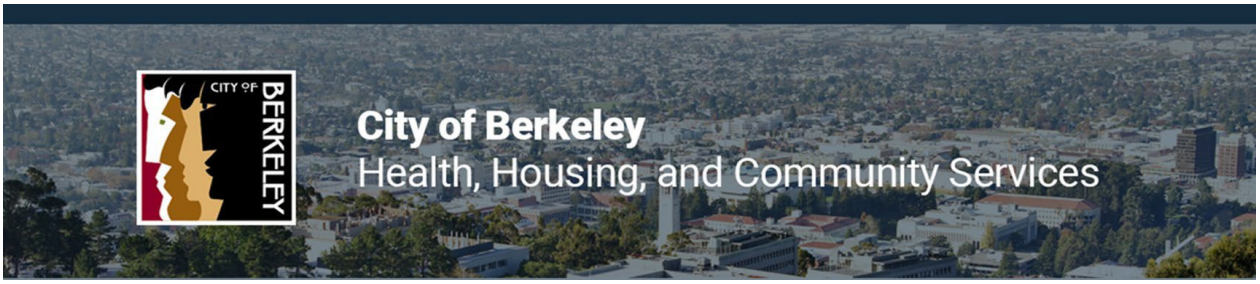

City of Berkeley Mental Health Mental Health Services Act (MHSA)

FY23/24 – 25/26

Three Year Program and Expenditure Plan

RESOLUTION NO. 70,990-N.S.

MENTAL HEALTH SERVICES ACT (MHSA) FISCAL YEARS 2024 THROUGH 2026 THREE YEAR PROGRAM AND EXPENDITURE PLAN

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

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

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

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

WHEREAS, since 2015 the City Council has authorized multiple Three-Year Plans and Annual Updates, most recently on July 26, 2022 by Resolution No. 70,461-N.S. approving the MHSA Fiscal Year 2022 through 2023 Annual Update; and

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

WHEREAS, in order to comply with state requirements, the MHSA Fiscal Years 2024 through 2026 Three Year Program and Expenditure Plan must be approved by City Council.

NOW THEREFORE, BE IT RESOLVED by the Council of the City of Berkeley that the MHSA Fiscal Years 2024-2026 Three Year Program and Expenditure Plan that, incorporated herein as Exhibit A, is hereby approved.

BE IT FURTHER RESOLVED that the City Manager is authorized to forward the MHSA Fiscal Years 2024-2026 Three Year Program and Expenditure Plan to appropriate state officials.

The foregoing Resolution was adopted by the Berkeley City Council on July 25, 2023 by the following vote:

Ayes: Bartlett, Hahn, Humbert, Kesarwani, Robinson, Taplin, Wengraf, and Arreguin.

Noes: None.

Absent: Harrison.

Jesse Arreguin, Mayor

Attest:
Mark Numainville, City Clerk

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: City of Berkeley FY24-26 Three Year Program and Expenditure Plan

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

I hereby certify that I am the official responsible for the administration of the City mental health services in and for the said City and that the City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this FY24-26 Three Year Program and Expenditure Plan, including stakeholder participation and nonsupplantation requirements.

This FY24-26 Three Year Program and Expenditure Plan has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The FY24-26 Three Year Program and Expenditure Plan was circulated to representatives of stakeholder interests and interested parties for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The Annual Update attached hereto, was adopted by the City Council on July 25, 2023.

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

Jeffrey Buell
Local Mental Health Director/Designee

Signature

8/22/23
Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

County: City of Berkeley

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

I hereby certify that the FY24-26 Three Year Program and Expenditure Plan is true and correct and that the City has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a County/City which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties/cities in future years. I declare under penalty of Perjury under the laws of this state that the foregoing and the attached FY24-26 Three Year Program and Expenditure Plan is true and correct to the best of my knowledge.

Jeffrey Buell — Local Mental Health Director (PRINT)

Signature — 8/22/23 — Date

I hereby certify that for the fiscal year ended June 30, 2022 the City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 12/15/22 for the fiscal year ended June 30, 2022. I further certify that for the fiscal year ended June 30, 2022 the State MHSA distributions were recorded as revenues in the local MHS Fund; that City MHSA expenditures and transfers out were appropriated by the City Council and recorded in compliance with such appropriations; and that the City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

HENRY OYEKANMI — City Financial Officer (PRINT)

Signature — 8/31/2023 — Date

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BACKGROUND AND OVERVIEW

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

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

- Community Services & Supports (CSS): Primarily provides treatment services and supports
- for Severely Mentally Ill Adults and Seriously Emotionally Disturbed Children and Youth.

- Prevention & Early Intervention (PEI): For strategies to recognize early signs of mental illness and to improve early access to services and programs, including the reduction of stigma and discrimination, and for strategies to prevent mental illness from becoming severe and disabling.
- Innovation (INN): For short-term pilot projects designed to increase new learning in the mental health field.
- Workforce, Education & Training (WET): Primarily for strategies to identify and remedy mental health occupational shortages, promote cultural competency and the employment of mental health peers and family members in the workplace.
- Capital Facilities and Technological Needs (CFTN): For capital projects on owned buildings and on mental health technology projects.

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

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

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

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

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

The Community Services & Supports, Prevention & Early Intervention, and Innovation funding components are the only re-occurring 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 2020/21 - 2022/23 Three Year Program and Expenditure Plan in place and Annual Updates to that plan which covers each funding component.

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 (ACBHCS), the Division transitioned to only using MHSA funds for services and supports in Berkeley, and ACBHCS now provides MHSA funded services in Albany.

As a result of the City's approved MHSA Plans and Annual Updates, a number of new 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 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 individuals.

This City of Berkeley MHSA FY2024-2026 Three Year Program and Expenditure Plan (Three Year Plan) is a stakeholder informed plan that provides an update to the previously approved FY2021-2023 Three Year Plan. This Three-Year Plan summarizes proposed program additions, descriptions and updates of currently funded MHSA services which the Division is proposing to continue during the plan timeframe, and a reporting on FY22 program data.

MESSAGE FROM THE MENTAL HEALTH MANAGER

The past several years have been an eye-opening test of our community, our relationships, our resolve. As we emerge from the pandemic landscape and seek longer term equilibrium, our Berkeley community is faced with challenges and uncertainties. Health disparities and inequities keep the playing field uneven for the most vulnerable in our community; rising costs and inflation have eroded the efficacy of our assets; many of us have had our internal resources exhausted by the heavy and constant tolls of the pandemic; the income and wealth gaps continue to widen and propagate inequity before our very eyes; housing and racial injustices continue to disproportionately impact our neighbors with the fewest resources. These are some of the difficult tasks we face as we navigate and rebuild our system to better evolve with the needs of our community.

And yet, this is not a situation out of which one person or entity can bring us to the place where we need to be. This is an important opportunity for us as partners, as leaders, as neighbors to come together so that we can find and share our common strengths and synergies to create the best path forward. The Health Housing and Community Services (HHCS) Department, of which the Mental Health Division is a part, is engaging in a Community Health Assessment and Community Health Improvement Plan, designed to assess and interweave the participation and needs of the community into an overarching plan and response. This is one example of many vital steps before us where we can take a moment, a pause, to lay out our next steps and where we want them to take us.

As the landscape shifts, Mental Health is undergoing a parallel evolution. A reorganization is under way to better align our services, our teams, and our efforts. The ultimate goal of these changes is to right-size workloads and support teamwork and synergy to better address increasing community needs and priorities. Supporting the mental health needs of our most vulnerable residents, youth, and those with co-occurring substance use disorders will be great focuses of the community's needs and priorities. As we all seek to heal from the effects of enormous systems change, Mental Health is looking to prioritize openness, kindness, partnership, and ways to move forward in concert with our community.

Our MHSA FY24-26 Three Year plan will seek to understand the changing needs of the community and build on the efforts to strengthen the foundations that we have been supporting through important community services and partnerships. A capacity assessment for our jurisdiction will underpin our strategies to focus and grow the services most needed. With results based accountability, the use of data will be better integrated to inform services. Continued support will be provided for services to our most vulnerable populations, as well as our partners providing culturally responsive services to Latino/Latina/Latinx, African American/Black, Asian Pacific Islander, and LGBTQIA+ communities. Programs providing services to the community through schools, community centers, clinics, and non-traditional settings will continue to receive funding. New funding will be added to increase mental health service capacity for teams serving the most vulnerable, youth, older adults and those with co-occurring substance use disorders. A

commitment to diversity and cultural humility will continue with an enhanced coordinator position within Berkeley Mental Health.

With Governor Newsome's recent proposal to fundamentally shift key components and usage of MHSA, there are some questions about the trajectory of MHSA and its future. It is likely that this Three Year Plan will encompass this process, including great discussion, advocacy, and possible change to MHSA. No matter what the future holds, it is vital that the City continue to deepen its valuable relationships with community and partners, growth and learning from people who use and depend on services, and partnerships with stakeholders, advisory groups, commissioners, and workers. With great appreciation and deep respect, we offer the City of Berkeley's MHSA FY24-26 Three Year Plan.

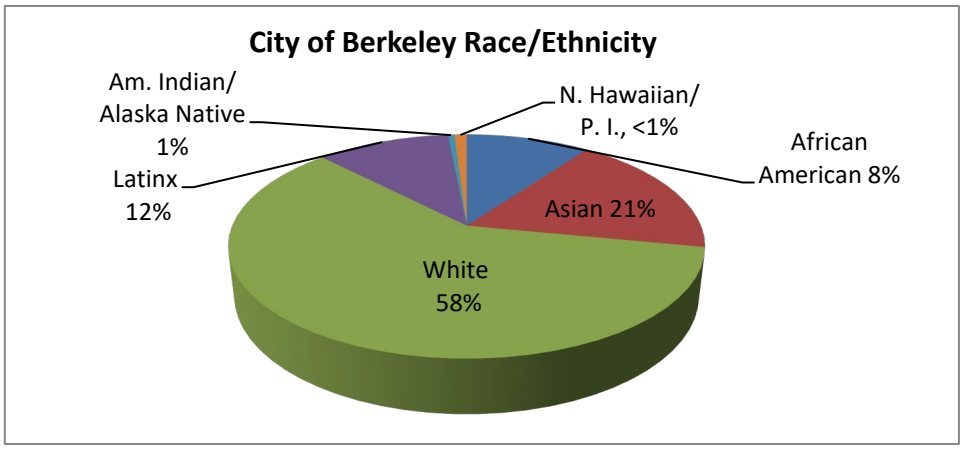
DEMOGRAPHICS

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 117,145 (US Census estimates since the 2020 census), the City of Berkeley is densely populated and larger than 23 of California's small counties.

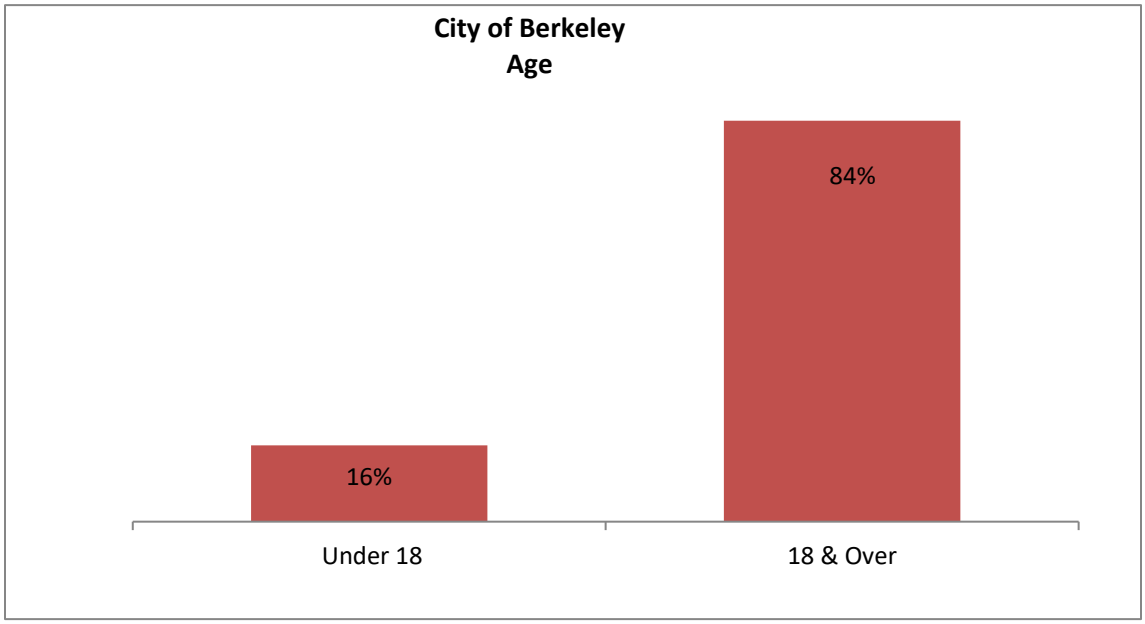
Race/Ethnicity

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 29% of Berkeley residents speak a language other than English at home. Berkeley is comprised of the following racial and ethnic demographics: African American; Asian; Latino/Latina/Latinx; White; American Indian/Alaska Native; and Native Hawaiian/Pacific Islander (P.I.). Demographics are outlined below:

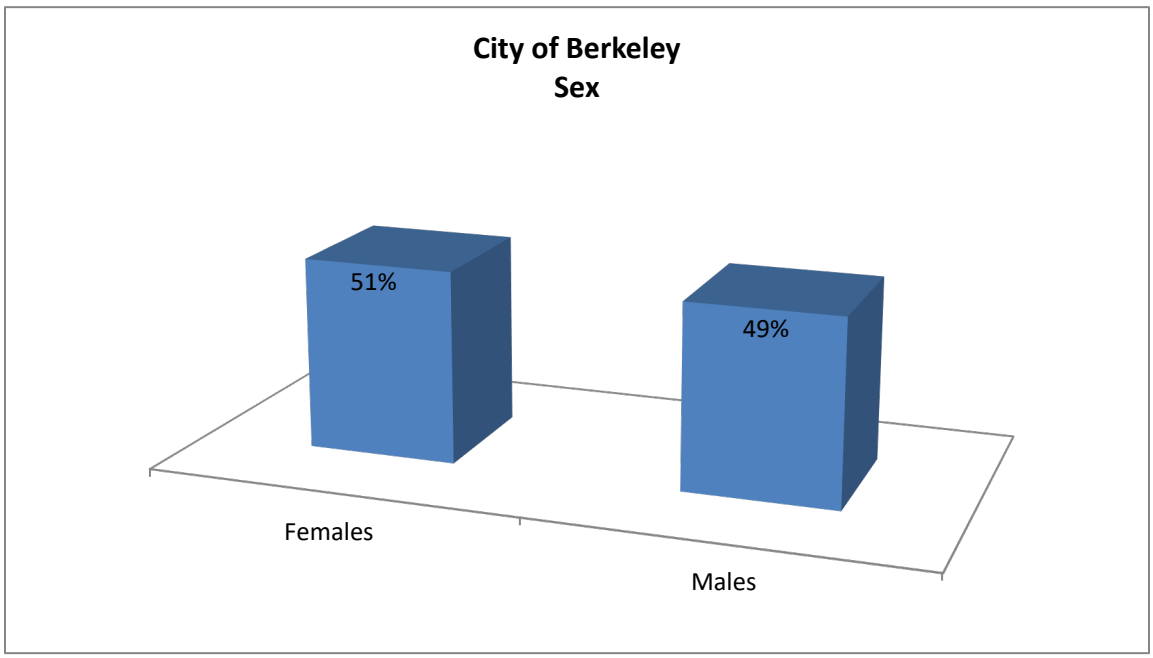


Age/Gender

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



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 $97,834. Nearly 18% of Berkeley residents live below the poverty line and approximately 40% 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 2022 Alameda County Everyone Home Point-in-Time Count, which included a detailed assessment of the City of Berkeley, approximately 1,057 individuals were experiencing homelessness. Of this amount 24% were in some form of shelter, and 76% were unsheltered. Following the street count, the City of Berkeley administered a survey to 147 unsheltered and sheltered individuals experiencing homelessness. The top 5 responses to the primary causes of homelessness were as follows: 33% indicated that family/friends couldn’t afford to let them stay; 23% were facing either an eviction or a foreclosure; 17% were experiencing mental health needs; 17% were experiencing domestic violence; and 10% lost their jobs.

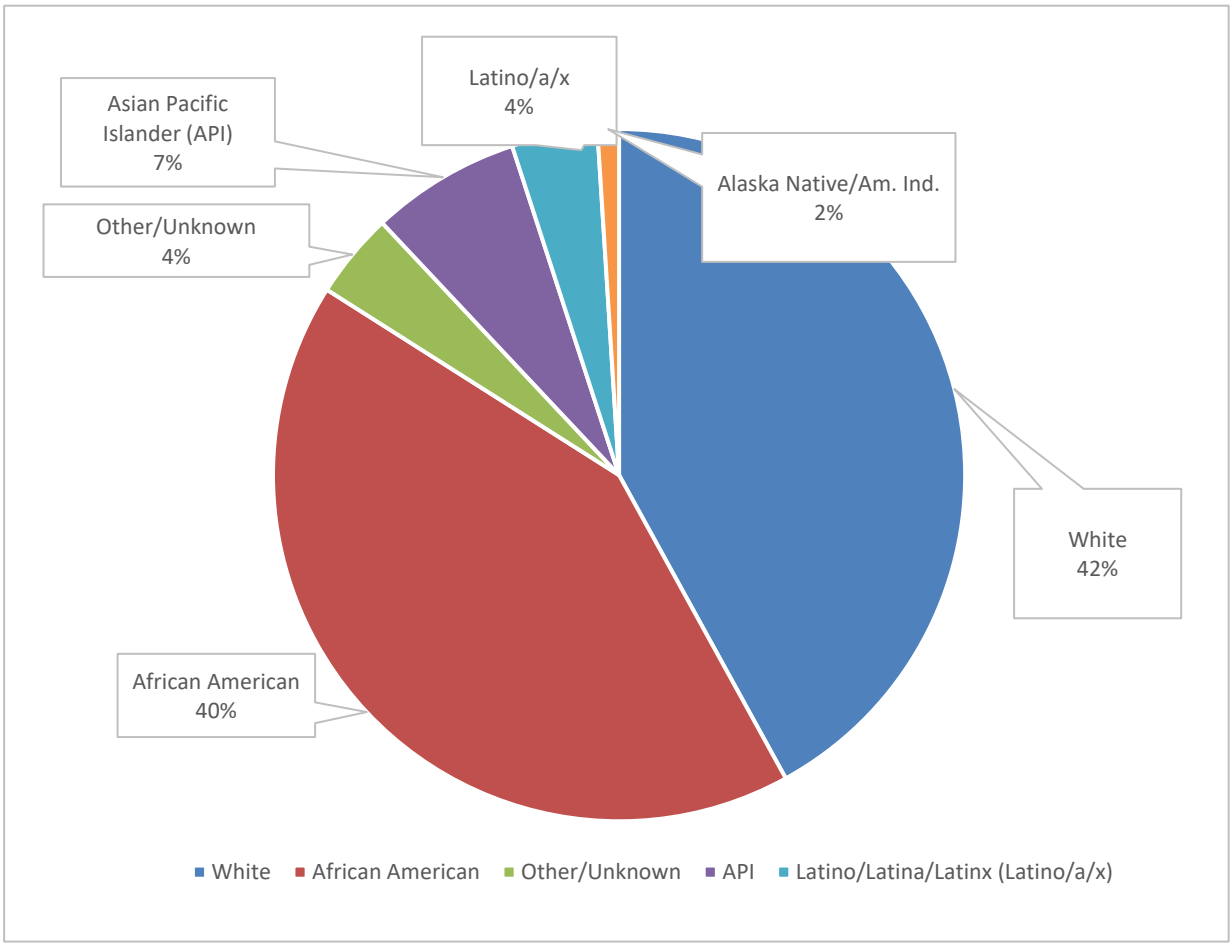
Education

Berkeley has a highly educated population: 96% 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 2022 was as follows:



CAPACITY ASSESSMENT

Per MHSA State requirements, a Capacity Assessment is to be conducted and included in the Three-Year Plan. The assessment should include:

- The strengths and limitations of the mental health jurisdiction and service providers that impact the ability to meet the needs of racially and ethnically diverse populations;
- An assessment of bilingual proficiency in threshold languages;
- Percentages of diverse cultural, racial/ethnic and linguistic groups represented among direct service providers, as compared to the percentage of the total population needing services and the total population being served; and
- Identification of possible barriers to implementing the proposed programs/services and methods of addressing these barriers.

In preparation for this Three-Year Plan, Division staff created a Capacity Assessment Tool that was submitted to the State Department of Healthcare Services (DHCS) Community Services Division for review and approval. Following approval from DHCS, a Capacity Assessment Survey was created in Survey Monkey, and a link to the survey was emailed to community organizations within the City of Berkeley system of care. The MHSA Capacity Assessment Survey is outlined below:

MHSA CAPACITY ASSESSMENT SURVEY

1.) Please indicate the percentage(s) of the primary age group(s) the organization currently serves:
Children/Youth (0-15 years):
Transition Age Youth (16-25 years):
Adults (26-59 years):
Older Adults (60 and above):

2.) Please indicate the percentage of the following diverse cultural, racial/ethnic and linguistic groups that were served in your organization from July 2021 – June 2022.
African American/Black:
Asian:
Caucasian/White:
Latinx/Hispanic:
American Indian or Alaska Native:
Native Hawaiian or Other Pacific Islander:
Other:
More than one race:

3.) Please indicate the percentage of your staff that are proficient in each threshold language below:
Arabic:
Cantonese:
Mandarin:
English:
Farsi:
Korean:
Spanish:
Tagalog:
Vietnamese:

4.) Please indicate the percentage of individuals from the following sexual orientation groups that were served in your organization from July 2021-June 2022.
Heterosexual:
Lesbian:
Gay:
Bisexual:
Queer:
Questioning or unsure:
Other:

5.) Please indicate the percentage of individuals from the following gender identity groups that were served in your organization from July 2021-June 2022.
Male:
Female:
Transgender:
Genderqueer:
Questioning or unsure:
Other:

6.) Please indicate the percentage of the following diverse cultural, racial/ethnic and linguistic groups that are currently represented among staff in your organization.
African American/Black:
Asian:
Caucasian/White:
Latinx/Hispanic:
American Indian or Alaska Native:
Native Hawaiian or Other Pacific Islander:
Other:
More than one race:

7.) Please indicate the percentage of the following sexual orientation groups that are currently represented among staff in your organization.
Heterosexual:
Lesbian:
Gay:
Bisexual:
Queer:
Questioning or unsure:
Other:

8.) Please indicate the percentage of the following gender identity groups that are currently represented among staff in your organization.
Male:
Female:
Transgender:
Genderqueer:
Questioning or unsure:
Other:

9.) Please describe any limitations that have impacted the organization’s ability to meet the needs of racially and ethnically diverse populations.

10.) Has the organization recently experienced difficulties in recruiting/retaining Behavioral Health staff positions?

11.) Please provide the percentage of Behavioral Health staff positions that have been hard-to-fill and/or retain are within the organization. Enter N/A if this is not applicable.

12.) Please list the titles of the Behavioral Health staff positions that have been hard-to-fill and/or retain within the organization. Enter N/A if this is not applicable.

13.) Are the vacancies in the organizations Behavioral Health staff positions, currently creating barriers to implementing services? If yes, please describe how the vacancies are impacting the delivery of services to affected population. Enter N/A if this is not applicable.

14.) Has the organization recently experienced difficulties in recruiting and/or retaining staff from various diverse cultural, racial/ethnic and linguistic groups?

15.) Are the vacancies in staff from various diverse cultural, racial/ethnic and linguistic groups currently creating barriers to implementing services? If yes, please describe how the vacancies are impacting the delivery of services to each impacted population. Enter N/A if this is not applicable.

16.) Has the organization recently experienced difficulties in recruiting and/or retaining staff from various diverse sexual orientation groups?

17.) Are the vacancies in staff from various diverse sexual orientation groups currently creating barriers to implementing services? If yes, please describe how the vacancies are impacting the delivery of services to each impacted population. Enter N/A if this is not applicable.

18.) Has the organization recently experienced difficulties in recruiting and/or retaining staff from various diverse gender identity groups?

19.) Are the vacancies in staff from various diverse gender identity groups currently creating barriers to implementing services? If yes, please describe how the vacancies are impacting the delivery of services to each impacted population. Enter N/A if this is not applicable.

20.) Please describe any other barriers your organization is currently experiencing in implementing Behavioral Health programs/services.

21.) Please describe how the organization is addressing these barriers to implementing Behavioral Health programs and services.

22.) What do you consider to be the most pressing Behavioral Health needs that the City should focus on within the next three years?

23.) Please share any other comments or input you may have regarding any of your responses on this survey, or anything else you may want to share.

The survey was open for an eight-week period. Despite multiple attempts to engage local providers to fill out the survey, the response rate was very low, and the Division was unable to obtain a comprehensive assessment of the local system of care for this Three-Year Plan. As a result of the low response rate the Division is proposing to allocate funds through this Three-Year Plan to hire a consultant to conduct a Capacity Assessment over the next three years. The consultant will be chosen through a Request for Proposal (RFP) process.

Responses to a question and inquiry on the Capacity Assessment regarding the most pressing mental health needs, and anything else the respondent wanted to share, are outlined below:

-What do you think are the most pressing mental health needs over the next three years?

- High needs clients who do not succeed with regular housing case management or life skills counseling.
- People who need to be in residential programs or who are deemed to be just below this need but still vulnerable and not safe to be on the street
- From our perspective, the scarcity of mental health professionals to fill positions in clinics and nonprofits is a huge challenge. With Medi-Cal soon expanding to cover all income-eligible undocumented people, demand will be greater than ever. Another gap is funding for culturally and linguistically accessible behavioral health programs - not just therapy, but support groups and community building for marginalized populations, especially recently arrived immigrants, LGBTQIA people, women, and youth. There are huge gaps for minority language groups such as Indigenous immigrants.
- The City's unhoused population is growing, and this population's need for high-level mental health services is growing as well. Also, as the percentage of older adults increases in our community, need for mental health services for this sub-population will also increase, including resources and referrals related to dementia.

-Please share any other comments or input you may have regarding any of your responses on this survey, or anything else you may want to share.

- More mental health services, regular engagement, more indoor places people can gather to feel safe and be in the presence of others who have the time and capacity to provide support.
- The City can play a crucial role in expanding services for underserved populations that do not currently have access to services - asylum seekers, LGBTQIA immigrants, unaccompanied minors, immigrant women and children who are survivors of gender-based violence, and Indigenous immigrant communities.

All responses to the MHSA Capacity Assessment are outlined in Appendix B.

COMMUNITY PROGRAM PLANNING

The Community Program Planning (CPP) process for this City of Berkeley MHSA FY24-26 Three Year Plan Program and Expenditure Plan (Three-Year Plan) was conducted over a three month period. During this time, two MHSA Advisory Committee meetings were held on Tuesday, April 18 and May 23, and a total of ten Community Input Meetings were held on the following dates/times:

- Wednesday April 19th: 3:00-4:30pm
- Monday April 24th: 6:00pm-7:30pm
- Tuesday April 25th: 11:00am-12:30pm
- Thursday April 27th: 5:00-6:30pm
- Tuesday, May 2nd: 6:00-7:30pm
- Wednesday, May 3rd: 3:30pm-5:00pm
- Thursday, June 1st: 4:30pm-6:00pm
- Tuesday, June 7th: 6:00pm-7:30pm
- Wednesday, June 7th: 3:00pm-4:30pm
- Monday, June 12th: 6:00pm-7:30pm

Two of the Community Input Meetings were held in-person, and eight were conducted on the Zoom Platform. Announcements of the meetings were posted on the MHSA webpage and on the City's event calendar and 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. Additionally, specific outreach to engage the Mental Health Commission in the CPP Process and provide information regarding opportunities on how they could inform the Three-Year Plan was conducted through emails and a meeting with the Chair and Vice Chair.

During the MHSA Advisory and Community Input Meetings, a presentation was conducted to provide information on MHSA background, funding, program requirements, and the CPP process. The presentation also covered detailed information on the proposed MHSA Three Year Plan 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. Survey results of 34 individuals who provided input in the CPP Process and 30-Day Public Review were as follows:

DEMOGRAPHICS N=34		
Gender Identity	*Participant Number*	*% of total*
Male	4	12%
Female	16	47%
Genderqueer	1	3%
Other Gender Identity	1	3%
Declined to Answer (or Unknown)	12	35%
Race/Ethnicity		
Race/Ethnicity	*Participant Number*	*% of total*

Black or African American	10	29%
Asian Pacific Islander	1	3%
White	10	29%
Other	1	3%
Declined to Answer (or Unknown)	12	35%
Age Category		
Age Category	*Participant Number*	*% of total*
Transition Age Youth (Ages 16-25)	1	3%
Adult (Ages 26-59)	13	38%
Older Adult (Ages 60+)	8	24%
Declined to Answer (or Unknown)	12	35%
Sexual Orientation		
Sexual Orientation	*Participant Number*	*% of total*
Heterosexual	16	47%
Gay or Lesbian	3	9%
Bisexual	1	3%
Queer	1	3%
Declined to Answer (or Unknown)	13	38%
Veteran Status		
Veteran Status	*Participant Number*	*% of total*
Non-Veteran	20	59%
Declined to Answer (or Unknown)	14	41%
Disability Status		
Disability Status	*Participant Number*	*% of total*
Disabled	9	26%
Not Disabled	11	33%
Declined to Answer (or Unknown)	14	41%
Representative Categories*		
Representative Status	*Participant Number*	*% of total*
Consumer	4	12%
Family Member of Consumer	8	24%
Community Member or MHSA Stakeholder	9	26%
Representative of City of Berkeley Commission	3	9%
Parent, Student or Representative of UC Berkeley or City College	1	3%
Representative of Mental Health or Social Services Agency	2	6%
Representative of Health Care Organization	4	12%
City of Berkeley Staff	4	12%
Other	2	6%
Declined to Answer (or Unknown)	10	29%

*Many participants were in more than one category.

As with previous MHSA Plans and Annual Updates, a methodology utilized for conducting CPP for this Three-Year Plan was implemented to enable a collaborative process to occur between BMH staff, MHSA Advisory Committee members and other MHSA stakeholders. Development of this Three-Year Plan 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 other stakeholders.

Proposed new additions include the following:

- An increase in staffing and program capacity on all three of the Full Services Partnership programs; Crisis Services; Administration; and the High School Prevention Project;
- A transfer of CSS funds to the Workforce Education & Training to hire a Workforce Development Coordinator;
- A one-time transfer of funds to Insight Housing (previously named Berkeley Food & Housing Project) to support increased costs at the Russell Street Residence;
- A transfer of funds to the Aging Services Division to increase staffing and program capacity;
- Funding to hire a consultant to conduct the state required MHSA Capacity Assessment.

A substantive change to the draft Three Year Plan will be the proposed new addition of funding for the African American Holistic Resource Center for the Sankofa Program.

Details on each proposed addition are outlined in the "Proposed New Additions" section of this Three-Year Plan.

A 30-Day Public Review was held from Wednesday, May 16th through Thursday, June 15th to invite input on this MHSA Three-Year Plan. A copy of the Three-Year Plan was posted on the BMH MHSA website, and announcements of the 30-Day Public Review were mailed and/or emailed to community stakeholders and City staff. A Public Hearing on the Three-Year Plan was conducted on Thursday, June 15th, during the Mental Health Commission meeting that was held at the North Berkeley Senior Center on 1901 Hearst Avenue.

Input received during the CPP process which includes the 30-Day Public Review and Public Hearing, was as follows:

- Provide an ongoing increase for the Trauma Support Project for LQBTQIA;
- Provide a one-time funding amount to support the move of the Pacific Center of Human Growth (an MHSA funded contractor), to a new location;
- Provide an ongoing increase to support the SoulSpace Project;
- Provide funding for the African American Holistic Resource Center, Sankofa Project. Additional information on this program is in Appendix F;
- Implement the Community Mental Health First Aid Program through the Mental Health Division and/or form collaborations with trainers of this program;
- Reach out to local businesses for input on community mental health needs;
- Information on area resources, services and supports is not accessible to individuals in the community, particularly those who experience homelessness who often have vision issues and/or don't have glasses. A Resource Guide should be created of all providers of social services and resources in Berkeley in large font, for distribution in the community;
- Implement a Digital Call Center for information on area resources;
- Services throughout the City should be advertised in multiple languages;

- Want to know how the City is going to be using resources. As a disabled individual and a wheelchair user it makes me feel very vulnerable and it affects my safety when I encounter individuals in a mental health crisis, who sometimes block my way or prevent me from going forward;
- Allocate funds for an "Open Dialogue" Pilot program. The Open Dialogue process would occur within 24 hours of a crisis and includes everyone connected to it, including the person at the center, their family and social network, all professional helpers and anyone else closely involved. All discussions and decisions take place with everyone present. Additional information on this program is in the Public Comment Appendix F;
- Mental Health services and supports are needed for individuals who are unhoused around the Berkeley Marina. The 311 number for City services should be advertised on billboards and posters around the City for unhoused individuals at the marina and in Berkeley;
- Utilize funds to implement an Early Intervention in Psychosis program. Additional information on this program is in the Public Comment Appendix F;
- How is the City advertising information on services to individuals who can't read?
- Can MHSA funds be used for reparations for Black/African Americans who have been displaced from Berkeley or are living in poverty?
- Can MHSA funds be utilized for a targeted guaranteed income pilot program?
- What is the City and State doing about vacancies in staff that subsequently create the inability to provide services and/or delays in executing contracts for services?
- How will the Encampment-based Mobile Wellness Center work amid City policies that are being implemented regarding the unhoused population, possibly that money should be used for other programming?
- Concerned about the low number of attendees at Community Meetings and that the Commission is just now seeing this at the Public Hearing, which doesn't provide the time for us to discuss, and submit any recommendations.

During the Public Hearing the Mental Health Commission passed the following motion:

M/S/C (Prichett, Appel) Motion that the Mental Health Commission write a letter that explains why we are not taking an action and that includes that we didn't have enough time to make a thoughtful and constructive recommendation and there are points which we feel that the policies pursued by the City Manager are at odds with the budgeting priorities described in this document. Point 1. They take no recommendation 2. Ran out of time and will revise our time line for reviewing the MHSA report 3. We have concern's that portions of the policies currently being pursued by the City Manager conflict with the priorities expressed in this budget.

Ayes: Appel, Prichett, Turner Noes: None; Abstentions: Fine, Opton; Absent: Harrison, Jones, Kimber-Smith

MHSA FY24-26 THREE YEAR PLAN

This City of Berkeley MHSA FY24-26 Three Year Program and Expenditure Plan (Three Year Plan) is a stakeholder informed plan that provides an update to the previously approved MHSA FY20/21 – 22/23 Three Year Program and Expenditure Plan. This Three-Year Plan summarizes proposed program changes and additions, includes descriptions and updates of currently funded MHSA services that are proposed to be continued in the next three years, and a reporting on FY22 program data. Additionally, per state regulations, this Three-Year Plan includes the Prevention and Early Intervention (PEI) Fiscal Year 2021/2022 (FY22) Annual Evaluation Report (Appendix D), and the Innovations (INN) Fiscal Year 2021/2022 (FY22) Annual Evaluation Report (Appendix E).

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. An aggregated summary of some of the results of this initiative are outlined in the PEI Community Education & Supports program section of this Three-Year Plan.

- 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 RDA conducted in FY22 on this evaluation is included in this Three Year Plan.

  RBA outcomes in FY22 are outlined throughout this Three-Year Plan 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 C.

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

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

Per State requirements, Evaluation Report for PEI and INN programs are also included in this Three-Year Plan 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 D for the Prevention & Early Intervention Fiscal Year 2021/2022 (FY22) 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 E for the Innovation (INN) Fiscal Year 2021/2022 (FY22) Annual Evaluation Report.

PROPOSED NEW FUNDING ADDITIONS

The Division is proposing to add several new positions, and supportive services through this Three-Year Plan. The proposed new staffing additions are a result of a Division re-organization and community needs that have risen since the previous Three-Year Plan was approved. Unless otherwise noted, funding allocations for the proposed additional staffing outlined below are calculated at 85% of the total costs for FY24, which is based on the projected amount of time it will take to recruit and hire for each position. The proposed staffing and services to be added through this Three-Year Plan, are as follows:

Increase Oversight and synergy of the TAY, Adult, and Older Adult Full Services Partnership (FSP) and the Homeless FSP

Full Services Partnership (FSP) programs are programs that serve individuals with the highest level of need through a “no-wrong door, do whatever it takes”, wrap-around approach.

The TAY, Adult and Older Adult FSP is the largest program in the MHSA Community Services and Supports funding component. This FSP provides intensive support services to TAY, Adults and Older Adults with severe mental illness using an Assertive Community Treatment (ACT) team approach. The program focuses on serving individuals who have had difficulty with obtaining or maintaining housing; frequent and/or lengthy psychiatric hospitalizations; and/or frequent or lengthy incarcerations. Priority populations also include individuals from un-served,

underserved and inappropriately served cultural communities. The Homeless FSP provides the same such services and supports for individuals appropriate for FSP services who are also experiencing or particularly vulnerable to homelessness.

In order to provide oversight, consistency and expertise in managing and connecting these two FSP programs together, the Division is proposing to utilize Community Services and Supports (CSS) FSP funds to expand and consolidate these teams into one program through the addition of the following position:

- 1.0 Mental Health Program Supervisor - $247,628

Increase Program Capacity on the Children/Youth Intensive Support Services FSP

The Children/Youth Intensive Support Services FSP is for children and youth, age 0-21, 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 well-being. This FSP 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.

In order to increase the program capacity of this FSP, the Division is proposing to add the following position through CSS FSP funds:

- 1.0 Behavioral Health Clinician II - $154,343

Increase Program Capacity and Administrative Support for Access Services and the Transitional Outreach Team

BMH provides Access services, and a Transitional Outreach Team for children, youth, TAY, adults and older adults. In order to increase the program capacity, and provide administrative support for Crisis Services, the Division is proposing to add the following positions through CSS System Development funds:

- 1.0 Behavioral Health Clinician II - $77,172
- 1.0 Assistant Management Analyst - $132,705

It is envisioned that the Behavioral Health Clinician II will be hired in FY24 mid-year.

Upgrade the Diversity & Multicultural Coordinator Position

The Diversity & Multicultural Coordinator position 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 Diversity & Multicultural Coordinator 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.

Since the initial approved MHSA Plan the Health Services Program Specialist City classification has been used for this position. In order to be able to expand services, the Division is proposing to upgrade the classification of this position to the following:

- Community Services Specialist II - $165,982
  Through this classification the Diversity & Multicultural Coordinator will be able to take on the added role of supervising a staff, and will oversee the community-based Mental Health First Aid Program.

Provide Funding to Increase the Program Capacity in the Aging Services Division

The HHCS Aging Services Division provides a variety of social services for older adults in Berkeley as well as Shelter Plus Care program participants. To provide management of the Shelter Plus Care caseload, and increased clinical services, the Division is proposing to transfer a portion of CSS System Development funds to the Aging Services Division to add the following position:

- 1.0 Behavioral Health Clinician II - $154,343

Increase Administrative Support for Division Contracts

MHSA provides funding for various services and supports that are implemented by community partners, through contracts with the Division. In order to increase administrative support for the execution, monitoring and oversight of contracts, the Division is proposing to utilize CSS and PEI Administration funds to hire the following position:

- 1.0 Associate Management Analyst - $182,531
  (.60 will be funded through CSS Administrative Funds, and .40 from PEI Administration Funds).

Increase Services for High School Youth

The High School Prevention Project provides youth 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 to 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.

To order to increase the capacity to provide mental health services for high school youth and program oversight, the Division is proposing to utilize a portion of PEI funds to add the following positions to the High School Prevention Project:

- .80 Mental Health Program Supervisor - $168,452
  This position will oversee and direct the High School Prevention Project.
- 1.0 Behavioral Health Clinician II - $77,172

This position is projected to be hired in mid-year FY24, and will provide mental health services and supports to youth.

- .30 Social Services Specialist - $39,835
  This position will provide supportive Substance Use Disorder (SUD) services to youth. It will be funded with .30 of MHSA PEI funds, and .70 of Opioid Settlement funds.

Add a Workforce Development Coordinator Position

The Division is proposing to provide a portion of CSS System Development funds in FY24 to hire the following position:

- 1.0 Community Services Specialist III - $170,535
  This position will serve as a Workforce Development Coordinator for the Division and will oversee Intern recruitment, and coordinate training and support for graduate level interns

This allocation of funds for this position will involve transferring CSS System Development funds to the Workforce, Education and Training (WET) funding component, through the following process:

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

Approximately $208,654 in FY25 and $217,000 in FY26 of CSS System Development funds will also be transferred in the Three-Year timeframe to support this position.

Allocate a one-time funding amount to conduct a Capacity Assessment

Per MHSA legislation, mental health jurisdictions are required to conduct a Capacity Assessment of the local system of care and report out on it in each Three-Year Plan. The purpose of the Capacity Assessment is to understand where there are strengths, limitations, disparities, gaps and/or barriers in the system in accessing care or meeting local mental health needs.

To meet this requirement, Division staff created a Capacity Assessment Tool, that was reviewed and approved by the Department of Healthcare Services (DHCS) Community services Division. From the Capacity Assessment Tool, a Survey was created that was sent to providers in the local system of care. Despite multiple attempts to engage local providers to fill out the survey, the response rate was very low, and the Division was unable to obtain a comprehensive assessment of the local system of care for this Three-Year Plan.

The Division is proposing through this Three-Year Plan, to allocate $60,000 of CSS Administration Funds to hire a consultant who will conduct a Capacity Assessment of the local system of care. The consultant will be chosen through a Request for Proposal (RFP) process.

Allocate a one-time funding increase for Insight Housing

Insight Housing (formerly named Berkeley Food & Housing Project) operates the Russell Street Residence which provides permanent supportive housing for 17 formerly homeless adults who have experienced severe and persistent mental illness. Residents receive the following: supportive services; meals; therapeutic groups, activities and outings; transportation to medical appointments; and assistance with daily activities including laundry and personal hygiene.

Through this Three-Year Plan the Division is proposing to allocate a one-time amount of $150,000 of CSS System Development funds to Insight Housing to help defray increases to rental costs, and services at the Russell Street Residence.

Allocate funding for the African American Holistic Resource Center – Sankofa Program

The African American/Black community in Berkeley has the highest rate of morbidity and mortality of any racial/ethnic group. According to the City of Berkeley's Health Status Summary Report 2018, "African Americans are 2.3 times more likely to die in a given year from any condition compared to Whites, and the COVID-19 virus has increased the morbidity and mortality rates for this population. Socioeconomic factors, birth outcomes, and morbidity rates that stretch across the life span of African Americans indicates they are not thriving in the City of Berkeley. Therefore, it is essential that a paradigm shift take place for this population in the delivery of care and services. Culturally Centered Engagement System of Care that is effective in welcoming, supporting, healing, and empowering the Black community in the City of Berkeley must be developed.

In April 2011, the African American/Black Professionals & Community Network (AABPCN) crafted the report titled A Community Approach for African American/Black Culturally Congruent Services. In the AABPCN report it identified challenges that the African American community faces in areas of education, employment, health, and mental health, housing, and community relationships. A vision and framework were provided in the report for the development of an African American Holistic Resource Center (AAHRC) in South Berkeley. The center will include the use of culturally congruent practices, embedded in an integrated service delivery system, which will help to decrease inequities and disparities in the African American community in Berkeley. The AAHRC facility as outlined in the Feasibility Study, is stated to be a state-of-the-art green building ranging in size of 6,000 Square feet, that includes but is not limited to a multipurpose room, library, medical screening room, two therapy offices, two classrooms, dance studio, game room, kitchen, offices with a reception area, and a yard/garden area. The delivery of culturally congruent services at the AAHRC will provide African Americans with the support they need to decrease inequities and disparities, and build community. The AAHRC will be a beacon of light and hope for Berkeley's African American community when it is developed.

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

Per the previously approved FY20-23 Three Year Plan, the HHCS Department and Mental Health Division is very interested in providing funding support for the AAHRC, once specific needs have been determined. During the CPP process for this Three Year Plan the AAHRC Steering and Leadership Committees submitted a proposal for MHSA funding, which was revised and resubmitted during the 30 Day Public Review (see Appendix F, for both proposals). The revised proposal outlines a request for MHSA funds to specifically support the AAHRC Sankofa Project. The Division is proposing to allocate $300,000 of Community Services and Supports (CSS) System Development funds in FY24 for this project.

(Some information was taken from the A Community Approach for African American/Black Culturally Congruent Services and the African American Holistic Resource Center Feasibility Study, 2018 reports)

Increase Administrative Support for the Division Manager

Beginning in FY25, in order to provide the Mental Health Manager with increased staffing support for special projects, data collection and analysis, and assistance with policy, procedure, and budget development, the Division is proposing to allocate CSS System Development and Administration funds to add the following position:

- 1.0 Assistant Management Analyst - $138,013

Any other future staffing and program additions during the three-year plan timeframe will be proposed through Annual Updates to this plan.

PROGRAM DESCRIPTIONS AND FY22 DATA BY FUNDING COMPONENT

Outlined in this section per each funding component are descriptions of current City of Berkeley MHSA services that are proposed to be continued through this Three-Year Plan and FY22 program data. In FY22, across all MHSA funded programs, approximately 6,086 individuals participated in some level of services and supports. As with FY20 and FY21, among the largest of accomplishments in FY22 is that almost all MHSA funded services were able to continue providing services in some capacity during the COVID-19 pandemic. Some of the FY22 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; multicultural trainings, projects and events; Wellness Center

services; consumer driven wellness recovery activities; housing, and benefits advocacy services and supports for clients; augmented prevention and intervention services for children and youth in the schools and community; increased outreach, and supportive services for TAY, Adults and Older Adults and individuals in unserved, underserved and inappropriately served cultural and ethnic populations; and free access to the MyStrength and HeadSpace Mental Health Apps 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 is proposed to be continued through this Three-Year Plan, and FY22 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 FY24 by each age category is as follows: 9 individuals aged 6-12; 9 individuals aged 13-17; and 2 individuals aged 18-21.

In FY22, a total of 14 children/youth and their families were served through this program. Demographics on those served were as follows:

DEMOGRAPHICS N=14		
Age	*Number Served*	*% of total*
6-12 years	6	43%
13-17 years	7	50%
18-21 years	1	7%
Gender Identity	*Number Served*	*% of total*
Male	8	57%
Female	6	43%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*% of total*
Black or African American	5	36%
Alaska Native or American Indian	1	7%
Asian Pacific Islander	2	14%
White	3	21%

Latino/a/x	3	22%
Sexual Orientation		
Sexual Orientation	*Number Served*	*% of total*
Heterosexual or Straight	8	57%
Gay	1	7%
Questioning	1	7%
Other	1	7%
Declined to Answer (or Unknown)	3	22%

Flex funds are used to provide various supports for FSP program participants and/or the families of program participants. In FY22, flex funds were utilized as follows: 8 individuals/families received funding for food/groceries; 6 individuals/families received funds for clothing/hygiene; 4 individuals/families received funding for Bus Passes or transportation; and 8 individuals/family members received funding for other various needs.

Program Successes:

- Successfully transitioned 10 participants back to in-person care as the pandemic subsided. As school reopened, many of the services were provided on campus or in the community.
- Increased access to other services within the Division to support the acute needs of FSP participants and their families. These included psychiatric medication services and individual/family therapy. One participant who was over the age of 18 was referred to community-based services to support their behavioral health needs.
- Reduced psychiatric hospitalizations and the usage of crisis services.
- Five participants met and/or exceeded stated objectives in their treatment plan.
- Services continued to be provided by clinicians who mirrored the racial/ethnic identity of the populations served.
- The FSP Team was able to provide flex funding to support the felt needs of the program participants as the pandemic eased; this was extremely important as there was an increase in needs due to parental loss of employment and/or the increase costs of goods and services. The flex fund purchases supported the purchase of food, clothing, household items, transportation, and fun activities for program participants and their siblings.
- Successfully on-boarded a bilingual/bicultural Senior Behavioral Health Clinician who assumed primary care coordination for the families in the program. This hire expanded the program's capacity to provide services to mono-lingual Spanish speaking families.

Program Challenges:

- Providing FSP level care to program participants and their families with the ongoing transition of staff was a challenge as individuals who presented with the most acute needs had to be prioritized. This required the Program Supervisor to support staff with providing care and to step down cases to a lower level of care in spite of an individual's ongoing needs.
- A reduction in referrals were accepted due to staff transitions. As a result, some individuals had to be placed on wait lists or were referred to other FSP programs within the county.

- The program was only able to provide services in English until a bi-lingual staff was hired in May 2022.

In FY22, 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	

Measure	Definition	Data Source
	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 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, the ongoing impact of the COVID-19 pandemic and the shelter in place, as staff were working to rebuild engagement with families/clients, affected service provision. Staff and clients were still contracting the virus which impacted their ability to meet and many families had other priorities that impacted service provision and school attendance. Staffing changes which left the team understaffed, also had an impact on service provision and outcomes.

In FY22, the RBA Outcomes for this FSP were as follows:

Child Full Service Partnership (FSP)
Reporting Period: July 2021-June 2022 (Baseline)

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

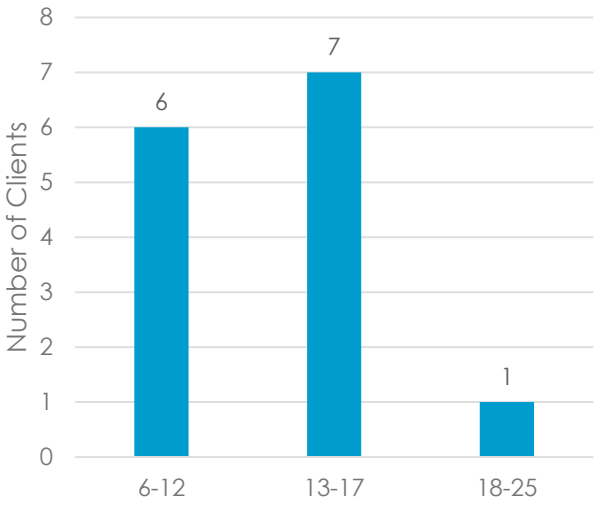
14
Clients Served

7
New Clients

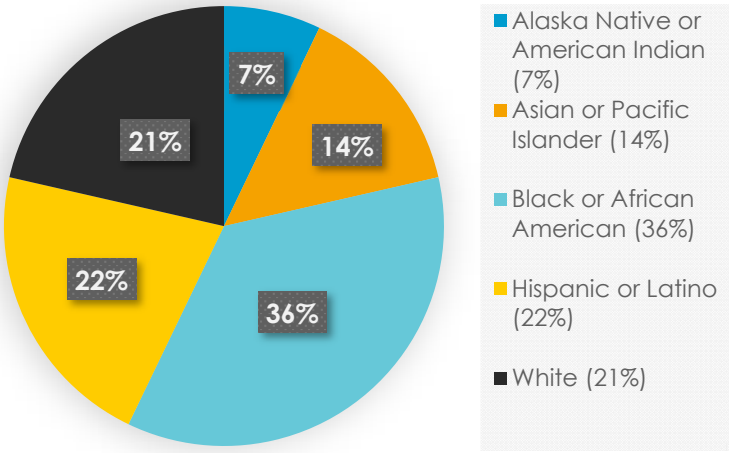
Program Description: This team provides wrap around services to children and families with acute needs, who meet the following criteria: child is at risk of/has been removed from their parent/guardian; child is involved with the Juvenile Justice System or at risk of that; has been recently had a psychiatric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

represents 5 clients

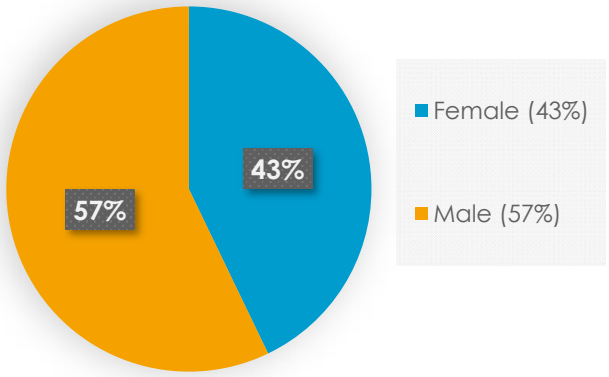
Client Demographics (Age)



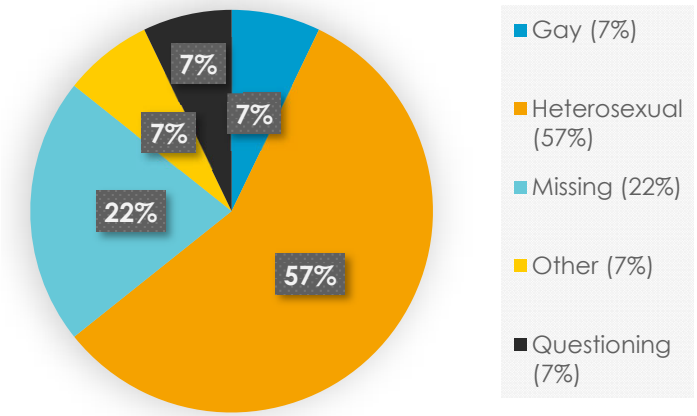
Client Demographics (Race)



Client Demographics (Gender Identity)



Client Demographics (Sexual Orientation)

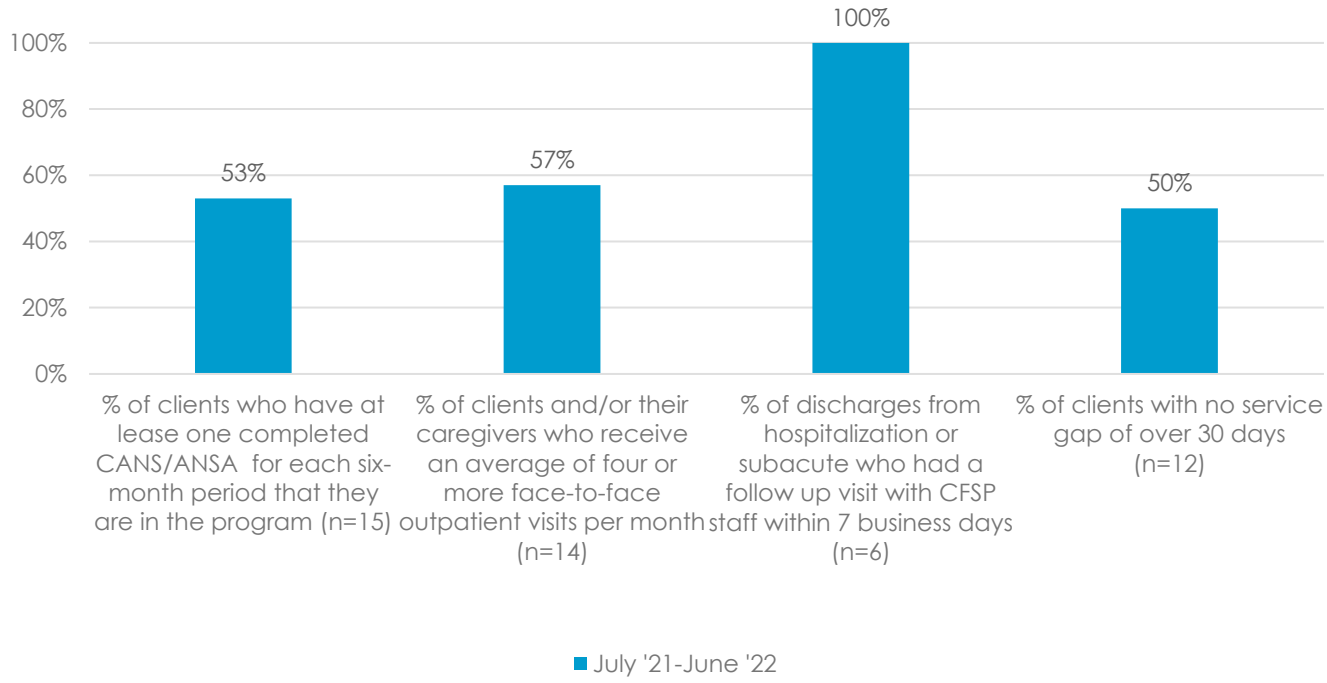


Quality Outcomes ("How well did we do it?")

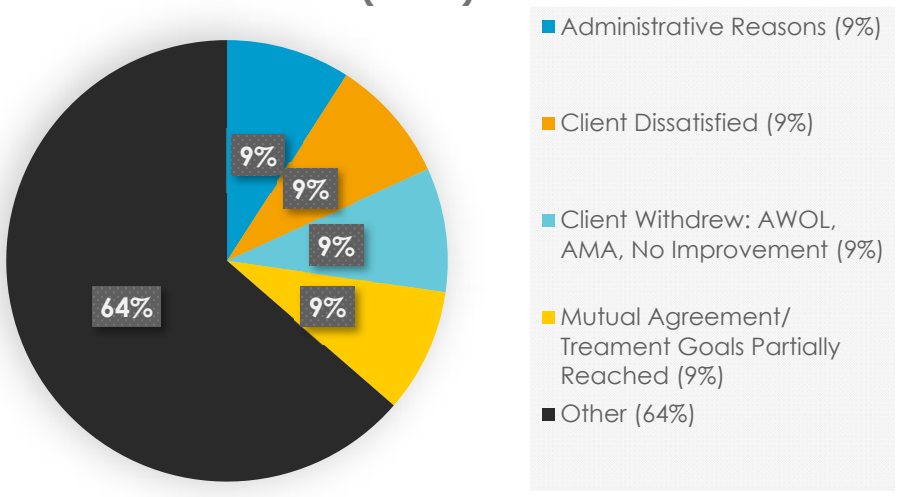
The average client served in 2021-2022:

- remained in the FSP program for **336 days**
- received **10.22 hrs** of services per month
- received **6.88 services** per month

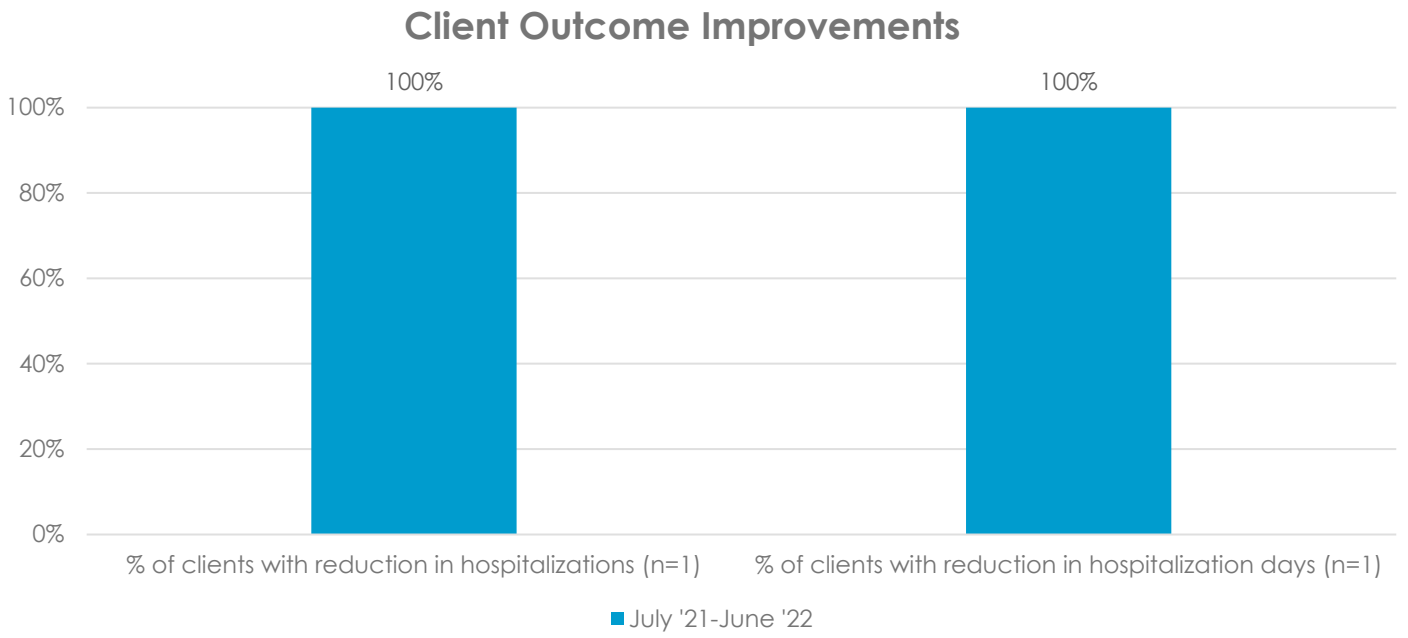
Service Consistency

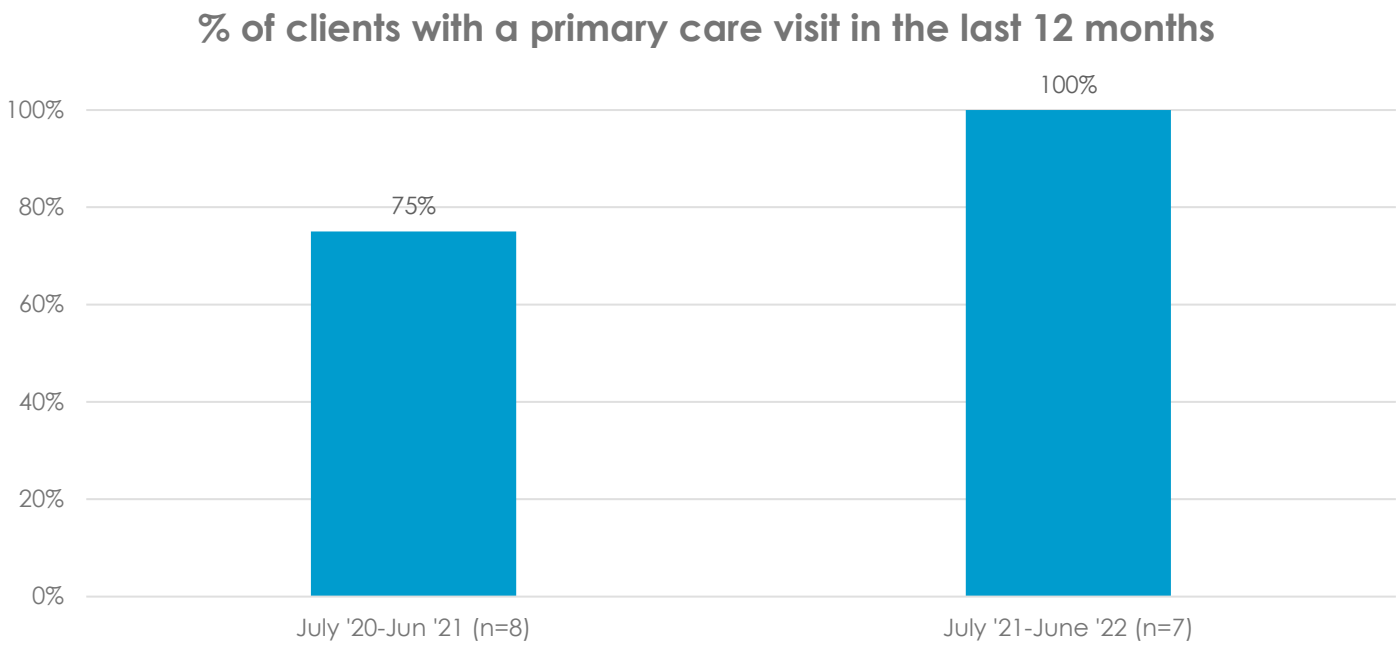


Clients Closed, by Reason Closed (n=11)



Impact Outcomes ("Is anyone better off?")





TAY, Adult and Older Adult Full Service Partnership

This FSP program provides intensive support services for adults aged 18 and older, including TAY, adults and older adults, who are experiencing severe mental illness. The focus is on individuals who face difficulties in obtaining or maintaining housing, have a history of frequent or lengthy psychiatric hospitalizations, or have experienced repeated or prolonged incarcerations. Additionally, the program gives priority to individuals from unserved, underserved, and inappropriately populations.

The team utilizes an Assertive Community Treatment (ACT) approach which maintains a low staff-to-client ratio of 12:1, enabling frequent and intensive support services to clients. Individuals are provided with assistance in finding appropriate housing and in some cases may qualify for temporary financial assistance. The primary objectives of the program are to engage clients in their treatment and to reduce their days spent homeless, hospitalized and/or incarcerated. The program aims to enhance client's employment and educational readiness; promote self-sufficiency; and foster wellness and recovery. The projected number of individuals to be served in each age category in FY24 is as follows: 5 Transition Age Youth; 55 Adults; and 20 Older Adults.

In FY22 a total of 75 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=75		
Gender Identity		
Gender Identity	*Number Served*	*% of total*
Male	44	59%
Female	25	33%
Multiple Gender Identities	1	1%
Missing	3	4%
Declined to Answer (or Unknown)	2	3%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*% of total*
Alaska Native/Native American	1	1%
Black or African American	34	46%
White	37	49%
Latino/a/x	1	1%
Declined to Answer (or Unknown)	2	3%
Age Category		
Age Category	*Number Served*	*% of total*
Transition Age Youth	4	5%
Adult	53	71%
Older Adult	18	24%
Sexual Orientation		
Heterosexual	53	71%
Bisexual	3	4%
Lesbian	1	1%
Gay	2	2%
Multiple Sexual Orientations	2	3%

Missing	12	16%
Declined to Answer (or Unknown)	2	3%

Flex funds are used to provide supports for FSP program participants. In FY22, 21 partners received rental and housing assistance; 34 received food and groceries and 20 partners were provided with miscellaneous assistance with cleaning, clothing, bus passes, furniture, etc.

Reflected in narrative format and charts on the preceding pages is data collected in FY22 for this program. It is important to note that there are two different sources of data regarding the reasons why participants were closed from the program. The first set of data below is based on the outcomes of the 61 TAY, Adult, and Older Adult clients who completed at least one full year of services, and is derived from the State DCR data collection and reporting. The second set of data in the Results Based Accountability (RBA) data outcomes section is presented in a pie chart in the Clients closed by reason section, and is obtained from an Alameda County data site. This pie chart data includes all participants who are enrolled in the Adult FSP for any period during FY22, however the county data site has limited options for selecting reasons for closure. Due to these differences in data sources, there may be discrepancies between the two sets of data.

Program Successes:
Of the 61 TAY, Adult and Older Adult clients (or partners) who completed at least 1 full year of services, outcomes included the following: 18 partners were disenrolled from the program during FY22: 5 partners met treatment goals and graduated to lower levels of care (28%), 4 partners were transferred to a new Full Service Partnership team specializing in individuals who are chronically homeless (22%), 5 partners died (28%), 2 partners could not be located (11%) and 2 partners were institutionalized in psychiatric settings (11%).
There were also positive outcomes with comparing data for participants in the current fiscal year to the most recent prior 12 months including the following: 82% of participants had a reduction in psychiatric emergency services/Inpatient/Crisis stabilization compared with the prior 12 months prior (n=22); 69% of clients had a reduction in jail days when comparing the current fiscal year to the most recent prior 12 months (n=16).

Program Challenges:
- As the Bay Area housing crisis continued, finding safe and affordable housing was extremely difficult as housing prices continued to rise and were among the most expensive in the country. Some of the Licensed Board & Cares that provided clients 24/7 support and monitored medication adherence closed down. Single Room Occupancy Hotels raised their monthly rates such that clients were not able to afford staying there without housing subsidies.
- The Coordinated Entry System in Alameda County is intended to address homelessness more efficiently and equitably. The system standardizes the assessment process and prioritizes resources for individuals who are assessed to have the highest need. Helping the highest need homeless individuals get through the assessment process can be challenging given the need for the individuals to participate in an assessment appointment. Also, some individuals served in the FSP were reluctant to acknowledge their mental health and

substance use disorder needs which in turn lowered their “needs” assessment score and chances of obtaining permanent supported housing resources.

- The COVID-19 pandemic continued to present challenges in FY22 in providing services to clients. In-person visits continued to occur at slightly reduced levels to minimize unnecessary risks to clients and staff. Hospitals, Board and Cares and various other programs closed sites to visitors during periods of outbreak.
- Retaining and hiring staff continued to be very difficult. Several staff left the team and it has been very difficult to fill those vacancies. There have been significantly fewer applicants over the past two years than in previous years. Staff that applied for and were offered positions reported receiving multiple job offers from other organizations. The COVID-19 pandemic likely played a part in the hiring crisis. The FSP requires working in the community with individuals who are considered the highest need within the service system. The work can be challenging. Current employees also had to manage their concerns about possible exposure to COVID-19 while doing front line services as well as managing their burnout as staffing levels decreased. It is anticipated that the current vacancies will be filled in the coming fiscal year.

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

In FY22, the RBA measures that were established for this FSP were as follows:

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

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is Anyone Better off?
		• % 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
% 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

Measure	Definition	Data Source
% 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 FY22 RBA Outcomes for this FSP, there were a number of staff vacancies and difficulty in filling positions. The FSP teams keep individuals open to services for a number of months, even when the they are missing, disengaged or incarcerated in a hope to get them back into care. This may account for gaps in services of over 30 days reflected in the data.

RBA Outcomes for this FSP were as follows:

Adult Full Service Partnership (FSP)
Reporting Period: July 2021-June 2022 (Baseline)

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

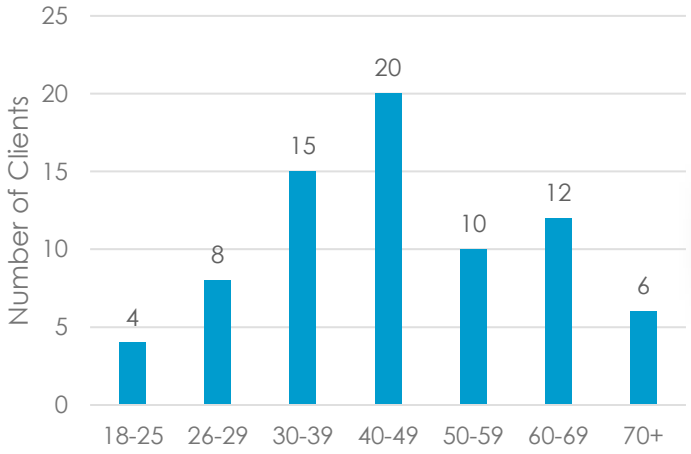
75
Clients Served

11
New Clients

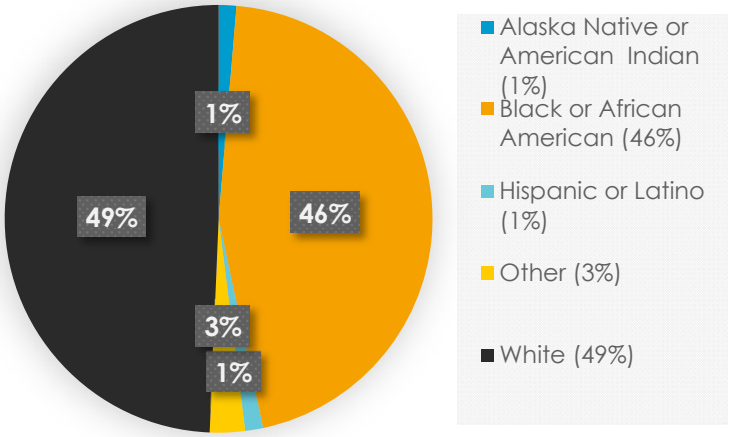
represents 10 clients

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 Model which involves low staff-to-client ratios at approximately 10:1 and a focus on providing care as a team rather than individual case load assignments. Services are primarily provided in the community rather than in an office setting.

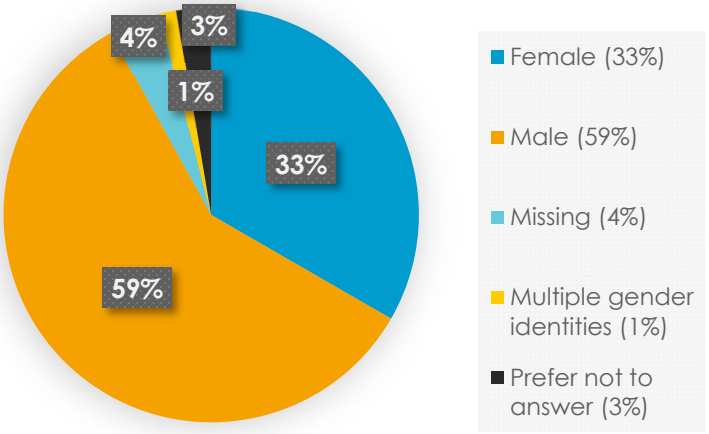
Demographics (Age)



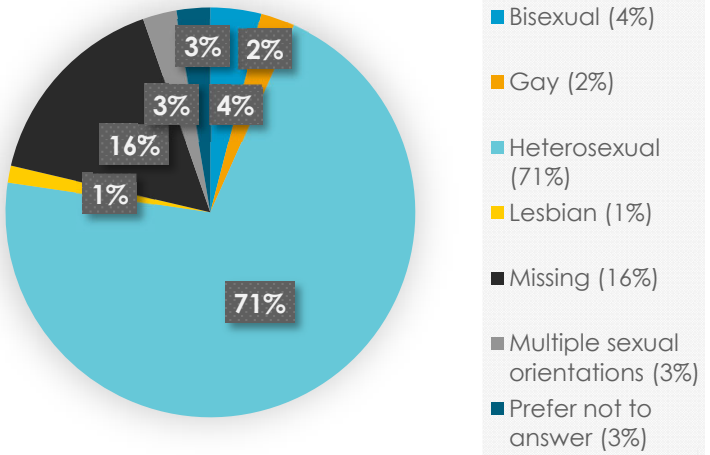
Demographics (Race)



Demographics (Gender Identity)



Demographics (Sexual Orientation)

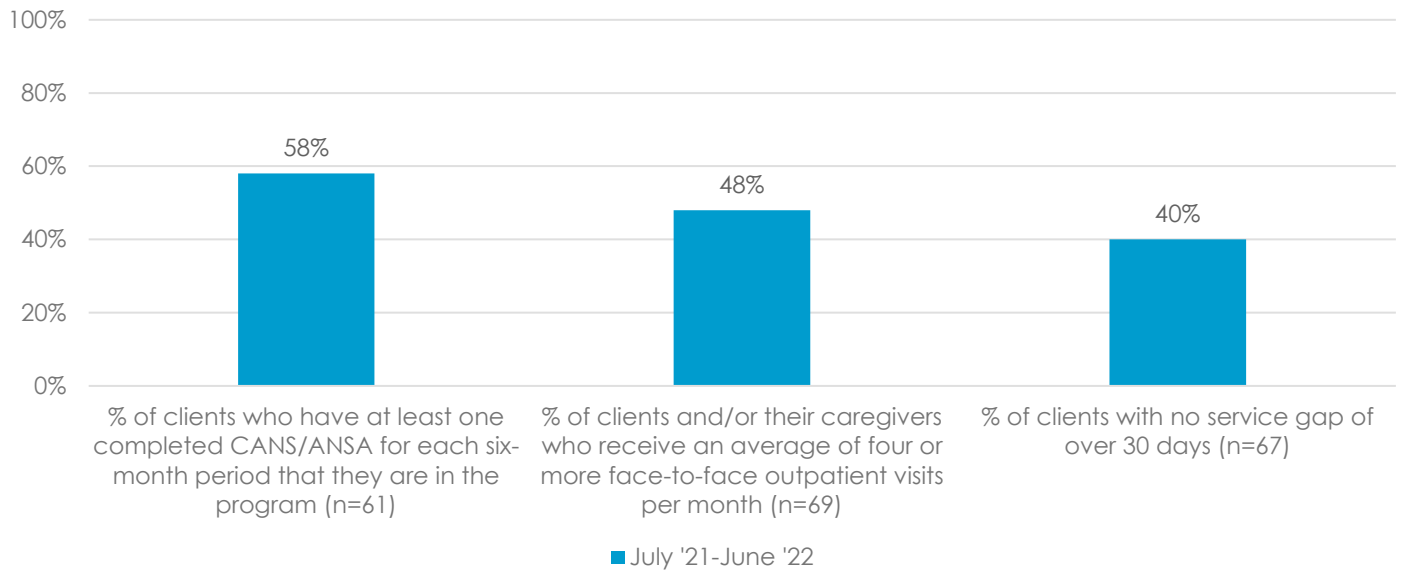


The average client served in 2021-2022:

- remained in the FSP program for **1,231 days**
- received **5.17 hrs** of services per month
- received **4.53 services** per month

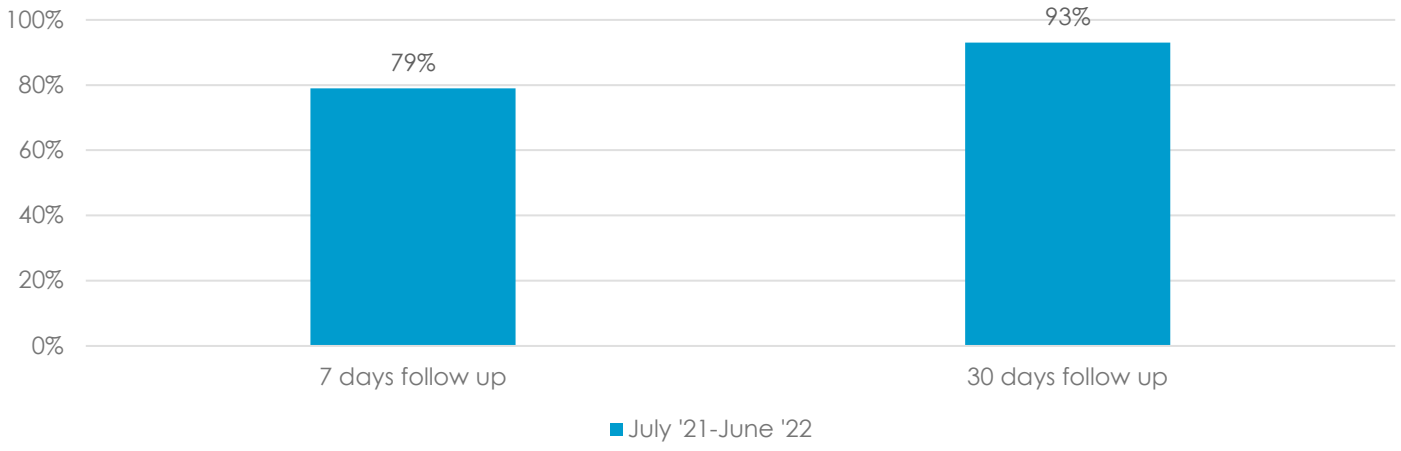
Quality Outcomes ("How well did we do it?")

Service Consistency

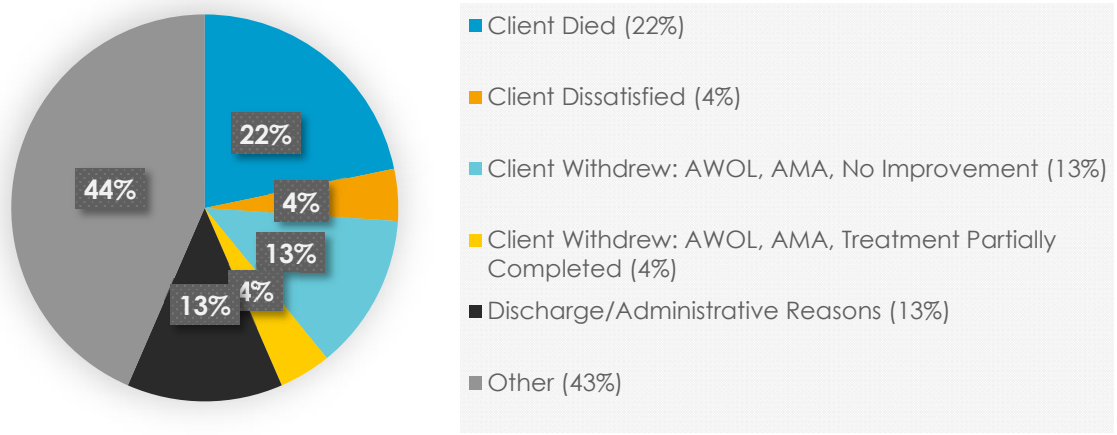


Hospital Follow Up Consistency

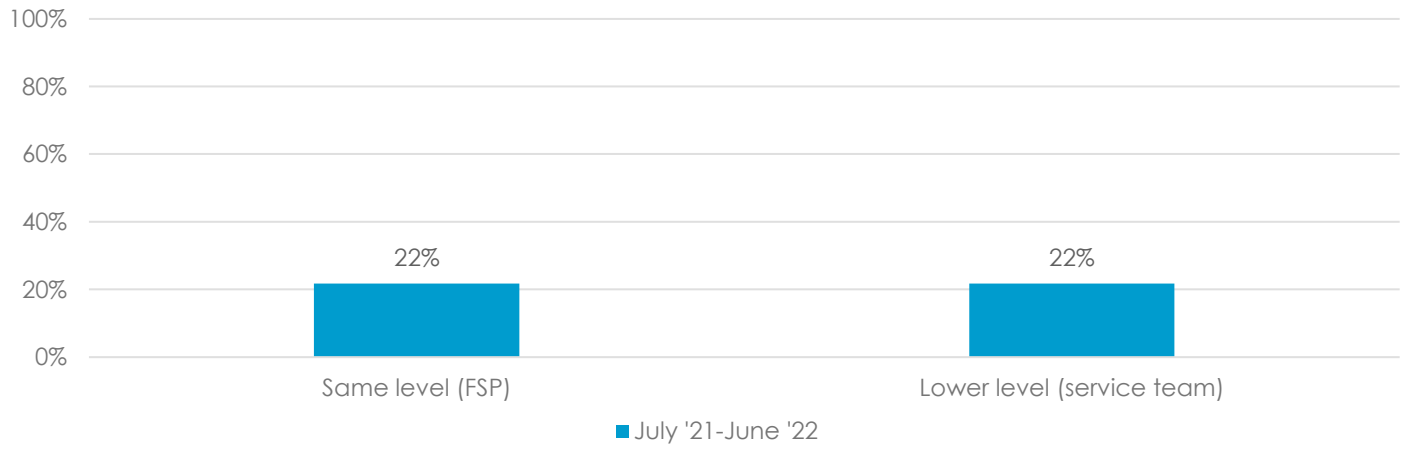
% of discharges from hospitalization or subacute who received FSP follow up within 7 and 30 days (n=28)



Clients Closed by Reason Closed (n=23)

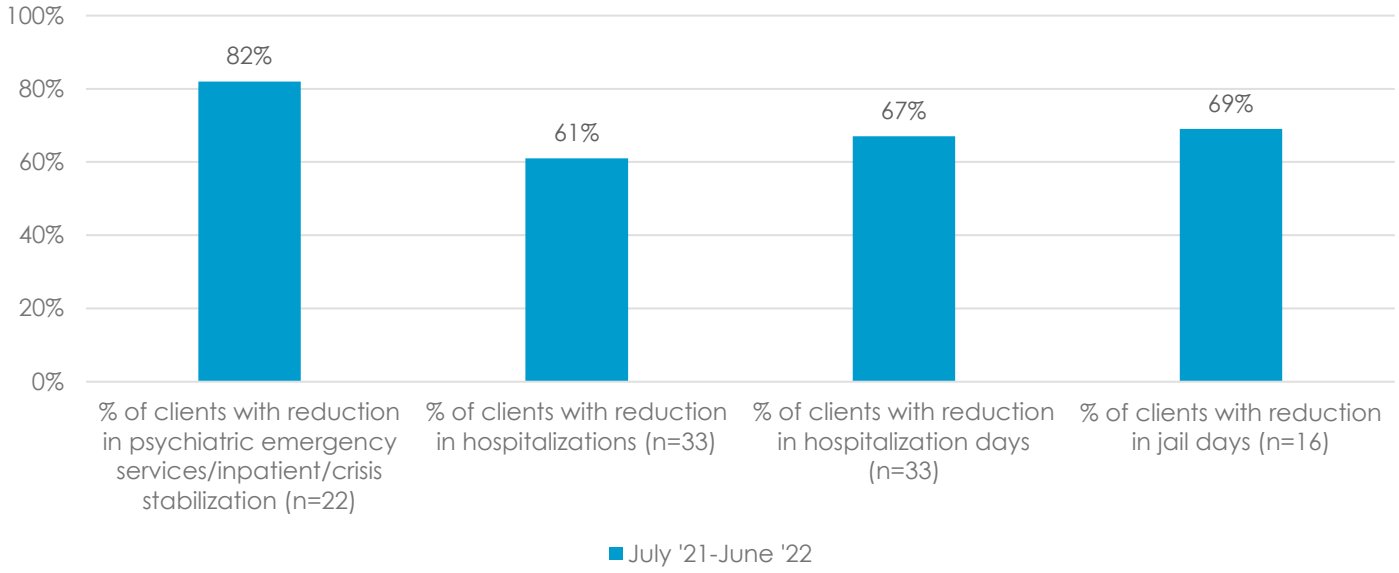


Clients Transferred to Another Program, by Level of Care (n=23)

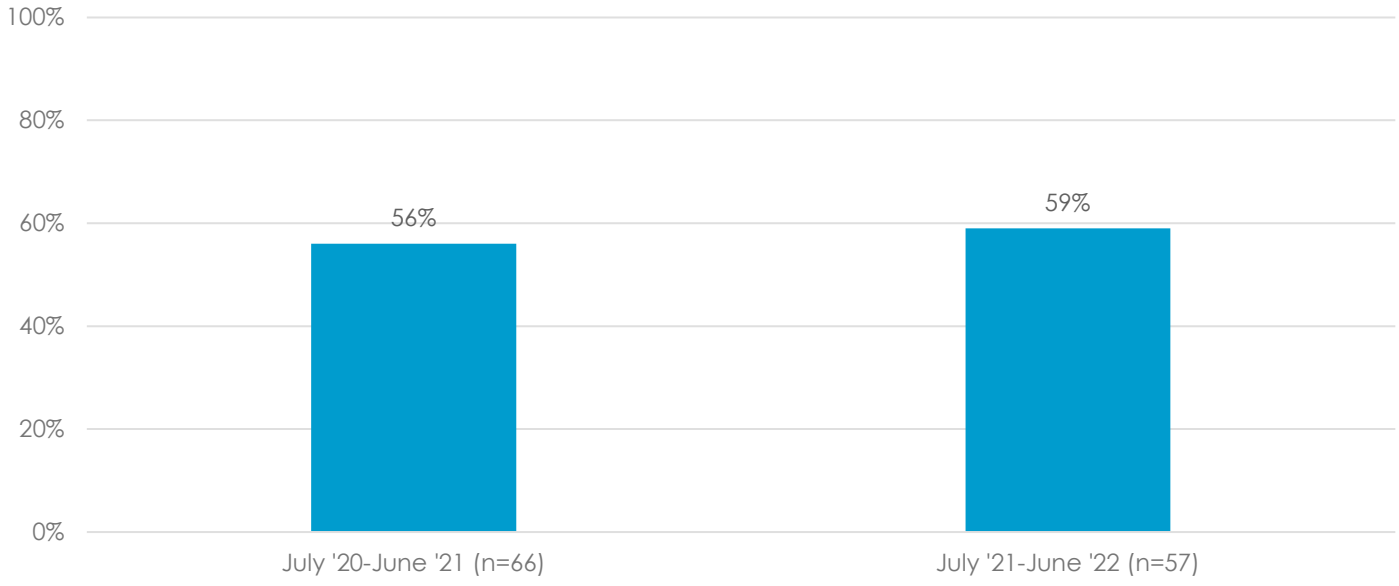


Impact Outcomes ("Is anyone better off?")

Client Outcome Improvements



% of Clients with a Primary Care Visit in the Last 12 Months



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 Service 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. The projected number of individuals to be served through this program in FY24 by age category is as follows: 3 Transition Age Youth; 40 Adults; and 12 Older Adults.
In FY24, 36 individuals were served. Demographics on individuals served are as follows:

DEMOGRAPHICS N=36		
Gender Identity		
Gender Identity	*Number Served*	*% of total*
Male	25	69%
Female	10	28%
Declined to Answer (or Unknown)	1	3%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*% of total*
Black or African American	18	50%
Asian Pacific Islander	2	5%
Latino/a/x	1	3%
White	14	39%
Other	1	3%
Age Category		
Age Category	*Number Served*	*% of total*
Transition Age Youth	1	3%
Adult	28	78%
Older Adult	7	19%
Sexual Orientation		
Sexual Orientation	*Number Served*	*% of total*
Heterosexual	28	78%
Bisexual	2	5%
Gay	1	3%
Multiple Sexual Orientations	1	3%
Declined to Answer (or Unknown)	4	11%

Flex funds are used to provide supports for FSP program participants. During the timeframe of December 2021-June 2022, 7 partners received rental and housing assistance; 8 received food

and groceries; 1 partner received bus passes; and 1 partner was provided with assistance with their pharmacy needs.

Program Successes:
The HFSP team has systematically worked to engage individuals who historically have had challenges connecting or maintaining connections in team services. This has been accomplished by providing outreach to potential clients; assisting with initial engagement and providing intake assessments in the field; gradually building rapport and trust; overlapping treatment for individuals who have been transferred from another BMH program; providing services and engagement when clients are in in-patient facilities; and maintaining treatment contact, despite challenges to engagement. The team has demonstrated their ability to be flexible to redirect its efforts to support the needs of the unhoused community during the pandemic through the following:

- Met clients where they were at, both physically (e.g. encampments, parks, public spaces, in-patient facilities, shelters) and with respect to their mental health needs (e.g. supporting individuals with challenging behaviors, various stages of change, etc).
- Provided wide range of intensive services, using a client-centered team approach (e.g. clinical case management, providing skill building, direct assistance and tasks, therapy, access to psychiatry, provision of basic needs, symptom management and de-escalation, transportation, foster independence).
- Assisted clients in gaining & maintaining shelter at various placements (e.g. Horizon, Safer Ground COVID respite sites, etc), transitioning to “being housed,” and getting “document ready” (e.g., obtaining documents needed for various housing placements).
- Worked to build collaborative partnerships with staff at community agencies, including but not limited to Lifelong Medical Street Medicine, Homeless Action Center, Bay Area Community Services, Aging Services Division, Housing and Community Services Division, Dorothy Day, East Bay Community Law Center, UC Berkeley, Alameda County Healthcare for the Homeless, Berkeley Food and Housing Project (now Insight Housing), Bonita House, and Villa Fairmont Mental Health Rehabilitation Center.

Program Challenges:
Though the program officially started in March 2021, hiring mental health workers for this new intensive treatment team was slow and the team was not able to be fully staffed until 2023, possibly due in part to the COVID-19 pandemic, overall staffing shortages within the City of Berkeley and the Health Housing & Community Services Department, and staffing turnover. This includes the resignation of the Mental Health Clinical Supervisor, who had been managing some of the data, thus total numbers in FY22 may not fully illustrate the services of the team. Due to the challenges with obtaining and maintaining staffing levels, enrolling individuals into service was also delayed.

In FY22, 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 program officially started in March 2021, hiring mental health workers for this new intensive treatment team was slow and the team was not able to be fully staffed until 2023, possibly due in part to the COVID-19 pandemic, overall staffing shortages within the City of Berkeley and the Health Housing & Community Services Department, and staffing turnover. This includes the resignation of the Mental Health Clinical Supervisor and transfer of one of the team's case managers to another division program. Also, due to the challenges with obtaining and maintaining staffing levels, enrolling individuals into service was delayed. In the future, we hope to have more robust data sets to better provide a picture of the work the team is providing to the community.

In FY22, the RBA Outcomes for this FSP were as follows:

Homeless Full Service Partnership (FSP)
Reporting Period: July 2021-June 2022 (Baseline)

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

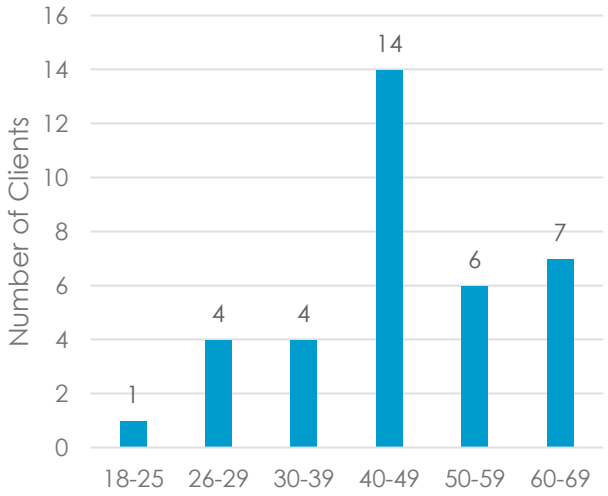
36
Clients Served

34
New Clients

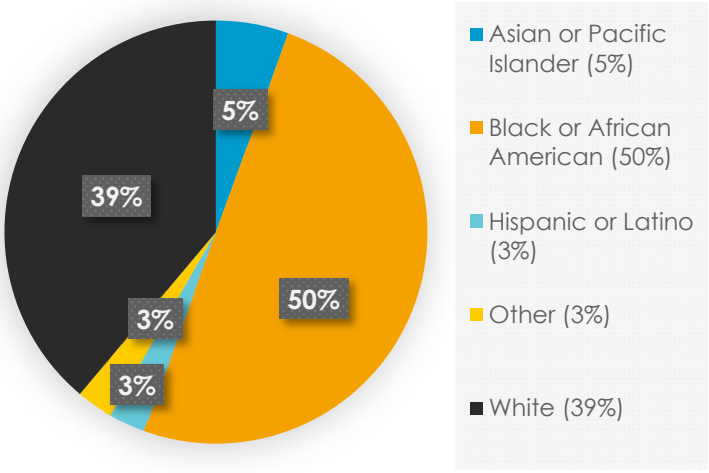
Program Description: HFSP serves unhoused residents of Berkeley in an Assertive Community Treatment (ACT) model at high staff to client ratios, providing intensive case management and mental health services in a multi-disciplinary team approach. This team serves those with the highest level of need,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

represents 10 clients

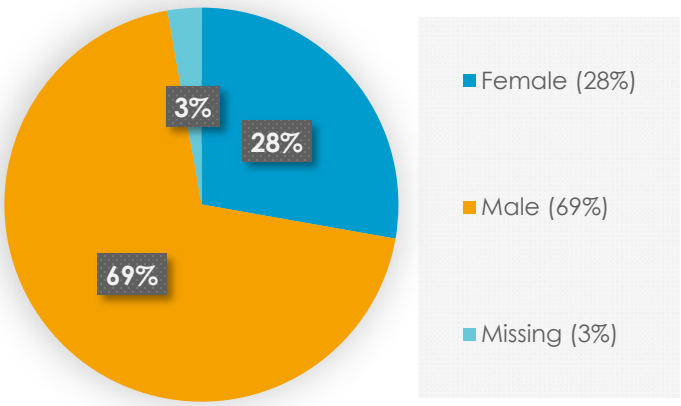
Client Demographics (Age)



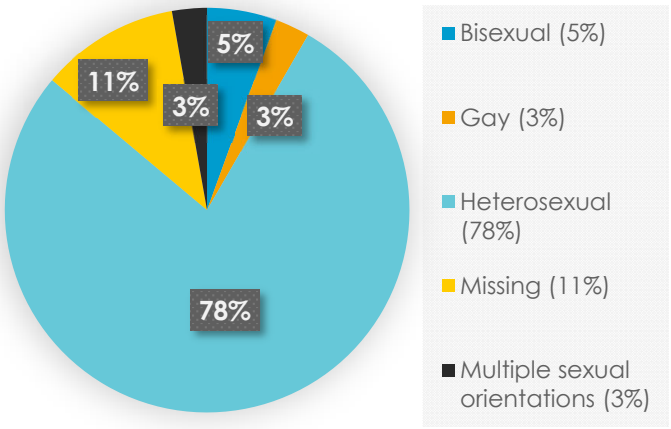
Client Demographics (Race)



Client Demographics (Gender Identity)



Client Demographics (Sexual Orientation)

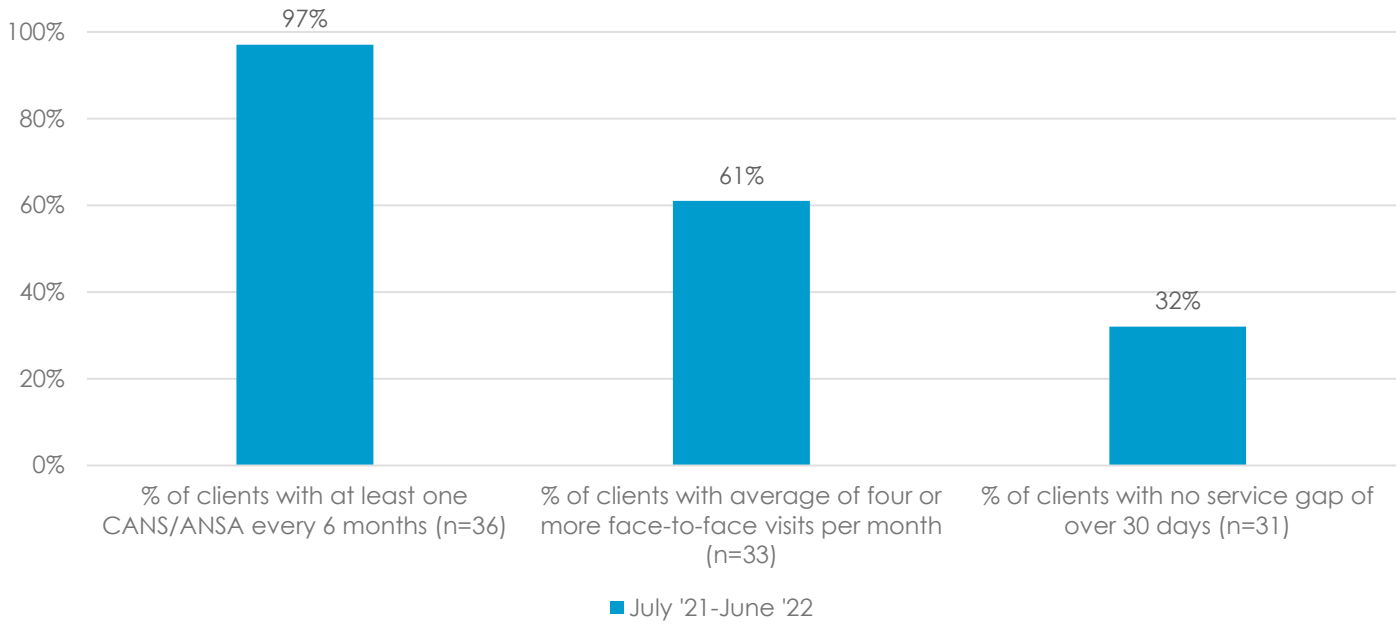


Quality Outcomes ("How well did we do it?")

The average client served in 2021-2022:

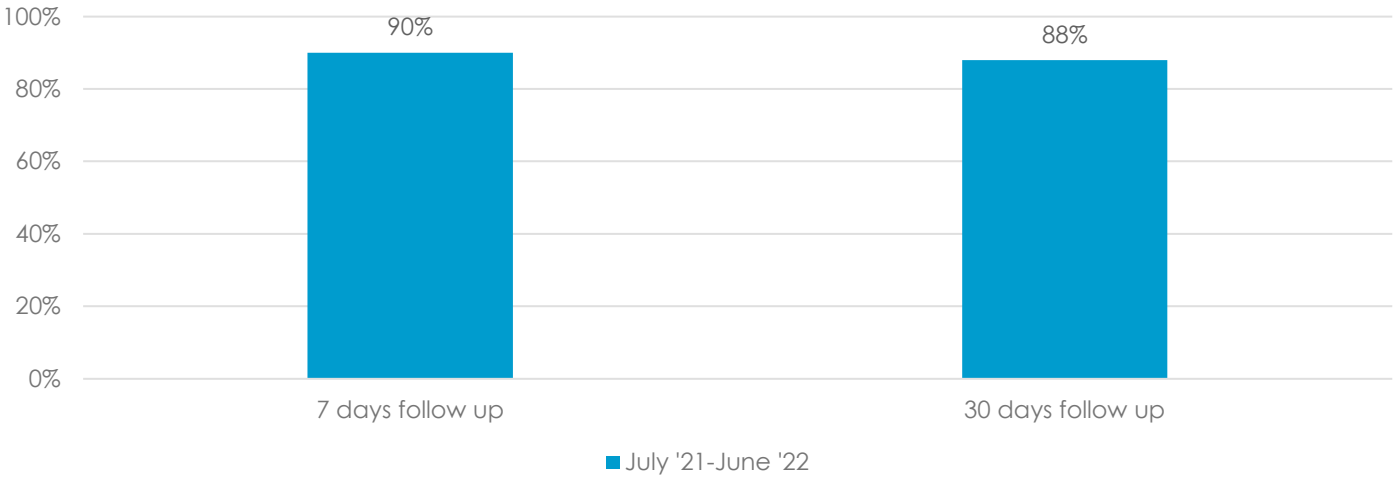
- remained in the FSP program for **263 days**
- received **8.82 hrs** of services per month
- received **6 services** per month

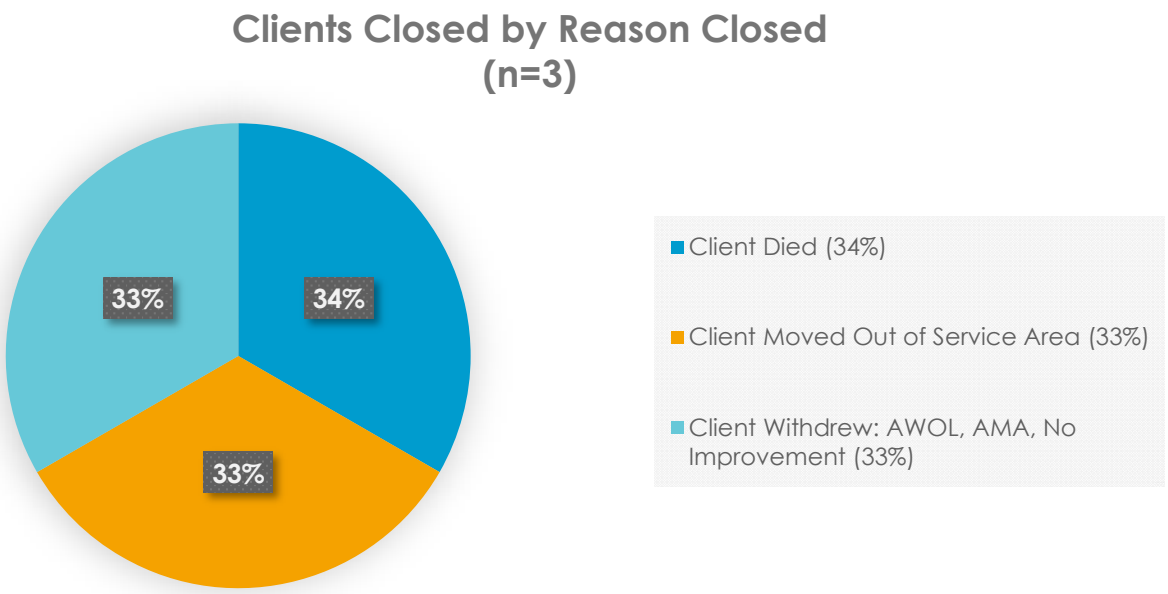
Service Consistency



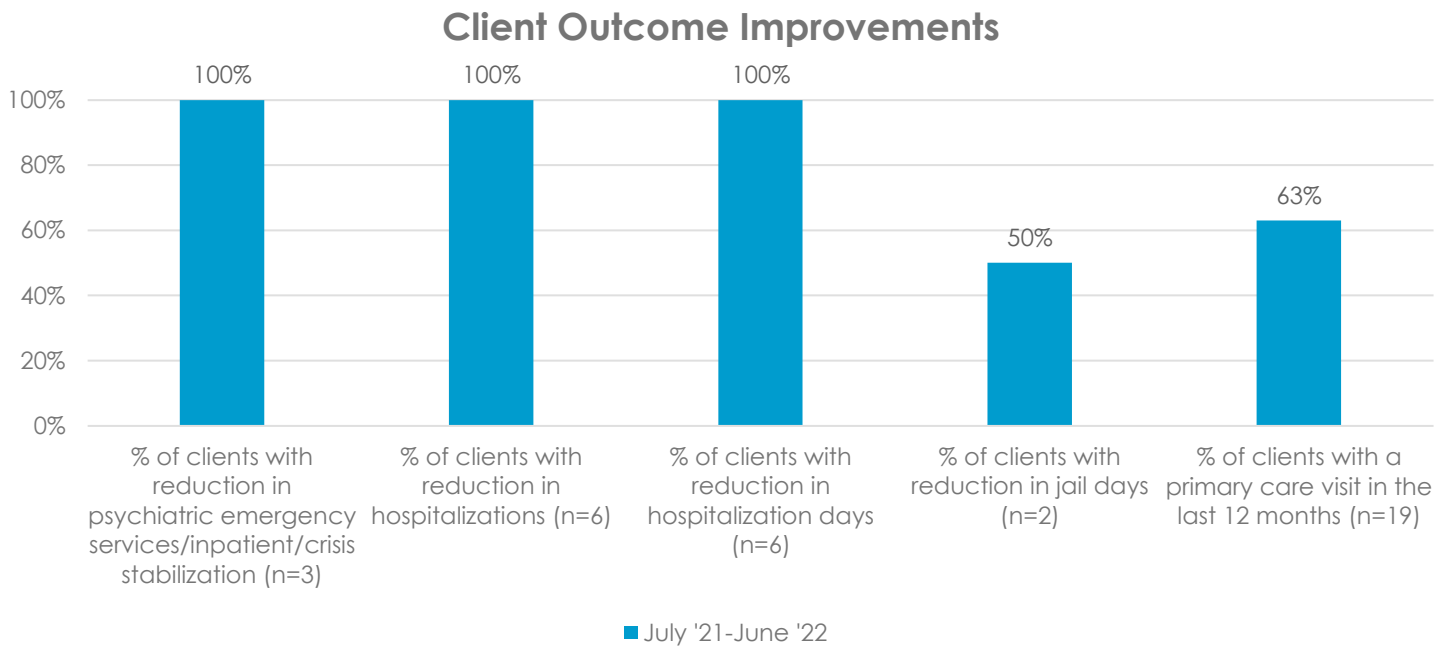
Hospital Follow Up Consistency

% of discharges from hospitalization or subacute who received FSP follow up within 7 and 30 days (n=10)





Impact Outcomes ("Is anyone better off?")



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 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 Plan as needed.

Data and information on Diversity & Multicultural Trainings and Events in FY22, is not available.

Transition Age Youth (TAY) Support Services

The Transition Age Youth (TAY) Support Services program provides outreach, services, supports, and/or referrals to TAY with serious mental health issues who are homeless or marginally housed and not currently receiving services. Priority is given to youth coming out of foster care and/or the juvenile justice system and particular outreach strategies are utilized to engage youth from various ethnic communities, including African Americans, Asian and Latino/a/x populations, among others. Program services include: Culturally appropriate outreach and engagement; peer counseling and support; assessment; individual and group therapy; family education; case management, coaching, ancillary program referrals and linkages. Also provided are services in housing attainment and retention, financial management, employment, schooling, and community involvement. Services are designed to be culturally relevant, tailored to each individual's needs, and delivered in multiple, flexible environments. The main goals of the program are to increase outreach, treatment services, and supports for mentally ill TAY in need, and to promote self-sufficiency, resiliency and wellness. This program serves 15-20 youth at a time. In FY22 this program was not implemented.

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 for 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 FY22, there were a total of 381 clients in the BMH system.

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

<u>Walking Groups</u>

In FY22 the Wellness Recovery Team continued with the offering of walking groups to help with isolation, promote physical activities and socialization. This group was started in 2020 and continues to be a great addition to the Wellness Recovery Activities/groups. The walks in FY22 took place at local parks and neighborhoods in Berkeley and they varied in physical intensity. Participants were required to wear masks and socially distance themselves during the activity. The walks were advertised in the Wellness Recovery monthly newsletter and calendars. There were 36 walks scheduled throughout the year. The parks visited were Ohlone, Grove,

Strawberry Creek, Codornices, Aquatic, and San Pablo Park and the University of California at Berkeley campus and Rose Garden. A total of 11 unduplicated individuals participated in the Walking Groups.

Field Trips

In FY22 there weren't any field trips held due to staff shortage and the COVID-19 pandemic.

Card Party Groups

In FY22 a total of 35 Card Party groups were offered to inspire individuals to create inspirational cards for individuals in psychiatric hospitals. This program is modeled after the Do-Send-A-Card program created by the San Francisco Mental Health Association. BMH Wellness Recovery staff partnered with the Alameda Network of Mental Health Clients' Reach-Out Program to distribute the cards that were created from the Card Party groups, when they visit the hospitals throughout the County. Patients can choose the card they want to receive. This group was conducted online and the participation was low due to doing the online format. Through this program 175 cards were created and given to the Reach-Out Program. This program has been operating on the Zoom platform and the participants used their personal craft materials to make cards for others. A total of 3 unduplicated individuals participated in the Card Party Groups.

Mood Groups

The Mood group is designed for people to share their thoughts and feelings in a safe place where support is offered. In FY22 the weekly support group focused on reviewing moods scales to help participants identify where they were and then share whatever they wanted among non-judgmental peers. This group was impacted in the attendance by the COVID-19 pandemic and conflict among participants. The group was held 23 times in the reporting year and a total of 3 unduplicated individuals participated.

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 FY22 there weren't any requests for this service.

The Wellness Recovery Team also conducted and participated in the following activities during the reporting timeframe: Maintained a monthly newsletter from July 2021-December 2021 that was written, edited and prepared by the Wellness Recovery Staff. The newsletter highlighted wellness tools, community resources, food recipes, fun activities, information about diagnoses, and interviews with community members. The newsletters were published and sent to approximately 150 individuals via mail and another 130 individuals by email. The team transitioned back to calendars in January 2022.

The team of two, became one in January 2022 and it had some impact on the number of groups and services that were provided to the community and peers. The team hosted a Peers Organizing Community Change (POCC) open house to promote peer organization, advocacy and leadership. The Wellness Recovery Team also participated in: The planning and implementation of the May is Mental Health Month event in Berkeley; the Health and Human Resource and Education Center-10x10 8 Dimensions of Wellness, "We move for Health 10x10"

campaign; POCC listening sessions; and the Alameda County Peer Support Specialist certification forums. The Wellness Recovery Team also conducted the Consumer Perception Survey in May 2022 by mail and in person during the State survey period and submitted completed surveys to the state.

In FY22, a total of 35 unduplicated individuals participated in Wellness Recovery services. Demographics on individuals served are as follows:

DEMOGRAPHICS N=35		
Gender Identity		
Gender Identity	*Number Served*	*Percent of Total Number Served*
Male	5	14%
Female	24	69%
Gender Non-Conforming	1	3%
Declined to Answer (or Unknown)	5	14%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*Percent of Total Number Served*
Black or African American	8	23%
Asian Pacific Islander	4	11%
Multi-racial	2	6%
White	14	40%
Declined to Answer (or Unknown)	7	20%
Age Category		
Age in Years	*Number Served*	*Percent of Total Number Served*
25-44 years of Age	4	11%
45-64 years of Age	23	66%
65 and older	3	9%
Declined to Answer (or Unknown)	5	14%
Sexual Orientation		
Heterosexual or Straight	7	20%
Bisexual	3	9%
Questioning	1	3%
Declined to Answer (or Unknown)	24	69%

Program Successes:
Groups continued to meet during the reporting timeframe and there was a consistent number of individuals who benefitted from the activities, especially Walking Group participants who enjoyed the socialization and physical activity it provided. Even though the Card Group met online, a staff member was able to arrange for the cards to be picked up and provided to an agency to be distributed to individuals at Board and Care's and locked facilities.

Program Challenges:
The number of groups that were provided to the community was scaled down due to only having one staff running the programs and groups. The Card Party Group which originally met four times a month had to be scaled back to meeting twice a month. The number of cards made were also reduced due to individuals not having the materials to make the cards, or drop them off, despite the efforts staff made available to them.

In FY22, 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.

In FY22, the RBA Outcomes for this program were as follows:

Wellness & Recovery Services RBA Outcomes

Reporting Period: July 2021-June 2022 (Baseline)

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

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

35

Participants served

8

Different groups convened

139

Group events

20

Participants who meet the requirements for "Telling Your Story"

represents 10 clients/events/groups

Quality Outcomes ("How well did we do it?")	Impact Outcomes ("Is anyone better off?")
71% of participants returned for group events	**4 out of 5** participants reported feeling less shame about their experiences and challenges (n=5). **3 out of 5** participants reported recognizing progress in their recovery (n=5).

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 FY22, there were a total of 381 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 FY22 a total of 14 family members were served. Demographics of individuals served are outlined below:

DEMOGRAPHICS N=14		
Gender Identity		
Gender Identity	*Number Served*	*Percent of Total Number Served*
Male	2	14%
Female	12	86%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*Percent of Total Number Served*
Black or African American	1	7%

Asian Pacific Islander	1	7%
White	11	79%
Multi-racial	1	7%
Age Category		
Age in Years	*Number Served*	*Percent of Total Number Served*
25-44 years	1	7%
45-64 years	6	43%
65+ years	7	50%
Sexual Orientation		
Declined to answer (or unknown)	14	100%

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. In addition, the global COVID-19 pandemic resulted in a pause of the Family Support Group which is reflected in the low number of individuals served during the reporting timeframe.

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

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

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

Housing Services and Supports

The Housing Specialist provides housing resource services for clients; working with landlords to increase housing opportunities; collaborating with case management staff, landlords, and Board & Care Managers to provide additional supports for clients who are already housed; and 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 FY22, 7 clients were served through this program. Demographics on those served were as follows:

DEMOGRAPHICS N=7		
Gender Identity		
Gender Identity	*Number Served*	*Percent of Total Number Served*
Male	4	57%
Female	2	29%
Gender Non-Conforming	1	14%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*Percent of Total Number Served*
Black or African American	3	43%
White	3	43%
Latino/a/x	1	14%
Age Category		
Age	*Number Served*	*Percent of Total Number Served*
18-24 years	1	14%
25-44 years	5	71%
45-64 years	1	14%

Sexual Orientation		
Declined to Answer (or Unknown)	7	100%

Program Successes:
In FY22, all cases were closed because they were won. In each case, the win was at the Initial or Reconsideration level of the SSI application process, the client did not have to wait for the next level of appeal, the Administrative Law Judge (ALJ) hearing, which often means an additional wait of over a year. Success at the Initial and Reconsideration stages of the process are fairly rare without advocacy and without treating providers who care enough to help document the case. Because of the MHSA-funded referral partnership between HAC and Berkeley Mental Health, these clients had both of these advantages.

Program Challenges:
The caseload for the year was lower than anticipated. Four of the referrals received during the fiscal year were closed without the case being taken due to either not being able to locate the client or the client being ineligible for SSI benefits. The process will continue to be reviewed to see if there are ways to improve the ability to connect with the clients that are referred, and to get referrals that are appropriate for the service.

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 FY22, there were a total of 381 clients in the BMH system.

Mobile Crisis Team (MCT) Expansion

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

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

In FY22, 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	• % of clients who receive a visit (phone contact with client or hospital provider)	• None available at this time

contacts	in the 24 hours after hospitalization • % of Mobile Crisis Team who had a Crisis, Assessment Team staff attempt to contact • % of clients who were satisfied with services**	

*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.

In FY22, the RBA Outcomes for this program were as follows:

Mobile Crisis Team (MCT) RBA Outcomes
Reporting Period: July 2021-June 2022 (Baseline)

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

932 Clients Served

=100 clients

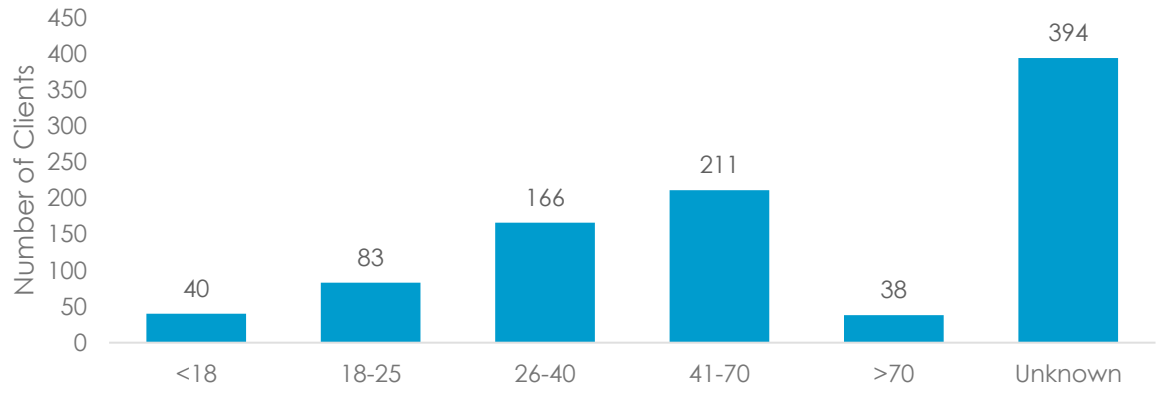
1486 Incidents Responded To

=100 incidents

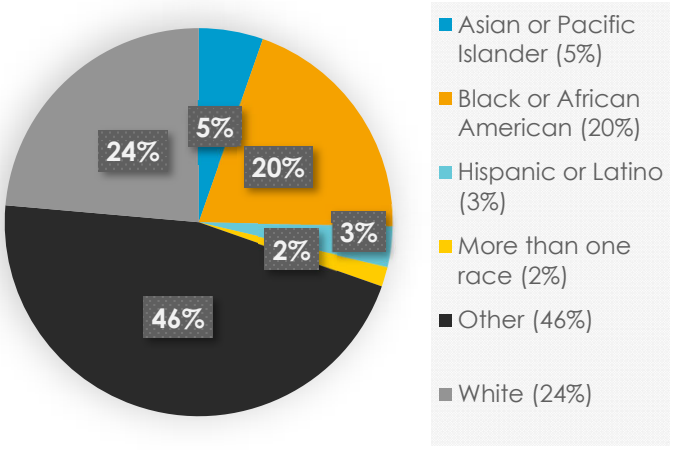
Program Description

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

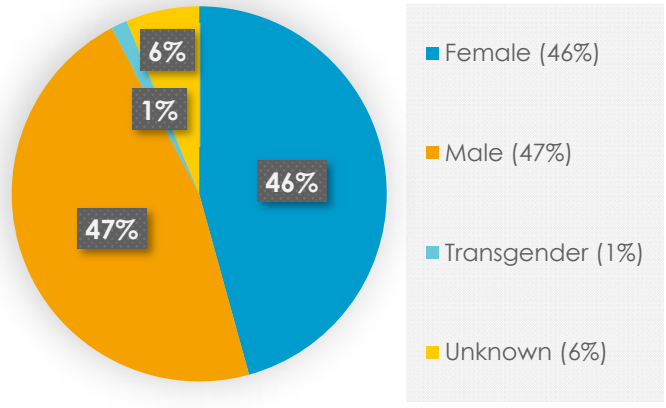
Demographics (Age)



Demographics (Race)



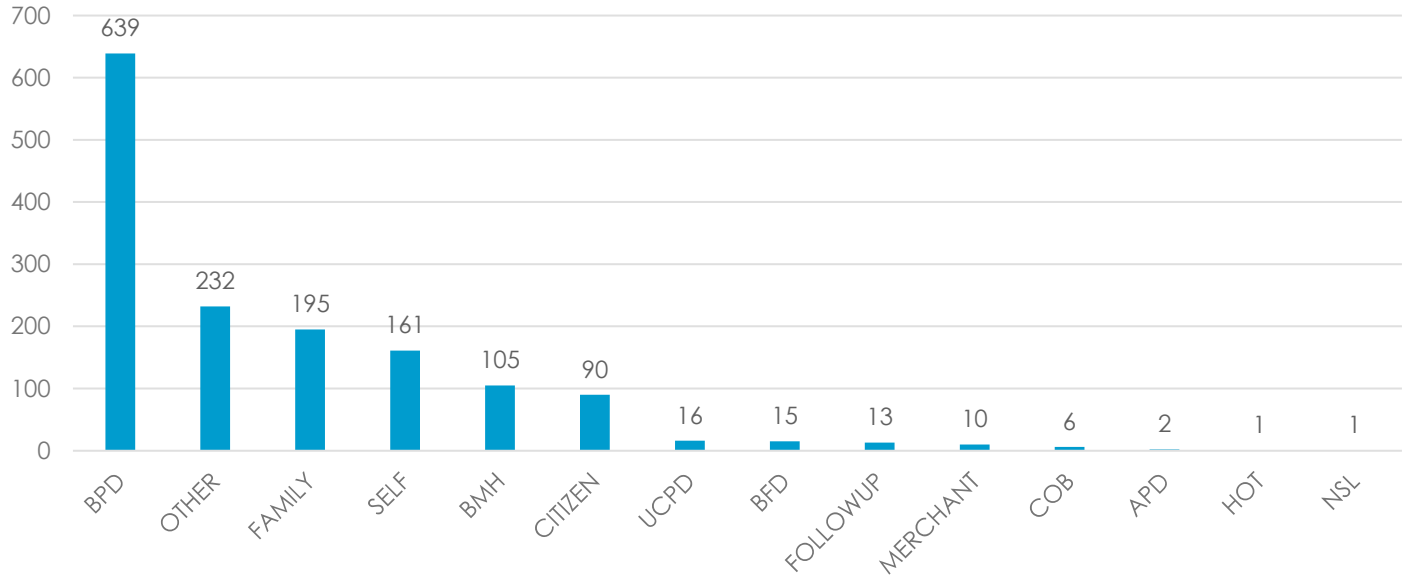
Demographics (Gender Identity)



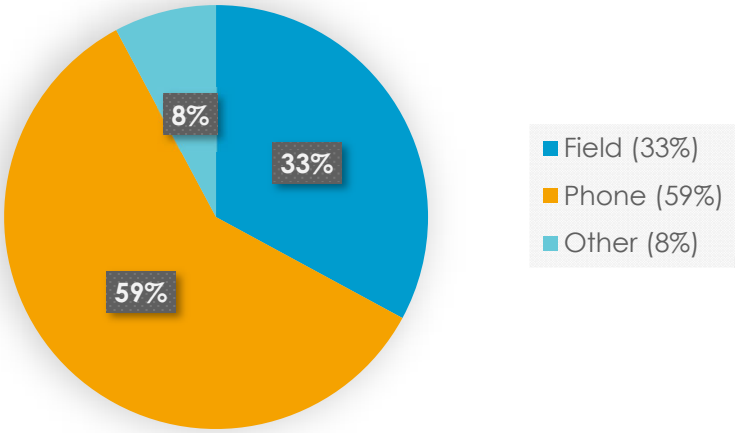
*Sexual Orientation data not available

In 2021-2022, the MCT program performed **395** 5150 Evaluations

Total Referrals, by Referring Party (n=1486)

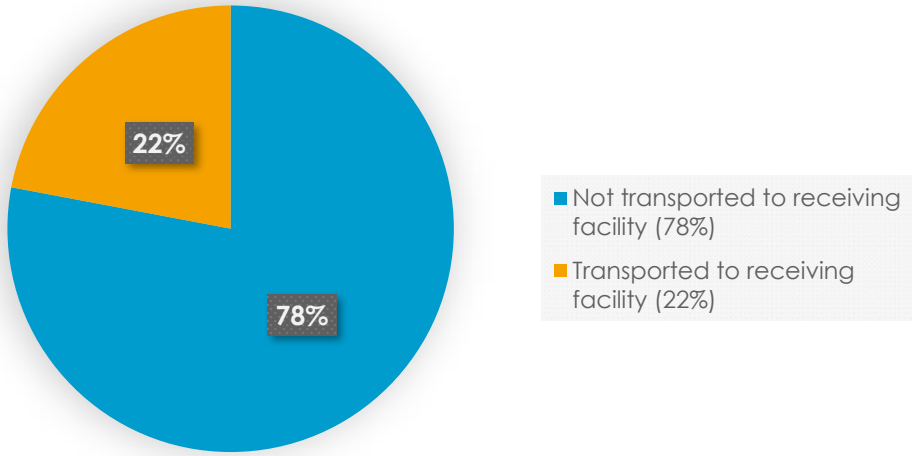


Client Contact Types (n=1486)



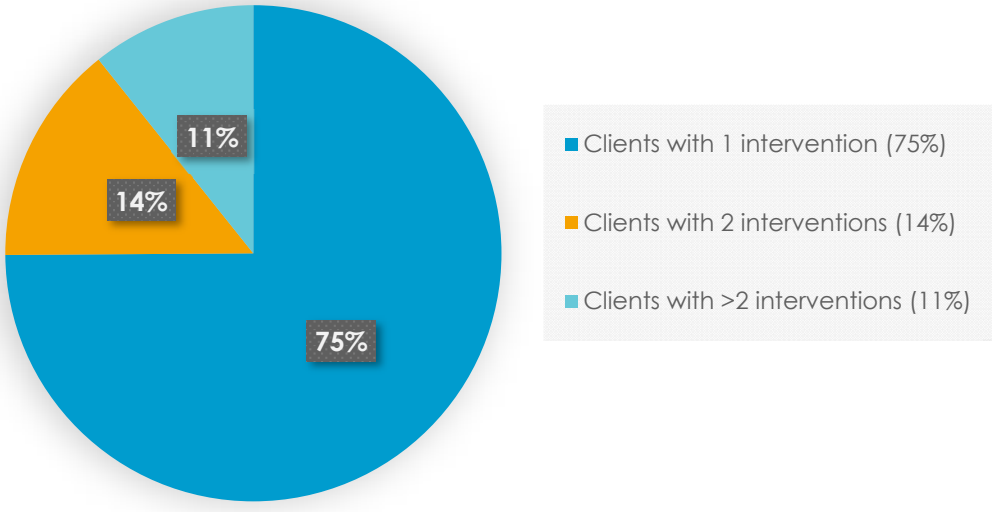
Quality Outcomes ("How well did we do it?")

Results of 5150 Evaluations (n=395)



Impact Outcomes ("Is anyone better off?")

Number of Interventions per Client (n=932)



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 FY22, 127 individuals were served through this project. Demographics on those served were as follows**:**

DEMOGRAPHICS N=127		
Gender Identity		
Gender Identity	*Number Served*	*Percent of Total Number Served*
Male	58	46%
Female	65	51%
Declined to Answer (or Unknown)	4	3%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*Percent of Total Number Served*
Black or African American	39	31%
Asian Pacific Islander	9	7%
Latino/a/x	7	6%
Multi-racial	1	<1%
White	34	27%
Declined to Answer (or Unknown)	37	29%
Age Category		
Age in Years	*Number Served*	*Percent of Total Number Served*
0-15	12	10%
16-25	18	14%
26-59	61	48%
60 years and older	18	14%
Declined to Answer (or Unknown)	18	14%
Sexual Orientation		
Declined to Answer (or Unknown)	127	100%

Services provided by this team are subject to the number of referrals that are generated by the Mobile Crisis Team crisis calls. Clients served by TOT often enter the crisis system with fewer resources such as collateral supports, lack of insurance, etc. As a result of the pandemic many services were switched from in-person to telephone supports and tele-health.

Outcomes during the reporting timeframe:

- 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, linkages, psychoeducation, and active support in connecting with needed services in Berkeley or elsewhere in the system of care.
- Provided remote outreach and engagement to individuals in inpatient settings who needed assistance connecting to treatment and were unlikely to make it to the clinic for an intake. Settings included John George Psychiatric Facility, Villa Fairmont, Herrick Hospital, Woodrow House, and other sites. TOT staff worked with facility staff in addition to mental health peers.
- 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. Also conducted in-person outreach at Horizon Transitional Shelter and Spark RV Park.
- Coordinated with other programs within the Division, including the Crisis/Assessment/Triage (CAT) On Duty staff; field-based services such as Mobile Crisis (MCT); the Homeless Outreach and Treatment Team (HOTT) which was discontinued in FY21 and replaced with the Homeless Full Services Partnership; and with the case management teams at the Adult and Children's clinics.

In September FY22, the TOT merged with the CAT team to form CAT/TOT. This was done due to several reasons: 1) One TOT staff resigned and there was only one remaining clinician; 2) Many of the duties completed by TOT were similar to those provided by the CAT team and it made sense to combine teams to increase flexibility of staffing capacity and services.

Program Successes:

- TOT continued to provide services during the COVID-19 pandemic, though the majority of the work was via telephone and other remote service options (e.g. Zoom).
- Continued to link individuals who may have had barriers, ambivalence, or difficulty engaging with the mental health system to appropriate and desired services through outreach and engagement.
- Although staff was decreased by 50% in 2021, once the TOT program was merged with the CAT Team, the numbers of contacts increased again.

Program Challenges:

- The COVID-19 pandemic led to psychiatric facilities and hospitals limiting or halting in-person visits, leading to a steep decline in possible outreach options.
- TOT as a program was set up as a two-person team. During FY22, one staff person resigned, which lead to a sharp decrease in the ability of staff to provide services.
- The data collection system utilized does not capture all necessary information that would support accurate outcome reporting.

In FY22, 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 • % of clients who were satisfied with services**	• None available at this time

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

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 FY22 RBA Outcomes, during the reporting period the TOT merged with the Crisis Assessment and Triage (CAT) team to form CAT/TOT as previously stated due to staffing limitations and to increase flexibility of staffing capacity. As a result of this merger, the number of clients served is higher than in previous years.

1) COVID-19 pandemic led to psychiatric facilities and hospitals limiting or halting in-person visits, leading to a steep decline in possible outreach options, both in person and via phone.

2) TOT as a program was set up as a two-person team. During FY22, one staff person resigned, which lead to a sharp fall in the ability of staff to provide services until the merger of the two teams and the increase of staff to provide TOT services.

RBA Outcomes in FY22 were as follows:

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

Reporting Period: July 2021-June 2022 (Baseline)

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

721 Clients Served

=100 clients

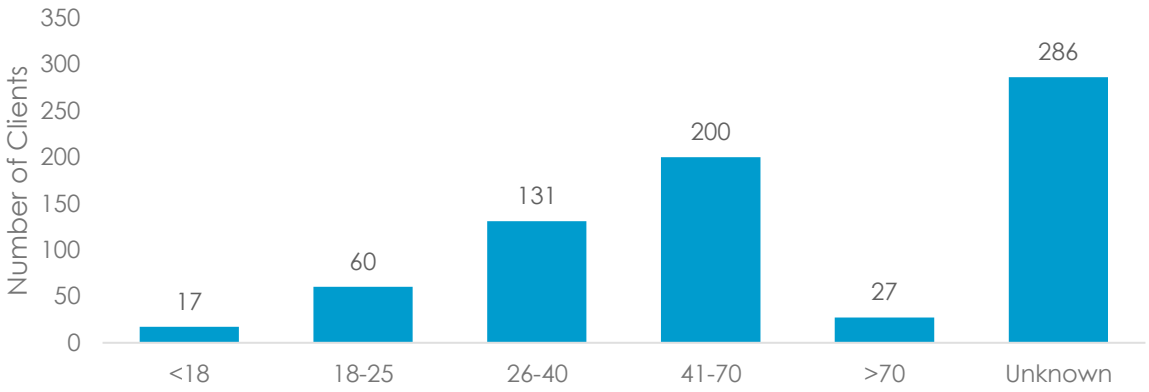
1448 Contacts

=100 contacts

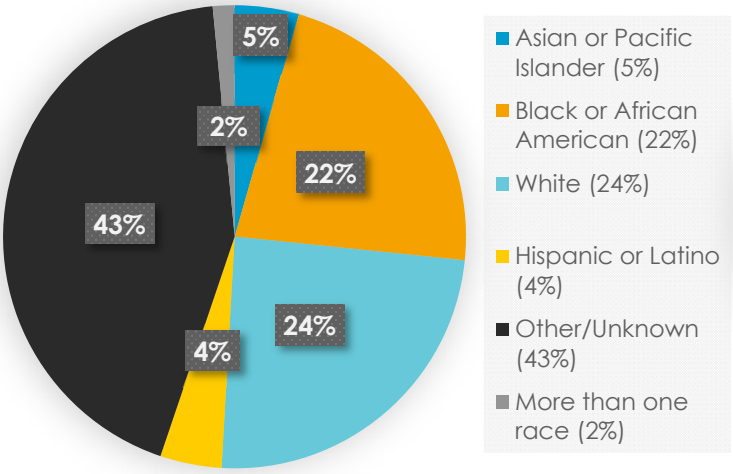
Program Description

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 our clinic, as well as via the team phone line.

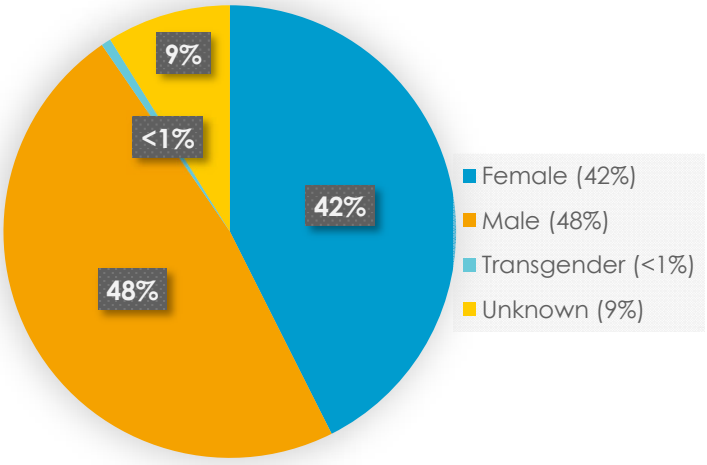
Demographics (Age)



Demographics (Race)



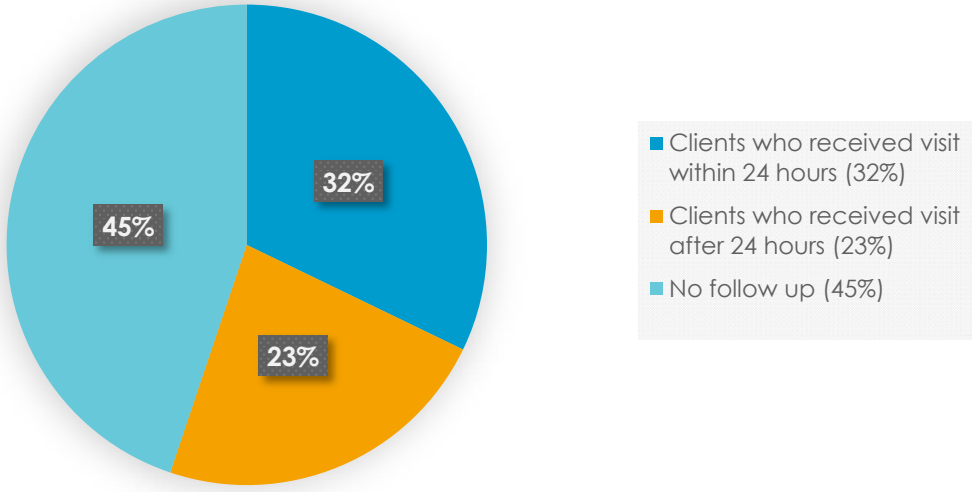
Demographics (Gender Identity)



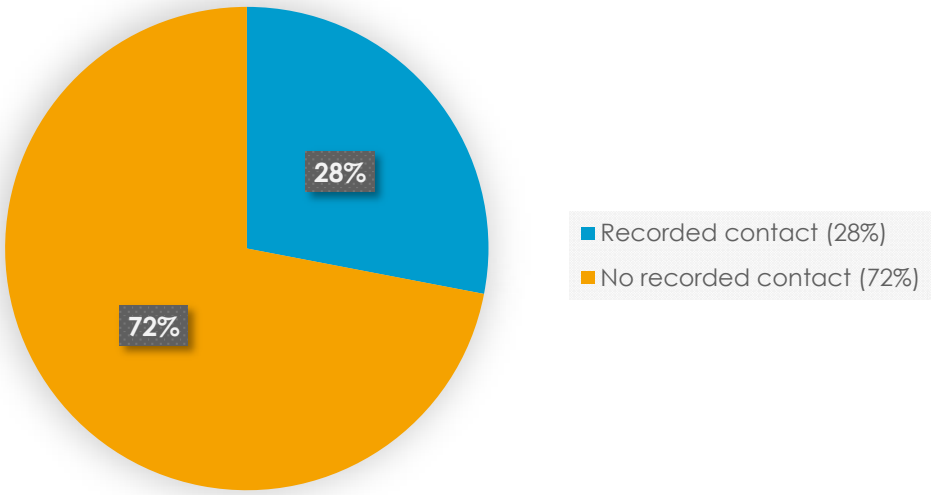
*Sexual Orientation data not available

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

Follow-up after hospitalization (n=87)



MCT contacts with CAT attempt to contact (n=932)



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 FY22, 75 individuals were served. Demographics on individuals served were as follows:

DEMOGRAPHICS N=75		
Gender Identity		
Gender Identity	*Number Served*	*% of total*
Male	53	71%
Female	22	29%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*% of total*
Black or African American	47	63%
Asian Pacific Islander	2	3%
Latino/a/x	8	11%
Native American	1	1%
White	22	29%
Age Category		
Age In Years	*Number Served*	*% of total*
18-24	2	3%
25-44	13	17%
45-64	29	39%
65 years or older	31	41%
Sexual Orientation		
Declined to Answer (or Unknown)	75	100%

Program Successes:

One of the biggest successes in working with individuals in the Sub-Representative Payee Program in FY22 was a collaboration with Horizon Transitional Village (HTV). In the HTV program individuals were able to bring their tents inside a gymnasium with all their supplies along with their peers. On-site staff included doctors, clinicians, case managers, and frontline workers who were there to provide wrap-around services. HTV closed in FY22, and transitioned to a different program.

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 FY22, a total of 986 individuals were served through weekly online support groups. Demographics on individuals served were as follows:

DEMOGRAPHICS N=986		
Gender Identity		
Gender Identity	*Number Served*	*% of total*
Male	385	39%
Female	601	61%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*% of total*
White	878	89%
Latino/a/x	53	5%
Unknown (Declined to Answer)	55	6%
Age Category		
Age Category	*Number Served*	*% of total*
25-44 years	237	24%
45-64 years	394	40%
65 years or older	296	30%
Unknown (Declined to Answer)	59	6%
Sexual Orientation		
Heterosexual or Straight	661	67%
Bisexual	108	11%
Gay	108	11%
Declined to Answer (or Unknown)	109	11%

Program Successes:

- Group attendance increased this year indicating the program's appeal to both adult voice hearers and family members.
- Groups were successfully transitioned on-line via zoom.
- Monthly training sessions were implemented for all group facilitators.
- This program is unique in the peer mental health community as it successfully includes clinicians, family members, and peers on their board of directors.
- Continued to offer a monthly, on-line newsletter to the mental health community.
- Received overwhelming positive feedback from participants about facilitators and groups.

Program Challenges:

- Continued efforts to have a larger presence on social media in order to reach more at risk, young people.
- Continued outreach efforts to increase newsletter circulation.

A survey questionnaire was sent to group participants during the reporting timeframe with a total of 34 individuals responding to the survey. Responses to survey questions on the impact of the groups were as follows:

How have the groups helped you?

- "It's given me tools for harm reduction."
- "A community of support'"

- “It has helped me deal with my voices and connected me to people who can help and relate to me!”
- “It has been great, please keep it going!”
- “The group helps me connect in a genuine way with others who don't judge or invalidate my experiences.”
- “It's a safe place to share my experiences; I feel like people understand me.”

How has the group changed your life?
- “The grouped has changed my life by helping me help myself and get through difficult times.”
- “Allowed me to become more stable.”
- “It is a forum which I can express myself.”
- “It has connected me to others who relate exactly to what I experience and listen!”
- “I feel less isolated and more confident that I can accomplish things in society.”
- “I am not alone.”

How has the group helped you deal with stigma?
- “I am not alone, I have an outlet.”
- “I am now able to understand how uncomfortable folks are about certain subjects and why they act or react the way they do. I realize it's not always about me, but instead it's about others' insecurity, ignorance, and their fear of the unknown.”
- “It is very helpful for that. I have more confidence, and twice I went looking and found work after many years of not working.”

What are the advantages/disadvantages of the group being on line?
- “Big advantage for me as I cannot commute.”
- “Though I enjoyed in person groups to an extent, I like virtual groups better. I don't have to leave the house and put myself in danger, deal with traffic and all that comes with that.”
- “Group has gotten better. More people from varied places can participate.”
- “I can quickly, silently and discreetly enter or exit the sessions in a virtual setting”
- “Great online! More people.”
- “Great diversity, I can come in the evenings.”
- “Transportation is an issue for me.”

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 FY22, 21 individuals participated in this program. Demographics on individuals served were as follows:

DEMOGRAPHICS N=21		
Gender Identity		
Gender Identity	*Number Served*	*% of total*
Male	8	38%
Female	13	62%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*% of total*
Black or African American	2	10%
White	19	90%
Age Category		
Age in Years	*Number Served*	*% of total*
46-64 years	16	76%
65 years and older	5	24%
Sexual Orientation		
Declined to State (or Unknown)	21	100%

Program Successes:

- The morning support group was strongly attended, and participants describe it as "essential" to their well-being.
- A new, peer-led, support group was added and well attended. It was implemented to encourage and support peer leadership. "A Writer's Workshop", a guitar class, and a yoga were also added.
- Art therapy has continued to be an exceptional program activity.
- Two iPads were acquired to teach computer skills which will provide better access in another pandemic-like situation.
- The Wellness Center received substantial donations of materials such as board games, puzzles, a CD player and CD's, a library of musical instruments, and a coffee maker, to transform one of the rooms into a place where individuals could feel warmly welcomed and could engage and interact between sessions.
- The first field trip, to Berkeley Art Museum and Pacific Film Archive (BAMPFA), was held at the end of the fiscal year. In FY22 it was envisioned that going forward, field trips would become a monthly activity as weekends are particularly difficult times for participants, when they are alone.

Program Challenges**:**

The program wasn't as well attended in the afternoons. Many program participants are drawn to a very popular program at the adult school. Staff have been developing connections with the teacher in that program to inform individuals of the Wellness Center services.

BMH Peer and Family Member Positions

Since the first MHSA Plan, BMH has included positions for peers and family members with lived experience to be added to various programs throughout the Division. The 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 FY22, 3 youth were served through this project. Demographic data on youth participants is outlined below:

DEMOGRAPHICS N=3		
Gender Identity		
Gender Identity	*Number Served*	*% of total*
Male	1	33.3%
Female	1	33.3%
Gender Non-Conforming	1	33.3%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*% of total*
Black or African American	2	67%
White	1	33%
Age Category		
Age Category	*Number Served*	*% of total*
18-24 years	3	100%
Sexual Orientation		
Heterosexual or Straight	2	67%
Bisexual	1	33%

Program Successes:
Program staff provided a significant amount of outreach and were able to begin to establish a presence at area locations. Three clients were successfully enrolled into the program. The youth served during the reporting timeframe were provided engagement, wellness planning, individual counseling, and linkage to services they needed. All youth were successfully transitioned out of the program to less intensive services within and outside of the agency. In order to begin to establish a clinical and programmatic support structure for staff providing case management to youth who experience significant mental health and neurological challenges, planning began in the last quarter of FY22 for the implementation of a Wellness Team.

Program Challenges:
The program continued to have significant challenges with staff retention, outreach efforts not producing meaningful partnerships with providers or enrollments, and lack of management support to assist with program development, personnel management, and management-level coordination with potential collaborating organizations serving at risk TAY. The program invested in the recruitment and onboarding of an experienced full-time social worker, who left the agency seven weeks after being hired. The staff departure put a strain on relationships nurtured during the prior 6 months and left the program understaffed. Recruitment efforts continued during the reporting timeframe.

Staff reported that outreach efforts at Berkeley High and Berkeley Tech were difficult to coordinate with school staff, who were not very responsive and had little time for new initiatives in the midst of coping with pivoting for providing education in the midst of the COVID-19 pandemic. Consistency and outreach in other locations was challenged by COVID-19 pandemic restrictions, the public's general fear of face-to-face contact, and staff illnesses. Program challenges were compounded by the agency's rapid growth and lagging recruitment of management and development of infrastructure to support the expansion.

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. It is envisioned that services will be implemented in FY24 through a community partner.

Results Based Accountability Evaluation

As a result of feedback received regarding the need for increased evaluation efforts, 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. In FY19 a competitive RFP process was executed, and Resource Development Associates (RDA) was the chosen consultant. In FY21, RDA began working with the Division and a Community Advisory Group of key stakeholders, to execute this evaluation.

In FY22, RDA facilitated staff workshops, developed and finalized program and division-level RBA measures, collected program data, and laid the groundwork for developing program dashboards. Activities are outlined detailed below:

- Conducted 16 meetings (1 with BMH management; 2 with BMH program staff; 11 check in meetings with BMH management/program staff; and 2 meetings with the Community Advisory Group to review, provide feedback and finalize measures).
- Trained BMH staff/managers on headline measures, data development agenda items and how to prioritize measures.
- Mapped program identified measures against the available data and BMH staff/managers reviewed it for accuracy.
  - Worked with BMH staff/managers on prioritizing measures.
  - Selected headline measures and set data development agenda with guidance and feedback from BMH management and the Community Advisory Group.
  - Cross-walked measures to streamline and provide consistency.
  - Worked with BMH on data availability.
  - Updated data development agendas based on availability.
  - Worked with BMH to confirm Division-wide measures.
  - Worked with Community Advisory Group to obtain feedback on Division-wide measures.
- Finalized program and Division-wide measures.
- Developed the Data collection plan.
- Developed document that tracks all data sources, parameters for data collection, and data queries by data source and program.
- Began developing a program-level template and dashboard. This work continued in FY23.
  - Began development of a Division "scorecard" or dashboard. This work continued in FY23.
  - Began requesting baseline data from each program. This work continued in FY23.

In FY23, RDA collected, analyzed and reported on FY22 RBA Division-wide data. The RBA outcomes for FY22 are outlined throughout this Three-Year Plan 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 C.

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 97 individuals received services in FY22, however as data wasn't collected in the 1st and 2nd quarters, demographics reflect data collected on 64 individuals who received services in the 3rd and 4th quarters of the year.

DEMOGRAPHICS N=64		
Gender Identity		
Gender Identity	*Number Served*	*% of total*
Male	14	22%
Female	50	78%
Race/Ethnicity		
Race/Ethnicity	*Number Served*	*% of total*
Black or African American	4	6%
Asian Pacific Islander (API)	9	14%
White	47	74%
Multi-racial	2	3%
Unknown (Declined to Answer)	2	3%
Age Category		
Age Category	*Number Served*	*% of total*
45-64 years	2	3%
65 years and older	62	97%
Sexual Orientation		
Heterosexual or Straight	57	89%
Lesbian	2	3%
Gay	3	5%
Bisexual	2	3%

Program Successes:
According to the Aging Division that oversees this program, the Wright Institute has been a very reliable and collaborative partner. They have been open and available to meet with Aging Services staff to discuss needs of older adult community, and to brainstorm best ways to promote therapeutic groups and workshops. Their clinicians have been skilled, as well as committed and flexible in meeting with members of the older adult community. Their promotional flyers for the groups and workshops have been easy to read and are shared promptly in order to maximize attendance. They have provided a valuable service, as many older adults have expressed appreciation anecdotally.

Program Challenges:
There were some initial program initiation pains in the beginning. Registration and intake processes were not solidly defined and were hard to navigate for older adults as they were not able to speak to a person directly. Additionally, the Aging Division would receive flyers and announcements for groups after the monthly newsletter deadline, so they were unable to

promote the groups in advance, or in a timely manner. These processes have since been streamlined. There were also some minor miscommunication situations that resulted in confusion around group and workshop outreach and registration. This again, was also promptly addressed.

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. A contract with a local provider was executed in FY23. 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.

Specialized Care Unit

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

In FY21, Resource Development Associates (RDA), chosen through a competitive Request for Proposal (RFP) process to evaluate the current crisis system in Berkeley, received an expanded scope of work to provide recommendations on the implementation of the SCU. To oversee and advise RDA in their work, the City formed an SCU Steering Committee consisting of Health, Housing and Community Services Department and Fire Department staff, and community representatives from the Mental Health Commission and the Berkeley Community Safety Commission. The Steering Committee met from January 2021 through January 2022 and advised on RDA's completion of three critical reports. The first two reports summarized crisis response programs in the United States and internationally as well as gathered perspectives from community and City stakeholders regarding the crisis response system. This included gathering input from City of Berkeley and Alameda County agencies, local community-based organizations (CBOs), local community leaders, and utilizers of Berkeley's crisis response services. These reports laid the foundation for the twenty-five recommendations that were the subject of the third and final report to inform the SCU model. Each recommendation put forth in the final report is deeply rooted in the stakeholder feedback included in the two previous reports.

In Spring 2022, the design for the SCU received City Council approval and the work of the SCU Steering Committee transitioned from planning to implementation. At the beginning of FY23, the City of Berkeley launched a competitive RFP process, which included providing live question and answer as well as published resources on the City website. After an extensive review process, the City chose Bonita House to implement the SCU pilot program.

Since the beginning of 2023, Bonita House has taken initial steps to implementing the SCU including: selecting an operating location for the program, working with the City to obtain response vehicles, and hiring staff. The Berkeley and Bonita House teams are hoping to launch a version of the SCU at the end of FY23, or beginning of FY24, as the full program ramps up.

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 is in process of being executed through the Housing and Community Services Division of HHCS, to allocate funding for this purpose and provide monitoring and oversight.

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 the funding allocated for this use, 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 D of this Three-Year Plan is the Prevention & Early Intervention (PEI) Fiscal Year (FY) 2021/2022 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. An aggregated summary of some of the results of this initiative are outlined in the PEI Community Education & Supports program section of this Three-Year Plan.

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 FY22 are outlined throughout this Three-Year Plan 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 C.

PEI Regulations

Per PEI State Regulations, Mental Health jurisdictions are to utilize PEI funds to implement the following programs: Prevention, Early Intervention, Access and Linkage to Treatment, Stigma and Discrimination Reduction, and Outreach for Increasing Recognition of Early Signs of Mental

Illness. Programs and/or strategies within programs can also be combined. Jurisdictions may also opt to utilize some PEI funds to implement a Suicide Prevention program. The definitions of each program are outlined below along with the City of Berkeley corresponding program:

PEI Program Type	Program Definition	City of Berkeley PEI Program(s)
Prevention	A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors.	• Mental Health Promotion Campaign • High School Prevention • DMIND • MEET • African American 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)
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 Three-Year Plan. Many PEI projects meet multiple established priorities. Per PEI regulations, outlined below are the City of Berkeley PEI programs, priorities, and FY24 projected funding amounts:

CITY OF BERKELEY PEI PROGRAMS	PEI PRIORITIES	FY24 Projected Funding Per Priority
• Be A Star • Supportive Schools	Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.	$148,551
• High School Youth Prevention Project • Mental Health Peer Mentor Program • Dynamic Mindfulness Program • Specialized Care Unit • African American Success Project	Youth Engagement and Outreach Strategies that target secondary school and transition age youth 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)	$865,280 $141,389 $68,000 $150,000
• 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 not in college. Strategies targeting the mental health needs of older adults.	$409,000 $32,046 $32,046

PEI Funded Children and Youth and TAY Services

Per MHSA regulations 51% of PEI funds are to be used on services and supports for Children, Youth, and TAY. Small counties, of which the City of Berkeley is considered, may elect to forego this regulation as long as a community vetted, locally approved justification is provided as to why children and youth services are funded at a lower level. Since the initial PEI Plan, the City of Berkeley has allocated more than 51% of PEI funds to services and supports for children, youth and TAY as the majority of PEI funds has been utilized to serving these populations.

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

Programs and services funded with PEI funds that are proposed to be continued through this Three Year Plan, and FY22 data are outlined below by PEI Program type.

PREVENTION PROGRAMS

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

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 envisioned that this campaign will be implemented in FY24 and the Division will continue to work with the community to determine how to best promote mental health and wellness in Berkeley.

EARLY INTERVENTION PROGRAMS

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

The City of Berkeley Early Intervention programs are as follows:

Early Childhood Health and Wellness Program (formerly named Behavioral-Emotional Assessment, Screening, Treatment, and Referral - BE A STAR)

The Early Childhood Health and Wellness program is a collaboration with the City of Berkeley's Public Health Department providing 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 FY22, a total of 1,654 children were screened through this program (183 at BUSD, and 1,471 at the Help Me Grow sites) however data was not collected on all individuals screened. Only Race/Ethnicity data was collected on a subset the 183 children screened at BUSD as follows:

DEMOGRAPHICS N=183	
Age Groups	
0-15 (Children/Youth)	100%
Race	
Asian	19%
Black or African American	25%
White	20%
More than one Race	8%
Other	4%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican/Mexican-American/Chicano	24%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	100%
Primary Language	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Gender: Assigned Sex at Birth	
Declined to Answer (or Unknown)	100%

Program Successes:

- In FY22 on-site technical assistance visits to all Berkeley Help Me Grow providers resumed and the visits went well.
- The program conducted 1,654 ASQ developmental screenings in Berkeley.
- BUSD referred a total of 53 preschool students and the Help Me Grow providers referred 94 infants/children.
- Approximately 78% of all Help Me Grow referrals reached their goals.

Program Challenges:

- Continued to see an impact of the COVID-19 pandemic on program services which decreased the number of screenings that were conducted.
- Staffing changes/turnovers at the Berkeley Help Me Grow sites impacted the continuity of the partnership with the program.
- The Help Me Grow sites did not collect race/ethnicity, language spoken data, or gender; and BUSD did not collect specific ethnicity data, language spoken for all students who received an ASQ, or gender.
- There was a delay in getting the annual data for the Help Me Grow sites.

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 FY22 Early Intervention Services were provided at each of the BUSD elementary schools. BUSD sub-contracted with local agencies to provide early intervention services based upon the standard of evidence-based practices. Bay Area Community Resources (BACR), Child Therapy Institute (CTI), and Lifelong Medical (Lifelong) were subcontracted to provide services at BUSD elementary schools.

BACR provided services to improve emotional functioning and success in school and life, including individual and group therapy, family consultation, conflict resolution/restorative justice, suicide prevention, check-in/check-out, crisis intervention, and classroom presentations. Additionally, BACR participated in weekly Coordination of Services (COST), Student Success Team (SST), and Individualized Education Program (IEP) meetings for students, providing mental health and trauma informed perspectives. BACR consulted with staff on many issues and provided trauma informed coaching for teachers needing support. BACR also made referrals to outside providers, parenting classes/support groups, crisis hotlines, and other programs. Due to the continuation of the impacts of the COVID-19 pandemic, BACR also provided resource networking and support for families in navigating the public health crisis.

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

Supports for each school per each service provider, and numbers served in FY22 were as follows:

Elementary School	Agency/Provider	Number of Students Served
• Cragmont • Emerson • John Muir • Malcolm X • Oxford • Ruth Acty • Sylvia Mendez • Thousand Oaks	Bay Area Community Resources (BACR)	420
• Bay Area Arts Magnet (BAM) • Washington	Child Therapy Institute	55
• Rosa Parks	Lifelong Medical Care	116
Total		**591**

Demographic data provided by BUSD on 591 students that were served through this project in FY22, is outlined below:

DEMOGRAPHICS N= 591	
Age Group	
0-15 (Children/Youth)	100%
Race	
American Indian or Alaska Native	3%
Asian	6%
Black or African American	25%
Native Hawaiian/Pacific Islander	<1%
White	47%
More than one Race	20%
Declined to Answer (or Unknown)	1%

Ethnicity: Hispanic or Latino/Latina/Latinx	
Unspecified Hispanic or Latino/Latina/Latinx	34%
South American	<1%
Declined to Answer (or Unknown)	1%
Ethnicity: Non-Hispanic or Non- Latino/Latina/Latinx	
Black or African American	15%
Asian Indian/South Asian	<1%
Chinese	1%
Eastern European	27%
European	1%
Filipino	1%
Other	4%
More than one Ethnicity	8%
Declined to Answer (or Unknown)	7%
Primary Language Used	
English	25%
Spanish	3%
Declined to Answer (or Unknown)	72%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Communication Domain	<1%
Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)	5%
Declined to Answer (or Unknown)	8%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	15%
Female	14%
Declined to Answer (or Unknown)	71%

Current Gender Identity	
Male	53%
Female	44%
Transgender	<1%
Genderqueer	<1%
Other Gender Identity	2%

Community-Based Child & Youth Risk Prevention Program

Through FY22, the Community-Based Child & Youth Risk Prevention program targeted children (aged 0-5) who were impacted by multiple risk factors including trauma, family or community violence, familial distress, and/or family substance use disorders, (among other issues). A BMH clinician served as the Mental Health Consultant on this project providing information, services and supports to teachers and parents at the YMCA Head Start program in South Berkeley. Services included individual case consultation for teachers and parents, group consultations, classroom observations and interventions, assessments, brief treatment, and referrals to other resources as needed. The main goals were to reduce risk factors or other stressors, and promote positive cognitive, social, and emotional well-being. This program served approximately 50 Children & Youth a year.

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

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

This program was discontinued in April 2022 when the BMH Mental Health Consultant received a promotion to a different position. Once that position was vacated the YMCA Head Start program decided to create an internal staff position for a Mental Health Specialist.

In FY22, 41 children were served through this program. Demographics on those served is as follows:

DEMOGRAPHICS N=41	
Age Groups	
0-15 (Children/Youth)	100%
Race	
Asian	5%
Black or African American	44%
White	2%
Other	12%

More than one Race	2%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Declined to Answer or Unknown	35%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	100%
Primary Language	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Gender: Assigned Sex at Birth	
Declined to Answer (or Unknown)	100%

Program Successes:

- Returned to in-person Mental Health Consultations in the summer of 2021 which enabled the provision of in-person classroom consultation and direct interventions with children and teachers; increased visibility and interactions with parents; and helped to improve the overall collaborations with administrators, teachers, and parents.
- Participated in person in meetings with parents, teachers and administrators to provide direct consultation around behavior management in the classroom and at home.
- Modeled parent engagement strategies for teachers, advocates and staff. Modeling how to have difficult conversations using a trauma-informed perspective is essential to mental health consultations.
- Provided in vivo conflict management among teachers and with parents as well as provided case management and support as conflicts occurred.
- Return to in-person care also enabled the Mental Health Consultant to be able to observe classrooms and child behaviors over a period of time at different times of the day which allowed for better overall clinical understanding of the children's behaviors and needs, and improved their ability to make recommendations for services and classroom interventions.

Program Challenges:

- The onsite manager at the YMCA resigned mid-year, which made collaborating with the teachers and classroom staff challenging.
- There were center and classroom closures and due to flooding in the infant room.
- COVID-19 pandemic exposures continued to impact the center and caused temporary classroom closures that caused disruptions to the continuity of care.

Community Education & Supports

The Community Education & Supports program implements culturally-responsive psycho-educational trauma support services for individuals (18 and above) in various cultural, ethnic,

and age specific populations that are unserved, underserved and inappropriately served in Berkeley including: African Americans; Latino/a/x; LGBTQIA+; TAY; and Senior Citizens. All services are conducted through area community-based organizations.

In FY22 three of the five contractors in the Community Education & Supports project participated in the HHCS Results-Based Accountability (RBA) Evaluation. RBA evaluation results are presented in an aggregated format across all programs as follows:

How Much Did We Do?	How Well Did We Do It?	Is Anyone Better Off?
• 527 Support Groups/Workshops • 2,427 Support Groups/Workshop Encounters • 121 Individual Contacts (2 of 3 programs reporting) • 132 Outreach Activities • 1.815 Outreach Contacts • 443 Referrals	• 94% of program respondents reported satisfaction with the services they received • Referrals by type: 135 Mental Health 55 Social Services 72 Physical Health 20 Housing 161 Other Services	• 90% of program participants reported an increase in social supports or trusted people they can turn to for help • 92% of program participants reported positive changes in terms of coping strategies, feeling anxious or overwhelmed

Descriptions for each of the five projects within the Community Education & Supports program and FY22 data are outlined below:

➢ **Transition Age Youth Trauma Support Project**

In FY22 this project was 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 FY22, 105 TAY participated in one or more program services. Demographics on youth served were as follows:

DEMOGRAPHICS N = 105	
Age Group	
16-25 (Transition Age Youth)	99%
26-59 (Adults)	1%
Race	
American Indian or Alaska Native	1%
Asian	4%
Black or African American	12%
White	2%
More than one Race	8%
Declined to Answer (or Unknown)	47%
Ethnicity: Latino/Latina/Latinx	
Other	12%
Declined to Answer (or Unknown)	13%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	74%
Primary Language Used	
Declined to Answer (or Unknown)	100%
Sexual Orientation	
Gay or Lesbian	13%
Heterosexual or Straight	22%
Declined to Answer (or Unknown)	65%
Disability Status	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Declined to Answer (or Unknown)	100%

Current Gender Identity	
Male	23%
Female	11%
Genderqueer	7%
Declined to Answer (or Unknown)	59%

Project Successes:

- Improved and integrated Art as Therapy content and ironed out project logistics.
- Conducted outreach to 59 youth, made numerous contacts to other providers and organizations, and conducted events to publicize project services.
- Successfully engaged increasing numbers of youth into Art as Therapy and Peer Mentoring over the course of the last three quarters of the year. Art as Therapy sessions consisted of activities that both teach art and provided a forum for sharing challenges common to TAY.
- Although, the program was not able to consistently conduct youth surveys, staff reported that youth indicated that services were helpful. Increased attendance was also an indication that Art as Therapy and Peer Mentoring sessions were valuable to the youth participants.
- Despite challenges with engagement, project outreach efforts resulted in 21 TAY trying out the Behavioral Health support groups. This progress was disrupted by staff turnover and attendance dropped off towards the end of the reporting timeframe.
- Engaged 29 new TAY into Peer Mentoring training. Meetings were held on a weekly basis at the Tiny House Empowerment Village (THEV) serving the residents there, as well as other youth in the community. Transportation was provided for youth at the studio to easily attend the meetings.
- Many of the youth were pursuing education in the social services field or they wanted to explore this opportunity to see if they wanted to be in the field. The youth received training on healthy communication, coping with crisis and de-escalation, giving constructive feedback, health insurance and other topics. Youth were encouraged and supported to share and teach topics they found interesting to their peers.
- Six events were planned and conducted with 55 total youth in attendance. Youth expressed that they enjoyed and valued these events and would attend more if offered.
- In FY23 a new Director of Operations was hired who brings extensive experience in supporting agencies to develop and provide transformational services to youth and adults.

Project Challenges:

- Project challenges were compounded by the agency's rapid growth over the past two years, staff turnover, and lagging recruitment for the management function needed to operationalize the expansion, develop infrastructure, and implement better systems to gather client data and track outcomes.
- Engaging youth in services was challenging due to continued concerns and fears about the COVID-19 pandemic, and staff turnover, and the process of nearly doubling the services offered by this contractor during the COVID-19 pandemic.

- The holiday season seemed to impact responsiveness from the school district as school staff prepared for the end of the semester and district closure during the holidays. During this time, Omicron also became a serious threat and schools were again overwhelmed with new and changing restrictions. These factors caused significant barriers to having a consistent presence at the schools, along with delays in communication regarding the project implementation efforts and coordinating outreach and logistics for groups and events.
- The project social worker engaged both staff and students at Berkeley High and Berkeley Technical Academy (BTA), attending weekly staff meetings at BTA, conducting outreach to students on both campuses, and presenting about PEI activities in classes at different times throughout the year, although consistency was difficult to achieve during the COVID-19 pandemic and holiday season. Despite these efforts, students were not readily engaged and project attendance was inconsistent. Reports were that staff seemed to be ambivalent about new initiatives. Feedback from two students indicated that they (and their friends) didn't want mental health type services and that they didn't want to attend groups during their free period when they have a break from classes.
- By the beginning of March 2022 many of the existing participants obtained full time jobs and could no longer commit to the project activities.

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

Implemented through the Pacific Center for Human Growth, this project provides outreach, engagement and support group services for individuals (18 and above) in the LGBTQIA+ community who are suffering from the impact of oppression, trauma and other life stressors. Particular emphasis is on outreaching and providing supportive services to identified underserved populations within the local LGBTQIA+ community. 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 FY22, a total of 439 support groups were conducted, serving 45 individuals. *Demographics on individuals served include the following:

DEMOGRAPHICS N=45	
Age Groups	
16-25 (Transitional Age Youth)	29%
26-59 (Adult)	62%
Ages 60+ (Older Adult)	2%
Declined to Answer (or Unknown)	7%
Race	
Asian	16%
Black or African American	11%
White	42%
More than one Race	13%
Declined to Answer (or Unknown)	18%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Caribbean	2%
Central American	2%
Puerto Rican	2%
South American	2%
Declined to Answer (or Unknown)	2%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	4%
Asian Indian/South Asian	7%
Chinese	2%
Eastern European	2%
European	22%
Filipino	2%
Korean	4%
Middle Eastern	2%
More than one Ethnicity	20%

Declined to Answer (or Unknown)	24%
Primary Language Used	
English	98%
Declined to Answer (or Unknown)	2%
Sexual Orientation	
Gay or Lesbian	9%
Heterosexual or Straight	7%
Bisexual	18%
Questioning or Unsure	9%
Queer	22%
Another Sexual Orientation	24%
Declined to Answer (or Unknown)	11%
Disability	
Difficulty Seeing	2%
Mental (not Mental Health)	9%
Chronic Health Condition	4%
Other (Specify) – More than one disability	7%
No Disability	78%
Veteran Status	
No	98%
Declined to Answer (or Unknown)	2%
Gender: Assigned Sex at Birth	
Declined to Answer (or Unknown)	100%
Current Gender Identity	
Male	4%
Female	13%
Transgender	31%
Genderqueer	11%

Questioning or Unsure	4%
Another gender identity	29%
Declined to Answer (or Unknown)	7%

*(From Project staff report, the state PEI demographic data requirements requires the inclusion of percentages, therefore the contractor had to code folx – used to explicitly signal the inclusion of groups commonly marginalize - with any multiple identities, into some form of a "multiple identity" category or "other" category. For example, in the ethnicity section when folx selected multiple ethnicities, it was reported as "More than one ethnicity." While this strategy generally works well to reduce confusion by ensuring legible percentages, this manner of reporting is reductive and doesn't allow for the full picture of the data. For instance, someone who identified as both Native and white is only being reported as "multiple races" and therefore, the category for Native participants is blank. This caused it to appear as though there weren't any Native participants in the project, when there were. The demographic reporting structure required simply does not allow for the level of detail and nuance needed to have a fuller picture of the project data).

There were 76 referrals for additional services and supports. The number and type of referrals were as follows: 24 Mental Health; 27 Physical Health; 2 Social Services; 23 other unspecified services. To assess the project services, a self-administered Peer Support Group Survey was distributed to all peer group members. Survey results were as follows:

- 81% indicated they would recommend the organization to a friend or family member;
- 77% felt like staff and facilitators were sensitive to their cultural background;
- 77% reported they deal more effectively with daily problems;
- 70% indicated they have trusted people they can turn to for help;
- 79% felt like they belong in their community.

Program Successes:

- The impact of the COVID-19 pandemic continued to be felt throughout the LGBTQIA+ community. The project continued providing peer groups online, providing spaces for the community members to gather; to receive and provide emotional support, feel a sense of belonging and connection; and to share resources.
- Some folx were not able to move to the online space due to privacy concerns, other safety issues, lack of devices, or unstable Wi-Fi. Despite that, the peer group facilitators reported that many of their group members expressed appreciation for the access to the virtual space during a time of increased isolation, especially those with chronic pain, disability, transportation or other barriers to in-person services.
- Community members also asked about possibilities of new groups for FY23 including: Q-Finity for neurodiverse folx; a group focusing on the needs of the QT polyamorous community; a parents group; as well as a restarting of the Thursday Night Men's group. New peer group facilitators were scheduled to be onboarded in Aug 2022.
- Opportunities for project outreach increased dramatically through the website, and through

the Meetup, Instagram and Facebook accounts.

- A few quotes from feedback forms on the support group were as follows:
  "I love the sense of community and support I feel in the group."
  "Thank You for holding the space."
  "I found the group understanding and supportive and [it] makes me feel I am not alone on an island, as others have [the] same circumstances."

Program Challenges:

- With more online offerings, the facilitators had additional work to do including checking their email frequently, coping with technology issues, navigating facilitation while some group members and even facilitators joined via phones. These challenges were used as an opportunity to evaluate how to support facilitators as the project migrates to an in-person/hybrid model and how facilitators can be set up to easily navigate the technological needs.
- While COVID-19 pandemic protocols were developed, the project space was in transition since it was purchased by a development corporation and that hindered the ability to fully return to all in-person services.
- During FY22, the contractor that implements this project experienced big leadership changes in the Executive Director, Clinical Director, Finance Director and Community Programs Director positions. These shifts impacted staff capacity and resulted in some schedule changes until the vacancies were able to be filled.
- The project will be examining ways to broaden and deepen community engagement, especially to community members who live at intersections of disabled, trans, and Black, Indigenous, and People of Color (BIPOC) communities. An outreach committee was assembled to better track and prioritize engagement with more of a systematic approach.
- Although there was a decrease in numbers on the demographic sheets gathered on the peer group members and therefore, a lower number of group members reported, the number of duplicated participants was 2,118 in FY22, which indicated that despite lower unduplicated participants, individuals who joined groups returned regularly to meetings.
- Project staff will continue to evaluate issues of attrition and Zoom fatigue while exploring in-person and hybrid models of meeting, as well as ways to improve completion and submission of the demographic forms and surveys by peer group members.

➢ **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 FY22, 47 Living Well Workshop sessions were conducted. Each Living Well Workshop series included the following sessions: Orientation; Goal Setting; Problem Solving; Healthy Reactions; Beating the Blues (Depression and Moods); Healthy Communication; Seeking Information; Physical Activity; Eating Well (Nutrition); Advocacy (Self and Systems Change); and Maintenance. Topics of Grief and Loss, Depression, Retirement, and Senior Invisibility were also incorporated into the project. In all 14 Senior Citizens participated in the Living Well Workshops. Demographics of Workshop participants are outlined below:

DEMOGRAPHICS N=14	
Age Groups	
26-59 (Adult)	7%
Age 60+ (Older Adult)	93%
Race	
Asian	7%
Black or African American	14%
White	65%
Other	7%
More than one race	7%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Other	7%
Declined to Answer (or Unknown)	7%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
European	14%
Other	7%
Declined to Answer (or Unknown)	65%

Primary Language Used	
English	100%
Sexual Orientation	
Heterosexual or Straight	7%
Questioning or Unsure	7%
Declined to Answer (or Unknown)	86%
Disability	
Difficulty Seeing	7%
Difficulty Hearing or Having Speech Understood	7%
Mental (not mental health)	21%
Physical/mobility disability	14%
Chronic health condition	7%
Other Disability	29%
No Disability	7%
Declined to Answer (or Unknown)	8%
Veteran Status	
No	100%
Gender: Assigned Sex at birth	
Male	21%
Female	79%
Current Gender Identity	
Male	21%
Female	79%

During the reporting timeframe 14 outreach and informational events were conducted reaching 38 individuals, with 45 unduplicated individuals receiving further engagement services. There were 257 referrals for additional services and supports. The number and type of referrals were as follows: 80 Mental Health; 35 Physical Health; 20 Social Services; 20 Housing; 102 other unspecified services. A total of 100% of project participants completed a Living Well Workshop Series. Feedback per participant self-report was as follows:

- 100% reported they felt satisfied with the workshops;
- 100% indicated an improvement in feeling satisfied in general;

- 100% had increased feelings of social supports;
- 100% felt prepared to make positive changes; and
- 100% reported they felt less overwhelmed and helpless.

Project Successes**:**
The workshops were well attended with lively engagement. The workshops provided a safe space where some of the participants were able to share painful testimonies of isolation, sadness and fear and others of loneliness. Many missed their families, their grandchildren, and friends. To help seniors stay connected 96 tele-support group sessions were held. Living Well Program virtual/tele-workshops were offered every Monday and tele-support groups were held every Tuesday. In December and May laptops and technical training were provided to previous participants and individuals who completed The Living Well Workshop Series.

Project Challenges:
Some participants had to travel out of state to support adult children with life-threatening illnesses and two struggled with potentially life-threatening diagnoses themselves. There was a lot of uncertainty revolving around the COVID-19 pandemic. Many participants had difficulties connecting with others due to the technological gap. The Workshop Series facilitator also had to learn systems that had not been used before.

- **SoulSpace Project**

In FY22, following a competitive Request For Proposal (RFP) process, ONTRACK Program Resources began implementing the SoulSpace Project for African Americans in Berkeley. The project assists African Americans in Berkeley to access culturally, ethnically, and linguistically responsive and trauma-informed prevention and early intervention services. Project services include: community education; outreach and engagement; 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.

This project began operating in the last month of the 2nd Quarter of FY22. During that timeframe ONTRACK served 16 individuals in intensive case management, including a total of 45 empowerment activities, and support groups. Demographics on individuals served are as follows:

DEMOGRAPHICS N=16	
Age Groups	
Transition Age Youth (16-25)	19%
Adults (26-59)	62%
Older Adults (60+)	19%
Race	
Black or African American	100%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Other	100%
Primary Language	
English	100%
Sexual Orientation	
Heterosexual or Straight	94%
Another sexual orientation	6%
Disability	
Mental (not mental health)	6%
Physical/Mobility Disability	6%
No Disability	88%
Veteran Status	
No	100%
Gender: Assigned Sex at Birth	
Male	56%
Female	44%
Current Gender Identity	
Male	56%
Female	44%

Project Successes**:**

Despite a start date of December 2021, ONTRACK launched the Soul Space project and accomplished the following during the reporting timeframe:

- Hired two staff who have deep familiarity with Berkeley.
- Secured a work space.
- Built out the case management platform Apricot by Social Solutions, to match the reporting system used by Berkeley—City Data Services.

- Conducted outreach and began implementing services.
- In order to quickly gain a foot in Berkeley's mental provider network, ONTRACK established several partnerships with longstanding organizations in the city of Berkeley including:
  -A partnership with Options for Recovery which included co-hosting an in-person public education event with Roland Williams, an expert in co-existing substance use and mental health concerns among African Americans. ONTRACK also provided one-to-one empowerment services for some of their dually-diagnosed clients as well as members of their staff working through the compassion fatigue that often accompanies work with this population.
  -Through a partnership with Building Opportunities for Self-Sufficiency (BOSS), ONTRACK conducted onsite—and off-site-one-to-one and group empowerment services to their other-wise unsheltered population of African Americans.
- Conducted two well-reviewed community education events. Dr. La Tanya Takla conducted a 2-part series on trauma informed care to African Americans, and Roland Williams conducted an in-person workshop at the Veterans Memorial Building.

Project Challenges:

- ONTRACK experienced a number of challenges during the program period, several of which have been rectified since the ending of the June 30, 2022 MHSA reporting period.
  The truncated MHSA 2021-2022 service period was short due to a contract execution date of December 1, 2021, and a delay in final contracting processes.
- Outreach efforts to community members was restricted due to the COVID-19 pandemic, which meant greater reliance on social media and outreach to other community organizations who were seeking to adapt to their own challenges.
- The initial location of the Soul Space office in West Berkeley was less accessible to community members than the current location in North Berkeley on Adeline Street.

➢ Latinx Trauma Support Project

In FY22, following a competitive Request For Proposal (RFP) process, East Bay Sanctuary Covenant began implementing the Latinx Trauma Support Project. This project assists low-income, Latinx families in Berkeley to access culturally, ethnically, and linguistically responsive and trauma-informed prevention and intervention services. Project services are in direct response to, and in collaboration with, Latinx community members, and are largely facilitated by individuals from within the targeted community and conducted in Spanish or an indigenous language. Services include: One-on-one outreach and support; support groups; staff and partner training and warm referrals.

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

PEI Priorities:

- Culturally competent and linguistically appropriate prevention and intervention; 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 FY22, this project began implementing services. Over the course of the year a total of 224 individuals were served. Demographics on individuals served through this project were as follows:

DEMOGRAPHICS N=224	
Age Groups	
Children and Youth (0-15)	2%
Transition Age Youth (16-25)	13%
Adults (26-59)	82%
Older Adults (60+)	1%
Declined to Answer (or Unknown)	2%
Race	
American Indian or Alaska Native	10%
Asian	1%
Black or African American	<1%
White	2%
Other	85%
Declined to Answer (or Unknown)	2%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Central American	45%
Mexican/Mexican-American/Chicano	29%
South American	8%
Other	8%
Declined to Answer (or Unknown)	7%
Ethnicity: Non-Hispanic or Latino/Latina/Latinx	
African	<1%
Asian Indian/South Asian	1%
Chinese	<1%

Eastern European	<1%
Middle Eastern	<1%
Other	<1%
Primary Language	
English	3%
Spanish	83%
Declined to Answer (or Unknown)	14%
Sexual Orientation	
Gay or Lesbian	28%
Heterosexual or Straight	43%
Questioning or unsure of sexual orientation	1%
Queer	1%
Another sexual orientation	2%
Declined to Answer (or Unknown)	25%
Disability	
Difficulty Seeing	<1%
Other	1%
No Disability	95%
Declined to Answer (or Unknown)	4%
Veteran Status	
No	91%
Declined to Answer (or Unknown)	9%
Gender: Assigned Sex at Birth	
Male	49%
Female	50%
Declined to Answer (or Unknown)	2%
Current Gender Identity	
Male	46%
Female	50%
Transgender	1%
Genderqueer	1%
Declined to Answer (or Unknown)	2%

During the reporting timeframe 41 Support Group sessions were conducted reaching 26 individuals, and 76 individuals received One-on-One Supports. A total of 49 Trainings were conducted, reaching 78 individuals. There were 110 warm referrals for additional services and supports. The number and type of referrals were as follows: 31 Mental Health; 10 Physical Health; 33 Social Services; 36 other unspecified services.

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

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

Training feedback per participant self-report was as follows:

- 98% 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**:**

- In the first fiscal year of this contract, an effective and efficient support services project was built to better serve members of the Latinx community through a holistic trauma-informed approach.
- Having a dedicated staff allowed the project to connect more deeply with Latinx community members, offering early intervention and prevention education, one-on-one supports, warm referrals to a wide range of social and mental health services, and two support groups (one for LGBTQ Latinx asylum seekers and one for Indigenous Maya Mam women).
- The project trained a total of seventy-eight staff and employees of partner agencies in the trauma-informed approach. These trainings were designed after the Program Manager interviewed key stakeholders within the organization about their understanding of trauma and what training needs they saw for improving services. Externally, customized trainings for partners working in healthcare, education, and social services were offered.
- The Support Services Manager strengthened partnerships with community agencies around a range of services that clients desperately needed, including health care, public benefits, services for survivors of domestic violence, housing, and many other needs.
- A sophisticated comprehensive system for identifying the resources available to community members and tracking referrals after initial contact using the Airtable platform, was created and utilized.

Project Challenges:

An early challenge was that the project was not able to hire a Support Services Program Manager until two months after the contract was initiated, however despite this delay, project goals were still met.

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 FY22, DMIND was provided both live on-line and in-person. Training and coaching services were also provided through this program. The training and coaching services build capacity among teachers and staff, so they have the skills for their own self-care, stress resilience and personal sustainability, and for the professional application with students to teach emotional regulation as well as social-emotional learning. Training and coaching were also used to build capacity among student peer leaders, with structured opportunities for application in conflict resolution, peer mediation, restorative justice circles, and leading DMIND practice in their classrooms. Additionally, this program provided videos to the schools and Yoga at Independent Study. A total of 1,546 students and 139 teachers and school staff received services through

this program during the reporting timeframe as follows:

School	Number of Students Served	Number of School Staff Served
• Berkeley High School	455	76
• Berkeley Technical Institute	28	12
• King Middle School	248	15
• Longfellow Middle School	127	19
• Willard Middle School	688	17
Total	**1,546**	**139**

Data on individuals served was not provided by BUSD.

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 FY22, this program was not in operation.

African American Success Project

The African American Success Project (AASP) implements “Umoja” - a daily elective class offered at Longfellow Middle School. Umoja provides African American students a safe affinity space to explore their cultural heritage and identity, while building positive peer relationships and establishing relational trust with adults. Umoja provides an ongoing focus on social and emotional development, including building skills, habits and mindsets that enable self-regulation, interpersonal skills, perseverance and resilience. 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 FY22, 73 students participated in this project. Outlined below are demographics on individuals served through this project:

DEMOGRAPHICS N=73	
Age Groups	
Children/Youth (0-15)	100%

Race	
Black or African American	79%
More than one Race	10%
Declined to Answer (or Unknown)	1%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Hispanic/Latino/Latina/Latinx	10%
Primary Language	
English	96%
Other	4%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Other	25%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	53%
Female	47%
Current Gender Identity	
Male	53%
Female	47%

Worth noting is this project's continued emphasis on school success and reinforcing literary skills. In addition to incorporating literacy structures into the class setting, the project made a strategic investment to establish a classroom library, which affords students access to over 100 unique titles. Efforts were made to select books written by Black/African American authors whose books feature Black/African American history, culture, and stories. Building the library was a direct response to a student survey conducted in a prior school year in which project participants indicated they would read more, if books were available that reflected their lived experience and related to their cultural background.

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

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

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

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

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

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.

In FY22, approximately 233 students received services through this project. Demographics on youth served are outlined below:

DEMOGRAPHICS N=233	
Age Groups	
0-15 Years	33%
16-25 Years	67%
Race	
American Indian or Alaska Native	2%
Asian	7%
Black or African American	17%
Native Hawaiian or other Pacific Islander	<1%
White	33%
More than one Race	14%
Other	11%
Declined to Answer (or Unknown)	16%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Other	22%
Declined to Answer (or Unknown)	16%
Primary Language	
English	93%
Spanish	6%
Declined to Answer (or Unknown)	1%
Sexual Orientation	
Gay or Lesbian or Bisexual or Questioning or Queer, or Unsure or Another Sexual Orientation	21%
Heterosexual or Straight	35%
Declined to Answer (or Unknown)	44%

Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	21%
Female	45%
Gender non-conforming, transgender, genderqueer	11%
Declined to Answer (or Unknown)	23%
Current Gender Identity	
Male	21%
Female	44%
Transgender	3%
Genderqueer	7%
Another gender identity	<1%
Declined to Answer (or Unknown)	25%

Program Successes:

- Resumed providing the full range of services when students returned to full-time in-person learning.
- Following multiple staff transitions during the summer of 2021, this project was able to add two diverse, experienced, highly skilled, licensed clinicians, one of whom is a native bilingual Spanish speaker. Both clinicians quickly became part of a cohesive and collaborative mental health team and have integrated well into the larger Health Center team.
- The mental health team was able to substantially increase service utilization year-over-year compared to the FY21 school year. As half of the student body were new to campus in FY22, the project focused more of its efforts on outreach in order to familiarize students with the array of services.
- The mental health team maintained the use of the JotForm application for referrals. The team also integrated QR code technology into the referral form so that it can be more easily accessed and completed by students and school staff.
- The mental health team maintained a collaborative and productive relationship with the Berkeley High School Coordination of Services Team (COST) throughout the school year in order to ensure that appropriate referrals were made to the program.
- The mental health team provided an array of crisis support services following the tragic death of a Berkeley High School student in April 2022.
- The mental health team was also able to build upon and improve existing relationships and partnerships with Berkeley High School stakeholders. To this end the team collaborated with

several different on-campus programs throughout the year such as the Multi-cultural Program, McKinney-Vento Program, Special Education Program, and Intervention Counselors. The team also conducted stakeholder meetings at the end of the school year in order to elicit feedback around the services that are provided with a focus on how to improve collaboration, advance equity, and improve service accessibility.

Program Challenges:

- Two newly hired full-time Mental Health Clinicians were onboarded in FY22 in September and November. From August through December FY22 one full-time bilingual Mental Health Clinician was on parental leave. These staffing limitations contributed to the teams reduced service capacity during the Fall FY22 timeframe.
- Due to staff transitions during the preceding summer, the project was not able to host a cohort of graduate-level trainees, which also contributed to reduced service capacity during the FY22 school year.
- As a result of reduced staffing and service capacity, the mental health team did not facilitate support groups during the FY22 school year.
- Berkeley High School administration and staff also experienced difficulties with the transition back to full-time in-person learning and it took time to rebuild coordinated systems for supporting a range of student's needs. Project leadership and Berkeley High School Administration continued to develop relevant protocols during the course of the school year to better support student accessibility to needed services.

In FY22, 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 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
% 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.

In FY22, the RBA Outcomes for this program were as follows:

High School Health Center (HSHC)
RBA Outcomes
Reporting Period: July 2021-June 2022 (Baseline)

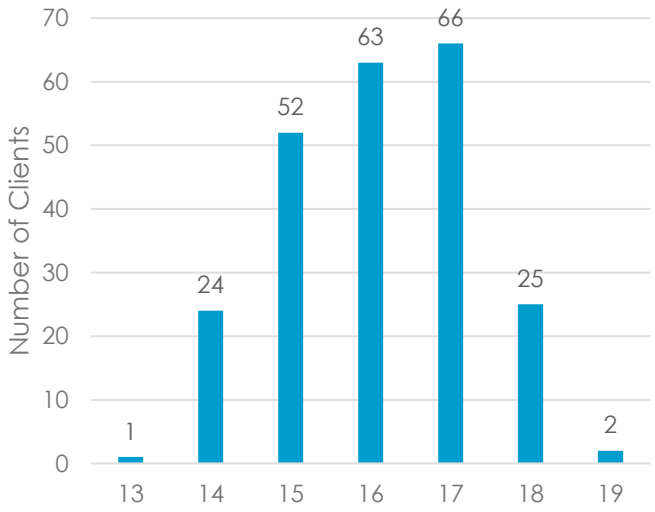
Process Outcomes ("How much did we do?")

233
Clients Served

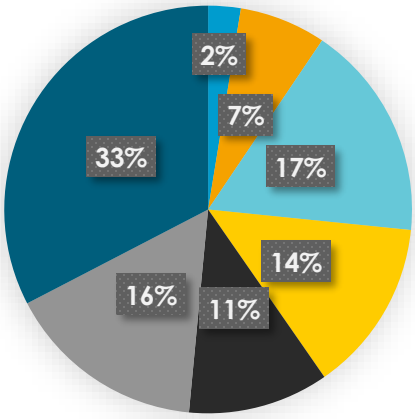
represents 20 clients

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

Demographics (Age)

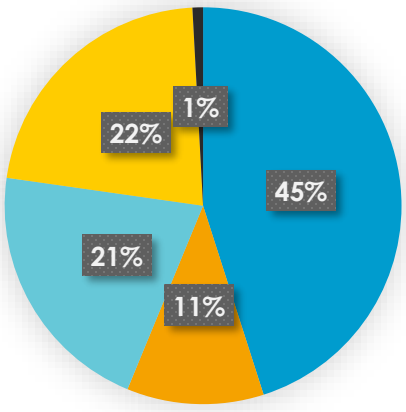


Demographics (Race)



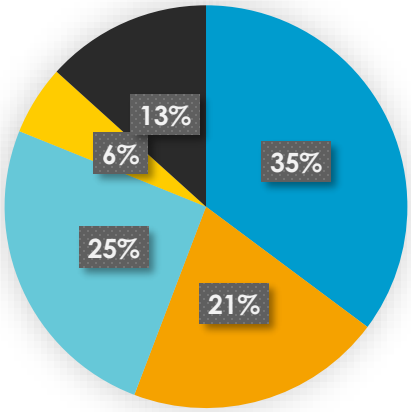
- Alaska Native or American Indian (2%)
- Asian or Pacific Islander (7%)
- Black or African American (17%)
- More than one race (14%)
- Other (11%)
- Prefer not to answer (16%)
- White (33%)

Demographics (Gender Identity)



- Female (45%)
- Gender nonconforming, transgender, genderqueer (11%)
- Male (21%)
- Missing (22%)
- Prefer not to answer (1%)

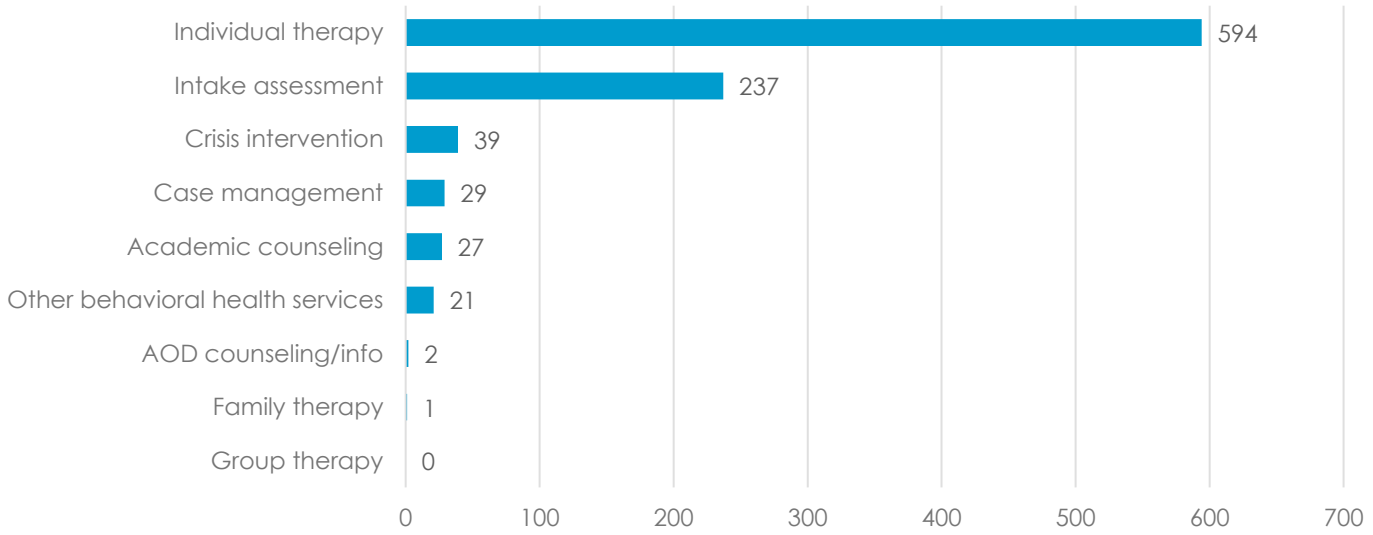
Demographics (Sexual Orientation)



- Heterosexual (35%)
- LGBTQ* (21%)
- Missing (25%)
- Prefer not to answer (6%)
- Unknown/unsure (13%)

*includes students who self-identified as aromantic, asexual, bisexual, gay, homosexual, lesbian, pansexual, queer, and questioning

Services Provided by Service Type

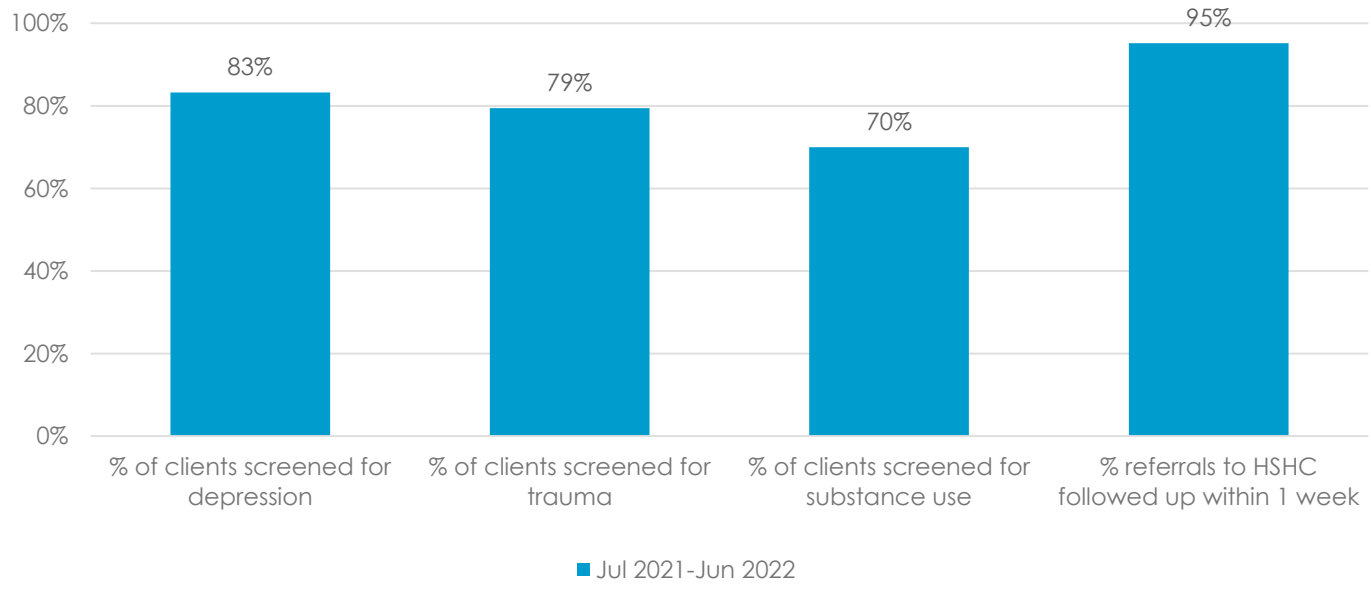


Note that multiple services could be provided in one visit (e.g. crisis assessment and referral) so total services by type (n=950) is greater than total encounters (n=846)

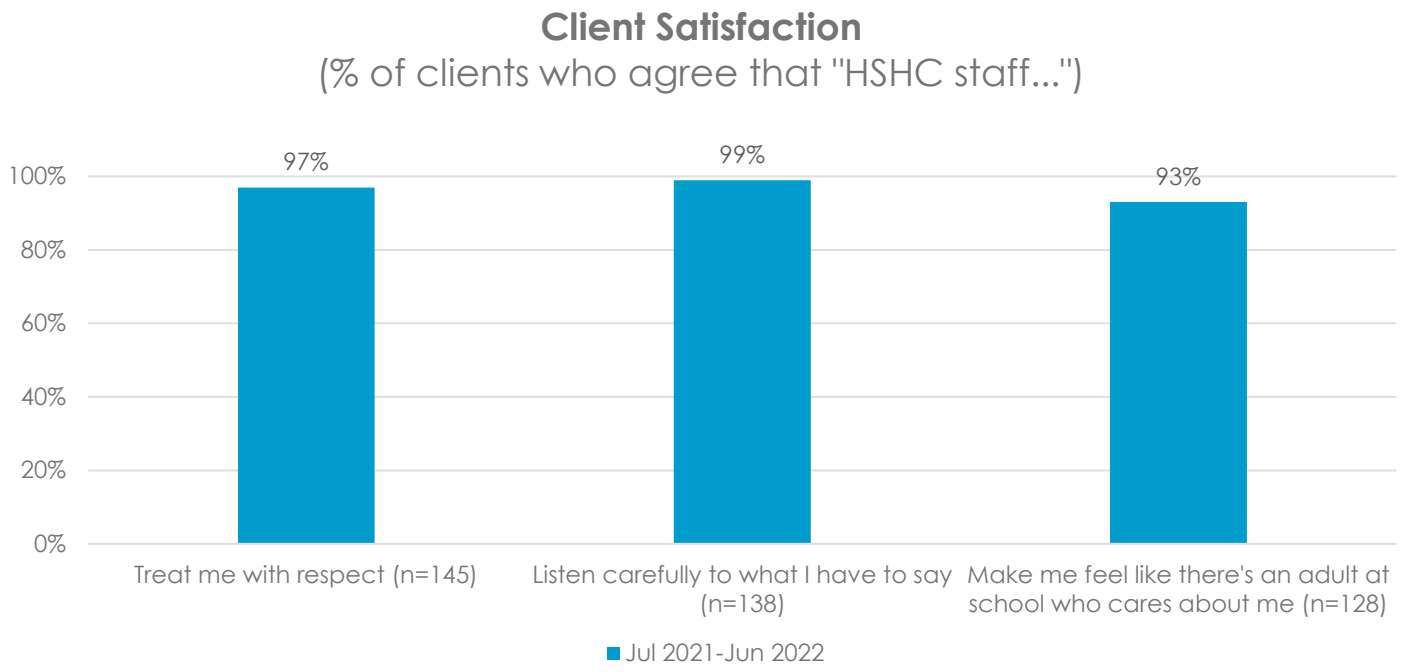
Quality Outcomes ("How well did we do it?")

In 2021-2022, the HSHC program served **7%** of the school population.

Service Consistency



Impact Outcomes ("Is anyone better off?")



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 provides funding for one 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, on July 14, 2020 City Council passed Resolution No, 69,501-N.S.; a package of items providing direction for the development of a new paradigm of public safety in Berkeley. One of the items adopted by City Council directed the City Manager to analyze and develop a pilot program to re-assign mental health and substance use calls, that do not include a threat of violence to a Specialized Care Unit (SCU). The SCU will consist of trained crisis-response field workers who will respond to behavioral health occurrences that do not pose an imminent threat to safety without the involvement of law enforcement. The SCU will be implemented as a pilot model and lessons-learned will inform the long-term implementation. Through the FY22 Annual Update the City of Berkeley provided a one-time amount of CSS and PEI funding to support this program, while the City determines how to best fund this initiative.

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

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

In FY21, Resource Development Associates (RDA), chosen through a competitive Request for Proposal (RFP) process to evaluate the current crisis system in Berkeley, received an expanded scope of work to provide recommendations on the implementation of the SCU. To oversee and advise RDA in their work, the City formed an SCU Steering Committee consisting of Health, Housing and Community Services Department and Fire Department staff, and community representatives from the Mental Health Commission and the Berkeley Community Safety Commission. The Steering Committee met from January 2021 through January 2022 and advised on RDA's completion of three critical reports. The first two reports summarized crisis response programs in the United States and internationally as well as gathered perspectives from community and City stakeholders regarding the crisis response system. This included

gathering input from City of Berkeley and Alameda County agencies, local community-based organizations (CBOs), local community leaders, and utilizers of Berkeley's crisis response services. These reports laid the foundation for the twenty-five recommendations that were the subject of the third and final report to inform the SCU model. Each recommendation put forth in the final report is deeply rooted in the stakeholder feedback included in the two previous reports.

In Spring 2022, the design for the SCU received City Council approval and the work of the SCU Steering Committee transitioned from planning to implementation. At the beginning of FY23, the City of Berkeley launched a competitive RFP process, which included providing live question and answer as well as published resources on the City website. After an extensive review process, the City chose Bonita House to implement the SCU pilot program.

Since the beginning of 2023, Bonita House has taken initial steps to implementing the SCU including: selecting an operating location for the program, working with the City to obtain response vehicles, and hiring staff. The Berkeley and Bonita House teams are hoping to launch a version of the SCU at the end of FY23, or beginning of FY24, as the full program ramps up.

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 FY22, 13 unduplicated individuals participated in the program. Demographics on program participants served were as follows:

DEMOGRAPHICS N= 13	
Age Groups	
26-59 (Adult)	38.5%
Ages 60+ (Older Adult)	38.5%
Declined to Answer (or Unknown)	23%
Race	
Asian	8%
Black or African American	23.5%
White	38.5%
Other	15%
Declined to Answer (or Unknown)	15%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican/Mexican-American Chicano	8%
Puerto Rican	8%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	15%
European	15%
Japanese	8%
Other	31%
Declined to Answer (or Unknown)	31%
Primary Language Used	
English	84%
Declined to Answer (or Unknown)	16%
Sexual Orientation	
Gay or Lesbian	8%
Heterosexual or Straight	54%
Bisexual	15%
Questioning or Unsure	8%
Declined to Answer (or Unknown)	15%

Disability	
Difficulty Hearing	15%
Mental Domain not including a mental illness	15%
Physical Mobility domain	31%
Chronic Health Condition	23%
Other (Specify):	8%
Declined to Answer (or Unknown)	31%
Veteran Status	
Yes	77%
No	33%
Gender: Assigned sex at birth	
Male	15.4%
Female	69.2%
Declined to Answer (or Unknown)	15.4%
Current Gender Identity	
Male	15%
Female	54%
Questioning or unsure	8%
Another gender identity	8%
Declined to Answer (or Unknown)	15%

Program Successes:
In FY22 the Telling Your Story group had more consistent attendees who were prepared to share based on the topics provided. The structure of having a brainstorming session proved to be really beneficial for the attendees. Some participants enjoyed having the group virtually in the comfort of their home, they felt safer and the hassle of commuting was eliminated. Participants felt more prepared during their shares and enjoyed the support they received from their peers.

Program Challenges:
The Telling Your Story group challenges were a lack of in-person connection and some participants who didn't have access to Zoom were unable to see others on the screen. This group provided gift cards for each session that a person participated within the program guidelines. There was a challenge for some individuals to come into the office to sign for the gift cards which created some disdain from the participants, or they waited months before they decided to have their gift card mailed. A similar gift card challenge was that some participants

waited for months until they picked them up, so it would be worth the commute they had to make to come to the office.

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. The Division is proposing to allocate 4% of PEI funds each year of the three-year timeframe for this initiative, and to execute a participation agreement with CalMHSA to access services.

In FY22, 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.

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 current INN programs that are proposed to be continued in the Three-Year Plan, and FY22 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 allocates INN funding to participate in a Statewide Collaborative with other California counties to pilot a Mental Health Technology Project that makes various technology-based mental health services and supports applications (Apps) locally available in Berkeley.

The Help@Hand Project seeks to learn whether the use of the Apps will increase access to mental health services and supports; and whether it will lead to better outcomes. Since plan approval, 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 being on TAY and Older Adults, to include anyone who lives, works and goes to school in Berkeley.

Per a competitive recruitment process, the Division contracted with Resource Development Associates (RDA), who conducted Project Coordination work through early FY22 on this project. 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 will be available through September 2023. 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 Headspace licenses for the community.

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.

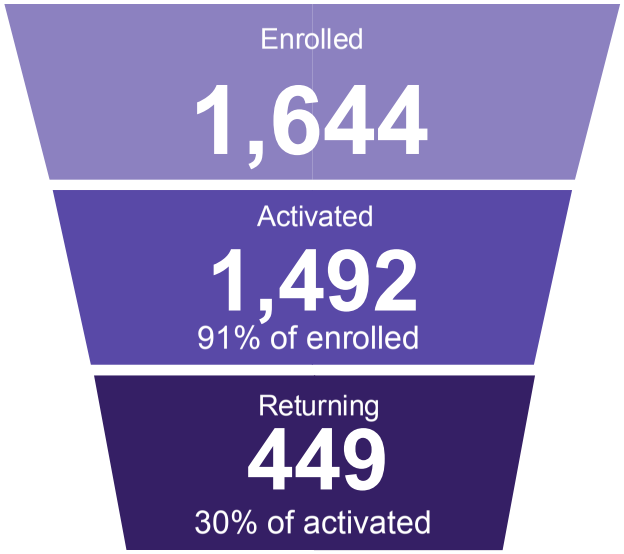
In FY22 there were 1,644 Berkeley community members who accessed MyStrength, and 5,097 accessed Headspace. Each App company collected and provided reporting on various user data measures. Local usage data in FY22 for each App is outlined on the preceding pages.

myStrength scorecard

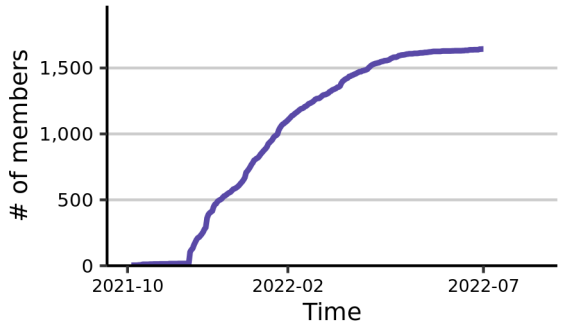
City of Berkeley

Program launch: 2021-09-20 Data thru: 2022-06-30

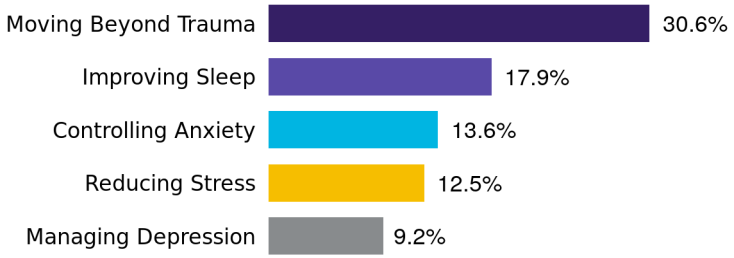
Members enrolled



Enrollment trends



Top 5 digital recommendations



Program engagement

Average 90 day member engagement rates (% of returning)

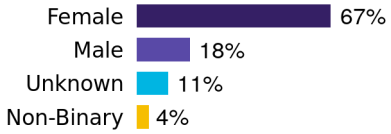
127

23%	9%	NA%
104/449	42/449	NA/449
Logged in	Completed activity	Used engagement guidance
5 average logins/member	7 average activities completed/member	NA average messages sent to guide/member

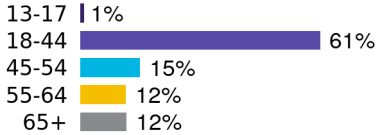
Member demographics

(% of enrolled)

Gender



Age Group



myStrength scorecard

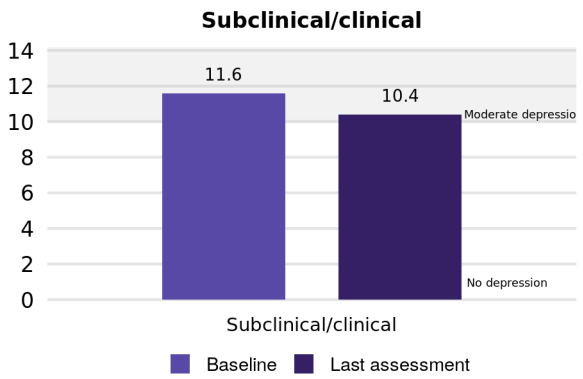
City of Berkeley

Program launch: 2021-09-20 Data thru: 2022-06-30

Depression outcomes

Clinical and subclinical population

Scored 5 or more in the PHQ-9 assessment



68.7%

Maintained or improved

41%

Clinically Improved

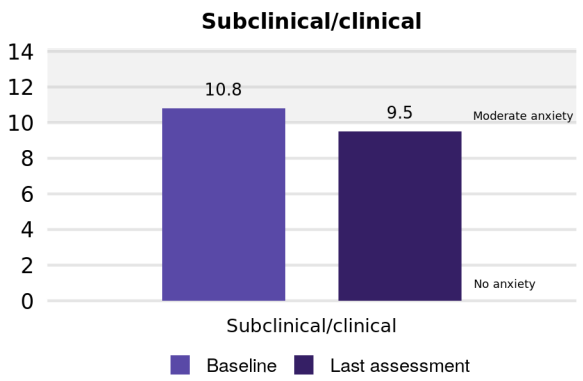
Started with scores ≥15 and decreased their score by at least 5 points

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



70.9%

Maintained or improved

27.6%

Clinically Improved

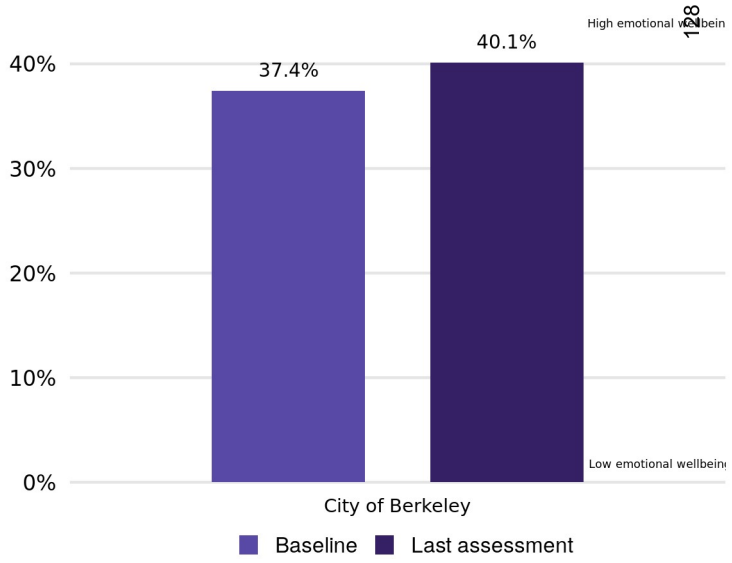
Started with scores ≥15 and decreased their score by at least 5 points

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

25.6%

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

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

129

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.

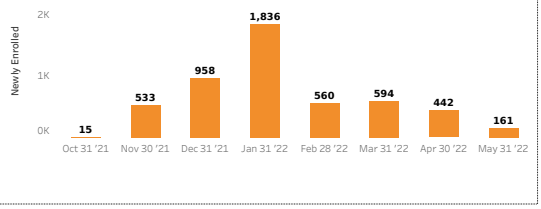
*For each clinical outcome, the reported population has at least 10 members in the program and completed at least two assessments.

Help@Hand FY22 Report

Members

5,097

Enrollments



Engagement

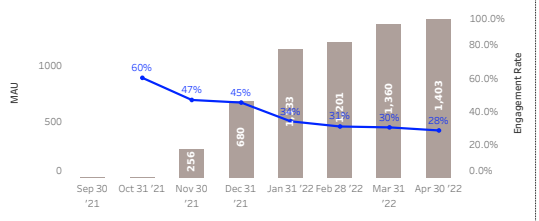
Headspace Minutes Used

1,225,384

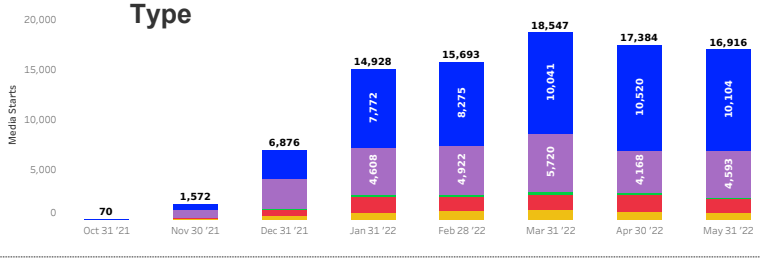
Minutes Meditated

334,955

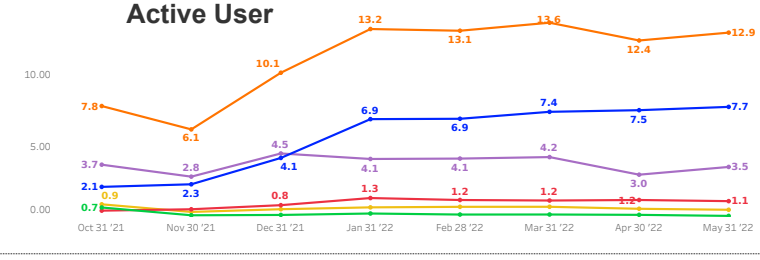
Monthly Active Users



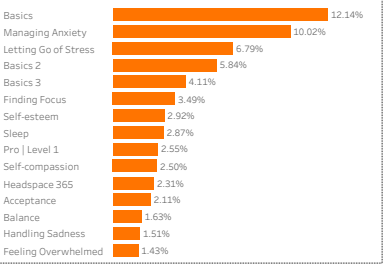
Engagement by Content Type



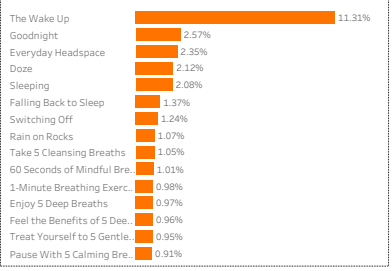
Depth of Engagement per Active User



Top 15 Courses



Top 15 Non-Courses



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 a community partner who will be 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 RFP process was executed in the third quarter of FY23 and it is envisioned that the program will be implemented in early FY24. The program will include an evaluation which will be reported on in future MHSA Plans and Annual Updates.

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 Three-Year Plan, and a proposed transfer of funds from CSS to WET to fund the addition of a Workforce Development Coordinator.

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 period of two years. This program was implemented in FY23.

Workforce Development Coordinator

Through this Three-Year Plan the Division is proposing 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 new position will support staff recruitment and retention for the Division; oversee Intern recruitment; and coordinate 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.

FY22 AVERAGE COST PER CLIENT*

*(Includes FY22 expenditures attributed to the MHSA Funding component)

COMMUNITY SERVICES & SUPPORTS			
Program Name	**Approx. # of Clients**	**Cost**	**Average Cost Per Client**
Children and Youth Intensive Support Services FSP	12	$267,599	$22,300
TAY, Adult & Older Adult FSP	75	$937,541	$12,501
Homeless FSP	36	$971,797	$26,994
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)	1,455	$1,839,530	$1,264
PREVENTION & EARLY INTERVENTION			
Be A Star	1,654	$36,250	$22
Supportive Schools Program	591	$110,000	$186
Living Well Project	14	$32,046	$2,289
LGBTQI Trauma Project	45	$100,000	$2,222
TAY Trauma Project	105	$32,046	$305
SoulSpace Project	17	$75,000	$4,412
Trauma Project for Latinx	224	$100,000	$446
High School Youth Prevention Program	223	$422,057	$1,893
Dynamic Mindfulness	1,685	$95,000	$56
African American Success Project	73	$150,000	$2,055

PRUDENT RESERVE FUNDS

Per MHSA legislation mental health jurisdictions are required to maintain a local Prudent Reserve to be able to fund the most crucial CSS support services in the event there is a year where there is a downturn in the amount of MHSA funds received at the state. Beginning in 2019, new state regulations required a report out on the level of local Prudent Reserves every five years. Mental health jurisdictions must show that the amount of the Prudent Reserve is not higher than 33% of a total of the past five years of MHSA funding distributions and must submit the “Mental Health Services Act Prudent Reserve Assessment/Reassessment” form attesting to the amount in the Prudent Reserve fund.

Based on state regulations on how to calculate the allowable amount in the Prudent Reserve, the City of Berkeley’s MHSA Prudent Reserve should not exceed $2,140,243. The current amount of the City of Berkeley’s MHSA Prudent Reserve is $1,237,629, which does not exceed the allowable amount.

The signed “Mental Health Services Act Prudent Reserve Assessment/Reassessment” form will be submitted to the state by 6/30/23.

State of California
Health and Human Services Agency

Department of Health Care Services

MENTAL HEALTH SERVICES ACT
PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City: City of Berkeley

Fiscal Year: 2023

Local Mental Health Director

Name: Jeffrey Buell, LCSW

Telephone: (510) 981-7682

Email: jbuell@berkeleyca.gov or jbuell@cityofberkeley.info

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

Jeffrey Buell		5/8/23
Local Mental Health Director (PRINT NAME)	Signature	Date

[1] Welfare and Institutions Code section 5892 (b)(2)

DHCS 1819 (02/19)

BUDGET NARRATIVE

The enclosed budget provides estimated revenue and expenditures for this Three-Year Plan. 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 Three-Year Plan reflect an increase in MHSA funds in FY24, followed by estimated decreases in FY25 and FY26.

The budget includes funding allocations for most of the proposed new staffing in FY24 calculated at 85% of the total costs, which is based on the projected amount of time it will take to recruit and hire for each position. Additionally, two of the proposed new positions are calculated at 50% of the total costs, as it is estimated they will be hired by mid-year. Savings from previous years (due to staff vacancies, slower start-ups with new programs, etc.), and projected additional revenue in FY24, will assist in providing funding to support MHSA programs and services over the next couple of years when the MHSA fund is estimated 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 Annual Updates to this Three-Year Plan.

APPENDIX A

PROGRAM BUDGETS

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: City of Berkeley Date: 6/22/23

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2023/24 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	8,810,925	2,437,727	1,858,707	0	0	1,237,629
2. Estimated New FY2023/24 Funding	9,302,674	2,325,669	612,018			
3. Transfer in FY2023/24[a/]	(170,535)			170,535		
4. Access Local Prudent Reserve in FY2023/24						
5. Estimated Available Funding for FY2023/24	17,943,065	4,763,395	2,470,725	170,535	0	1,237,629
B. Estimated FY2023/24 MHSA Expenditures	8,415,066	2,085,566	1,223,159	170,535	0	
C. Estimated FY2024/25 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	9,527,999	2,677,829	1,247,566	0	0	1,237,629
2. Estimated New FY2024/25 Funding	4,605,820	1,151,455	303,014			
3. Transfer in FY2024/25[a/]	(208,654)			208,654		
4. Access Local Prudent Reserve in FY2024/25						0
5. Estimated Available Funding for FY2024/25	13,925,164	3,829,284	1,550,581	208,654	0	1,237,629
D. Estimated FY2024/25 Expenditures	8,735,316	2,066,785	534,334	208,654	0	
E. Estimated FY2025/26 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	5,189,849	1,762,499	1,016,247	0	0	1,237,629
2. Estimated New FY2025/26 Funding	4,543,527	1,135,882	298,916			
3. Transfer in FY2025/26[a/]	(217,000)			217,000		
4. Access Local Prudent Reserve in FY2025/26						0
5. Estimated Available Funding for FY2025/26	9,516,375	2,898,381	1,315,163	217,000	0	1,237,629
F. Estimated FY2025/26 Expenditures	9,037,987	2,115,658	534,334	217,000	0	
G. Estimated FY2025/26 Unspent Fund Balance	478,388	782,723	780,829	0	0	1,237,629

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2023	1,237,629
2. Contributions to the Local Prudent Reserve in FY 2023/24	0
3. Distributions from the Local Prudent Reserve in FY 2023/24	0
4. Estimated Local Prudent Reserve Balance on June 30, 2024	1,237,629
5. Contributions to the Local Prudent Reserve in FY 2024/25	0
6. Distributions from the Local Prudent Reserve in FY 2024/25	0
7. Estimated Local Prudent Reserve Balance on June 30, 2025	1,237,629
8. Contributions to the Local Prudent Reserve in FY 2025/26	0
9. Distributions from the Local Prudent Reserve in FY 2025/26	0
10. Estimated Local Prudent Reserve Balance on June 30, 2026	1,237,629

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

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: City of Berkeley Date: 6/22/23

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. TAY, Adult & Older Adult FSP	1,716,647	1,716,647				
2. Children's FSP	594,640	594,640				
3. Homeless FSP	1,324,009	1,324,009				
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	217,132	217,132				
2. CSS System Development	3,308,414	3,308,414				
3.						
4.						
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					
CSS Administration	1,254,223	1,254,223				
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	8,415,066	8,415,066	0	0	0	0
FSP Programs as Percent of Total	43.2%					

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: City of Berkeley Date: 6/22/23

	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	1,791,768	1,791,768				
2. Children's FSP	618,426	618,426				
3. Homeless FSP and Outreach Team	1,438,908	1,438,908				
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	225,817	225,817				
2. CSS System Development	3,358,394	3,358,394				
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					
CSS Administration	1,302,001	1,302,001				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	8,735,316	8,735,315.52	0	0	0	0
FSP Programs as Percent of Total	44.1%					

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: City of Berkeley Date: 6/22/23

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. TAY, Adult & Older Adult FSP	1,886,161	1,886,161				
2. Children's FSP	643,163	643,163				
3. Homeless FSP and Outreach Team	1,492,384	1,492,384				
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	234,850	234,850				
2. CSS System Development	3,448,106	3,448,106				
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					
CSS Administration	1,333,323	1,333,323				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	9,037,987	9,037,987	0	0	0	0
FSP Programs as Percent of Total	44.5%					

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: City of Berkeley

Date: 6/22/23

	Fiscal Year 2023/24					
	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	362,097	362,097				
2. African American Success Project	37,500	37,500				
3. Cal MHSA	93,027	93,027				
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.						
10.						
PEI Programs - Early Intervention						
11. Early Childhood Health & Wellness Program	38,550	38,550				
12. Community Education & Supports	364,092	364,092				
13. High School Prevention Program	362,097	362,097				
14. African American Success Project	112,500	112,500				
15. Dynamic Mindfullness	23,750	23,750				
16. Mental Health Peer Education Program (MEET)	11,597	11,597				
17. Supportive Schools	110,000	110,000				
PEI Programs - Stigma & Discrimination						
18. Social Inclusion	9,000	9,000				
PEI Administration	355,313	355,313				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	2,085,566	2,085,566	0	0	0	0

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: City of Berkeley

Date: 6/22/23

	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	410,334	410,334				
2. African American Success Project	37,500	37,500				
3. Cal MHSA	46,058	46,058				
4. Dynamic Mindfullness	71,250	71,250				
5. Mental Health Peer Education Program (MEET)	34,792	34,792				
6.						
7.						
8.						
9.						
10.						
PEI Programs - Early Intervention						
11. Early Childhood Health & Wellness Program	40,092	40,092				
12. Community Education & Supports	364,092	364,092				
13. High School Prevention Program	410,334	410,334				
14. African American Success Project	112,500	112,500				
15. Dynamic Mindfullness	23,750	23,750				
16. Mental Health Peer Education Program (MEET)	11,597	11,597				
17. Supportive Schools	110,000	110,000				
PEI Programs - Stigma & Discrimination						
18. Social Inclusion	9,360	9,360				
PEI Administration	385,125	385,125				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	2,066,785	2,066,785	0	0	0	0

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: City of Berkeley Date: 6/22/23

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. High School Prevention Program	426,391	426,391				
2. African American Success Project	37,500	37,500				
3. Dynamic Mindfullness	71,250	71,250				
4. Mental Health Peer Education Program (MEET)	34,792	34,792				
5. Cal MHSA	45,435	45,435				
6.						
7.						
8.						
9.						
10.						
PEI Programs - Early Intervention						
11. Early Childhood Health & Wellness Program	41,696	41,696				
12. Community Education & Supports	364,092	364,092				
13. High School Prevention Program	426,391	426,391				
14. African American Success Project	112,500	112,500				
15. Dynamic Mindfullness	23,750	23,750				
16. Mental Health Peer Education Program (MEET)	11,597	11,597				
17. Supportive Schools	110,000	110,000				
PEI Programs - Stigma & Discrimination						
18. Social Inclusion	9,734	9,734				
19.						
PEI Administration	400,530	400,530				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	2,115,658	2,115,658	0	0	0	0

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: City of Berkeley

Date: 6/22/23

	Fiscal Year 2023/24					
	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	1,201,000	1,201,000				
2. MHSA INN Tech Suite	22,159	22,159				
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					
INN Administration						
Total INN Program Estimated Expenditures	1,223,159	1,223,159	0	0	0	0

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: City of Berkeley Date: 6/22/23

	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	534,334	534,334				
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					
INN Administration						
Total INN Program Estimated Expenditures	534,334	534,334	0	0	0	0

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: City of Berkeley

Date: 6/22/23

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. MHSA INN Encampment	$534,334.00	534,334				
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					
INN Administration						
Total INN Program Estimated Expenditures	534,334	534,334	0	0	0	0

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: City of Berkeley

Date: 6/22/23

	Fiscal Year 2023/24					
	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	170,535	170,535				
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	170,535	170,535	0	0	0	0

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: City of Berkeley Date: 6/22/23

	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 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: City of Berkeley Date: 6/22/23

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce Development Coordinator	217,000	217,000				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	217,000	217,000	0	0	0	0

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: City of Berkeley

Date: 6/22/23

	Fiscal Year 2023/24					
	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.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: City of Berkeley Date: 6/22/23

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

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: City of Berkeley Date: 6/22/23

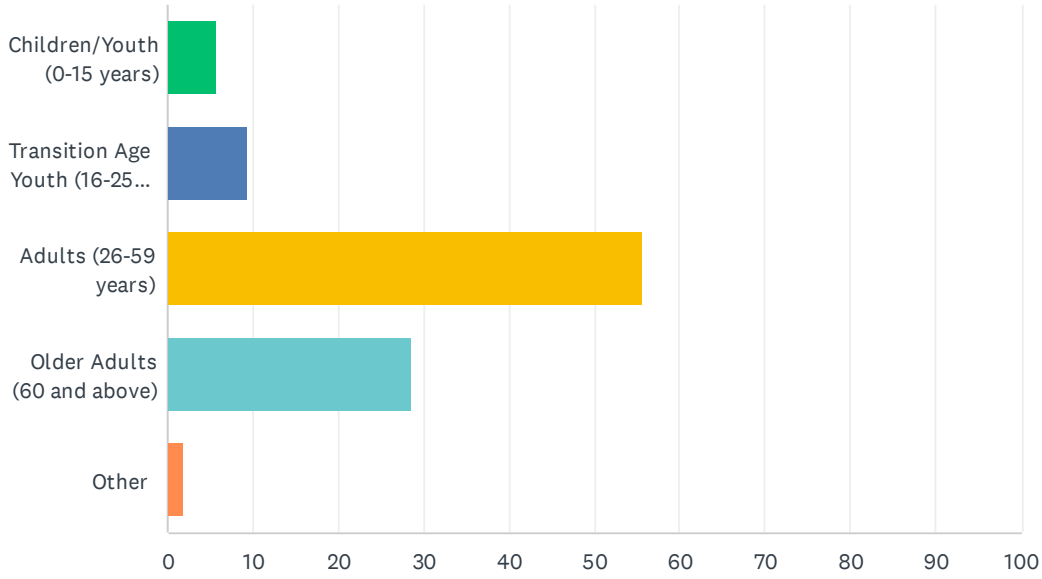
	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

APPENDIX B

MHSA CAPACITY ASSESSMENT
RESPONSES

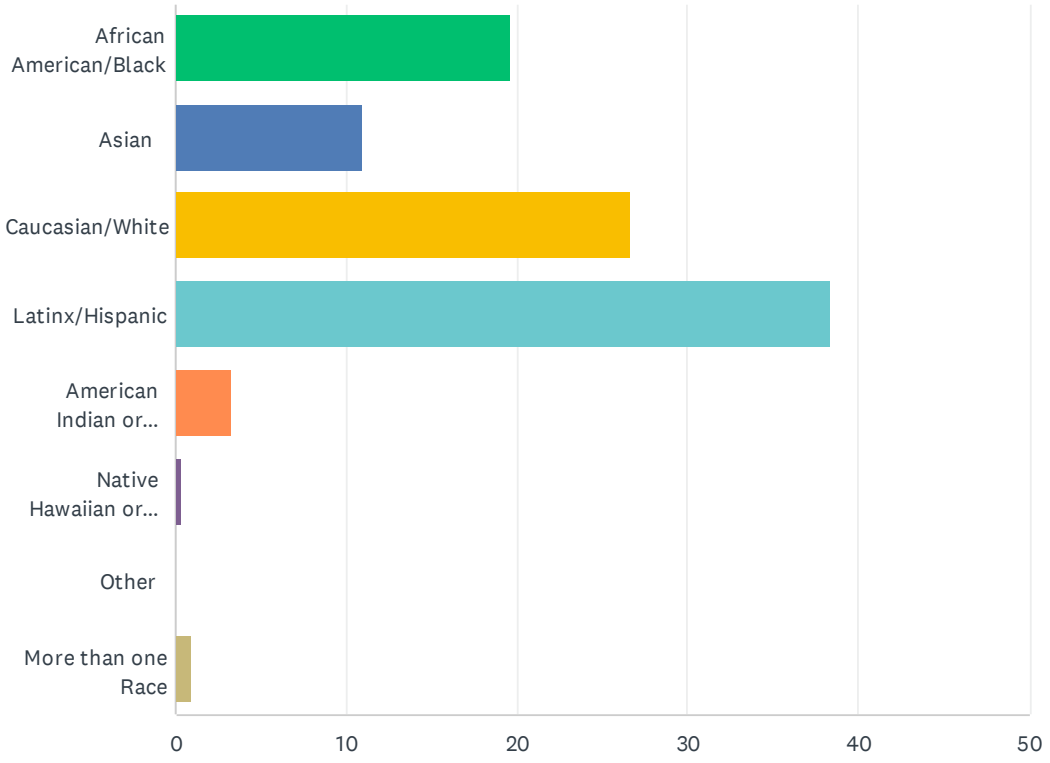
MHSA Capacity Assessment Responses

Q1 Please indicate the percentage(s) of the primary age group(s) the organization currently serves.



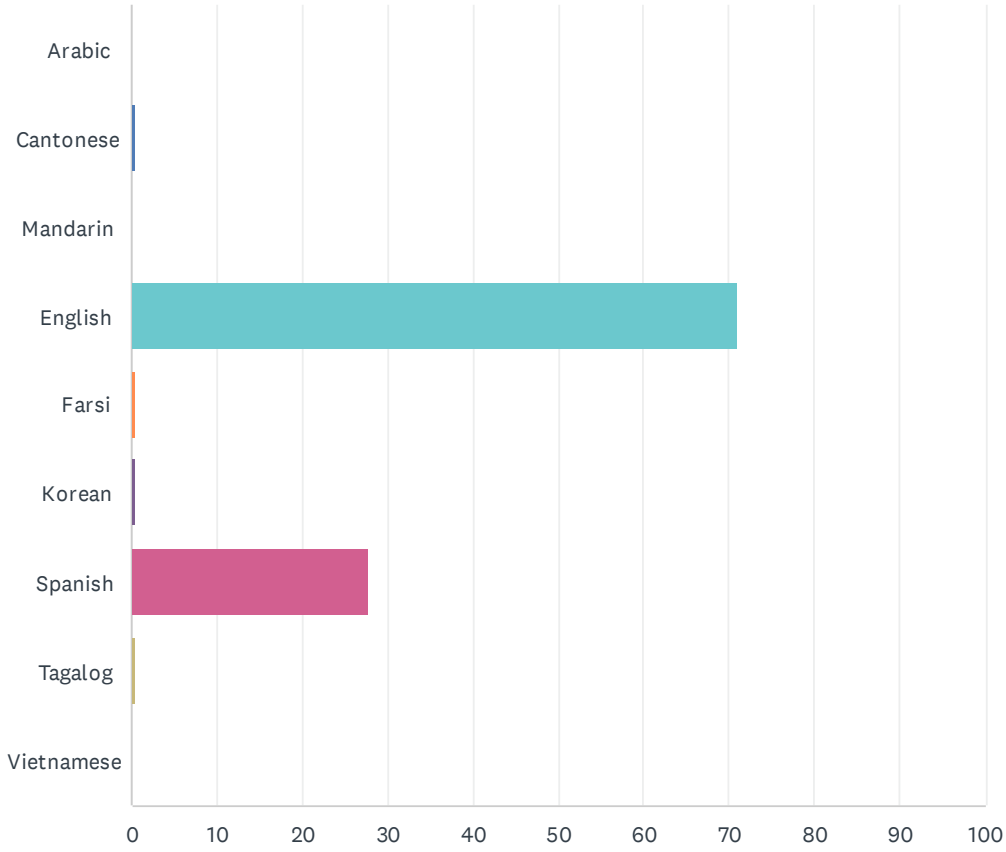
ANSWER CHOICES	AVERAGE NUMBER	TOTAL NUMBER	RESPONSES
Children/Youth (0-15 years)	6	17	3
Transition Age Youth (16-25 years)	9	28	3
Adults (26-59 years)	56	167	3
Older Adults (60 and above)	29	86	3
Other	2	2	1
Total Respondents: 3			

Q2 Please indicate the percentage of the following diverse cultural, racial/ethnic, and linguistic groups that were served in your organization from July 2021 - June 2022.



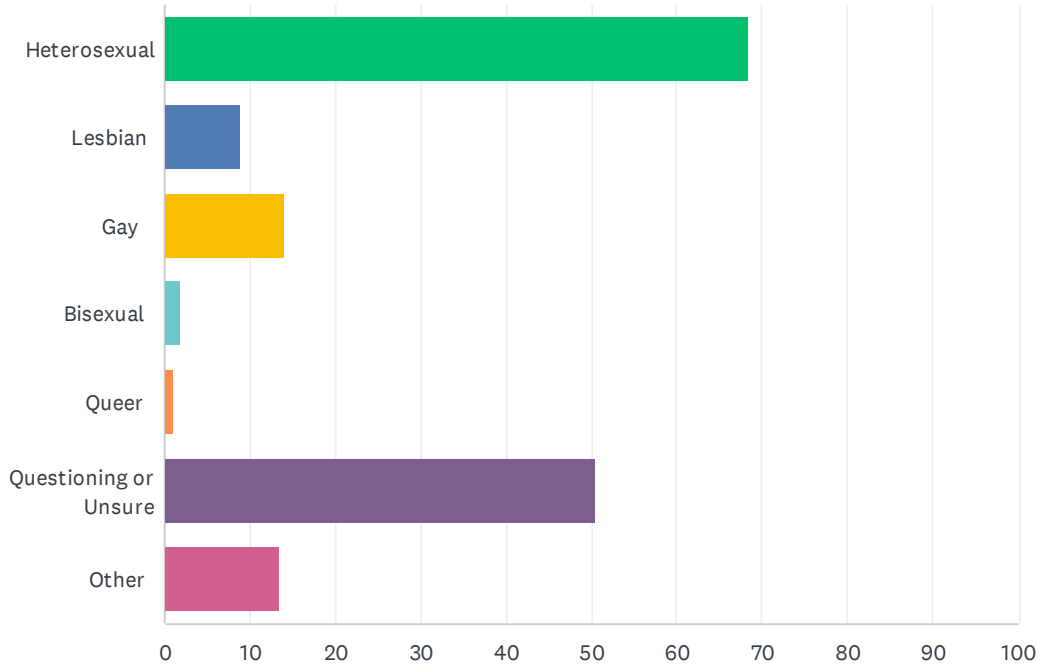
ANSWER CHOICES	AVERAGE NUMBER	TOTAL NUMBER	RESPONSES
African American/Black	20	59	3
Asian	11	33	3
Caucasian/White	27	80	3
Latinx/Hispanic	38	115	3
American Indian or Alaska Native	3	10	3
Native Hawaiian or other Pacific Islander	0	1	3
Other	0	0	1
More than one Race	1	2	2
Total Respondents: 3			

Q3 Please enter the percentage of your staff that are proficient in each threshold language listed below.



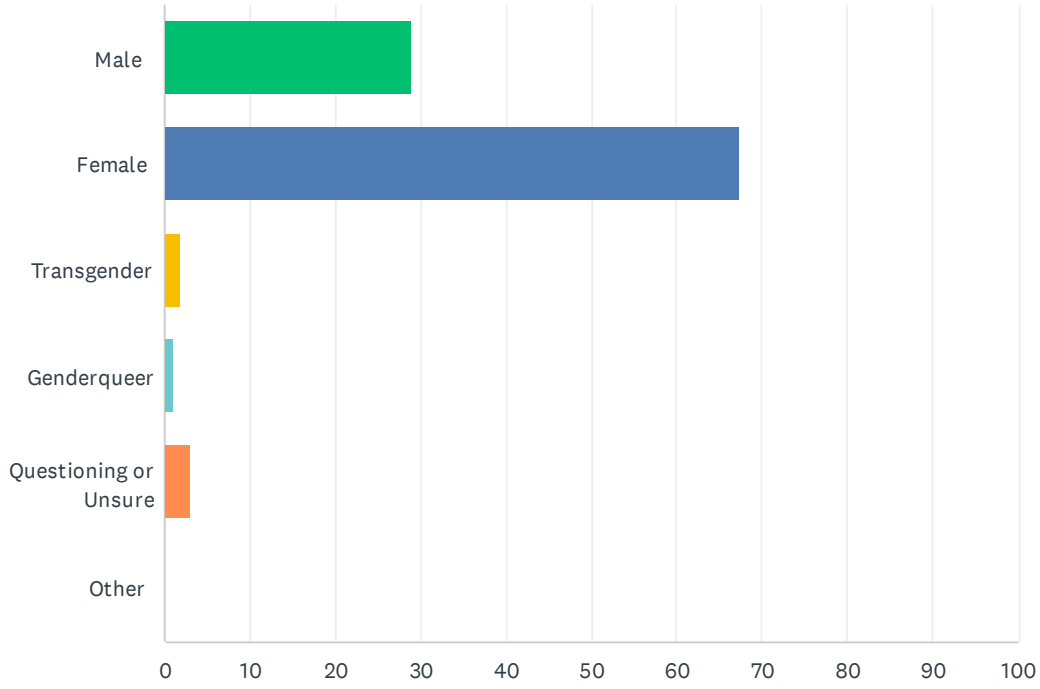
ANSWER CHOICES	AVERAGE NUMBER	TOTAL NUMBER	RESPONSES
Arabic	0	0	2
Cantonese	1	1	2
Mandarin	0	0	2
English	71	213	3
Farsi	1	1	2
Korean	1	1	2
Spanish	28	83	3
Tagalog	1	1	2
Vietnamese	0	0	2
Total Respondents: 3			

Q4 Please enter the percentage of individuals from the following sexual orientation groups that were served in your organization from July 2021-June 2022.



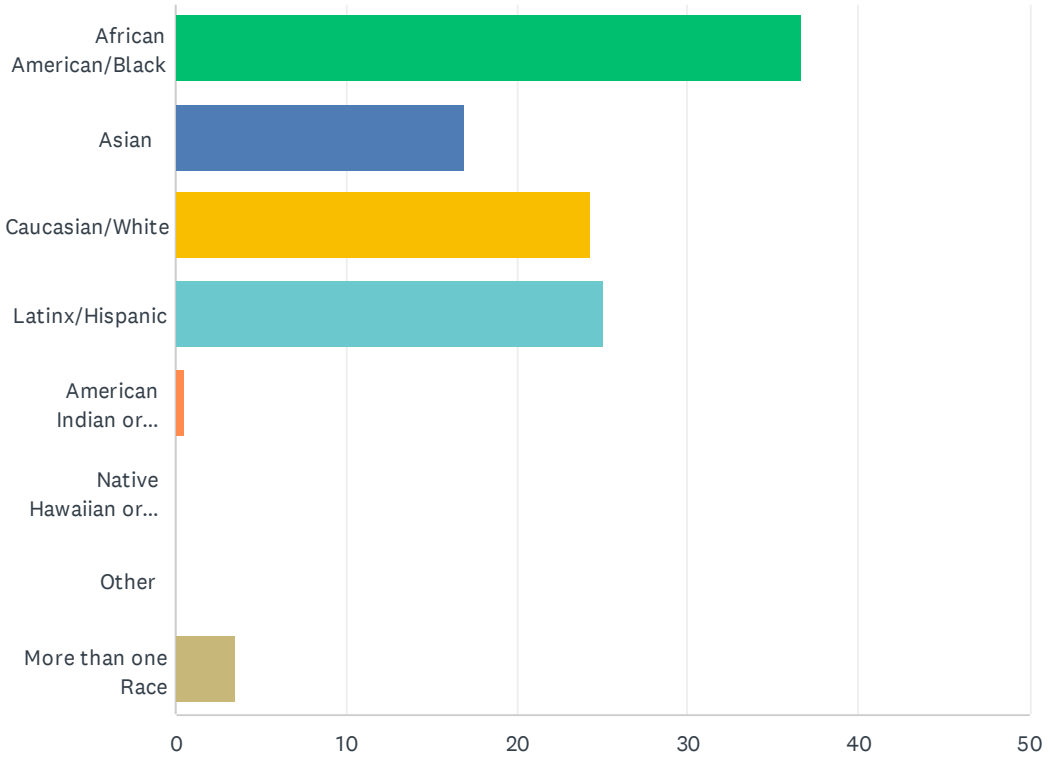
ANSWER CHOICES	AVERAGE NUMBER	TOTAL NUMBER	RESPONSES
Heterosexual	69	137	2
Lesbian	9	18	2
Gay	14	14	1
Bisexual	2	2	1
Queer	1	1	1
Questioning or Unsure	51	101	2
Other	14	27	2
Total Respondents: 3			

Q5 Please indicate the percentage of individuals from the following gender identity groups that were served in your organization from July 2021-June 2022.



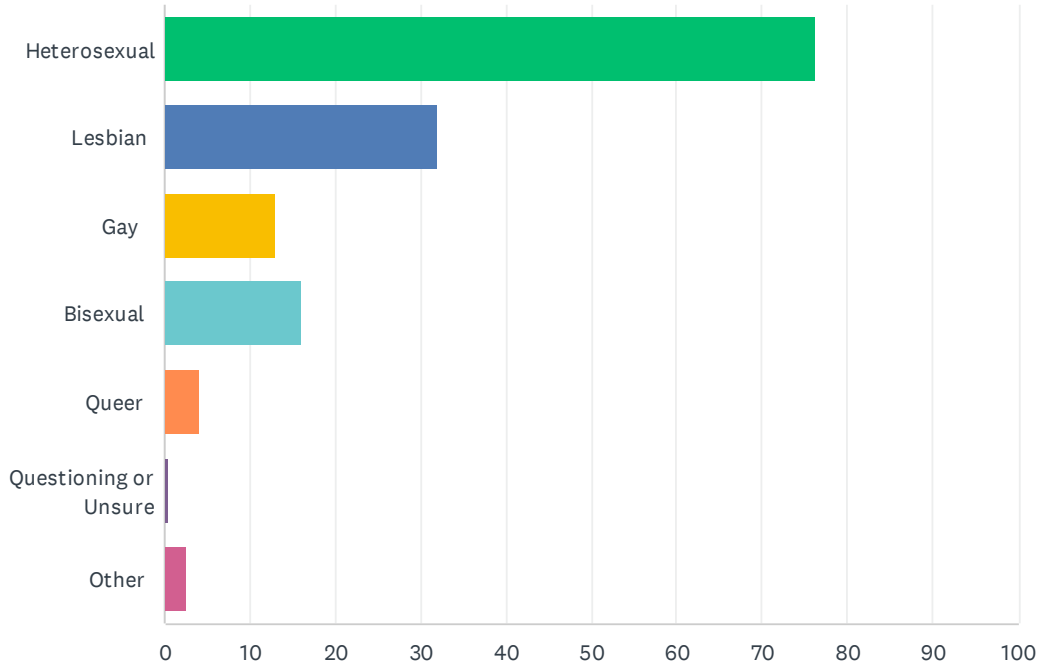
ANSWER CHOICES	AVERAGE NUMBER	TOTAL NUMBER	RESPONSES
Male	29	87	3
Female	67	202	3
Transgender	2	4	2
Genderqueer	1	1	1
Questioning or Unsure	3	6	2
Other	0	0	1
Total Respondents: 3			

Q6 Please indicate the percentage of the following diverse cultural, racial/ethnic and linguistic groups that are currently represented among staff in your organization.



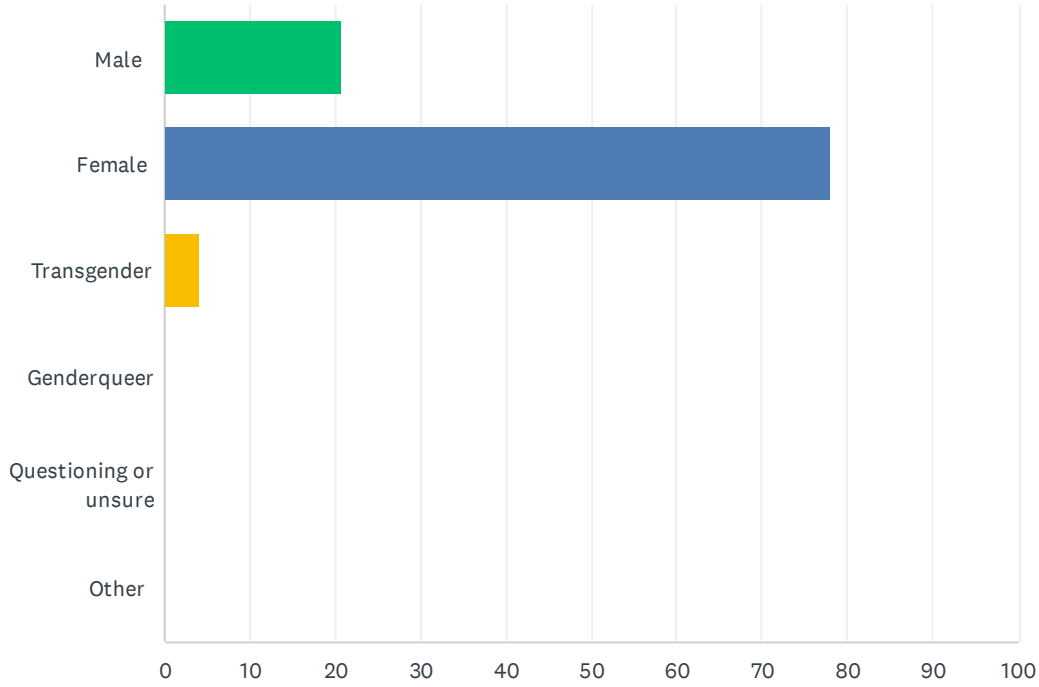
ANSWER CHOICES	AVERAGE NUMBER	TOTAL NUMBER	RESPONSES
African American/Black	37	110	3
Asian	17	34	2
Caucasian/White	24	73	3
Latinx/Hispanic	25	75	3
American Indian or Alaska Native	1	1	2
Native Hawaiian or Other Pacific Islander	0	0	2
Other	0	0	2
More than one Race	4	7	2
Total Respondents: 3			

Q7 Please indicate the percentage of the following sexual orientation groups that are currently represented among staff in your organization.



ANSWER CHOICES	AVERAGE NUMBER	TOTAL NUMBER	RESPONSES
Heterosexual	76	229	3
Lesbian	32	32	1
Gay	13	13	1
Bisexual	16	16	1
Queer	4	4	1
Questioning or Unsure	1	1	2
Other	3	5	2
Total Respondents: 3			

Q8 Please indicate the percentage of the following gender identity groups that are currently represented among staff in your organization.



ANSWER CHOICES	AVERAGE NUMBER	TOTAL NUMBER	RESPONSES
Male	21	62	3
Female	78	234	3
Transgender	4	4	1
Genderqueer	0	0	1
Questioning or unsure	0	0	1
Other	0	0	1
Total Respondents: 3			

Q9 For each question above where you choose "other" as a response please specify the definition of other per each response:

-We do not ask or track employees sexual preference.

-Percentage(s) of the primary age group(s) the organization currently serves (2%) -preferred not to answer

-Percentage of individuals from the following sexual orientation groups that were served in your organization from July 2021 - 6/30/22 (25%) - preferred not to answer

-N/A

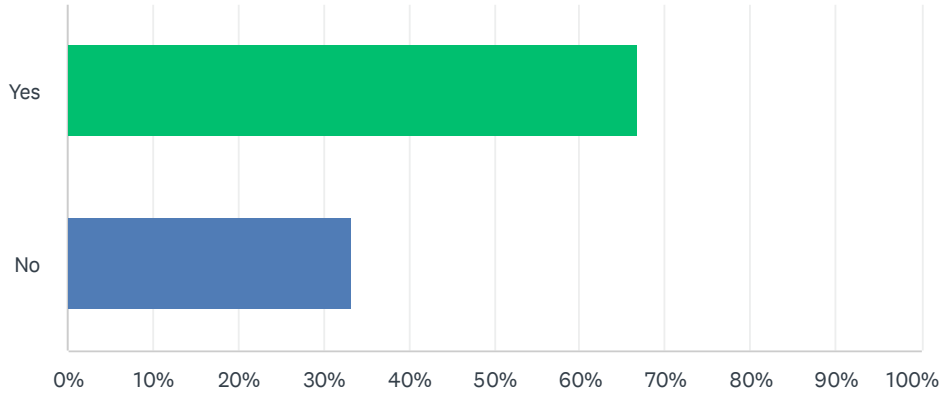
Q10 Please describe any limitations that have impacted the organizations ability to meet the needs of racially and ethnically diverse populations.

-No limitations. Aging Services has an ethnically diverse staff that possesses cultural awareness.

-Berkeley is a very diverse city, with speakers of many languages beyond those spoken by our staff (which include English, Spanish, Maya Mam, Portuguese, French, and Russian). We use volunteer interpreters for other languages, and remote interpretation when volunteers aren’t available, but in terms of building trust and rapport with clients, having staff members who speak their language is vastly preferable.

-We have positions open and will be increasing our Spanish speaking staff.

Q11 Has the organization experienced difficulties in recruiting/retaining Behavioral Health staff positions?



ANSWER CHOICES	RESPONSES	
Yes	66.67%	2
No	33.33%	1
TOTAL		3

Q12 Please provide the percentage of Behavioral Health staff positions that have been hard-to-fill and/or retain within the organization. Enter N/A if this is not applicable.

-We have one part-time MFT, there are not enough candidates and we need more BIPOC counselors in the field.

-50%

-N/A

Q13 Please list the titles of the Behavioral Health staff positions that are currently vacant within the organization. Enter N/A if this is not applicable.

-Behavioral Health Clinician I

-Using funds from CDSS's new program for serving unaccompanied immigrant youth, we hoped to hire a licensed therapist (MFW/LCSW). Three months of searching produced zero serious candidates. In the end, we decided to have an existing staff member, who was serving as a caseworker for public benefits, shift into the role of a caseworker exclusively for unaccompanied minors (we then hired a new benefits caseworker).

-Currently none open but if we had more applicants and funding we would increase our staff in this category.

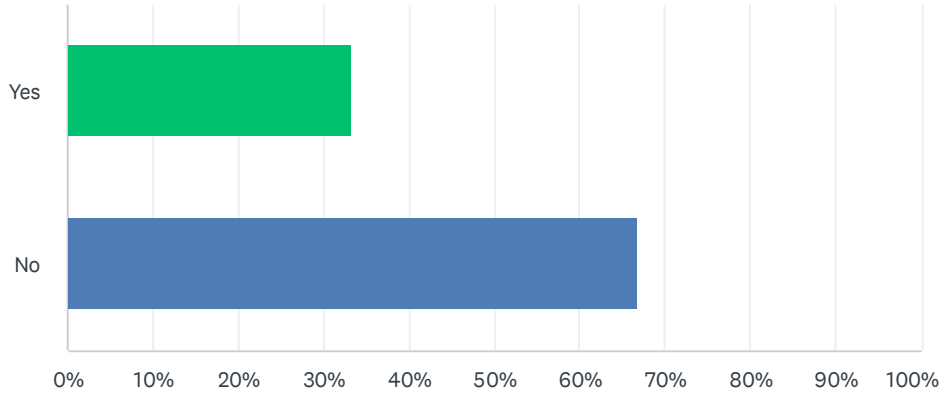
Q14 Are the vacancies in the organizations Behavioral Health staff positions, currently creating barriers to implementing services? If yes, please describe how the vacancies are impacting the delivery of services to each affected population. Enter N/A if this is not applicable.

-If we had additional funding and could hire additional highly skilled behavioral health providers then we could help more people if there were a place to refer higher need people...

-Switching our existing caseworker into a new role has worked very well in terms of meeting our clients' basic needs. She came to us with experience working with teenagers, and is clearly acting as a source of emotional support for these clients. Still, we were not able to hire a mental health professional as we had hoped. We are currently in the process of trying to recruit an on-site graduate student intern from U.C. Berkeley's MSW program.

-Yes. A licensed clinician is needed to provide case management services to Shelter+Care voucher holders. This is a high-need, high- acuity population, and we are currently short staffed in this unit. Current staffing is holding too high caseloads.

Q15 Has the organization recently experienced difficulties in recruiting and/or retaining staff from various cultural, racial/ethnic and/or linguistic groups ?



ANSWER CHOICES	RESPONSES	
Yes	33.33%	1
No	66.67%	2
TOTAL		3

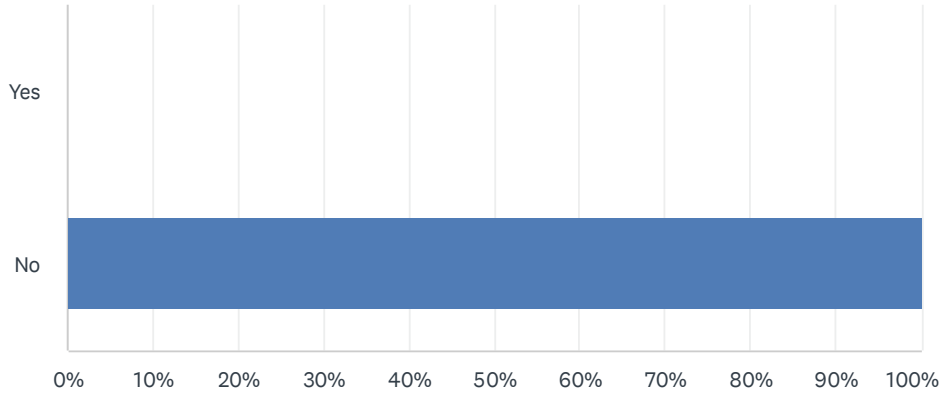
Q16 Are the vacancies in staff from various cultural, racial/ethnic and linguistic groups currently creating barriers to implementing services? If yes, please describe how the vacancies are impacting each affected population.

-No.

-As noted above, it would be ideal to have native speakers of all the languages spoken by our clients. Notable gaps include Dari, Pashto, and Ukrainian. But we have not found these gaps to be fundamental barriers to serving all immigrant communities.

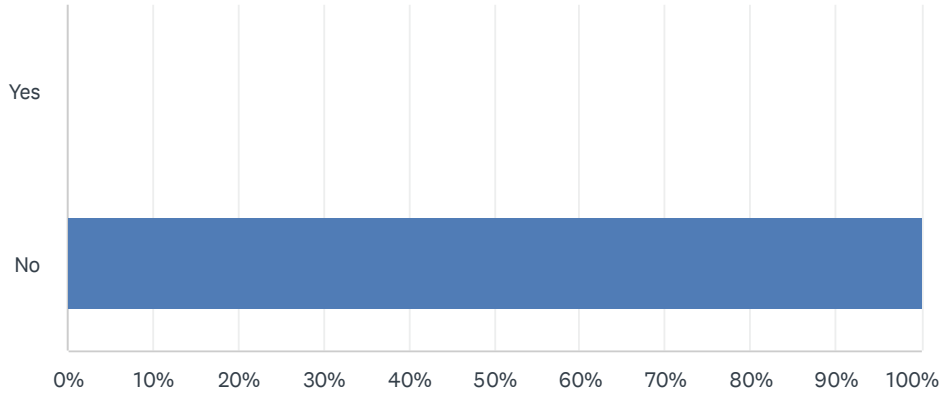
-We hope to fill open positions with Spanish speaking people.

Q17 Has the organization recently experienced difficulties in recruiting and/or retaining staff from various diverse sexual orientation groups?



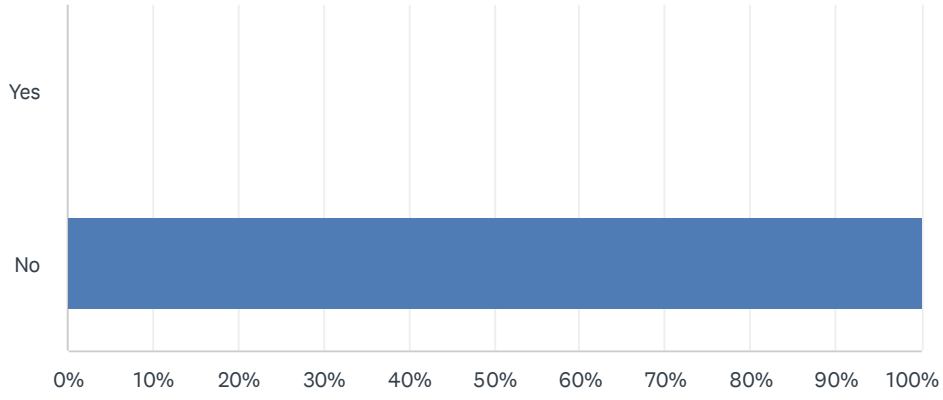
ANSWER CHOICES	RESPONSES	
Yes	0.00%	0
No	100.00%	3
TOTAL		3

Q18 Are the vacancies in staff from various diverse sexual orientation groups creating barriers to implementing services? If yes, please describe how the vacancies are impacting the delivery of services to each affected population.



ANSWER CHOICES	RESPONSES	
Yes	0.00%	0
No	100.00%	3
TOTAL		3

Q19 Has the organization recently experienced difficulties in recruiting and/or retaining staff from various diverse gender identity groups?



ANSWER CHOICES	RESPONSES	
Yes	0.00%	0
No	100.00%	3
TOTAL		3

Q20 Are the vacancies in staff from various gender identity groups currently creating barriers to implementing services? If yes, please describe how the vacancies are impacting the delivery of services to each affected population.

-No

-N/A

-No

Q21 Please describe any other barriers the organization is currently experiencing in implementing Behavioral Health programs/services.

-All of our staff should have the capacity to work with clients who may experience stress or mental health issues. Finding staff who have strong background and skills is always challenging although we are lucky to have a great team.

-The primary challenge has been, and continues to be, the scarcity of mental health care services available. We are fortunate to operate in an area with an abundance of excellent clinics, hospitals, and nonprofit mental health organizations, but the shortage of licensed professionals means that many of our clients must wait months to access care. This is not an issue of ability to pay or immigration status, as HealthPAC means that essentially all of our clients qualify for affordable care. It is an issue of scarcity. Another significant barrier is having mental health professionals who are linguistically and culturally competent.

-No other barriers.

Q22 Please describe how the organization is currently addressing these barriers to implementing Behavioral Health programs and services.

-N/A

-We pay close attention to what organizations are currently accepting new patients. We sometimes rely on organizations utilizing peer counseling, which tend to have shorter waits. For example, Communities United Against Violence in San Francisco provides peer counseling by phone to low-income LGBTQ survivors of violence anywhere in the Bay Area and has a wait-list of a few weeks, rather than a few months.

We have also been facilitating a range of support groups and workshops to help LGBTQIA and Latinx/Mam populations who might not feel comfortable seeking out one-on-one therapy. These groups are typically facilitated by mental health professionals and focus on peer support and psychosocial educational themes. We have found this to be a great way to address mental health needs and build trust and community for people who have been isolated and experiencing PTSD.

-Increasing funding to provide for more staff.

Q23 What do you consider to be the most pressing Behavioral Health needs that the City should focus on over the next three years?

-High needs clients who do not succeed with regular housing case management or life skills counseling. People who need to be in residential programs or who are deemed to be just below this need but still vulnerable and not safe to be on the street.

-From our perspective, the scarcity of mental health professionals to fill positions in clinics and nonprofits is a huge challenge. With MediCal soon expanding to cover all income-eligible undocumented people, demand will be greater than ever. Another gap is funding for culturally and linguistically accessible behavioral health programs - not just therapy, but support groups and community building for marginalized populations, especially recently arrived immigrants, LGBTQIA people, women, and youth. There are huge gaps for minority language groups such as Indigenous immigrants.

-The City's unhoused population is growing, and this population's need for high-level mental health services is growing as well. Also, as the percentage of older adults increases in our community, need for mental health services for this sub-population will also increase, including resources and referrals related to dementia.

Q24 Please share any other comments or input you may have regarding any of your responses on this survey, or anything else you may want to share.

-No additional comments.

-The City can play a crucial role in expanding services for underserved populations that do not currently have access to services - asylum seekers, LGBTQIA immigrants, unaccompanied minors, immigrant women and children who are survivors of gender-based violence, and Indigenous immigrant communities. Many thanks!

-More mental health services, regular engagement, more indoor places people can gather to feel safe and be in the presence of others who have the time and capacity to provide support.

APPENDIX C

RESULTS BASED ACCOUNTABILITY (RBA) FY22 DIVISION-WIDE MEASURES AND OUTCOMES

Berkeley Mental Health Division-level Measures

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # of clients served (ALL) 2. # of unduplicated clients served (ALL but MCT, CAT/TOT)	3. Responsiveness of service (e.g. x days following qualifying event) (FSPs, CCT, FIT, CAT/TOT only) 4. Consistency of service (e.g. % clients who had met targeted frequency of services) (FSPs, CCT, FIT only) 5. Equity of services (e.g. client demographics compared to MediCal population) (FSPs, CCT, FIT only) 6. Customer service (% of clients who were satisfied with services) (ALL but Wellness)**	7. % 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 (FSPs, CCT, FIT only) 8. % of clients with a decrease in hospitalizations/hospitalization days (FSPs, CCT, FIT only) 9. % of clients with a decrease in incarceration days (FSPs, CCT, FIT only) 10. % clients who had a primary care visit in the last year (FSPs, CCT, FIT only) 11. % of clients who moved out of homelessness (i.e. homeless at intake, placed into housing) (ALL but MCT, CAT, and Wellness)**

*Please note: demographic data will be reported at the division level, where available

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

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

1. % clients who feel they received culturally/racially responsive care
2. % of clients meeting treatment goals
3. % of community members eligible for BMH services that BMH serves
4. Timeliness of service (e.g., x days following a referral)
5. # of new clients opened for ongoing services

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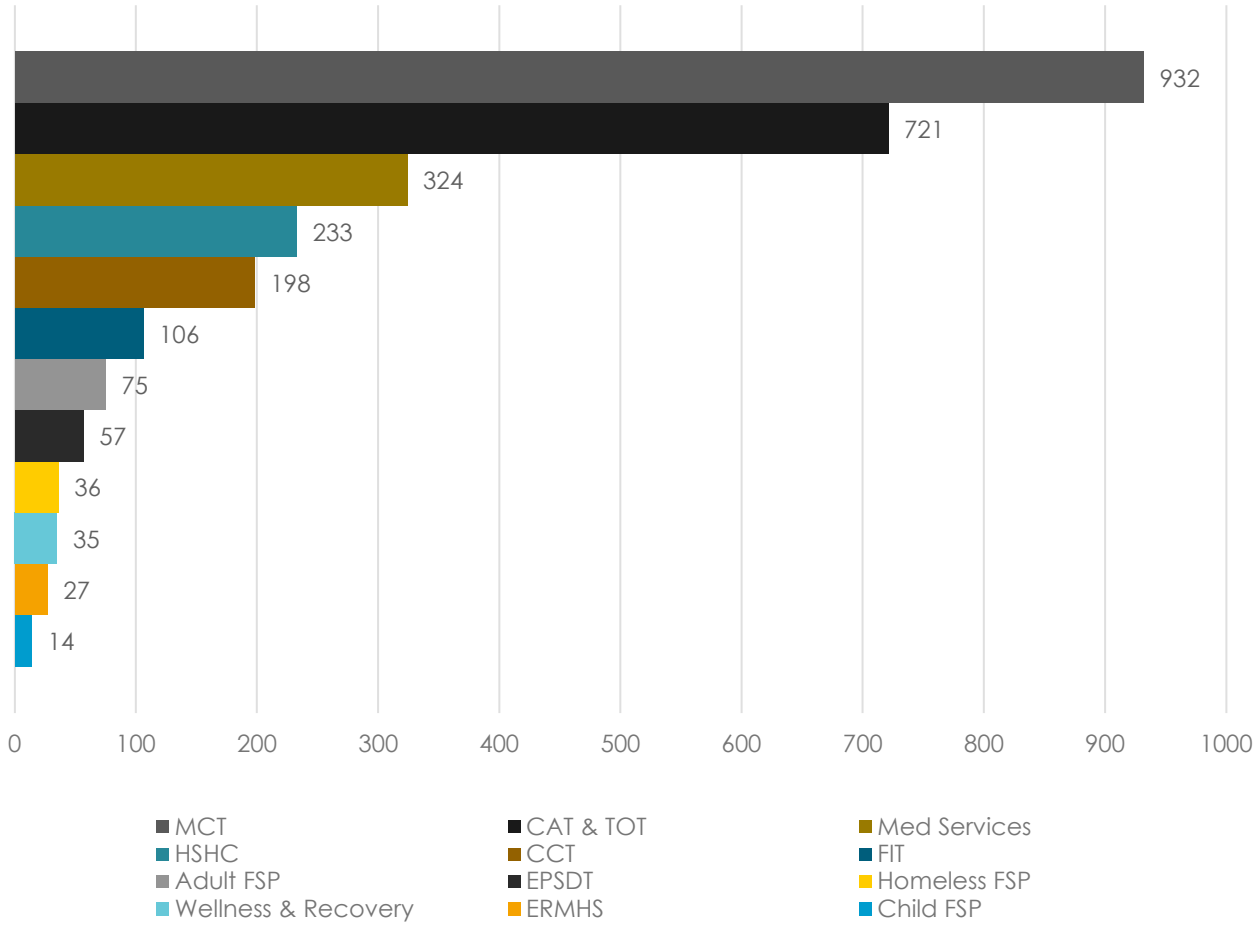
Berkeley Mental Health - Division-Level
Reporting Period: July 2021-June 2022 (Baseline)

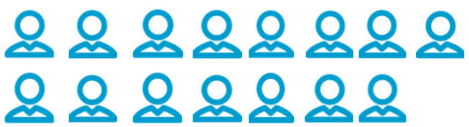
Process Outcomes ("How much did we do?")

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.

Clients Served, by Program



750



represents 50 clients

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

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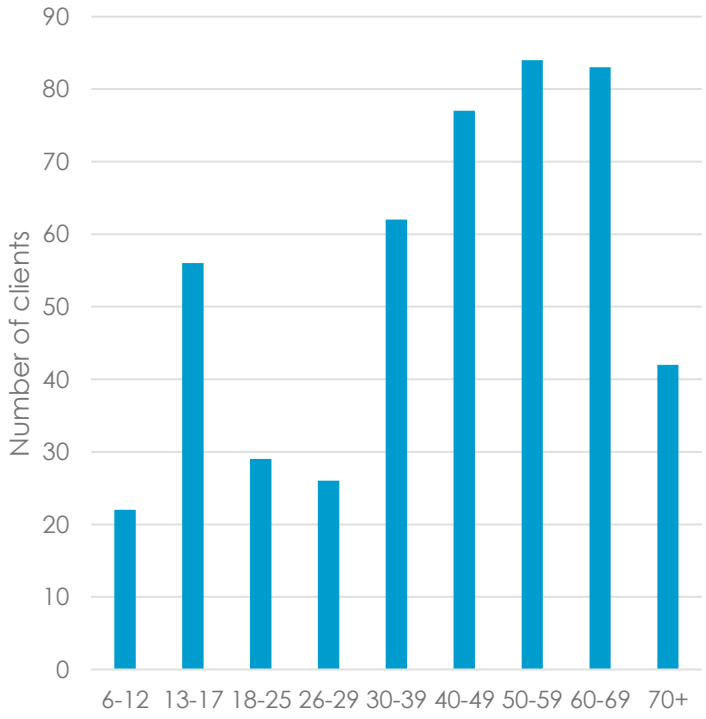
Quality Outcomes ("How well did we do it?")

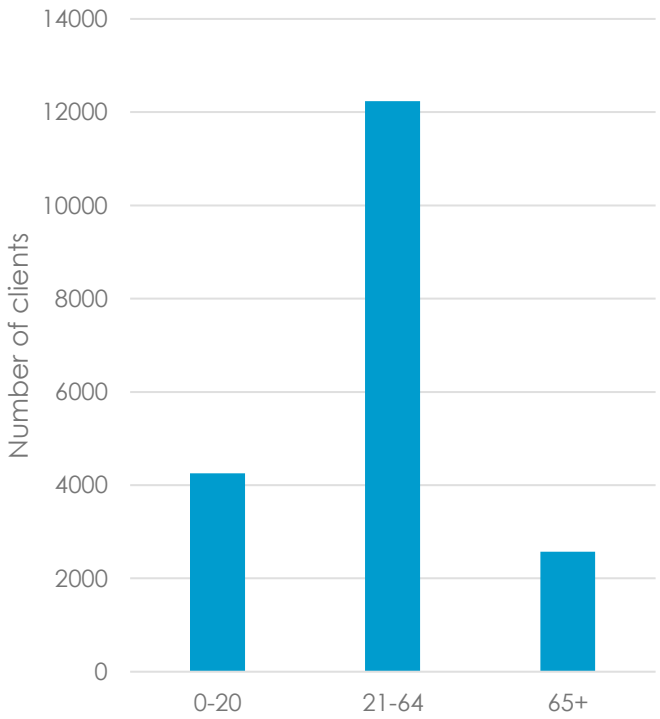
Equity of Services

Client demographics compared to the Medi-Cal population of Berkeley

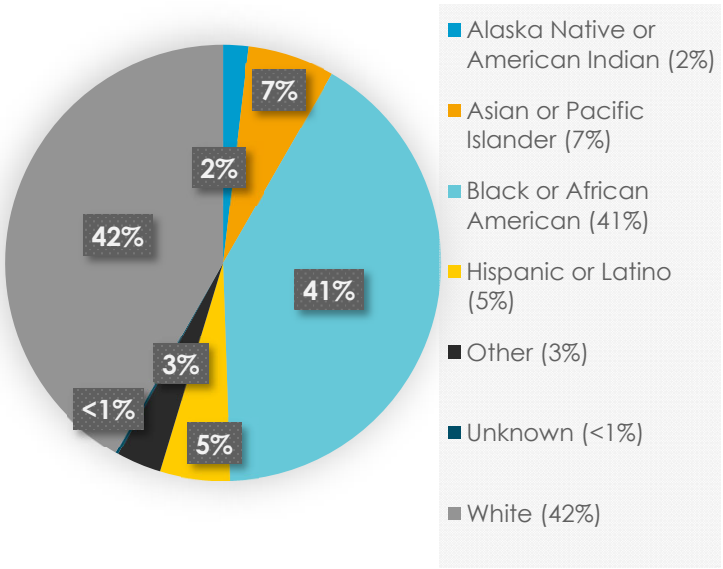
BMH Demographics (Age) (n=481)



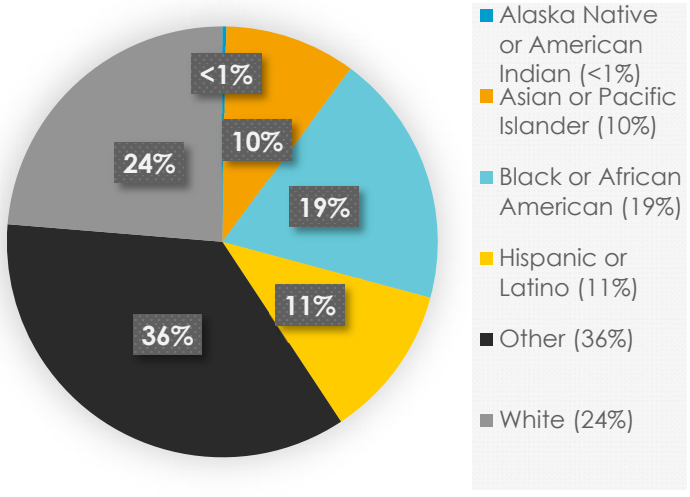
Medi-Cal Demographics (Age) (n=19,064)



BMH Demographics (Race) (n=481)



Medi-Cal Demographics (Race) (n=19,064)



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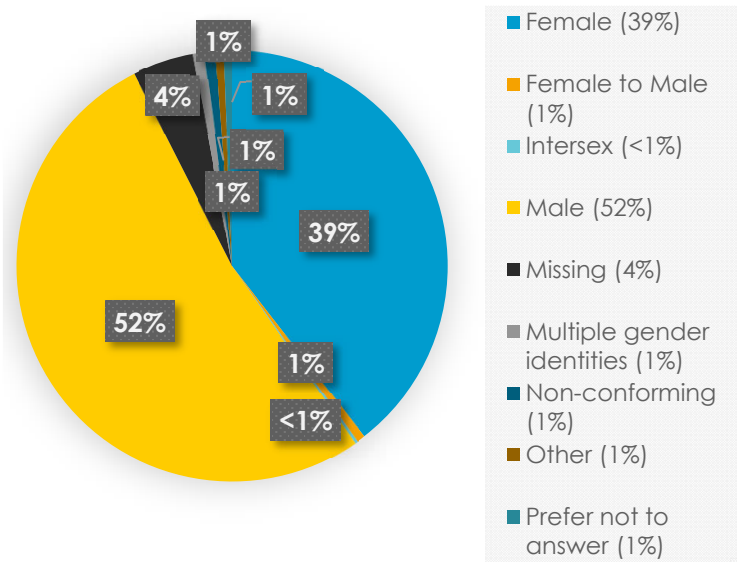
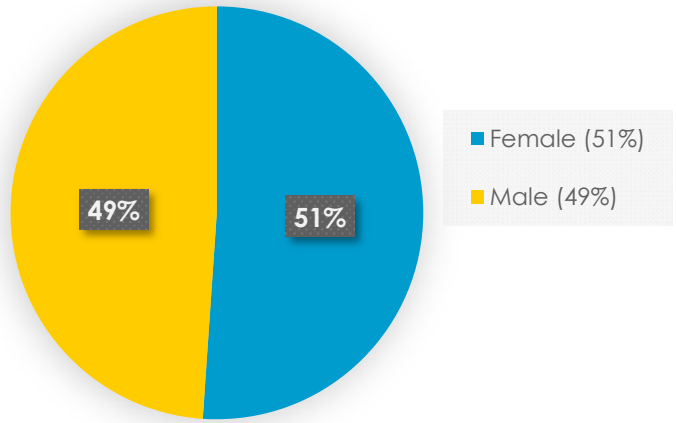
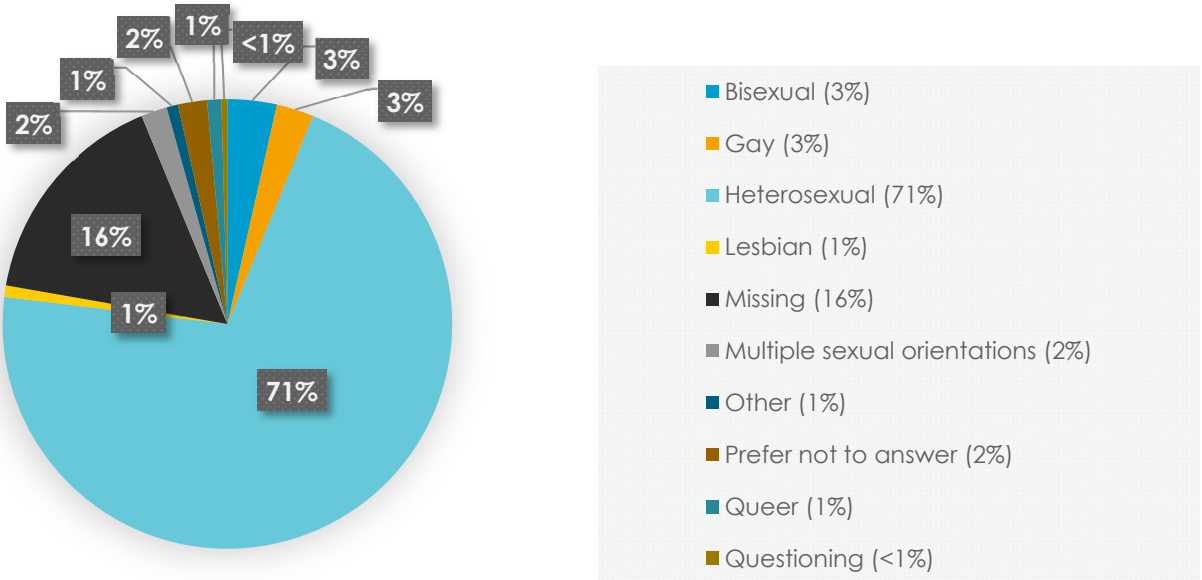
BMH Demographics (Gender Identity) (n=481)



Medi-Cal Demographics (Gender Identity) (n=19,064)



BMH Demographics (Sexual Orientation) (n=481)



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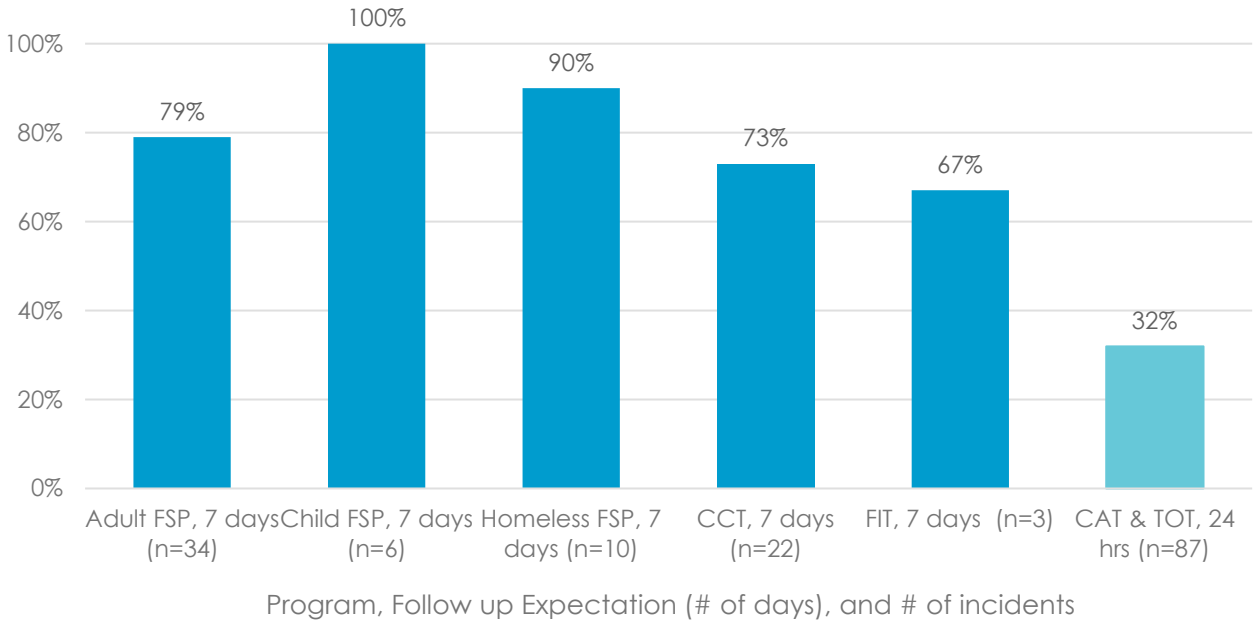
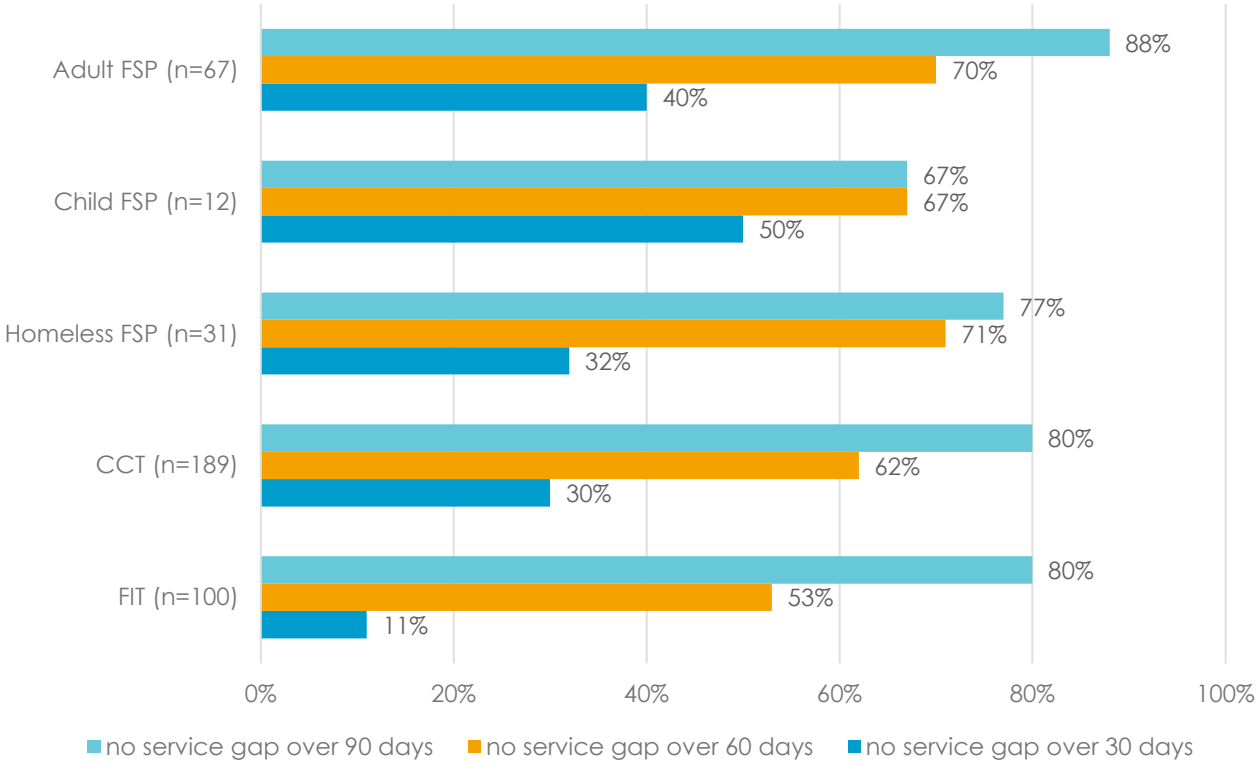
Responsiveness of Service

(% of discharges from hospitalization or subacute who had a follow up visit within specified time period)



Consistency of Service

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



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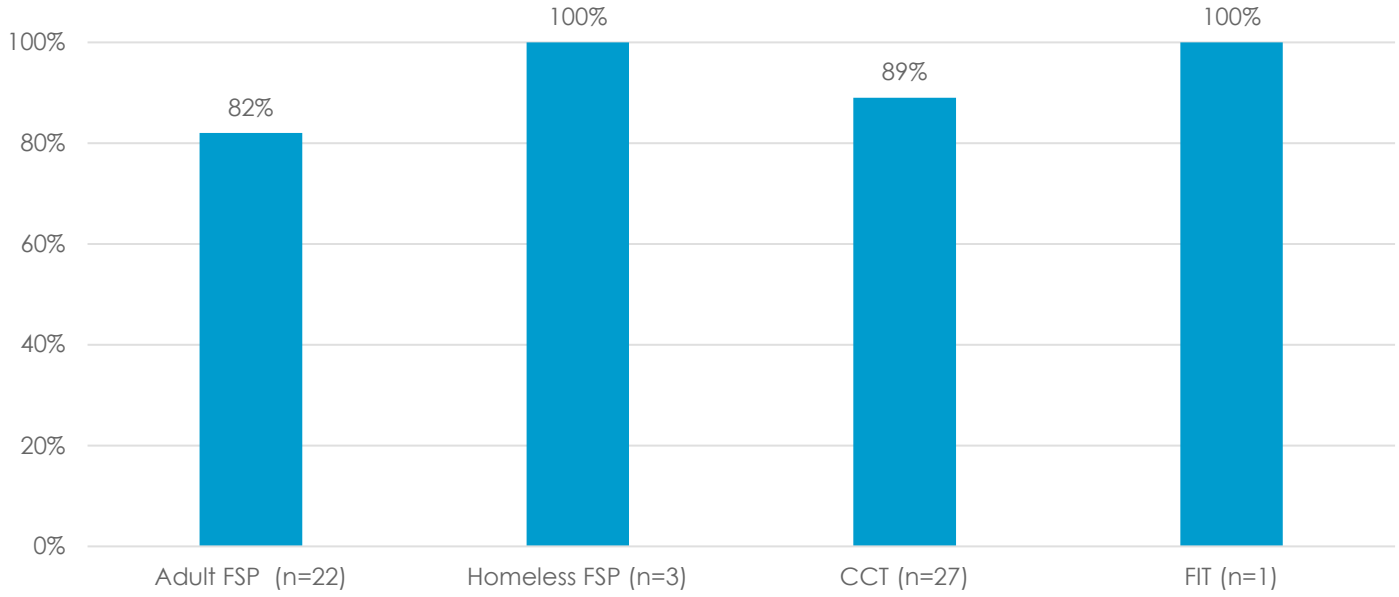
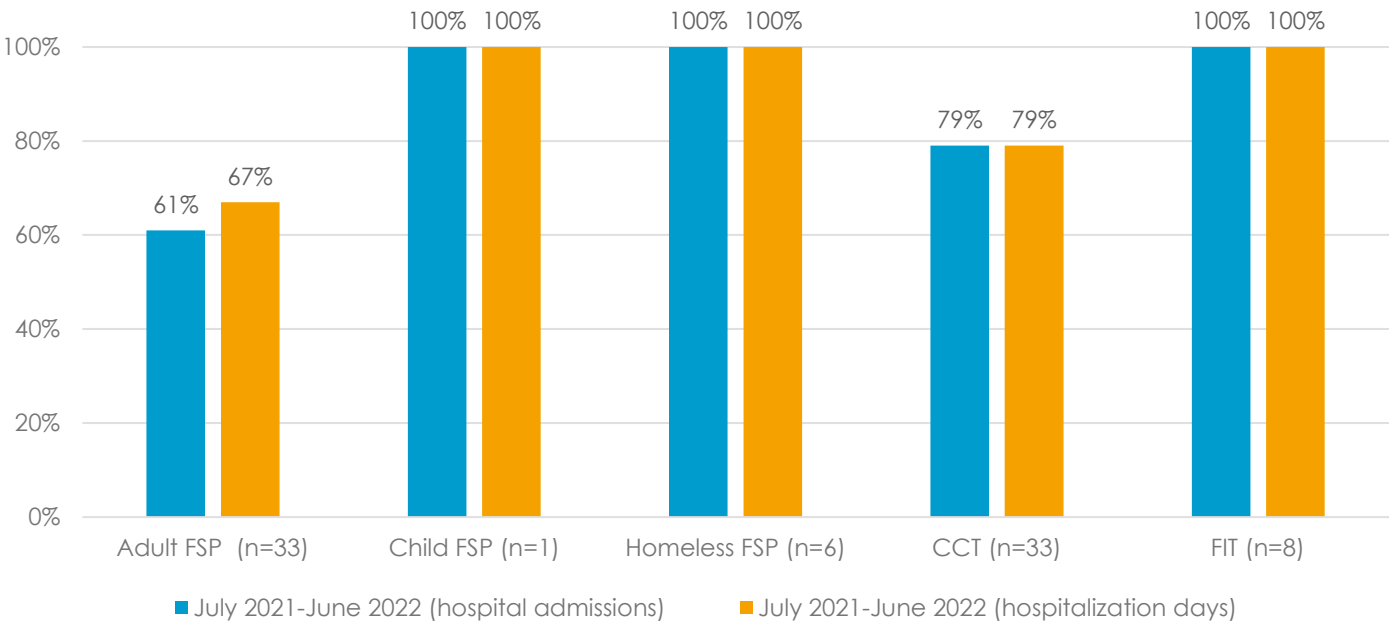
Impact Outcomes ("Is anyone better off?")

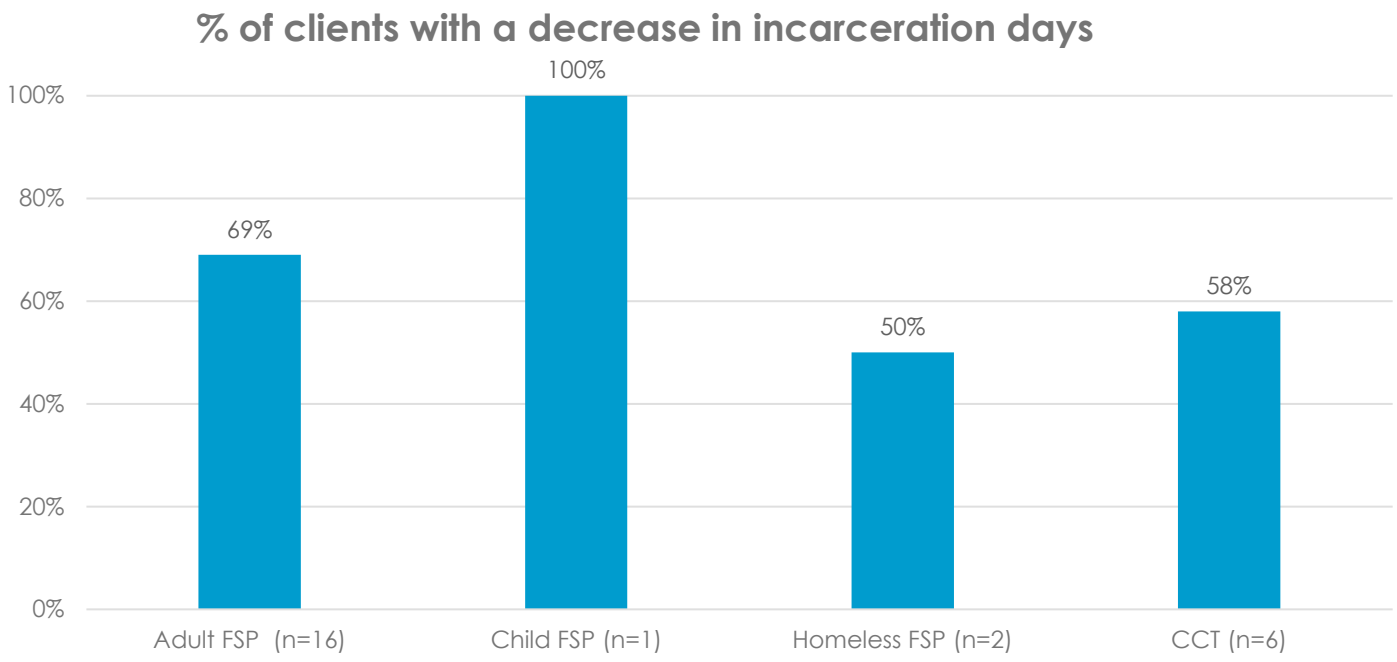
% of clients with a reduction in psychiatric emergency/inpatient/crisis stabilization*

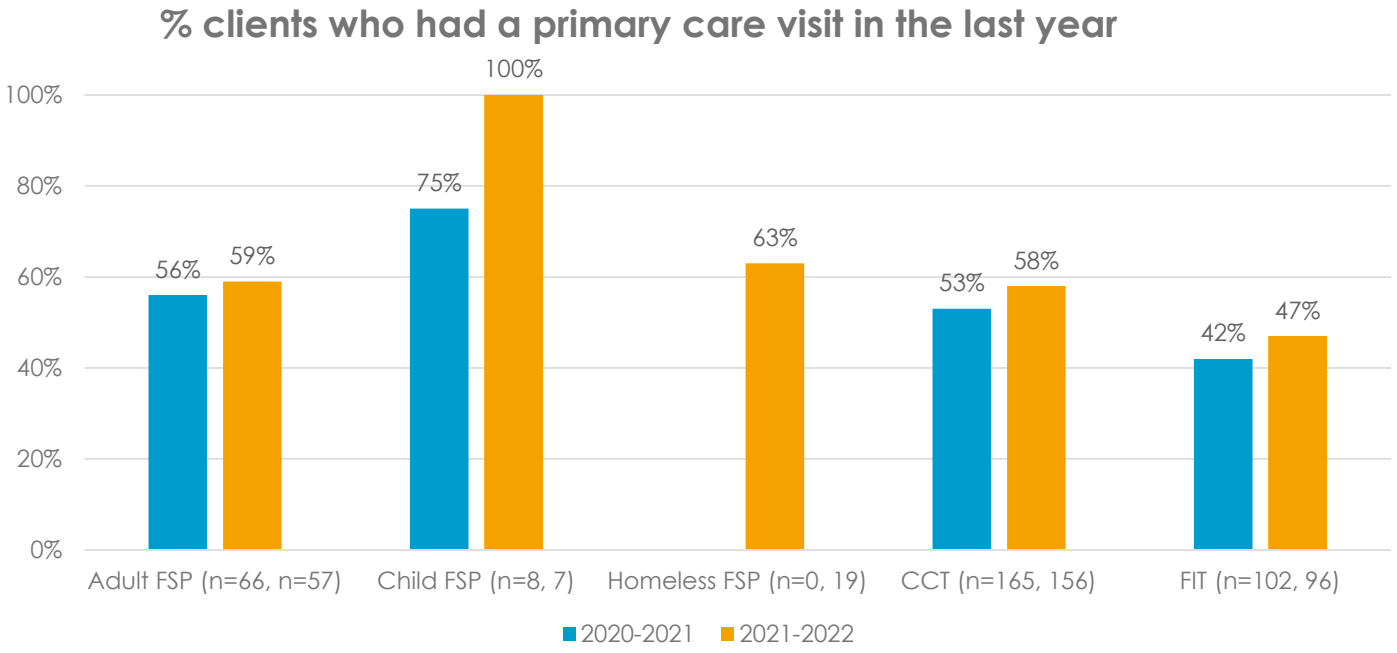


% of clients with a reduction in hospitalization



BMH RBA Report FY 2022





BMH RBA Report FY 2022

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
Equity of services (demographics compared to Medi-Cal population)	Age, race, and gender identity of BMH clients and Medi-Cal beneficiaries in the City of Berkeley. Available for: Adult FSP, Children's FSP, Homeless FSP, CCT, FIT. No data available for sexual orientation of Medi-Cal beneficiaries. Does not include clients from CAT/TOT, High School Health Center, MCT, Medical Services, Wellness (may be duplicated or limited data available)	Yellowfin
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.	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 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 Available for: Adult FSP, Children's FSP, Homeless FSP, CCT, FIT.	Yellowfin

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% of clients with a decrease in incarcerations	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in jail days, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in hospital and/or subacute) for six or more months during the current fiscal year or the prior fiscal year. Available for: Adult FSP, Children's FSP, Homeless FSP, CCT, FIT.	Yellowfin
% clients who had a primary care visit in the last year	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/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). Available for: Adult FSP, Children's FSP, Homeless FSP, CCT, FIT.	Yellowfin

Adult Full Service Partnership (FSP)

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served 2. # of new clients opened for ongoing services 3. Average # of days in FSP per client 4. Average # of service hours per client per month 5. Average # of services per client per month	6. % of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program 7. % of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month 8. % of clients with no service gap of over 30 days 9. % of discharges from hospitalization or subacute who had a follow up visit with FSP staff within 7 and within 30 calendar days 10. #/% of clients closed, by reason closed 11. #/% of clients transferred to another level of care 12. % of clients who were satisfied with services**	13. % of clients who had a reduction in jail days in the last 12 months compared to the 12 months before enrollment 14. % 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 15. % of clients with a decrease in hospitalizations/hospitalization days 16. % of clients with a primary care visit in the last 12 months 17. % of clients who moved out of homelessness**

*Please note: demographic data will be reported at the program level, where available

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

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

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

BMH RBA Report FY 2022

Adult Full Service Partnership (FSP)

Reporting Period: July 2021-June 2022 (Baseline)

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

75

Clients Served

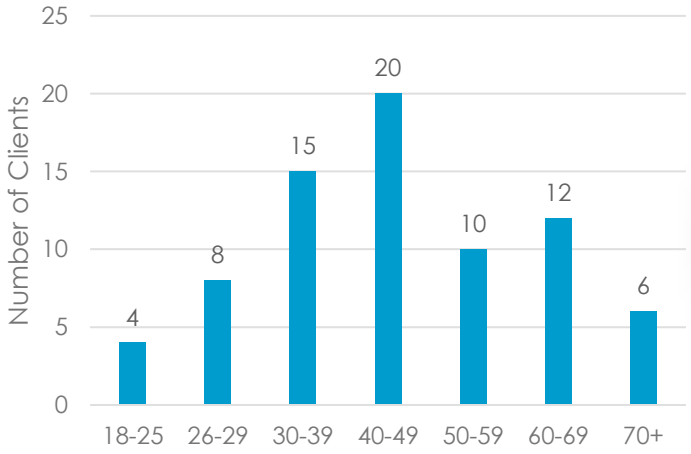
11

New Clients

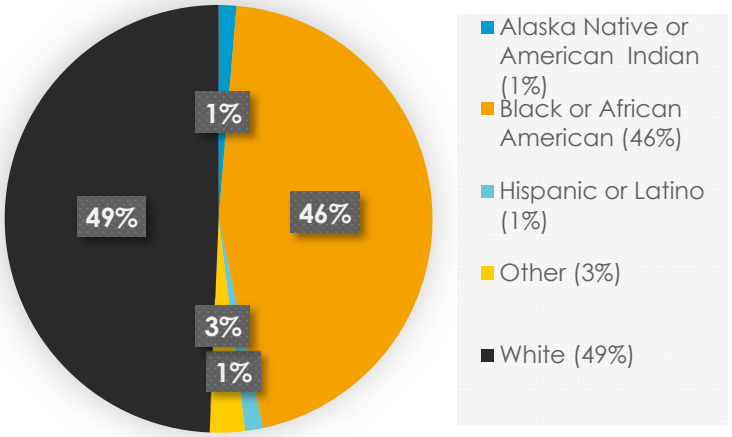
represents 10 clients

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 Model which involves low staff-to-client ratios at approximately 10:1 and a focus on providing care as a team rather than individual case load assignments. Services are primarily provided in the community rather than in an office setting.

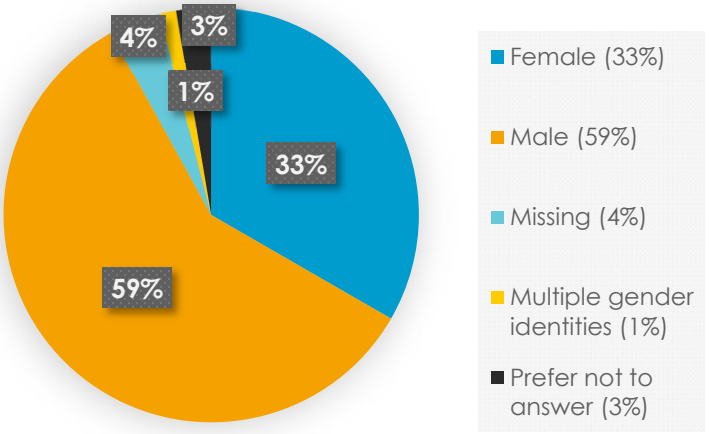
Demographics (Age)



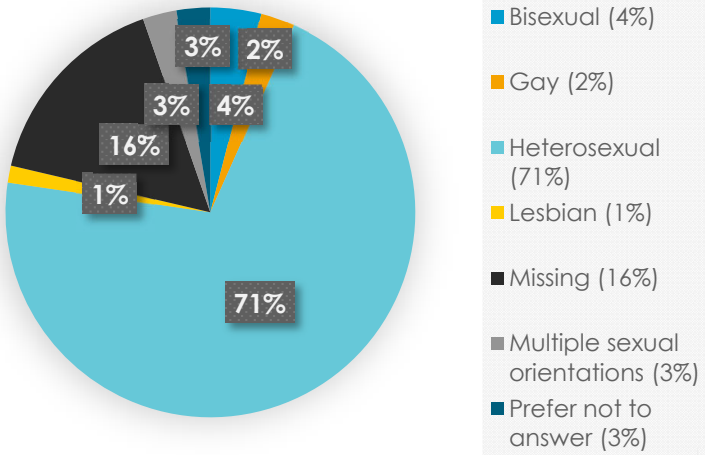
Demographics (Race)



Demographics (Gender Identity)



Demographics (Sexual Orientation)



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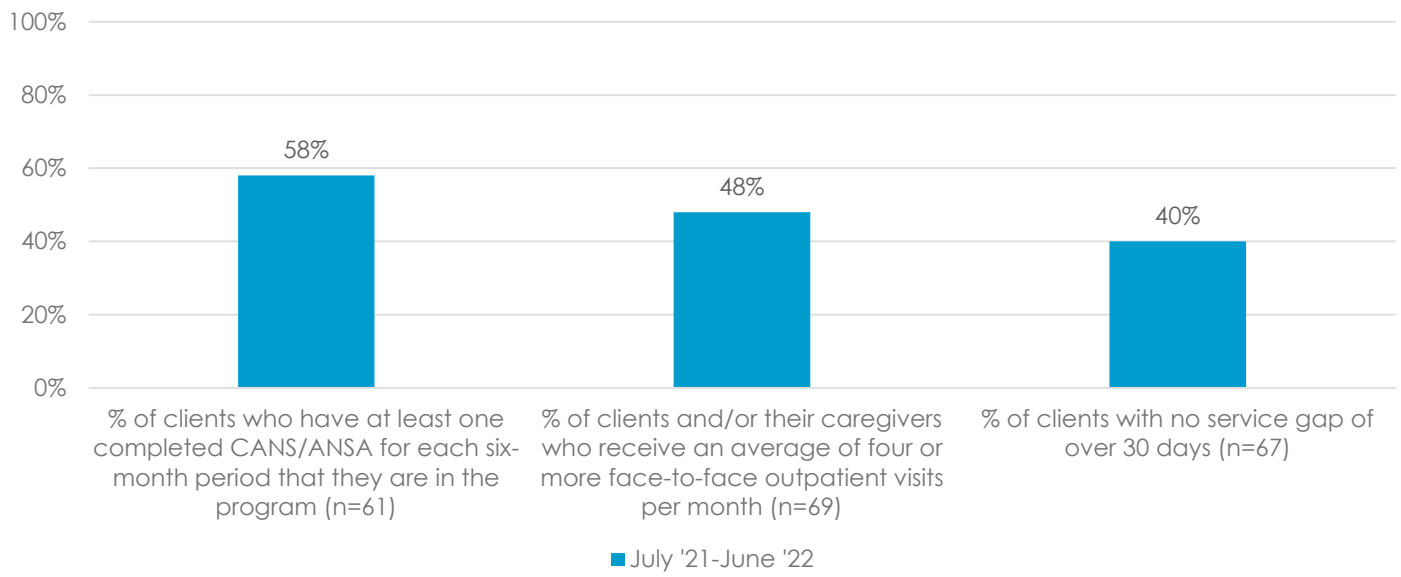
The average client served in 2021-2022:

- remained in the FSP program for **1,231 days**
- received **5.17 hrs** of services per month
- received **4.53 services** per month

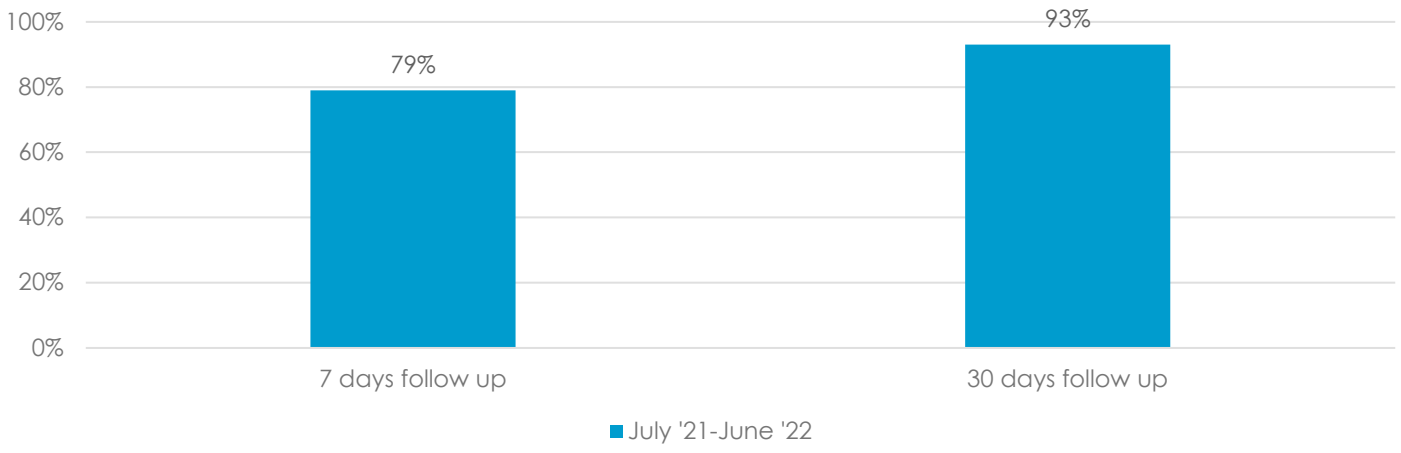
Quality Outcomes ("How well did we do it?")

Service Consistency



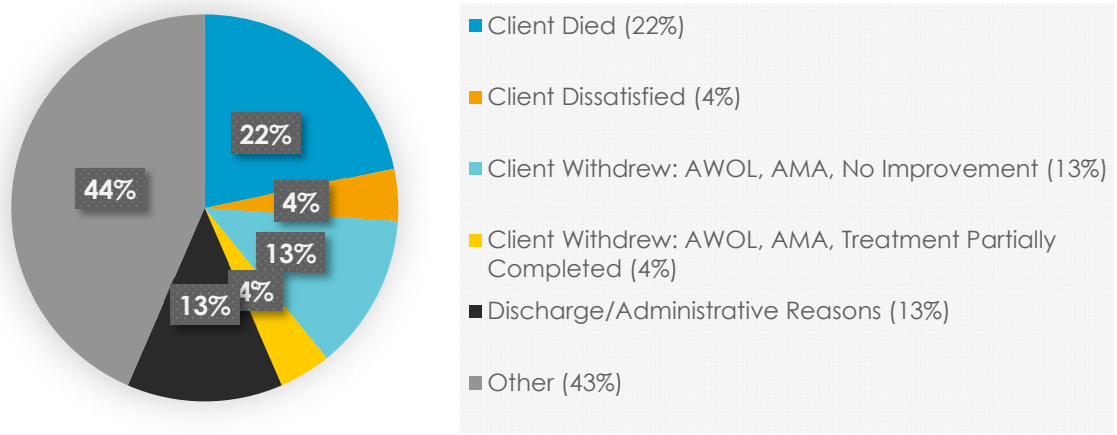
Hospital Follow Up Consistency

% of discharges from hospitalization or subacute who received FSP follow up within 7 and 30 days (n=28)

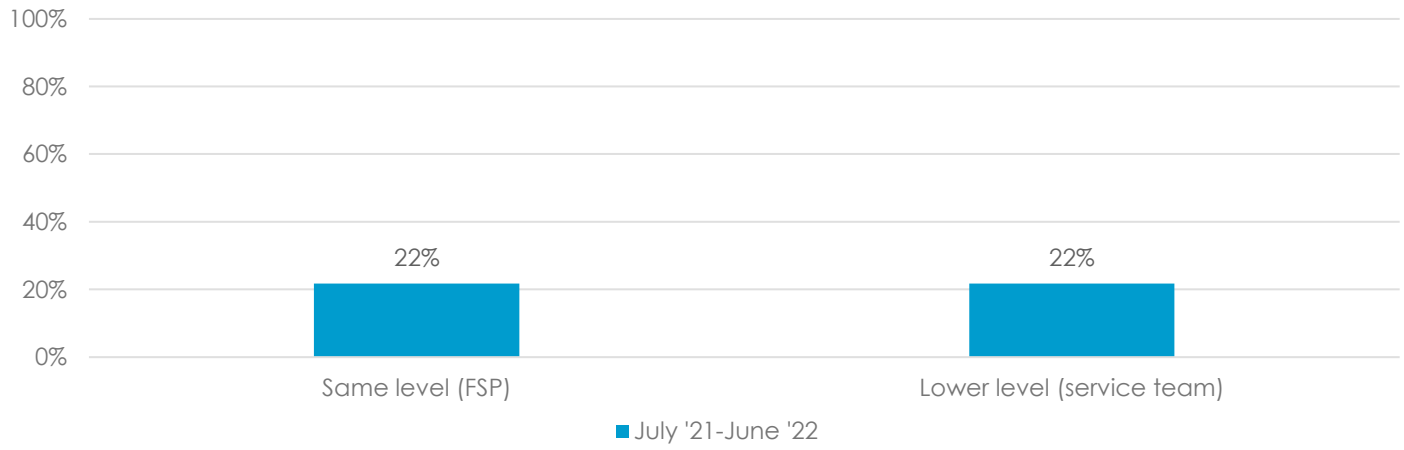


BMH RBA Report FY 2022

Clients Closed by Reason Closed (n=23)

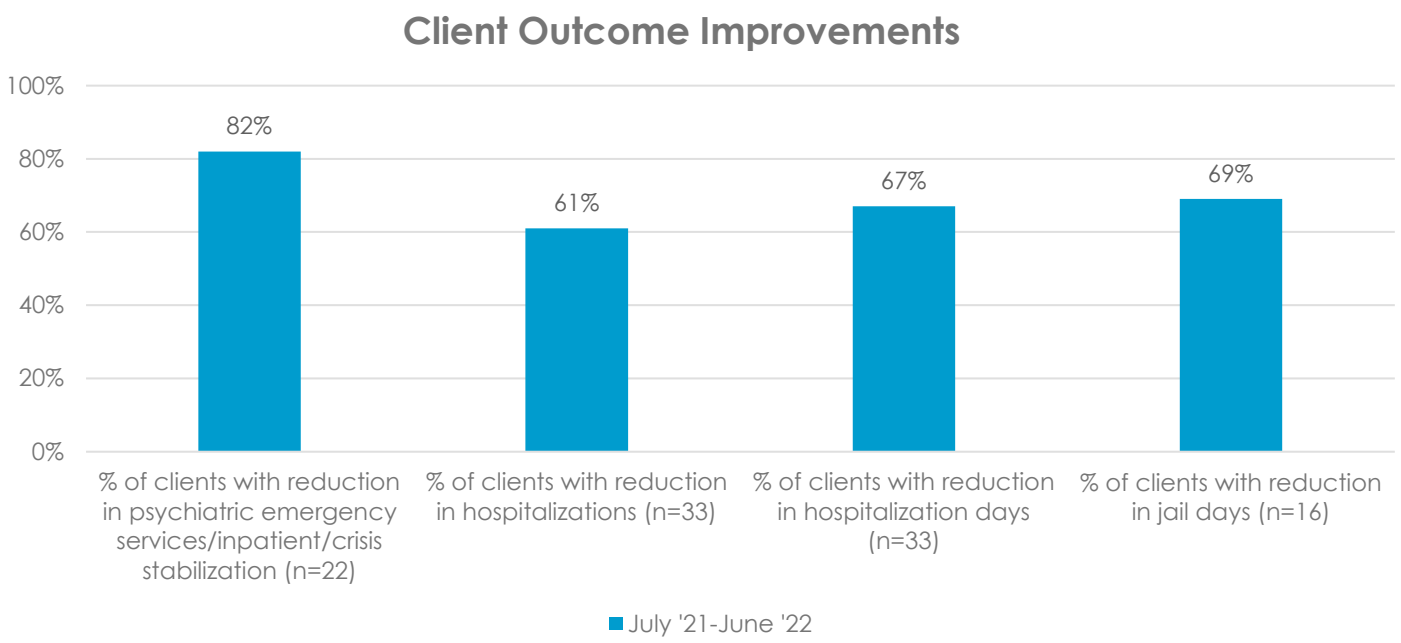


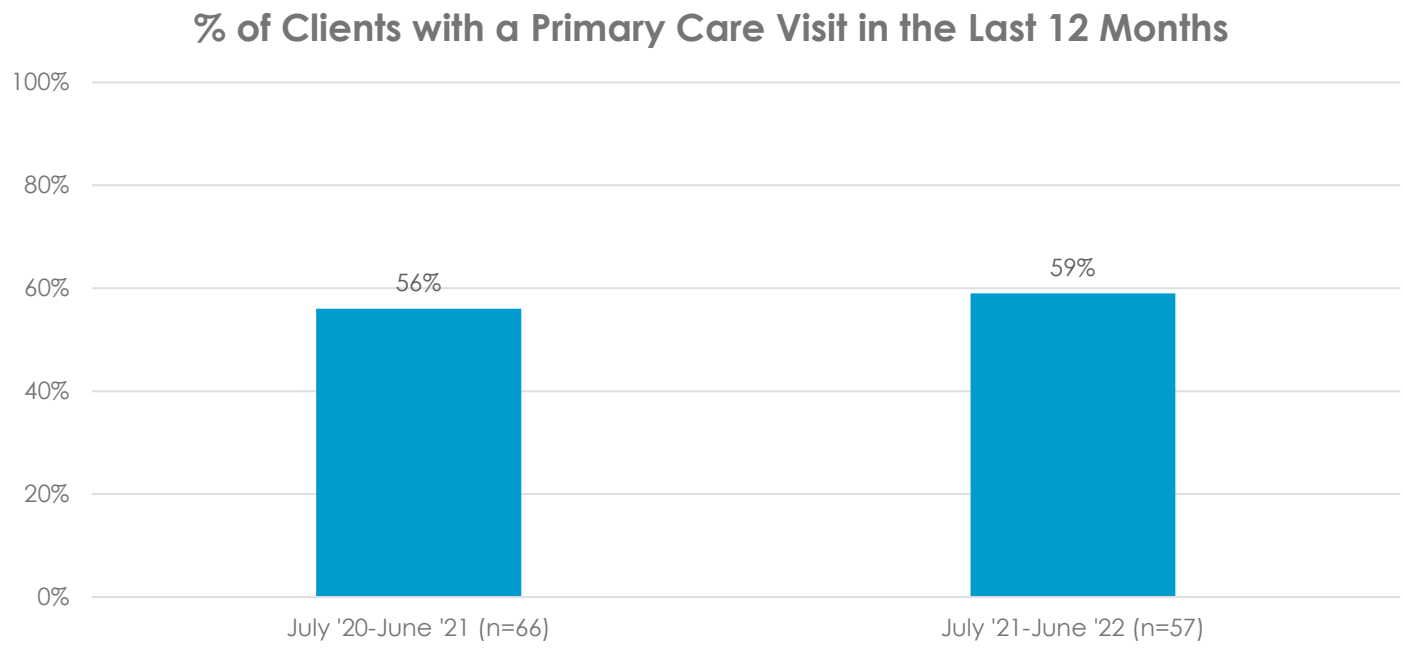
Clients Transferred to Another Program, by Level of Care (n=23)



BMH RBA Report FY 2022

Impact Outcomes ("Is anyone better off?")





BMH RBA Report FY 2022

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 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

BMH RBA Report FY 2022

#/% of clients closed, by reason closed	Discharge reason for clients discharged during the reporting period	Yellowfin
# of clients transferred to another program, by 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
% 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 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 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

Comprehensive Community Treatment (CCT)

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served 2. # of new clients opened for ongoing services 3. Average # of service hours per client per month 4. Average # of services per client per month	5. % of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program 6. % of clients with no service gap of over 90 days 7. % of discharges from hospitalization or subacute who had a follow up visit with staff within 7 and within 30 calendar days 8. #/% of clients closed, by reason closed 9. #/% of clients transferred to another level of care 10. % of clients who were satisfied with services**	11. % 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 12. % of clients with a decrease in hospitalizations/hospitalization days 13. % of clients who had a reduction in jail days in the last 12 months compared to the 12 months before enrollment 14. % of clients with a primary care visit in the last 12 months

*Please note: demographic data will be reported at the program level, where available

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

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

1. % of clients who have a billable contact with FSP staff within 7 calendar days:
    a. Following discharge (from a hospital, crisis residential or release from jail)
    b. After assignment to the team
2. % of clients who drop out of service within the first 6 months following enrollment
3. % of clients who had a decrease in days spent in psychiatric hospital settings comparing most recent 12 months in the program to the 12 months prior to enrollment
4. Average # of contacts per month per client
5. "Other" reason for client being closed
6. No-shows/missed contacts

BMH RBA Report FY 2022

Comprehensive Community Treatment Team (CCT)

Reporting Period: July 2021-June 2022 (Baseline)

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

198

Clients Served

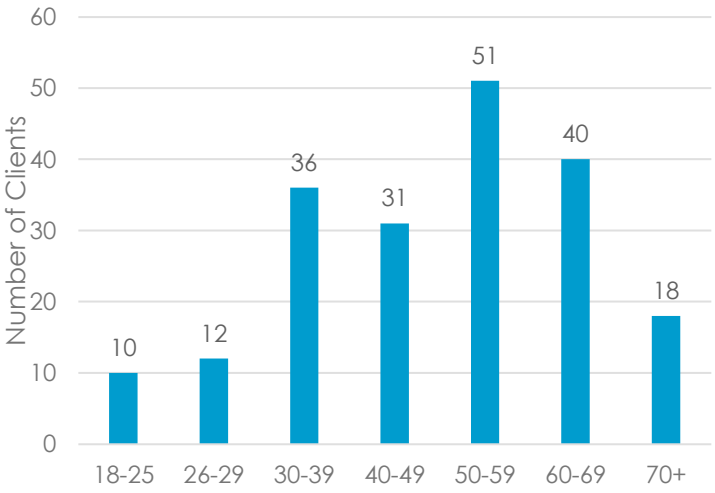
12

New Clients

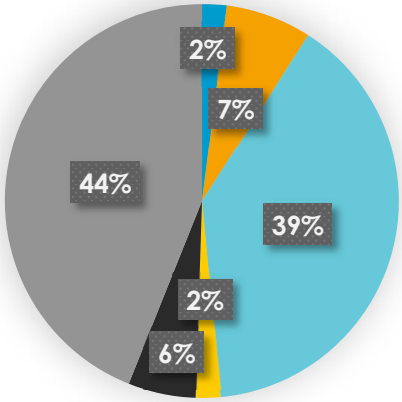
Program Description: The CCT team is responsible for providing services to adults with severe and persistent mental illness who require specialty mental health services. Staff provide case management, therapeutic services, and group services both in the field and in the clinic.

represents 10 clients

Demographics (Age)

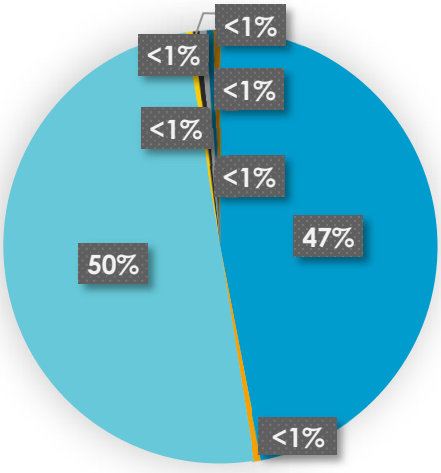


Demographics (Race)



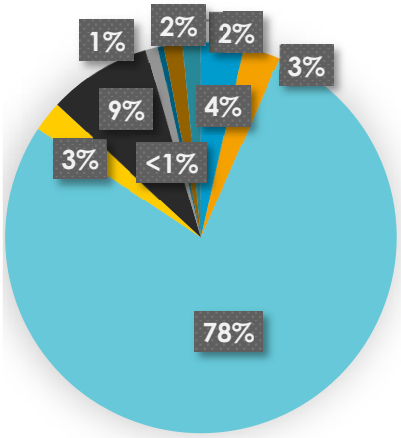
- Alaska Native or American Indian (2%)
- Asian or Pacific Islander (7%)
- Black or African American (39%)
- Hispanic or Latino (2%)
- Other (6%)
- White (44%)

Demographics (Gender Identity)



- Female (47%)
- Female to Male (<1 %)
- Male (50%)
- Missing (<1%)
- Multiple gender identities (<1%)
- Non-conforming (<1%)
- Other (<1%)
- Prefer not to answer (<1%)

Demographics (Sexual Orientation)



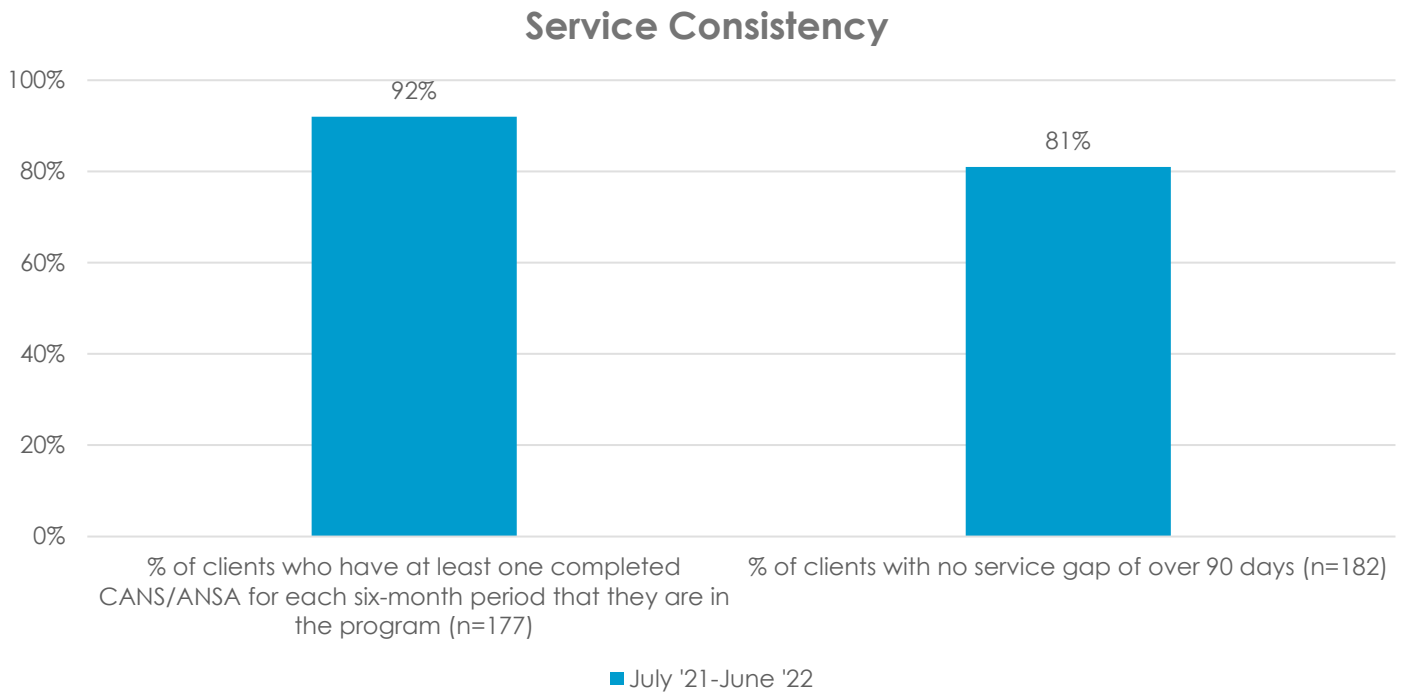
- Bisexual (4%)
- Gay (3%)
- Heterosexual (78%)
- Lesbian (3%)
- Missing (9%)
- Multiple sexual orientations (1%)
- Other (<1%)
- Prefer not to answer (2%)
- Queer (2%)

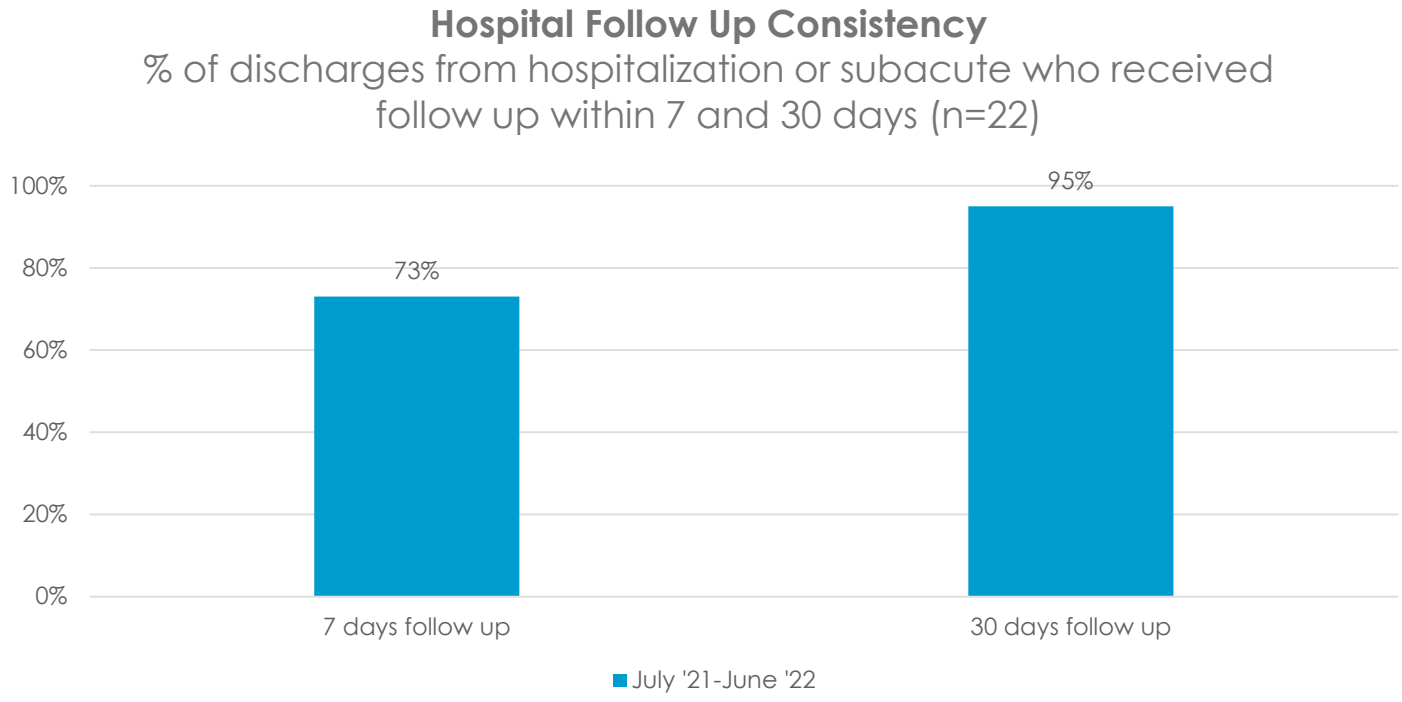
BMH RBA Report FY 2022

The average client served in 2021-2022 received:

- received **3.3 hrs** of services per month
- received **3.3 services** per month

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





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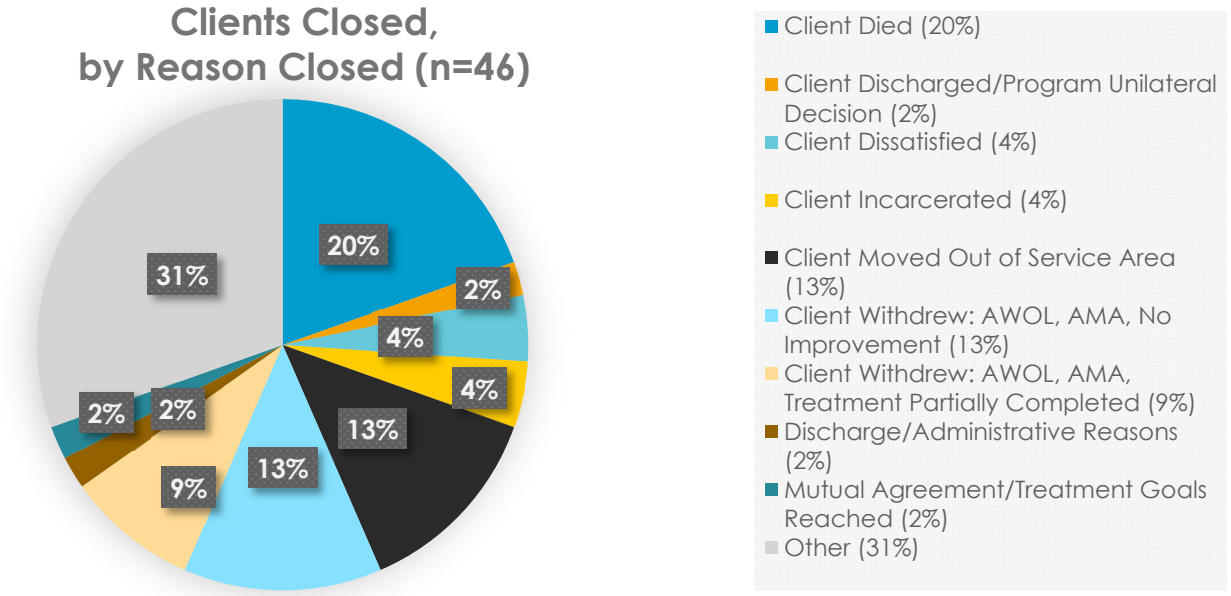
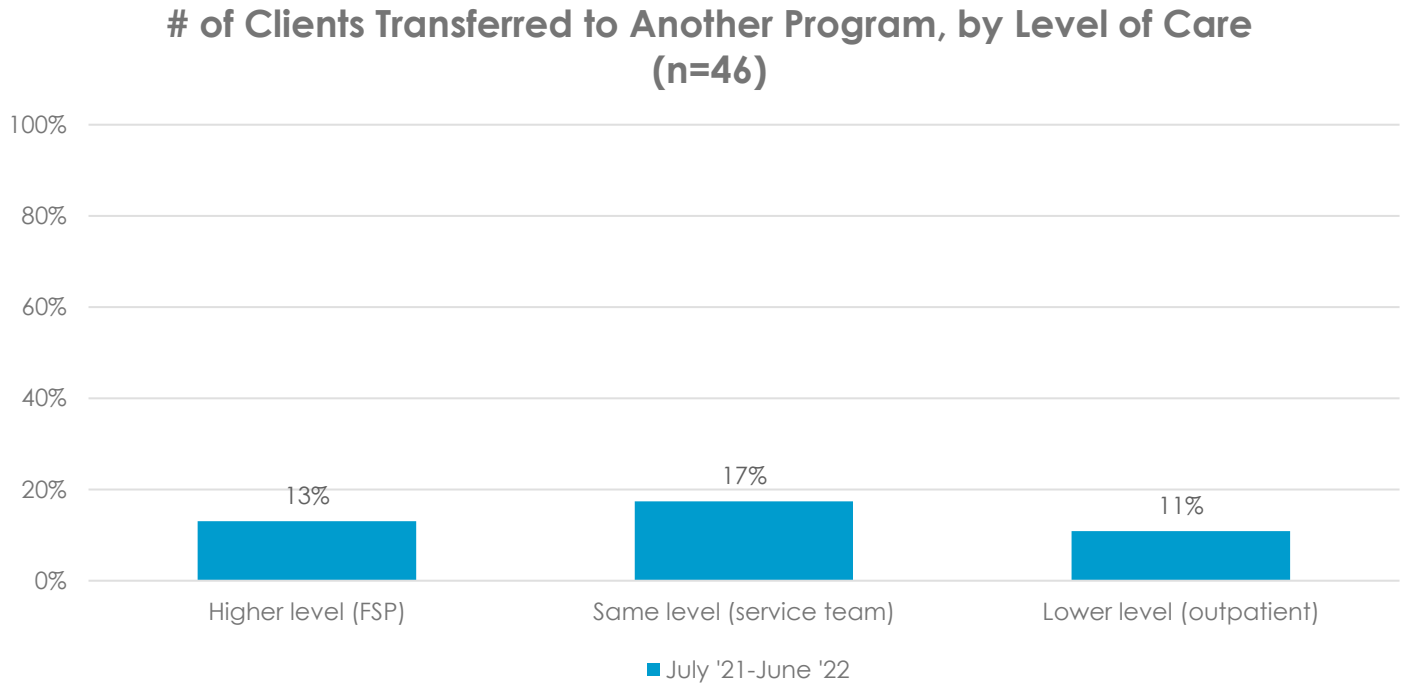
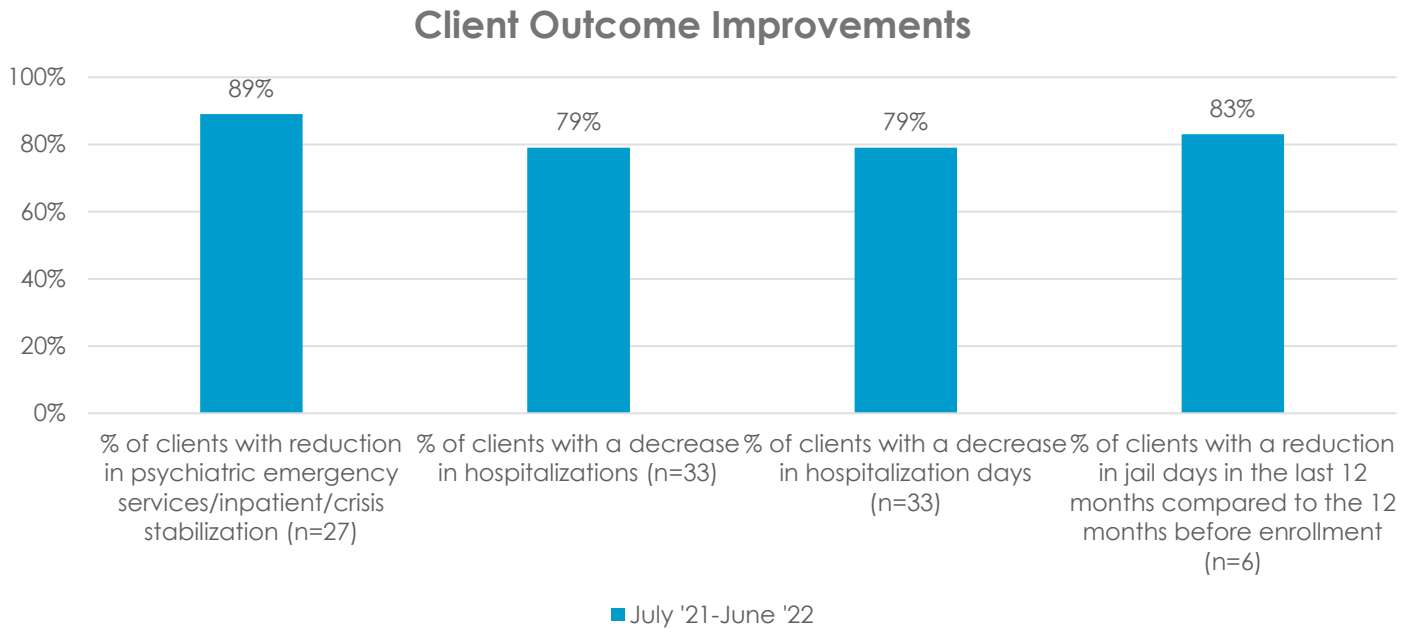
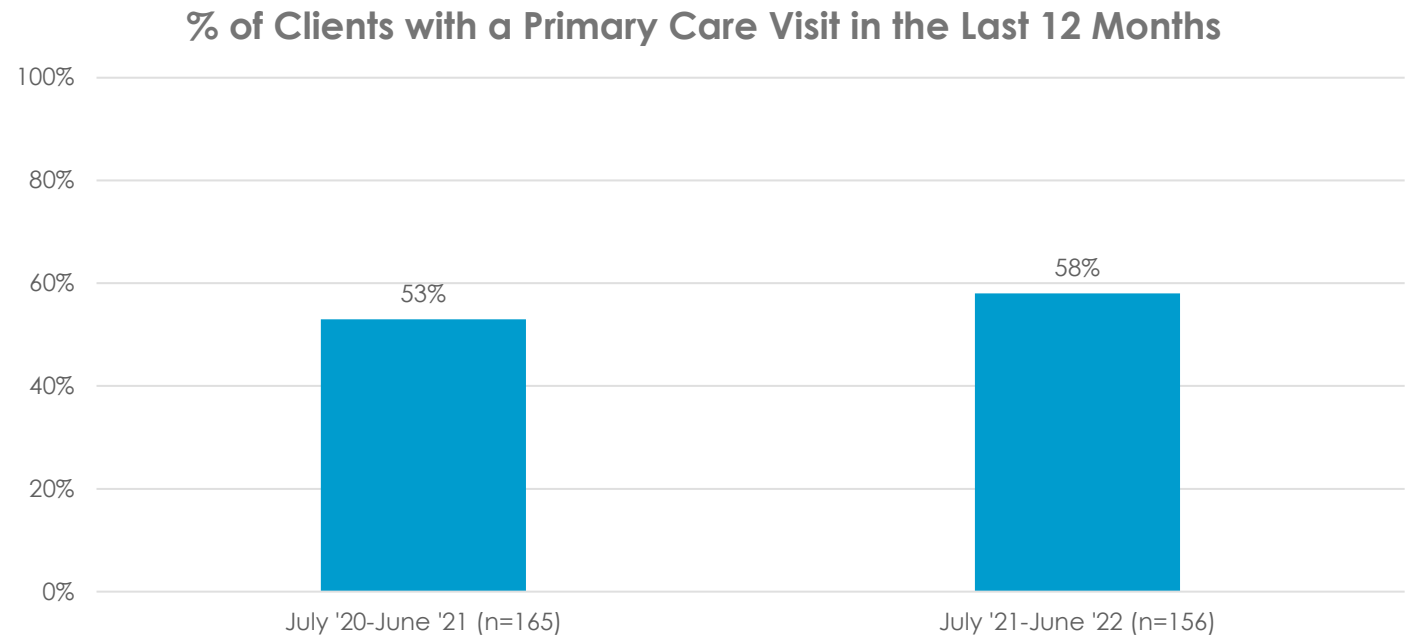




BMH RBA Report FY 2022

Impact Outcomes ("Is anyone better off?")





BMH RBA Report FY 2022

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 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 (n=177)	Of clients with a completed 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 (n=182)	% 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 (n=22)	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 transferred to another program, by 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

BMH RBA Report FY 2022

% 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 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	Yellowfin
% of clients with a reduction in jail days in the last 12 months compared to the 12 months before enrollment (n=6)	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
% increase in number of clients with connection to primary care compared to the last 12 months (FY22 n=156, FY21 n=165)	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

Focus on Independence Team (FIT)

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served 2. # of new clients opened for ongoing services 3. Average # of service hours per client per month 4. Average # of services per client per month	5. % of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program 6. % of clients with no service gap of over 90 days 7. % of discharges from hospitalization or subacute who had a follow up visit with staff within 7 and within 30 calendar days 8. #/% of clients closed, by reason closed 9. #/% of clients transferred to another level of care 10. % of clients who were satisfied with services**	11. % 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 12. % of clients with a decrease in hospitalizations/hospitalization days 13. % of clients with a primary care visit in the last 12 months

*Please note: demographic data will be reported at the program level, where available

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

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

1. % of appointments kept by clients
2. % of clients who engage in leisure activities
3. Average # of contacts per month per client
4. "Other" reason for client being closed
5. No-shows/missed contacts

BMH RBA Report FY 2022

Focus on Independence Team (FIT)
Reporting Period: July 2021-June 2022 (Baseline)

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

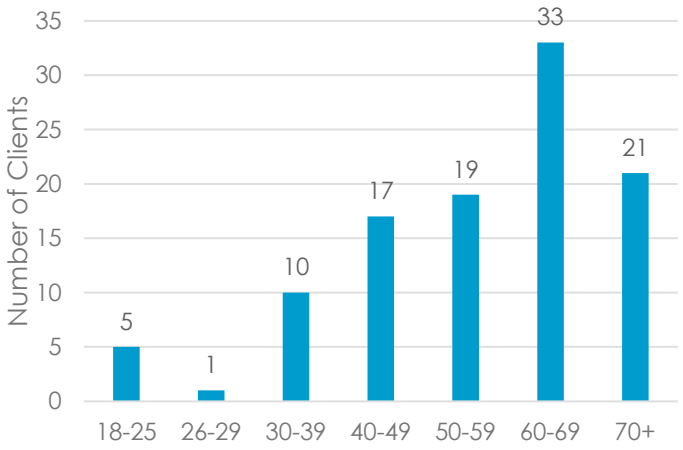
106
Clients Served

9
New Clients

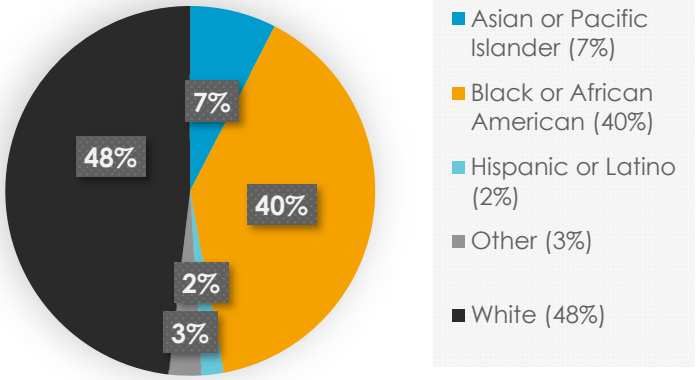
represents 10 clients

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

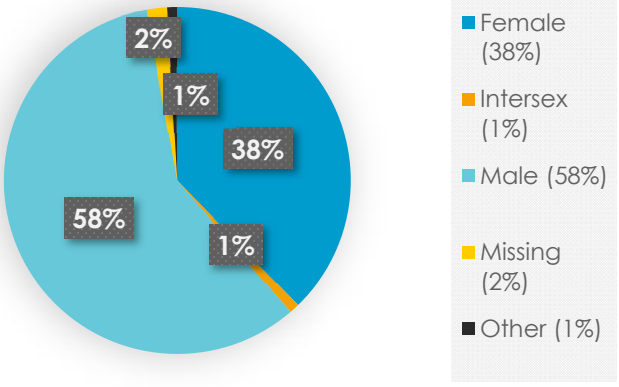
Demographics (Age)



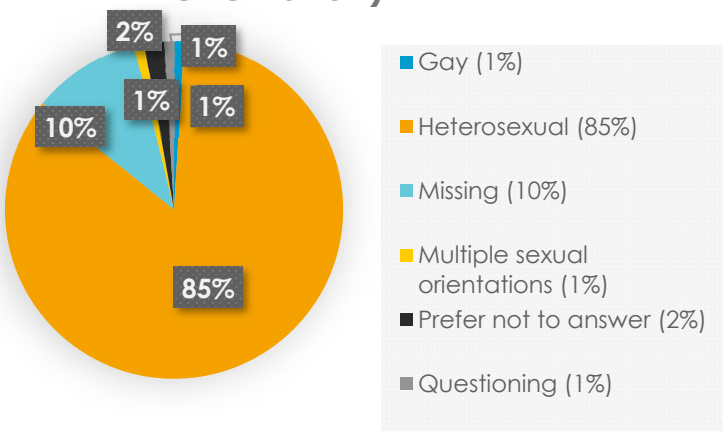
Demographics (Race)



Demographics (Gender Identity)



Demographics (Sexual Orientation)

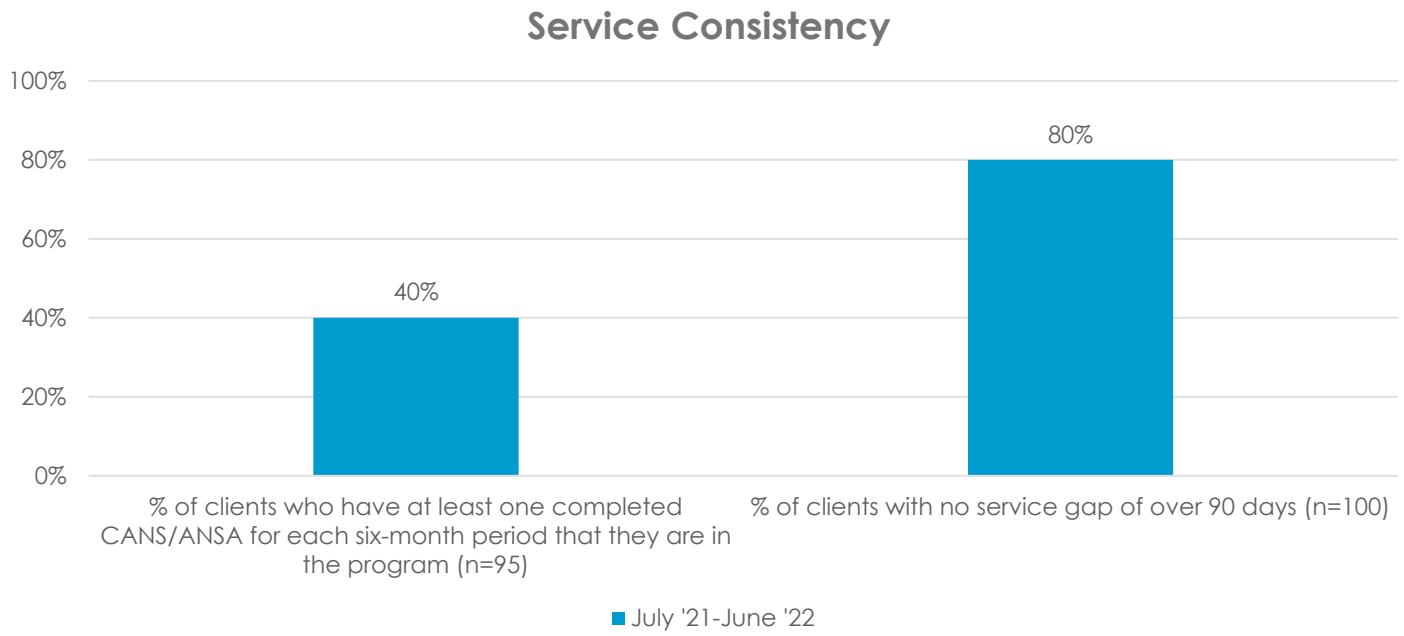


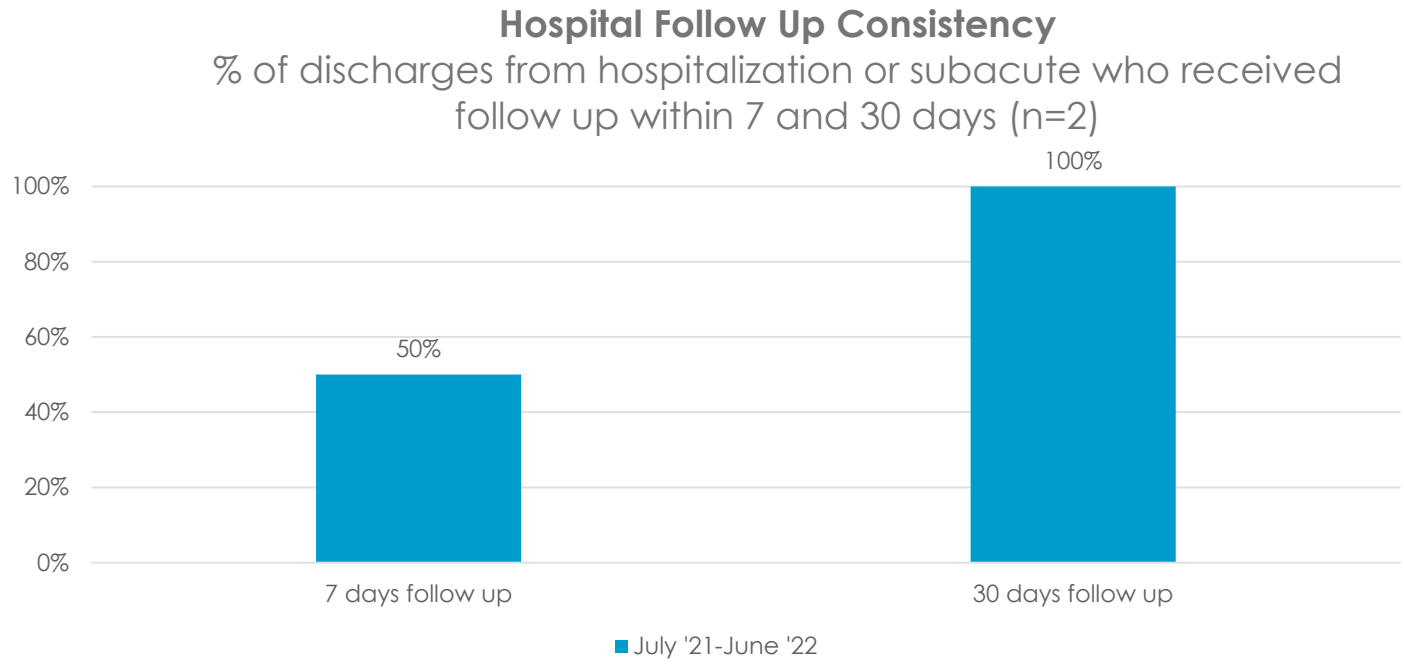
BMH RBA Report FY 2022

The average client served in 2021-2022 received:

- received **1.76 hrs** of services per month
- received **2.28 services** per month

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





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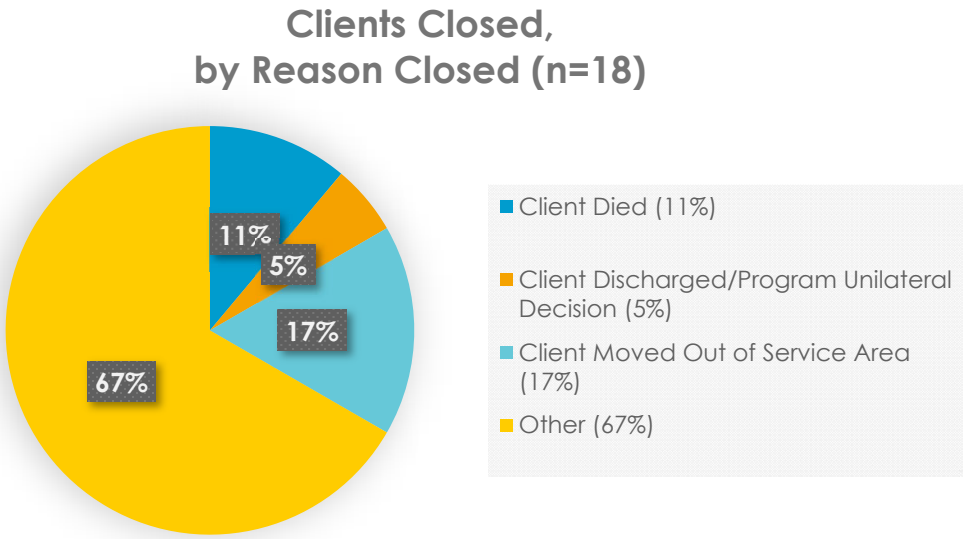
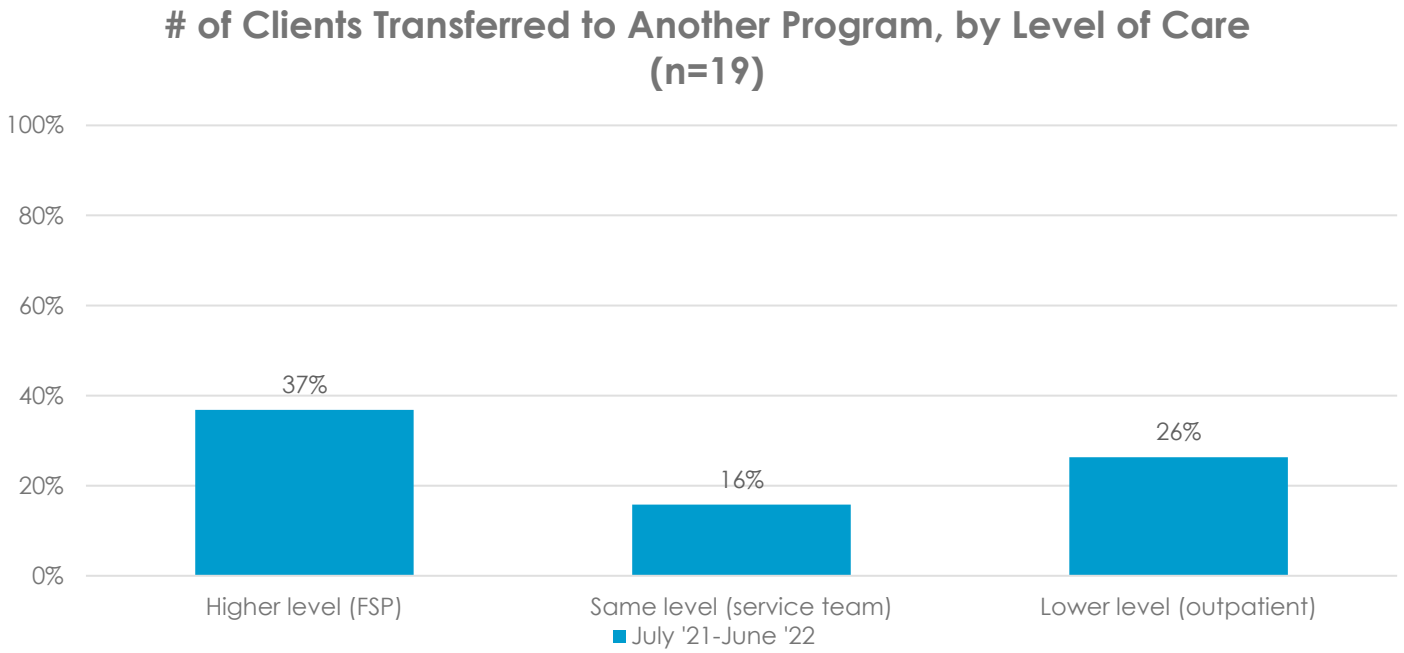
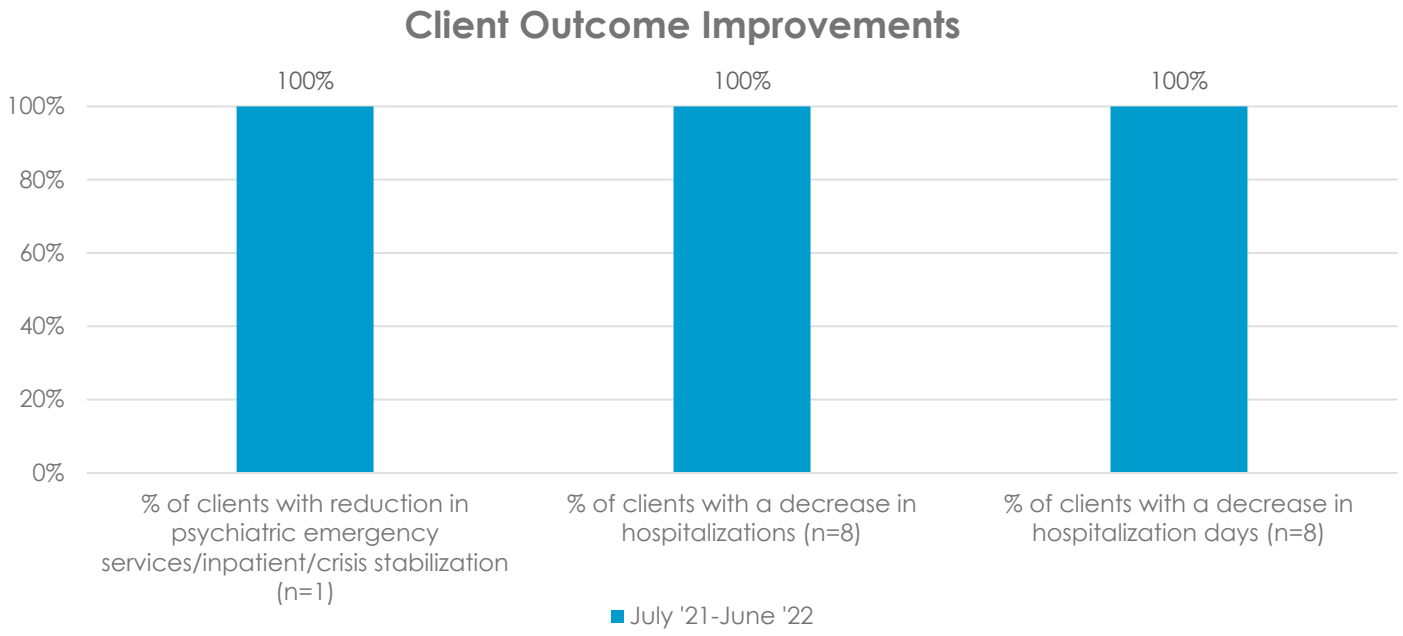
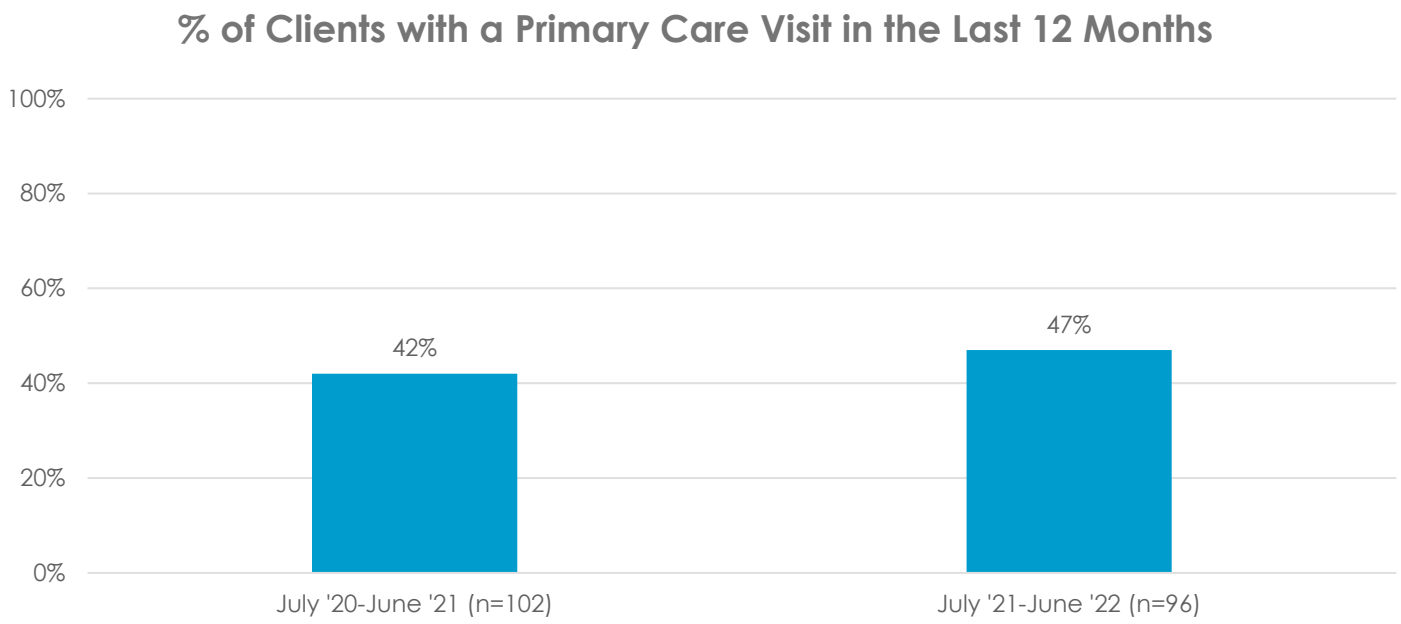




BMH RBA Report FY 2022

Impact Outcomes ("Is anyone better off?")





BMH RBA Report FY 2022

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 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 (n=95)	Of clients with a completed 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 (n=100)	% 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 MH hospital discharge.	Yellowfin
#/% of clients closed, by reason closed	Discharge reason for clients discharged during the reporting period	Yellowfin
# of clients transferred to another program, by 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
% 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 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	Yellowfin
% of clients with a primary care visit in the last 12 months (n=96)	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

High School Health Center (HSHC)

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served 2. # of new clients opened for ongoing services 3. # of services provided by service type	4. % clients screened for depression, trauma, and substance use 5. % clients contacted within a week following a referral to the HSHC 6. % of school population served 7. % of clients satisfied with services, as measured by % of clients who agree with the following: HSHC staff… a. Treat me with respect b. Listen carefully to what I have to say c. Make me feel like there's an adult at school who cares about me	8. % of clients able to receive needed care, as measured by % of clients who agree with the following: The HSHC… a. Is easy to get help from when I need it b. Helps me to meet many of my health needs

*Please note: demographic data will be reported at the program level, where available

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

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

BMH RBA Report FY 2022

High School Health Center (HSHC)

Reporting Period: July 2021-June 2022 (Baseline)

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

233

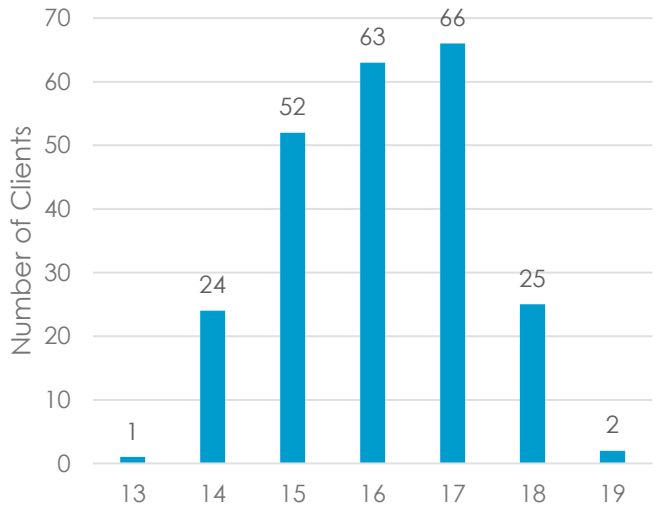
Clients Served

represents 20 clients

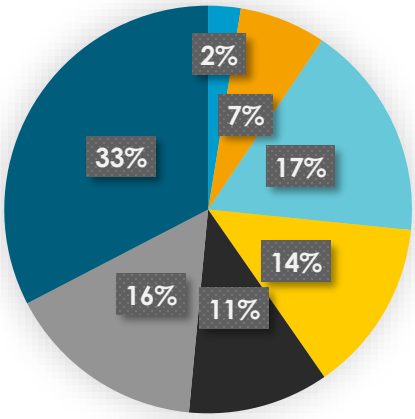
Program Description

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

Demographics (Age)

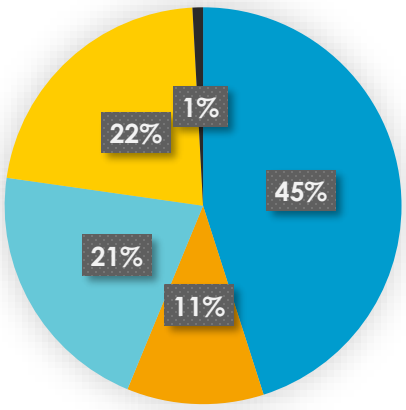


Demographics (Race)



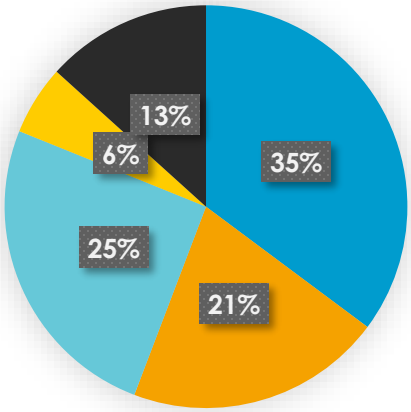
- Alaska Native or American Indian (2%)
- Asian or Pacific Islander (7%)
- Black or African American (17%)
- More than one race (14%)
- Other (11%)
- Prefer not to answer (16%)
- White (33%)

Demographics (Gender Identity)



- Female (45%)
- Gender nonconforming, transgender, genderqueer (11%)
- Male (21%)
- Missing (22%)
- Prefer not to answer (1%)

Demographics (Sexual Orientation)



- Heterosexual (35%)
- LGBTQ* (21%)
- Missing (25%)
- Prefer not to answer (6%)
- Unknown/unsure (13%)

*includes students who self-identified as aromantic, asexual, bisexual, gay, homosexual, lesbian, pansexual, queer, and questioning

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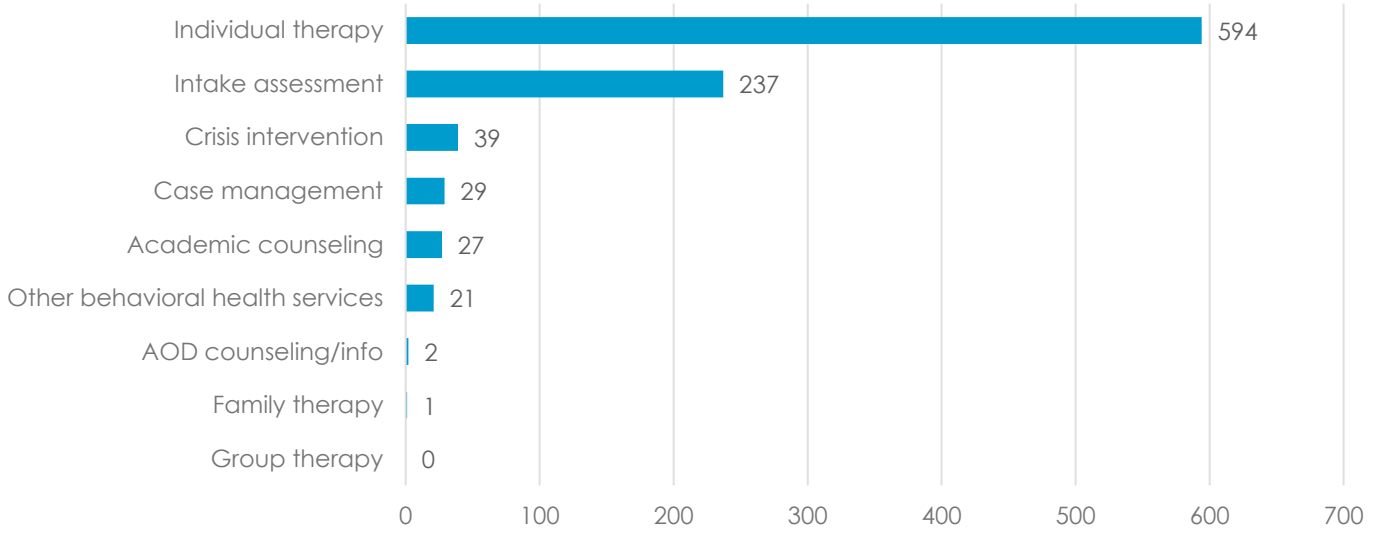
Services Provided by Service Type

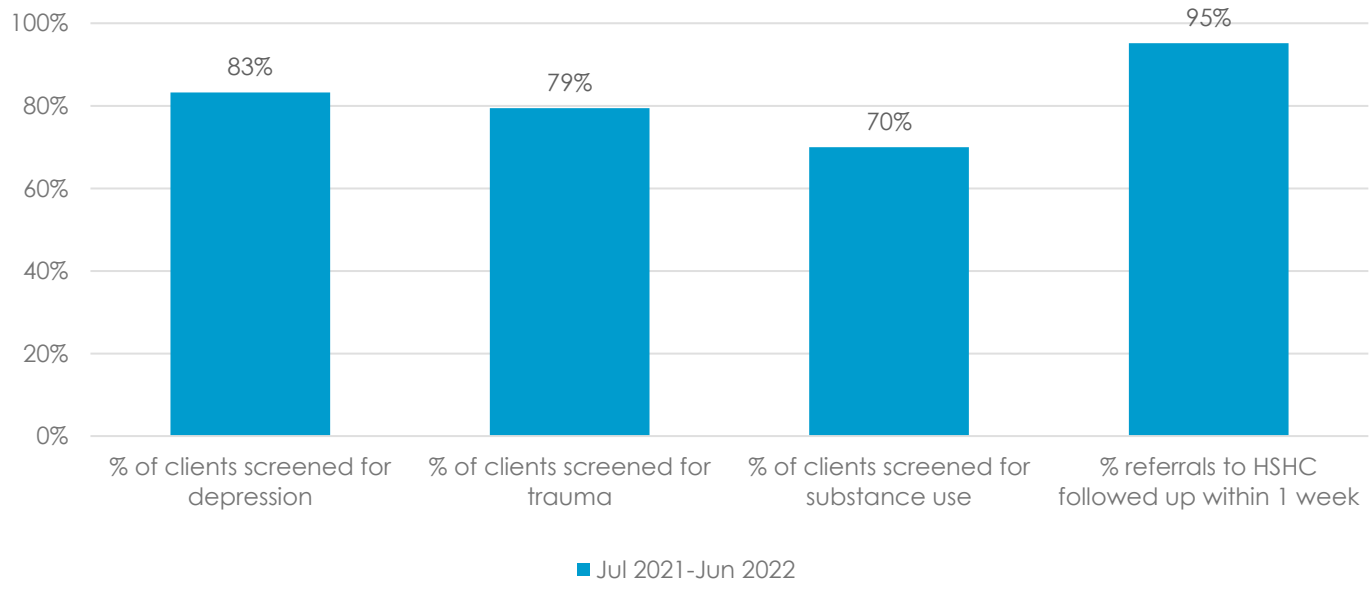


Note that multiple services could be provided in one visit (e.g. crisis assessment and referral) so total services by type (n=950) is greater than total encounters (n=846)

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

In 2021-2022, the HSHC program served **7%** of the school population.

Service Consistency



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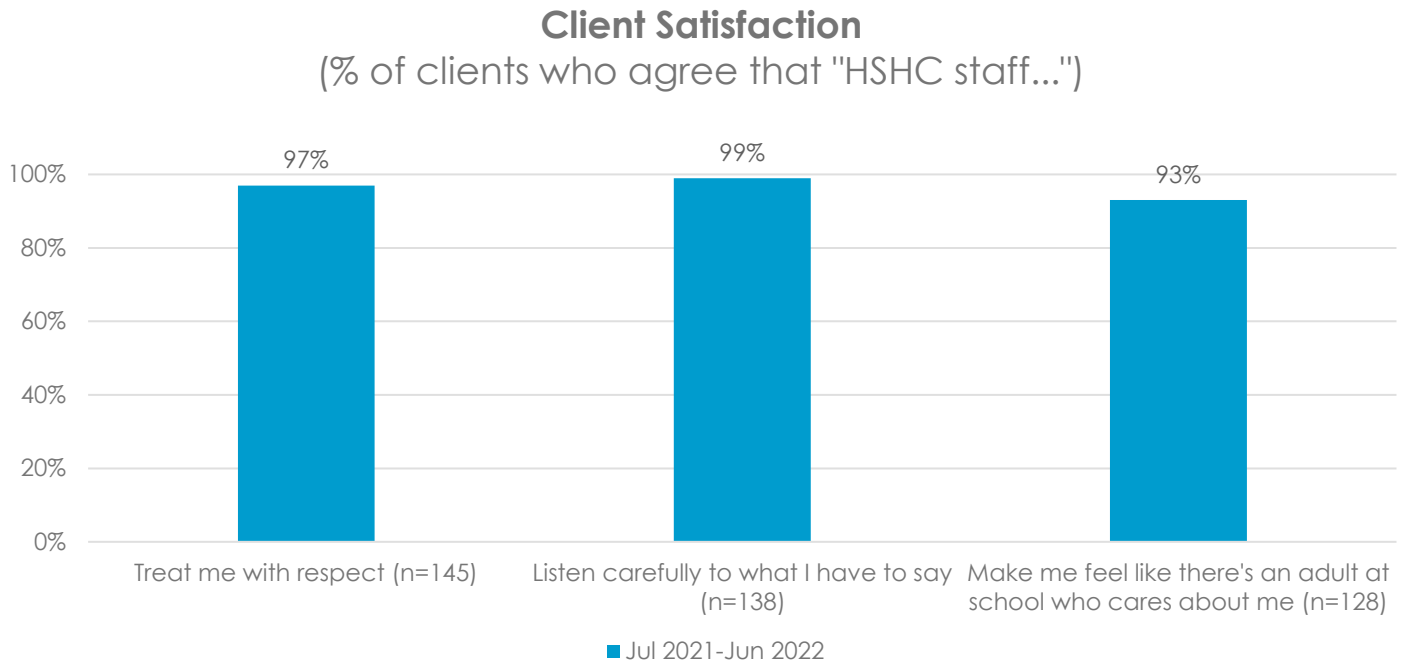
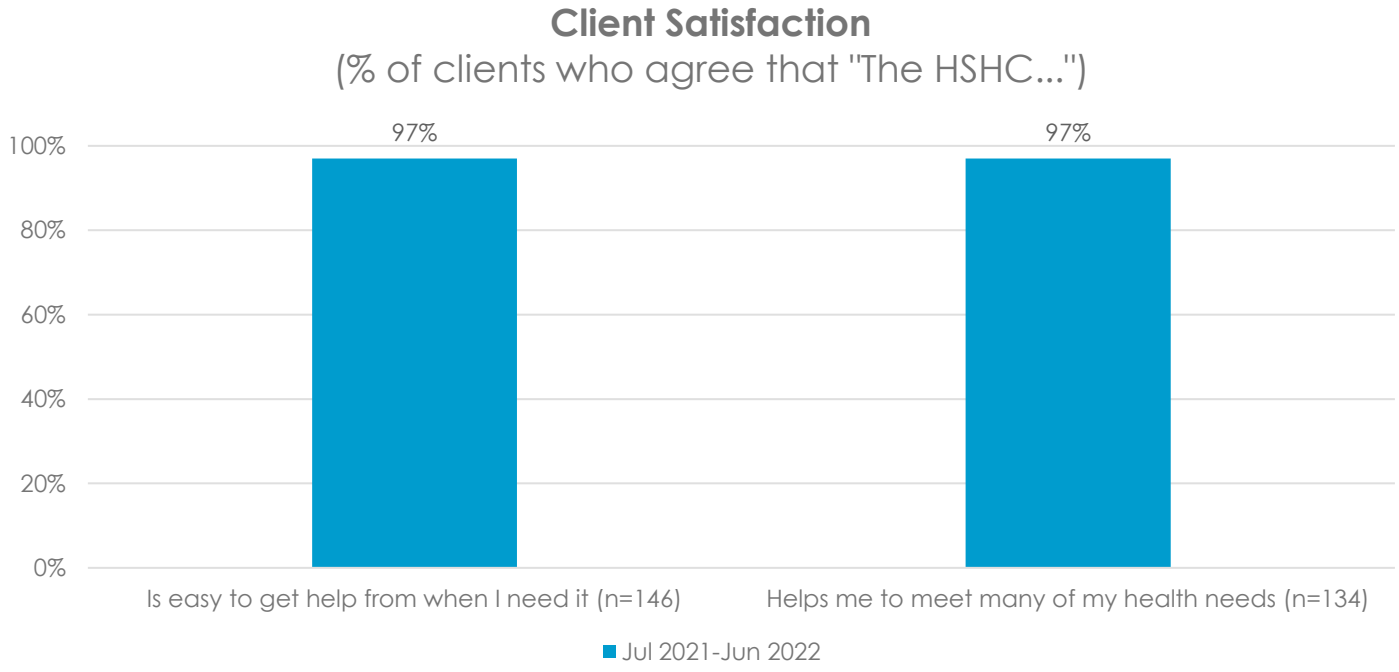
Impact Outcomes ("Is anyone better off?")





BMH RBA Report FY 2022

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
% 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

Educationally Related Mental Health Services (ERMHS)

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served 2. # of new clients opened for ongoing services 3. # of individual therapy hours provided 4. # of collateral hours per client	5. % of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program 6. % of clients with at least one session per month** 7. % of clients who had collateral sessions 8. % of clients who were satisfied with services**	9. Of clients who were discharged from the program, #/% who met mental health goals

*Please note: demographic data will be reported at the program level, where available

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

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

1. #/% of IEP meetings clinicians attended per client - Unavailable currently, as there is no code exclusively for IEP meetings.
2. Disaggregate data by BUSD school
3. Responsiveness of service (e.g. x days following qualifying event)
4. % of clients with no gap in therapy sessions over 21 days

BMH RBA Report FY 2022

Educationally Related Mental Health Services (ERMHS)

Reporting Period: July 2021-June 2022 (Baseline)

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

27

Clients Served

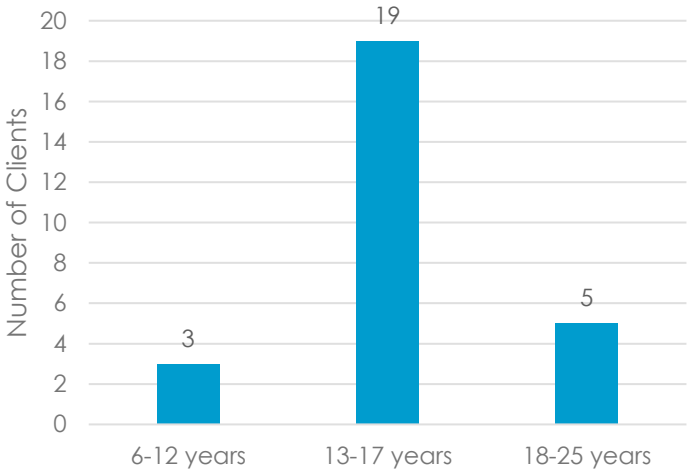
8

New Clients

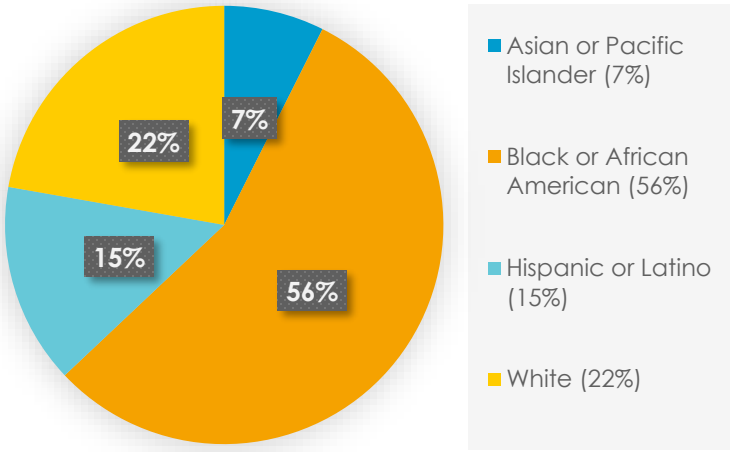
represents 10 clients

Program Description: The ERMHS program provides mental health services to the special education population in Berkeley Unified School District. Services include assessment, plan development, individual therapy, and collateral.

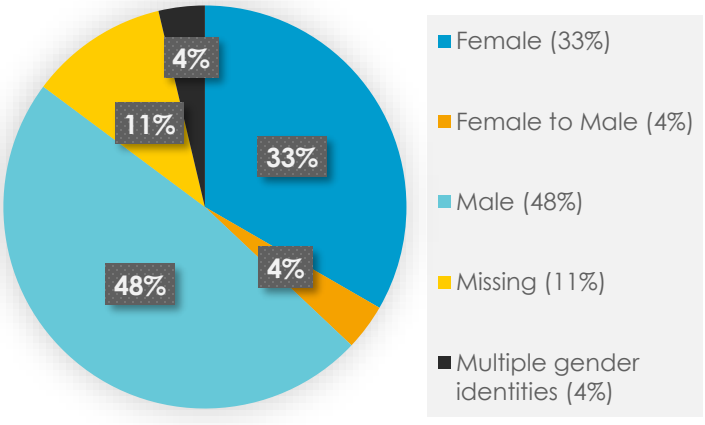
Demographics (Age)



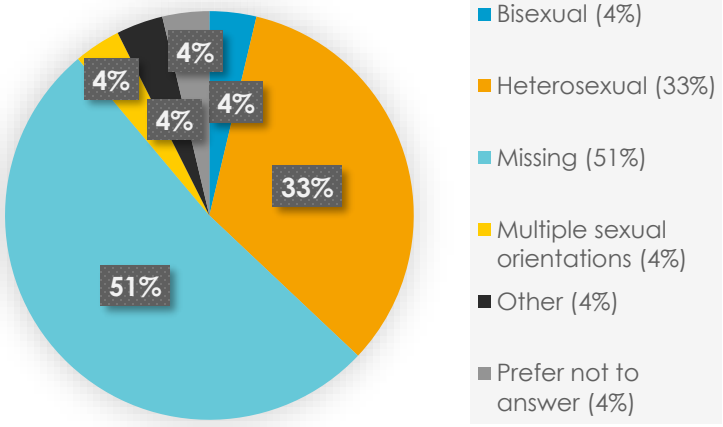
Demographics (Race)



Demographics (Gender Identity)



Demographics (Sexual Orientation)



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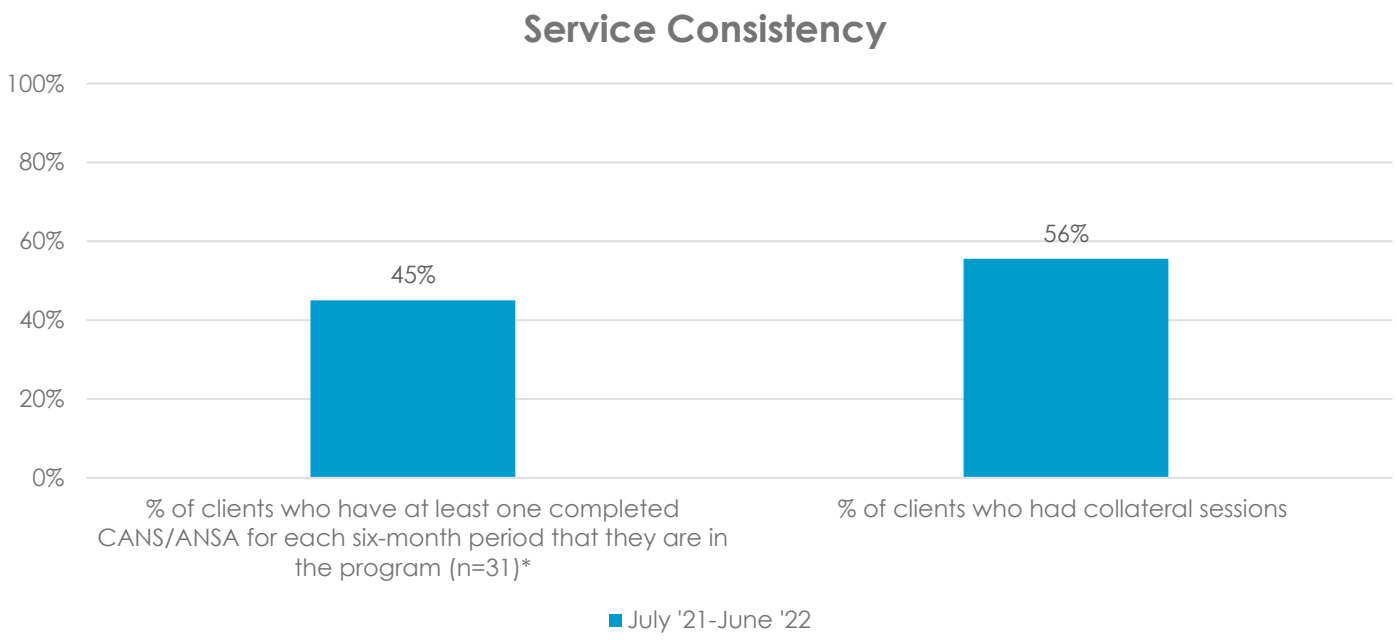
In 2021-2022, the ERMHS program provided:

- **379 hours** of individual therapy
- **1 hour** of collateral per client

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



*Note: number of clients with CANS assessments is higher than total number of clients in Yellowfin

Impact Outcomes ("Is anyone better off?")

In 2021-2022, **30%** of discharged ERMHS clients (n=20) met their mental health goals:

- **15%** of clients fully met their mental health goals
- **15%** of clients partially reached their mental health goals

BMH RBA Report FY 2022

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
# 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/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 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

Early and Periodic Screening Diagnosis and Treatment (EPSDT)

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served 2. # of new clients opened for ongoing services 3. # of individual therapy hours provided 4. # of collateral hours per client	5. % of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program 6. % of clients with at least three sessions per month** 7. % of clients who had collateral sessions 8. % of clients or family members who participate in the survey**	9. Of clients who were discharged from the program, #/% who met mental health goals

*Please note: demographic data will be reported at the program level, where available

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

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

1. % of clients who receive two or more visits within 30 days of their episode opening date
2. % of clients who receive four or more visits within 60 days of their episode opening date
3. Responsiveness of service (e.g. x days following qualifying event)
4. % of clients with no gap in therapy sessions over 21 days

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Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Reporting Period: July 2021-June 2022 (Baseline)

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

57

Clients Served

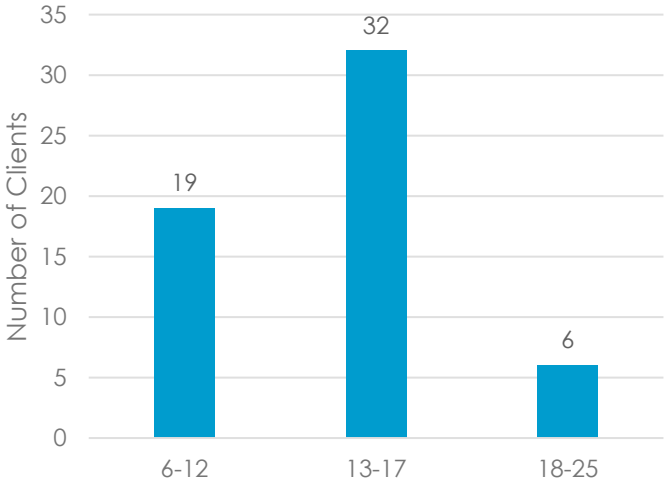
26

New Clients

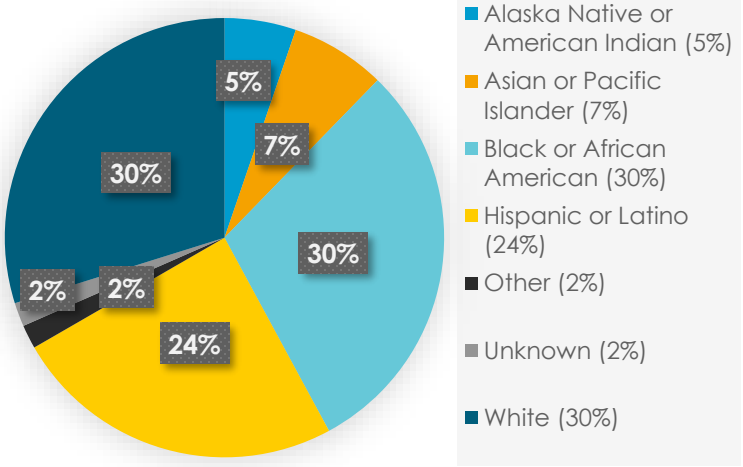
represents 10 clients

Program Description: 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.

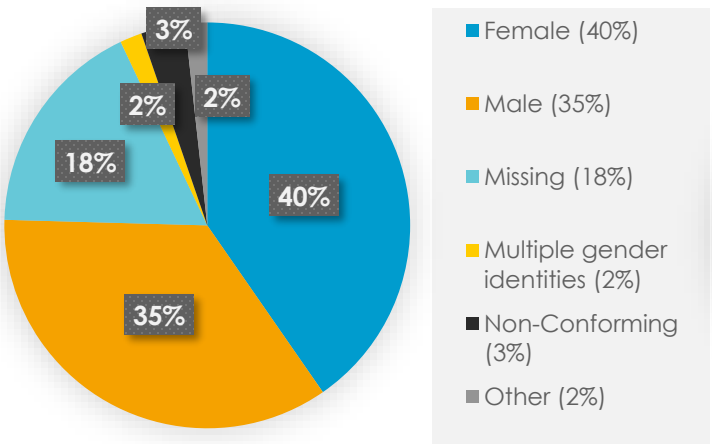
Demographics (Age)



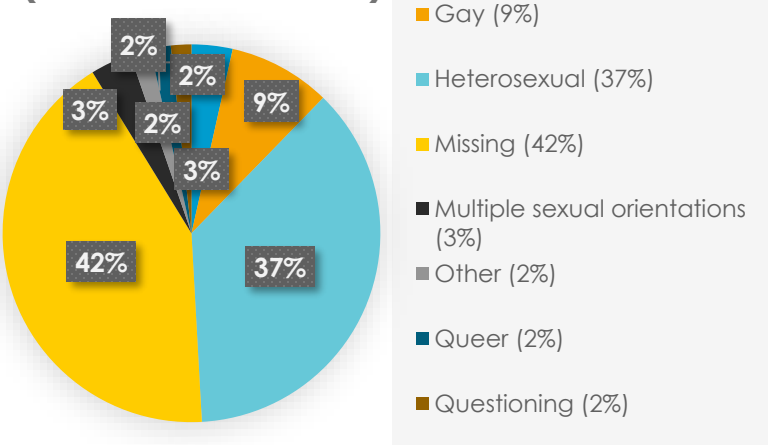
Demographics (Race)



Demographics (Gender Identity)



Demographics (Sexual Orientation)



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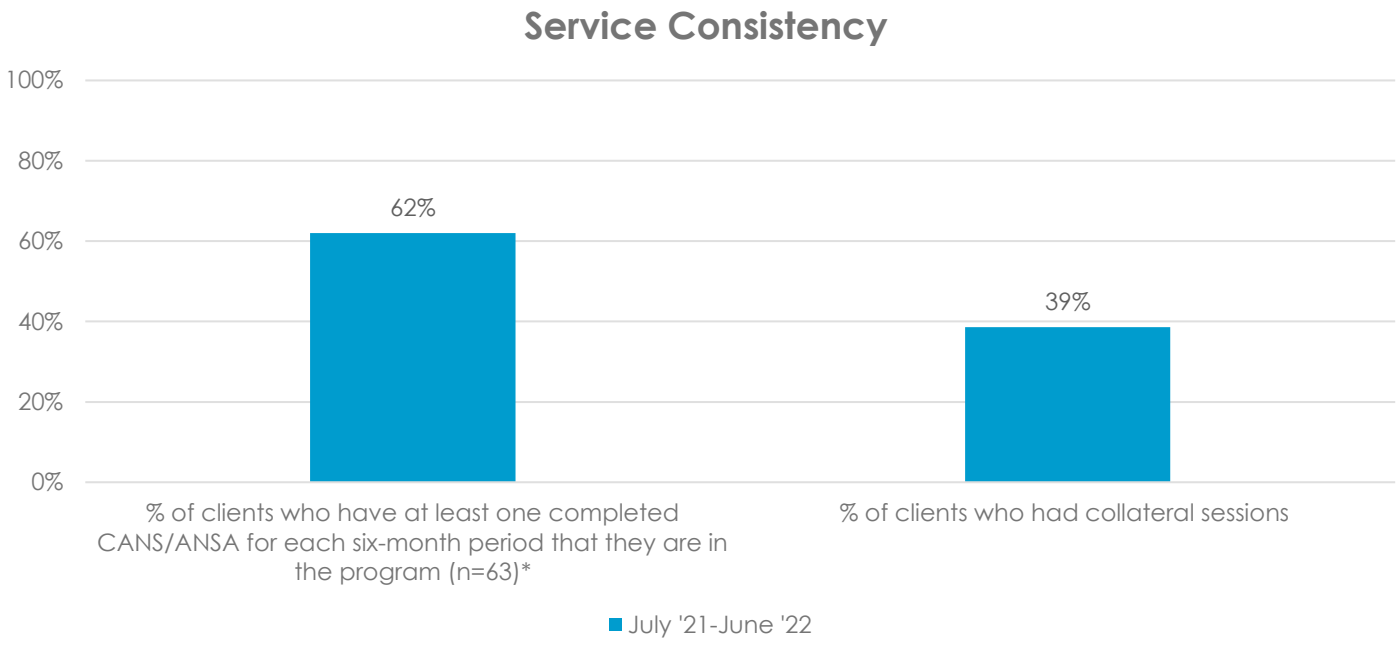
In 2021-2022, the EPSDT program provided:

- **1,016 hours** of individual therapy
- **1.25 hours** of collateral per client

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



*Note: number of clients with CANS assessments is higher than total number of clients in Yellowfin

Impact Outcomes ("Is anyone better off?")

In 2021-2022, **32%** of discharged EPSDT clients (n=31) met their mental health goals:

- **29%** of clients fully met their mental health goals
- **3%** of clients partially reached their mental health goals

BMH RBA Report FY 2022

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
# 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/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 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

Children's Full Service Partnership (CFSP)

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served 2. # of new clients opened for ongoing services 3. Average # of days in FSP per client 4. Average # of service hours per client per month 5. Average # of services per client per month	6. % of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program 7. % of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month 8. % of discharges from hospitalization or subacute who had a follow up visit with CFSP staff within 7 business days 9. % of clients with no service gap of over 30 days 10. #/% of clients closed, by reason closed 11. % of clients or family members who participate in the survey**	12. % of clients with a primary care visit in the last 12 months 13. % 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** 14. % of clients with a decrease in hospitalizations/hospitalization days

*Please note: demographic data will be reported at the program level, where available

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

<u>Data Development Agenda</u> – measures the team is interested in reporting on but for which reliable data are not available

1. Spending: # of Flex Funds spent on a family per year, based on tenure in program
2. Service provision: % of clients who received unscheduled service contacts due to low engagement or necessity/acuity of family needs
3. Staff training:
    a. % of staff trained in WRAP
    b. % of staff who are skilled to implement trauma-informed interventions
4. Staff satisfaction: % of staff who report that they have the tools/resources necessary to do their jobs

5. Client satisfaction, specifically in regards to measuring racially responsive care
    a. #/% of clients/families who report high quality, racially responsive care on the annual Consumer Perception Survey
6. Client/family outcomes:
    a. # of clients/families who can navigate systems better to address their needs
    b. # of clients with improved school attendance and increased engagement in class/school
    c. % of clients with improved family relations (communication and stability, problem solving, support)
7. Client-to-staff ratio
8. % staff retention year-to-year
9. % of clients who schedule a meeting with FSP team within 14 calendar days of referral
10. % 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
11. % of new clients who receive a face-to-face visit within 7 calendar days of the episode opening date
12. % of clients/families discharged from services within 9-12 months because of improved life circumstances

BMH RBA Report FY 2022

Child Full Service Partnership (FSP)

Reporting Period: July 2021-June 2022 (Baseline)

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

14

Clients Served

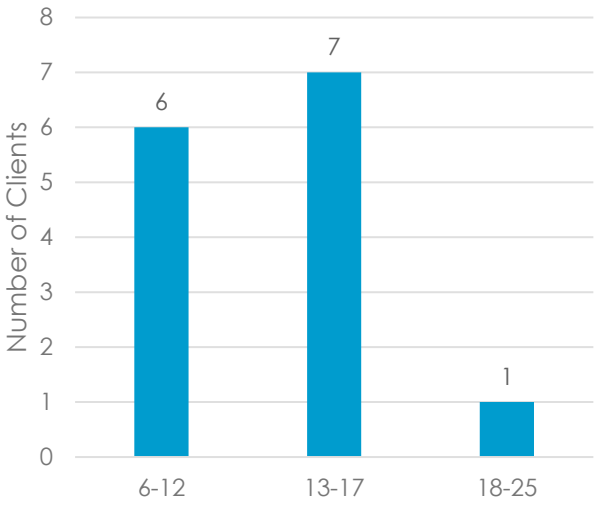
7

New Clients

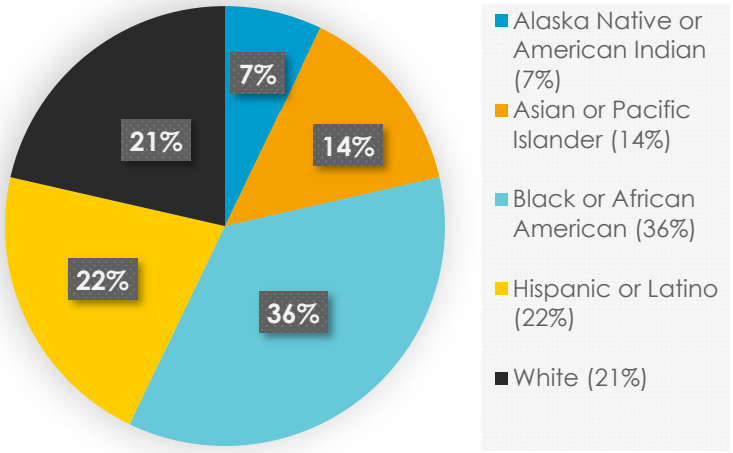
represents 5 clients

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.

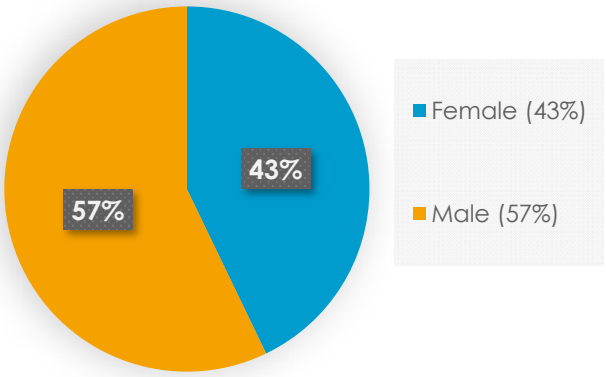
Client Demographics (Age)



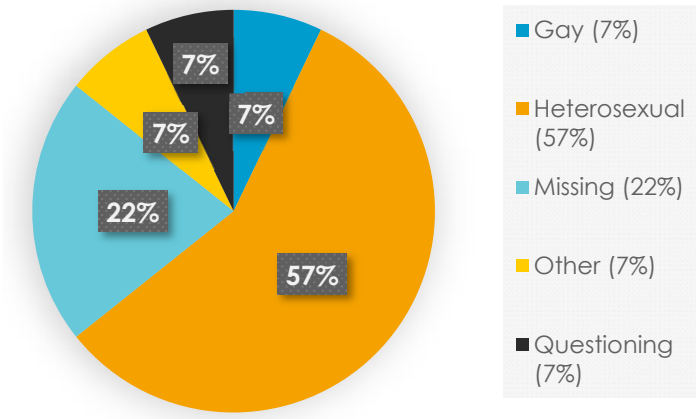
Client Demographics (Race)



Client Demographics (Gender Identity)



Client Demographics (Sexual Orientation)



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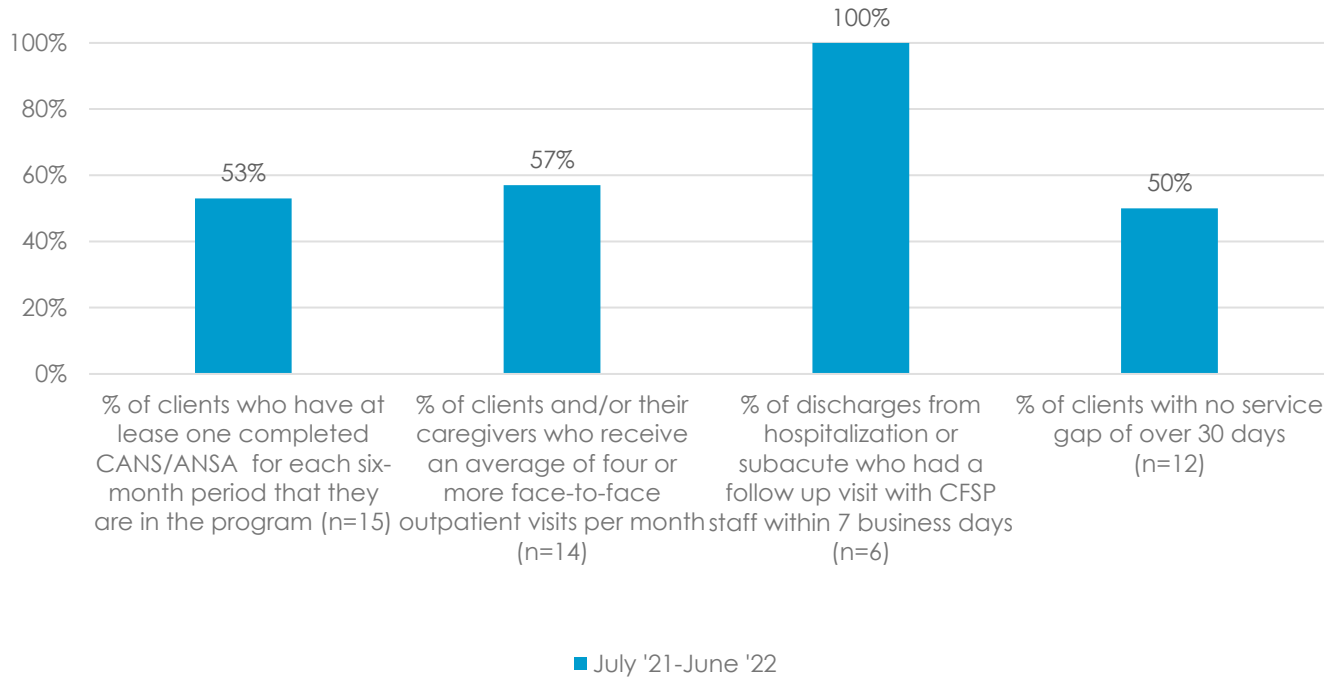
Quality Outcomes ("How well did we do it?")

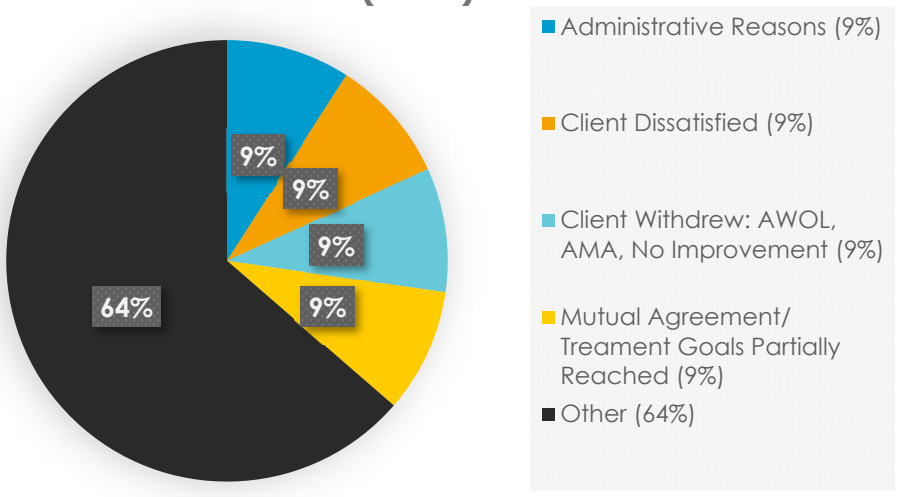
The average client served in 2021-2022:

- remained in the FSP program for **336 days**
- received **10.22 hrs** of services per month
- received **6.88 services** per month

Service Consistency



Clients Closed, by Reason Closed (n=11)



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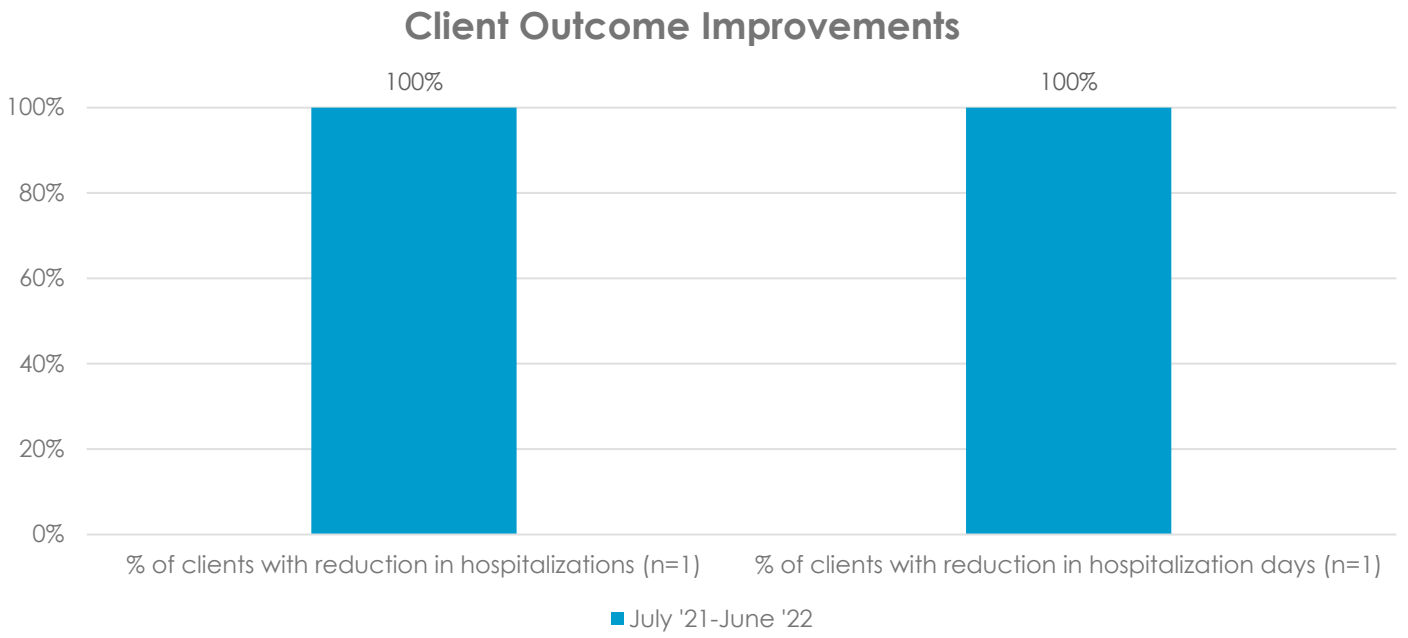
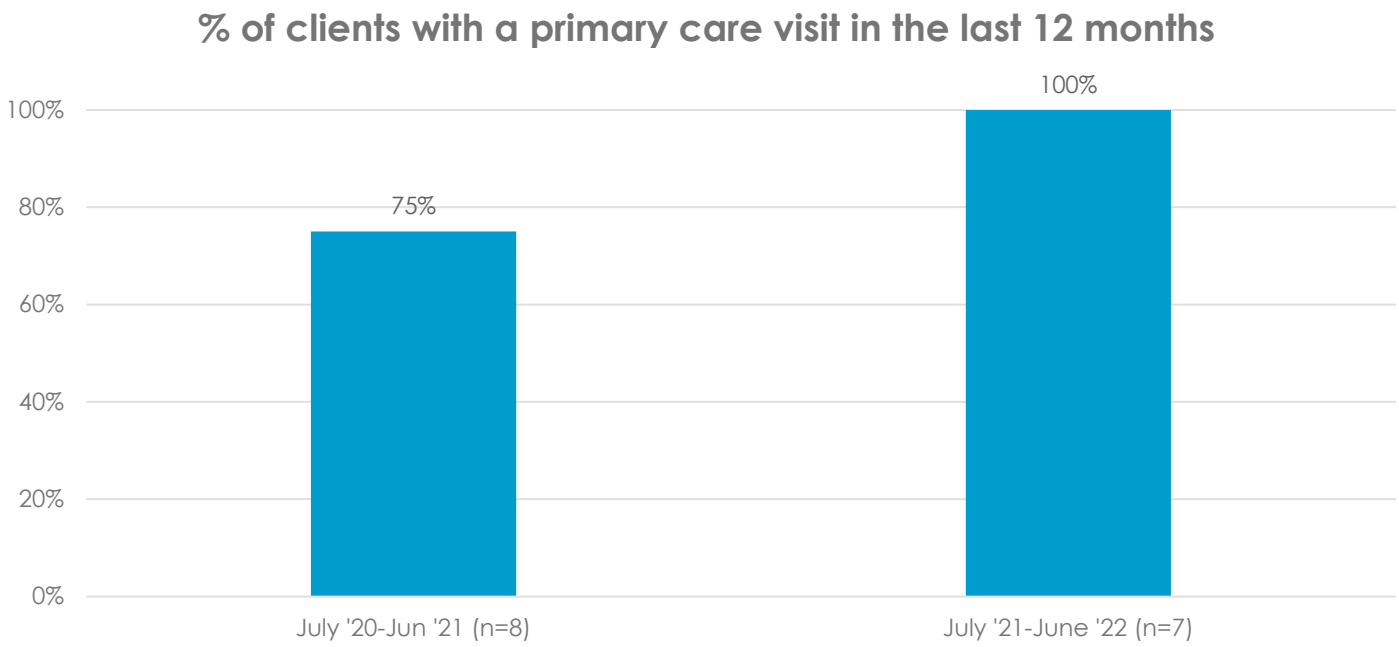
Impact Outcomes ("Is anyone better off?")





BMH RBA Report FY 2022

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 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

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% 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 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

Mobile Crisis Team (MCT)

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served 2. # of client contacts made, by a. Field contacts b. Phone contacts 3. # of crisis services referrals made to the MCT, by referring party (i.e. BPD, BFD, BMH, community, etc.) 4. # of 5150 evaluations conducted	5. % of 5150 evaluations that did not result in transportation to a receiving facility for further evaluation 6. % of clients who were satisfied with services**	7. #/% of repeat interventions

*Please note: demographic data will be reported at the program level, where available

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

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

1. Response times: average response time, by call type
2. Receiving facilities data:
    a. #/% evaluations upheld at receiving facility

BMH RBA Report FY 2022

Mobile Crisis Team (MCT)

Reporting Period: July 2021-June 2022 (Baseline)

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

932 Clients Served

=100 clients

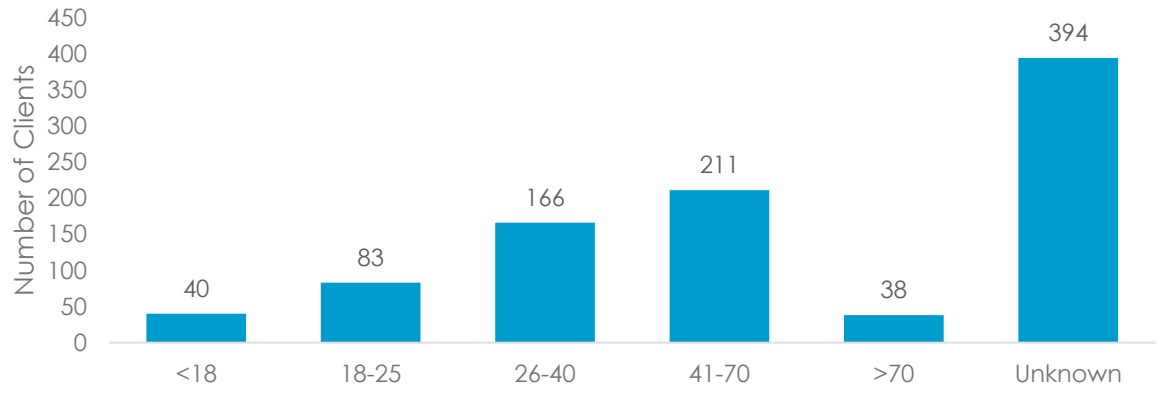
1486 Incidents Responded To

=100 incidents

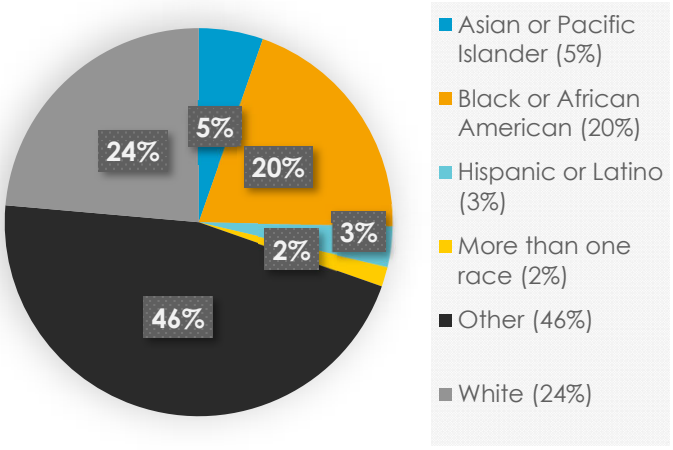
Program Description

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

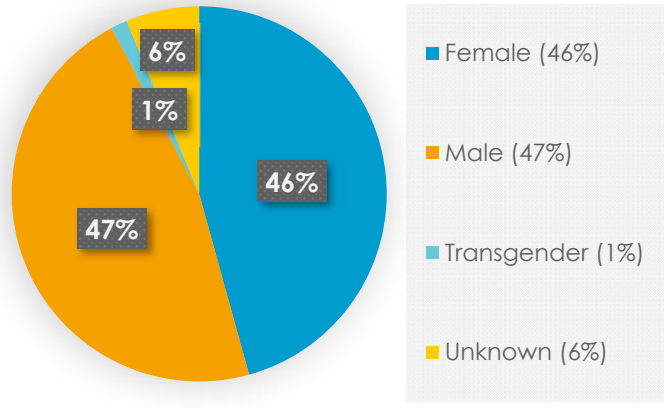
Demographics (Age)



Demographics (Race)



Demographics (Gender Identity)



*Sexual Orientation data not available

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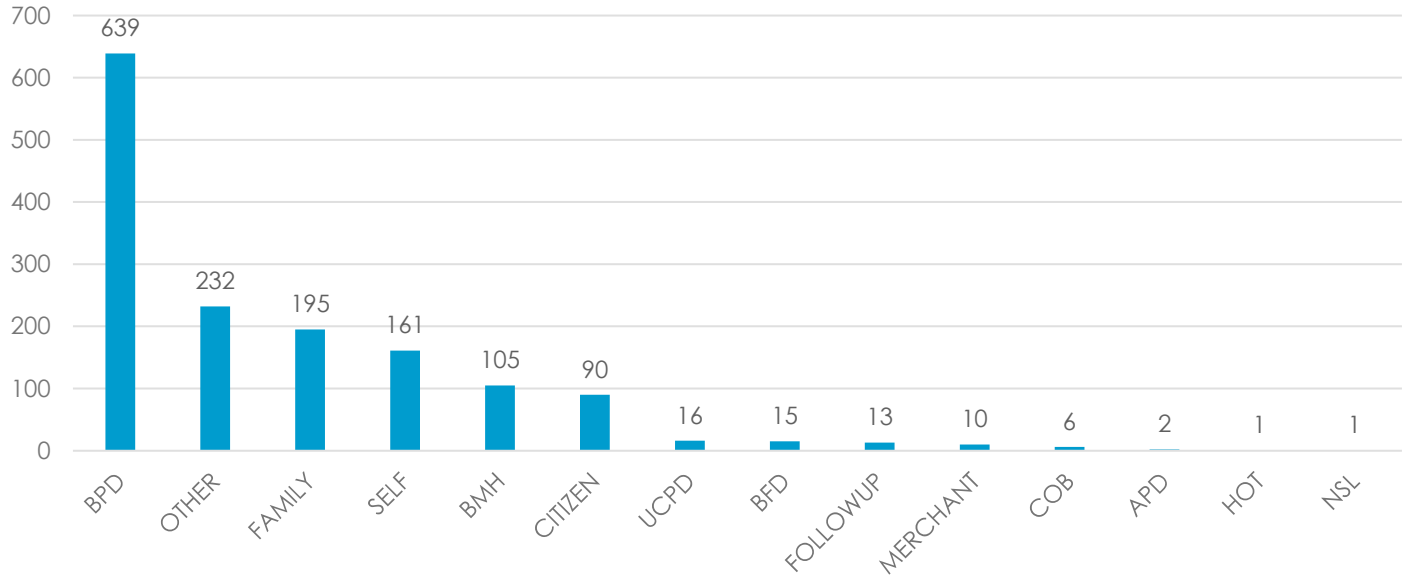
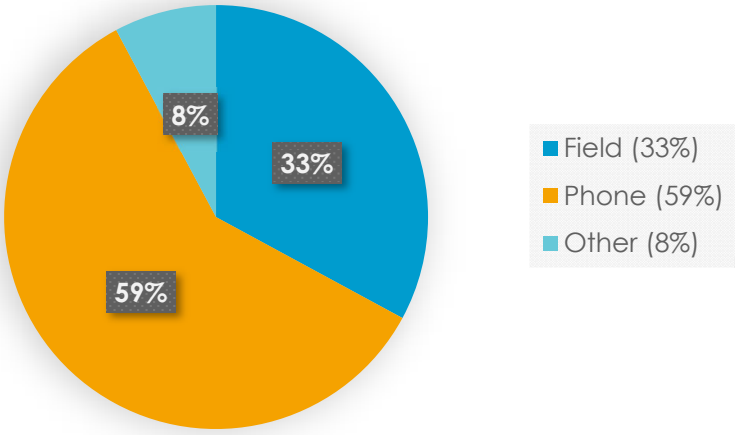
In 2021-2022, the MCT program performed **395** 5150 Evaluations

Total Referrals, by Referring Party (n=1486)



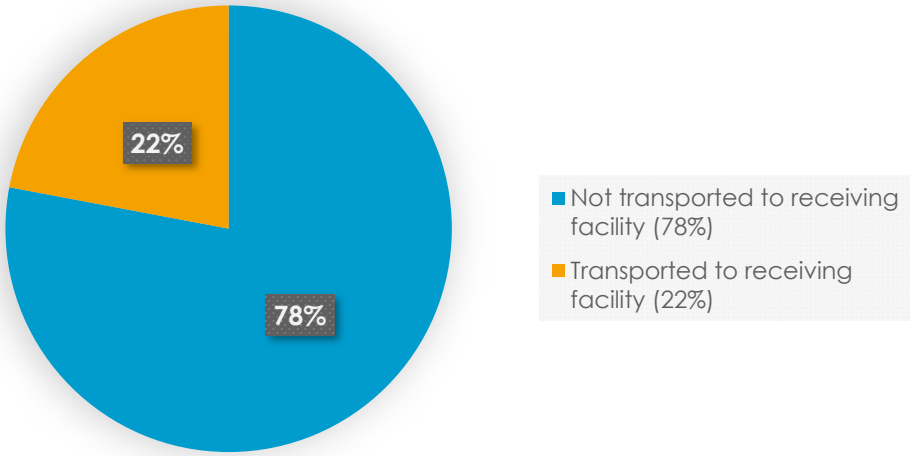
Client Contact Types (n=1486)



BMH RBA Report FY 2022

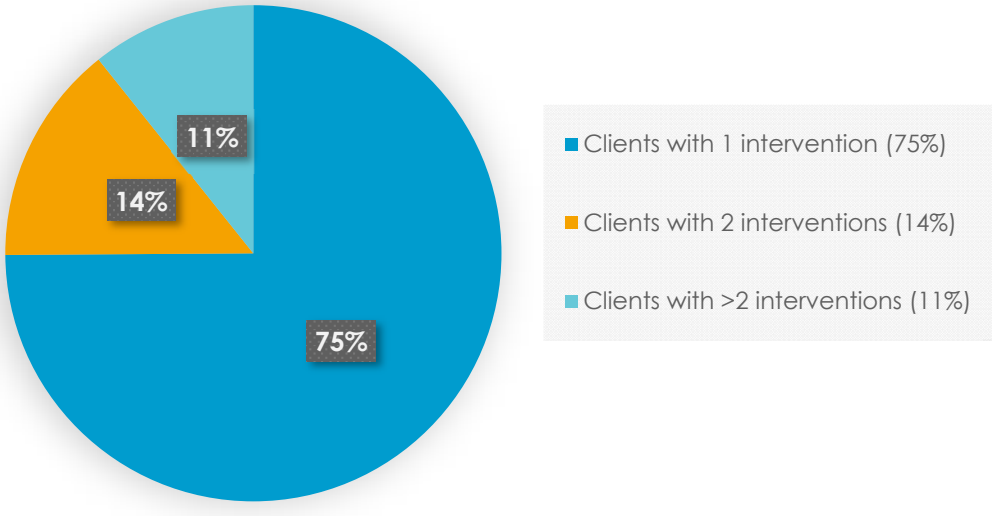
Quality Outcomes ("How well did we do it?")

Results of 5150 Evaluations (n=395)



Impact Outcomes ("Is anyone better off?")

Number of Interventions per Client (n=932)



BMH RBA Report FY 2022

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

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

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served 2. # of documented contacts	3. % of clients who receive a visit (phone contact with client or hospital service provider) in the 24 hours after hospitalization 4. % of MCT contacts who had a CAT attempt to contact 5. % of clients who were satisfied with services**	None available at this time**

*Please note: demographic data will be reported at the program level, where available

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

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

1. #/% 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
2. % of clients who receive a follow-up call for a no-show screening, intake or appointment
3. #/% of no-show clients for whom there is inter-system coordination to engage
4. #/% of clients and families who receive connection to grief counseling and other services
5. % of clients connected to a service team within 7 calendar days
6. % of clients assessed or referred on the same day as inquiry

BMH RBA Report FY 2022

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

Reporting Period: July 2021-June 2022 (Baseline)

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

721 Clients Served

=100 clients

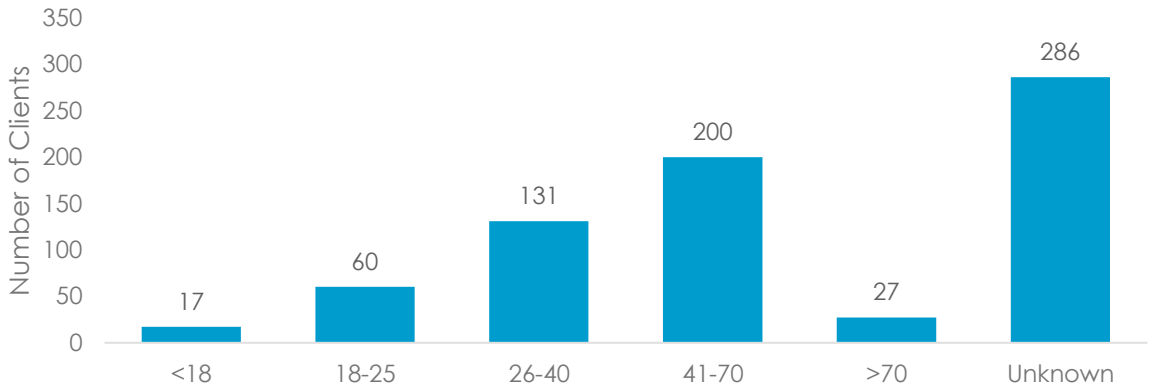
1448 Contacts

=100 contacts

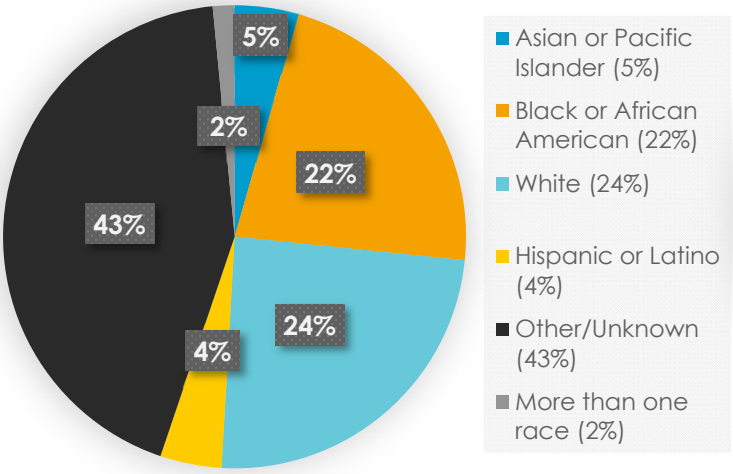
Program Description

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 our clinic, as well as via the team phone line.

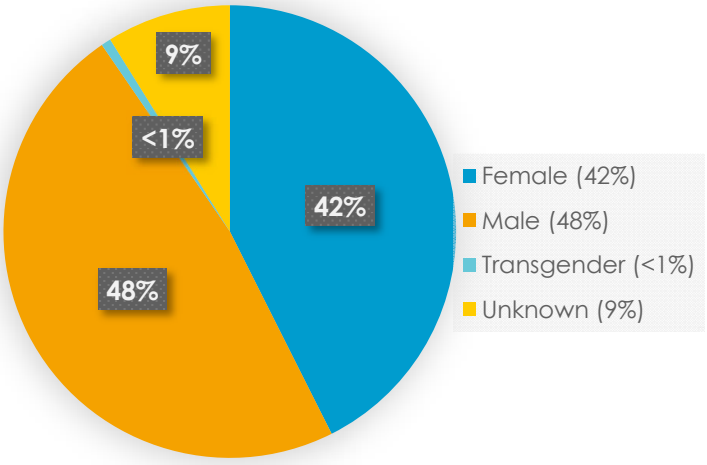
Demographics (Age)



Demographics (Race)



Demographics (Gender Identity)

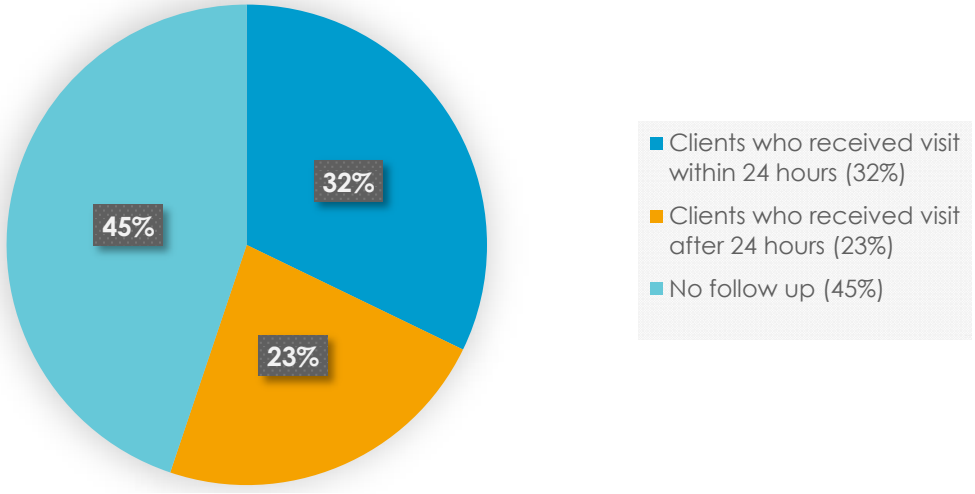


*Sexual Orientation data not available

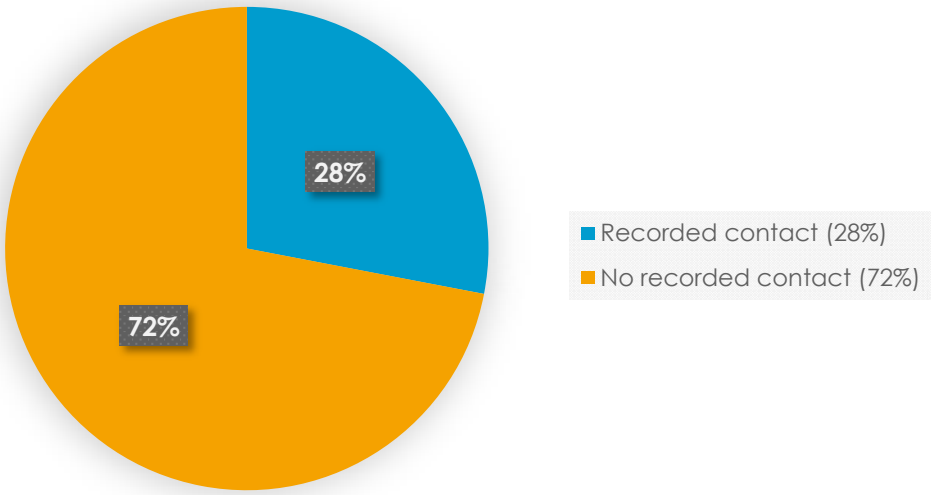
BMH RBA Report FY 2022

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

Follow-up after hospitalization (n=87)



MCT contacts with CAT attempt to contact (n=932)



BMH RBA Report FY 2022

Measure	Definition	Data Source
# clients served	Total clients served	MCT & 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

Homeless FSP (HFSP)

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served 2. # of new clients opened for ongoing services 3. Average # of days in FSP per client 4. Average # of service hours per client per month 5. Average # of services per client per month	6. % of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program 7. % of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month 8. % of discharges from hospitalization who had a follow up visit with HFSP staff within 7 and within 30 calendar days 9. % of clients with no service gap of over 30 days 10. #/% of clients closed, by reason closed 11. % of clients who were satisfied with services**	12. #/% of clients housed** 13. #/% of clients who gained or maintained housing since enrollment** 14. % of clients who had a reduction in jail days in the last 12 months compared to the 12 months before enrollment 15. % of clients with a primary care visit in the last 12 months 16. % 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 17. % of clients with a decrease in hospitalizations/hospitalization days 18. % of clients with an increase in the number of days in community living compared to 12-month period before enrollment**

*Please note: demographic data will be reported at the program level, where available

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

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

1. Client satisfaction with services
2. Client engagement in interpersonal activities

3. Client income (incl. entitlements)
4. Change in violence (e.g. # of violent interactions reported) experienced by the client
5. Change in educational or workforce training status of client
6. Client-to-staff ratio
7. % staff retention year-to-year
8. % 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
9. #/% of clients who maintained housing at 6 months from housing placement date

BMH RBA Report FY 2022

Homeless Full Service Partnership (FSP)
Reporting Period: July 2021-June 2022 (Baseline)

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

36

Clients Served

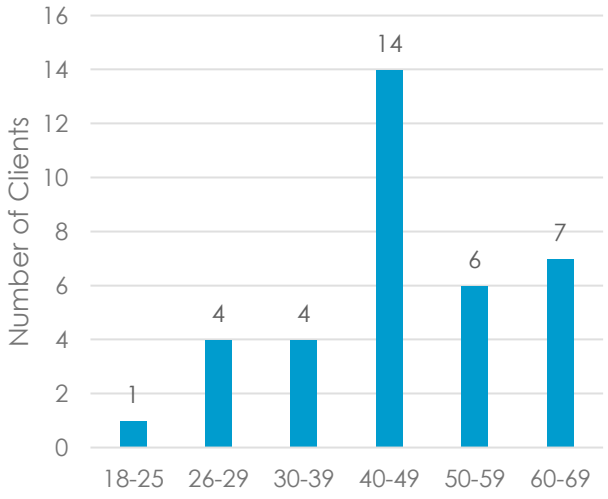
34

New Clients

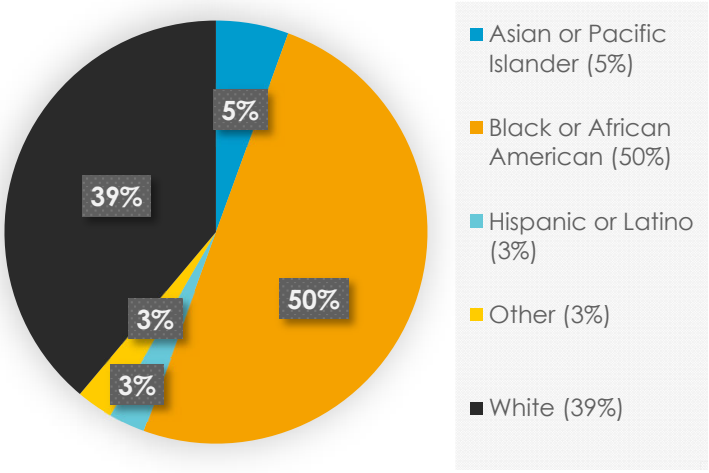
Program Description: HFSP serves unhoused residents of Berkeley in an Assertive Community Treatment (ACT) model at high staff to client ratios, providing intensive case management and mental health services in a multi-disciplinary team approach. This team serves those with the highest level of need,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

represents 10 clients

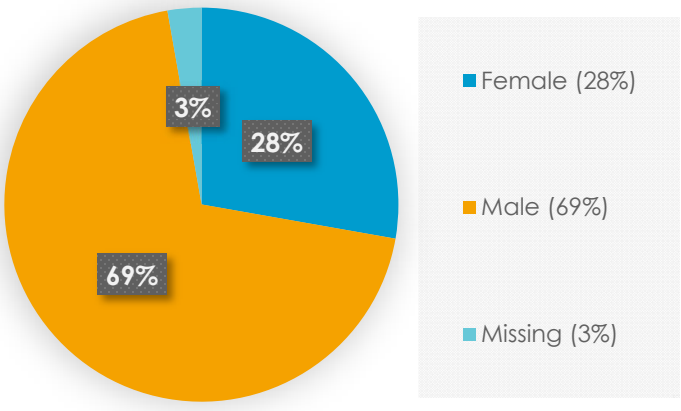
Client Demographics (Age)



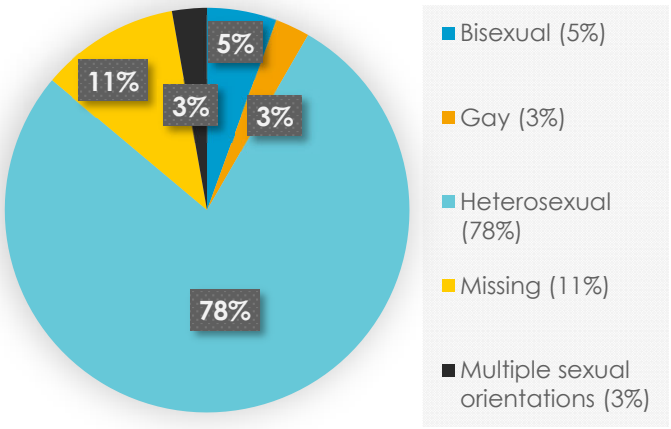
Client Demographics (Race)



Client Demographics (Gender Identity)



Client Demographics (Sexual Orientation)



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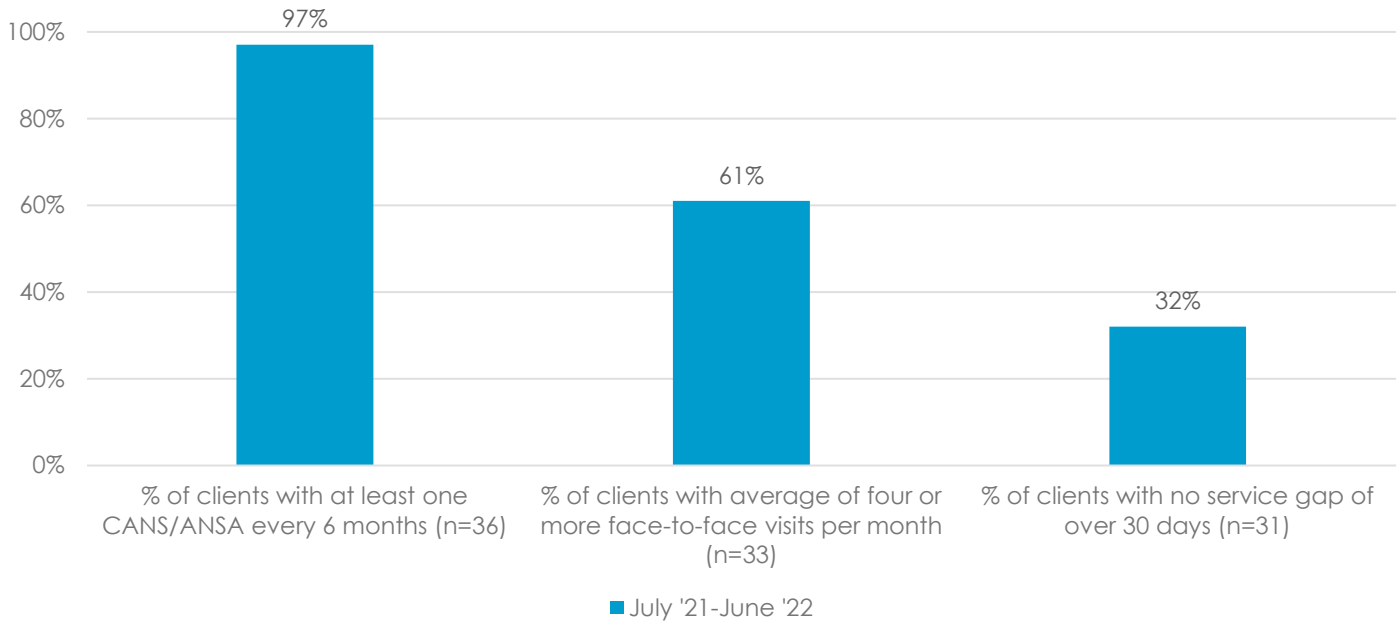
Quality Outcomes ("How well did we do it?")

The average client served in 2021-2022:

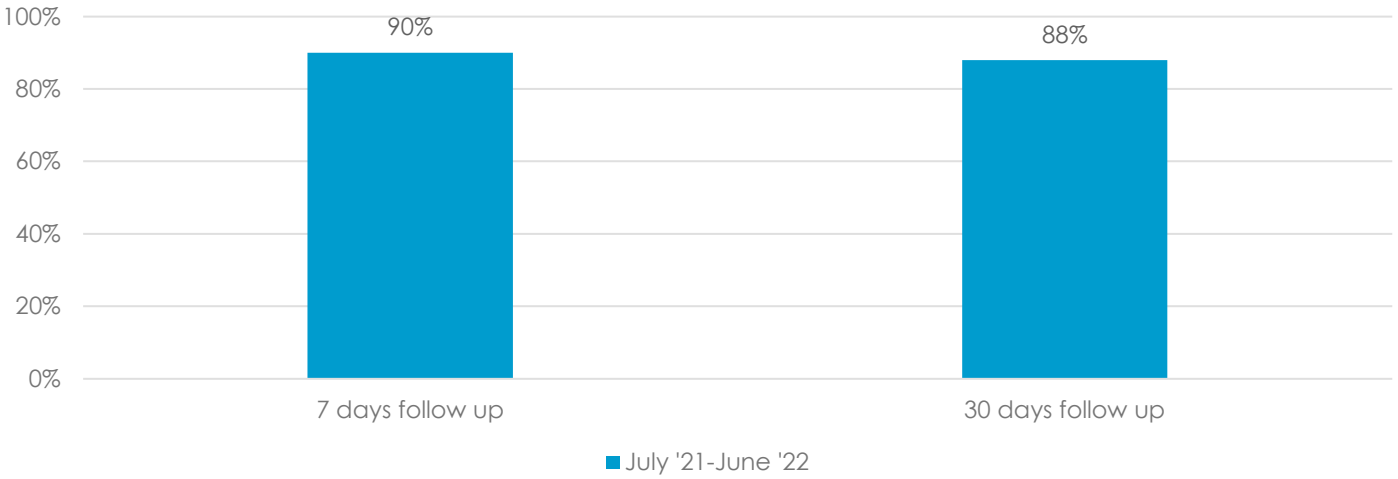
- remained in the FSP program for **263 days**
- received **8.82 hrs** of services per month
- received **6 services** per month

Service Consistency



Hospital Follow Up Consistency

% of discharges from hospitalization or subacute who received FSP follow up within 7 and 30 days (n=10)



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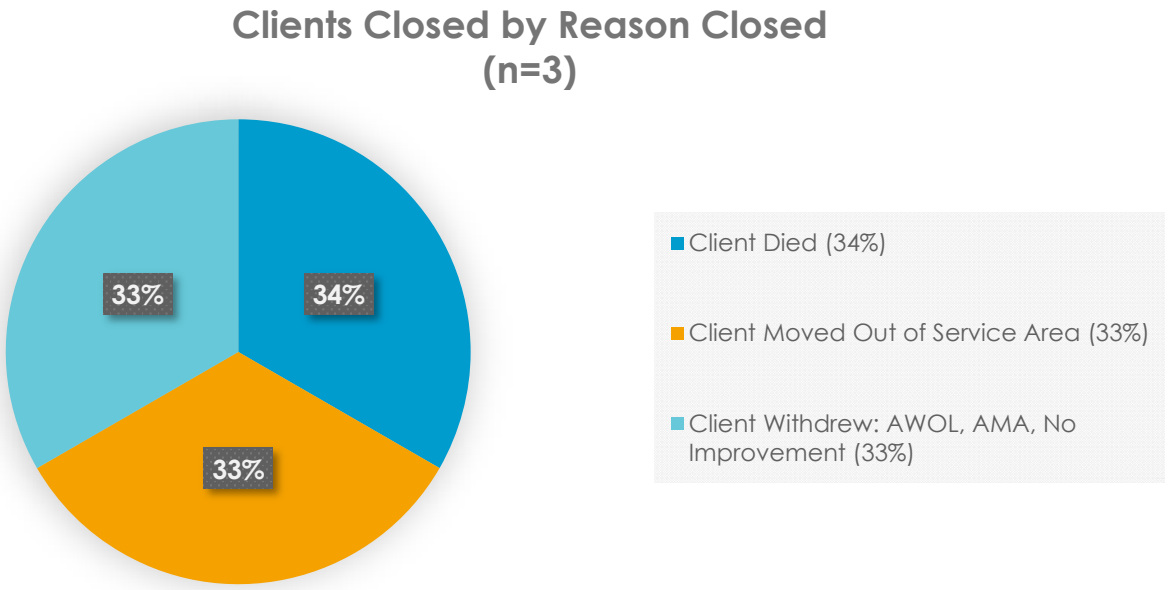
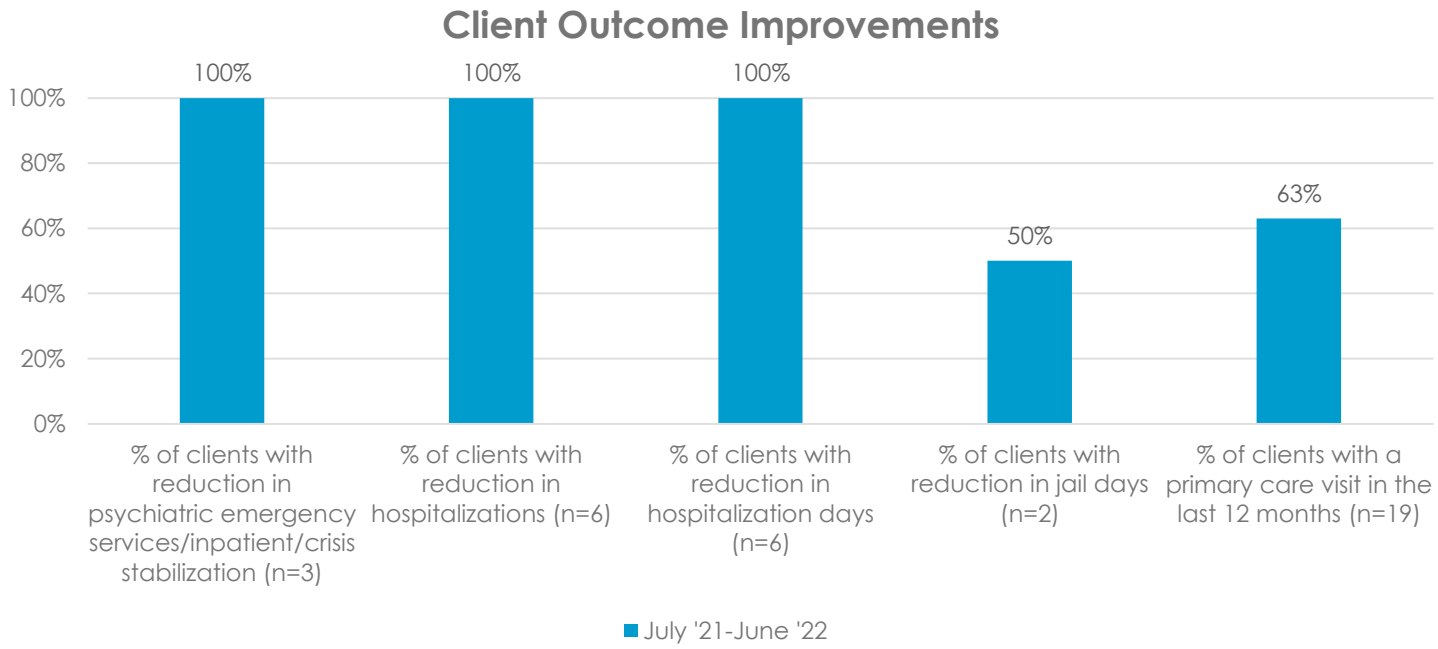


Impact Outcomes ("Is anyone better off?")



BMH RBA Report FY 2022

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 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

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% 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 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 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

Medical Services

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served	2. % of appointments kept per year	3. % clients connected to a primary care provider

*Please note: demographic data will be reported at the program level, where available

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

1. Average service hours per patient per year, with a demographic breakdown and adjusted for client panel
2. #/% of patients who report improvement in their quality of life
3. Reduction in number of hospitalization days per patient
4. Consistency of service (e.g. % clients who had met targeted frequency of services)
5. Responsiveness of service (e.g. x days following qualifying event)
6. % clients who had a primary care visit in the last year
7. # of new clients opened for ongoing services
8. % of clients who had a meeting with a psychiatrist every x months
9. % decrease of days incarcerated per client
10. % decrease of incarceration events per client
11. #/% of clients re-hospitalized within 1 month of inpatient discharge

BMH RBA Report FY 2022

Medical Services

Reporting Period: July 2021-June 2022 (Baseline)

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

324

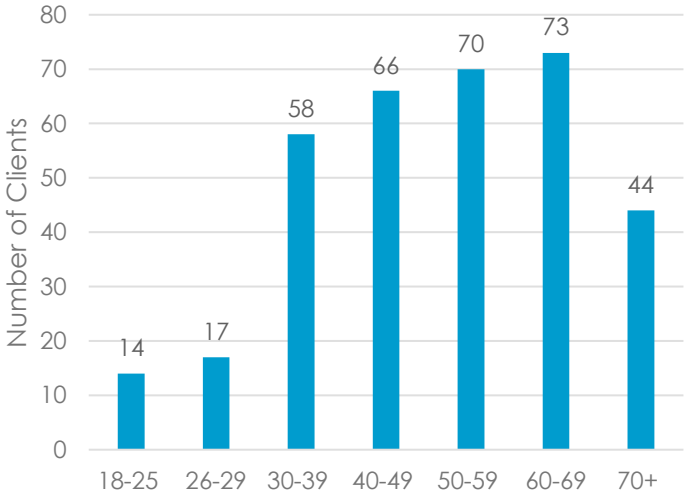
Clients Served

represents 25 clients

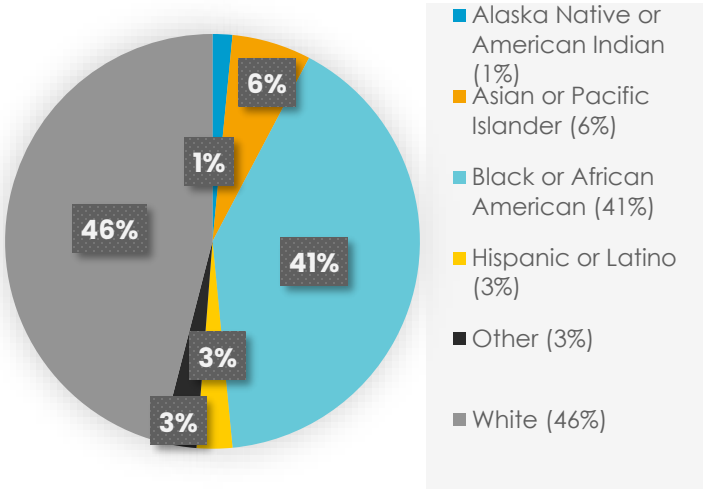
Program Description

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.

Client Demographics (Age)



Client Demographics (Race)



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

73%

of appointments were kept

Impact Outcomes ("Is anyone better off?")

48%

of clients were connected to a primary care provider

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Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
% of appointments kept	Of scheduled appointments, % which were kept for the time period	MD Attendance Tracker
% of clients connected to a primary care provider	Of total clients, % who had Primary Care Practitioner listed in Primary Care Tracker	Primary Care Provider Tracker

Wellness Services

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # participants served 2. # of different groups convened per year 3. # of group events held per year 4. # of participants who meet the requirements for "Telling Your Story" *(MHSA PEI requirement)*	5. #/% of participants who return for group events	6. #/% of participants who reported feeling less shame about their experiences and challenges 7. #/% of participants who reported recognizing progress in their recovery

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

1. Advance directives data:
    a. #/% of participants with an advance directive completed
    b. #/% participants able to advocate for themselves with service providers
2. Equity of services (e.g. client demographics compared to MediCal population)
3. % of clients who were satisfied with services

BMH RBA Report FY 2022

Wellness & Recovery Services

Reporting Period: July 2021-June 2022 (Baseline)

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

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

35

Participants served

8

Different groups convened

139

Group events

20

Participants who meet the requirements for "Telling Your Story"

represents 10 clients/events/groups

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

71%

of participants returned for group events

Impact Outcomes ("Is anyone better off?")

4 out of 5

participants reported feeling less shame about their experiences and challenges (n=5).

3 out of 5

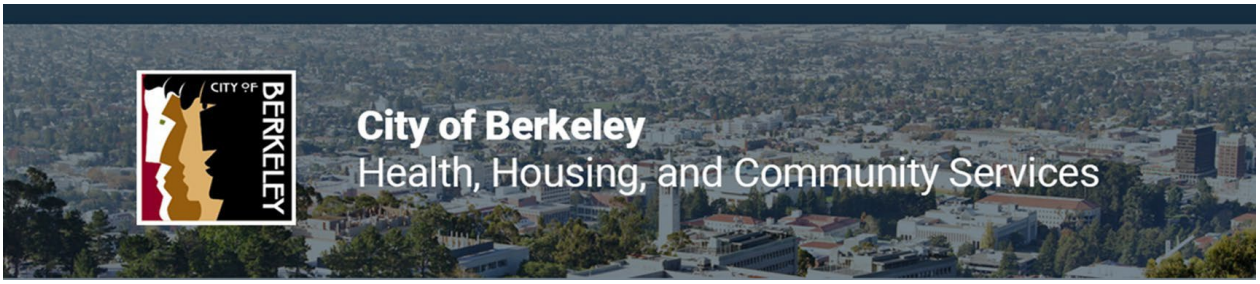
participants reported recognizing progress in their recovery (n=5).

BMH RBA Report FY 2022

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
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

APPENDIX D

PREVENTION AND EARLY INTERVENTION FY22 ANNUAL EVALUATION REPORT



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

Prevention and Early Intervention (PEI)

FY21/22 Annual Evaluation Report

INTRODUCTION

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

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

Per MHSA State requirements, mental health jurisdictions are required to submit a PEI Evaluation Report to the Mental Health Services Oversight and Accountability Commission (MHSOAC) on an annual basis. Additionally, a Three-Year PEI Evaluation Report is due to the MHSOAC every three years. Regulations also require mental health jurisdictions to submit PEI Evaluation Reports to the State Department of Healthcare Services (DHCS). The PEI Evaluation Report is to be included with the MHSA Annual Update or Three-Year Program and Expenditure Plan and undergo a 30-Day Public Comment period and approval from the local governing board. In the MHSA FY24-26 Three Year Plan, the Prevention and Early Intervention (PEI) Fiscal Years 2021/2022 (FY22) Annual Evaluation Report is due.

This PEI FY22 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. While, it may be a multi-year process before the City of Berkeley will be able to present a complete data set for each PEI Program on an Annual basis, ongoing efforts will continue towards accomplishing this goal.

Impact Berkeley Initiative

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

1. How much did you do?

2. How well did you do it?

3. Is anyone better off?

RBA has been incorporated into selected programs within the Department. 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. RBA outcomes in FY22 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 – Due to unaddressed emotional and behavioral problems.
- Children and Youth at Risk of or Experiencing Juvenile Justice Involvement – Individuals with signs of behavioral/emotional problems who are at risk of or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through MHSA Community Services and Supports funded services.

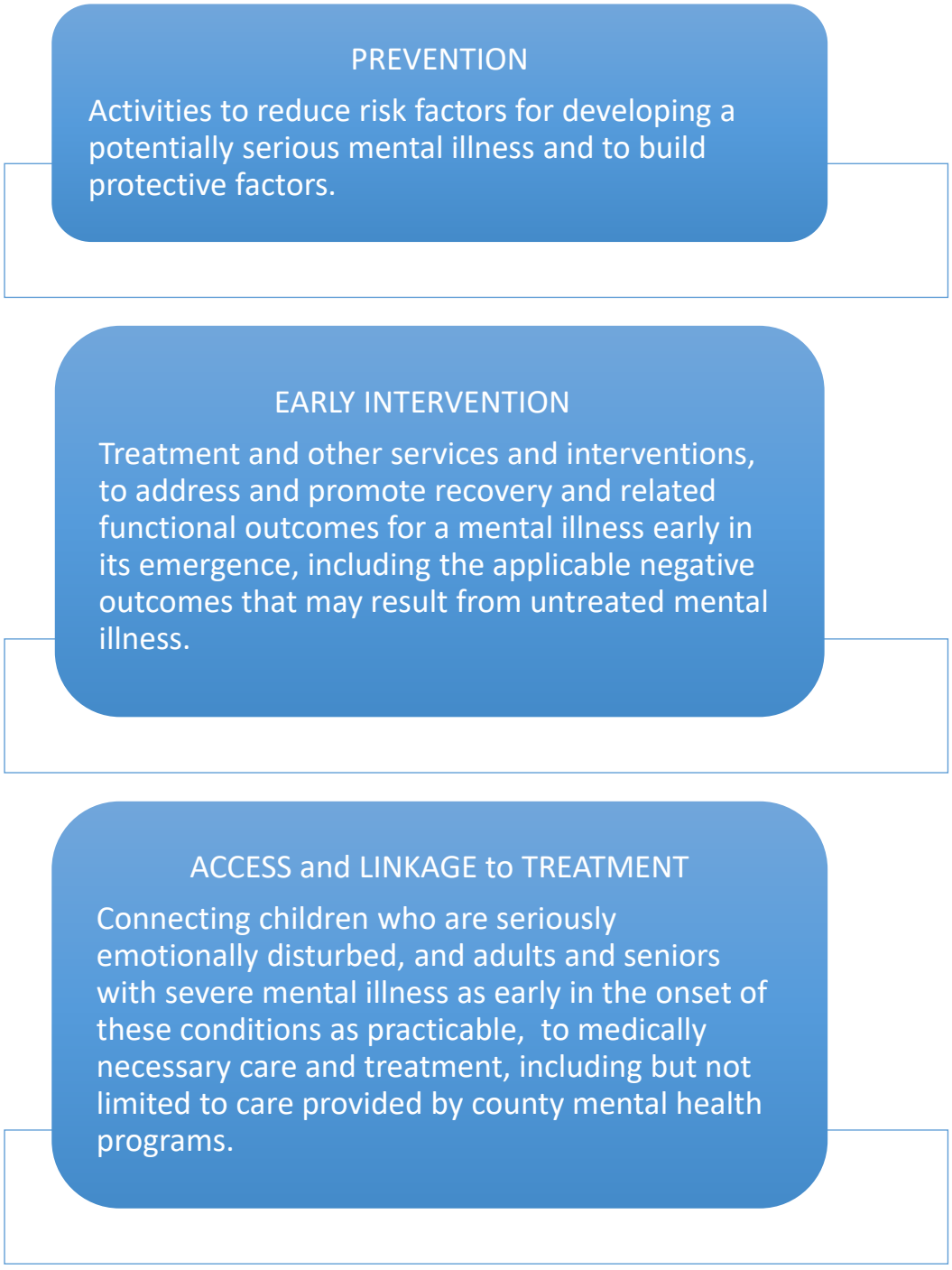
In April 2009, following a nine-month long Community Planning Process, the original City of Berkeley PEI plan was approved. Since the approval of the original plan, Three Year Plans or Annual Updates outlining proposed PEI funding and programming have been developed and approved on an annual basis. Based on the DMH Regulations, through the original PEI Plan (or subsequent updates) programs were created to address Key Community Mental Health Needs and PEI Priority Populations as follows:

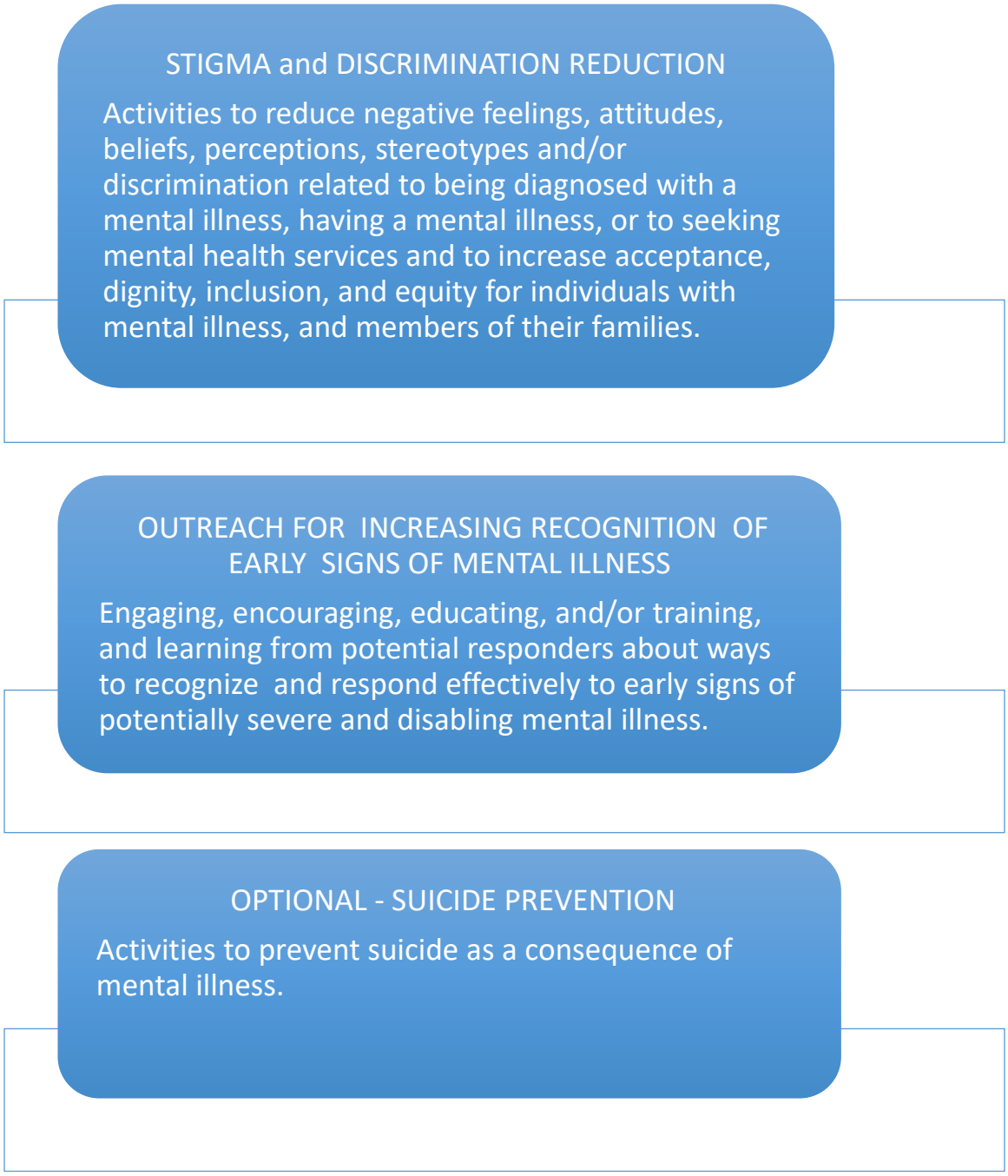
PEI Programs	Key Community Mental Health Needs	PEI Priority Populations
Behavioral-Emotional Assessment, Screening, Treatment and Referral – (BE A STAR) Program Supportive Schools Program Community Based Child & Youth Risk Prevention Program	➢ At-Risk Children, Youth and Young Adult Populations	• Children and Youth in Stressed Families • Children and Youth at Risk for School Failure • Underserved Cultural Populations
High School Youth Prevention Project Mental Health Peer Mentor Program Dynamic Mindfulness Program African American Success Project	➢ At-Risk Children, Youth and Young Adult Populations ➢ Disparities in Access to Mental Health services ➢ Psycho-social Impact of Trauma	• Trauma Exposed • Children and Youth in Stressed Families • Children and Youth at Risk for School Failure • Underserved Cultural Populations
Community Education & Supports	➢ Psycho-social Impact of Trauma ➢ At-Risk Children, Youth and Young Adult Populations	• Trauma Exposed • Underserved Cultural Populations • Children/Youth in Stressed Families • Children and Youth at Risk for School Failure

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 FY22

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


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


STIGMA and DISCRIMINATION REDUCTION
Activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.
OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS
Engaging, encouraging, educating, and/or training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.
OPTIONAL - SUICIDE PREVENTION
Activities to prevent suicide as a consequence of mental illness.

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

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

PEI Regulations, also include program and demographic data requirements that are to be reported to the MHSOAC through Annual and Triennial PEI Evaluation Reports.

The following pages outline the PEI Program and Demographic reporting requirements.

PEI PROGRAM REQUIREMENTS

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

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

Stigma and Discrimination	Direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.	• Social Inclusion
Access and Linkage to Treatment	Connecting children who are seriously emotionally disturbed, and adults and seniors with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs.	• 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 Commission-established priorities or other priorities as determined through their respective, local stakeholder processes. If a mental health jurisdiction chooses to focus on priorities other than or in addition to those established by the Commission, "the plan shall include a description of why those programs are included and metrics by which the effectiveness of those programs is to be measured" (WIC Section 5840.7 (d)(1)).

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

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

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

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

. Many PEI projects meet multiple established priorities. Per PEI regulations, outlined below is a crosswalk of the City of Berkeley PEI Programs with the MHSOAC PEI Priorities for programs during the reporting timeframe:

CITY OF BERKELEY PEI PROGRAMS	PEI PRIORITIES
• Be A Star • Supportive Schools • Child & Youth At Risk	Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.
• High School Youth Prevention Project • Mental Health Peer Mentor Program • Dynamic Mindfulness Program • Specialized Care Unit • African American Success Project	Youth Engagement and Outreach Strategies that target secondary school and transition age youth with a priority on partnership with college mental health programs, and transition age youth not in college. Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis. Culturally competent and linguistically appropriate prevention and intervention, including community defined evidence practices (CDEPs).
• Mental Health Promotion Campaign • Social Inclusion • Community Education & Supports	Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs). Youth Engagement and Outreach Strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs, and transition age youth not in college. Strategies targeting the mental health needs of older adults.

This PEI FY22 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 Transition Age Youth (TAY). Small counties, of which the City of Berkeley is considered, may elect to forego this regulation as long as a community vetted, locally approved justification is provided as to why children and youth services are funded at a lower level. Since the initial PEI Plan, the City of Berkeley has allocated more than 51% of PEI funds to services and supports for children, youth and TAY as the majority of PEI funds has been utilized to serving these populations.

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

Programs and services funded with PEI funds, and FY22 data are outlined below by PEI Program type.

PREVENTION PROGRAM

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

Through the FY22 Annual Update the City of Berkeley funded the following Prevention initiative:

Mental Health Promotion Campaign

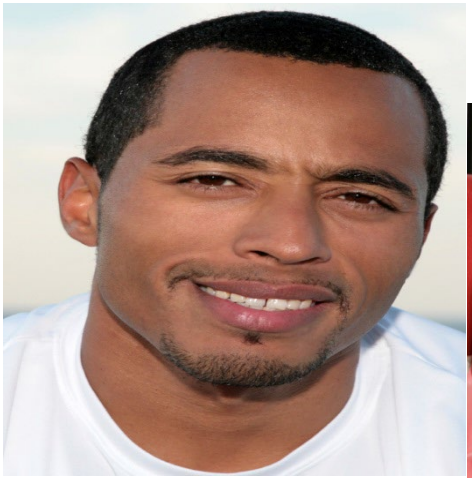
As a result of the impact of the pandemic, and public input around the overwhelming need for mental health supports in the community, the Division proposed through the FY22 Annual Update to allocate PEI funds for a community Mental Health Promotion Campaign to support the wellness and self-care of Berkeley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

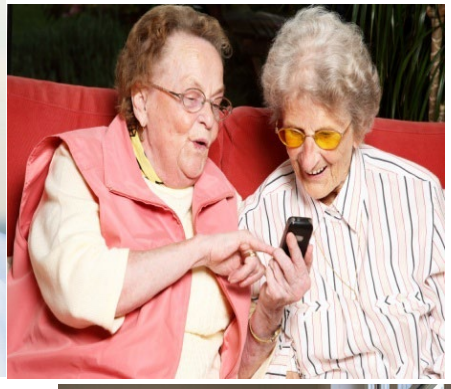
PEI Goals: The goal of this campaign is to increase prevention efforts and response to early signs of emotional and behavioral health problems.

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

It is envisioned that this campaign will get implemented in FY24 and the Division will continue to work with the community to determine how to best promote mental health and wellness in Berkeley.

EARLY INTERVENTION AND PREVENTION & EARLY INTERVENTION COMBINED PROGRAMS





EARLY INTERVENTION PROGRAMS

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

The City of Berkeley Early Intervention programs are as follows:

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

The Be A Star program is a collaboration with the City of Berkeley's Public Health Department providing a coordinated system in Berkeley 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 FY22, a total of 1,654 children were screened through this program (183 at BUSD, and 1,471 at the Help Me Grow sites) however data was not collected on all individuals screened. Only Race/Ethnicity data was collected on a subset the 183 children screened at BUSD as follows:

DEMOGRAPHICS N=183	
Age Groups	
0-15 (Children/Youth)	100%
Race	
Asian	19%
Black or African American	25%

White	20%
More than one Race	8%
Other	4%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican/Mexican-American/Chicano	24%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	100%
Primary Language	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Gender: Assigned Sex at Birth	
Declined to Answer (or Unknown)	100%

Program Successes:

- On-site technical assistance visits to all Berkeley Help Me Grow providers resumed and the visits went well.
- The program conducted 1,654 ASQ developmental screenings in Berkeley.
- Berkeley Unified School District (BUSD) referred a total of 53 preschool students and the Help Me Grow providers referred 94 infants/children.
- Approximately 78% of all Help Me Grow referrals reached their goals.

Program Challenges:

- There continued to be an impact of the COVID-19 pandemic on program services which decreased the number of screenings that were conducted.
- Staffing changes/turnovers at the Berkeley Help Me Grow sites impacted the continuity of the partnership with the program.
- The Help Me Grow sites do not collect race/ethnicity, language spoken data, or gender; and BUSD does not collect specific ethnicity data, language spoken, or gender for all students who received an ASQ.
- There was a delay in getting the annual data for the Help Me Grow sites.

Community-Based Child & Youth At Risk Prevention

Through FY22, the Community-Based Child & Youth Risk Prevention program targeted children (aged 0-5) who were impacted by multiple risk factors including trauma, family or community violence, familial distress, and/or family substance abuse, (among other issues). A BMH clinician served as the Mental Health Consultant on this project providing information, services and supports to teachers and parents at the YMCA Head Start program in South Berkeley. Services included individual case consultation for teachers and parents, group consultations, classroom observations and interventions, assessments, brief treatment, and referrals to other resources as needed. The main goals were to reduce risk factors or other stressors, and

promote positive cognitive, social, and emotional well-being. This program served approximately 50 Children & Youth a year.

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

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

This program was discontinued in April 2022 when the BMH Mental Health Consultant received a promotion to a different position. Once that position was vacated the YMCA Head Start program decided to create an internal staff position for a Mental Health Specialist.

In FY22, 41 children were served through this program. Demographics on those served is as follows:

DEMOGRAPHICS N=41	
Age Groups	
0-15 (Children/Youth)	100%
Race	
Asian	5%
Black or African American	44%
White	2%
Other	12%
More than one Race	2%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Declined to Answer or Unknown	35%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	100%
Primary Language	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Gender: Assigned Sex at Birth	
Declined to Answer (or Unknown)	100%

Program Successes:

- Returned to in-person Mental Health Consultations in the summer of 2021 which enabled the provision of in-person classroom consultation and direct interventions with children and teachers; increased

visibility and interactions with parents; and helped to improve the overall collaborations with administrators, teachers, and parents.
- Participated in-person in meetings with parents, teachers and administrators to provide direct consultation around behavior management in the classroom and at home.
- Modeled parent engagement strategies for teachers, advocates and staff. Modeling how to have difficult conversations using a trauma-informed perspective is essential to mental health consultations.
- Provided in vivo conflict management among teachers and with parents as well as provided case management and support as conflicts occurred.
- Return to in-person care also enabled the Mental Health Consultant to be able to observe classrooms and child behaviors over a period of time at different times of the day which allowed for better overall clinical understanding of the children's behaviors and needs, and improved their ability to make recommendations for services and classroom interventions.

Program Challenges:
- The onsite manager at the YMCA resigned mid-year, which made collaborating with the teachers and classroom staff challenging.
- There were center and classroom closures due to flooding in the infant room.
- COVID-19 pandemic exposures continued to impact the center and caused temporary classroom closures that created disruptions to the continuity of care.

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

Supportive Schools Program

Through this program leveraged MHSA PEI funds support the provision of mental health prevention and early intervention services at each of the Elementary Schools in Berkeley. Services include: outreach; mental health programming; classroom; group; one-on-one psycho-social education and support; and consultation with parents and/or teachers.

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

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

In FY22 Early Intervention Services were provided at each of the BUSD elementary schools. BUSD sub-contracted with local agencies to provide early intervention services based upon the standard of evidence-based practices. Bay Area Community Resources (BACR), Child Therapy Institute (CTI), and Lifelong Medical (Lifelong) were subcontracted to provide services at BUSD elementary schools.

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

programs. Due to the continuation of the impacts of the COVID-19 pandemic, BACR also provided resource networking and support for families in navigating the public health crisis.

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

Supports for each school per each service provider, and numbers served in FY22 were as follows:

Elementary School	Agency/Provider	Number of Students Served
• Cragmont • Emerson • John Muir • Malcolm X • Oxford • Ruth Acty • Sylvia Mendez • Thousand Oaks	Bay Area Community Resources (BACR)	420
• Bay Area Arts Magnet (BAM) • Washington	Child Therapy Institute	55
• Rosa Parks	Lifelong Medical Care	116
Total		**591**

Demographic data provided by BUSD on 591 students that were served through this project in FY22, is outlined below:

DEMOGRAPHICS N= 591	
Age Group	
0-15 (Children/Youth)	100%
Race	
American Indian or Alaska Native	3%
Asian	6%
Black or African American	25%
Native Hawaiian/Pacific Islander	<1%
White	47%
More than one Race	20%
Declined to Answer (or Unknown)	1%

Ethnicity: Hispanic or Latino/Latina/Latinx	
Unspecified Hispanic or Latino/Latina/Latinx	34%
South American	<1%
Declined to Answer (or Unknown)	1%
Ethnicity: **Non-Hispanic or Non- Latino/Latina/Latinx**	
Black or African American	15%
Asian Indian/South Asian	<1%
Chinese	1%
Eastern European	27%
European	1%
Filipino	1%
Other	4%
More than one Ethnicity	8%
Declined to Answer (or Unknown)	7%
Primary Language Used	
English	25%
Spanish	3%
Declined to Answer (or Unknown)	72%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Communication Domain	<1%
Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)	5%
Declined to Answer (or Unknown)	8%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	15%
Female	14%

Declined to Answer (or Unknown)	71%
Current Gender Identity	
Male	53%
Female	44%
Transgender	<1%
Genderqueer	<1%
Other Gender Identity	2%

Community Education & Supports Program

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

In FY22 three of the five contractors in the Community Education & Supports project participated in the HHCS Results-Based Accountability (RBA) Evaluation. RBA evaluation results are presented in an aggregated format across all programs as follows:

How Much Did We Do?	How Well Did We Do It?	Is Anyone Better Off?
• 527 Support Groups/Workshops • 2,427 Support Groups/Workshop Encounters • 121 Individual Contacts (2 of 3 programs reporting) • 132 Outreach Activities • 1.815 Outreach Contacts • 443 Referrals	• 94% of program respondents reported satisfaction with the services they received • Referrals by type: 135 Mental Health 55 Social Services 72 Physical Health 20 Housing 161 Other Services	• 90% of program participants reported an increase in social supports or trusted people they can turn to for help • 92% of program participants reported positive changes in terms of coping strategies, feeling anxious or overwhelmed

Descriptions for each project within the Community Education & Supports program and FY22 data are outlined below:

- **Transition Age Youth Trauma Support Project**

In FY22 this project was 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 FY22, 105 TAY participated in one or more program services. Demographics on youth served were as follows:

DEMOGRAPHICS N = 105	
Age Group	
16-25 (Transition Age Youth)	99%
26-59 (Adults)	1%
Race	
American Indian or Alaska Native	1%
Asian	4%
Black or African American	12%
White	2%
More than one Race	8%
Declined to Answer (or Unknown)	47%
Ethnicity: Latino/Latina/Latinx	
Other	12%
Declined to Answer (or Unknown)	13%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	74%
Primary Language Used	
Declined to Answer (or Unknown)	100%

Sexual Orientation	
Gay or Lesbian	13%
Heterosexual or Straight	22%
Declined to Answer (or Unknown)	65%
Disability Status	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Declined to Answer (or Unknown)	100%
Current Gender Identity	
Male	23%
Female	11%
Genderqueer	7%
Declined to Answer (or Unknown)	59%

Project Successes:

- Improved and integrated Art as Therapy content, and ironed out logistics.
- Successfully engaged increasing numbers of youth into Art as Therapy and Peer Mentoring over the reporting timeframe. Art as Therapy sessions consisted of activities that both teach art and provided a forum for sharing challenges common to TAY.
- Conducted outreach to 59 youth, made numerous contacts to other providers and organizations, and conducted events to publicize project services.
- Although, the program was not able to consistently conduct youth surveys, per staff report, youth indicated that services were helpful. Increased attendance was also an indication that Art as Therapy and Peer Mentoring sessions were valuable to the youth participants.
- Despite challenges with engagement, project outreach efforts resulted in 21 TAY trying out the Behavioral Health support groups. This progress was disrupted by staff turnover, and attendance dropped off towards the end of the year.
- The project engaged 29 new TAY into Peer Mentoring training this year. Meetings were held on a weekly basis at the Tiny House Village (THEV) serving the residents there, as well as other youth in the community. Transportation was provided for youth at the studio so they could easily.
- Many of the youth were pursuing education in the social services field or they wanted to explore this opportunity to see if they wanted to be in the field. The youth received training on healthy communication, coping with crisis and de-escalation, giving constructive feedback, health insurance and other topics. Youth were encouraged and supported to share and teach topics they found interesting to their peers.

- Six events were planned and conducted with 55 total youth in attendance. Youth expressed that they enjoyed and valued these events and would attend more if offered.

Project Challenges:

- Project challenges were compounded by the agency's rapid growth over the past two years, staff turnover, and lagging recruitment for the management function needed to operationalize the expansion, develop infrastructure, and implement better systems to gather client data and track outcomes.
- Engaging youth in services was challenging due to continued concerns and fears about the COVID-19 pandemic, and staff turnover, and the process of nearly doubling the services offered by this contractor during the COVID-19 pandemic.
- The holiday season seemed to impact responsiveness from the school district as school staff prepared for the end of the semester and district closures during the holidays. During this time, Omicron also became a serious threat and schools were again overwhelmed with new and changing restrictions. These factors caused significant barriers to having a consistent presence at the schools, along with delays in communication regarding the project implementation efforts and coordinating outreach and logistics for groups and events.
- The project social worker engaged both staff and students at Berkeley High School (BHS) and Berkeley Technical Academy (BTA), attended weekly staff meetings at BTA, conducted outreach to students on both campuses, and presented about PEI activities in classes at different times throughout the year, although consistency was difficult to achieve during the COVID-19 pandemic and holiday season. Despite these efforts, students were not readily engaged and attendance was inconsistent. Reports were that staff seemed to be ambivalent about new initiatives. Feedback from two students indicated that they (and their friends) didn't want mental health type services and that they didn't want to attend groups during their free period when they have a break from classes.
- By the beginning of March 2022 many of the existing program participants obtained full time jobs and could no longer commit to the project activities.

- **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 FY22, a total of 439 support groups were conducted, serving 45 individuals. *Demographics on individuals served include the following:

DEMOGRAPHICS N=45	
Age Groups	
16-25 (Transitional Age Youth)	29%
26-59 (Adult)	62%
Ages 60+ (Older Adult)	2%
Declined to Answer (or Unknown)	7%
Race	
Asian	16%
Black or African American	11%
White	42%
More than one Race	13%
Declined to Answer (or Unknown)	18%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Caribbean	2%
Central American	2%
Puerto Rican	2%
South American	2%
Declined to Answer (or Unknown)	2%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	4%
Asian Indian/South Asian	7%

Chinese	2%
Eastern European	2%
European	22%
Filipino	2%
Korean	4%
Middle Eastern	2%
More than one Ethnicity	20%
Declined to Answer (or Unknown)	24%
Primary Language Used	
English	98%
Declined to Answer (or Unknown)	2%
Sexual Orientation	
Gay or Lesbian	9%
Heterosexual or Straight	7%
Bisexual	18%
Questioning or Unsure	9%
Queer	22%
Another Sexual Orientation	24%
Declined to Answer (or Unknown)	11%
Disability	
Difficulty Seeing	2%
Mental (not Mental Health)	9%
Chronic Health Condition	4%
Other (Specify) – More than one disability	7%
No Disability	78%

Veteran Status	
No	98%
Declined to Answer (or Unknown)	2%
Gender: Assigned Sex at Birth	
Declined to Answer (or Unknown)	100%
Current Gender Identity	
Male	4%
Female	13%
Transgender	31%
Genderqueer	11%
Questioning or Unsure	4%
Another gender identity	29%
Declined to Answer (or Unknown)	7%

*(From Project staff report, the state PEI demographic data requirements requires the inclusion of percentages, therefore they had to code folx (folks – used to explicitly signal the inclusion of groups commonly marginalize) with any multiple identities, into some form of a "multiple identity" category or "other" category. For example, in the ethnicity section when folx selected multiple ethnicities, it was reported as "More than one ethnicity." While this strategy generally works well to reduce confusion by ensuring legible percentages, this manner of reporting is reductive and doesn't allow for the full picture of the data. For instance, someone who identified as both Native and white is only being reported as "multiple races" and therefore, the category for Native participants is blank. This caused it to appear as though there weren't any Native participants in the project, when there were. The demographic reporting structure required simply does not allow for the level of detail and nuance needed to have a fuller picture of the project data).

There were 76 referrals for additional services and supports. The number and type of referrals was as follows: 24 Mental Health; 27 Physical Health; 2 Social Services; 23 other unspecified services. To assess the project services, a self-administered Peer Support Group Survey was distributed to all peer group members. Survey results were as follows:

- 81% indicated they would recommend the organization to a friend or family member;
- 77% felt like staff and facilitators were sensitive to their cultural background;
- 77% reported they deal more effectively with daily problems;
- 70% indicated they have trusted people they can turn to for help;
- 79% felt like they belong in their community.

Program Successes:

- The impact of the COVID-19 pandemic continued to be felt throughout the LGBTQIA+ community. The project continued providing peer groups online, providing spaces for the community members to gather; to receive and provide emotional support, feel a sense of belonging and connection; and to share resources.
- Some folx were not able to move to the online space due to privacy concerns, other safety issues, lack of devices, or unstable WiFi. Despite that, the peer group facilitators reported that many of their group members expressed appreciation for the access to the virtual space during a time of increased isolation, especially those with chronic pain, disability, transportation or other barriers to in-person services.
- Community members also asked about the possibilities of additional new groups in FY23 including: Q-Finity for neurodiverse folx; a group focusing on the needs of the QT polyamorous community; a parent's group; as well as a restarting of the Thursday Night Men's group. New peer group facilitators were scheduled to be onboarded in Aug 2022.
- Opportunities for project outreach increased dramatically through the website, and through the Meetup, Instagram and Facebook accounts.
- A few quotes from feedback forms on the support group were as follows:
  "I love the sense of community and support I feel in the group."
  "Thank You for holding the space."
  "I found the group understanding and supportive and [it] makes me feel I am not alone on an island, as others have [the] same circumstances."

Program Challenges:

- With more online offerings, the facilitators had additional work to do. For example, checking their email frequently, coping with technology issues, navigating facilitation while some group members and even facilitators joined via phones. These challenges were used as an opportunity to evaluate how to support facilitators as the project migrates to an in-person/hybrid, model and how facilitators can be set up to easily navigate the technological needs.
- While COVID-19 pandemic protocols were developed the project space was in transition since it was purchased by a development corporation and that hindered the ability to fully return to all in-person services.
- The contractor that implements this project experienced big leadership changes in the Executive Director, Clinical Director, Finance Director and Community Programs Director positions. These shifts impacted staff capacity and resulted in some schedule changes until the vacancies were able to be filled.
- The project will be examining ways to broaden and deepen community engagement, especially to community members who live at intersections of disabled, trans, and Black, Indigenous, and People Of Color (BIPOC) communities. An outreach committee was assembled to better track and prioritize engagement with more of a systematic approach.
- Although there was a decrease in numbers on the demographic sheets gathered on the peer group members and therefore, a lower number of group members reported, the number of duplicated participants was 2,118 in FY22, which indicated that despite lower unduplicated participants, individuals who joined groups returned regularly to meetings.
- Project staff will continue to evaluate issues of attrition and Zoom fatigue while exploring in-person and hybrid models of meeting, as well as ways to improve completion and submission of the demographic forms and surveys by peer group members.

- **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 FY22, 47 Living Well Workshop sessions were conducted. Each Living Well Workshop series included the following sessions: Orientation; Goal Setting; Problem Solving; Healthy Reactions; Beating the Blues (Depression and Moods); Healthy Communication; Seeking Information; Physical Activity; Eating Well (Nutrition); Advocacy (Self and Systems Change); and Maintenance. Topics of Grief and Loss, Depression, Retirement, and Senior Invisibility were also incorporated into the project. In all, 14 Senior Citizens participated in the Living Well Workshops. Demographics of Workshop participants are outlined below:

DEMOGRAPHICS N=14	
Age Groups	
26-59 (Adult)	7%
Age 60+ (Older Adult)	93%
Race	
Asian	7%
Black or African American	14%
White	65%
Other	7%
More than one race	7%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Other	7%
Declined to Answer (or Unknown)	7%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
European	14%
Other	7%
Declined to Answer (or Unknown)	65%
Primary Language Used	
English	100%
Sexual Orientation	
Heterosexual or Straight	7%
Questioning or Unsure	7%
Declined to Answer (or Unknown)	86%
Disability	
Difficulty Seeing	7%
Difficulty Hearing or Having Speech Understood	7%
Mental (not mental health)	21%
Physical/mobility disability	14%
Chronic health condition	7%
Other Disability	29%

No Disability	7%
Declined to Answer (or Unknown)	8%
Veteran Status	
No	100%
Gender: Assigned Sex at birth	
Male	21%
Female	79%
Current Gender Identity	
Male	21%
Female	79%

During the reporting timeframe 14 outreach and informational events were conducted reaching 38 individuals, with 45 unduplicated individuals receiving further engagement services. There were 257 referrals for additional services and supports. The number and type of referrals were as follows: 80 Mental Health; 35 Physical Health; 20 Social Services; 20 Housing; 102 other unspecified services. A total of 100% of project participants completed a Living Well Workshop Series. Feedback per participant self-report was as follows:

- 100% reported they felt satisfied with the workshops;
- 100% indicated an improvement in feeling satisfied in general;
- 100% had increased feelings of social supports;
- 100% felt prepared to make positive changes; and
- 100% reported they felt less overwhelmed and helpless.

Project Successes**:**
The workshops were well attended with lively engagement. The workshops provided a safe space where some of the participants were able to share painful testimonies of isolation, sadness and fear and others of loneliness. Many missed their families, their grandchildren, and friends. To help participants stay connected 96 tele-support group sessions were held. Living Well Program virtual/tele-workshops were offered every Monday and tele-support groups every Tuesday. In December and May laptops and technical training were provided to previous participants and individuals who completed The Living Well Workshop Series.

Project Challenges:
Some participants had to travel out of state to support adult children with life-threatening illnesses and two struggled with potentially life-threatening diagnoses themselves. There was a lot of uncertainty revolving around the COVID-19 pandemic. Many participants had difficulties connecting with others due to the technological gap. The Workshop Series facilitator also had to learn systems that had not been used before.

- **SoulSpace Project**

In FY22, following a competitive Request For Proposal (RFP) process, ONTRACK Program Resources began implementing the SoulSpace Project for African Americans in Berkeley. The project assists African Americans in Berkeley to access culturally, ethnically, and linguistically responsive and trauma-informed

prevention and early intervention services. Project services include: community education; outreach and engagement; 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.

This project began operating in the last month of the 2nd Quarter of FY22. During that timeframe ONTRACK served 16 individuals in intensive case management, including a total of 45 empowerment activities, and support groups. Demographics on individuals served through this project were as follows:

DEMOGRAPHICS N=16	
Age Groups	
Transition Age Youth (16-25)	19%
Adults (26-59)	62%
Older Adults (60+)	19%
Race	
Black or African American	100%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Other	100%
Primary Language	
English	100%
Sexual Orientation	
Heterosexual or Straight	94%
Another sexual orientation	6%
Disability	
Mental (not mental health)	6%
Physical/Mobility Disability	6%
No Disability	88%

Veteran Status	
No	100%
Gender: Assigned Sex at Birth	
Male	56%
Female	44%
Current Gender Identity	
Male	56%
Female	44%

Project Successes**:**

Despite a program starting date of December, 1, 2021, ONTRACK launched the SoulSpace project and accomplished the following during the reporting timeframe:

- Hired two staff who have deep familiarity with Berkeley.
- Secured a work space.
- Built out the case management platform, Apricot by Social Solutions, to match the system used by Berkeley—City Data Services.
- Conducted outreach and began implementing services.
- In order to quickly gain a foot in Berkeley's mental health provider network, the contractor established several partnerships with longstanding organizations in the city of Berkeley including:
  -A partnership with Options for Recovery which included their co-hosting an in-person public education event with Roland Williams, an expert in co-existing substance use and mental health concerns among African Americans. The contractor also provided one-to-one empowerment services for some of their dually-diagnosed clients as well as members of their staff working through the compassion fatigue that often accompanies work with this population.
  -Through a partnership with Building Opportunities for Self-Sufficiency (BOSS), the contractor conducted onsite—and off-site-one-to-one and group empowerment services to their otherwise unsheltered population of African Americans.
- Conducted two well-reviewed community education events. Dr. La Tanya Takla conducted a 2-part series on trauma informed care to African Americans, and Roland Williams conducted an in-person workshop at the Veterans Memorial Building.

Project Challenges:

- The contractor experienced a number of challenges during the program period, several of which have been rectified since the ending of the June 30, 2022 MHSA reporting period.
  The truncated MHSA 2021-2022 service period was short due to a contract execution date of December 1, 2021, and a delay in final contracting processes.
- Outreach efforts to community members was restricted due to the COVID-19 pandemic, which meant greater reliance on social media and outreach to other community organizations who were seeking to adapt to their own challenges.
- The initial location of the Soul Space office in West Berkeley was less accessible to community members than the current location in North Berkeley on Adeline Street.

- **Latinx Trauma Support Project**

In FY22, following a competitive Request For Proposal (RFP) process, East Bay Sanctuary Covenant began implementing the Latinx Trauma Support Project. This project assists low-income, Latinx families in Berkeley to access culturally, ethnically, and linguistically responsive and trauma-informed prevention and intervention services. Project services are in direct response to, and in collaboration with, Latinx community members, and are largely facilitated by individuals from within the targeted community and 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 FY22, this project began implementing services. Over the course of the year a total of 224 individuals were served. Demographics on individuals served through this project were as follows:

DEMOGRAPHICS N=224	
Age Groups	
Children and Youth (0-15)	2%
Transition Age Youth (16-25)	13%
Adults (26-59)	82%
Older Adults (60+)	1%
Declined to Answer (or Unknown)	2%
Race	
American Indian or Alaska Native	10%
Asian	1%
Black or African American	<1%
White	2%
Other	85%
Declined to Answer (or Unknown)	2%

Ethnicity: Hispanic or Latino/Latina/Latinx	
Central American	45%
Mexican/Mexican-American/Chicano	29%
South American	8%
Other	8%
Declined to Answer (or Unknown)	7%
Ethnicity: Non-Hispanic or Latino/Latina/Latinx	
African	<1%
Asian Indian/South Asian	1%
Chinese	<1%
Eastern European	<1%
Middle Eastern	<1%
Other	<1%
Primary Language	
English	3%
Spanish	83%
Declined to Answer (or Unknown)	14%
Sexual Orientation	
Gay or Lesbian	28%
Heterosexual or Straight	43%
Questioning or unsure of sexual orientation	1%
Queer	1%
Another sexual orientation	2%
Declined to Answer (or Unknown)	25%
Disability	
Difficulty Seeing	<1%
Other	1%
No Disability	95%
Declined to Answer (or Unknown)	4%

Veteran Status	
No	91%
Declined to Answer (or Unknown)	9%
Gender: Assigned Sex at Birth	
Male	49%
Female	50%
Declined to Answer (or Unknown)	2%
Current Gender Identity	
Male	46%
Female	50%
Transgender	1%
Genderqueer	1%
Declined to Answer (or Unknown)	2%

During the reporting timeframe 41 Support Group sessions were conducted reaching 26 individuals, and 76 individuals received One-on-One Supports. A total of 49 Trainings were conducted, reaching 78 individuals. There were 110 warm referrals for additional services and supports. The number and type of referrals were as follows: 31 Mental Health; 10 Physical Health; 33 Social Services; 36 other unspecified services.

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

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

Training feedback per participant self-report was as follows:

- 98% pf participants indicated that they were satisfied with the training;
- 100% of participants indicated that the information in the training was informative;
- 100% of participants indicated that the training would help them in their work.

Project Successes**:**

- In the first fiscal year of this contract, an effective and efficient support services project was built to better serve members of the Latinx community through a holistic trauma-informed approach.
- Having a dedicated staff allowed the project to connect more deeply with Latinx community members, offering early intervention and prevention education, one-on-one supports, warm referrals to a wide range of social and mental health services, and two support groups (one for LGBTQ Latinx asylum seekers and one for Indigenous Maya Mam women).
- The project trained a total of seventy-eight staff and employees of partner agencies in the trauma-informed approach. These trainings were designed after the Program Manager interviewed key

stakeholders within the organization about their understanding of trauma and what training needs they saw for improving our services. Externally, customized trainings for partners working in healthcare, education, and social services were also provided.

- The Support Services Manager strengthened partnerships with community agencies around a range of services that clients desperately needed, including health care, public benefits, services for survivors of domestic violence, housing, and many other needs.
- A sophisticated comprehensive system for identifying the resources available to community members and tracking referrals after initial contact using the Airtable platform, was created and utilized.

Project Challenges:
An early challenge was that the project was not able to hire a Support Services Program Manager until two months after the grant began, however despite this delay, project goals were still met.

PREVENTION & EARLY INTERVENTION COMBINED PROGRAMS

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

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

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

Mental Health Peer Education Program

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

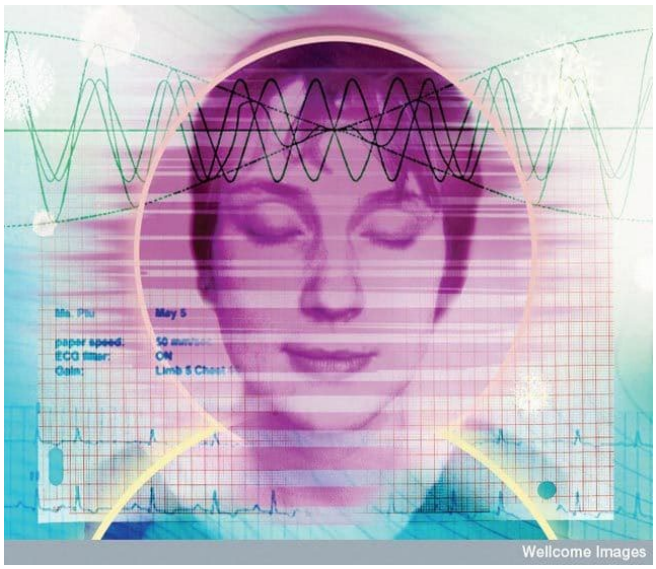
PEI Goals: The goal of this program is to bring about mental health, including the reduction of school failure and the removal of children from their homes.

PEI Priorities:

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

In FY22, although the funding was allocated for this program, it was implemented by BUSD.

Dynamic Mindfulness Program (DMind)



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

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

PEI Priorities:

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

In FY22, DMIND was provided both live on-line, and in-person. Training and coaching services were also provided through this program. The training and coaching services build capacity among teachers and staff, so they have the skills for their own self-care, stress resilience and personal sustainability, and for the professional application with students to teach emotional regulation as well as social-emotional learning. Training and coaching was also used to build capacity among student peer leaders, with structured

opportunities for application in conflict resolution, peer mediation, restorative justice circles, and leading DMIND practice in their classrooms. Additionally, this program provided videos to the schools and Yoga at Independent Study. A total of 1,546 students and 139 teachers/school staff received services through this program during the reporting timeframe as follows:

School	Number of Students Served	Number of School Staff Served
• Berkeley High School	455	76
• Berkeley Technical Institute	28	12
• King Middle School	248	15
• Longfellow Middle School	127	19
• Willard Middle School	688	17
Total	**1,546**	**139**

Demographic data on individuals served in FY22 was not provided by BUSD.

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 Priority:

- 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 FY22, 73 students participated in this project. Outlined below are demographics on individuals served through this project:

DEMOGRAPHICS N=73	
Age Groups	
Children/Youth (0-15)	100%
Race	
Black or African American	79%
More than one Race	10%
Declined to Answer (or Unknown)	1%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Hispanic/Latino/Latina/Latinx	10%
Primary Language	
English	96%
Other	4%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Other	25%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	53%
Female	47%
Current Gender Identity	
Male	53%
Female	47%

Worth noting is this project's continued emphasis on school success and reinforcing literary skills. In addition to incorporating literacy structures into the class setting, the project made a strategic investment to establish a classroom library, which affords students access to over 100 unique titles. Efforts were made to select books written by Black/African American authors whose books feature Black/African American history, culture, and stories. Building the library was in direct response to a student survey conducted in a prior school year in which project participants indicated they would read more, if books were available that reflected their lived experience and related to their cultural background.

ACCESS AND LINKAGE TO TREATMENT PROGRAM and COMBINED PROGRAMS

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 would also qualify as an Access and Linkage to Treatment program:

High School Youth Prevention Program

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

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.

In FY22, approximately 233 students received services through this project. Demographics on youth served are outlined below:

DEMOGRAPHICS N=233	
Age Groups	
0-15 Years	27%
16-25 Years	73%
Race	
American Indian or Alaska Native	3%
Asian	6%
Black or African American	17%
Native Hawaiian or other Pacific Islander	<1%
White	33%
More than one Race	14%
Other	11%
Declined to Answer (or Unknown)	16%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Other	22%
Declined to Answer (or Unknown)	16%
Primary Language	
English	93%
Spanish	6%
Declined to Answer (or Unknown)	1%
Sexual Orientation	
Gay or Lesbian	2%
Heterosexual or Straight	33%
Bisexual	14%
Questioning or unsure of sexual orientation	13%
Queer	<1%
Another sexual orientation	9%
Declined to Answer (or Unknown)	28%

Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	29%
Female	71%
Current Gender Identity	
Male	21%
Female	44%
Transgender	3%
Genderqueer	7%
Another gender identity	<1%
Declined to Answer (or Unknown)	25%

Program Successes:

- Resumed providing the full range of services when students returned to full-time in-person learning.
- Following multiple staff transitions during the summer of 2021, this project was able to add two diverse, experienced, highly skilled, licensed clinicians, one of whom is a native bilingual Spanish speaker. Both clinicians quickly became part of a cohesive and collaborative mental health team and have integrated well into the larger Health Center team.
- The mental health team was able to substantially increase service utilization year-over-year compared to the FY21 school year. As half of the student body were new to campus in FY22, the project focused more of its efforts on outreach in order to familiarize students with the array of services.
- The mental health team maintained the use of the JotForm application for referrals. The team also integrated QR code technology into the referral form so that it can be more easily accessed and completed by students and school staff.
- The mental health team maintained a collaborative and productive relationship with the Berkeley High School Coordination of Services Team (OST) throughout the school year in order to ensure that appropriate referrals were made to the program.
- The mental health team was able to support students by providing an array of crisis support services following the tragic death of a Berkeley High School student in April 2022.
- The mental health team was also able to build upon and improve existing relationships and partnerships with Berkeley High School stakeholders. To this end the team collaborated with several different on-campus programs throughout the year such as the Multi-cultural Program, McKinney Vento Program, Special Education Program, and Intervention Counselors. The team also conducted stakeholder meetings at the end of the school year in order to elicit feedback around the services that are provided with a focus on how to improve collaboration, advance equity, and improve service accessibility.

Program Challenges:

- Two newly hired full-time Mental Health Clinicians were onboarded in FY22 in September and November. From August through December 2021 one full-time bilingual Mental Health Clinician was on parental leave. These staffing limitations contributed to the teams reduced service capacity during the Fall 2021 timeframe.
- Due to staff transitions during the preceding summer, the project was not able to host a cohort of graduate-level trainees, which also contributed to reduced service capacity during the FY22 school year.
- As a result of reduced staffing and service capacity, the mental health team did not facilitate support groups during the FY22 school year.
- Berkeley High School administration and staff also experienced difficulties with the transition back to full-time in-person learning and it took time to rebuild coordinated systems for supporting a range of student's needs. Project leadership and Berkeley High School Administration continued to develop relevant protocols during the courses of the school year to better support student accessibility to needed services.

Results Based Accountability (RBA) measures for this project in FY22, 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 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	ETO/RedCap

Measure	Definition	Data Source
	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

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

In FY22, the RBA Outcomes for this program were as follows:

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High School Health Center (HSHC)

Reporting Period: July 2021-June 2022 (Baseline)

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

233

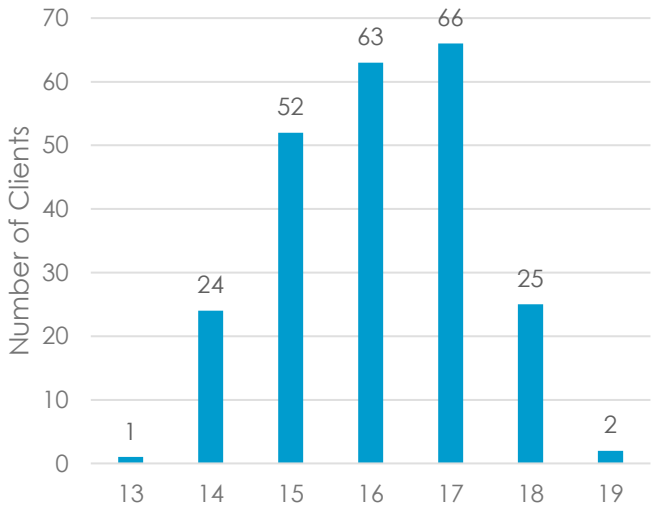
Clients Served

represents 20 clients

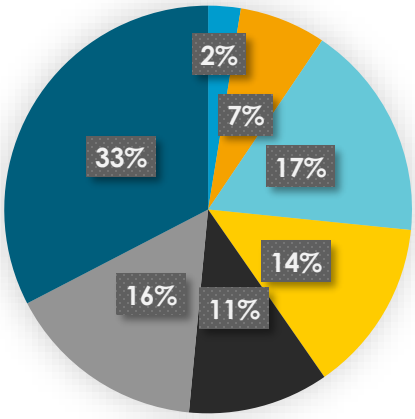
Program Description

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

Demographics (Age)

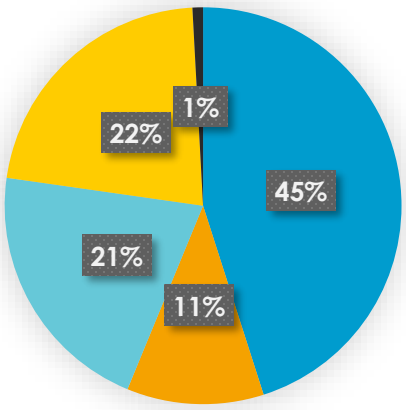


Demographics (Race)



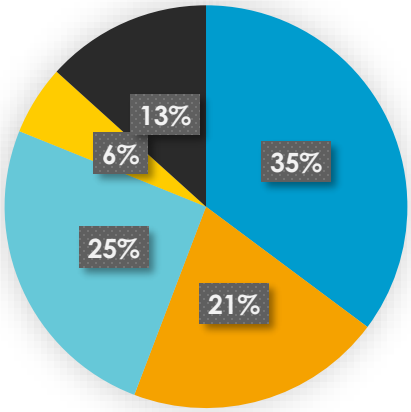
- Alaska Native or American Indian (2%)
- Asian or Pacific Islander (7%)
- Black or African American (17%)
- More than one race (14%)
- Other (11%)
- Prefer not to answer (16%)
- White (33%)

Demographics (Gender Identity)



- Female (45%)
- Gender nonconforming, transgender, genderqueer (11%)
- Male (21%)
- Missing (22%)
- Prefer not to answer (1%)

Demographics (Sexual Orientation)



- Heterosexual (35%)
- LGBTQ* (21%)
- Missing (25%)
- Prefer not to answer (6%)
- Unknown/unsure (13%)

*includes students who self-identified as aromantic, asexual, bisexual, gay, homosexual, lesbian, pansexual, queer, and questioning

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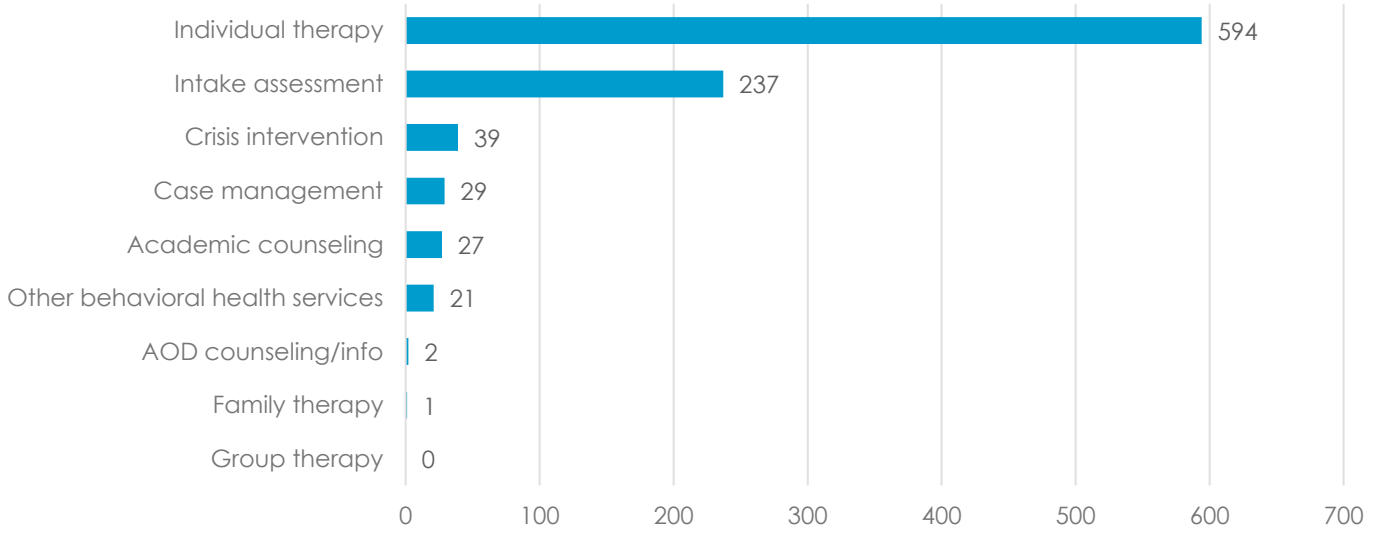
Services Provided by Service Type

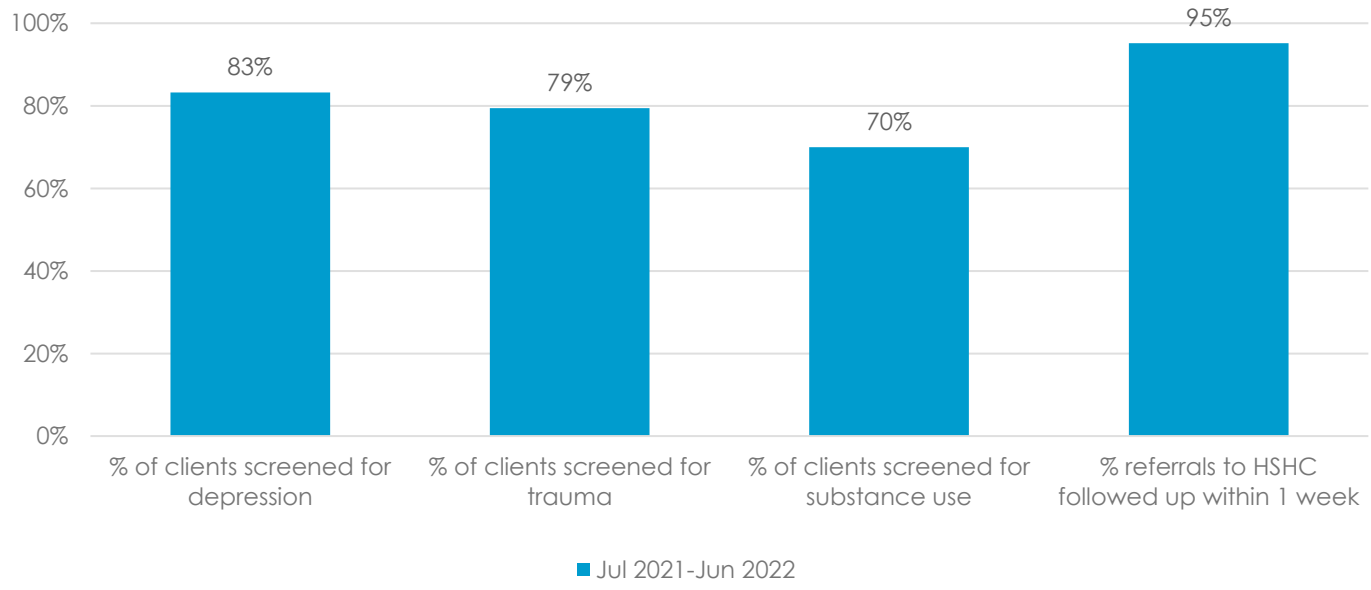


Note that multiple services could be provided in one visit (e.g. crisis assessment and referral) so total services by type (n=950) is greater than total encounters (n=846)

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

In 2021-2022, the HSHC program served **7%** of the school population.

Service Consistency



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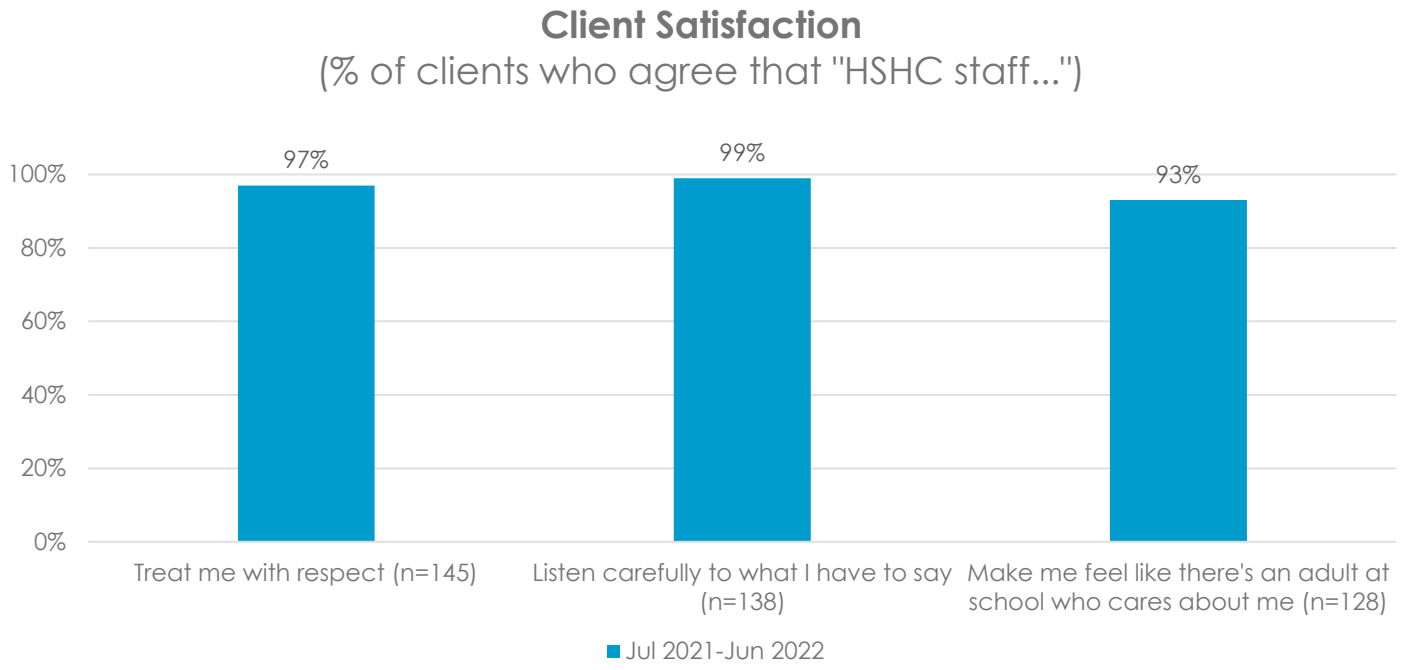
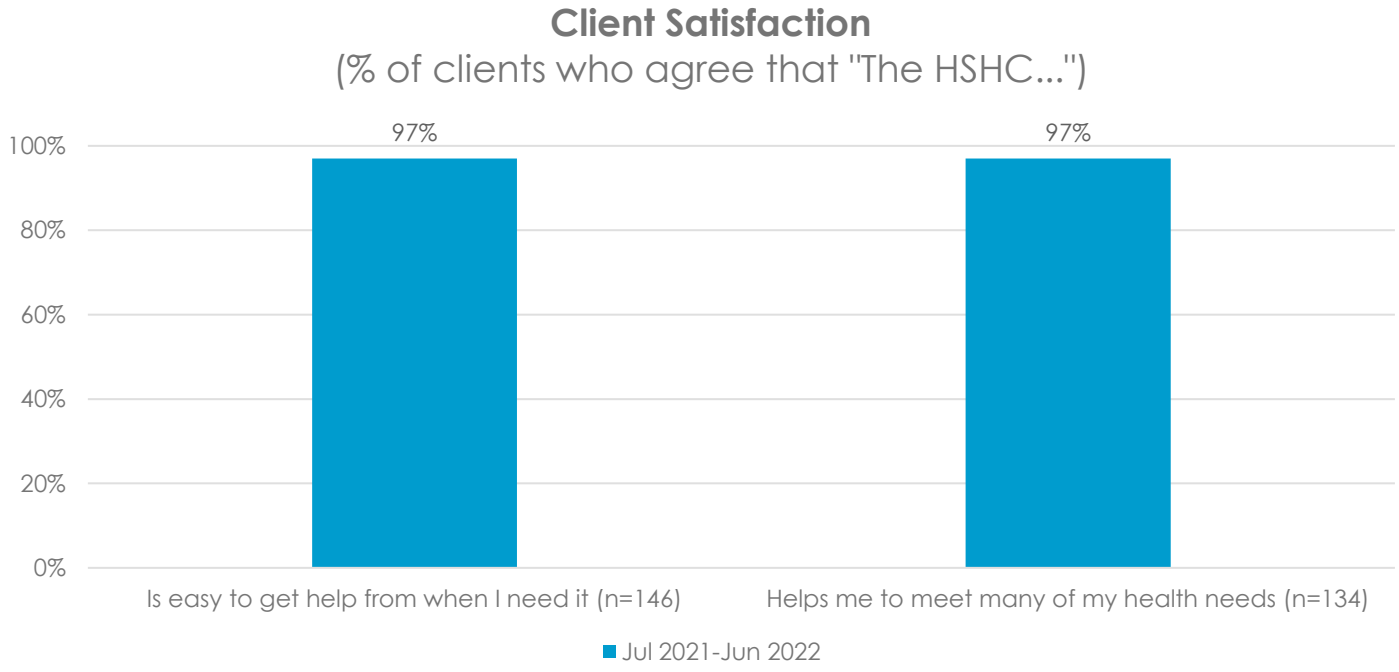
Impact Outcomes ("Is anyone better off?")





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.

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

Specialized Care Unit

On July 14, 2020 City Council passed Resolution No, 69,501-N.S.; a package of items providing direction for the development of a new paradigm of public safety in Berkeley. One of the items adopted by City Council directed the City Manager to analyze and develop a pilot program to re-assign mental health and substance use calls, that do not include a threat of violence to a Specialized Care Unit (SCU). The SCU will consist of trained crisis-response field workers who will respond to behavioral health occurrences that do not pose an imminent threat to safety without the involvement of law enforcement. The SCU will be implemented as a pilot model and lessons-learned will inform the long-term implementation.

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.

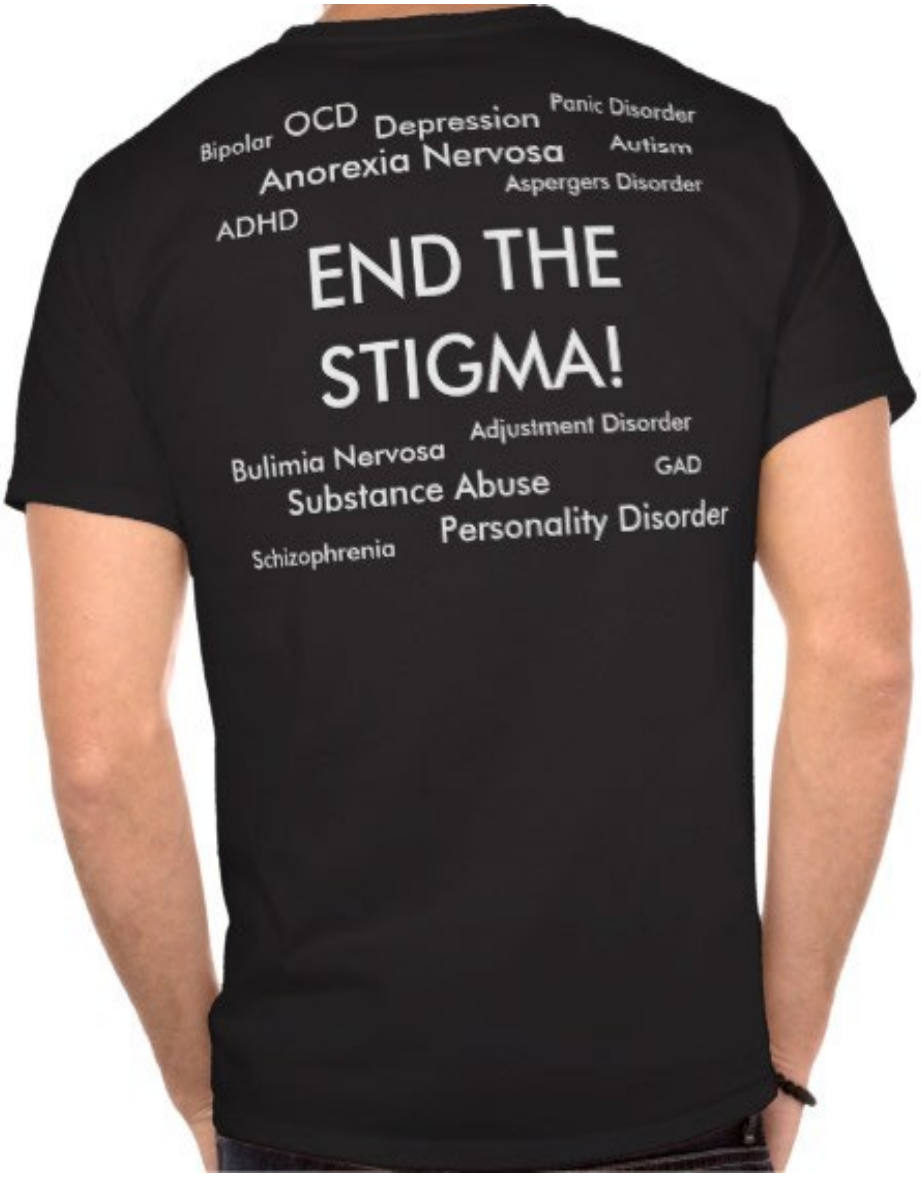
PEI Priority: Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

In FY21, Resource Development Associates (RDA), chosen through a competitive Request for Proposal (RFP) process to evaluate the current crisis system in Berkeley, received an expanded scope of work to provide recommendations on the implementation of the SCU. To oversee and advise RDA in their work, the City formed an SCU Steering Committee consisting of Health, Housing and Community Services Department and Fire Department staff, and community representatives from the Mental Health Commission and the Berkeley Community Safety Commission. The Steering Committee met from January 2021 through January 2022 and advised on RDA's completion of three critical reports. The first two reports summarized crisis response programs in the United States and internationally as well as gathered perspectives from community and City stakeholders regarding the crisis response system. This included gathering input from City of Berkeley and Alameda County agencies, local community-based organizations (CBOs), local community leaders, and utilizers of Berkeley's crisis response services. These reports laid the foundation for the twenty-five recommendations that were the subject of the third and final report to inform the SCU model. Each recommendation put forth in the final report is deeply rooted in the stakeholder feedback included in the two previous reports.

In Spring 2022, the design for the SCU received City Council approval and the work of the SCU Steering Committee transitioned from planning to implementation. At the beginning of FY23, the City of Berkeley launched a competitive RFP process, which included providing live question and answer as well as published resources on the City website. After an extensive review process, the City chose Bonita House to implement the SCU pilot program.

Since the beginning of 2023, Bonita House has taken initial steps to implementing the SCU including: selecting an operating location for the program, working with the City to obtain response vehicles, and hiring staff. The Berkeley and Bonita House teams are hoping to launch a version of the SCU at the end of FY23, or beginning of FY24, as the full program ramps up.

STIGMA AND DISCRIMINATION REDUCTION 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 FY22, 13 unduplicated individuals participated in the program. Demographics on program participants served were as follows:

DEMOGRAPHICS N= 13	
Age Groups	
26-59 (Adult)	38.5%
Ages 60+ (Older Adult)	38.5%
Declined to Answer (or Unknown)	23%
Race	
Asian	8%
Black or African American	23.5%
White	38.5%
Other	15%
Declined to Answer (or Unknown)	15%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican/Mexican-American Chicano	8%
Puerto Rican	8%

Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	15%
European	15%
Japanese	8%
Other	31%
Declined to Answer (or Unknown)	31%
Primary Language Used	
English	84%
Declined to Answer (or Unknown)	16%
Sexual Orientation	
Gay or Lesbian	8%
Heterosexual or Straight	54%
Bisexual	15%
Questioning or Unsure	8%
Declined to Answer (or Unknown)	15%
Disability	
Difficulty Hearing	15%
Mental Domain not including a mental illness	15%
Physical Mobility domain	31%
Chronic Health Condition	23%
Other (Specify):	8%
Declined to Answer (or Unknown)	31%
Veteran Status	
Yes	77%
No	33%
Gender: Assigned sex at birth	
Male	15.4%
Female	69.2%
Declined to Answer (or Unknown)	15.4%
Current Gender Identity	
Male	15%
Female	54%

Questioning or unsure	8%
Another gender identity	8%
Declined to Answer (or Unknown)	15%

Program Successes:
The Telling Your Story group had more consistent attendees who were prepared to share based on the topics provided. The structure of having a brainstorming session proved to be really beneficial for the attendees. Some participants enjoyed having the group virtually in the comfort of their home, they felt safer and the hassle of commuting was eliminated. Participants felt more prepared during their shares and enjoyed the support they received from their peers.

Program Challenges:
The Telling Your Story group challenges were a lack of in-person connection and some participants who didn't have access to Zoom were unable to see others on the screen. This group provided gift cards for each session that a person participated within the program guidelines. There was a challenge for some individuals to come into the office to sign for the gift cards which created some distain from the participants, or they waited months before they decided to have their gift card mailed. A similar gift card challenge was that some participants waited for months until they picked them up, so it would be worth the commute they had to make to come to the office.

In FY22, as the Social Inclusion – Telling Your Story Project, is conducted by the same staff who operate Wellness Recovery Services, the Results Based Accountability (RBA) Measures for this project were combined with the Wellness Recovery program measures. 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

In FY22, the RBA Outcomes for this program were as follows:

BMH RBA Report FY 2022

Wellness & Recovery Services

Reporting Period: July 2021-June 2022 (Baseline)

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

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

35

Participants served

8

Different groups convened

139

Group events

20

Participants who meet the requirements for "Telling Your Story"

represents 10 clients/events/groups

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

71%

of participants returned for group events

Impact Outcomes ("Is anyone better off?")

4 out of 5

participants reported feeling less shame about their experiences and challenges (n=5).

3 out of 5

participants reported recognizing progress in their recovery (n=5).

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

Outreach for Recognizing the Early Signs of Mental Illness Program - A process of engaging, encouraging, educating, and/or training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.

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

Mental Health First Aid

City of Berkeley Mental Health staff has previously implemented a Mental Health First Aid Training to the community through non-MHSA funds. Mental Health First Aid is a groundbreaking public education program that helps the public identify, understand, and respond to signs of mental health issues and substance use disorders. Mental Health First Aid presents an overview of mental health issues and substance use disorders and introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and provides an overview of common treatments. Through this training a five step action plan is taught that encompasses the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care.

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

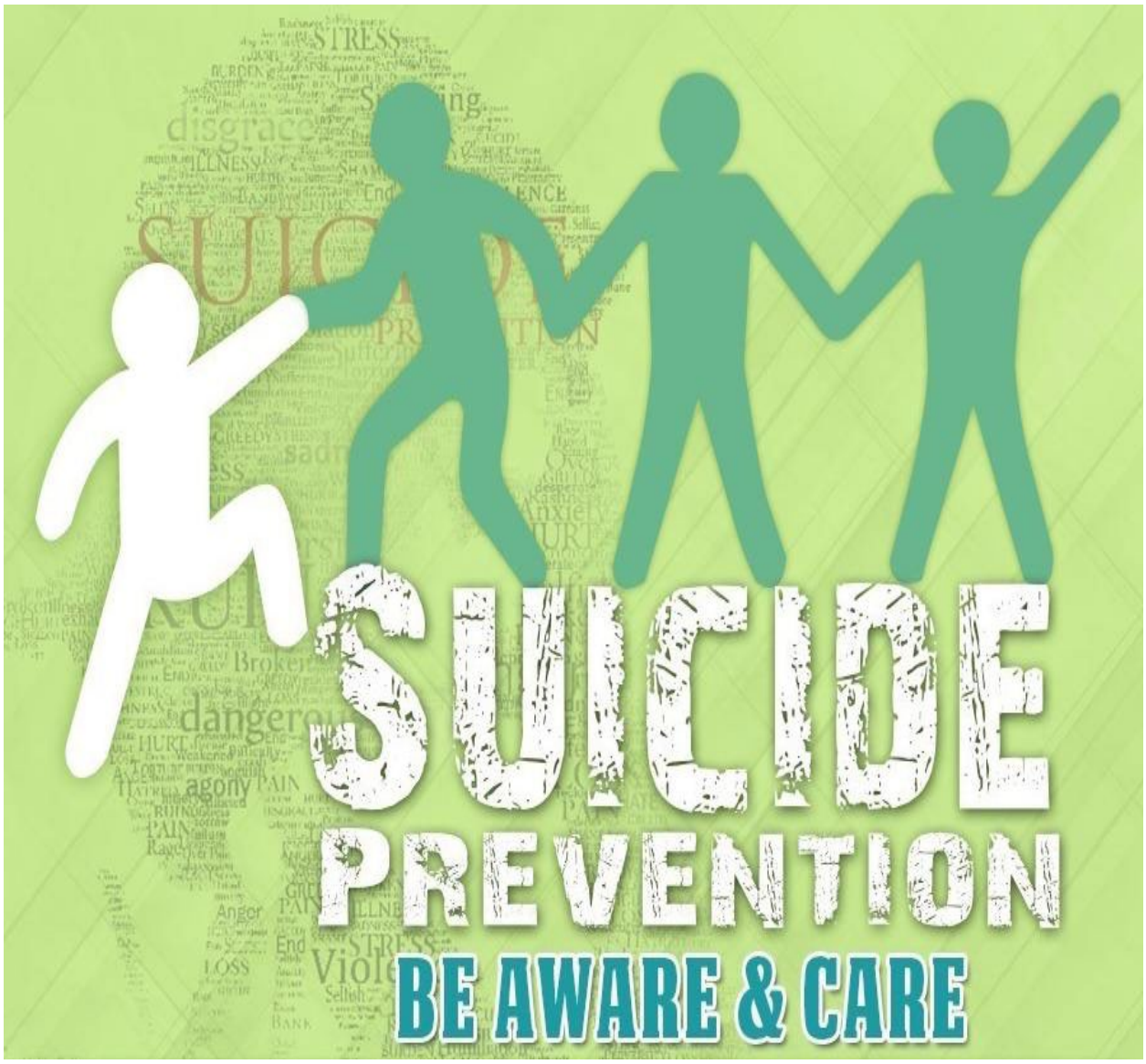
PEI Priorities:

- Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs).
- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

Due to the pandemic and 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 FY24 through MHSA CSS funds.

SUICIDE PREVENTION

(OPTIONAL PEI PROGRAM)



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:

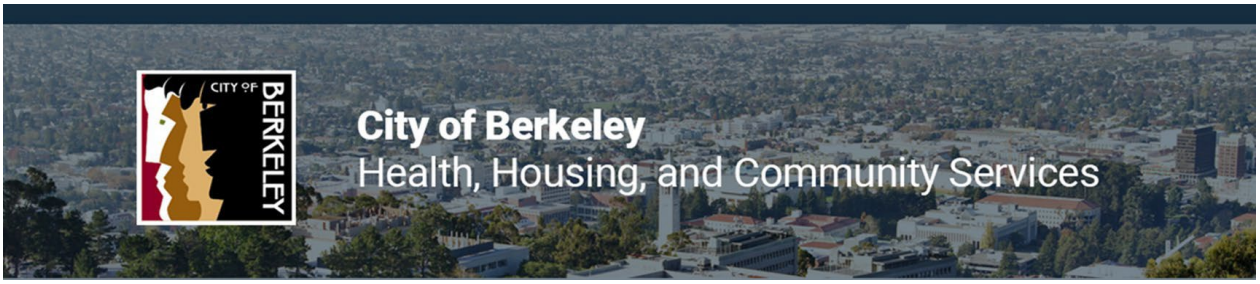
- Culturally competent and linguistically appropriate prevention and intervention; including community defined evidence practices (CDEPs).
- Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

In FY22, 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.

APPENDIX E

INNOVATION

FY22 ANNUAL EVALUATION REPORT



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

Innovations (INN)

FY21/22 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 released in 2018 also require mental health jurisdictions to submit an Annual Evaluation Report to the State each fiscal year. The Evaluation Report should be included with the MHSA Annual Update or Three Year Program and Expenditure Plan and undergo a 30 Day Public Comment period and approval from the local governing board. Per state regulations, the MHSA INN Fiscal Year 2021/2022 (FY22) Annual Evaluation Report that covers data from FY22 is due.

This FY22 INN Annual Evaluation Report provides descriptions of currently funded MHSA INN services, and reports on FY22 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 the currently funded INN programs and FY22 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 allocates INN funding to participate in a Statewide Collaborative with other California counties to pilot a Mental Health Technology Project that makes various technology-based mental health services and supports applications (Apps) locally available in Berkeley. The Help@Hand Project seeks to learn whether the use of the Apps will increase access to mental health services and supports; and whether it will increase the quality of mental health services, including leading to better outcomes.

Since plan approval, 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 being on TAY and Older Adults, to now include anyone who lives, works and goes to school in Berkeley.

Per a competitive recruitment process, the Division contracted with Resource Development Associates (RDA), who conducted Project Coordination work through early FY22 on this project. Following that timeframe 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 will be available through September 2023. 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.

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 City of Berkeley 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.

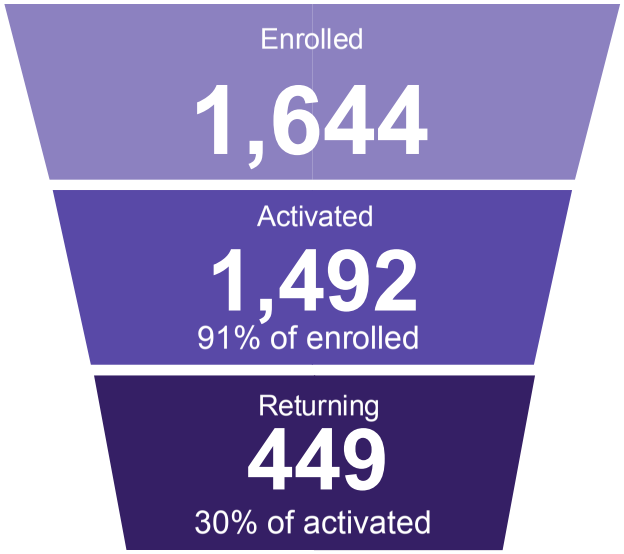
Local usage data in FY22 for each App is outlined on the preceding pages.

myStrength scorecard

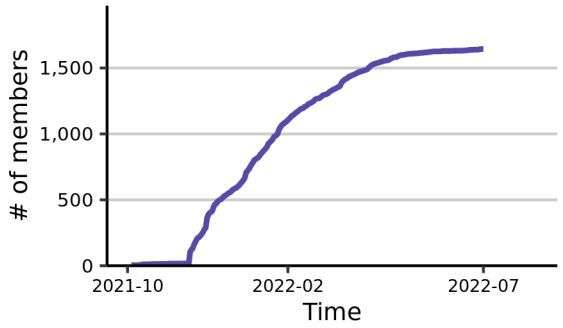
City of Berkeley

Program launch: 2021-09-20 Data thru: 2022-06-30

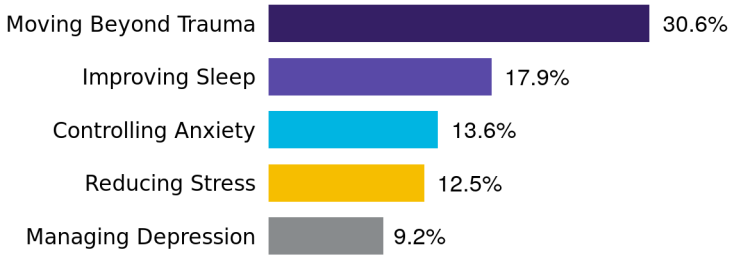
Members enrolled



Enrollment trends



Top 5 digital recommendations



Program engagement

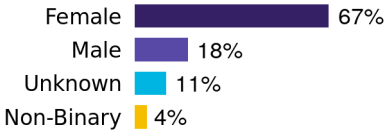
Average 90 day member engagement rates (% of returning)

23%	9%	NA%
104/449	42/449	NA/449
Logged in	Completed activity	Used engagement guidance
5 average logins/member	7 average activities completed/member	NA average messages sent to guide/member

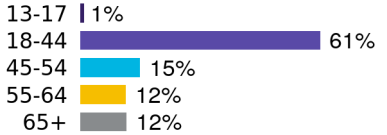
Member demographics

(% of enrolled)

Gender



Age Group



myStrength scorecard

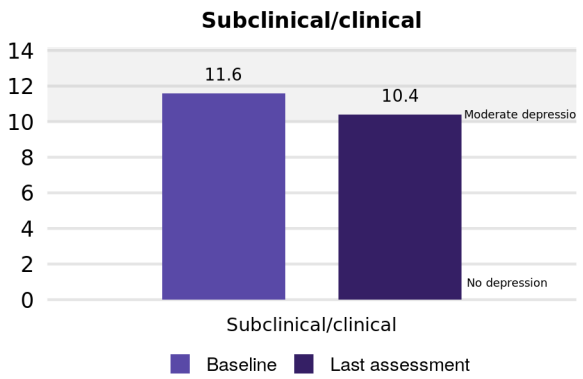
City of Berkeley

Program launch: 2021-09-20 Data thru: 2022-06-30

Depression outcomes

Clinical and subclinical population

Scored 5 or more in the PHQ-9 assessment



68.7%

Maintained or improved

41%

Clinically Improved

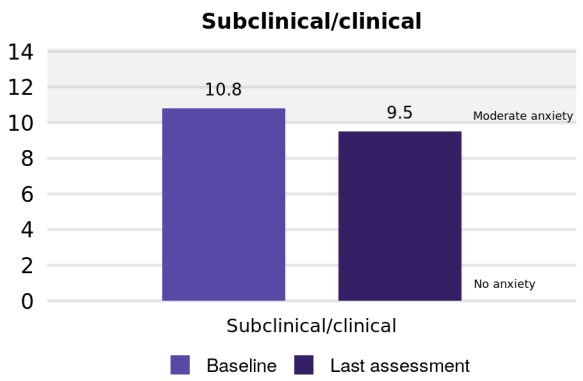
Started with scores ≥15 and decreased their score by at least 5 points

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



70.9%

Maintained or improved

27.6%

Clinically Improved

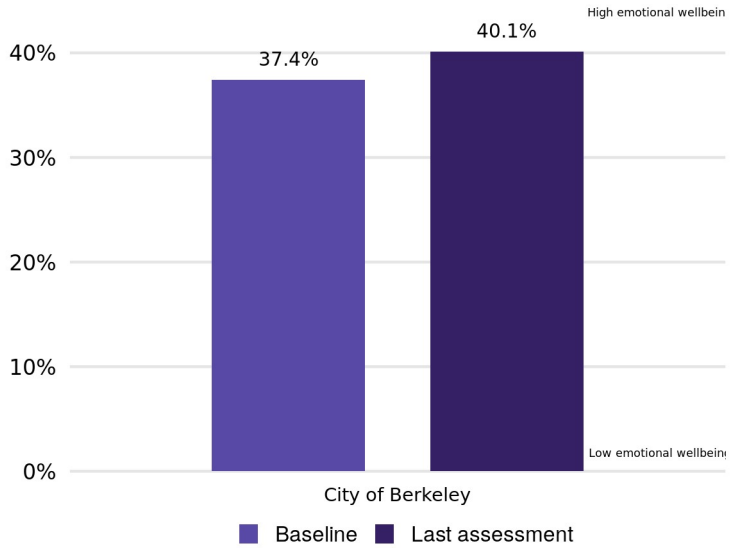
Started with scores ≥15 and decreased their score by at least 5 points

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

25.6%

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

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.

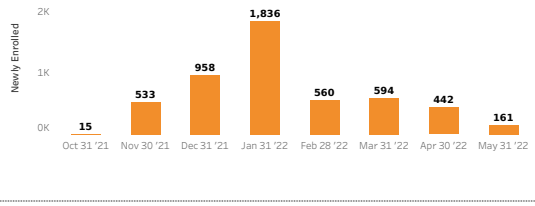
headspace

Help@Hand FY22 Report

Members

5,097

Enrollments



Engagement

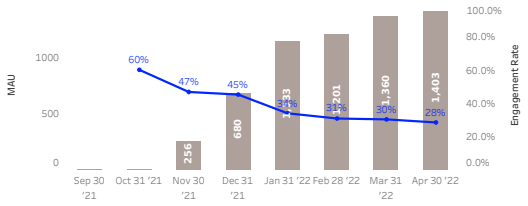
Headspace Minutes Used

1,225,384

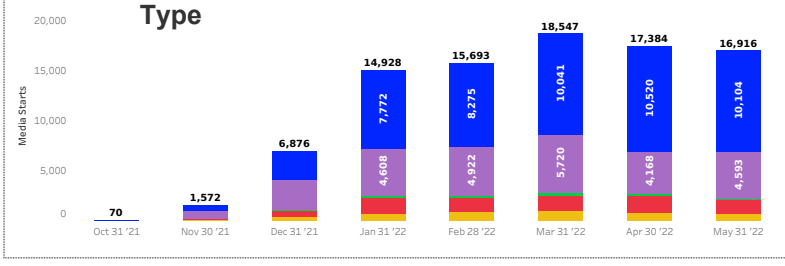
Minutes Meditated

334,955

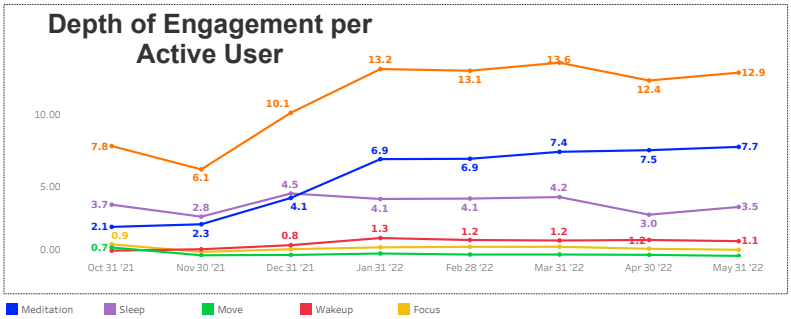
Monthly Active Users



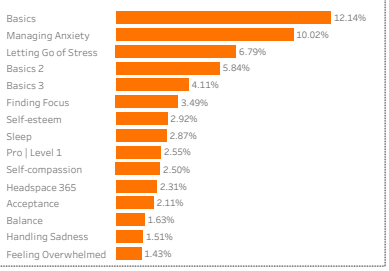
Engagement by Content Type



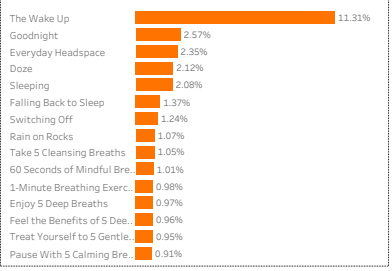
Depth of Engagement per Active User



Top 15 Courses



Top 15 Non-Courses



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 a community partner who will be 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 RFP process was executed in the third quarter of FY23 and it is envisioned that the program will be implemented in early FY24. The program will include an evaluation which will be reported on in future MHSA INN Evaluation Reports.

APPENDIX F

PUBLIC COMMENTS

AFRICAN AMERICAN HOLISTIC RESOURCE CENTER

REQUEST FOR INCLUSION IN THE MENTAL HEALTH SERVICES ACT (MHSA) THREE-YEAR FUNDING PLAN FY 2024-2026

FOR COMMUNITY-DEFINED CULTURALLY CONGRUENT HOLISTIC SERVICES AND PROGRAMMING

The African American Holistic Resource Center Mission Statement

The mission of the African American Holistic Resource Center (AAHRC) is to eliminate inequities and disparities by using community-defined best practices and approaches. Culturally responsive services are offered in order to address social determinants of overall health, mental wellness and equity across the life span. The AAHRC provides advocacy, support and referral services for an array of educational issues, legal matters and programming and services for cultural, social and recreation. A strong focal point is on promoting self-awareness and strengthening connections by fostering unity in the African American community.

Summary of the needs assessment

The African American/Black community in Berkeley has the highest morbidity and mortality rate of any racial/ethnic group. According to the City of Berkeley *Health Status Summary Report 2018*, "African Americans are 2.3 times more likely to die in a given year from any condition than Whites"[2]. The intersectionality between wealth, race/ethnicity, and class has a slight positive effect on the health status of African Americans due to institutionalized racism and implicit bias. Unfortunately, the Black community in Berkeley is experiencing poor quality outcomes regarding adverse health indicators across the lifespan. According to comprehensive community assessments, most African American/Black community members who live, work, and/or connect to Berkeley believe that the City of Berkeley needs to show their community a sign that they are valued citizens and that *their lives matter*.

The African American Holistic Resource Center is submitting this proposal for funding from the Mental Health Services Act to improve mental health and wellness outcomes for the Berkeley community in general and the African American/Black community in particular. The AAHRC achieves its goals for improving the social determinants of mental health (SDOMH) outcomes within the African American/Black community by utilizing a culturally congruent healing-centered engagement system model of care. The AAHRC has developed collaborative partnerships with culturally congruent service providers and organizations to assist in achieving its goal.

THE OBJECTIVE

The AAHRC facility, as outlined in the Feasibility Study, 2018 is stated to be a state-of-the-art green building of 6,000 Square feet that includes but is not limited to a multipurpose room, culinary learning kitchen, South Berkely Legacy Library, medical screening room, two therapy offices, two classrooms, dance studio, game room, kitchen, offices with a reception area, and a yard/garden area. The delivery of culturally congruent services at the AAHRC will provide African Americans with the support they need to decrease inequities and disparities and build community.

- **Need #1: [FY 24] Community capacity building efforts; publish the operational plan; Barbara Ann White Scholarship Award to expand the Black Mental Health Workforce**
- **Need #2: [FY 25] Secure peer navigator and community specialist; Secure furniture, fixtures, and equipment (FF&E); Barbara Ann White Scholarship Award to expand the Black Mental Health Workforce**
- **Need #3: [FY 26] Secure peer navigator and community specialist; Barbara Ann White Scholarship Award to expand the Black Mental Health Workforce**

THE OPPORTUNITY

Welcoming and Culturally Congruent Services and Staff

Numerous survey respondents commented on a sense of belonging and receiving culturally-appropriate services. There was an emphasis on the significance of Black people being treated with respect and their presence being acknowledged by professional staff when they showed up for services. Also highlighted was creating a safe space for the African American community.

- **Goal #1: Implement 1st stage of a culturally centered engagement system of care model**
- **Goal #2: Implement 2nd stage of the culturally centered engagement system of care model; equip mental wellness space for mild to moderate consumers**
- **Goal #3: Implement 3rd stage of the culturally centered engagement system of care model**

"The assessment identified the need to have a haven or safe space for members of the African American/Black community to gather and unwind from the daily stressors of being Black in America. Survey respondents expressed the need to have a safe healing space to address the traumas and challenges of life". "Respondents expressed a need to have a place where they can gather and organize in order to develop leadership skills and improve community engagement. It was evident from the data collected that respondents want a place for the Black community, where they can unite, organize, and develop action plans, as it relates to uplifting the African American community. The information shared in this category appears paramount in terms of Black people wanting to problem-solve for themselves and find solutions to issues that negatively impact their community" (AAHRC Feasibility Study, p. 10).

Recommendation #1:	**Include the AAHRC in the MHSA Three-year plan** with maximum available funding
Recommendation #2:	**Add the AAHRC under the following areas:** • Community Services and Supports (CSS) • Prevention and Early Intervention (PEI) • Capital Expenditure Funding to assist with the construction of the new City of Berkeley owned 6,000 square-foot facility
Recommendation #3:	**Follow up on previous MHSA Plan Three-Year cycle recommendations:** • On page 2 of the DRAFT Mental Health Services Act (MHSA) FY20/21 – 22/23 Three Year Program and Expenditure Plan, it states that: 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". • Follow up on the previous MHSA cycle recommendation: "The Mental Health Division is very interested in supporting the African American Holistic Resource Center, and will work with the planning group for the AAHRC to obtain a specific proposal. The Mental Health Division intends to work with the planning group to propose funding for the AAHRC in the FY21/22 Plan Update, once the specific needs and appropriate funding categories are determined. Following the Public Hearing the Mental Health Commission made the following motion regarding the Three-Year Plan: 16 M/S/C (Pritchett, Davila) Motion to approve the report and forward to the City Council for approval. Ayes: Davila, Hawkins, Kealoha-Blake, Moore, Opton, Pritchett; Noes: None; Abstentions: None; Absent: None." (City of Berkeley Mental Health Services Act FY 2020/21-2022/23 Three Year Program Expenditure Plan, page 14).

CONCLUSION

The AAHRC is expected to provide the following services to address inequities and disparities and support the African American/Black community in Berkeley: health education, health screenings, mental wellness services, educational support, cultural events, legal services, social and recreational programs, and other services as needed. Services at the AAHRC will be open to all. However, the primary focus will be to enhance and strengthen the lives of African Americans. The center will acknowledge and celebrate the cultural values, rituals, and traditions of Black people. The center will support an African American/Black way of life by using African American community-defined approaches and practices and African-centered treatment models and services to decrease inequities and disparities in all aspects of life for African Americans in Berkeley.

We look forward to collaborating with the City of Berkeley Mental Health MHSA board to accomplish the AAHRC goals and objectives.

If you have questions on this funding request proposal, feel free to contact any of the three listed persons at your convenience:

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Phone: 510-725-8776

Thank you for being so considerate,

AAHRC Steering Committee

AFRICAN AMERICAN HOLISTIC RESOURCE CENTER: PROJECT SANKOFA

MHSA Project Proposal

Abstract

Project Sankofa is a Black holistic radical healing mental wellness campaign to designed to break mental health stigma in the Black community and to create a new paradigm shift on the ways in which mental health is messaged within communities of color.

Babalwa Kwanele
ProjectSankofa@AAHRC.org

AFRICAN AMERICAN HOLISTIC RESOURCE CENTER

PROJECT SANKOFA
A BLACK MENTAL HEALTH WELLNESS CAMPAIGN
(MHSA) THREE-YEAR FUNDING PLAN
FY 2023-2027

FOR COMMUNITY-DEFINED CULTURALLY CONGRUENT HOLISTIC SERVICES AND PROGRAMMING

Abstract

The African American Holistic Resource Center has various components, and one of them is Project Sankofa. This project is being introduced before the official opening of the African American Holistic Resource Center's new physical location in Berkeley. Project Sankofa is focused on promoting mental wellness and is a campaign that aims to eradicate the stigma around mental health through love and compassion. It uses Black affirming methodologies to bring about a paradigm shift in how mental health and wellness are approached and communicated within communities of color. Deliverables include group/family/community mental health and wellness workshops and healing circles; community engagement activities; online social media campaign

The African American Holistic Resource Center Mission Statement

The mission of the African American Holistic Resource Center (AAHRC) is to eliminate inequities and disparities by using community-defined best practices and approaches. Culturally responsive services are offered in order to address social determinants of overall health, mental wellness and equity across the life span. The AAHRC provides advocacy, support and referral services for an array of educational issues, legal matters and programming and services for cultural, social and recreation. A strong focal point is on promoting self-awareness and strengthening connections by fostering unity in the African American community.

Statement of Project Need

The African American/Black community in Berkeley has the highest rate of morbidity and mortality of any racial/ethnic group. According to the City of Berkeley's *Health Status Summary Report 2018*, "African Americans are 2.3 times more likely to die in a given year from any condition compared to Whites"2. The report further indicates that "The risk of an African American mother having a low-birth weight (LBW) rate baby is 2.5 times higher than the risk for White mothers"1.

In comparing 2013 and 2018 COB Health Status Summary Reports, the rate of poverty among African American families has quadrupled. During a five-year period the poverty rate for African Americans has gone from two times more likely to live in poverty to eight times more likely to live in poverty in the City of Berkeley. According to both Health Status Summary Reports, children under the age of eighteen are seven times more likely to live in poverty. Unfortunately, this implies that White wealth is increasing, while Black wealth is rapidly decreasing in the city. This level of wealth inequity has numerous negative implications for African Americans, as it relates to, but is not limited to, housing, mental health, physical health, education, criminal justice, social and recreational activities, and overall community sustainability.

It is well documented that poverty is linked to poor quality health outcomes and shorter life expectancy for African Americans. Middle class and affluent Black people's health is worse compared to their white counterparts in Berkeley. The intersectionality between wealth, race/ethnicity and class has a small positive effect on the health status of African Americans, due to institutionalized racism and implicit bias. Unfortunately, the Black community in Berkeley is experiencing poor quality outcomes in terms of adverse health indicators across the life span.

The data indicates that health inequities disproportionately impact the Black community in the city and have persisted for a long period of time. As suggested in the AABPCN report, "Health inequities and disparities have been caused by trenched social and racial injustices

in American systems. It has been stated that every social determinant, including but not limited to education, employment, physical and mental health and housing, is impacted by the rules of law and the institutions that uphold the laws"2.

Socioeconomic factors, birth outcomes, and morbidity rates that stretch across the life span of African Americans indicates they are *not* thriving in the City of Berkeley. The results clearly illustrate in this feasibility study that Black individuals and families in Berkeley are not experiencing optimal life outcomes in all areas. Therefore, it is essential that a paradigm shift take place for this population in the delivery of care and services. Culturally appropriate services and community-defined practices that are imbedded in the creation of a Culturally Centered Engagement System of Care that is effective in welcoming, supporting, healing, and empowering the Black community in the City of Berkeley must be developed. *Insanity* is defined as doing the same thing and expecting different results; the time for a new integrated holistic approach to care and services for Berkeley's African American community is long overdue.

The AAHRC facility is slated to be a state-of-the-art green building 6000 square feet in size, that includes but is not limited to a multipurpose room, library, medical screening room, two therapy offices, two classrooms, dance studio, game room, kitchen, and an office with a reception area. The delivery of culturally congruent services at the AAHRC will provide African Americans with the support they need to decrease inequities and disparities in their community. The African American/Black community in Berkeley has the highest morbidity and mortality rate of any racial/ethnic group. According to the City of Berkeley *Health Status Summary Report 2018*, "African Americans are 2.3 times more likely to die in a given year from any condition than Whites"[2]. The intersectionality between wealth, race/ethnicity, and class has a slight positive effect on the health status of African Americans due to institutionalized racism and implicit bias. Unfortunately, the Black community in Berkeley is experiencing poor quality outcomes regarding adverse health indicators across the lifespan. According to comprehensive community assessments, most African American/Black community members who live, work, and/or connect to Berkeley believe that the City of Berkeley needs to show their community a sign that they are valued citizens and that *their lives matter*.

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THE METHOD OF APPROACH

Project Sankofa Theoretical Approach

The theoretical underpinnings of Project Sankofa are drawn from radical healing, from the works of Ginwright (2010), and anti-Blackness, from the works of Dumas

(2016). The works of Dumas (2016) will be utilized to help understand the role of anti-Blackness as a contributing factor to the problem of disparities in the availability of culturally appropriate and responsive care in the mental health industry. The theoretical variables and concepts from Ginwright (2010) that will be employed are: the psychology of radical healing, social justice healing, healing as a political act of resistance, civic activism and radical imagination, and keeping a focus on healing. This case study uses a healing-centered pedagogy with the Radical Healing (Ginwright, 2016) theory and a case study approach was modeled from the learning from Smith's (2021) case study of Māori framework at the center. Radical healing is best described as using a social justice lens to healing, which influences civic engagement, hope, joy, while being encircled by a deep respect for one's culture, viewing the culture as a curative medicine (Tello, 2018). This framework explores the methods, practices, and guidelines used by a social justice-oriented educational wellness program that focuses on environmental justice education that addresses complex global issues using root cause analysis.

Project Sankofa is a Black-affirming, culturally conscious, community-based educational training program that will address the issues that contribute to mental health stigma in the Black community and investigates the impact of anti-blackness on wellness. The goal of the project is to educate and train a cadre group who will, in turn, work within the schools and community to address mental health and wellness. Project Sankofa will work with the cadre group and leadership to employ the social justice-oriented project curriculum. Project Sankofa staff will evaluate the efficacy of the program design, implementation, and results/outcomes. The entities that will benefit from Project Sankofa are members of the Black community, Black students, and community-based affinity programs. Ultimately, all students will benefit from Project Sankofa as students learn in the community. Research supports the understanding that when all members of a learning community feel that they belong, are safe, and understood, learning can become a positive growth experience (Alvarez, 2020, 2017; Alvarez & Farinde-Wu, 2022; Ginwright, 2016; Howard, 2016; and Ladson-Billings, 2021; Powell & Toppin, 2021). Thus, Project Sankofa will use the theory of radical healing, which provides an inclusive, holistic framework by which to bridge the conversation of education and mental health to help to deepen the discourse on complex and racial trauma from a humanizing salutogenic lens, or a solution focused approach (Ginwright, 2010). Some of the key ideas Project Sankofa will be messaging to the community are (a) the psychology of radical healing, (b) social justice healing, (c) healing as a political act of resistance, and (d) Civic activism and radical imagination.

Radical Healing

Radical healing is a transformative framework and a process whereby collective hope is centered, love is primary, imagination is empowered, and care is realized; combined it fosters optimism, rebuilds collective communities, identities, and civic life (Ginwright, 2010). Radical healing centers cultural and racial empowerment, and teaches the youth and communities of color the language to describe their racialized and complex trauma experiences not from a lens that is pathogenic, rather from a lens that embraces hope and is salutogenic (Ginwright, 2016). Radical healing has five features. Ginwright (2016) explains, "I call these features CARMA, which stands for Culture, Agency, Relationship, Meaning, and Achievement" (p. 25). Ginwright (2016) offers details of the role of each component of CARMA, to help make meaning of radical healing:

- Culture, the first component, is an element by which people become connected to their racial, ethnic, historical and contemporary realities which embody a celebratory and hope centered way of being.
- Agency is a transformative step, in which one develops the ability to create change for themselves and actively explore new possibilities.
- Relationships are a necessity whereby one is able to build a strong capacity to develop and sustain healthy creative connections with self and others. There is strength in the understanding that legacies of struggle and triumph are integral elements in relationships.
- Meaning is the discovery of one's purpose for existence, the applicable lessons one learns with the growth from personal struggles and the profound understanding of one's influence in the advancement of justice.
- Achievement means to celebrate the accomplishment of goals and acknowledge the movement toward personal and collective advancement, "to understand oppression but not be defined by it", and to have an awareness of new possibilities (p. 26).

Radical healing offers a fresh understanding and framework analysis to aid in shifting the lens from pathological deficit-based logics to one that embraces the humanization of youth and communities who are faced with complex and racialized trauma. It is critical to embrace radical healing when seeking to understand the role that systemic oppression plays as the catalyst for traumatic harm; radical healing helps to prevent the default hegemonic thinking of the youth of color as the problem (Ginwright, 2016; & French, et.al, 2020).

The theory of radical healing helps educators and policymakers to understand the importance of "restoring and healing individual and collective harm" (Ginwright, 2016). Radical healing provides an alternative to moving through the compulsive desire to conduct "business as usual" and to move quickly to solve problems in order to return to the status quo which supports hegemonic practices and beliefs. The theory of radical healing provides a profound framework by which to bridge the conversation of education and mental health that helps to deepen the discourse on complex and racial trauma from a humanizing salutogenic lens.

The Psychology of Radical Healing

The main idea of this new theoretical framework, Psychology of Radical Healing, is that it factors in systemic racism, cultural concerns, and explores the healing connections between individual and community with BIPOC clients/students, and teaches students how to "resisting self-blame for racism is healing" (Adames, et.al., 2022). The psychology of radical healing theoretical framework maintains that it is essential to incorporate culture into clinical practice and for mental health practitioners to critically understand the "interlocking systems of oppression" (p.2). In addition, the purpose is to support clients/students as they develop their own level of consciousness to critically strengthen their own self-awareness, embrace their culture, and build "Radical Hope and Envisioning Possibilities", joy, and resistance (p.2). The theory came from an intersection of Black psychology, liberation psychology, and ethnopolitical psychology and was developed as a framework to assist mental health clinicians working with BIPOC clients/students harmed by systemic racism. This framework differs from others that address trauma in that the psychology of radical healing framework centers on race and racism, whereas the race-neutral works or works that center on whiteness, seldom acknowledge systemic racism as a factor in trauma. The key essential leaders in this work are Ginwright, Adames, Neville, French, and Lewis. This idea connects to my area of research in that it provides a viable alternative to the deficit-based, race-neutral

psychological theoretical orientation models that are typically used with the youth in school-based mental health programs and clinics.

Social justice healing

The authors point out "that social and racial justice is a necessary condition for healing", and that this is a key component in psychology that promotes radical healing from trauma (French, et.al, 2020). This framework moves beyond coping to radical healing for BIPOC; the roots derived from "social justice education and activism" and centers "healing and transformation" (p.16). The purpose of this radical healing framework is to provide a call to action to providers and educators working with BIPOC clients/students. This framework offers new applications for "clinical practice, research, training, and social justice advocacy", which will ultimately build hope and healing for the population being served (p. 15). The authors introduce a new "psychological framework of radical healing" essentially grounded in with five key points: "(a) collectivism, (b) critical consciousness, (c) radical hope, (d) strength and resistance, and (e) cultural authenticity and self-knowledge" (p. 14). This theory derived from grassroots community work with Black youth living in urban areas who had endured various levels of trauma Radical healing is strengths-based, focuses on centering hope, and the imagination of possibilities using 4 core concepts: (a) building caring trusting relationships, (b) understanding that healing happens in community and fellowship with others, (c) assisting youth to have a working and deep level of critical consciousness of social justice issues, and (d) Embracing culture, learning how historical knowledge and love of oneself culturally, helps with healing. The key concept is that healing from trauma is a political act of resistance from hegemonic systems of oppression. Simultaneously, radical healing is also an act of love, hope, freedom, respect, and positivity. The key important leaders in this work are Ginwright, Alvarez, A. & Farinade-Wu, A., Adames, Neville, French, and Lewis. This work supports my area of research in that it may provide a data point to research the ways in which Black-affirming programs help others advocate for their own needs and the needs of their community, which in turn will help in their healing and recovery.

Healing as a political act of resistance

As previously stated, healing from trauma is a political act of resistance from hegemonic systems of oppression and is simultaneously an act of radical healing, love, hope, freedom, respect, and positivity (Ginwright, 2010). The purpose of radical healing as a theory is to understand the important role of hope, love and joy while simultaneously embracing social justice to address the effects of the multifaceted layers of oppression, marginalization, and systemic racism in an effort to heal from trauma (p.9). The key important leaders in this work are Ginwright. This idea connects to my area of research in that it teaches the youth how to transform their growth and learned survival trauma experiences into social justice actionable steps toward their own healing.

Civic activism and Radical imagination

An essential component within radical healing is civic activism and radical imaginations. The activism component is a strategy for empowerment and is used individually and communally to aid in gaining or maintaining a sense of worth and self-determination by fighting back against the systems of oppression. Radical imagination is the ability to create systems or movements that reject the status quo or the norm and build systems and movements that center on hope, multigenerational growth, success, and liberation. In other words, Black youth are taught that they can dream and that such dreams build the capacity to hope and create a community that truly benefits them with a

sense of belonging. Black youth also learn to embrace self-love and reassurance and learn that the system of oppression works by reducing or eliminating the possibility of dreaming and creating (Ginwright, 2010). This concept explores the new era of Black youth activism, youth who have faced unprecedented social, political, economic, and educational challenges that have impacted their communities. The article also analyzes the ways in which systemic oppression have created conditions that cause challenges in the other social determinants of health (SDOH) that impact Black youth, such as school, community violence, employment, and housing/physical space caused by the effects of gentrification. This idea connects to my area of research in that it helps the youth who are struggling to heal from trauma so that they can become productive and contributing members of our society.

Keeping a focus on healing

One key takeaway is that the radical healing framework seeks to understand that individual and collective harm should have a focus on healing rather than using discipline as a corrective action for behaviors that stem from trauma or trauma exposure. In addition, it is also important to understand wellness rather than focusing strictly on harm (Ginwright, 2016). Ginwright provides case studies that guide educators and communities on how to respond to challenging situations that jeopardize hope and to teach how to build a community for healing. The author titled chapter eight of the book, Ubuntuism, with the root word being Ubuntu, in the South African language of Xhosa being; translated means everyone is connected to everyone else. The understanding of Ubuntu is what also creates hope needed to shape critical consciousness in radical healing. In other words, the purpose of this framework is to give personal and collective meaning to civic action in the pursuit of healing (pp. 142-145). Project Sankofa operates under the premise that it helps the youth and the community to maintain a positive focus on healing, to not be deterred by the systems of oppression set to benefit from their suffering.

Researchers (Williams, et.al., 2021; Ladson-Billings, 2021; Alvarez, A. & Farinade-Wu, A., 2022; Howard, 2013, 2016; Goldin, et. al., 2022; Stovall, 2018; and Roberson & Carter, 2022) have suggested in their studies such a nexus which occurs between power, financial control, social injustice, and race presents a problem in making readily available scholarly mainstream research in understanding the ways in which Black-affirming/ culturally-affirming pedagogies are consistently employed across existing affinity-based community programs designed to address holistic health/mental wellness and academic success needs. This issue exists in part because the authors, researchers, and funders of normative curricula have deemed such practices and contributions as inferior. Project Sankofa will holistically employ approaches used to address mental health/wellness, community cultural wealth, academic success, belonging, and antiblackness within community-based settings as it is situated within the program's practices, policies, procedures, and guidelines. The problem identified here between an increased need and the lack of availability of culturally responsive programs is supported by an abundance of transdisciplinary research that exposes social injustice and inequities within the social determinants of health (SDOH) as having a profound negative impact on health and academic success experiences of Black students in particular, and within Black communities in general (De France, et al., 2022; Gunnar, et al., 2022; Woo et al., 2022; Sandifer, et al., 2022; Murky, et al., 2022; Guidi, et al., 2022; and Ladson-

Billings, 2021). Such problems ultimately impact all members of our community because when one of us flourishes, all of us will flourish.

AAHRC PROJECT SANKOFA RECOMMENDATIONS

Recommendation #1: Include the AAHRC in the MHSA Three-year plan with an annual budget of $300,000

Recommendation #2: Add the AAHRC under the following areas:

- Community Services and Supports (CSS)
- Prevention and Early Intervention (PEI)

Capital Expenditure Funding to assist with the construction of the new City of Berkeley owned 6,000 square-foot facility
$300,000

Recommendation #3: Follow up on previous MHSA Plan Three-Year cycle recommendations:

- On page 2 of the DRAFT Mental Health Services Act (MHSA) FY20/21 – 22/23 Three Year Program and Expenditure Plan, it states that: 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".

- Follow up on the previous MHSA cycle recommendation: "The Mental Health Division is very interested in supporting the African American Holistic Resource Center, and will work with the planning group for the AAHRC to obtain a specific proposal. The Mental Health Division intends to work with the planning group to propose funding for the AAHRC in the FY21/22 Plan Update, once the specific needs and appropriate funding categories are determined. Following the Public Hearing the Mental Health Commission made the following motion regarding the Three-Year Plan: 16 M/S/C (Pritchett, Davila) Motion to approve the report and forward to the City Council for approval. Ayes: Davila, Hawkins, Kealoha-Blake, Moore, Opton, Pritchett; Noes: None; Abstentions: None; Absent: None." (City of Berkeley Mental Health Services Act FY 2020/21-2022/23 Three Year Program Expenditure Plan, page 14).

AAHRC PROJECT SANKOFA CONTACT AND FISCAL INFORMATION

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Berkeley, CA 94703
(510) 285-6689
https://healthyblackfam.org/

- **Fiscal Sponsor Purpose and Role:** Healthy Black Families is a 501(c)(3) non-profit organization, and will oversee the financial operations and fiduciary administrative tasks for the new AAHRC Project Sankofa. The fiscal sponsor will have regular financial meetings with the AAAHRC Steering Committee of volunteers, and with the paid and volunteer staff of Project Sankofa. The fiscal sponsor will be responsible for ensuring that Project Sankofa staff, Fellows, stipends, and trainers are paid. The fiscal sponsor will also ensure that the website, multi-media, and electronic training program accounts are paid. The fiscal sponsor will also ensure that costs of supplies and materials and funded. The fiscal sponsor will work with the Program Manager to manage the aforementioned responsibilities.

THE BUDGET SUMMARY

Personnel Costs*
• $87,000 – (1 FTE) AAHRC Program Manager
• $67,000 – (1 FTE) Office Specialist
Operating Costs*
• $21,000 – 7% Fiscal sponsor fee first year (Healthy Black Families),
• $17,600 – Office space
• $89,000 – Additional Expenditures (Advocacy Services and Programming)
• Stipends for youth council and Community Peer Specialists, Materials, Supplies, Mental Health Training Series Budget (Trainer Stipends)

***Please see spreadsheet for detailed report.**

DETAILED BUDGET REPORT*

*Listed by Fiscal year and categorical areas

Fiscal Year Predicated Expenditures	FY 23-24	FY 24-25	FY 25-26	FY 26-27	Total MHSA 3-Year Cycle Request
Personnel Budget					
(1 FTE) AAHRC-Project Sankofa Program Manager	$87,000	$87,000	$87,000	$87,000	348,000
Project Sankofa (1 FTE) Office Specialist	$67,000	$67,000	$67,000	$67,000	268,000
Operating Costs $89,000					
Healthy Black Families Fiscal sponsor fee	$21,000 (7%)	$21,000 (7%)	$21,000 (7%)	$21,000 (7%)	$84,000
Office Rental Space	$17,600	$17,600	$17,600	$17,600	$70,400
Advocacy Services and Programming $89,000					
Mental Health Intern Training Program • Deliverable Intern Stipends: @ $10,000/Intern 2 Interns	$20,000	$20,000	$20,000	$20,000	$80,000
Mental Health Intern/Fellow Trainer/Supervision Stipend: • Deliverable *2 trainings per month * Weekly clinical Supervision	$21,600	$21,600	$21,600	$21,600	$86,4000
Youth Fellow: Parttime - Annual Stipend	$5,0000	$5,0000	$5,0000	$5,0000	$20,000
Advertising Our Resources					
Website/Social media/online magazine costs/printing	$3,000	$3,000	$3,000	$3,000	$12,000
Importance of Mental Health Campaign: social media campaign Changing the mindset -Holistic Mental Wellness • # of Deliverables: 2 per week	--				
Community forum Talks: Live via Facebook/Instagram. # of Deliverables: Minimum 3: talk shows per year					

DETAILED BUDGET REPORT (CONTINUED)*

*Listed by Fiscal year and categorical areas

In -Person Family/ Community Nights: Focus on a discussion on Mental Health (with meals served) • # of Deliverables: Minimum 3 per year						--
Connect with Berkeley Schools African American students: provide space for consultation services. (pilot) Minimum 2 per Quarter	--					
SWAG supplies	$800	$800	$800	$800	$3,200	

CONCLUSION

The AAHRC is expected to provide the following services to address inequities and disparities and support the African American/Black community in Berkeley: health education, health screenings, mental wellness services, educational support, cultural events, legal services, social and recreational programs, and other services as needed. Services at the AAHRC will be open to all. However, the primary focus will be to enhance and strengthen the lives of African Americans. The center will acknowledge and celebrate the cultural values, rituals, and traditions of Black people. The center will support an African American/Black way of life by using African American community-defined approaches and practices and African-centered treatment models and services to decrease inequities and disparities in all aspects of life for African Americans in Berkeley.

We look forward to collaborating with the City of Berkeley Mental Health MHSA board to accomplish the AAHRC goals and objectives.

If you have questions on this funding request proposal, feel free to contact any of the three listed persons at your convenience:

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Thank you for being so considerate,

AAHRC Steering Committee

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6/1/23

Hi Karen,

What I would like to propose at the upcoming MHSA meeting is a partnership with BMH and BAHV to fund and implement a pilot program to implement an Open Dialogue program in Berkeley.

One of the weaknesses of the BMH program is the ability to meet families in their homes at times of mental health crisis, when loved ones are experiencing "psychosis" and avoid expensive and traumatic hospitalizations.

Open Dialogue is an innovative, network-based approach to psychiatric care that was first developed in the 1980s by a multidisciplinary team at Keropudas Hospital in Tornio, Finland. It is a new approach to mental healthcare. In contrast to standard treatments for early psychosis and other crises, **Open Dialogue** emphasizes listening and understanding and engages the social network from the very beginning – rather than relying solely on medication and hospitalization. It comprises both a way of organizing a treatment system and a form of therapeutic conversation, or **Dialogic Practice**, within that system.

The basic vehicle of **Open Dialogue** is its radically altered version of the treatment meeting, which typically occurs within 24 hours of the initial call to the crisis service. This treatment meeting gathers together everyone connected to the crisis, including the person at the center, their family and social network, all professional helpers and anyone else closely involved. Throughout this process there are no separate staff meetings to talk about the "case." Rather, all discussions and decisions take place in the treatment meeting with everyone present.

Open Dialogue is currently being successfully implemented in Connecticut, New York, and now in Atlanta.

Key Principles of Open Dialogue Practices

- **Immediate help** that begins with a treatment meeting within 24 hours
- **A social perspective** that includes the gathering of clinicians, family members, friends, co-workers and other relevant persons for a joint discussion
- **Embracing uncertainty** by encouraging open conversation and avoiding premature conclusions and treatment plans
- **Creating a dialogue,** or a **sense of "with-ness**" rather than "about-ness" with meeting participants by **dropping the clinical gaze** and listening to what people say – rather than what we think they mean

- With an emphasis on being responsive to the needs of the whole person, instead of trying to eradicate symptoms, studies have shown that the **Open Dialogue** approach leads to a reduction in hospitalization, the use of medication and recidivism when compared with standard treatments. In one five-year study, for example, 83% of patients had returned to their jobs or studies or were looking for a job (Seikkula et al. 2006). In the same study, 77% did not have any residual symptoms.
- ***Open Dialogue Courses***
- International Certification Training in Dialogic Practice
- Introductory Intensive in Dialogic Practice in Open Dialogue
-

Best
ED

MHSA is funding many worthy programs in Berkeley but nothing devoted to the treatment of severe mental illness, including schizophrenia. Schizophrenia is a disabling mental illness, which gets worse over time unless treatment is provided right away. Unlike drug addiction, where the addict can hit bottom and then overcome denial and go for treatment, people with schizophrenia never hit bottom—they just get worse and worse. Schizophrenia is more like cancer: early intervention is life-saving. Berkeley needs an Early Intervention in Psychosis program.

Early Intervention in Psychosis is a protocol developed at NIMH, an evidence-based treatment for schizophrenia that gives the young person the best chance of a stable recovery if begun early enough. The protocol has four parts, with an emphasis on team work:

Ongoing therapy with a therapist versed in psychotic illness, to help the young person cope with this calamitous set-back and learn to navigate life while coping with this illness.

A psychiatrist who works closely with the patient to find the most effective medication with the least side effects at the lowest dose. This care is ongoing throughout the program.

Family involvement at every stage, to collaborate with the clinicians, to learn how best to help their stricken loved ones and to receive emotional support, which they desperately need.

Vocational rehabilitation, to get the young person back into school or back to work as soon as possible, to make up lost ground and rejoin the rest of society. Too many people with a first psychotic break end up permanently disabled, hopeless about ever regaining their former place in life.

The guiding spirit of this program is collaboration between team members, family and the young patient. It's a team effort. Berkeley needs to sponsor an Early Intervention in Psychosis program. Treatment of severe mental illness is what we, the voters, had in mind when we passed Proposition 63 and created MHSA.