Inclusion Project, and the High School Prevention Project.

Results of both the Impact Berkeley and the BMH RBA Evaluations 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 – Individuals who are at risk of 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 needs who are at risk of or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through MHSA Community Services and Supports funded services.

In April 2009, following a nine-month long Community Planning Process, the original City of Berkeley PEI plan was approved. Since the approval of the original plan, Three Year Plans or Annual Updates outlining proposed PEI funding and programming have been developed and approved on an annual basis. Based on the State 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 and Emotional Education Team 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

PEI Programs	Key Community Mental Health Needs	PEI Priority Populations
Homeless Outreach & Treatment Team (HOTT)* Specialized Care Unit	➢ Psycho-social Impact of Trauma ➢ Disparities in Access to Mental Health services At-Risk Children, Youth and Young Adult Populations	• Underserved Cultural Populations • Trauma Exposed
Social Inclusion	➢ Stigma and Discrimination ➢ Psycho-social Impact of Trauma	• Trauma Exposed Underserved Cultural Populations

*This program was not in operation in FY23

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. Mental Health jurisdictions are now required 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 diagnosed with a mental illness,	➢ Collect the number of individuals reached by activity (e.g., # who participated in each service or activity)

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

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

PEI Demographic Reporting Requirements

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

(A) The following Age groups:

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

(B) Race by the following categories:

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

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

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

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

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

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

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

(E) Sexual orientation

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

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

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

(G) Veteran Status,

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

(H) Gender

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

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

Effective July 2018 amended PEI regulations specified the following:

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

CITY OF BERKELEY PEI PROGRAMS

Since the release of the 2018 PEI Regulations, the City of Berkeley has regularly reviewed PEI programs to ensure they fit within the required program definitions. As a result, PEI funded programs 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 • 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.	• High School Prevention • Specialized Care Unit
OPTIONAL Suicide Prevention	Activities to prevent suicide as a consequence of mental illness.	• CalMHSA PEI Statewide Project

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

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

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

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

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

Many PEI projects meet multiple established priorities. Per PEI regulations, outlined below is a crosswalk of the City of Berkeley PEI Programs with the MHSOAC PEI Priorities for programs during the reporting timeframe:

CITY OF BERKELEY PEI PROGRAMS	PEI PRIORITIES
• Early Child Health and Wellness Program (formerly 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 and Emotional Education Team • Dynamic Mindfulness Program • Specialized Care Unit • African American Success Project	Youth Engagement and Outreach Strategies that target secondary school and transition age youth with a priority on partnership with college mental health programs, and transition age youth not in college. Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis. Culturally competent and linguistically appropriate prevention and intervention, including community defined evidence practices (CDEPs).
• Mental Health Promotion Campaign • Social Inclusion • Community Education & Supports	Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs). Youth Engagement and Outreach Strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college. Strategies targeting the mental health needs of older adults.

This PEI FY23 Annual 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. All City of Berkeley PEI programs in FY25 will provide services for children and youth and/or Transition Age Youth. Five programs are in the Berkeley Unified School District (BUSD).

Programs and services funded with PEI funds that were approved to be continued in FY25 through the previously approved Three Year Plan, are outlined below by PEI Program type, along with FY23 data.

PREVENTION PROGRAM

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

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.

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

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

It is envisioned that this campaign will be implemented in FY25.

EARLY INTERVENTION PROGRAMS

Early Intervention Program - Provides treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that may result from untreated mental illness.

The City of Berkeley Early Intervention programs are as follows:

Early Childhood Health and Wellness Program

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

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

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

In FY23, a total of 2,339 children were screened through this program (255 at BUSD, and 2,084 at the Help Me Grow sites) however data was not collected on all individuals screened. Although all 2,339 of the

individuals that were either screened or were screened and received services, were aged 0-15, the other data elements were only collected on the 255 children screened at BUSD as follows:

DEMOGRAPHICS N=255	
Age Groups	
0-15 (Children/Youth)	100%
Race	
American Indian or Alaska Native	*
Asian	17%
Black or African American	30%
White	19%
More than one Race	*
Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican/Mexican-American/Chicano	25%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	100%
Primary Language	
English	51%
Spanish	18%
Declined to Answer (or Unknown)	31%
Disability	
Declined to Answer (or Unknown)	100%
Gender: Assigned Sex at Birth	
Male	44%
Female	56%

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

Program Successes:

- On-site technical assistance visits to all Berkeley Help Me Grow providers continued and went well.
- 2,339 ASQ developmental screenings were conducted in Berkeley, BUSD preschools and Berkeley Help Me Grow pediatric provider sites combined.
- Berkeley Help Me Grow sites conducted a total of 2,084 screenings, across all sites averaging a 20% increase in children screened from the previous year.
- Referrals to resources & follow-up: BUSD referred a total of 64 preschool students and Help Me Grow providers referred 94 infants/children.

- Approximately 72% of all Help Me Grow referrals had their goals met.

Program Challenges:

- The Early Childhood Health and Wellness Public Health Nurse vacancy occurring in May 2023 and staffing vacancies/turnovers at the Berkeley Help Me Grow provider sites impacted the continuity of services, with the need to introduce/train/orient provider sites to ASQ implementation, tracking, and resource referrals for clients.
- Help Me Grow sites did not collect race/ethnicity, language spoken data, or gender; and BUSD did not collect specific ethnicity data, gender, sexual orientation for this age group.
- There were delays in receiving the annual infographic data for Help Me Grow sites. The Help Me Grow Collaborative collects and analyzes the data from all Help Me Grow sites in Alameda County so it takes time to collect and synthesize the data and to receive the Berkeley specific data.

Beginning in FY25, the MHSA-PEI funding for this program will be discontinued, as the Public Health Division will be transitioning these program activities to be funded and housed programmatically under their Maternal, Child and Adolescent Health (MCAH) Program:

- The MCAH Program is a California Department of Public Health (CDPH) funded program committed to serving women, children, teens and their families by improving access to comprehensive, quality health care, and focusing on prevention and early intervention strategies.
- Within MCAH, there are program requirements which align with the focus of early identification, assessment, treatment, and referral for children (ages 0-5) and their families that provides rationale for the shift to MCAH.
- As part of the MCAH scope of work, the focus on supporting early childhood development screenings will be able to be integrated with other programs that reside within the MCAH scope, such as the Berkeley Black Infant Health Program and Fatherhood Initiative.

Going forward, the Early Childhood Health and Wellness Program (ECHW) moved under the MCAH Program will address the MCAH Child Priority Need: To optimize the healthy development of all children so they can flourish and reach their full potential with a child focus area to expand and support developmental screening.

Supportive Schools Program

Through this program leveraged MHSA PEI funds support the provision of mental health prevention and early intervention services at each of the Elementary Schools in Berkeley. Services include: outreach; mental health programming; classroom; group; one-on-one psycho-social education and support; and consultation with parents and/or teachers.

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

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

In FY23 Early Intervention Services were provided at each of the BUSD elementary schools. BUSD sub-contracted with local agencies to provide early intervention services based upon the standard of evidence-based practices. Bay Area Community Resources (BACR), Child Therapy Institute (CTI), and Lifelong Medical (Lifelong) were subcontracted to provide services at BUSD elementary schools.

Supports for each school per each service provider, and numbers served in FY23 were as follows:

Elementary School	Agency/Provider	Number of Students Served
• Cragmont • Emerson • John Muir • Malcolm X • Oxford • Ruth Acty • Sylvia Mendez • Thousand Oaks	Bay Area Community Resources (BACR)	644
• Bay Area Arts Magnet (BAM) • Washington	Child Therapy Institute	37
• Rosa Parks	Lifelong Medical Care	133
Total		**814**

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

Bay Area Community Resources (BACR): Bay Area Community Resources (BACR) provided services to improve emotional functioning and success in school and life, including individual and group therapy, family consultation, conflict resolution/restorative justice, suicide prevention, check-in/check-out, crisis intervention, and classroom presentations. BACR used many different therapy modalities as well as classroom support to develop skills and health. Additionally, the BACR Counselor participated in weekly Coordination of Services (COST), Student Success Team (SST), and Individualized Education Program (IEP) meetings for students, providing mental health and trauma informed perspectives. BACR consulted with school staff on many issues and provided trauma informed coaching for teachers needing support.

BACR also made referrals to outside providers, parenting classes/support groups, crisis hotlines, and other programs.

Program Successes:

- A total of 644 individuals were served.
- 90% of youth in therapy showed improved emotional functioning and resiliency through the Child and Adolescent Needs and Strengths Assessment Tool (CANS) and/or Stages of Change scale.
- 85% of students receiving classroom education reported gaining skills or knowledge.
- 95% of Caregivers reported that they are satisfied with the services their children/family received.
- 100% of school personnel reported that BACR is a great partner and supports their goals.

Program Challenges:
The biggest challenge was the increase in cost to fund the program. These increases required the district to make cuts in other programming areas, as well as moving resources around to be able to continue providing ongoing services at the same rate as in the previous year. An additional challenge was ensuring that each school site had an equivalent 1.0 FTE BACR counselor at all BUSD elementary schools, as there was a shortage of credentialed therapist and counselors and BACR had to compete with other agencies for employees.

Child Therapy Institute (CTI): The Child Therapy Institute (STI) continued providing services at Bay Area Arts Magnet and Washington Schools.

Program Successes:
CTI staff met with 37 students individually and in groups.

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

Lifelong Medical: A Licensed Clinical Social Worker (LCSW) and interns from Lifelong Medical provided individual counseling to students, family counseling, and mental health consultation to caregivers and school staff at Rosa Parks School. Full-class support was also provided in several classrooms. The full class support was tailored to the needs of the teacher and class and consisted of community building, regulation strategies such as Zones of Regulation, and social emotional learning.

Program Successes:
A total of 52 students received individual counseling and 81 students participated in group services. The Family Resource Center (FRC) was a valuable resource and support to children, families, and school staff during the reporting timeframe. Through individual counseling, groups, and as-needed support, the FRC staff worked hard to help make Rosa Parks a place of healing and joy. The Rosa Parks community experienced the ripple effects of global pandemic and many losses in the community. FRC created spaces for students to experience a sense of belonging and connection. FRC helped children develop regulation and coping strategies to help them manage their emotions so that they could be more present in the classroom for learning. FRC developed deep relationships with students in order to help guide them in the process of

making sense of the many scary and sad experiences they have had over the past few years. Additionally, FRC provided consultation and referrals to mental health services in the community.

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

Demographic data provided by BUSD on 814 students that were served through this project in FY23, is outlined below:

DEMOGRAPHICS N= 814	
Age Group	
0-15 (Children/Youth)	100%
Race	
American Indian or Alaska Native	*
Asian	*
Black or African American	26%
Native Hawaiian/Pacific Islander	*
White	35%
More than one Race	26%
Declined to Answer (or Unknown)	*
Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican/Mexican American - Chicano	*
Other	29%
Declined to Answer (or Unknown)	*
Ethnicity: **Non-Hispanic or Non- Latino/Latina/Latinx**	
African	*
Asian Indian/South Asian	*
Chinese	*
Eastern European	*
European	*
Middle Eastern	*
Other	13%

More than one Ethnicity	*
Declined to Answer (or Unknown)	55%
Primary Language Used	
English	*
Spanish	*
Other language	*
Declined to Answer (or Unknown)	81%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
No Disability	*
Declined to Answer (or Unknown)	96%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	50%
Female	40%
Declined to Answer (or Unknown)	10%
Current Gender Identity	
Male	44%
Female	37%
Another Gender Identity	*
Declined to Answer (or Unknown)	17%

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

The projected numbers of individuals to be served in FY25 per age groups are as follows:
0-15 years = 820 individuals.

Community Education & Supports Program

The Community Education & Supports program implements culturally-responsive psycho-educational trauma support services for individuals (18 and above) in various cultural, ethnic and age specific populations that are unserved, underserved and inappropriately served in Berkeley including: African Americans; Latino/a/x; LGBTQIA+; TAY; and Senior Citizens. Services are conducted through five community-based organizations.

In FY23 the Community Education & Supports program participated in the HHCS Results-Based Accountability (RBA) Evaluation. In an aggregated summary across the five projects within this program the following work was conducted: 549 Support Groups/Workshops; 2,693 Support Group/Workshop encounters; 476 Outreach activities; 4,001 Outreach Contacts; and 393 Referrals.

Descriptions of the five projects within the Community Education & Supports program along with FY23 data and RBA evaluation results, are outlined below:

➢ Transition Age Youth Trauma Support Project

Implemented through Youth Spirit Artworks (YSA) 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 to convene youth around a positive occasion to acknowledge the various small and large accomplishments of TAY participants, and build trust and community. Approximately 30-35 TAY receive services through this project a year.

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

PEI Priorities:

- Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs).
- Youth engagement and outreach strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college.

In FY23, YSA went through many changes. A new program model was crafted and implemented with the intention of redesigning and refining the organization's programs and theory of change. Staff received training on theory of change, program development, ACES Science, trauma informed practices, the politics of trauma, facilitation skills, positive youth development, strength-based model, community resilience

model, somatic awareness, individual coaching, housing navigation skills and curriculum and evaluation introduction. This change and shift in culture expanded the program offerings. The components and activities were designed with specific outcomes in mind and with the intention to increase intervention, engagement, and opportunities for the young people being served.

In FY23, 83 youth participated in one or more program services. Demographics on youth served were as follows:

DEMOGRAPHICS N = 83	
Age Group	
16-25 (Transition Age Youth)	100%
Race	
American Indian or Alaska Native	*
Asian	*
Black or African American	48%
White	*
More than one Race	28%
Declined to Answer (or Unknown)	*
Ethnicity: Latino/Latina/Latinx	
Mexican/Mexican American-Chicano	18%
Declined to Answer (or Unknown)	15%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	*
Declined to Answer (or Unknown)	66%
Primary Language Used	
English	100%
Sexual Orientation	
Gay or Lesbian	*
Heterosexual or Straight	27%
Bisexual	33%
Questioning or Unsure of sexual orientation	*

Another sexual orientation	*
Declined to Answer (or Unknown)	26%
Disability Status	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	21%
Female	28%
Declined to Answer (or Unknown)	51%
Current Gender Identity	
Male	25%
Female	28%
Transgender	*
Genderqueer	*
Another Gender Identity	*
Declined to Answer (or Unknown)	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

RBA measures during the reporting timeframe were as follows: Six Behavioral Health Education Groups were conducted reaching 99 individuals; 100 Peer Mentoring sessions were conducted reaching 75 individuals; 108 Art Therapy sessions were conducted reaching 107 individuals; and 32 individuals participated in 6 events.

Feedback per participant self-report was as follows:

- 84% reported that groups were helpful;
- 70% of Art as Therapy participants reported that they feel their Behavioral Health is improved or very improved.

Program Successes:

Youth participated and were engaged in the program changes. Youth engaged in being trained in theory of change and understood the feedback loop and how YSA would assess them to help evaluate program effectiveness, satisfaction, and facilitator engagement. In addition, youth engaged in leadership development through facilitation, curriculum, and event planning training to assist in their future developments in leading peers and community.

Youth within the village were also connected to youth leadership opportunities, and were engaged in life skills development such as financial wellness, and cooking workshops. Both workshops were created to

assist youth in being financially independent and well, while redirecting learned survival skills into resilience building opportunities that create building blocks for growth. Youth led and organized a fashion show "Out Of The Binary" where they created all of the fashion pieces for the runway. Youth also planned, organized, advertised, and facilitated the entire event using skills that they acquired through youth leadership meetings, and youth leadership training spaces. A total of 30 referrals & linkages were provided to youth in Berkeley.

Project Challenges:
A big program challenge was dealing with staff training and buy-in. Many of YSAs staff were former youth participants and many struggled with similar challenges as the youth that were being served. During this time YSA was challenged with staff understanding the importance of data collection and evaluation. Staff were not trained on using data to drive programmatic changes, which at times led to resistance and eventually the loss of some staff.

The projected numbers of individuals to be served in FY25 per age groups are as follows:
16-25 years = 85 individuals.

- **Trauma Support Project for LGBTQIA+ Population**

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

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

PEI Priorities:

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

In FY23, a total of 275 individuals were served. Demographics on individuals served include the following:

DEMOGRAPHICS N=275	
Age Groups	
16-25 (Transitional Age Youth)	13%
26-59 (Adult)	67%
Ages 60+ (Older Adult)	17%
Declined to Answer (or Unknown)	*
Race	
American Indian or Alaska Native	*
Asian	*
Black or African American	*
White	58%
More than one Race	*
Other	*
Declined to Answer (or Unknown)	*
Ethnicity: Hispanic or Latino/Latina/Latinx	
Carribbean	*
Mexican/Mexican-American Chicano	*
Puerto Rican	*
Other	*

Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	*
Asian Indian/South Asian	*
Chinese	5%
Eastern European	*
European	26%
Filipino	*
Korean	*
Middle Eastern	*
Vietnamese	*
More than one Ethnicity	14%
Other	*
Declined to Answer (or Unknown)	29%
Primary Language Used	
English	97%
Spanish	*
Declined to Answer (or Unknown)	*
Sexual Orientation	
Gay or Lesbian	19%
Heterosexual or Straight	*
Bisexual	10%
Questioning or Unsure	*
Queer	12%
Another Sexual Orientation	49%
Declined to Answer (or Unknown)	*

Disability	
Difficulty Hearing or Having Speech Understood	*
Mental Domain not including a mental illness (including but not limited to a learning disability, developmental disability or dementia)	8%
Physical/mobility domain	*
Chronic health condition (including but not limited to chronic pain)	8%
Other (Specify)	17%
No Disability	64%
Veteran Status	
Yes	*
No	95%
Declined to Answer (or Unknown)	*
Gender: Assigned Sex at Birth	
Declined to Answer (or Unknown)	100%
Current Gender Identity	
Male	15%
Female	12%
Transgender	29%
Genderqueer	*
Questioning or Unsure	*
Another gender identity	37%
Declined to Answer (or Unknown)	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

RBA outcomes during the reporting timeframe were as follows: There were 88 referrals for additional services and supports. The number and type of referrals were as follows: 47 Mental Health; 20 Physical Health; 12 Social Services; 3 Housing; 6 Other unspecified services. To assess the project services, a self-

administered Peer Support Group Survey was distributed to all peer group members. Survey results were as follows:

- 98% indicated they would recommend the organization to a friend or family member;
- 95% felt like staff and facilitators were sensitive to their cultural background;
- 88% reported they deal more effectively with daily problems;
- 84% indicated they have trusted people they can turn to for help;
- 85% felt like they belong in their community.

Program Successes:

- Peer groups continued to run uninterrupted and to be a vital support to the LGBTQIA+ community during the reporting timeframe.
- 92.4% of participants reported that the peer support group(s) they attended helped them to feel safe talking about their gender.
- 88% reported that the peer support group(s) they attended helped them to feel safe in talking about their sexuality.
- The primary goal in FY23 was to increase capacity and reduce burnout for the group facilitators. To that end,16 new facilitators were on-boarded and an additional 3 facilitators were re-trained at their request.
- A full set of Diversity Equity and Inclusion trainings were also offered including one that was co-facilitated by a peer facilitator and our Community Programs Director.

Program Challenges:

- During quarter three facilitators struggled with the Diversity Equity and Inclusion trainings offered and felt they were ready to move beyond the basics of inclusion and wanted more tools to interact with group members around issues of race, privilege, neurodivergence etc.
- In quarter four, the Diversity Equity and Inclusion training was co-facilitated by the Community Programs Director and a peer group facilitator and focused on lowering barriers to access and creating a more inclusive and welcoming space.

The projected numbers of individuals to be served in FY25 are as follows: 16-25 years = 40 individuals; 26-59 years = 176 individuals; 60+ years = 52 individuals.

➢ Living Well Project

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

Counseling sessions are designed to monitor curriculum impact and continually assess individual goals and resource needs. This project serves up to 150 Older Adults a year.

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

PEI Priorities:

- Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs).
- Strategies targeting the mental health needs of older adults.

In FY23, a total of 73 individuals participated in the Living Well Workshop Series program. Demographics of Workshop participants are outlined below:

DEMOGRAPHICS N=73	
Age Groups	
Age 60+ (Older Adult)	88%
Declined to Answer (or Unknown)	*
Race	
Asian	23%
Black or African American	22%
White	34%
Other	*
Declined to Answer (or Unknown)	*
Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican/Mexican-American-Chicano	*
Other	*
Declined to Answer (or Unknown)	*

Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Asian Indian/South Asian	*
Chinese	*
European	19%
Middle Eastern	*
Other	25%
Declined to Answer (or Unknown)	*
Primary Language Used	
English	79%
Other	*
Declined to Answer (or Unknown)	*
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Difficulty Seeing	*
Difficulty Hearing or Having Speech Understood	22%
Mental (not mental health)	*
Physical/mobility disability	*
Chronic health condition	22%
Other Disability	*
No Disability	*
Declined to Answer (or Unknown)	*
Veteran Status	
Yes	*
No	71%
Declined to Answer (or Unknown)	*
Gender: Assigned Sex at birth	
Male	*
Female	69%
Declined to Answer (or Unknown)	*

Current Gender Identity	
Male	*
Female	71%
Declined to Answer (or Unknown)	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

RBA outcomes during the reporting timeframe were as follows: Four outreach and informational events were conducted reaching 51 individuals. A total of 99 individuals participated in the Living Well Workshop series and 72 received engagement services. There were 149 referrals for additional services and supports. The number and type of referrals included 46 Mental Health; 27 Physical Health; 38 Social Services; 26 Housing; 12 other unspecified services.

Feedback per participant self-report was as follows:

- 93% reported they felt satisfied with the workshops;
- 93% indicated an improvement in feeling satisfied in general;
- 93% had increased feelings of social supports;
- 93% felt prepared to make positive changes; and
- 93% reported they felt less overwhelmed and helpless.

Project Successes**:**

- The Living Well programming continued to be well attended, especially the PEERS group, which is a peer-based support and discussion group focused on mental and emotional health for seniors.
- New seniors attended every quarter, and participant survey's demonstrated positive outcomes.
- Due to the success of the program, the Senior and Aging Engagement Specialist received numerous requests to host Living Well workshops at additional locations.

Project Challenges:

- The Living Well project continued to experience the impacts of the ongoing pandemic; older adults are still at higher risk for complications from Covid-19. Some staff also got COVID/experienced long COVID, which impacted the program.
- A majority of participants expressed that they did not feel comfortable answering all of the demographic and life situation questions required by the MHSA reporting. The Management Team is continuing to work with the Senior and Aging Engagement Specialist to devise strategies to support getting the required information, and also to ensure that trust, confidentiality, and person-centered services remain at the core of the work.
- The Center for Independent Living transferred to a new customer relationship management (CRM) software called MiCil, and the shift between the two CRMs, as well as the on-ramp period to get Living Well staff familiar with the new system and ensure it was accessible to them, created challenges in getting numbers and reports in in a timely manner.
- There was also some transition in Senior Management staff, which led to a delay in invoicing and financial reports on a couple of occasions.
- The agency had an Interim Executive Director during the reporting timeframe and has continued search for a new Executive Director.

- The program structure shifted to include more managers, which will hopefully alleviate some of the challenges, particularly around data management.
- A Data and Reporting Specialist was hired, who works closely with the Senior and Aging Engagement Specialist to ensure Living Well data is tracked in an accurate and comprehensive manner.

It is anticipated that these issues will be ameliorated within the current fiscal year, as the Living Well program systems, policies, and procedures are being revised and revitalized.

The projected numbers of individuals to be served in FY25 per age groups are as follows:
26-59 = 10 individuals; 60+ = 70 individuals

➢ Soul Space Project

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

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

PEI Priorities:

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

In FY23, 35 individuals were served. Demographics on individuals served are as follows:

DEMOGRAPHICS N=35	
Age Groups	
Transition Age Youth (16-25)	*
Adults (26-59)	69%
Older Adults (60+)	*
Race	
Black or African American	86%
Declined to Answer (or Unknown)	14%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	*
Primary Language	
English	100%
Sexual Orientation	
Heterosexual or Straight	*
Bisexual	*
Another sexual orientation	*
Declined to Answer (or Unknown)	*
Disability	
Mental (not mental health)	*
Physical/Mobility Disability	*
No Disability	*
Declined to Answer (or Unknown)	*
Veteran Status	
Declined to Answer (or Unknown)	100%
Gender: Assigned Sex at Birth	
Male	37%
Female	63%
Current Gender Identity	
Male	37%
Female	63%

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

RBA outcomes during the reporting timeframe were as follows: 20 Community Education Trainings were conducted and 417 individuals were reached through outreach and engagement services. A total of 19 individuals received case management and 20 participated in Support Groups. There were 4 referrals for additional services and supports.

Project Successes**:**

- *Community Engagement***:** Soul Space Berkeley integrated itself into the Berkeley community and is becoming a recognized and trusted resource for individuals seeking wellness and support services. Partnerships with community agencies, Building Opportunities for Self Sufficiency (BOSS) and Options for Recovery, yielded a reciprocal referral stream that has been beneficial.
- *Expanded Services*: One of the major accomplishments was the ability to serve individuals in the community effectively. The case management services proved to be highly beneficial assisting individuals in finding mental health resources; adjusting to life after the pandemic; offering financial education; and offering a safe place where individuals could openly express their needs and employment assistance.
- *Family Support*: Entire families received some of the Soul Space services, reflecting the broad impact of the programs in the community. This demonstrates the programs ability to address holistic well-being at both the individual and family levels. Given the need, Soul Space has continue to offer family services.
- *"Crown Never Off" Women's Group*: The establishment and success of the women's group "Crown Never Off" was a testament to the value of the services provided. This group provided a supportive and empowering space for women within the community.
- *Community Recognition*: Soul Space established meaningful connections with community organizations, enhancing the presence and reputation within the Berkeley community. The commitment to building community relationships yielded positive results.

Project Challenges:

- *Staffing*: Soul Space experienced staff turnover amid growth and an increased demand for services. Recruitment for new staff to ensure the right team is in place to meet the needs of the expanding program is an ongoing challenge given the program budget. In FY24, two new staff were hired. Soul Space is seeking additional funding to support the current staffing arrangement.
- *Location Accessibility*: In FY23, OnTrack, the provider of the Soul Space project, was relocated to a space within Inter-City Services. However, due to various building issues, this space was temporary and OnTrack had to relocate again to it's current space in South Berkeley.

The projected numbers of individuals to be served in FY25 are as follows: 16-25 years = 27 individuals; 26-59 years = 39 individuals; 60+ years = 7 individuals.

➢ Latinx Trauma Support Project

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

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

PEI Priorities:

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

In FY23, this project served 339 individuals. Demographics on individuals served were as follows:

DEMOGRAPHICS N=339	
Age Groups	
Children and Youth (0-15)	*
Transition Age Youth (16-25)	*
Adults (26-59)	84%
Older Adults (60+)	*
Declined to Answer (or Unknown)	*
Race	
American Indian or Alaska Native	*
Asian	*
Black or African American	*
White	*
Other	85%

Declined to Answer (or Unknown)	*
Ethnicity: Hispanic or Latino/Latina/Latinx	
Central American	47%
Mexican/Mexican-American/Chicano	35%
South American	*
Other	*
Declined to Answer (or Unknown)	*
Ethnicity: Non-Hispanic or Latino/Latina/Latinx	
African	*
Asian Indian/South Asian	*
Cambodian	*
Eastern European	*
European	*
Japanese	*
Korean	*
Other	*
Primary Language	
English	*
Spanish	87%
Declined to Answer (or Unknown)	*
Sexual Orientation	
Gay or Lesbian	36%
Heterosexual or Straight	43%
Bisexual	*
Queer	*
Another sexual orientation	*
Declined to Answer (or Unknown)	*

Disability	
Other	*
No Disability	93%
Declined to Answer (or Unknown)	*
Veteran Status	
No	100%
Gender: Assigned Sex at Birth	
Male	44%
Female	55%
Declined to Answer (or Unknown)	*
Current Gender Identity	
Male	41%
Female	55%
Another Gender Identity	*
Declined to Answer (or Unknown)	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

RBA outcomes during the reporting timeframe were as follows: 7 Support Group sessions were conducted reaching 132 individuals, and 94 individuals received One-on-One Supports. A total of 8 Trainings were conducted, reaching 30 individuals. There were 152 warm referrals for additional services and supports. The number and type of referrals included: 32 Mental Health; 8 Physical Health; 44 Social Services; 68 other unspecified services.

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

- 100% reported they liked participating in the Support Group;
- 98% indicated they would recommend the organization to a friend or family member;
- 100% indicated they felt safe, included and respected;
- 95% reported that they were able to deal more effectively with daily problems;
- 98% reported increased feelings of supports after participating in the support group.

Training feedback per participant self-report was as follows:

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

Project Successes**:**

- Continued to provide integrated support to low-income Latinx immigrants through case management, warm referrals, trilingual hotline, support groups, mental health support, and trainings, as well as quarterly retreats for LGBTQ asylum seekers and Mam women.

- Due to growth in the Support Services program an additional caseworker was hired, which helped clients connect to more public benefits, including Medi-Cal and CalFresh.
- In addition to one-on-one support, a support group was offered reaching 24 LGBTQ asylum seekers and a storytelling workshop reaching 17 people.
- Utilized undergraduate interns for 16-24 hours a week to provide direct service to individuals, and to assist with administrative tasks.
- Hosted four Trauma-Informed trainings for staff and partner organizations providing legal and mental health services to asylum seekers. Staff trainings on Wellness and Domestic Violence Prevention were also conducted. The Support Services team attended a training on Motivational Interviewing and participated in a convening of Bay Area nonprofits serving unaccompanied immigrant youth.
- Provided a training on Mental Health First Aid and suicide prevention, one for law student volunteers, and one in Spanish for outreach workers.
- Partnered with "No Separate Survival", a participatory documentary project, to offer asylees a chance to get behind the camera and share their perspectives as storytellers, and hosted a film screening for asylum seekers and their families in a single-day support group event.
- The OLAS LGBT Sanctuary Project held a retreat on the theme, "The Pride of Being," to empower participants to be proud of their unique identities, and to build community with each other.
- Connected clients to services such as rental assistance, state-funded medical services, mental health services, and more.
- Planned an integrated wellness workshop for clients, which took place in the Fall of 2023. The workshop covered topics such as sleep and stress, and offered a range of culturally appropriate approaches including Talk Therapy and traditional Mayan herbal remedies.
- The Community Education Manager and Amplifying Sanctuary Voices Team led two "Tell Your Story" workshop training sessions to help community members learn how to share their immigration stories with legislators and the public. These workshops helped community members find power and confidence in sharing their lived experiences to advocate for a greater cause.
- The OLAS LGBTQ Asylum Program Coordinator, led a support group retreat for new and returning members focused on the immigrant identity. Activities allowed participants to safely share their migration stories and discuss the dynamics of acculturation and chosen family.

Project Challenges:
It continued to be a challenge to connect clients with mental health services in a timely fashion, as the shortage of mental health workers seemingly only deepened. We stayed in close touch with groups like "Partnerships for Trauma Recovery" to make sure we had up-to-date information on which providers are accepting new patients and what wait times our clients could expect. A Team Member who specializes in working with teenagers and transition age youth, offered a support group for her clients, however it proved to be difficult to recruit for the group, as the need to earn money often overwhelmed all other needs of the potential participants.

The projected numbers of individuals to be served in FY25 per each age group are as follows:
0-15 years = 4 individuals; 16-25 years = 86 individuals; 26-59 years = 295 individuals; 60+ = 23 individuals.

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 and Emotional Education Team (MEET)

The Mental and Emotional Education Team (MEET) program implements a peer-to-peer mental health education curriculum to 9th graders and an internship program for a cohort of high school students to serve as peers to their fellow students. The goals of the program are to increase student awareness of common mental health difficulties, resources, and healthy coping and intervention skills. Through this program, students are trained by a licensed BUSD clinician to conduct class presentations covering common mental health disorders, on and off campus resources, and basic coping and intervention skills.

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

PEI Priorities:

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

In FY23, the MEET program was relaunched after having been discontinued for a couple of years. During this reporting timeframe,15 MEET Peer Educators participated in weekly trainings and in a 1 full day training for the purposes of developing leadership skills, learning about mental health needs and resources, and providing mental health education for their peers. The trained Peer Educators then presented in eight U-9 Freshman Seminar Classes.

Five of the MEET students participated in the City of Berkeley Health Justice (HJI) Internships with MEET as their internship site. The HJI interns participated in an additional weekly meeting and acted as leaders

within MEET by developing the presentation and leading practice sessions with other MEET peer educators to prepare for their classroom presentations.

In FY23, 15 individuals were served through this program. Demographics on individuals served were as follows:

DEMOGRAPHICS N=15	
Age Groups	
Children and Youth (0-15)	100%
Race	
Asian	*
Black or African American	*
White	*
More than one Race	*
Declined to Answer (or Unknown)	*
Ethnicity: Hispanic or Latino/Latina/Latinx	
Other	*
Declined to Answer (or Unknown)	*
Ethnicity: Non-Hispanic or Latino/Latina/Latinx	
African	*
Asian Indian/South Asian	*
Other	*
Declined to Answer (or Unknown)	*
Primary Language	
Declined to Answer (or Unknown)	100%
Sexual Orientation	
Gay or Lesbian	*
Heterosexual or Straight	*
Bisexual	*
Questioning or unsure of sexual orientation	*
Queer	*
Declined to Answer (or Unknown)	*

Disability	
Difficulty Seeing	*
Mental domain not including a mental illness(including but not limited to a learning disability, developmental disability or dementia)	*
Other	*
No Disability	*
Declined to Answer (or Unknown)	*
Veteran Status	
No	100%
Gender: Assigned Sex at Birth	
Declined to Answer (or Unknown)	100%
Current Gender Identity	
Male	*
Female	*
Genderqueer	*
Questioning or unsure of gender identity	*
Declined to Answer (or Unknown)	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

Program Successes:

- Developed informational PowerPoint and presentation for U-9 Freshman Seminar classes.
- Completed 8 educational presentations to U-9 Freshman Seminar classes.
- Presentations reached over 200 students and aimed to foster greater comfort in discussing mental health, providing information about common mental health issues, reducing mental health stigma, teaching coping skills, and showing students how to access mental health resources in and outside of Berkeley High School.
- Five MEET students participated in the City of Berkeley Health Justice (HJI) Internships with MEET as their internship site. The HJI interns acted as leaders within MEET by developing the PowerPoint presentation and leading practice sessions to prepare for their classroom presentations.
- Created informational posters about depression, anxiety, coping skills, and selfcare to be posted across campus.
- Helped design mental health survey questions that were used in the district-wide Mental Health Needs Assessment.
- Conducted over 40 interviews of Berkeley High Students for the district-wide Mental Health Needs Assessment.

- Assisted in designing a BHS Wellness Website.
- Nine weekly trainings and one full day training was facilitated for MEET students to foster community, learn about common mental health concerns, and prepare to facilitate presentations to U-9 freshmen.
- HJI MEET interns met with the training facilitator an additional 5 times to support their development of the PowerPoint presentation, foster their leadership within MEET, and provide feedback and assistance in creating mental health informational posters.
- Each MEET participant co-facilitated at least 2 classroom presentations.
- MEET students taught over 200 students (all U-9 freshmen) in their classrooms by facilitating the PowerPoint presentation and interactive activities focusing on mental health and coping skills.
- Feedback from MEET peer educators, U-9 students, and teachers was overall positive as 93% of MEET Peer Educators reported that they learned more about mental health and 100% reported that they felt comfortable or very comfortable expressing themselves within the group.

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

The projected numbers of individuals to be served in FY25 per each age group are as follows:
0-15 years = 15 individuals.

Dynamic Mindfulness Program (DMind)

Dynamic Mindfulness (DMind) is an evidence-based trauma-informed program implemented by the Niroga Institute in BUSD middle and high schools. Validated by independent researchers as a transformative program for teaching children and youth skills for optimal stress resilience and healing from trauma, the DMind program integrates mindful action, breathing, and centering into an intervention that is implemented in the classroom in 5-15 minute sessions, 3 to 5 times a week. This program has proven to be successful with vulnerable students who are exhibiting signs of chronic stress/trauma/PTSD from Adverse Childhood Experiences (ACEs), and/or disengagement from school, chronic absences, and significant behavioral

challenges, including emotion regulation, impulse control, anger management, and/or getting frequent referrals/suspensions and at high risk of school failure. DMind also enables teacher and staff well-being, which has been shown to enhance student learning. Program components include in-class and after-school DMind sessions for students, student peer leadership development, and training and coaching of school staff.

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

PEI Priorities:

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

In FY23, services were directly provided to 550 students and 66 staff. An additional 2,000 unduplicated students were reached through knowledge and skills shared by individuals who received direct services. Additionally, there were many more students who practiced along with the online curricular supports by accessing the DMind video library (containing over 300 brief DMind practices), and the "Mood Shifter" for emotion regulation in the programs InPower Mobile App. The big post-COVID change was going from online to in-person services/programs, including in-class sessions by Niroga instructors, as well as staff (teachers, counselors, administrators) training and coaching sessions.

The only demographic data provided by BUSD on individuals who were served in FY23, was as follows: 0-15 years = 84%; 16-25 years = 5%; 26-59 years = 11%.

Program Successes:

- Successfully pivoted from online to in-person programming after the COVID lockdown ended.
- Staff (teachers and counselors) reported that there was a substantial increase in student mental health issues, leading to challenging student behaviors, e.g. disruptive, distracted, disengaged (fight/flight/freeze), saying they were seeing a certain 'feral quality' to many students (as they re-learned socializing after the long period of social isolation because of COVID), Even so, staff and students responded very positively to the in-person movement-based mindfulness program.

In addition to engaging students, this program also works with school staff to (a) enhance their own personal sustainability (self-care, stress resilience and healing from vicarious trauma) as well as (b) professional application with their students (emotion regulation, de-escalation, focus/attention/engagement). This not only built staff capacity and ensured adequate DMind 'dosage' for enabling neuroplasticity and neurogenesis to rewire their brains and change behavior, but also provided a multiplier factor of ~30-40 (typical class size in middle and high schools, and nominal caseload for counselors), significantly increasing the reach and scope of programming, serving a much larger group of unduplicated students than would have been otherwise possible given budgetary limitations.

Program Challenges:

Program staff witnessed significant levels of overwhelmed school staff which limited their ability to participate in the capacity-building training and coaching offerings.

The projected numbers of individuals to be served in FY25 per each age group are as follows:
0-15 years = 517 individuals; 16-25 years = 31 individuals; 26-59 years = 68 individuals.

African American Success Project

The African American Success Project (AASP) implements "Umoja" - a daily elective class offered at Longfellow Middle School. Umoja provides African American students a safe affinity space to explore their cultural heritage and identity, while building positive peer relationships and establishing relational trust with adults. Umoja provides an ongoing focus on social and emotional development, including building skills, habits and mindsets that enable self-regulation, interpersonal skills, perseverance and resilience. This project aligns with stated needs found in key BUSD initiatives, and strategic actions, including but not limited to the: Black Lives Matter Resolution, Local Control & Accountability Plan (LCAP), the African American Success Framework (AASF), and the Comprehensive Coordinated Early Intervention Services (CCEIS) Plan.

This project provides a unique chance to expose learners to content traditionally overlooked by educational institutions. Umoja course lessons are rooted in African and African American cultural precepts, and are composed to guide African American learners through:

- An exploration of their identities;
- An interrogation (questioning or query) of their ancestral history;
- Development of a positive sense of purpose and cultural pride;
- Envisioning their futures and outlining a path for fulfillment;
- Developing an awareness of their communal role.

Direct services for parents and guardians**:**
The project seeks to increase entry points for caregivers to be informed and involved in their child's learning. Highlights in this area include:

- Providing digital newsletters, and updates using email marketing;
- Coordinating and hosting parent teacher conferences;
- Individual parent meetings/contacts, including advising, problem-solving, and updates regarding student progress;
- Hosting events including the Annual Kwanzaa celebration, and an end of the year meeting to gather qualitative program feedback.

Direct services for students (academic, social, behavioral):

- School-day cultural enrichment designed to uplift and empower African American learners using African centered pedagogical approaches;
- Equity centered support sessions (weekly);
- Structured class check-in sessions.

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

PEI Priorities:

- Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs).
- Youth engagement and outreach strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college.
- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

In FY23, 53 students participated in this project. Outlined below are demographics on individuals served through this project:

DEMOGRAPHICS N=53	
Age Groups	
Children/Youth (0-15)	100%
Race	
Black or African American	66%
Declined to Answer (or Unknown)	34%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Other	*
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Other	*
Primary Language	
English	100%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
No	72%
Declined to Answer (or Unknown)	28%

Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	45%
Female	55%
Current Gender Identity	
Declined to Answer (or Unknown)	100%

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

Program Successes:

- *Learning Outcomes*: 6th-grade participants demonstrated significant growth in Literacy on the BUSD STAR Assessment.
- *Learning Experiences*: Participants were exposed to a variety of learning experiences, including field trips, STEM enrichment, and guest speakers
- 6th-grade participants visited the Ramses the Great exhibit at the DeYoung Museum.
- *School Yard Raps*: All participants had the opportunity to attend the Ourstory: The Black History musical. The musical aligned with the program curriculum, and many students reported increased interest and engagement with the performance since their prior knowledge of the content. Additionally, this learning experience uplifted the significance of Black History Month and allowed students to be affirmed.
- *College Trips*: Umoja 7th graders visited Cal Berkeley and California State University, East Bay.
- *Berkeley Historical Society*: Participants were visited by members of the Berkeley Historical Society, who provided a guest lecture about local Black History that students learned in class.
- *STEM Enrichment Club*: 6th-grade boys gained access to a STEM Enrichment Club provided by Bay Area Sigmas. Four monthly Saturday sessions were held during the second semester. STEM Enrichment Club participants built STEM competencies using science-related activities.
- *BUSD Black History Oratorical Festival*: Umoja participants had a strong showing at the 2023 BUSD Black History Oratorical Festival and, for the third year in a row, placed as finalists for the secondary division. The winner of the 2022 and 2023 secondary division was a Umoja participant. A Umoja participant also placed third in the secondary division for 2023.
- *Community Engagement*: For the fourth consecutive year, Umoja held an annual Kwanzaa recognition. The 2022 Kwanzaa event was a great success and brought together many families and staff for an evening of celebration and shared learning.
- *Professional Development:* The Umoja team provided professional learning opportunities for Longfellow staff, including an annual presentation to support them in preparing for Black History Month.
- The Umoja team joined professional learning efforts provided under the BUSD African American Success Framework, which provided a year-long cultural competence training series for Longfellow staff.
- *Collaboration*: The Umoja instructor actively collaborated with the Longfellow team to create a safe, welcoming, and inclusive school environment by helping to organize and host community engagements

like the annual Rites of Passage Ceremony. They also attended Grade Level Team meetings, Content/Department Team meetings, IEP meetings, etc., to support Umoja participants. Their voices and perspectives about best supporting African-American students should be highlighted as a valuable resource to the school community.

- *Partnerships*: The Umoja team strategically partnered with organizations to meet program needs, including The City of Berkeley, The Mind of Milan LLC, AM1 Media, Freedom Soul Media Education Initiatives, Jason Seals and Associates, Bay Area Sigmas, Marcus Books, RT Fisher Educational Enterprises, and the Berkeley Public School Fund. These organizations provided financial support, subject matter expertise, services, and resources to keep the program running.

Program Challenges:
During the fiscal year, the program did not serve 8th-grade students as in past years. This caused a slight reduction in the number of participants served. Confusion regarding the course selection process and available options likely contributed to this circumstance.

The projected numbers of individuals to be served in FY25 per each age group are as follows:
0-15 years = 55 individuals.

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

Access and Linkage to Treatment Programs – Connects children who are seriously emotionally disturbed, and adults and seniors with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs.

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

Early Intervention Programs – Provides treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that may result from untreated mental illness.

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

High School Youth Prevention Program

The High School Youth Prevention program operates in conjunction with other health school related services offered at Berkeley High School (BHS) and Berkeley Technology Academy (BTA) and has become a successful partnership between BUSD and the Public Health and Mental Health Divisions of Berkeley's HHCS Department. The program provides young people with the information and individual support they need to make positive and healthy decisions in their lives. The program includes: outreach activities designed to provide students with basic information around the risks of certain behaviors, and ways to protect themselves and make positive and safer decisions; classroom presentations to enable students to receive more in-depth information around a variety of health topics and available resources, and provide the opportunity for students to do a personal assessment of risk and current lifestyle choices; drop-in crisis,

counseling services; individual appointments to identify young people who may need more intensive intervention; and short-term treatment. The individual appointments, held at the school-based health center, provide young people with the opportunity to hold very in-depth discussions around the choices they are making and the risks that are involved in their choices. They receive guidance about changes they can make to reduce or eliminate their risks, and are given the opportunity to identify barriers that might exist for them that prevent them from making healthier choices. In addition, they complete a 40 question, in-depth HEADSSS (Home, Education, Activities, Drugs/Alcohol, Sexuality, Safety, and Suicidality) assessment. Based on the outcome of the individual appointment and/or assessment, a young person may be referred to either a medical or mental health professional at the High School Health Center or in the community for follow-up care and intervention and/or treatment.

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

The Health Centers are operational year-round, Monday through Friday, from 8:30 AM-4 PM, with a daily closure from 12-1 PM for lunch and administrative tasks. There are brief periodic closures due to BUSD's academic calendar and in these instances some services are still provided via telehealth when possible. When fully operational, services can be accessed via student drop-in and/or via scheduled appointment. Services can also be requested via Jotform, an online, HIPAA-compliant, referral platform. This referral platform is accessible via QR code on informational flyers that are posted across campus and also online in several locations including the Health Center website. Students can self-refer using Jotform, and parents/caregivers, staff, and friends are also able to refer someone using this method. Additionally, students, parents/caregivers, and staff are able to request services via phone by calling the Health Center main phone number. Hours of operation at Berkeley Technology Academy Health Center are more limited due to the small student population and staffing constraints. When BTA students are unable to access a needed service at that Health Center, they are referred to BHS Health Center for those needed services.

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

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

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

PEI Priorities:

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

During the reporting timeframe, The Health Center resumed hosting a cohort of three graduate-level trainees due to stabilization of full-time staff capacity, which contributed to increased service capacity for the duration of the 22-23 school year. One full-time Behavioral Health Clinician II obtained a promotional opportunity outside of the City of Berkeley and transitioned out of his role in early August 2022. This position was temporarily vacant and eventually backfilled by a new Behavioral Health Clinician II in late November 2022. One additional full-time Behavioral Health Clinician I position was added to the High School Mental Health team in late October 2022, and this staff was based across multiple sites (0.4 FTE at Berkeley High School; 0.4 FTE at Berkeley Technology Academy; and 0.2 FTE at K-8 School-Based).

In April 2023, as a result of a Division-wide structural reorganization, High School Mental Health became a standalone program separate from Family, Youth & Children's Services. As part of this reorganization, a new full-time Mental Health Program Supervisor position was created. The team's existing full-time Mental

Health Clinical Supervisor was promoted into this new position in April 2023, and the Mental Health Clinical Supervisor position became vacant.

In FY23, approximately 244 students received services through this project. Demographics on youth served are outlined below:

DEMOGRAPHICS N=244	
Age Groups	
0-15 Years	24%
16-25 Years	76%
Race	
American Indian or Alaska Native	*
Asian	11%
Black or African American	20%
White	22%
More than one Race	18%
Other	22%
Declined to Answer (or Unknown)	*
Ethnicity: Hispanic or Latino/Latina/Latinx	
Other	32%
Declined to Answer (or Unknown)	*
Primary Language	
English	83%
Spanish	14%
Other	*
Declined to Answer (or Unknown)	*
Sexual Orientation	
Gay or Lesbian	*
Heterosexual or Straight	49%
Bisexual	13%
Questioning or Unsure of Sexual Orientation	*
Queer	*
Another Sexual Orientation	*

Declined to Answer (or Unknown)	21%
Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	34%
Female	66%
Current Gender Identity	
Male	31%
Female	55%
Transgender	*
Genderqueer	*
Another gender identity	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

Program Successes:

- Continued to provide the full suite of in-person mental health, reproductive & sexual health, and first aid services for the duration of the school year.
- The Mental Health (MH) team was able to resume its graduate-level training program and provide a wider array of multi-tiered services with the resumption of support groups.
- Substantially increase service utilization year-over-year compared to 21-22 school year.
- Continued to use the Jotform application for referrals in order to streamline accessibility and minimize barriers to care.
- Maintained a collaborative and productive relationship with BHS's Coordination of Services Team (COST) throughout the school year in order to ensure that appropriate referrals were made to the Health Center and other programs.
- Due to a vacancy and new position, the Health Center was able to recruit two diverse, experienced, highly skilled clinicians, one of whom is a native bilingual Spanish speaker. Both new clinicians quickly became part of a cohesive and collaborative mental health team and integrated well into the larger Health Center team.
- Provided an array of crisis support services following the tragic deaths of two BHS students in October 2022.
- Health Center leadership continued to develop strong working relationships with BHS admin, especially the BHS Principal, new Vice Principal of Climate & Wellness, and 504/COST Program Supervisor. Health Center leadership, City of Berkeley HHCS Departmental leadership, and the BHS VP of Climate & Wellness also developed a plan to open a differentiated Wellness Center space at BHS along with a

continuum of tiered wellness support services, to be implemented in the 23-24 school year by BHS staff with additional funding support and partnership from City of Berkeley.
- Continued to build upon and improve existing relationships and partnerships with other BHS stakeholders. To this end, the MH team collaborated with several different on-campus programs throughout the year such as the Multilingual Program, McKinney Vento Program, Special Education Program, and Intervention Counselors.

Program Challenges:
- From August through November 2022, one full-time bilingual Behavioral Health Clinician II position was vacant. This vacancy negatively impacted individual and group service provision as well as On Call crisis coverage. Nevertheless, the resumption of a graduate-level training program helped to offset some of these negative impacts.
- Staffing shortages across the Health Center's Public Health team, both administrative and clinical, contributed to less consistently available First Aid and Reproductive & Sexual Health services. This, in turn, negatively impacted students' ability to access integrated services. As a result of reduced administrative capacity, the MH Clinical Supervisor and MH team were also responsible for additional, sometimes time-consuming administrative tasks.
- Quality Assurance (QA)/Quality Improvement (QI) and related encounter data extraction/analysis were constrained for the duration of the 22-23 school year due the to an abrupt resignation of the City IT staff person who managed the Health Center's EHR, NextGen. As a result of this, other City IT staff were not sufficiently cross-trained to provide technical support. Furthermore, NextGen vendor staff were often unresponsive to the needs and requests of the Health Center program. This contributed to significant delays with data analysis and reporting, which contributed to additional challenges with data collection across demographic categories and also constrained supervisory decision-making that could have improved efficiencies and improvements in service provision.
- The MH team also continued to use multiple EHRs and applications that are not integrated with one another. This made clinical documentation more cumbersome and time-consuming for all staff and also made data collection and analysis more laborious.

The projected numbers of individuals to be served in FY25 per each age group are as follows:
0-15 years = 67 individuals; 16-25 years = 201 individuals**.**

The High School Prevention Program participated in the Division's Results Based Accountability Evaluation. Results Based Accountability (RBA) measures for this project in FY23, were as follows:

Process Measures **How much did we do?**	**Quality Measures** **How well did we do it?**	**Impact Measures** **Is Anyone Better off?**
• # of clients served • # of clients opened for ongoing services • # of services provided by service type	• # of clients screened for depression, trauma, and substance use • # of clients contacted within a week following a referral to the High School Health Center (HSHC) • % of school population served	• % of clients able to receive needed care, as measured by % of clients who agree with the following: The HSHC… -Is easy to get help from when I need it

	• % of clients satisfied with services, as measured by % of clients who agree with the following: HSHC Staff… -Treat me with respect -Listen carefully to what I have to say • Make me feel like there's an adult at school who cares about me	-Helps me to meet many of my health needs

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

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

Data Development Agenda: measures the team is interested in reporting on but for which reliable data was not available:

- Responsiveness of service (e.g. x days following qualifying event)
- % of clients who have at least one completed the CANS/ANSA for each six-month period that they are in the program

To provide a context for the FY23 RBA outcomes, the High School Health Center expanded its team for the 2022-2023 academic year by hiring two additional full-time employees and welcoming three master's-level interns. These new team members increased the client service capacity as well as reinitiated, group sessions. Significant challenges were with the Electronic Health Records (EHR) system, which impeded the Center's quality control efforts. RBA Outcomes in FY23 for this program are outlined on the following pages.

BMH RBA Report FY 2023

Reporting Period: July 2022 - June 2023

High School Health Center (HSHC)

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

244

Clients Served

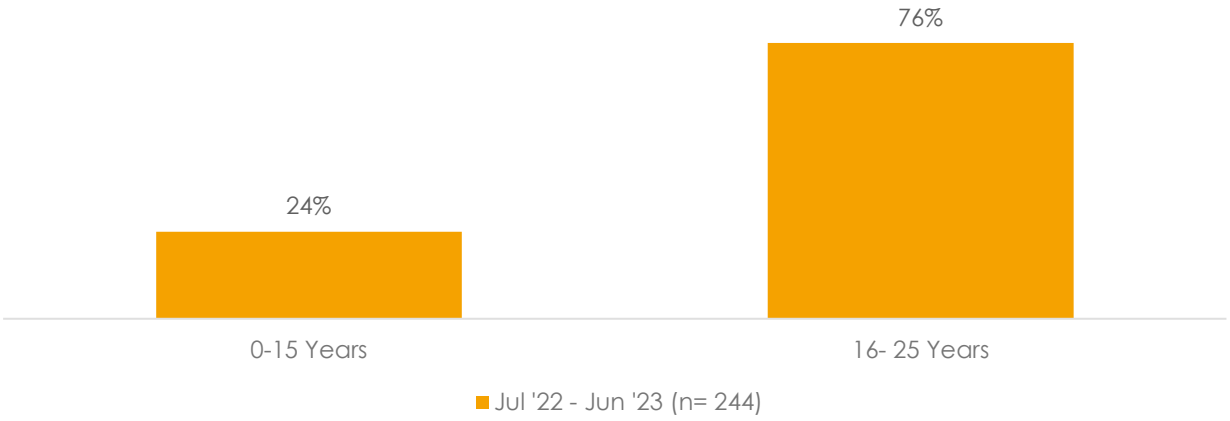
Program Description

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

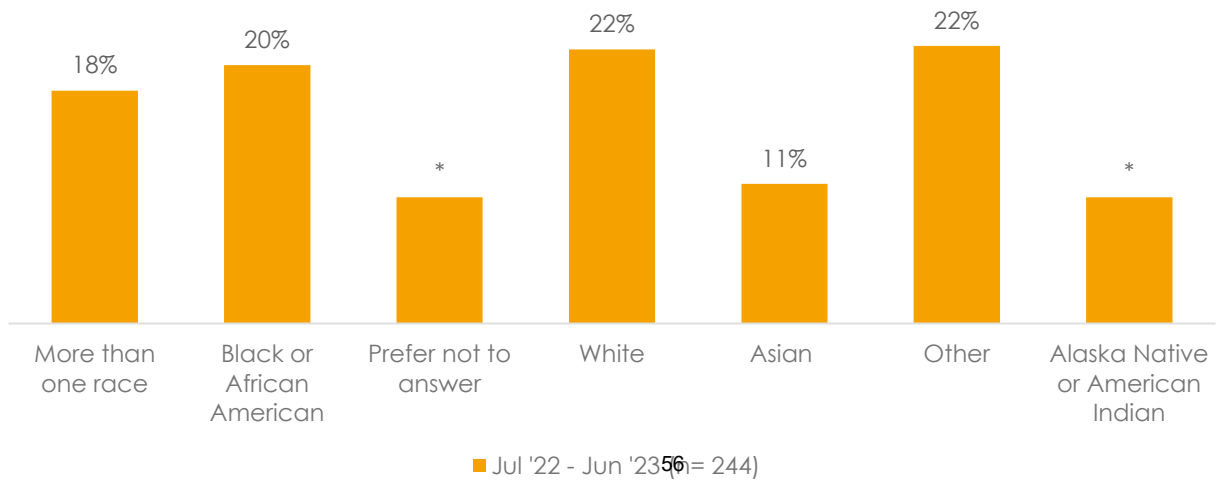
Program Updates

HSHC hired two new full time staff and onboarded 3 master's-level interns in the 2022-2023 school year. This allowed the team to serve more clients and restart groups. HSHC had significant challenges with their EHR, resulting in barriers to quality control.

Demographics (Age)

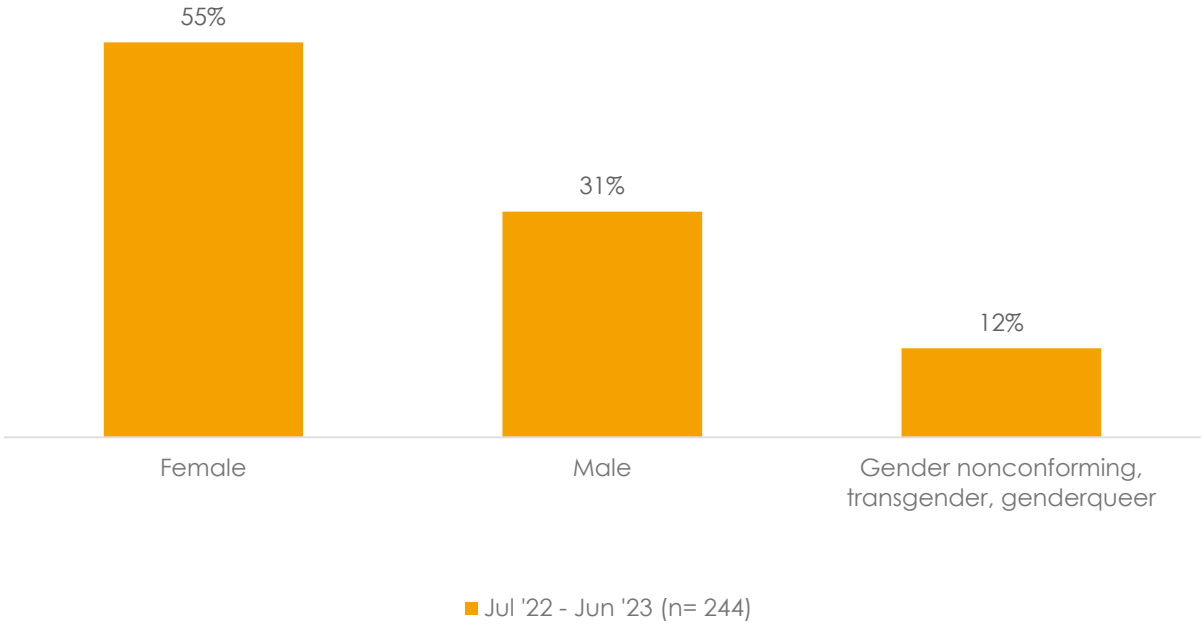


Demographics (Ethnicity)

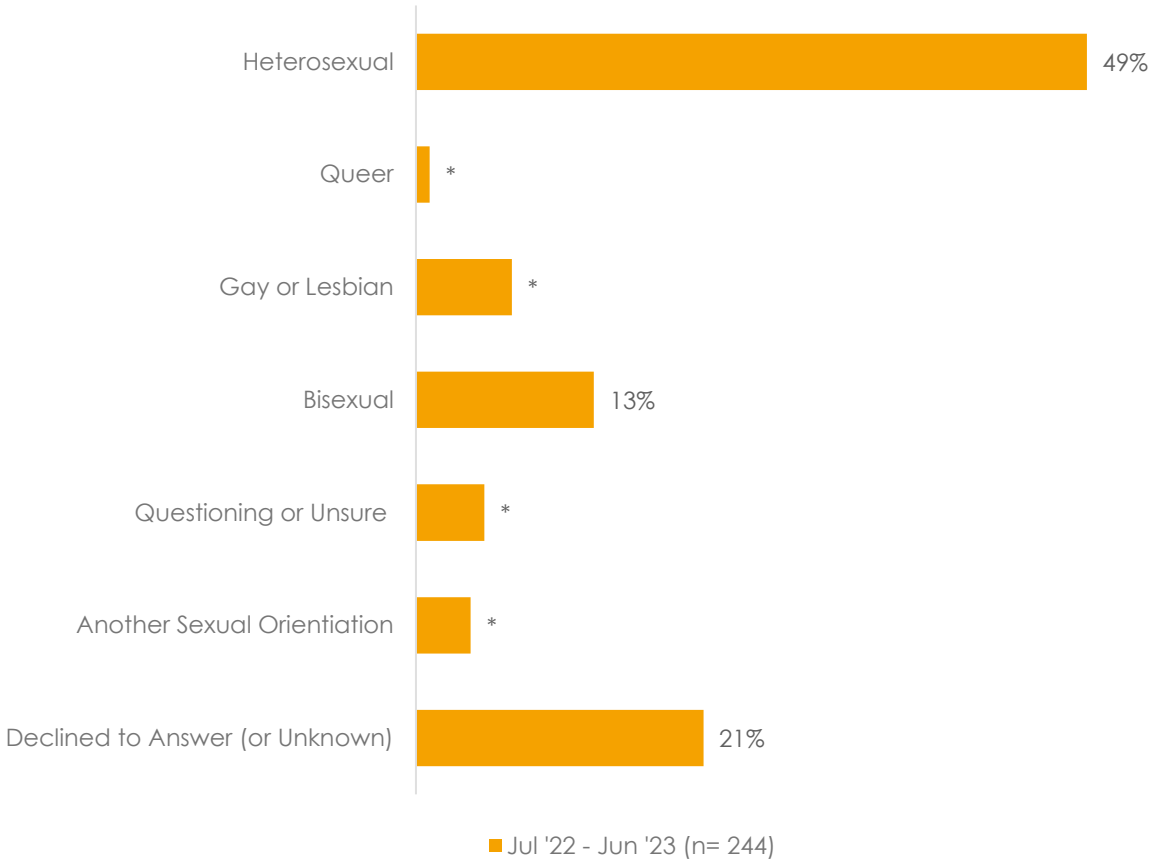


NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

Demographics (Gender Identity)



Demographics (Sexual Orientation)



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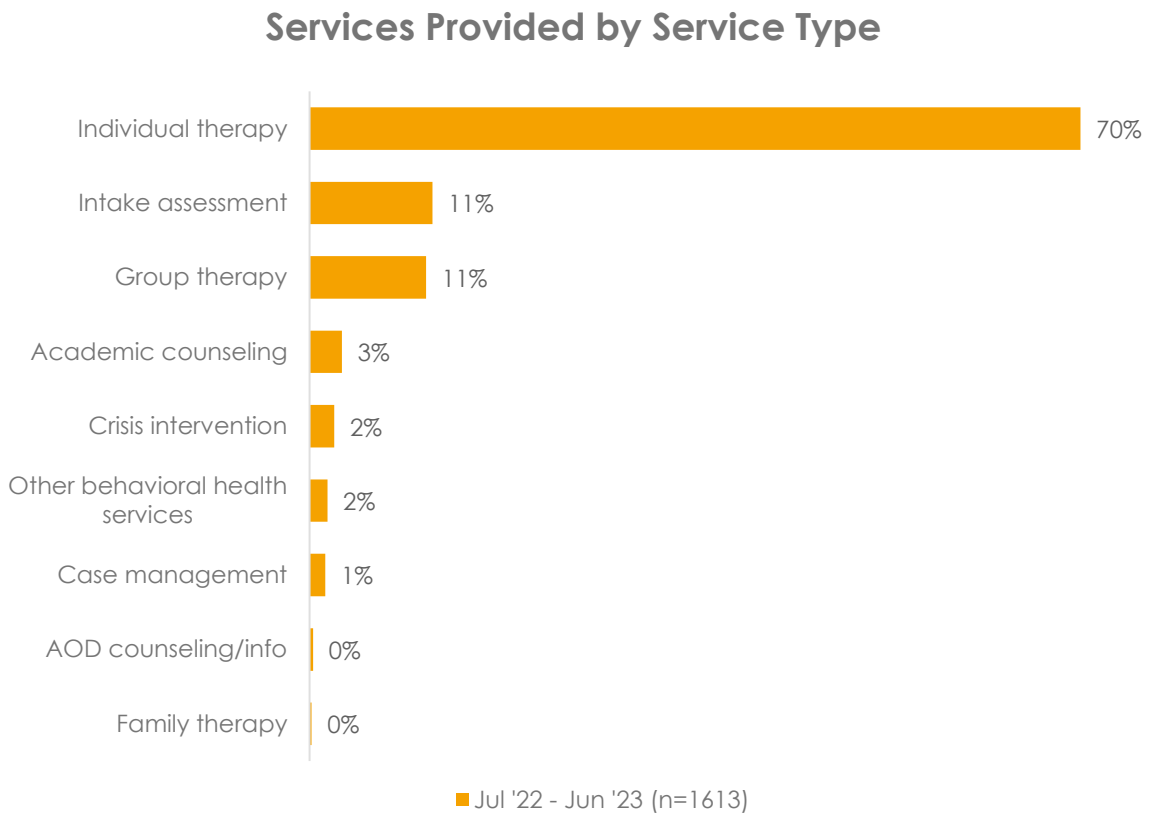
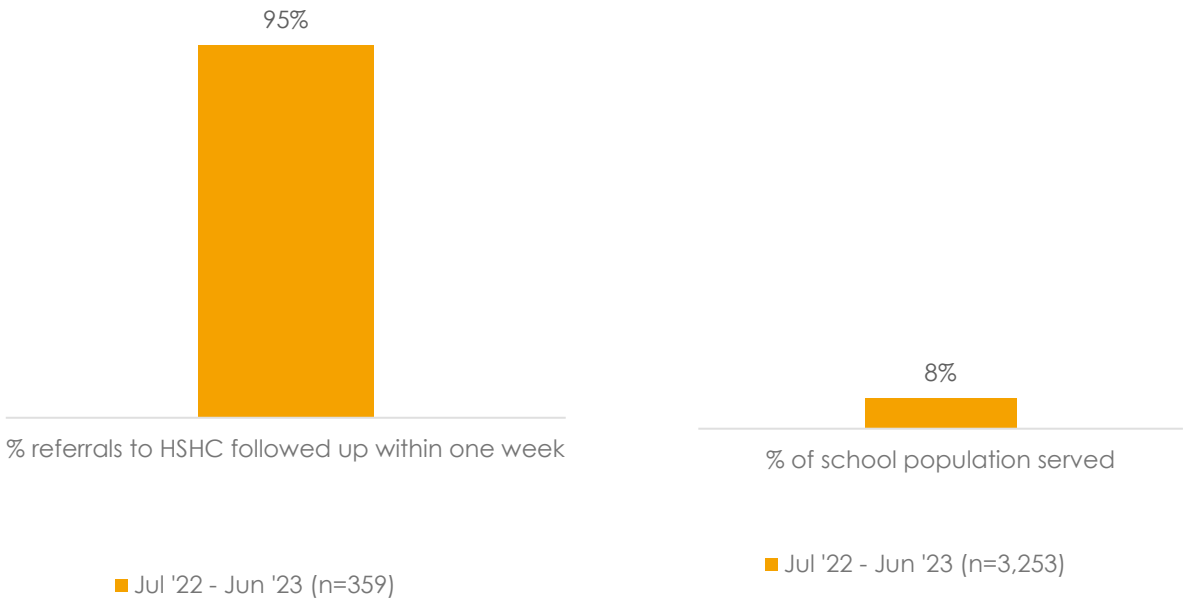


Note that multiple services could be provided in one visit (e.g. crisis assessment and referral) so total services by type is greater than total encounters.

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



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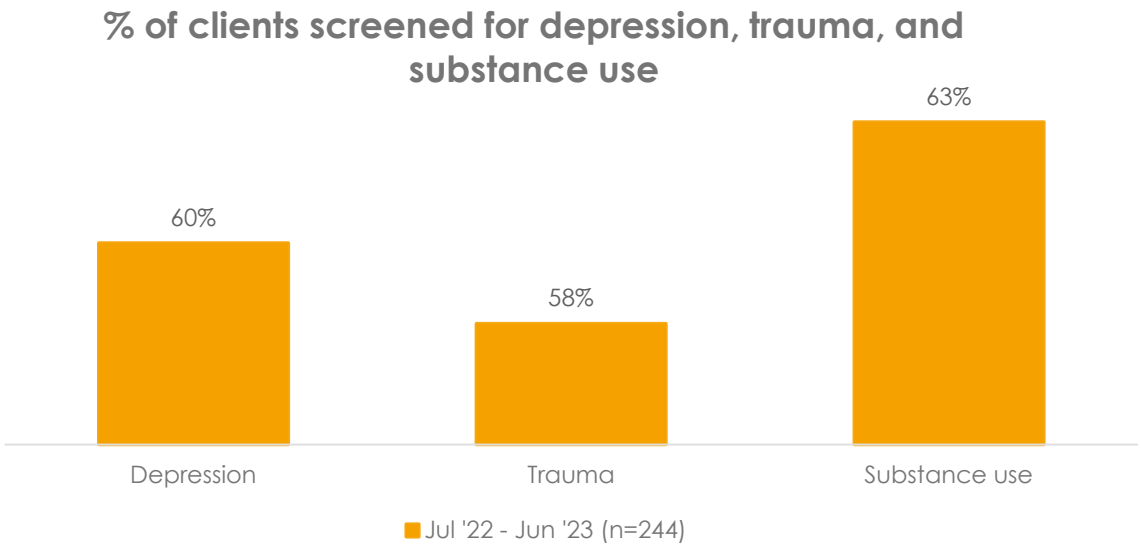
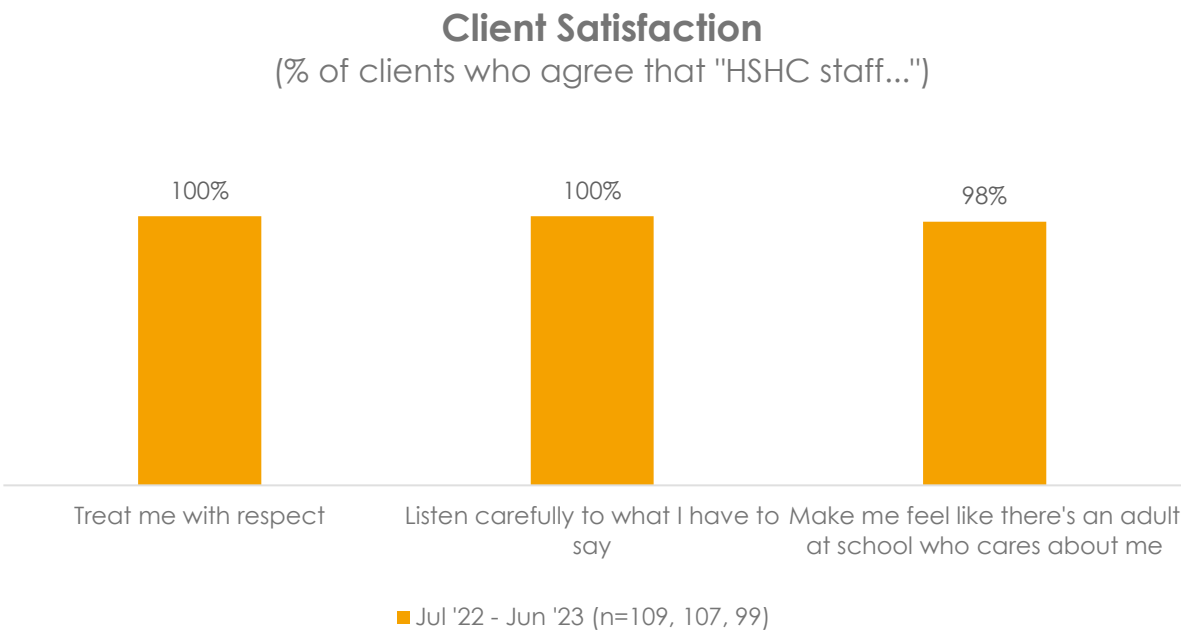
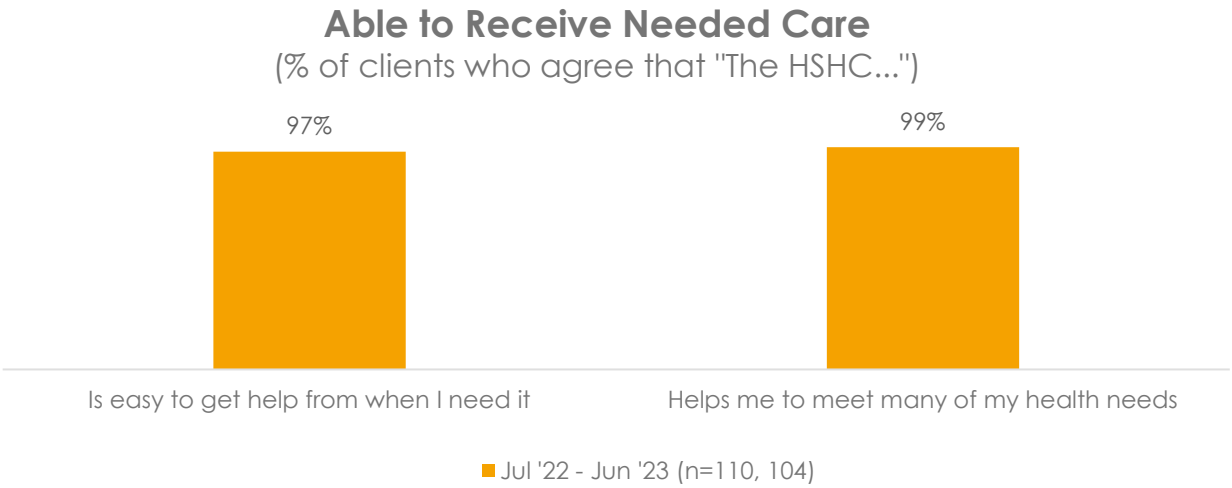






NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

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

NOTE: *Some data not displayed to protect individual privacy when N< 11. Smaller data was combined.

ACCESS & LINKAGE TO TREATMENT AND EARLY INTERVENTION COMBINED PROGRAM

Access and Linkage to Treatment Programs – Connect children who are seriously emotionally disturbed, and adults and seniors with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs.

Early Intervention Programs – Provide treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that may result from untreated mental illness.

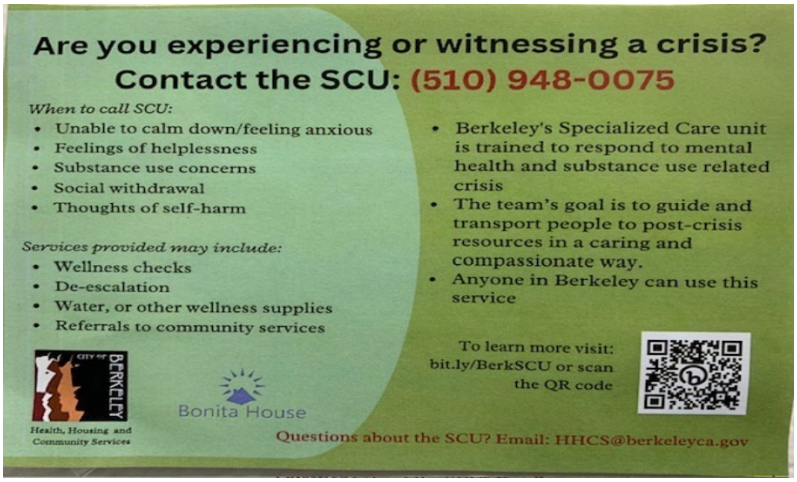
The City of Berkeley provides funding for one Early Intervention program that also has an Access to Treatment program component. The program is as follows:

Specialized Care Unit

Through the approved FY22 Annual Update, the Division allocated a portion of one-time CSS and PEI funds to be leveraged with other City funds to support the Specialized Care Unit (SCU). Implemented through Bonita House, the SCU is Berkeley's new behavioral health crisis response team without the involvement of law enforcement. The SCU consists of trained crisis-response field workers who respond to behavioral health occurrences that do not pose an imminent threat to safety.

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

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



In FY23, MHSA funds directly supported start-up costs of the program including recruitment, hiring, and training of Bonita House staff. Training included crisis support training through Bonita House's Crisis Training Academy as well as the design and training of Berkeley-specific procedures for the SCU program. Additionally, this funding supported the salaries of the SCU program management staff as additional team members were hired. During this time, program management staff worked closely with the City of Berkeley

to create the policies and procedures for a SCU that aligned with the implementation recommendations from the Berkeley community. The SCU began providing services in early FY24, and continues to operate daily from 6am to 4pm, eventually building toward a 24/7 crisis response service without involvement of law enforcement.

STIGMA AND DISCRIMINATION PROGRAM

Stigma and Discrimination programs - Direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families. The City of Berkeley has one Stigma and Discrimination program:

Social Inclusion Program

The Social Inclusion program was created to combat stigma, attitudes and discrimination around individuals with mental health issues. Through this program, a "Telling Your Story" group provides mental health consumers with opportunities to be trained, compensated and empowered to share their stories of healing in a supportive peer environment. When they feel ready, consumers can elect to be community presenters, sharing their inspirational stories at pre-arranged local public venues to dispel myths and educate others. This program serves approximately 10-20 individuals a year.

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

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

In FY23, 10 unduplicated individuals participated in the program. Demographics on program participants served were as follows:

DEMOGRAPHICS N= 10	
Age Groups	
26-59 (Adult)	*
Ages 60+ (Older Adult)	*
Race	
Black or African American	*
White	*
Other	*
Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican/Mexican-American Chicano	*
Puerto Rican	*
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	*
Eastern European	*
Other	*
Declined to Answer (or Unknown)	*
Primary Language Used	
English	100%
Sexual Orientation	
Heterosexual or Straight	*
Bisexual	*
Declined to Answer (or Unknown)	*
Disability	
Difficulty Seeing	*
Difficulty Hearing	*
Mental Domain not including a mental illness	*
Physical Mobility domain	*
Chronic Health Condition	*
Other (Specify):	*

Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	*
Female	*
Current Gender Identity	
Male	*
Female	*

*Indicates information is withheld to protect the privacy and confidentiality of individual participants.

Program Successes:
In FY23, the Telling Your Story group has grown to having more consistent attendees in person and on the zoom platform. Some participants enjoyed having the group virtually in the comfort of their home, they felt safer, and the hassle of commuting was eliminated. Other individuals enjoyed connecting in-person with participants who, joined the group in the same way. The group continued to be conducted through the structure of a brainstorming session and a sharing component. The topics of discussion were focused on the Eight Dimensions of Wellness. Per staff report, many participants benefitted from listening to answers to questions that staff developed based on the topics of discussions, as well as through staff assistance with formulating their story. Per staff report, participants felt more prepared during their shares and enjoyed the support they received from their peers.

Program Challenges:
In FY23, the Telling Your Story group had a few challenges, which the staff have been working to improve to make the group more enjoyable for all participants. Over the course of the last two years, staff hosted the group online and in-person and at times, this caused some delays to the start of the group due to individuals arriving at different times and having to update all participants. Managing and making sure everyone engaged, was difficult as individuals who joined by Zoom, called in so staff were unable to see participants faces. For individuals who primarily come to the group on Zoom, the questionnaire that required their feedback went unanswered, therefore staff wasn't able to obtain a full report of how the group was helping individuals to feel confident with sharing their story. Managing both platforms can be complicated and it lacks the in-person connection. This group was held twice a month and even though there was a brainstorming session of topics to discuss, some members didn't seem to come prepared to share based on the topic at the next group and this may be due to memory or not fully being engaged in the group when people are calling in on Zoom. The last challenge was the number of participants, a very consistent group of individuals participated, however staff would like to do more outreach to engage potential group participants, in an effort make a positive impact for more individuals in the community.

The projected numbers of individuals to be served in FY25 per each age group are as follows: 18-25 years = 2 individuals; 26-59 years = 6 individuals; 60+ = 4 individuals.

In FY23, The Telling Your Story Project participated in the Division's Results Based Accountability Evaluation. As the Telling Your Story Project, is conducted by the same staff who operate Wellness

Recovery Services, the Results Based Accountability (RBA) Measures for this project were combined with the Wellness Recovery program measures. RBA measures were as follows:

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

Measure	Definition	Data Source
# participants served	Total # of participants served	Wellness Recovery Group Attendance Tracker
# of different group convened	Number of different types of groups (i.e. walking group, mood group, Telling Your Story group) convened	Wellness Recovery Group Attendance Tracker
Group events	Total number of meetings held	Wellness Recovery Group Attendance Tracker
# of participants who meet the requirements for "Telling Your Story"	Total number of participants in all "Telling Your Story" meetings	Wellness Recovery Group Attendance Tracker
# of participants who return for group events	Of total number of participants, % who returned for more than one event or meeting	Wellness Recovery Group Attendance Tracker
% of participants who reported feeling less shame about their experiences and challenges	Of participants who took the survey, percent who responded "agree" or "strongly agree" to the question.	Telling Your Story Survey
% of participants who reported recognizing progress in their recovery	Of participants who took the survey, percent who responded "agree" or "strongly agree" to the question.	Telling Your Story Survey

Data Development Agenda: measures the team is interested in reporting on but for which reliable data was not available:

- Advance Directives Data:
  -#/% of participants with an Advance Directive completed
  -#/% of participants able to advocate for themselves with service providers
- Equity of services (e.g. client demographics compared to MediCal population)
- % of clients who were satisfied with services

RBA outcomes for this program are outlined on the following pages.

BMH RBA Report FY 2023

Reporting Period July 2022 - June 2023

Wellness & Recovery Services

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

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

Program Updates The Wellness Recovery Team added two Social Services Specialist positions to the program. Adding these positions made more people aware of the wellness groups, events and support that the clinic has to offer.

49

Participants served

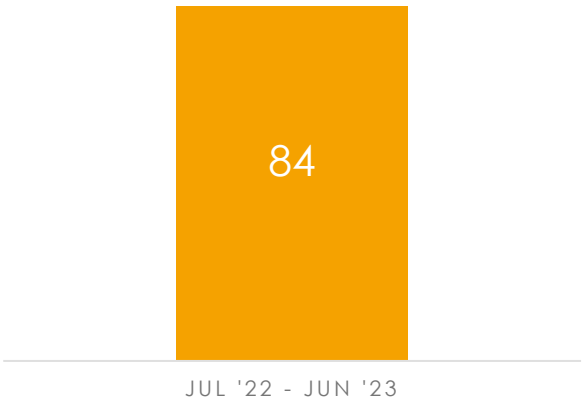
10

Participants who meet requirements for "Telling Your Story"

7

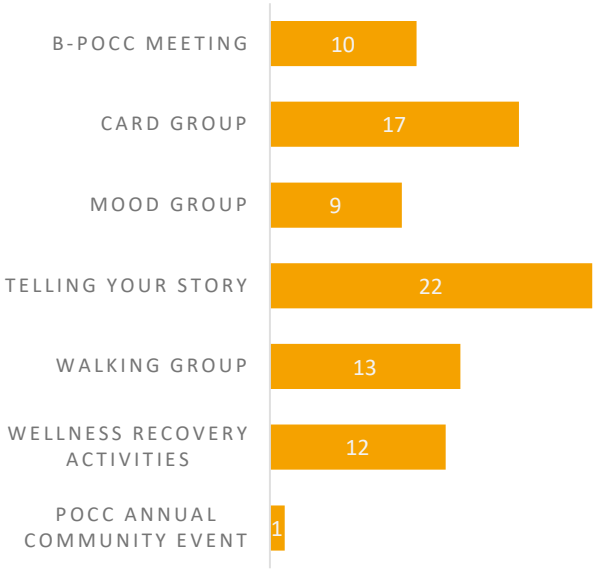
Different groups convened

WELLNESS GROUP MEETINGS ACROSS 7 DISTINCT GROUPS



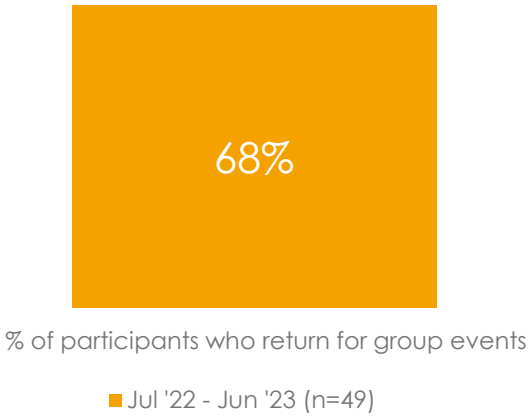
WELLNESS GROUP MEETINGS

JUL '22 - JUN '23 (N=84)

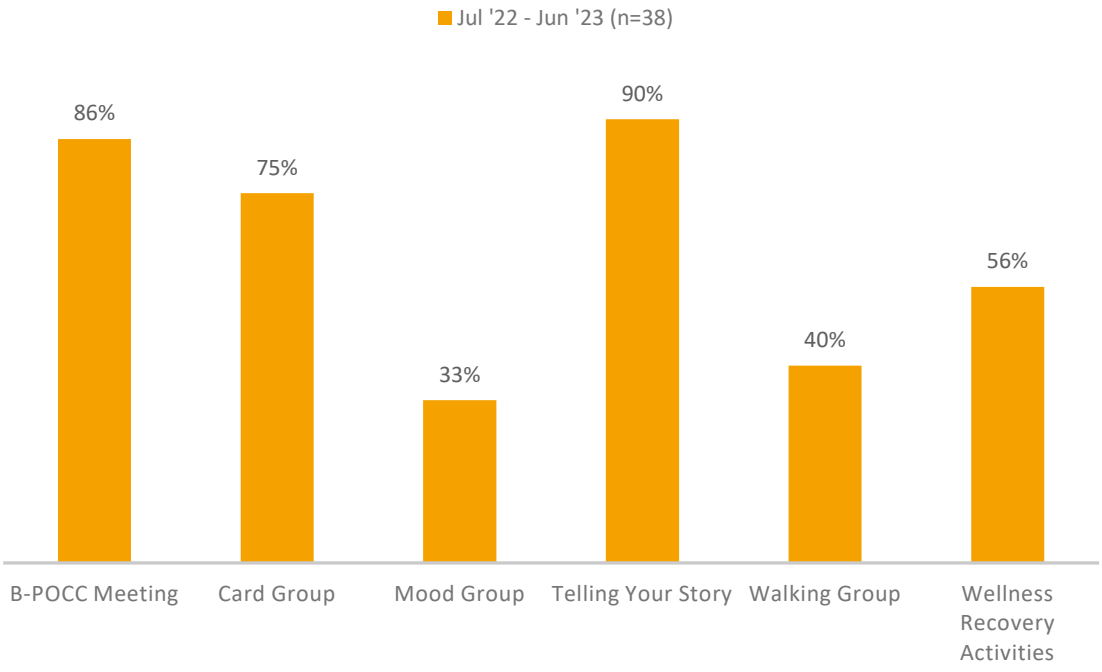


Quality Outcomes ("How well did we do it?")

Total Returning Participants



% Repeat Attendees for Wellness Groups



Measure	Definition	Data Source
# participants served	Total # of participants served	Wellness Recovery Group Attendance Tracker
# of different groups convened	Number of different types of groups (i.e. walking group, mood group, Telling Your Story group) convened	Wellness Recovery Group Attendance Tracker
Average # of group events held per 6 months	Total number of meetings held	Wellness Recovery Group Attendance Tracker
# of participants who meet the requirements for "Telling Your Story"	Total number of participants in all "Telling Your Story" meetings	Wellness Recovery Group Attendance Tracker
% of participants who return for group events	Of total number of participants, % who returned for more than one event or meeting	Wellness Recovery Group Attendance Tracker
% of participants reporting feeling less shame about their experiences and challenges	Percentage of survey respondents who agree or strongly agree that they feel less shame about their experiences and challenges	Telling Your Story Survey
% of participants reporting recognizing progress in their recovery	Percentage of survey respondents who agree or strongly agree that they recognize progress in their recovery	Telling Your Story Survey

OUTREACH FOR RECOGNIZING THE EARLY SIGNS OF MENTAL ILLNESS

Outreach for Recognizing the Early Signs of Mental Illness Program - A process of engaging, encouraging, educating, and/or training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.

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

Mental Health First Aid

City of Berkeley Mental Health staff 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.

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

PEI Priorities:

- Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs).
- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

Due to vacancies in staff, Mental Health First Aid trainings have not been provided in the past several years. It is envisioned that this program will be restarted in FY25.

SUICIDE PREVENTION

Suicide Prevention Programs (Optional) - Activities to prevent suicide as a consequence of mental illness.

The City of Berkeley has one PEI funded Suicide Prevention program:

California Mental Health Services Authority (CalMHSA) PEI Statewide Projects

Per PEI State Regulations mental health jurisdictions have an option on whether to utilize MHSA PEI funds on Suicide Prevention programs. While the City of Berkeley has not previously chosen to utilize PEI funds to implement a local Suicide Prevention program, in FY18 the Division began contributing 4% of PEI funding to the California Mental Health Services Authority (CalMHSA) to participate in the PEI Statewide Projects Initiative to locally obtain State resources on Suicide Prevention, Student Mental Health, and Stigma and Discrimination.

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

PEI Priorities:

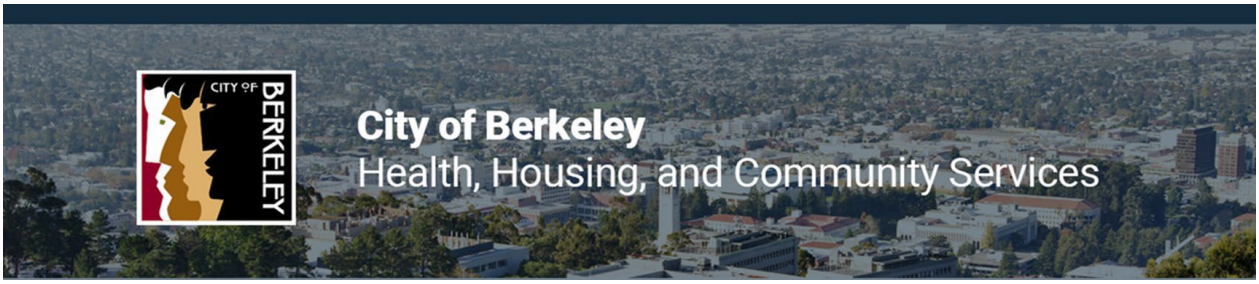
- Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs).
- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

In FY23, through this initiative resources on Suicide Prevention, Student Mental Health and Stigma and Discrimination reached approximately 1,624 individuals. Additionally, resources were distributed via email to local schools, community agencies and community members.

At present, the City has approximately $153,901 of unspent funds that were previously allocated to CalMHSA for this initiative. As a result, through this Annual Update, the Division is proposing to eliminate the allocation of local annual PEI funding for this initiative. Additionally, the Division will either utilize the previously allocated funds that are remaining at CalMHSA, to continue this initiative for a short-time, or to have the funds returned to the City for local use.

APPENDIX D

INNOVATION
FY23 ANNUAL EVALUATION REPORT



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

Innovations (INN)

FY22/23 Annual Evaluation Report

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 and mental health settings. INN projects can target any population and any aspect of the mental health system as long as the strategies or approaches that are being implemented address at least one of the following areas:

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

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

Per Mental Health Services Act (MHSA) State requirements, Mental Health jurisdictions are to submit an Innovation (INN) Evaluation Report to the Mental Health Services Oversight and Accountability Commission (MHSOAC) on an annual basis. INN Regulations 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 Comment period and approval from the local governing board. Per state regulations, the MHSA INN Fiscal Year 2022/2023 (FY23) Annual Evaluation Report that covers data from FY23 is due.

This FY23 INN Annual Evaluation Report provides descriptions of currently funded MHSA INN services, and reports on FY23 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, a description of the changes and the reasons for the changes.
- Available evaluation data, including outcomes of the Innovative Project and information about which elements of the Project are contributing to outcomes.
- Program information collected during the reporting period, including for applicable Innovative Projects that serve individuals, and the number of participants served.
- All Demographic Data as applicable per project (as outlined below).

INN Demographic Reporting Requirements

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

(A) The following Age groups:

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

(B) Race by the following categories:

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

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

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

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

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

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

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

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

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

(E) Sexual orientation

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

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

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

(G) Veteran Status,

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

(H) Gender

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

Effective July 2018 amended INN regulations specified the following:

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

CITY OF BERKELEY INN PROGRAMS

A description of INN programs and FY23 data are outlined below:

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 allocated INN funding to participate in a Statewide Collaborative with other California counties to pilot a Mental Health Technology Project that made various technology-based mental health services and supports applications (Apps) locally available in Berkeley. The Help@Hand Project sought to learn whether the use of the Apps would increase access to mental health services and supports; and whether it would increase the quality of mental health services, including leading to better outcomes.

The Division 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 lived, worked and or attended 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. Following that timeframe, the BMH MHSA Coordinator served as the Project Coordinator for this project. On behalf of the City and with locally designated Help@Hand project funds, CalMHSA executed a contract with Uptown Studios, 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 in Berkeley for a limited timeframe. The MyStrength App was available through October 2022. A large interest in the HeadSpace App in FY22 led the Division to decide to allocate a portion of non-MHSA funds to add additional licenses of this App for the community, and the HeadSpace App was available through September 2023.

The Division 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 Division entered into a contract with Hatchuel, Tabernik & Associates to conduct a local evaluation of this project. The evaluations are currently underway and will be reported on in future MHSA INN Evaluation Reports.

Over the duration of this project, there were 1,720 enrollees in MyStrength, and 7,328 enrollees in HeadSpace. Each App company collected and provided reporting on various user data measures. Local usage data provided by each App is outlined on the following pages.

myStrength scorecard

City of Berkeley

323

Program launch: 2021-09-20 Data thru: 2022-08-31

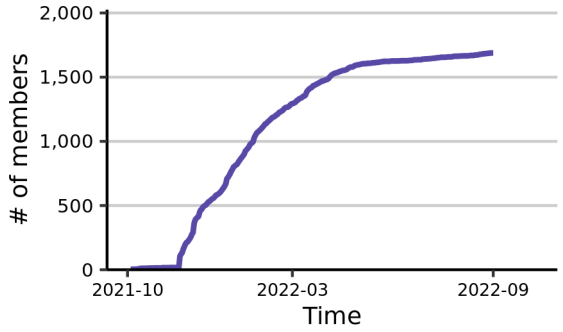
Members enrolled

Enrolled
1,688

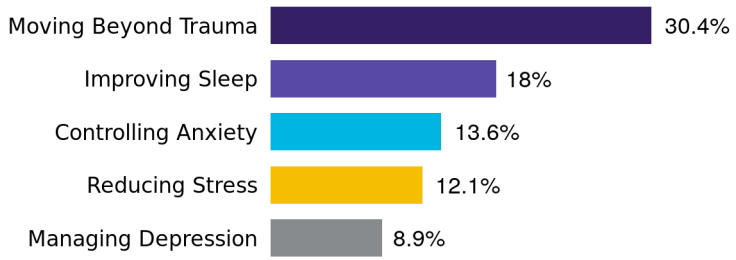
Activated
1,533
91% of enrolled

Returning
472
31% of activated

Enrollment trends



Top 5 digital recommendations



Program engagement

Average 90 day member engagement rates (% of returning)

14%
65/472
Logged in

3 average logins/member

4%
20/472
Completed activity

4 average activities completed/member

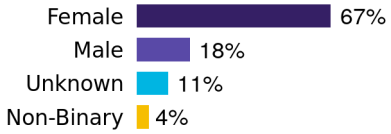
NA%
NA/472
Used engagement guidance

NA average messages sent to guide/member

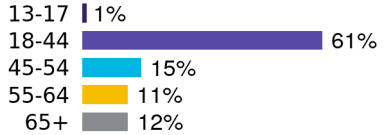
Member demographics

(% of enrolled)

Gender



Age Group



myStrength scorecard

City of Berkeley

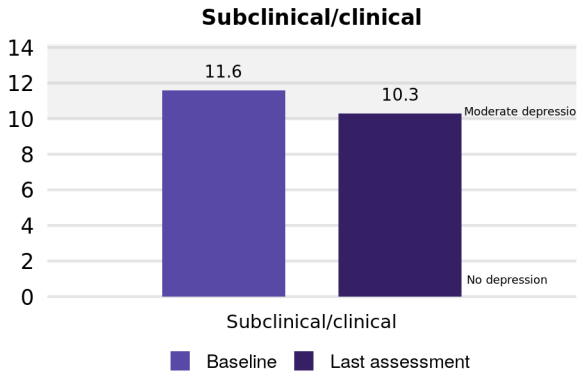
324

Program launch: 2021-09-20 Data thru: 2022-08-31

Depression outcomes

Clinical and subclinical population

Scored 5 or more in the PHQ-9 assessment



68.1%

Maintained or improved

40.5%

Clinically Improved

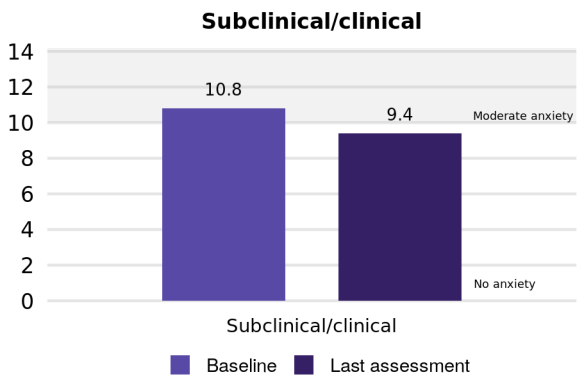
Started with scores ≥15 and decreased their score by at least 5 points

A PHQ-9 score indicates the severity level of a member's symptoms, where a score of 0-4 is nonclinical, 5-14 is subclinical, and 15+ is clinical.

Anxiety outcomes

Clinical and subclinical population

Scored 5 or more in the GAD-7 assessment



72.4%

Maintained or improved

25.8%

Clinically Improved

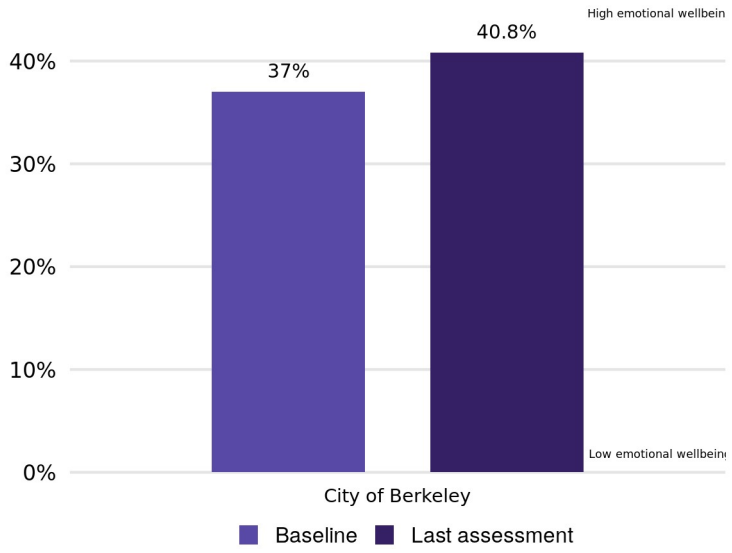
Started with scores ≥15 and decreased their score by at least 5 points

A GAD-7 score indicates the severity level of a member's symptoms, where a score of 0-4 is nonclinical, 5-14 is subclinical, and 15+ is clinical.

Wellbeing outcomes

28.4%

Of members' wellbeing improved at least 10% (Clinical definition of improvement)



A WHO-5 score below 52% (13 points) indicates poor well-being.

myStrength scorecard

City of Berkeley

325

DATA DEFINITIONS

Members enrolled

Enrolled: Number of members who registered and successfully enrolled

Activated: Number of members who completed the onboarding assessment

Returning: Number of activated members who have logged into the myStrength program at least once after onboarding assessment completion

Enrollment trends: Number of members who have enrolled (current enrolled) over time since the program launch date

Top 5 digital recommendations

The percentage of returning members that were recommended "Just for You" content or digital courses and programs.

Program engagement

Logged in: The percentage of returning members that logged into the myStrength application via the mobile app or the myStrength website at least once in the last 90 days.

Completed activity: The percentage of returning members that completed at least one activity in the last 90 days. Members must click the "Finish" button after going through all the steps in order to be counted.

Engagement guidance: The percentage of returning members that have sent at least one message to a guide in the last 90 days.
*N/A will display if engagement guidance is not a part of the program that was purchased

Clinical outcomes

PHQ-9 is a validated depression screening tool. Total score is between 0 and 27 with higher scores meaning more symptoms. Metrics show % of members who have taken the PHQ-9 assessment at least twice – once at baseline and at least once more after baseline.

GAD-7 is a validated anxiety screening tool. Total score is between 0 and 21 with higher scores meaning more symptoms. Metrics show % of members who have taken the GAD-7 assessment at least twice – once at baseline and at least once more after baseline.

WHO-5 is a validated measure of general wellbeing (not a specific diagnosis or problem). Total score is between 0 and 25 with lower scores showing lower quality of life and higher scores showing higher quality of life. Raw scores are multiplied by 4 to get a percentage score. Metrics show % of members who have taken the WHO-5 assessment at least twice – once at baseline and at least once more after baseline.

*For each clinical outcome, the reported population has at least 10 members in the program and completed at least two assessments.

headspace

City of Berkeley

Enrollment

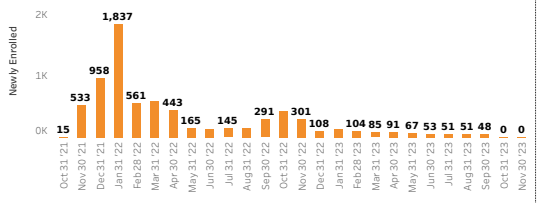
Current Members

Number of people (employees) from my organization enrolled to Headspace

New Enrollments

Number of new member enrollments by Month

For week view, weeks may include enrollments from prior/future month if these dates are in the chosen period; Week start is on Sunday and week end is on Saturday



Employee

Engagement

Headspace Minutes in None

Total minutes using ALL Headspace content within calendar year

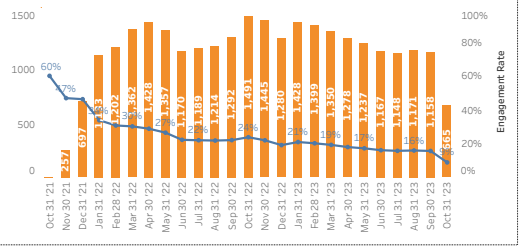
Minutes Meditated in None

Total minutes using meditation content within calendar year

Monthly Active Users

MAU: Number of enrolled members who have engaged with at least 1 piece of content in Headspace in the previous 30 days

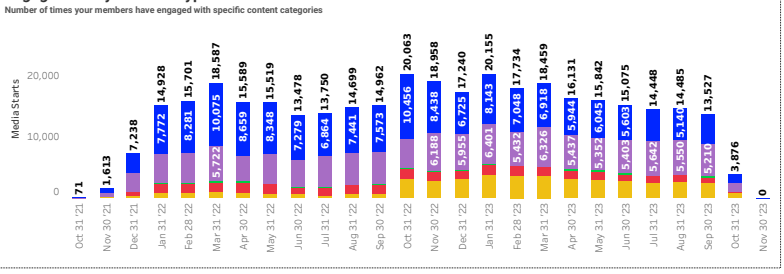
Engagement Rate: Percentage of total enrolled members who have engaged with at least 1 piece of content in Headspace in the previous 30 days



Engagement Rate MAU

Engagement by Content Type

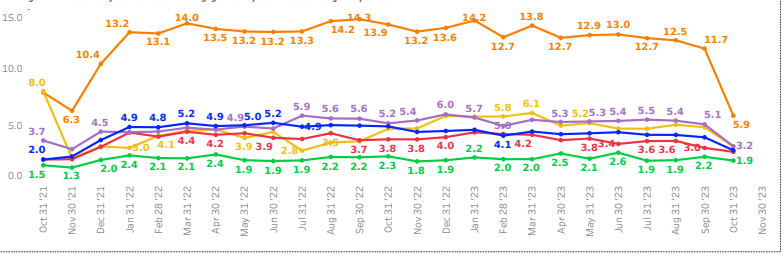
Number of times your members have engaged with specific content categories



Meditation Sleep Move Wakeup Focus

Depth of Engagement per Active User

Average number of times your members have engaged with specific content categories per month



Meditation Sleep Move Wakeup Focus ALL

Top 15 Courses

Percentage of sessions from courses over choosen period

Managing Anxiety	14.1%
Basics	10.8%
Letting Go of Stress	9.3%
Basics 2	5.3%
Sleep	4.2%
Basics 3	3.8%
Finding Focus	3.4%
Pro | Level 1	2.5%
Self-Esteem	2.4%
Headspace 365	2.4%
Acceptance	2.4%
Balance	2.3%
Handling Sadness	1.6%
Navigating Change	1.6%
Creativity	1.4%

Top 15 Non-Courses

Percentage of sessions from non-course content over choosen period

The Wake Up	9.3%
Goodnight	3.0%
Sleeping	2.4%
Everyday Headspace	2.1%
Doze	1.8%
Falling Back to Sleep	1.2%
Switching Off	1.2%
Unguided	1.0%
Rain on Rocks	0.9%
Take 5 Cleansing Breaths	0.9%
60 Seconds of Mindful Bre..	0.8%
Treat Yourself to 5 Gentle..	0.8%
Feel the Benefits of 5 Dee..	0.8%
1-Minute Breathing Exerc..	0.8%
Enjoy 5 Deep Breaths	0.8%

If you have issues or questions on your organization's report, please reach out to your customer success manager or contact teamsupport@headspace.com.

Encampment-Based Mobile Wellness Center Project

In April 2022, the Division received approval to implement an Encampment-Based Mobile Wellness Center Project from the Berkeley City Council and the State Mental Health Oversight and Accountability Commission (MHSOAC). This new project will pilot a Mobile Wellness Center at Homeless encampments in Berkeley. The Mobile Wellness Center project 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 by Options Recovery Services who was chosen through a competitive Request For Proposal (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. The project will include an Evaluation component, which will be reported on in future MHSA INN Evaluation Reports. It is envisioned that the project will be implemented in early FY25.

Health, Housing &
Community Services Department
Mental Health Commission

Proposed revisions to the MHC's letter to Auditor Jenny Wong:

July __, 2024

Proposed revision of request for audit

To:
City Auditor Jenny Wong
From: Berkeley Mental Health Commission
Re: Request for Programmatic Audit of Behavioral Health Programs
Date: July __, 2024

This memo requests a programmatic audit of our city's behavioral (i.e., mental health) health programs. Our primary concerns are:

1. Has Berkeley ever assessed the effectiveness of its behavioral health programs? If so, how? We would like to review those records.

2. What results do Berkeley's various mental health programs obtain? Are the benefits that Berkeley's efforts confer as valuable as the benefits that the same funds could provide in the form of other services such as housing, food, and non-behavioral social services? How have other governmental and non-governmental organizations approached these issues? Is it possible to assess the benefits of Berkeley's programs as compared to those provided by other organizations and government agencies?

3. How does Berkeley self-assess the achievements of its behavioral health programs? Has Berkeley studied the achievements of its programs in comparison to the programs of other organizations? Might it be worthwhile to do so?

4. Has Berkeley used data to assess the benefits of its behavioral health programs? If so, how? Are there reasons to believe that more, fewer, or different assessments of cost-effectiveness would benefit our city's efforts? We realize that answers to these questions require estimates of what, as a practical matter, is and isn't possible, as well as recognition that funds expended on assessment may have to be diverted from funding that otherwise would be available for treatment.

5. What are the costs per patient-contact-hour of Berkeley's behavioral health services? We note that these costs can and probably should be estimated in both of two ways: (1) Total expenditures by behavioral health services department, including occupancy, clerical, transportation, management, etc.,divided by number of patient contact hours; (2) total cost of therapist salaries and employment benefits (including estimated post-retirement benefits) divided by number of patient contact hours. How do these costs compare to the costs of non-governmental (private) therapy?

6. Has Berkeley audited or otherwise evaluated its mental health programs? Have the results made the evaluation expenditures worthwhile? If the results of past audits or evaluations have been disappointing or equivocal, how can current and future efforts be improved?

7. How can communications between Berkeley's behavioral health services and the Mental Health Commission be improved?

8. Have other providers of behavioral health services evaluated their programs in ways that Berkeley should consider? This may be a complex issue, but it may be as important as it is complex. Berkeley has expended many millions of dollars on behavioral health services and probably will expend many millions more in coming years. Is it likely to be worthwhile to attend to these issues?

9. What can Berkeley do to make employment in its behavioral health services more attractive for current and future employees?

The Mental Health Commission would like to emphasize that it is requesting a programmatic audit, not a financial audit. The Commission has not examined any accounting or financial records, and it has no information to suggest accounting, financial, or legal improprieties.

The Commission also recognizes that a programmatic audit could go in one or more of many directions, but it cannot go in all. Members of the Commission will make themselves available to consult with you and with behavioral health administrators as needed to enable a productive, forward-facing report.

[Chair's signature here]

Monica Jones,
Berkeley MHC Interim Chair
916-225-5735
Mjberkeleycommissioner18@gmail.com

Health Housing and
Community Services Department
Mental Health Division

MEMORANDUM

To: Mental Health Commission
From: Jeffrey Buell, Mental Health Division Manager
Date: 7/17/2024
Subject: Mental Health Manager Report

Mental Health Services Report

Please find the attached report on Mental Health Services for June 2024.

Information Requested by Mental Health Commission

No questions were submitted by the Mental Health Commission this month.

Mental Health Division Updates

Concerning community behaviors:
Members of the Downtown Berkeley area have and still continue to voice concerns for negative behaviors that residents experience in the community. These behaviors are often attributed to behavioral health needs, and often result from a complex and varied etiology. Questions and requests continue to arise regarding increases in crisis program offerings, outreach, legal enforcement, and security services. The City has been clear that voluntary services are the primary interventions that will be offered. Involuntary services/treatment are a last resort, few in number, and do not empirically result in great treatment outcomes. The Division, Department, and City is interested in knowing the concerns of the public, and will continue to best adjust our efforts to address those needs. Current services include but are not limited to: the Specialized Care Unit (SCU), Mobile Crisis Team (MCT), Homeless Response Team (HRT), Lifelong Street Medicine Team, Downtown Ambassadors.

CARE Court:
Alameda County (along with the remainder of California Counties that have not yet started) will be implementing Community, Assistance, Recovery, Empowerment (CARE) Court services by 12/1/24, per state requirements. The County has been facilitating connections between Alameda County, Judges and Courts, Agencies, and associated stakeholders to review the requirements and capabilities of this program. Counties with

active CARE Court programs are being reviewed, engaged, and visited to bring in best practices to our developing system. Alameda County is currently preparing to have one CARE dedicated Full Service Partnership (FSP) Team, 2 CARE dedicated In-Home Outreach Team (IHOT) units, and contracted providers for CARE Housing programs. Housing for this County program optimally will include interim/emergency shelter beds (160), Motel vouchers (15), Licensed board and care (40), Forensic Peer Respite (6), Rental Assistance (55), and additional funding for behavioral health housing expansion. Probate Division Court will be the location of CARE Act Court. Public FAQ and resource materials are being developed by the County to share information about this program. Public Defender's Office will be providing legal representation for CARE respondents.

Berkeley Mental Health Caseload Statistics for July 2024

Adult Services	Intended Ratio of staff to clients	Clinical Staff Positions Filled	# of clients open this month	Average Monthly System Cost Previous 12 Months	Fiscal Year 2025 (July '24-June '25) Demographics as of June 2025
Adult, Older Adult and TAY Full Service Partnership (AFSP) (Highest level outpatient clinical case management and treatment)	1-10 for clinical staff.	4 Clinicians, 1 Non-Licensed Clinician, 1 Clinical Supervisor	52	$2,239	Clients: 63 API: 2 Black or African-American: 35 Hispanic or Latino: 1 White: 25 American Indian: 0 Other/Unknown: 0 Male: 36 Female: 26 Missing Gender ID: 0 Prefer Not to Answer Gen ID: 1 Multiple Gender ID: 0 Heterosexual: 51 Unknown: 4 Missing Sex Orient: 0 Bisexual: 1 Queer: 1 Prefer Not to Answer Sex Orient: 3 Multiple Sex Orient: 2 Gay: 0 Questioning: 1 Lesbian: 0
Adult FSP Psychiatry (July Stats)	1-100	0 FTE	45		
AFSP FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)				$2,037,600	
Homeless Full-Service Partnership (HFSP) (Highest level outpatient clinical case management and treatment)	1-8 for clinical staff	3 Clinicians, 2 Non-Licensed Clinician, 1 Clinical Supervisor	41	$2,864	Clients: 42 API: 2 Black or African-American: 25 Hispanic or Latino: 1 Other/Unknown: 0 White: 14 Male: 27

					Female: 13 Missing Gender ID: 1 Unknown: 1 Prefer No to Answer: 0 Multiple Gender Identities: 0 Heterosexual: 33 Missing Sex Orient: 1 Bisexual: 3 Unknown: 3 Gay: 1 Questioning: 1 Multiple Sex Orient: 0 Prefer Not to Answer: 0 Lesbian: 0
HFPS Psychiatry (July Stats)	1-100	0.5 FTE	28		
HFSP FY22 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			TBD		
Comprehensive Community Treatment (CCT) **(High level outpatient clinical case management and treatment)**	1-20	7 Clinicians 1 Team Lead 1 Clinical Supervisor	144	$1,301	Clients: 178 American Indian: 2 API: 17 Black or African-American: 68 Hispanic or Latino: 7 Other/Unknown: 4 Pacific Islander: 1 White: 79 Male: 93 Female: 77 Multiple Gender Identities: 2 Missing Gender ID: 0 Non-Conforming Gender ID: 2 Prefer Not to Answer Gender ID: 1 Female to Male: 1 Queer Gender ID: 1 Unknown: 1 Heterosexual Sex Orient: 131 Unknown: 19 Missing Sexual Orient: 1

Berkeley Mental Health Caseload Statistics for July 2024

					Bisexual Sex Orient: 3 Lesbian Sex Orient: 5 Gay Sex Orient: 3 Prefer Not to Answer Sex Orient: 10 Multiple Sexual Orient: 1 Queer Sexual Orient: 2 Other Sexual Orient: 3
CCT Psychiatry (July Stats)	1-200	0.75 FTE	114		
CCT FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			$2,617,010		
Focus on Independence Team (FIT) (Lower level of care, only for individuals previously on FSP or CCT)	1-20 Team Lead, 1-50 Post Masters Clinical 1-30 Non-Degreed Clinical	1 Licensed Clinician 1 CHW Sp./ Non-Degreed Clinical, 1 Clinical Supervisor	86	$792	Clients: 92 API: 7 Black or African American: 33 Hispanic or Latino: 5 Other/Unknown: 2 White: 45 Male: 52 Female: 38 Intersex: 1 Missing Gender ID: 1 Other Gender ID: 0 Heterosexual: 79 Unknown: 5 Missing Sexual Orient: 1 Prefer Not to Answer Sexual Orient: 4 Gay: 2 Multiple Sexual Orient: 1 Questioning: 0
FIT Psychiatry (July Stats)	1-200	.25	72		
FIT FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			$900,451		

Family, Youth and Children's Services	Intended Ratio of staff to clients	Clinical Staff Positions Filled	# of clients open this month	Average Monthly System Cost Last 12 months	Fiscal Year 2025 (July '24-June '25) Demographics as of July 2024
Children's Full-Service Partnership (CFSP)	1-8	1 Senior Behavioral Health Clinician 1 Non-Licensed Clinician	10	$777	Clients: 13 American Indian: 0 API: 0 Black or African-American: 7 Hispanic or Latino: 6 Other/Unknown: 0 White: 0 Female: 5 Male: 6 Missing Gender ID: 1 Unknown: 1 Non-Conforming Gender ID: 0 Heterosexual: 6 Missing Sexual Orient: 1 Unknown: 5 Gay: 1 Other Sexual Orient: 0 Questioning Sexual Orient: 0
CFSP Psychiatry (July Stats)	1-100	0	4		
CFSP FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$489,235		
Early and Periodic Screening, Diagnostic and Treatment Prevention (EPSDT) /Educationally Related Mental Health Services (ERMHS)	1-20	2 Clinicians, 1 Clinical Supervisor	50	$1,719	Clients: 70 American Indian: 6 API: 4 Black or African-American: 29 Hispanic or Latino: 14 Other/Unknown: 2 White: 15 Female: 29 Male: 25 Missing Gender ID: 5 Unknown: 6 Multiple Gender ID: 3 Non-Conforming Gender ID: 2

					Female to Male: 0 Other Gender ID: 0 Heterosexual: 30 Unknown: 23 Missing Sexual Orient: 5 Gay: 4 Multiple Sexual Orient: 3 Bisexual: 2 Lesbian: 1 Prefer Not to Answer: 1 Other Sexual Orient: 0 Queer Sexual Orient: 0 Questioning Sexual Orient: 1
ERMHS/EPSDT Psychiatry (July Stats)	1-100	0	11		
EPSDT/ERMHS FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$1,062,409		
High School Health Center and Berkeley Technological Academy (HSHC)	1-6 Clinician (majority of time spent on crisis counseling)	3 Clinicians, 1 Clinical Supervisor	Drop-in: 3 Externally referred: 3 Ongoing tx:10 Groups: 0 Offered/ 0 Conducted		N/A
HSHC FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$396,106		

Crisis and ACCESS Services	Staff Ratio	Clinical Staff Positions Filled	Total # of Clients/Incidents	MCT Incidents Detail	Calendar Year 2024 (Jan '24- Dec '24) Demographics – From Mobile Crisis Incident Log (through July 2024)
Mobile Crisis (MCT)	N/A	2 Clinicians filled at this time	• 60 - Incidents • 11 - 5150 Evals • 6 - 5150 Evals leading to involuntary transport	• 33 - Incidents: Location - Phone • 18 - Incidents: Location - Field • 0 - Incidents: Location - Home	Clients: 298 API: 13 Black or African-American: 57 White: 79 Hispanic or Latino: 7 Other/Unknown: 142 Female: 143 Male: 127 Transgender: 2 Unknown: 26
MCT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$771,623		
Transitional Outreach Team (TOT)	N/A	.5 Licensed Clinician, (TOT and CAT have been recently merged)	• 4 – Incident(s)	N/A	Clients: 16 API: 1 Black or African-American: 2 White: 11 Hispanic or Latino: 0 Other/Unknown: 2 Female: 9 Male: 7 Transgender: 0 Unknown: 0
TOT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$272,323		
Crisis, Assessment, and Triage (CAT)	N/A	2 Non-Licensed Clinicians, .5 Licensed Clinician, 0 Clinical Supervisor	• 88 - Incidents	N/A	Clients: 305 API: 5 Black or African-American: 55 White: 47 Hispanic or Latino: 17 Other/Unknown: 181 Female: 98 Male: 106 Transgender: 1 Unknown: 100

CAT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)	$735,075

Not reflected in above chart is Early Childhood Consultation, Wellness and Recovery Programming, or Family Support.
In demographics, other/unknown is used both when a client indicates that they are multi-racial and when demographic info is not known.

*Average System Costs come from Yellowfin, and per ACBH include all costs to mental health programs, sub-acute residential programs, hospitals, and jail mental health costs.

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Friday, July 12, 2024 3:25 PM
To: Works-Wright, Jamie
Subject: FW: Mental Health Advisory Board Meeting (July 15, 2024)
Attachments: MHAB Main Board Agenda (July 2024) .pdf; MHAB Main Board Meeting UNAPPROVED Minutes (June 2024) .pdf; Draft Letter to BOS re MHSA FY24-25 Annual Plan Update .pdf; Housing as HealthCare Presentation (July 2024).pdf

Internal

Hello Commissioners,

Please see the attached documents and email below.

Jamie Works-Wright
Consumer Liaison
Jworks-wright@berkeleyca.gov
510-423-8365 cl
510-981-7721 office

From: MHB Communications, ACBH <ACBH.MHBCommunications@acgov.org>
Sent: Friday, July 12, 2024 3:18 PM
Subject: Mental Health Advisory Board Meeting (July 15, 2024)

Good afternoon,

Please see attached materials for the Mental Health Advisory Board meeting scheduled for **Monday, July 15, 2024 at 3:00 PM.**

This will be an in-person meeting to be held at 2000 Embarcadero Cove, Suite 400 (*Gail Steele Conference Room*), Oakland CA. Members of the public are invited to observe and participate in person or remotely via Zoom.

To participate via Zoom, please click on the meeting link below:

https://us06web.zoom.us/s/84285334458?pwd=bURyU1JqS2YvVGhRU2g4SW5yL0xRQT09

Webinar ID: 842 8533 4458
Passcode: 269505

Or Telephone:
USA 404 443 6397 US Toll
USA 877 336 1831 US Toll-free
Conference code: 988499

Alameda County
Mental Health Advisory Board

Mental Health Advisory Board Agenda

Monday, July 15, 2024 | 3:00 PM – 5:00 PM

2000 Embarcadero Cove, Suite 400 (Gail Steele Room) Oakland

This meeting will also be conducted through videoconference and teleconference

https://us06web.zoom.us/j/84285334458?pwd=bURyU1JqS2YvVGhRU2g4SW5yL0xRQT09

Teleconference: (877) 336-1831 | Teleconference Code: 988499

Webinar ID: 842 8533 4458 | Webinar code: 269505

MHAB Members:	**Brian Bloom** *(Chair, District 4)* **Terry Land** *(Vice Chair, District 1)* **Jennifer DeGroat-Penney** *(District 1)* **Carolynn Gray** *(District 2)* **Gina Lewis** *(District 2)*	**Thu Quach** *(District 2)* **Ashlee Jemmott** *(District 3)* **Warren Cushman** *(District 4)* **Mary Hekl** *(District 4)* **Larry Brandon** *(District 5)*	**Olivia Daprile** *(District 5)* **Juliet Leftwich** *(District 5)* **Amy Shrago** (*BOS Representative)*

Committees

Adult Committee
Terry Land, Co-Chair
Thu Quach, Co-Chair

Children's Advisory Committee
Ashlee Jemmott, Co-Chair
Warren Cushman, Co-Chair

Criminal Justice Committee
Brian Bloom, Co-Chair
Juliet Leftwich, Co-Chair

MHAB Mission Statement

The Alameda County Mental Health Advisory Board has a commitment to ensure that the County's Behavioral Health Care Services provide quality care in treating members of the diverse community with dignity, courtesy, and respect. This shall be accomplished through advocacy, education, review, and evaluation of Alameda County's mental health needs.

3:00 PM		Call to Order _____	Chair Bloom
3:00 PM	I.	Roll Call	
3:05 PM	II.	Approval of Minutes	
3:05 PM	III.	Public Comments (**Non-Agenda Items**)	
3:15 PM	IV.	MHAB Chair's Report	
3:25 PM	V.	ACBHD Director's Report	
3:35 PM	VI.	MHAB's Response to MHSA FY 2024-2025 Annual Update Plan (***Action Item***)	
3:45 PM	VII.	Committee and Liaison Reports A. Adult Committee B. Criminal Justice Committee C. Children's Advisory Committee D. MHSA Stakeholder Committee E. Budget Stakeholder Advisory Committee F. Berkeley Mental Health Committee Liaison	
4:05 PM	VIII.	Presentation: Housing as HealthCare	
4:50 PM	IX.	Public Comment (**Agenda Items**)	
5:00 PM	X.	Adjournment	

Behavioral Health Department
Alameda County Health

Mental Health Advisory Board UNAPPROVED Minutes
Monday, June 17, 2024 | 3:00 PM - 5:00 PM

Meeting Conducted In-Person and through Video/Telephone Conference

Alameda County
Mental Health Advisory Board

MHAB Members:	☒ **Brian Bloom** *(Chair, District 4)* ☒ **Terry Land** *(Vice Chair, District 1)* ☒ **Carolynn Gray** *(District 2)* ☐ **Gina Lewis** *(District 2)*	☒ **Thu Quach** *(District 2)* ☒ **Warren Cushman** *(District 3)* ☒ **Ashlee Jemmott** *(District 3)* ☒ **Olivia Daprile** *(District 5)*	☒ **Juliet Leftwich** *(District 5)* ☒ **Lawrence Brandon** *(District 5)* ☒ **Mary Hekl** *(District 5)* ☒ **Amy Shrago** *(BOS Representative)*
ACBH Staff:	☒ **Dr. Karyn Tribble** *(ACBHD Director)* ☒ **James Wagner** *(ACBHD Deputy Director, Clinical Operations)* ☐ **Vanessa Baker** *(ACBHD Deputy Director, Plan Administration)*	☒ **Dainty Castro** *(MHAB Liaison)* ☒ **Asia Jenkins** *(ACBHD Admin Support)*	
Excused Absences:			

Meeting called to order at 3:02 PM by Chair Brian Bloom.

ITEM	DISCUSSION	DECISION/ACTION
Roll Call / Introductions	Roll Call was completed.	
Approval of Minutes	Last month's meeting minutes were adopted and approved.	
Public Comments (Non-Agenda Items)	Public comments were given.	
MHAB Chair's Report	The Mental Health Advisory Board (MHAB) Chair provided a report: MHAB Officer Election: The election for two (2) MHAB officer positions, Chair and Vice Chair, is schedule in August. Chair Bloom will ask for volunteers at next month's full board meeting to request for assistance.	

ITEM	DISCUSSION	DECISION/ACTION
	MHAB Recruitment Update: The Board of Supervisors (BOS) District 3 is reviewing applications and plans to fill the two vacancies by August. Additionally, Chair Bloom and Vice Chair Land are in communication with BOS District 1 regarding the two vacancies in their district. Committee Meetings: MHAB members were encouraged to attend committee meetings. Recurring meeting schedules were also announced. Berekely Mental Health Advisory Committee: This committee does not allow virtual participation. Chair Bloom will connect the MHAB Member Brandon with the Berkely Mental Health Advisory Committee Chair to explore potentital partnership and liaison opportunities. SUD Facility Site Visit: MHAB Member Heckl has volunteered to organize an site visit to an SUD facility and will provide an update at next month's meeting. MHAB's Response to the MHSA Annual Report: This year's response will be less substantive than as last year's due to minimal changes in the Annual Report. Vice Chair Land has volunteered to draft the response which will be discussed at next month's meeting. MHAB Retreat Update: Chair Bloom shared comments regarding the MHAB retreat held on June 1, 2024 noting some challenges addressed during the retreat. He emplasized the importance of everyone feeling safe and heard, and working together despite differing opinions or point of views to achieve the board's common goal.	
ACBHD Director's Report	Alameda County Behavioral Health Department (ACBHD) Director, Dr. Karyn Tribble provided the following update: IST Grant: ACBHD received an $8.25 million grant from the Department of State Hospital for the Imcompetent to Stand Trial (IST) facility. This grant is designated for capital expenses, such as buildings and support the system, however, not for service delivery. MHSA Update: On June 10, 20024, ACBHD provided an update on the Mental Health Services Act (MHSA) to the Board of Sueprviors (BOS) Health Committee. Tracy Hazelton, MHSA Division Director, lead the presentation, covering the second year of a three-year cycle. The current services will largely remain unchanged, with a new plan set to begin in 2026. Dr. Tribble also mentioned that the State's Behavioral Health Continuum	

ITEM	DISCUSSION	DECISION/ACTION
	Infrastructure Program (BHCIP), initially intended to fund housing, has paused and Round 6 has been canceled. The program has now shifted to using bonds for treatment facilitites/sites. ACBHD Strategic Plan: Dr. Tribble ensured that the board received a copy of ACBHD's Strategic Plan and announced that once completed, it will be shared with the board. CalAIM Update: Signifant changes are coming to the California Advancing and Innovating Medi-Cal (CalAIM), particularly concerning the re-entry population, with implementation expected in October. CARE Court Update: The required implementation date is December 1, 2024. The county has initiated a Request for Proposal (RFP) process, and the awardee will be announced once the information has been submitted to the BOS for review and approval. Senate Bill 43 Update: Implementation is scheduled to begin January 2026	
Committee & Liaison Reports	Agenda item not discussed.	
Impact of Proposition 1 in Alameda County on Prevention and Early Intervention Programs	MHAB Member Thu Quach discussed the impacts of Proposition 1 in Alameda County. With the passing of Proposition 1, funding for core services will be reduced, and the county-administered prevention fund will be completely eliminated. Cultural factors, such as stigma, lack of language access, and health coverage contribute to these disparities. Member Quach also shared a real-life example illustrating the impacts of migration and intergenerational trauma. She urged the board to incorporate a health equity lense in the analysis of all topics discussed.	
Care First, Jails Last Overview Presentation and Discussion	MHAB Chair Bloom provided an overview of the Care First, Jails Last (CFJL) Task Force, of which he is also a member. • The CFJL Task Force Resolution, aimed at reducing the number of mentally ill individuals in the jail, was unanimously passed by the BOS on May 25, 2021	

ITEM	DISCUSSION	DECISION/ACTION
	• The Task Force included community members, CBOs and agency departments • After two years of diligent work, the Task Force developed a county-wide plan with a total of 58 Recommendations • The final meeting was had last month and a presentation to the BOS Joint Health and Public Protection Committee is scheduled for June 26, 2024 • Highlights from the Recommendations was discussed, including related or aligned county efforts already in progress • The MHAB's role involved data analysis and providing semi-annual reports to the BOS. The BOS recommended creating an ad hoc committee to oversee the development and implementation of the county agencies' draft plans. MHAB Board Discussion: • The BOS needs to affirm and may ask questions about the recommendations to be presented by the Task Force • Some recommendations include funding requests • The MHAB's role is to ensure that county agencies are on track with their commitments and report findings back to the BOS • The ad hoc committee will need to determine success metrics • Other options besides creating an ad hoc committee were also discussed. The advantage of an ad hoc committee is that it allows public participation since it is not subject to the Brown Act.	
Public Comment (Agenda Items)	Public comments were given.	
Adjournment	This meeting was adjourned at 5:25 PM.	

DRAFT MHAB Comments on the Draft Mental Health Services Act FY23-26 Annual Plan update FY24-25

[Letterhead]

[Date]
Alameda County Board of Supervisors
1221 Oak St., #536
Oakland, CA 94612
Re: Draft Mental Health Services Act Annual plan update FY24/25

Dear Alameda County Board of Supervisors,

The Alameda County Mental Health Advisory Board (MHAB) is pleased to provide these recommendations for the Draft Mental Health Services Act (MHSA) Annual Plan update FY24-25 of the FY23-26 plan. The recommendations are the culmination of our review of the draft MHSA Annual plan update FY24/25, discussions with County behavioral health leadership and participation in the MHSA Stakeholder Group. They are also informed by numerous MHAB board meetings and by the extensive input of experts and community members. The MHAB asks that the Board of Supervisors give these recommendations serious consideration.

As The Mental Health Services Act was intended to provide funding to people suffering from the most serious, disabling, and persistent forms of mental illness, our comments are focused on our County meeting this intent. (See MENTAL HEALTH SERVICES ACT (ca.gov)) However, the MHAB believes that it is no less important for Alameda County to meet less severe mental health needs utilizing community based, culturally and linguistically sensitive outreach programs. Accordingly, we urge the County to do everything in its power to make up the funding gaps caused by the passage of Proposition 1 and to find sustainable funding streams, outside of MHSA, to continue to support these essential and life sustaining programs.

Recommendations

1. **The County should prioritize evaluating the need for early psychosis and mood disorder treatment programs and expand providers and locations to meet the need. In addition, they should work with Felton to solve challenges that may be preventing them from seeing more patients and increase the client base age limit beyond 24 years old.** It should be a priority to provide intensive treatment for those experiencing early psychosis to improve outcomes, avoid the prevalence of self-medication with drugs and alcohol, avoid prolonged detrimental psychosis, and prevent relapse. It is very important to connect people with programs early on where they can learn how to manage their illness, be stabilized on a medication that works for them and be connected with a support network including a psychiatrist, therapist, social worker and care coordinator who can help them address challenges and barriers as they arise. This type of program

provides individuals with the best shot at having a sustained positive outcome and chance of normal life.

The Felton Institute is the only provider listed in the entire MHSA Plan that mentions early psychosis in their description. In Alameda County, they have one location on Alameda Island, and they are contracted to serve 100 clients (18–24 years old) per year but are only serving 47. The County should evaluate and help overcome the barriers to seeing more clients, including location accessibility. In addition, they should consider expanding to treat people over 24 years old as many experience their first psychotic break in their later twenties.

The County only has one focused early psychosis program. The Table on p.309 of the MHSA plan lists four programs in the early psychosis & mood disorder category. However, NOT ONE mentions psychosis or mood disorder in their descriptions and only one mentions connecting people with treatment/intervention services. From what is stated in their program descriptions, most of these are not focused on the intent of the MHSA for this category.[1]

2. **The County should strongly consider utilizing the expanded definition of "gravely disabled" in SB43 (the Lanterman-Petris-Short Act) to get more individuals into early and sustained treatment programs that will improve their outcomes and reduce cycling in and out of psychiatric facilities.** Many people who suffer from psychotic disorders are not able to see that they need help as they may be lost in their own reality. This is a really important tool to get people into treatment programs and off the streets. The Lanterman-Petris-Short Act provides for the involuntary commitment and treatment of a person who is a danger to themselves or others or who is gravely disabled. SB 43 expands the definition of "gravely disabled" to also include a condition in which a person, as a result of a severe substance use disorder, chronic alcoholism, mental health disorder, is, in addition to the basic personal needs, unable to provide for their personal safety or necessary medical care.

The Draft MHAS Plan makes it clear that for those individuals who are able to engage and participate in Full-Service Partnerships (FSPs), their chances of being hospitalized and/or arrested in the future are reduced. Clearly FSPs can work for

[1] "Early psychosis and mood disorder detection and intervention refers to a program that utilizes evidence-based approaches and services to identify and support clinical and functional recovery of individuals by reducing the severity of first, or early, episode psychotic symptoms, other early markers of serious mental illness, such as mood disorders. keeping individuals in school or at work, and putting them on a path to better health and wellness." The County should ensure that they have robust early psychosis programs that meet this important need.

those who engage and are amenable treatment. We don't see anything in the Draft Plan that funds programs aimed at the population who, by virtue of their mental illness, are not capable of engaging in an FSP.

3. **With the passing of Proposition 1 and anticipated reduction in Prevention, Education, and Intervention (PEI) funding, the county should find a way to support the community-based programs that are culturally responsive and are effective at connecting people with mental health services, addressing the reticence toward treatment and reducing the stigma associated with mental illness.**

4. **In the Interim, the MHSA PEI portfolio should be reviewed to focus investments on programs that address the specific stated goals. The County should consider developing and implementing more purposeful metrics and accountability for delivering on mental illness/health aspects of the program goals.** The Mental Health Services Oversight & Accountability Commission (MHSOAC) established priorities for the use of County's PEI funds. There are six priority focus areas listed as well as desired outcomes. "PEI programs focus on reducing seven negative outcomes that may result from untreated mental illness: suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes." This provides good guidance for what our county programs and portfolios should focus on in the PEI area using MHSA funding. When looking at the ensemble of our portfolio many do not appear to be specifically focused on these desired outcomes. It is unclear how the County manages the programs to ensure that the goals and outcomes are consistent with meeting the County goals and MHSA intent. There appears to be a disconnect between the goals outlined and stated accomplishments for a fair number of programs, particularly in the PEI section.

   There should be additional emphasis placed on relapse prevention. We do not see anything in the PEI funding "bucket" of the 3-year plan that is aimed at preventing relapse and deterioration for people who are already suffering from serious and persistent mental illness. Under California law, PEI is supposed to pay for "downstream" RELAPSE prevention for people who already have a severe mental illness. Welfare and Institutions Code section 5840(c) states: "[The PEI program] shall also include components similar to programs that have been successful in reducing the duration of untreated severe mental illness and assisting people in quickly regaining productive lives."

5. **Re-stating the MHAB's previous recommendation that the County should conduct a needs assessment to better understand the gaps in service and what it would take to fill the unmet needs for the SMI. They should take this on now for SMI and later add SUD when Proposition 1 takes effect.** This should include the continuum of care to support this population's complex needs from acute facilities, crisis programs, step down facilities and ongoing support programs. At this time, it is unclear how the County

decides what programs to fund or how they understand what it would take to fill the unmet needs for the SMI.

The County should also anticipate new needs coming with the passing of Proposition 1 and include funding specifically targeted to treat "homeless persons who are mentally ill." (See Welfare & Institutions Code sec. 5600.3(b)(4)(A).). This would mean funding permanent supportive housing programs. It would also mean ensuring that we have adequate acute treatment facilities to stabilize people prior to them being ready to thrive in supported housing options.

6. **Critical staffing shortages in Full-Service Partnership programs should be addressed.** Nearly every Full-Service Partnership program mentioned a shortage of housing and staff (clinical case managers, therapists etc.) to treat those in their programs.

Please let us know if you have any questions regarding our recommendations. The MHAB appreciates the opportunity to be of service to the Board of Supervisors and to the community and looks forward to working even more collaboratively with the Board of Supervisors in the future.

Please let us know if you have any questions.

Sincerely,

Supportive Housing Community Land Alliance

HOUSING AS HEALTHCARE: SHCLA'S ROLE IN THE PRODUCTION OF LICENSED RESIDENTIAL FACILITIES AND FAMILY PARTICIPATION IN THE AFFORDABLE BEHAVIORAL HOUSING CONTINUUM |

ALAMEDA COUNTY MENTAL HEALTH ADVISORY BOARD |

JULY 15, 2024

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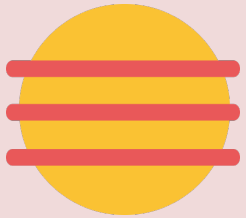
shcla

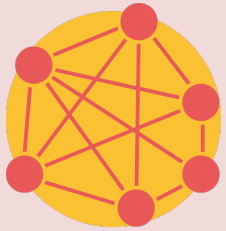
Table of Contents

About SHCLA

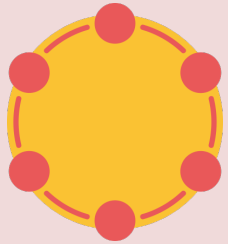
Wicked Problems



A problem where there is no single solution to the problem.



A problem whose social complexity means that it has no determinable stopping point.



Because of complex interdependencies, the effort to solve one aspect of a wicked problem may reveal or create other problems.

"Wicked" denotes resistance to resolution, rather than evil.

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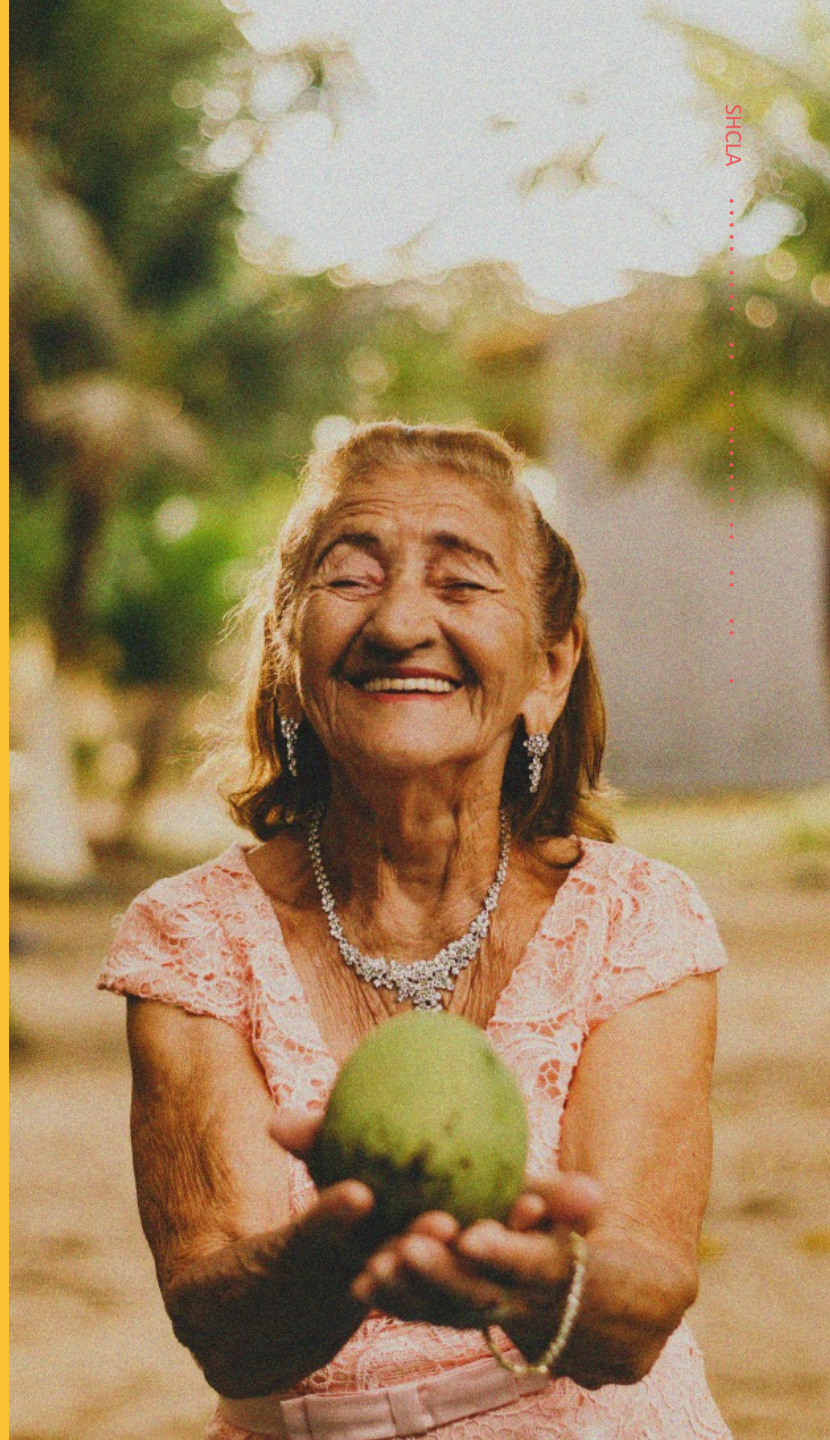
Mission

Supportive Housing Community Land Alliance (SHCLA) is a community land trust whose mission is to increase access to mental health services for low-income people with serious mental health challenges in Alameda County by creating and stewarding permanently affordable housing.

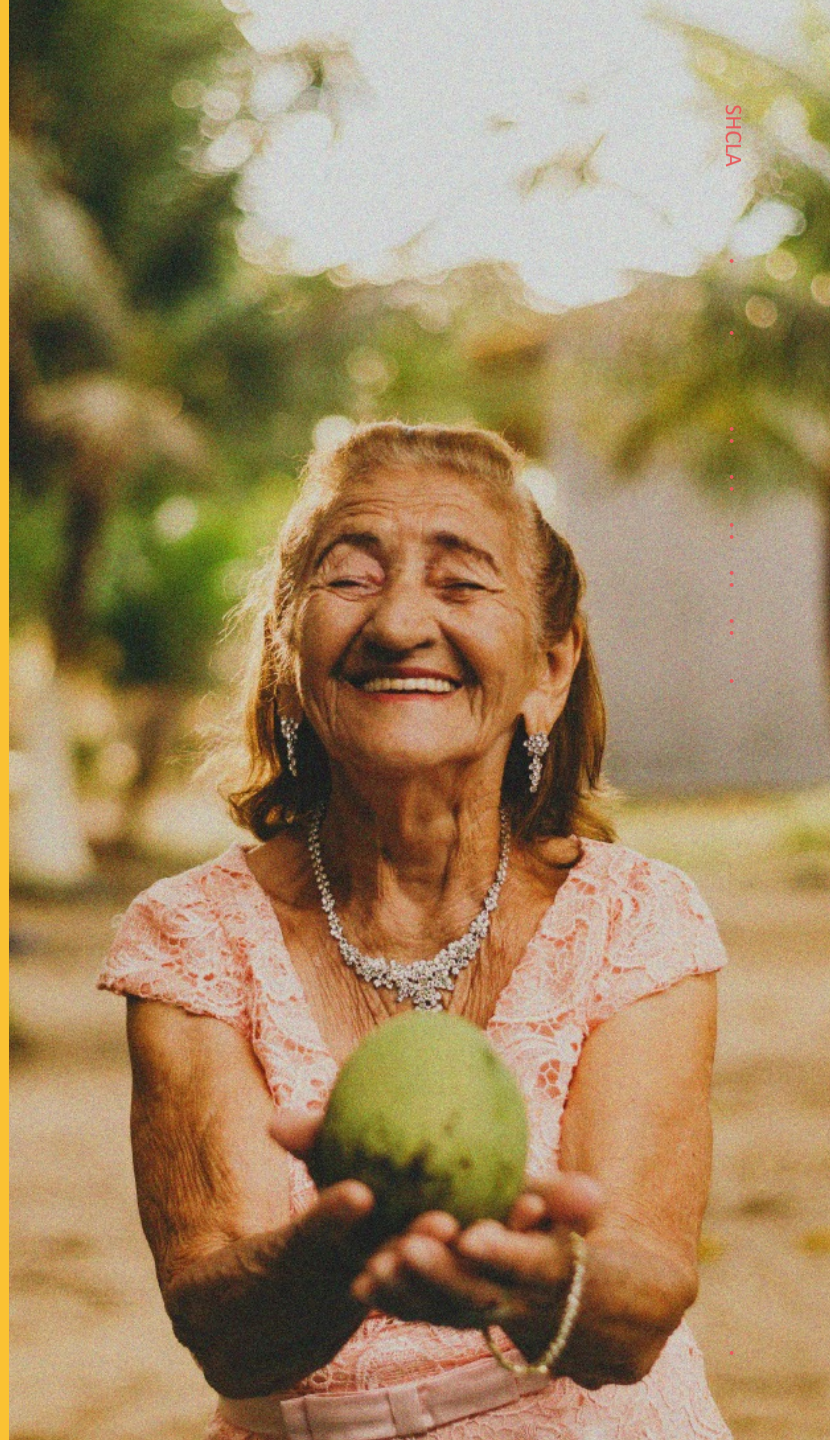
The homes on our land provide safe, secure, and supportive housing for residents whose income is 30% or less of the Alameda County Area Median Income.



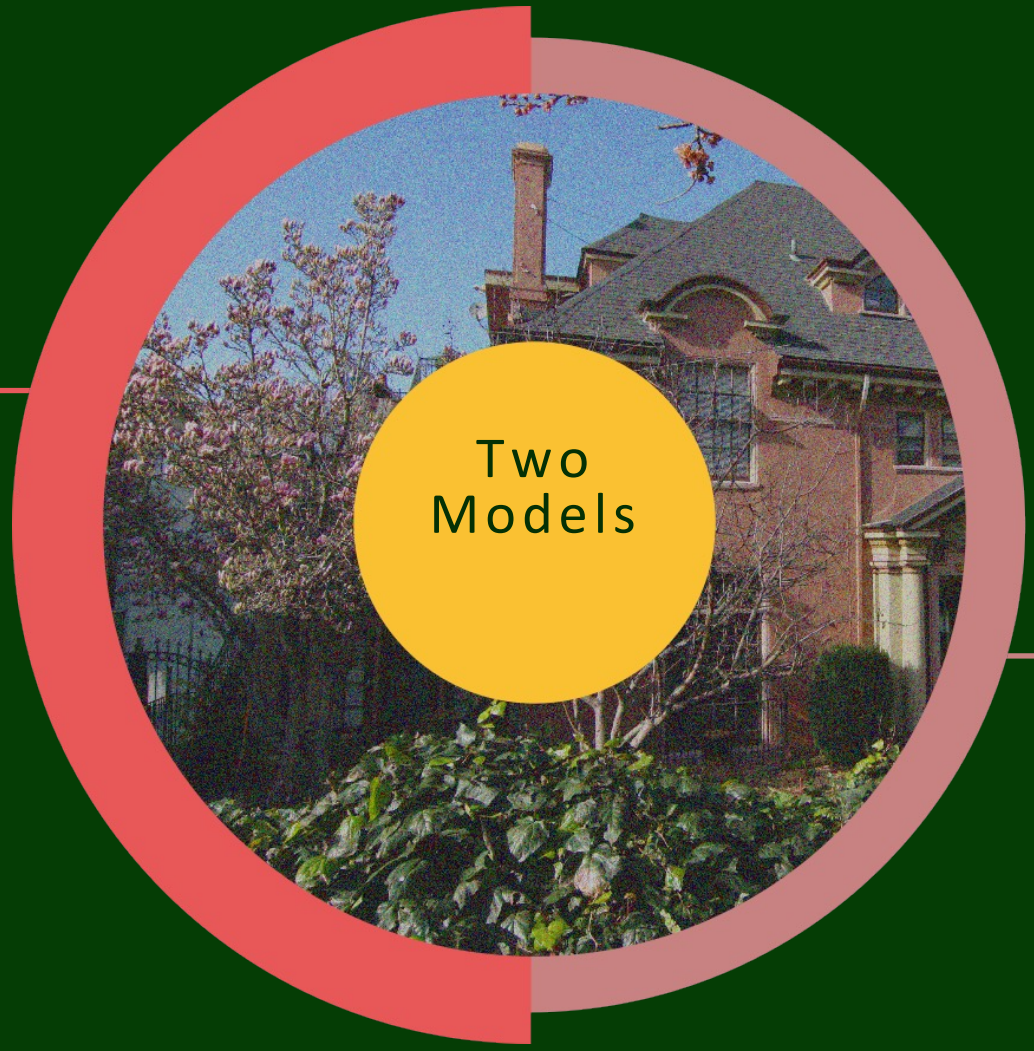
History of SHCLA

An Alameda County Behavioral Health-funded community land trust

- Housing and Homelessness oversight
- Convened families with adult children with serious mental health issues
- Broad support and involvement from community groups: NAMI East Bay, East Bay Supportive Housing Collaborative, Solutions for Supportive Housing, and Pool of Consumer Champions
- Advocated and secured a state Mental Health Services Act (MHSA) Innovations grant to support SHCLA operations (2020-2025)



Licensed Board and Care Model



Family Partnership Model

SHCLA

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WHO WE SERVE

Extremely low income residents (30% AMI) with serious mental health challenges, parents of adult children with mental health challenges, and board and care operators serving SMI residents in Alameda County.

WHAT WE PROVIDE

Licensed Board and Care

- Master leased to qualified operators serving SMI populations

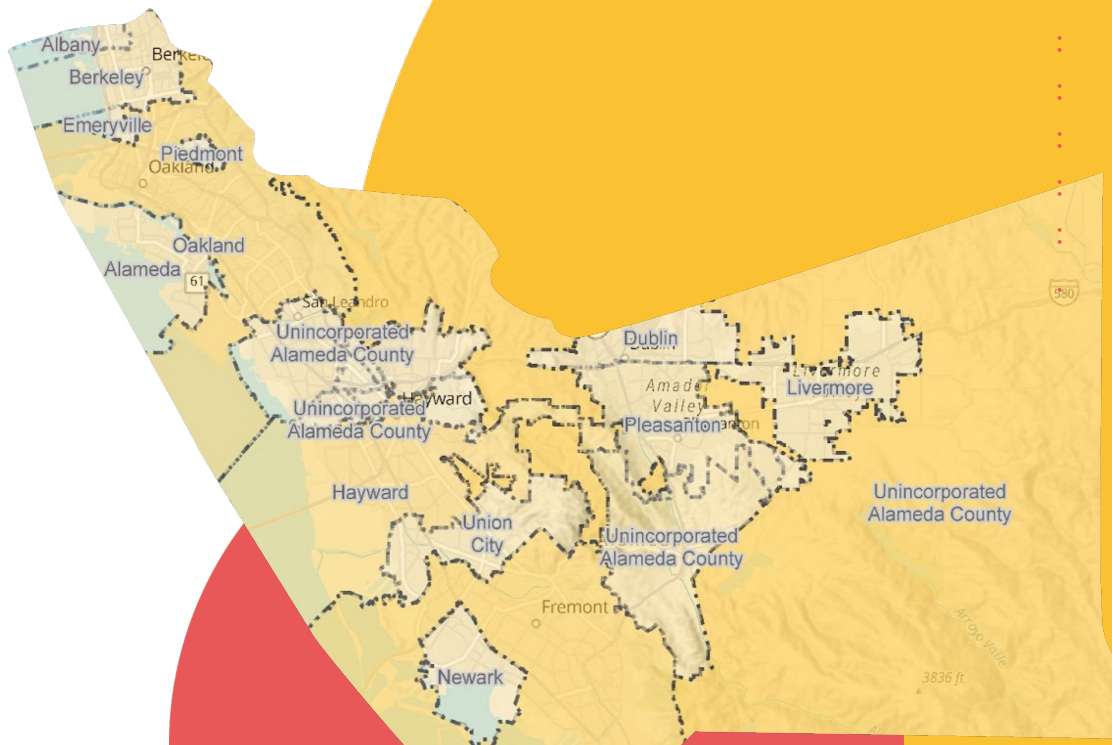
Independent Living Homes

- Parents of adult children receive long-term commitment to house their adult children living with SMI

*both models provide permanently affordable

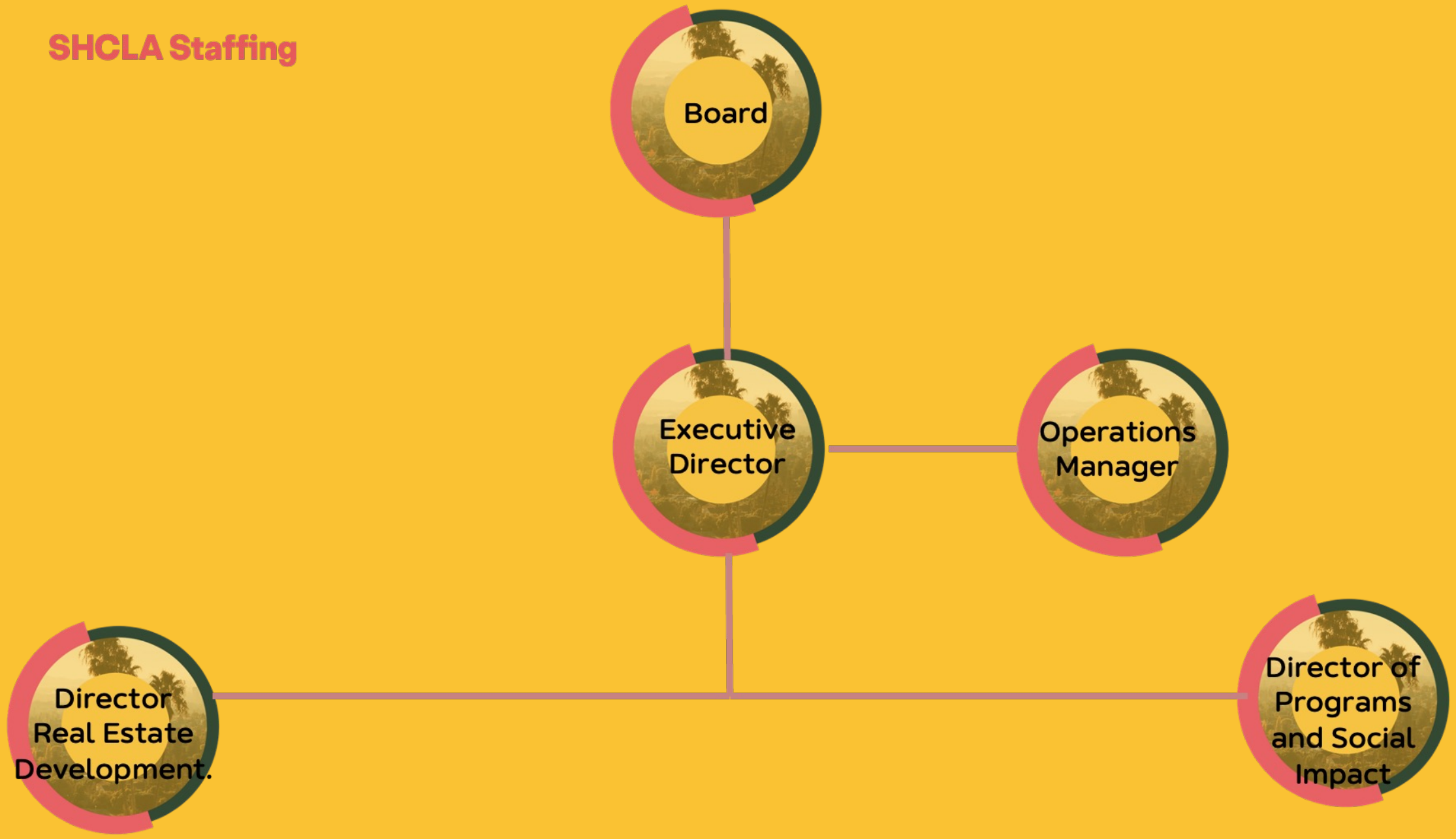
community controlled assets governed by a diverse

board of directors



SHCLA

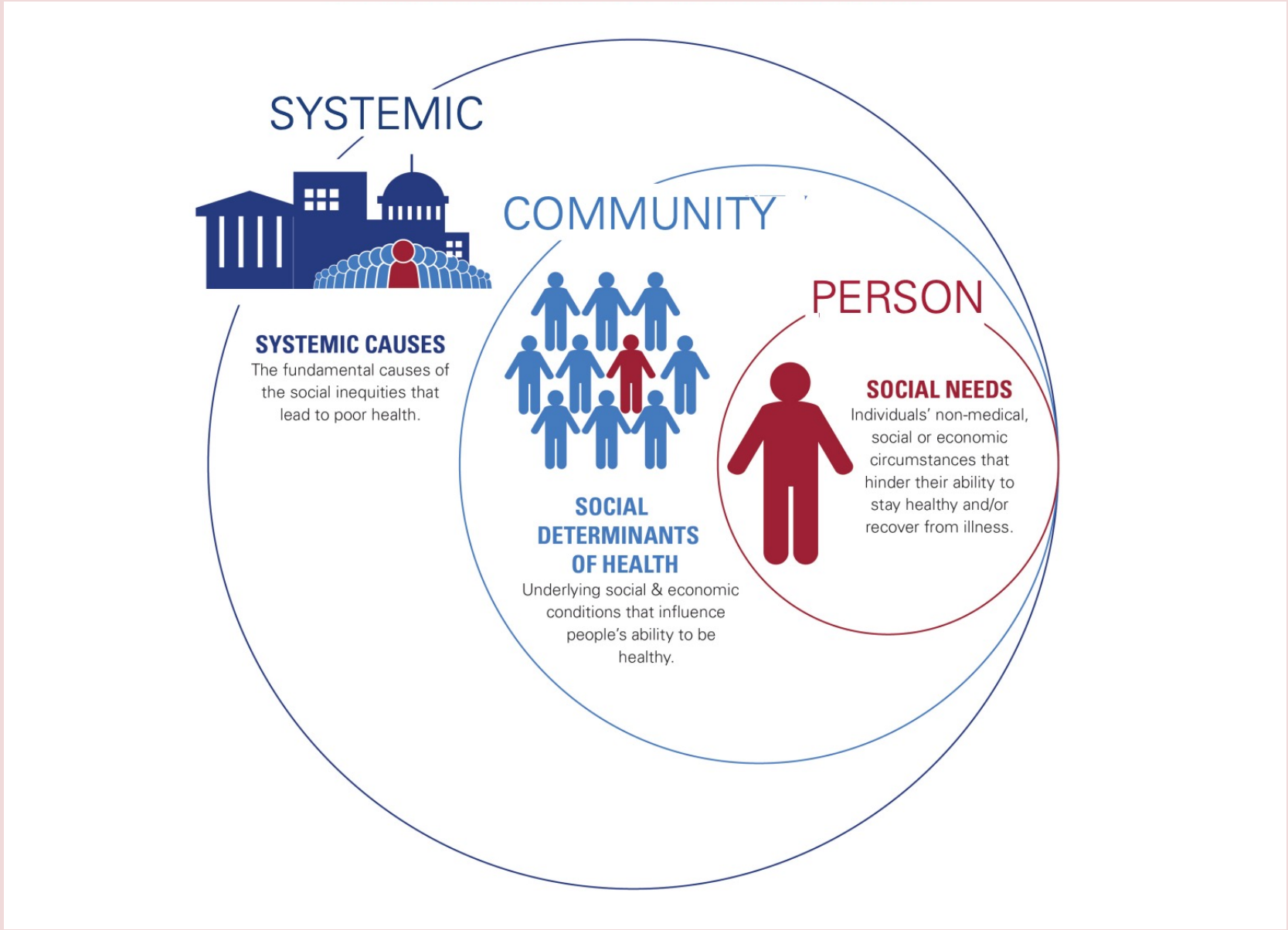
SHCLA Staffing



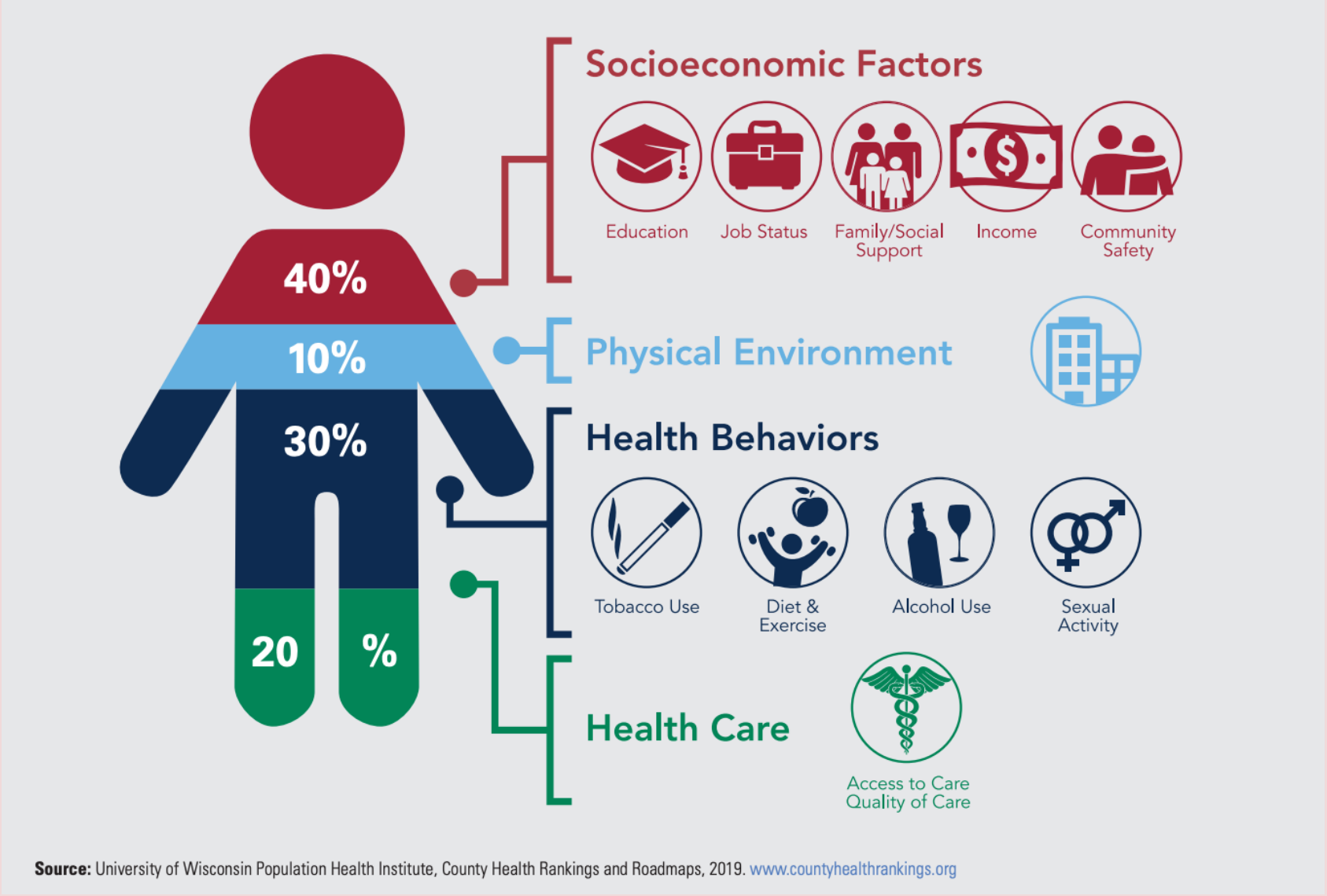
The Community Need

Homeless + Serious Metal Illness in Alameda County

Societal Factors that Influence Health



Social Determinants of Health



Source: University of Wisconsin Population Health Institute, County Health Rankings and Roadmaps, 2019. www.countyhealthrankings.org

Service provider/operator trends

Trend	Detail
Significant Deferred Maintenance	Service partners indicate significant need to address deferred maintenance requiring financial workouts and deal structuring; SHCLA to assist and serve as project manager
Need for Meaningful Community Engagement	Service partners indicate provision of services is challenging on its own; desire for SHCLA to engage community members as part of Alameda County supportive land trust competency
Need for real estate development expertise	Service partners indicate need for taking on real estate development projects, but staffing is expensive and ramp up period take time; SHCLA to project manage projects for service partners

Board and Care Homes

Board and Care Defined: CA CodeTitle 22

Adult Residential Facilities (ARFs) are non–medical facilities that provide room, meals, housekeeping, supervision, storage and distribution of medication, and personal care assistance with basic activities like hygiene, dressing, eating, bathing, and transferring. This level of care and supervision is for people who are unable to live by themselves but who do not need 24-hour nursing care. Historically and colloquially called board and care homes, these facilities are an important form of housing for adults with serious mental illness (SMIs), including seniors.

Mental Health Treatment Beds and Housing Continuum

SETTING	FORENSIC/ CORRECTIONS	TREATMENT BEDS		TREATMENT BEDS/ HOUSING	HOUSING	
		ACUTE	SUBACUTE	COMMUNITY AND RESIDENTIAL TREATMENT	INTERIM	HOUSING WITH SUPPORTS
Description	Most restrictive locked setting, offering varying levels of service	Highly structured institutional setting aimed at stabilizing acute conditions, with 24/7 staffing	Secured and structured setting aimed at rehabilitation, with 24/7 staffing	Intensive services in a residential setting focused on stability; a step-down from higher level of care	Supportive and temporary housing with a range of services and supports; typically transitional	Long-term, low-structure setting with a range of services and supports for stable individuals
Examples	▸ Jail ▸ Prison ▸ Juvenile detention facility ▸ Other correctional facilities	▸ Acute psychiatric hospital ▸ General acute care hospital ▸ State psychiatric hospital ▸ Psychiatric health facility ▸ Psychiatric residential treatment facility	▸ Mental health rehabilitation center ▸ Skilled nursing facility—special treatment program ▸ State psychiatric hospital ▸ Community treatment facility	▸ Adult Residential Care Facility and Residential Care Facility for the Elderly (ARF/RCFE) (board and care) ▸ Short-term residential therapeutic program ▸ Congregate care facility ▸ Social rehab facility ▸ Crisis residential program ▸ Peer supported housing ▸ Peer respite	▸ ARF/RCFE ▸ Emergency and interim shelter ▸ Recuperative care ▸ Short-term posthospitalization ▸ Tiny home ▸ Hotel/motel ▸ Modular home ▸ Recommissioned property ▸ Other types of housing as developed locally	▸ ARF/RCFE ▸ Permanent supportive housing ▸ Public subsidized housing ▸ Scattered site ▸ Master lease ▸ Single-room occupancy ▸ Boarding home ▸ Other types of housing as developed locally

Mental Health Treatment Beds Funding

SETTING	FORENSIC/ CORRECTIONS	TREATMENT BEDS		TREATMENT BEDS/ HOUSING	HOUSING	
		ACUTE	SUBACUTE	COMMUNITY AND RESIDENTIAL TREATMENT	INTERIM	HOUSING WITH SUPPORTS
Investments (programs, waivers, and initiatives)*	▸ CalAIM pre-release services	▸ BHCIP ▸ BH-CONNECT† ▸ BH Transformation (Proposition 1)	▸ BHCIP ▸ BH-CONNECT† ▸ BH Transformation (Proposition 1)	▸ ALW ▸ BHCIP ▸ BH-CONNECT† ▸ BH Transformation (Proposition 1) ▸ CalAIM CS ▸ CARE Court ▸ CCE ▸ HHIP ▸ IPP ▸ IST Diversion	▸ BHBH ▸ BH-CONNECT† ▸ BH Transformation (Proposition 1) ▸ CalAIM CS ▸ CARE Court ▸ CCE ▸ HHAP ▸ HHIP ▸ Homekey ▸ IPP ▸ IST Diversion	▸ ALW ▸ BH-CONNECT† ▸ BH Transformation (Proposition 1) ▸ CalAIM CS ▸ CARE Court ▸ CCE ▸ HHAP ▸ HHIP ▸ Homekey ▸ IPP ▸ IST Diversion ▸ NPLH

Source: Compiled from the authors' analysis of multiple sources.

Notes: The types of beds and housing included in the continuums reflect treatment placements and housing options that are procured and provided by managed care plans (MCPs), mental health plans (MHPs), Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), and other county agencies; are intended to last for more than 24 hours; and are in permanent structures. Programs with varying levels of services that span multiple categories on the continuum are included but are not explicitly listed within the framework (e.g., Full Service Partnerships [FSPs] and Transitional Housing for Foster Youth). Treatment beds and housing may also support people with co-occurring conditions.

Community and Residential Treatment may include both treatment bed types and housing types, depending on the level of care or service provided.

Forensic/Corrections is included but separated from the rest of the continuum. See box on page 2 for more detail.

* See Table 3 for a description of each program.
† BH-CONNECT is a proposed investment.

Total Capacity of All Licensed Alameda County ARFs & RCFEs

Adult Residential Facilities

241 licensed facilities
1,722 resident capacity

- In primary service to the East Bay Regional Center

Residential Care Facilities for the Elderly

245 licensed facilities
9,083 resident capacity

- In primary service to privately-funded residents

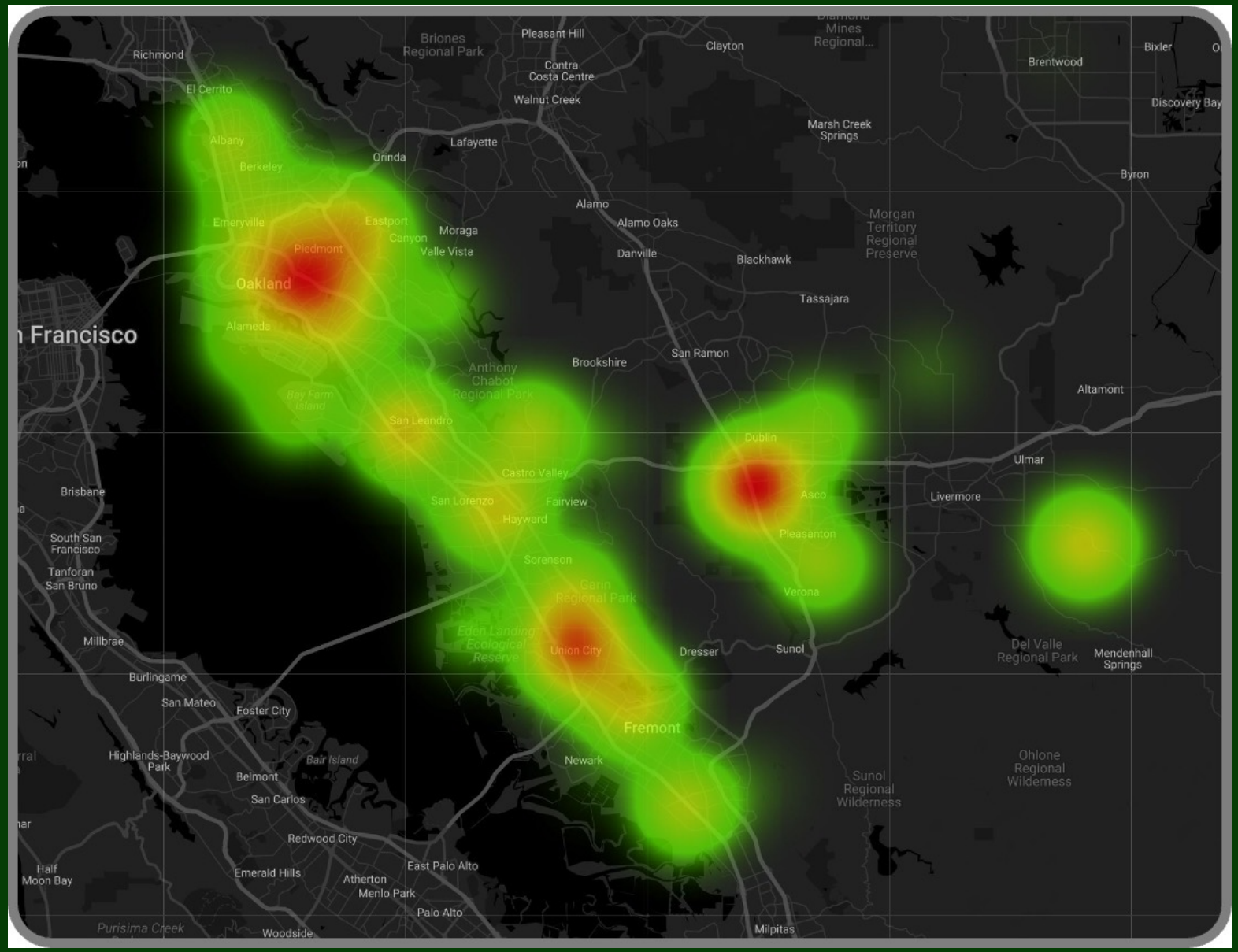
Total Service Capacity of Alameda County ARFs/RCFEs:

486 licensed facilities
10,805 resident capacity

(figures reported as at November 2023 by CA DPSS/CCLD)

SHCLA

Heatmap of All Alameda County Licensed RCFE Bed Capacity

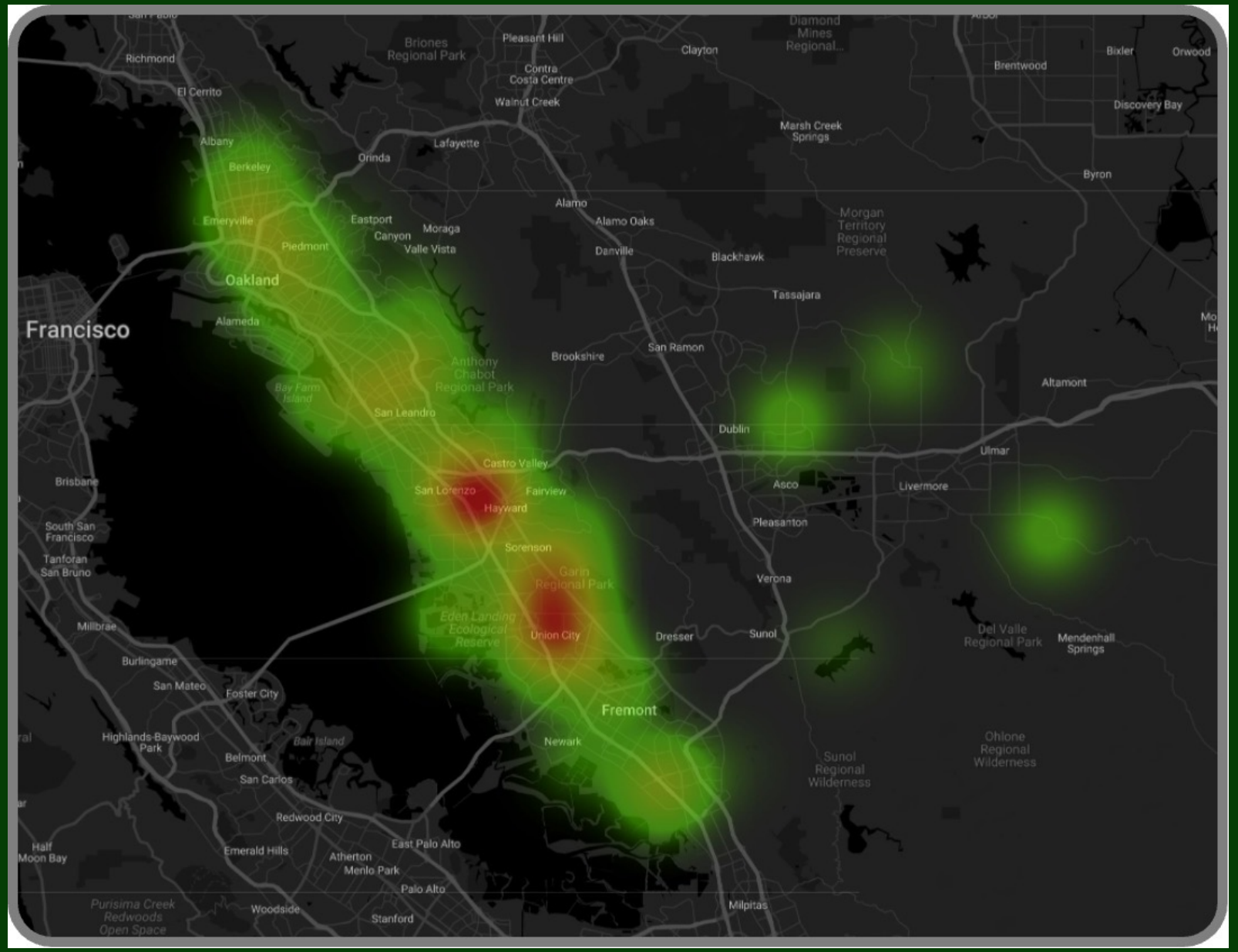


245 licensed facilities

9,083 resident capacity

Alameda County RCFE beds principally concentrated around Oakland/Piedmont Union City and Dublin/Pleasanton

Heatmap of All Alameda County Licensed ARF Bed Capacity



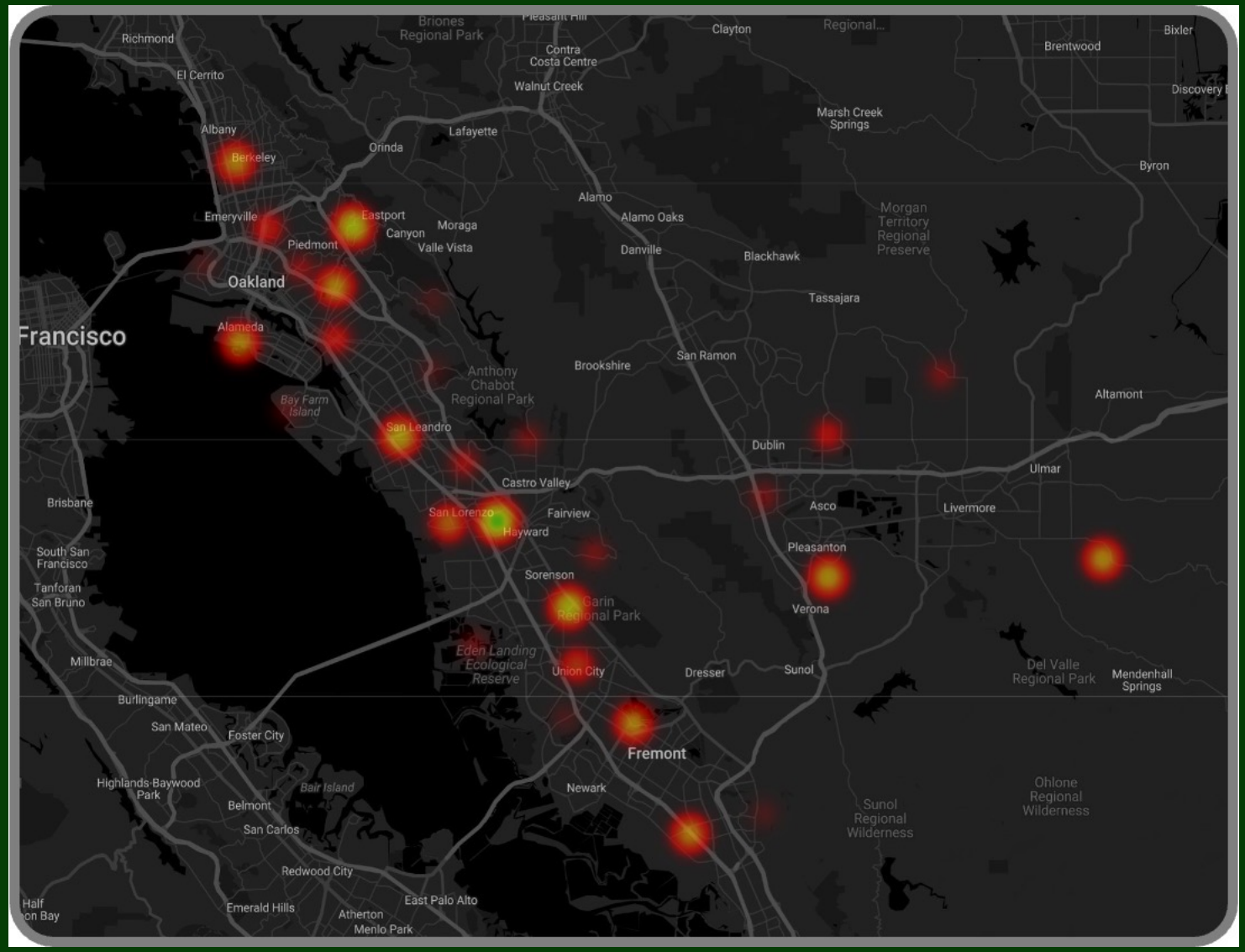
241 licensed facilities

1,722 resident capacity

Alameda County ARF beds principally concentrated around Hayward/San Lorenzo and Union City

Oakland has significant opportunity for increase of ARF facilities and beds.

Heatmap of All Alameda County Licensed ARF/RCFE Bed Closures (2022-2023)



ARFs Closed: 31

ARF Beds Lost: 468

RCFEs Closed: 50

RCFE Beds Lost: 1,122

SHCLA

The Need

Without an INNOVATIVE intervention, the matter will only get worse, creating an invisible pipeline to homelessness.

Our solution

SHCLA Internal Programs

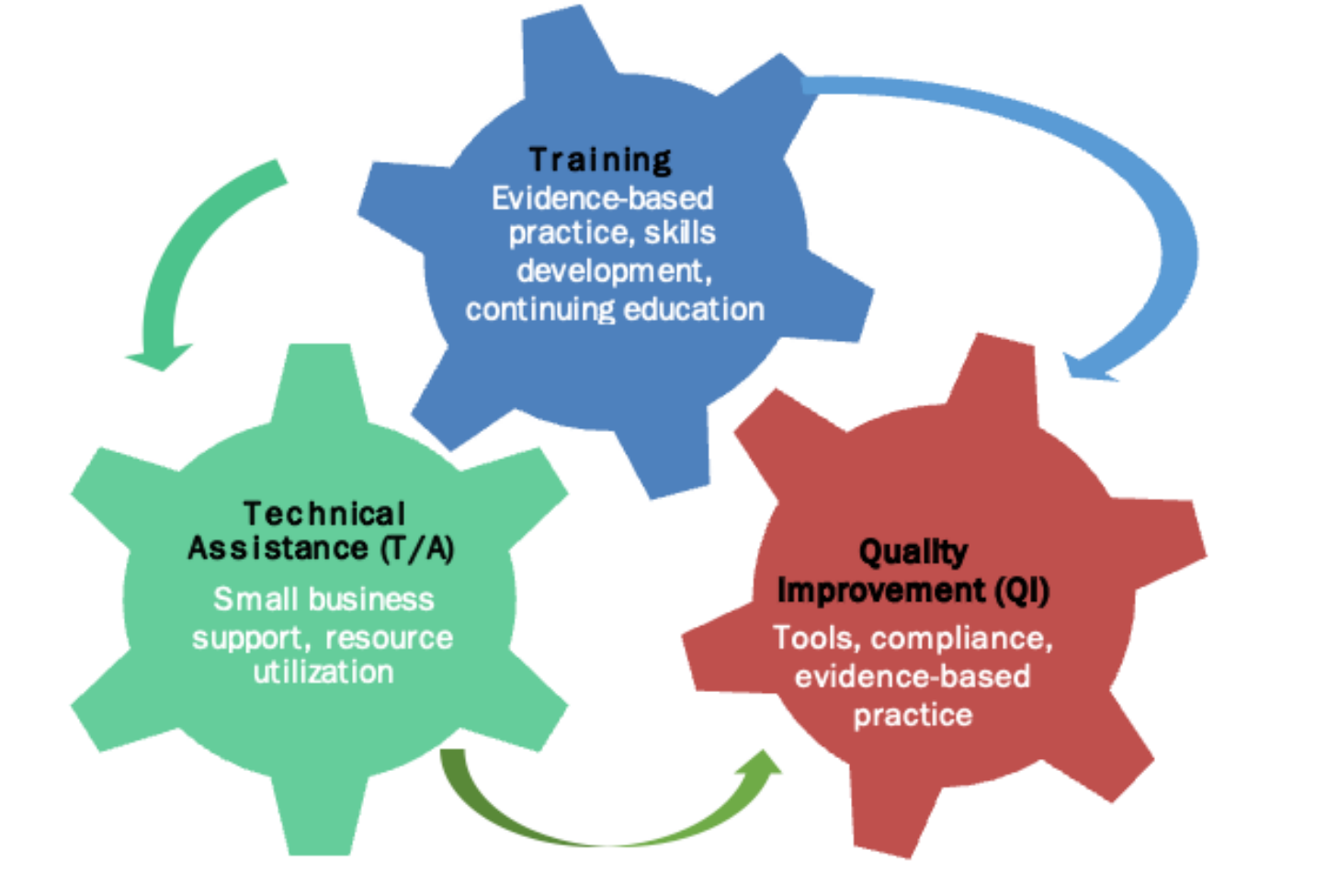
PROPERTY ACQUISITION
Acquiring and rehabbing existing properties in high opportunity/moderately resourced/transit oriented neighborhoods

SUPPORTIVE SERVICES
Provided by quality service partners and board and care operators; SHCLA provides of quality standards

MICRO-GRANTS
Deferred maintenance and quality of life improvements for board and care operators

SERVICES COLLABORATIVE
Collective Impact Approach to services including Federally Qualified Health Centers, peer support organizations, art therapists, city and county staff, and development partner

Services Collaborative



Our Model Approach

- On-site services
- Trauma informed
- Culturally responsive
- Compassionate & collaborative
- Peer-centered
- Community integration

Evidence Based Practices

- Supported Employment
- Assertive Community Treatment and Intensive Case Management
- Family Psychoeducation
- Illness Management and Recovery
- Integrated Treatment for Co-occurring Disorders
- Medication Treatment, Evaluation, and Management
- The Treatment of Depression in Older Adults

Biophilic Design

The Impact

Impact of Supportive Housing

supportive housing is one of the most effective methods of ensuring stable housing. With this model 97% of residents remain housed for more than a year and turnover is typically below 10% per year.

ARF + RCFE Cost Effectiveness

ARFs + RCFEs, even with enhanced rates of $50 per day (or $1500 per *month*), are cost effective compared to:

- **An "administrative" day in an inpatient acute care hospital, which in Alameda County (both public and private) averages ~ $1,000 per *day* (per Office of Statewide Health Planning and Development).**
- **An unnecessary day in an Institute for Mental Disease (IMD), which averages in Alameda County around $1,000 per *day* (per Office of Statewide Health Planning and Development).**
- **An avoidable day in a Skilled Nursing Facility, where the Medi-Cal rate is ~ $225/day.**

SHCLA's Need

- Capital to replace the $5 Million in Capital Financing and Technology Needs funding outlined in the initial MHSA Proposal to the state
- Operating subsidies for services
- Letters of support for funding applications
- Ongoing operating support beyond 12/15/2024 when SHCLA's contract sunsets

THANK YOU

SHCLA.LAND

TESLIM IKHARO, J.D.
EXECUTIVE DIRECTOR
TESLIM.IKHARO@SHCLA.LAND
510-964-9500

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Monday, July 1, 2024 3:43 PM
To: Works-Wright, Jamie
Subject: MHC agenda items for July

Hello Commissioners,

I want to welcome two new commissioners to the Mental Health Commission. Ajay Krishnan and Councilmember Cecilia Lunaparra.

The next MHC meeting will take place on Thursday, July 25 and if you would like anything added the agenda please send that to me by **Monday, July 8th**.
We will have a presentation by Karen Klatt regarding the MHSA plan and that will take about 1 hour of the meeting time.

If you would like to request anything specify from Jeff Buell for the managers' report please have that request by **Monday, July 8th** as well.

Any articles, reports and items that you would like in the packet the deadline is **Monday, July 15**.

Thank you for your time.

Jamie Works-Wright

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Cell #: 510-423-8365