Health, Housing & Community Services
Mental Health Commission

To: Mental Health Commissioners
From: Jamie Works-Wright, Commission Secretary
Date: July 14, 2021

Documents Pertaining to 7/22/21 Agenda items:

Health, Housing & Community Service Department
Mental Health Commission

Berkeley/ Albany Mental Health Commission

Regular Meeting
Thursday, July 22, 2021

Time: 7:00 p.m. - 9:00 p.m. **Zoom meeting** https://zoom.us/j/96361748103

Public Advisory: Pursuant to Section 3 of Executive Order N-29-20, issued by Governor Newsom on March 17, 2020, this meeting of the Mental Health Commission will be conducted exclusively through teleconference and Zoom Videoconference. Please be advised that pursuant to the Executive Order and the Shelter-in Place Order, and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, there will not be a physical meeting location available.

To access the meeting remotely: Join from a PC, Mac, and IPad, IPhone or Android device: Please use the URL: https://zoom.us/j/96361748103. If you do not wish for your name to appear on the screen, then use the drop-down menu and click on "rename" to rename yourself to be anonymous. To request to speak, use the "raise hand" icon by rolling over the bottom of the screen.

To Join by phone: Dial 1-669-900-9128 and enter the meeting ID 963 6174 8103. If you wish to comment during the public comment portion of the agenda, Press *9 and wait to be recognized by the Chair.

Please be mindful that the teleconference will be recorded, and all other rules of procedure and decorum will apply for Council meetings conducted by teleconference or videoconference.

All agenda items are for discussion and possible action

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

AGENDA

7:00pm

1. **Roll Call**
2. **Preliminary Matters**
    a. Action Item: July 22, 2021 Agenda Approval
    b. Public Comment
    c. Action Item: Approval of the June 24, 2021 minutes

3. **Mental Health Service Act (MHSA) Annual Report FY 21/22 presentation and public hearing – Karen Klatt**
4. **Interview and vote on the nomination of Tommy Escarcega on the Mental Health Commission**
5. **Specialized Care Unit Update – Dr. Lisa Warhuus**
6. **Re-Imagining Public Safety Task Force Update**
7. **Discussion re: SCU & Reimagining Public Safety Initiative, including how they interface and coordinate**
8. **Public Education Campaign**
9. **Mental Health Manager's Report and Caseload Statistics - Steve Grolnic-McClurg**
    a. **Electronic information available to Division Staff**
    b. **Demographic information gathered for service users**
10. **U.S. Department of Justice Investigation of Santa Rita Jail Report**
11. **Request/Prioritize Topics for Mental Health Manager Report and Presentations**
12. **Prioritize Agenda Items for September Meeting (no meeting in August)**
13. **Adjournment**

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

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

SB 343 Disclaimer

Any writings or documents provided to a majority of the Commission regarding any item on this agenda will be made available for public inspection in the SB 343 Communications Binder located at the Adult Clinic at 1521 University Ave, Berkeley, CA 94703

Department of Health,
Housing & Community Services
Mental Health Commission

Berkeley/Albany Mental Health Commission
Draft Minutes

7:00pm
Zoom Webinar

Regular Meeting
June 24, 2021

Members of the Public Present: Jennifer Martinez, Carole Marasovic, Cristi Iannuzzi , Paul Kealoha-Blake, Wendy Alfsen, Andrew Phelps
Staff Present: Fawn Downs, Jamie Works-Wright, Yvette Katuala

1) **Call to Order at 7:00pm**
Commissioners Present: boona cheema, Margaret Fine, Monica Jones, Maria Moore Edward Opton, Andrea Prichett Terry Taplin **Absent:** Javonna Blanton

2) **Preliminary Matters**
   a) **Approval of the June 24, 2021 Agenda**
   M/S/C (Fine, Prichett) Motion to adopt the approval of the agenda for June 24, 2021.
   PASSED
   Ayes: cheema, Fine, Jones, Moore, Opton, Prichett, Taplin **Noes:** None; **Abstentions:** None; **Absent:** Blanton

   b) **Public Comment** – 1 Public Comment –

   c) **Approval of the May 27, 2021 Minutes**
   M/S/C (Prichett, Fine) Make a motion to approve the May 27, 2021 minutes
   PASSED
   Ayes: cheema, Fine, Jones, Moore, Opton, Prichett, Taplin **Noes:** None; **Abstentions:** None; **Absent:** Blanton

3. **Whole Person Care Presentation by Jennifer Martinez and Cristi Iannuzzi**
   M/S/C (Fine, Opton) Motion to Present the video presentation about Alameda County Care Connect by Jennifer Martinez, Director of Program Development, and Cristi Iannuzzi, Director of Strategy and Implementation, to City of Berkeley staff, the Mayor and the Berkeley City Council on behalf of the Mental Health Commission.
   PASSED
   Ayes: cheema, Fine, Jones, Moore, Opton, Prichett, Taplin **Noes:** None; **Abstentions:** None; **Absent:** Blanton

4. **Specialized Care unit Update – Dr. Lisa Warhuus read by Margaret Fine MHC chair M/S/C (Fine, Prichett) Motion to submit a letter to mayor, Berkeley City Council to establish, develop and implement a phase in the Specialized Care unit non-police response that does not operate with police**
   PASSED
   Ayes: cheema; Fine, Jones, Moore, Opton, Prichett **Noes:** None; **Abstentions:** (recused) Taplin **Absent:** Blanton

***Motion to extend the meeting by another 15 minutes**
M/S/C (cheema, Fine)
PASSED
Ayes: cheema; Fine, Jones, Moore, Opton, Prichett **Noes:** Taplin; **Abstentions:** None
Absent: Blanton

5. **Reimagining Public Safety Task Force Update – No motion made**
6. **US Department of Justice ADA Investigation of Santa Rita Jail –**

   M/S/C (Prichett, Opton) Motion to conduct research and develop a recommendation to Berkeley City Council, Alameda County Board of Supervisors, and Alameda County health care services agency on behalf of the Mental health Commission, to address human rights violations based on the U.S. Department of Justice's investigation at the Santa Rita Jail.
   PASSED
   Ayes: cheema; Fine, Jones, Moore, Opton, Prichett**,** Taplin **Noes:** None; **Abstentions:**
   Absent: Blanton

***Motion to extend the meeting for additional 5 minutes**
M/S/C (cheema, Fine)
PASSED
Ayes: cheema; Fine, Jones, Moore, Opton, Taplin **Noes:** None; **Abstentions:** Prichett**,**
Absent: Blanton

7. **Mental Health Manager Update – Steven Grolnic-McClurg – Did not get to this item**
   a. Mental Health Manager Report
   b. Berkeley Mental Health Caseload Statistics for April 2021
   c. Full Contract City of Berkeley MH FY 2020-21 final pending insurance

8. **Pride Program Report – Transgender TAY: Finding Self and Love in transition- Did not get to this item**

9. **Discussion Topic for Mental Health Manager Report and Presentation – Did not get to this item**

10. **Prioritize Agenda items for July Meeting –**
    a. **Public education Campaign**

11. Adjournment – 9:22pm Meeting ended

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

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

FY2021/22 Annual Update

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BACKGROUND AND OVERVIEW

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

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

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

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

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

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

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

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

In order to access MHSA funds, a stakeholder informed plan outlining how funds will be utilized must be developed and locally approved. Development of an MHSA Plan includes: community program planning with the involvement of area stakeholders, writing a draft plan, initiating a 30-day public review, conducting a public hearing at a Mental Health Commission meeting, and obtaining approval on the plan from City Council. The Community Services & Supports, Prevention & Early Intervention, and Innovation funding components are the only re-occurring monies that are allocated annually and may be spent over a five-year period. Workforce, Education & Training and Capital Facilities and Technological Needs funds had initial expenditure time periods of 10 years each, and were to be utilized by the end of Fiscal Year 2018 or 2019. Per the City Council approved MHSA AB114 Reversion Expenditure Plan some CFTN and WET projects were continued past the original timeframes.

MHSA legislation requires mental health jurisdictions to provide updates on MHSA Plans on an annual basis and an integrated Program and Expenditure Plan must also be developed every three years. Currently, the City of Berkeley Mental Health (BMH) Division has a City Council approved MHSA Fiscal Years 2020/21 - 2022/23 Three Year Program and Expenditure Plan (Three Year Plan) in place which covers each funding component. Since 2006, as a result of the City's approved MHSA plans, a number of new services and supports have been implemented to address the various needs of the residents of Berkeley including the following:

- Intensive services for Children, TAY, Adults and Older Adults;
- Multi-Cultural Outreach engagement, trainings, projects and events;
- Increased mental health services and supports for homeless individuals;
- Wellness Recovery services and activities;
- Family Advocacy, Housing services and supports, and Benefits Advocacy;
- Case management and mental health services and supports for TAY;
- Trauma support services for unserved, underserved and inappropriately served populations;
- Increased mental health prevention, and intervention services for children and youth in area schools and communities;
- A Wellness Recovery Center in collaboration with Alameda County Behavioral Health Care Services (ACBHCS);
- Funding for increased services for Older adults and the API population.

Additionally, an outcome of the implementation of the MHSA is that mental health consumers, family members and other stakeholders now regularly serve on several of BMH internal decision making committees. These individuals share their "lived experience" and provide valuable input

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

MHSA funding is based on a percentage of the total population in a given area. The amount of MHSA funds the City of Berkeley receives is comprised of a calculation based on the total population in Berkeley. MHSA funding has been utilized to provide mental health services and supports in Berkeley. Additionally, from Fiscal Year 2011 (FY11) through FY20, the City of Berkeley has also utilized a portion of MHSA funds to provide services in the City of Albany, although Albany is a part of the Alameda County total population. As agreed to in contract negotiations with ACBHCS, beginning in FY21 the Division began only using MHSA funds for services and supports in Berkeley. Going forward, ACBHCS will provide MHSA funded services in Albany.

This City of Berkeley MHSA FY2021-2022 (FY22) Annual Update is a stakeholder informed plan that provides an update to the previously approved Three Year Plan. This Annual Update summarizes proposed program changes and additions, includes descriptions and updates of currently funded MHSA services, and provides a reporting on FY20 program data.

As with the Three Year Plan last year, community program planning for this Annual Update was conducted while a global pandemic and public outcry for racial justice amid the excessive use of force by police against many African Americans around the country, were still occurring. Both crises further exposed the pervasive racial, social and health inequities that exist and detrimentally impact African Americans and other communities of color. Additionally, since the beginning of the pandemic, and particularly recently during the planning timeframe for this Annual Update, there has been a significant increase in violence and hate crimes around the country against individuals in the API community.

In response to public input received through previous MHSA planning processes and from a variety of other local gatherings and venues, one of the additions the Division proposed through the previously approved Three Year Plan was to increase funding in the Prevention and Early Intervention Community Education and Supports program to provide additional services for the African American, Latinos/Latinas/Latinx, and LGBTQIA+ populations. Additionally, through previous MHSA Plans and Updates, increased funding has been allocated from the Community Services and Supports System Development funding component to provide enhanced services and supports for the API, Older Adult and TAY populations. It is envisioned that the existing programs that will be continued, and new programs that will be implemented out of this funding, will provide vital services and supports for these vulnerable populations in Berkeley.

MESSAGE FROM THE MENTAL HEALTH MANAGER

Our community faces enormous challenges. Racial injustice, health inequities, isolated families and children, far too many unhoused people, and a continuing pandemic; these are just a few of the myriad issues impacting the mental health of residents of Berkeley. At the same time, the Covid-19 pandemic has made providing care much more difficult. During the past year, Mental Health Division staff and community providers have worked hard to adapt to this changing landscape and to provide services in new ways. Through the use of tele-health and with the help of emerging safety procedures and Personal Protective Equipment, clinical and peer staff have continued to maintain care and connection both virtually and in person. Despite these efforts, many children, youth, adults and families still remain disconnected and need support. The coming year will require all of us to work together to collaborate on providing this needed care. An important part of our community's response to these enormous needs will be made possible by the MHSA FY22 Annual Update.

The MHSA FY22 Annual Update reflects the input of a wide variety of community stakeholders. Ongoing funds will support the Berkeley Wellness Center in providing an accessible place for all to connect to peers and community. We are using funds allocated in this plan to attempt to contract with community-based organizations to provide culturally specific services for Latino/Latina/Latinx, African American/Black, Asian Pacific Islander, and LGBTQIA+ communities. We will be utilizing MHSA Innovation funding to make available for all adults who live, work or go to school in Berkeley mental health apps at no cost. We have created a Homeless Full-Service Partnership to outreach to and provide services for unhoused individuals. Utilizing MHSA funding, the Aging Division will be contracting with a provider to deliver counseling services for Seniors. New funding will support a pilot Specialized Care Unit that will help individuals in mental health crisis without the use of law enforcement; the doubling of the size of our Wellness and Recovery team; a new mental health promotion campaign; and an increase in school based mental health services.

This year also marks significant improvements in the facilities where City of Berkeley mental health services are provided, with the re-opening of the renovated Adult Mental Health Clinic at 2640 Martin Luther King Jr. Way and the coming move of the Family, Youth and Children Clinic to 1521 University Avenue. With the support of MHSA funds, treatment sites will be accessible, welcoming, wellness and recovery focused, and safe for clients and staff. While there remains a lot of economic uncertainty as California re-opens, we thankfully have not seen decreases in MHSA funding yet. In coming years, we will closely watch both revenue and expenditures to ensure that we are able to sustain existing mental health investments.

The Mental Health Division presents the City of Berkeley's MHSA FY22 Annual Update with gratitude for all the hard work that went into the programs it describes. Our community partners, consumers, Mental Health Commission, and City staff all deserve appreciation for their efforts, input, and partnership.

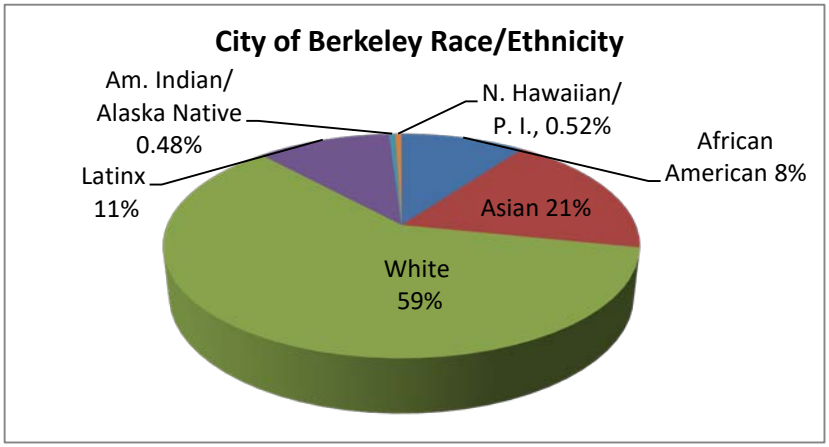
DEMOGRAPHICS

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 120,763 the City of Berkeley is densely populated and larger than 23 of California's small counties.

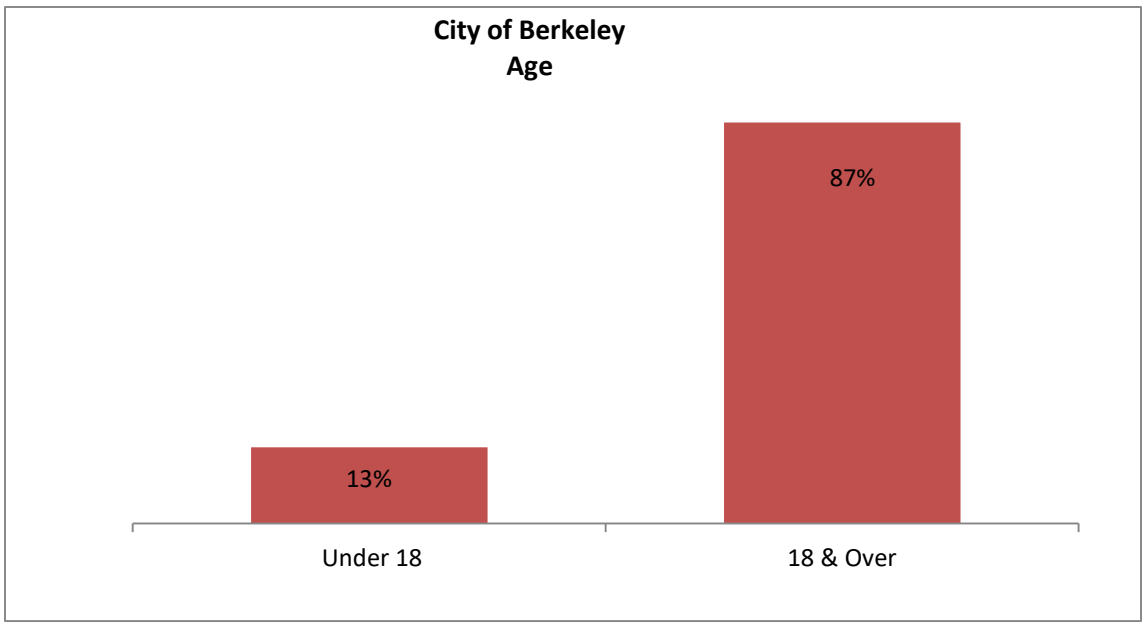
Race/Ethnicity

Berkeley is a diverse community with changing demographics. The African American population has decreased in recent years while the Latino and Asian populations have both increased. Berkeley has a large student population, which provides housing for many of University of California's foreign students and their families. Threshold languages include English, Spanish, Farsi, Cantonese, and Vietnamese, and approximately 29% of Berkeley residents speak a language other than English at home. Berkeley is comprised of the following racial and ethnic demographics: African American; Asian; Latino/Latina/Latinx; White; American Indian/Alaska Native; and Native Hawaiian/Pacific Islander (P.I.). Demographics are outlined below:

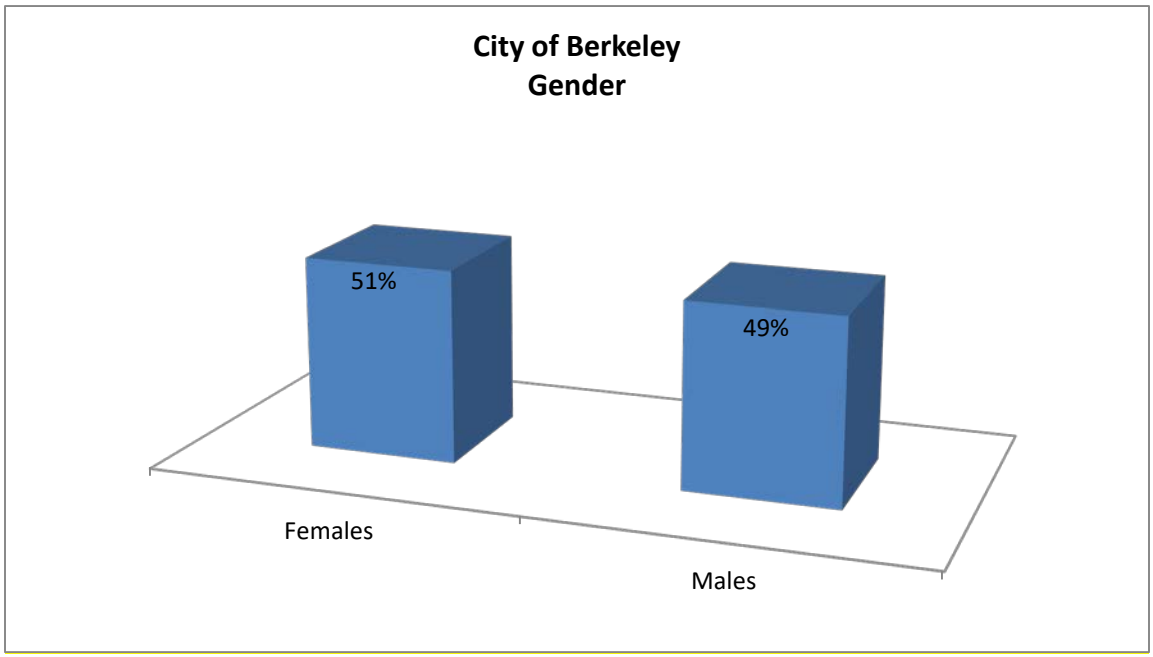


Age/Gender

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



Gender demographics are as follows:



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

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

cities. The City of Berkeley had 2.1% same-sex households according to the 2010 United States Census.

Income/Housing

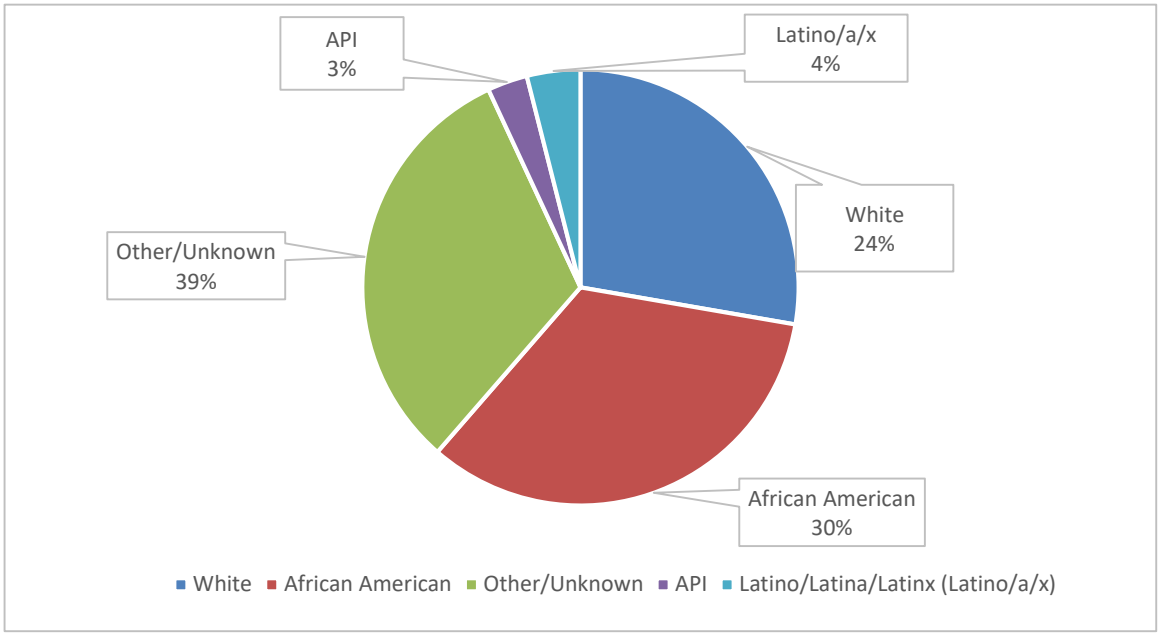
With some of the highest housing costs in the Bay Area, the Berkeley median household income is $85,530. Nearly 20% of Berkeley residents live below the poverty line and approximately 42% of Berkeley children qualify for free and reduced lunches. While 43% of Berkeley residents own their own homes, there are many homeless individuals including women, TAY, and Older Adults. In Berkeley, approximately 46% of the homeless population meets the federal definition for chronic homelessness (adults unaccompanied by children, who have at least one disability and have been homeless for over a year or four or more times in the last year). This is a disproportionately high percentage compared to other municipalities, and a sub-group with higher rates of both mental illness and substance abuse.

Education

Berkeley has a highly educated population: 97% of individuals aged 25 or older are high school graduates; and approximately 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 units providing services: Access; Family, Youth & Children; and Adult Services. Services include: assessment, assertive community treatment, individual and group therapy, case management, and crisis intervention. In addition to offering homeless outreach and support, some services are provided through a variety of community-based agencies and at school sites. As part of the Access unit, a Mobile Crisis Response Team operates seven days a week. The majority of mental health services provided by BMH are aimed towards the Medi-Cal and uninsured population; as such it is important to note the ways in which the Medi-Cal population demographics differ from the overall demographics in Berkeley. Using data available from Alameda County, the Medi-Cal population in Berkeley in 2020 was as follows:


API
3%
Latino/a/x
4%
White
24%
Other/Unknown
39%
African American
30%
White
African American
Other/Unknown
API
Latino/Latina/Latinx (Latino/a/x)

Community Program Planning (CPP)

Community Program Planning (CPP) for this City of Berkeley MHSA FY22 Annual Update was conducted while a global pandemic was still occurring. For the first three and a half months of FY21, the MHSA Coordinator was deployed for two days a week to the City's Emergency Operation Center to support the work around the vaccine roll-out response to the pandemic. During the same timeframe the MHSA Analyst was working on a reduced time schedule. Both of these changes impacted the ability to do some of the regular outreach to the community that is usually conducted during community program planning for a Three Year Plan or Annual Update.

During the CPP process, one MHSA Advisory Committee meeting and four Community Input meetings were conducted through the Zoom platform. A copy of the presentation that was conducted during community meetings was also posted on the City of Berkeley MHSA Webpage. The meetings and posting of the presentation enabled opportunities for input from MHSA Advisory Committee members, consumers, family members, representatives from community-based organizations, individuals from unserved, underserved and inappropriately served populations, BMH Staff, City Commissioners, and other MHSA Stakeholders.

As with previous MHSA Plans and Annual Updates, a methodology utilized for conducting CPP for this Annual Update was implemented to enable a collaborative process to occur between BMH staff, MHSA Advisory Committee members and other MHSA stakeholders. Development of the MHSA FY22 Annual Update began with an internal examination of existing programs, unaddressed needs, and available funding which included a review of input received during previous MHSA planning processes. Following an internal review, proposed ideas and potential programs were vetted through the MHSA Advisory Committee prior to engaging other stakeholders.

Proposed additions that were considered in this process included:

- Increase in funds for the Berkeley Food and Housing Project, Russell Street Residence;
- Addition of two full-time Peer positions to augment Wellness Recovery Services;
- Increase in funding and flexibility around Substance Use Disorder Services;
- One-time funding to support the Specialized Care Unit Pilot Program;
- Increase in funding for the Supportive Schools Project; and
- One-time funding for a Mental Health Promotion Campaign.

The Division is also proposing to increase funding to McKinley House.
Input received during Community Program Planning Zoom meetings largely supported the proposed additions. Additional input received during community meetings and/or through email was as follows:

- There is a broad category breakdown with Dissociative Identity Disorders (DID) and Trauma. Training should be provided to staff on how to provide DID group services, and group services for this population should be implemented;
- There is a need for internal support services and systems to help identify trauma and to prevent misdiagnosis of individuals, especially people of color;
- Continue supporting the Prevention Early Intervention programs;

- Having peers at the location of services is super helpful;
- Implement phone-in program services and tailor services for those who do not have a computer;
- There is a need to address underused funding resources to PEI programs; and
- The Division should consider combining and integrating funding streams.

Input that was specific to the proposed new INN Homeless Encampment Project (that is currently undergoing a separate plan development and approval process) was as follows:

- For the proposed new INN Homeless Encampment project the Division should take into consideration how Homeless Encampments may change in several years per the federal American Rescue Act and State Whole Person Care funding; and
- The Division should think through how confidential services and supports will be provided to individuals who experience Domestic Violence and their partners.

All input received through the community program planning process will be utilized to inform current and proposed mental health programs through this Annual Update, and/or future MHSA Plans and Updates. A 30-Day Public Review is currently being held from Tuesday, May 25th through Wednesday, June 23rd to invite input on this MHSA Annual Update. A copy of the Annual Update is posted on the BMH MHSA website. An announcement of the 30-Day Public Review was mailed and/or emailed to community stakeholders. A Public Hearing will be held at 7:00pm on Thursday, July 22nd during a Mental Health Commission meeting which will be held on the Zoom platform. Comments received during the 30-Day Public Review or Public Hearing will be included in the Annual Update.

COVID-19 PANDEMIC AND MHSA FLEXIBILITIES

The Covid-19 pandemic has caused an unprecedented, unstable time where individuals have experienced a variety of physical health, mental health and financial needs. In response to uncertainties around the amount of MHSA revenue that would be generated, and the increased workload that staff in Mental Health jurisdictions would be undertaking as a result of the pandemic, new temporary MHSA regulations were enacted. The following regulations around MHSA Flexibilities were passed on July 1, 2020, and have been extended through July 1, 2022:

- **Three Year Program and Expenditure Plan Extension:** If a County/City is unable to complete and submit a Three Year Program and Expenditure Plan for the year beginning FY20/21 or an Annual Update beginning year FY21/22 due to the Covid-19 Public Health Emergency, they may extend their current approved plan. The new due deadline for the FY21/22 Annual Update has been extended to July 1, 2022.

- **Prudent Reserve:** Per MHSA legislation mental health jurisdictions are required to maintain a local Prudent Reserve to be able to fund the most crucial support services in the event there is a downturn in the amount of MHSA revenues received. MHSA regulations require the State to determine when Prudent Reserve funds can be locally accessed. New MHSA flexibilities allow mental health jurisdictions to determine when Prudent Reserve funds are needed for local use, and enables the transfer of funds into their CSS and PEI components to meet local needs, without a determination or initiation from the State.

- **CSS Allocations:** MHSA Generally requires at least 51% of CSS funds to be allocated to Full Service Partnership (FSP) programs. To allow more flexibility in allocating CSS funding according to local needs during the Public Health Emergency, counties can determine the allocation percentages across the three CSS funding components: Full Service Partnership; General System Development and Outreach and Engagement.

Local MHSA Services During the Pandemic

Through the implementation of social distancing protocol, and utilization of tele-health and Zoom technologies, local MHSA funded programs and services have largely continued during the Covid-19 pandemic. This Annual Update provides a reporting on programs and services in FY20, a timeframe that included the first three months of the pandemic.

MHSA FY21/22 Annual Update

This City of Berkeley's MHSA FY21/22 (FY22) Annual Update is a stakeholder informed plan that provides an update to the previously approved MHSA FY20/21 – 22/23 Three Year Program and Expenditure Plan (Three Year Plan). The Annual Update summarizes proposed program changes and additions, includes descriptions and updates of currently funded MHSA services that are proposed to be continued in the next three years, and a reporting on FY20 program data. Additionally, per state regulations, this Annual Update includes the FY20 Prevention and Early Intervention (PEI) Annual Evaluation Report (Appendix A) and the FY20 Innovations (INN) Annual Evaluation Report (Appendix B).

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

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

  RBA has been incorporated into selected programs within the Department. This has included community agency programs funded through the MHSA Prevention & Early Intervention (PEI) Community Education & Supports program. Through this initiative the Department worked with each contractor to envision, clarify and develop measures on the outcomes and results each program is seeking to achieve, and used a rigorous framework to begin measuring and enhancing progress towards these results. Page 55 of this Three Year Plan provides an aggregated summary of some of the results of this initiative. The full report on the Impact Berkeley PEI program results can be accessed on the MHSA website: MHSA Plans and Updates - City of Berkeley, CA

- Homeless Outreach & Treatment Team: This pilot project supports homeless mentally ill individuals in Berkeley/Albany engaging them in mental health services. A local consultant, Resource Development Associates (RDA), was hired to measure the outcomes and effectiveness of this pilot project. In late FY20, the Homeless Outreach and Treatment Team Final Evaluation Report was released. Some of the many results of this evaluation can be reviewed in the PEI Section of this Three Year Plan.

- PEI Data Outcomes: Per MHSA PEI regulations, all PEI funded programs have to collect additional state identified outcome measures (specific to the category of services provided) as well as detailed demographic information. Beginning in FY19, PEI Evaluations were required to

be included in each MHSA Annual Update or Three Year Plan. See Appendix A for the Fiscal Year 2020 Prevention & Early Intervention Annual Evaluation Report.

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

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

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

PROPOSED NEW FUNDING ADDITIONS

A review of proposed staffing and services to be added through this MHSA Annual Update, are outlined below:

- **Increase Funding for the Berkeley Food & Housing Project, Russell Street Residence**

  The Berkeley Food & Housing Project (BFHP) operates the Russell Street Residence (RSR) which provides permanent supportive housing for seventeen formerly homeless adults diagnosed with serious and persistent mental illness. Residents at RSR receive the following services: meals; therapeutic groups, activities and outings; transportation to medical appointments; assistance with daily activities including laundry and personal hygiene.

  BMH has provided funding to the BFHP for many years, to operate the RSR which provides housing to clients served by the Division. In FY21, the RSR experienced an increase in rent. The Division is proposing through this Annual Update, to utilize CSS System Development monies to increase the amount of funding for the BFHP RSR to cover the rent increase. The total proposed amount of the increase to cover FY21 and FY22 is $47,716. Following FY22, the proposed annual increase going forward will be an additional $17,716 on top of the base contract amount each year.

- **Add two Social Service Specialist Positions to hire Mental Health Peer Staff**

  The Division is proposing to allocate $321,993 of CSS System Development funds to add two Social Service Specialist positions to increase staff with lived experience as mental health peers, on the Wellness and Recovery Team. This proposed use of funds comes out of a desire to both increase mental health peer staff at BMH and the provision of peer driven services, and to reduce the use of security guards in the mental health setting. The addition of

peer staff will enable a greater ability to provide a variety of peer led services, and will allow the Wellness Recovery Team to provide activities and supports to individuals in the waiting room, replacing the use of security guards. It is envisioned that this change in practice will create a more welcoming space for individuals waiting for their appointments.

- **Increase funding and flexibility for Substance Use Disorder Services**

  A large portion of individuals who currently receive services at BMH are also suffering from co-occurring disorders, having both mental health issues and substance use disorders (SUD). In an effort to increase the capacity to serve individuals with SUD, the Division proposed through the previously approved MHSA FY20 Annual Update to add a Social Services Specialist staff position, who would work directly with individuals to assist them in obtaining the resources and supports they need.

  Through this Annual Update, the Division is proposing to increase the flexibility of the use of the previously allocated MHSA Funds, and to add $100,003 of MHSA CSS System Development Funds to support SUD services. The additional funding and flexibility will enable the Division to work with a local SUD provider to co-locate SUD services at the Mental Health Adult clinic. This will increase the provision of SUD services for BMH clients, provide an opportunity for staff to obtain consultations on SUD services, and will make referrals into SUD services outside of the Mental Health Adult clinic easier for consumers.

- **Provide funding for the Specialized Care Unit**

  On July 14, 2020 City Council passed Resolution No, 69,501-N.S., City Council passed a package of items providing direction for the development of a new paradigm of public safety in Berkeley. One of the items adopted by City Council directed the City Manager to analyze and develop a pilot program to re-assign non-criminal police service calls to a Specialized Care Unit (SCU). The SCU will consist of trained crisis-response field workers who will respond to calls that a Public Safety Communications Center evaluate as non-criminal and posing no threat to the safety of community members, responding crisis workers, and/or other involved parties. The SCU will be a pilot model that will inform the long-term implementation of the program.

  Currently, Resource Development Associates (RDA), who was chosen through a competitive Request For Proposal (RFP) process is providing a comprehensive feasibility study, community engagement process, best practice research, data collection, program design, and an implementation plan for the SCU. Through this Annual Update, the Division is proposing to allocate MHSA funding in the amount of $200,000 ($132,000 of CSS System Development funds and $68,000 of PEI funds) to be used to leverage other City funds for this pilot program. This is a one-time funding amount, as the City determines how to best fund this Specialized Care Unit.

- **Increase funding for the Supportive Schools Project**

  Through the Supportive Schools Project, $55,000 of MHSA PEI funds are allocated on an annual basis to 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.

  The effects of the Covid-19 pandemic on youth has increased the scope and number of students requiring interventions, and mental health services. In an effort to increase and strengthen the mental health support for each school site, the Division is proposing through this Annual Update to allocate an additional $55,000 of PEI funds for this project, for a total amount of $110,000 on an annual basis.

- **Allocate funds for a 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 is proposing through this Annual Update to allocate $100,000 of 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. This is a one-time funding amount as the Division works with the community to determine how to best promote mental health and wellness in Berkeley.

- **Increase funding for McKinley House for Permanent Housing for FSP Clients**

  Through the previously approved FY15/16 Annual Update the Division allocated $100,000 of CSS FSP funds to be allocated on an annual basis to provide seven permanent housing units at McKinley House for FSP level clients. Through this Annual Update the Division is proposing to add $40,000 to cover the actual costs for the operating site and subsidies in FY21 and FY22. Following FY22, the ongoing amount will be $120,000 on an annual basis.

PROGRAM DESCRIPTIONS AND FY20 DATA BY FUNDING COMPONENT

Outlined in this section per each funding component are descriptions of current City of Berkeley MHSA services along with FY20 program data. Across all MHSA funded programs, in FY20, a total of 4,601 individuals participated in some level of services and supports. Additionally, a total of 781 individuals attended BMH Diversity and Multi-cultural trainings aimed at transforming the system of care, and 130 individuals attended BMH Diversity and Multicultural events. Among the largest of accomplishments in FY20 is that almost all MHSA funded services were able to continue providing services in some capacity during the pandemic. Some of the FY20 MHSA funded program highlights included: A reduction in psychiatric inpatient hospital and/or incarceration days for severely mentally ill clients; a decrease in the number of days severely mentally ill clients spent

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

COMMUNITY SERVICES & SUPPORTS (CSS)

Following a year-long community planning and plan development process, the initial City of Berkeley CSS Plan was approved by the Califonia Department of Mental Health (DMH) in September 2006. Updates to the original plan were subsequently approved in September 2008, October 2009, April 2011, May 2013, May 2014, May 2015, June 2016, January 2017, July 2017, October 2018, July 2019, and December 2020. From the original CSS Plan and/or through subsequent plan updates, the City of Berkeley has provided the following services:

- Wrap-around Services for Children and their families;
- TAY, Adult and Older Adult Intensive Treatment Services;
- Multi-cultural Outreach & Engagement;
- TAY Support Services;
- Consumer Advocacy;
- Wellness and Recovery Services;
- Family Advocacy;
- Housing Services and Supports;
- Homeless Outreach Services;
- A Wellness Recovery Center;
- Benefits Advocacy; and
- Transitional Outreach Services.

Descriptions and updates for each CSS funded program and FY20 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 0-25 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 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.

In FY20, a total of 28 children/youth and their families were served through this program. Demographics on those served were as follows:

CLIENT DEMOGRAPHICS N=28		
Client Gender	*Number Served*	*% of total*
Male	19	68%
Female	9	32%
Race/Ethnicity		
Client Race/Ethnicity	*Number Served*	*% of total*
African American	14	50%
Asian Pacific Islander	1	4%
Caucasian	4	14%
Latino/a/x	2	7%
More than one Race	5	18%
Declined to Answer (or Unknown)	2	7%

Flex funds are used to provide various supports for FSP program participants. In FY20, a total of 119 flex funds were provided to 30 children/youth and/or their families for field trips, food, transportation, school supplies and pro-social activities.

Children/youth outcomes were as follows: 7 clients reached 100% of their treatment goals and their cases were closed; 8 clients stepped down to a lower level of care; 7 client cases were closed due to low/no engagement; 4 clients moved out of the area; 9 clients were placed on 5150/5585 hold.

<u>Successes:</u>

- Linkage to other service providers for psychiatric medication, on going therapy, and numerous community based organizations for pro-social activities;
- Reduction in psychiatric hospitalizations and the use of crisis services;
- Eleven clients met and/or exceeded stated objectives in their treatment plan;

- FSP services continued to be provided by clinicians who mirror the racial/ethnic identity of the populations served;
- On going access to services for clients/families whose primary language is Spanish;
- Team transitioned to online mental health care in Mid-March 2020, due to the pandemic. Staff were provided a HIPPA compliant Zoom account and they worked with their individual clients to transition to the platform;
- Families/clients typically used their chrome books that were provided by the school to meet with the team. The clinicians also connected by telephone, for families who were unable to access the technology necessary for Zoom;
- FSP team supported the families to connect with their school so they could pick up their chrome book and Wi-Fi hot spot;
- Team used flex funds to support the needs of families during the shelter in place (food, clothing, school supplies, utility bills etc.); and
- Addition of a licensed clinician to the FSP team in April 2020.

Challenges:

- Unable to provide medication support to clients within the division; and
- The transition during the pandemic while seamless for some clients, presented challenges for other FSP clients due to Zoom fatigue, financial stress within the family, Covid-19 health concerns, grief due to the death of family members, and social isolation.

TAY, Adult and Older Adult Full Service Partnership

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

The team utilizes an ACT approach which maintains a low staff-to-client ratio (12:1) that allows for frequent and intensive support services. Clients are provided assistance with finding appropriate housing and in some cases may qualify for temporary financial assistance. A full range of mental health services are provided by a team comprised of 1 Clinical Supervisor, 5 masters level Behavioral Health Clinicians, 1 Social Services Specialist, 1.5 mental health nurses and a ½ time psychiatrist. The primary goals of the program are to engage clients in their treatment and to reduce days spent homeless, hospitalized and/or incarcerated. Goals also include increasing, employment and educational readiness; self-sufficiency; and wellness and recovery. The program serves up to 60-70 clients at a time.

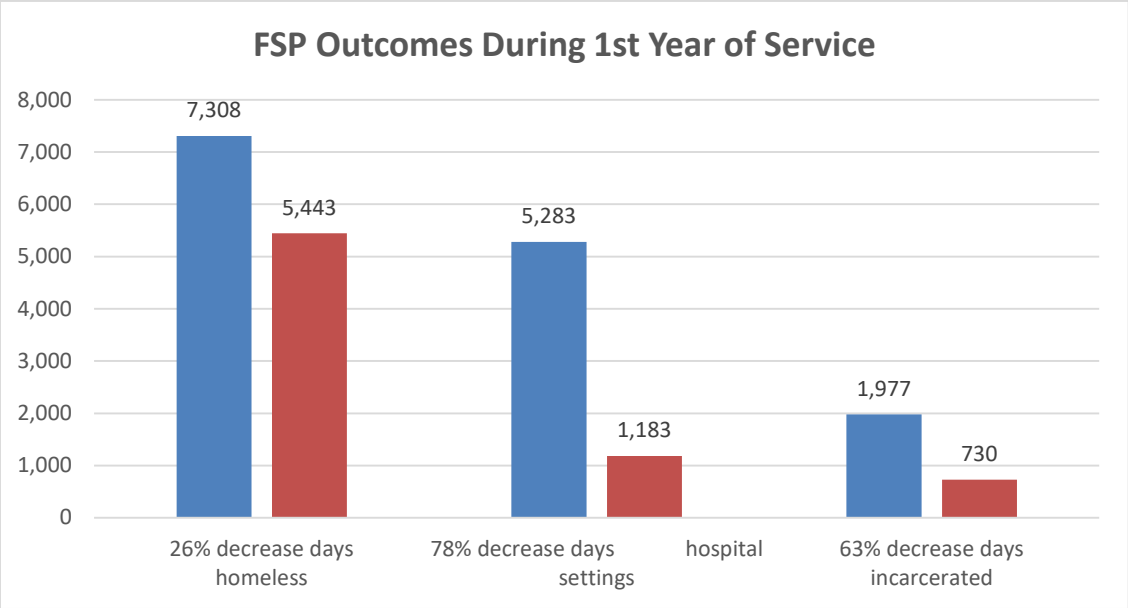
In FY20 a total of 82 TAY, Adults, and Older Adults participated in the program for all or part of the fiscal year. Demographics on those served include the following:

CLIENT DEMOGRAPHICS N=82*		
Client Gender	*Number Served*	*% of total*
Male	53	65%
Female	29	35%
Race/Ethnicity		
Client Race/Ethnicity	*Number Served*	*% of total*
African American	24	29%
Asian Pacific Islander	1	1%
Caucasian	18	22%
Latino/a/x	4	5%
Declined to Answer (or Unknown)	35	43%
Age Category		
Client Age Category	*Number Served*	*% of total*
Transition Age Youth	6	7%
Adult	56	68%
Older Adult	20	24%

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

Flex funds are used to provide supports for FSP program participants. In FY20, 21 partners received rental and housing assistance; 26 received food and groceries and 19 partners were provided with miscellaneous assistance with clothing, bus passes, pharmacy needs, furniture, etc. FSP outcomes included the following: 8 partners were dis-enrolled from the program during FY20: 2 partners met treatment goals and graduated to lower levels of care (25%), 2 partners moved out of the county (25%), 2 partners died (25%), 1 partner made the decision to discontinue services (12.5%) and 1 partner was transferred to a Full Service Partnership team specializing in criminal justice involved individuals (12.5%). 20 new partners were enrolled and completed 1 year of service during the course of the fiscal year.

There were 71 FSP program participants in FY20 who completed at least 1 full year of service in the program and are included in the program outcome report data. There were positive outcomes with regard to reductions in days spent homeless, in hospital settings and/or incarcerated. There was a **26% reduction in days spent homeless**. Partners spent 7,308 days homeless (on the street, couch surfing and in shelters) the year before program enrollment and 5,443 days homeless during the first year of program participation. There was and **78% reduction in days spent in hospital settings** (Psychiatric Emergency, acute psychiatric inpatient, IMDs, MHRCs, state psychiatric hospitals and medical hospitals, SNF) during the first year of program participation. Partners spent 5,283 days in hospital settings the year before program enrollment and 1,183 days in these settings during the first year of program participation. There was a **63% reduction of days spent incarcerated** during the first year of program participation. Partners spent 1,977 days incarcerated (jail and prison) the year prior to program enrollment as compared with 730 days incarcerated during the first year of program participation.



Overall, as with previous years, the program continued to have strong outcomes with regard to reducing days spent in hospital settings (78%) and days spent incarcerated (63%). The program had more modest success with reducing the number of days spent homeless for participants (26%). Program challenges included the ongoing housing crisis in the Bay Area, the rollout of the Coordinated Entry System for access to housing resources and the Covid-19 pandemic.

Homeless Full Service Partnership

Through the previously approved MHSA FY20 Annual Update, and as a result of the need to ensure ongoing services and supports for homeless individuals following the ending of the Homeless Outreach and Treatment Team (HOTT) Pilot Program, a Homeless Full Services Partnership was developed. This program was implemented in FY21 and provides services and supports for homeless individuals who are experiencing mental health needs.

MULTI-CULTURAL OUTREACH AND ENGAGEMENT

Diversity & Multicultural Services

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

The Diversity & Multicultural Coordinator accomplishes these goals by:

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

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

Program services, events and activities conducted in FY20, are summarized below:

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

Latino Conference 2019 - Cultural Values, Unity & Respect: Creating Safe Spaces - September 20, 2019 - (Approximately 125 individuals attended this event) - Attendees included staff, consumers, family members, community partners, students, and residents. This training was a collaboration with the City of Berkeley Public Health and Aging Services Divisions; BAHIA, Inc.; and RISE.

Mental Health And Spirituality Conference - October 10th & 11th, 2019 - (Approximately 100 individuals attended on the 10th & 140 on the 11th attended the conference) - Attendees included faith-based community, staff, consumers, family members, community partners, students, and residents. This was a collaborative with the California Mental Health and Spirituality Statewide Initiative and NAMI Contra Costa County.

Black History Month Youth Celebration - Talent Show - Thursday, February 20, 2020 - (Approximately 80 individuals attended this event) - Attendees included youth, family members, teachers, staff, and residents. This was collaboration with BUSD.

Berkley Mental Health's Black History Month - Wednesday, February 26, 2020 - (Approximately 50 individuals attended this event) - Attendees included staff, consumers/peers, and family members.

"Supporting the Asian Community during this COVID-19 Pandemic: Wellness and Self-Care" - May 27, 2020 - (16 individuals attended this webinar training) - Attendees included staff and community partners.

Embracing and Healing the Latino/x Community in the Midst of COVID-19 - May 28, 2020 - (60 individuals attended this webinar training) - Attendees included staff, consumers, family members, community partners, students, and residents.

Confronting the Devastation of Covid-19 in the African American Community: Utilizing Faith Based Approaches - Jun 3, 2020 - (91 individuals attended this webinar training) - Attendees included staff, consumers, family members, faith-based community, community partners, students, and residents.

"Inspiring Healing, Hope, and Understanding" - Jun 25, 2020 - (64 individuals attended this webinar training) - Attendees included staff, consumers, family members, community partners, students, and residents. - This training was a collaborative with BUSD.

LGBTQQI2-S People of Color - Health and Wellness - Jun 30, 2020 - (124 individuals attended this webinar training) - Attendees included staff, consumers, family members, community partners, students, and residents.

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

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

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

Suicide Prevention and Intervention Skills Building Workshop - September 2nd & 3rd, 2019 - (55 individuals attended this training) - Attendees included staff and community partners.

Cranky and Speedy Patients/Clients: Identifying, Understanding, and Offering Treatment for Harmful Stimulant Use - October 2, 2019 - (38 individuals attended this training) - Attendees included staff and community partners.

Working with Freeze (Dissociation) - November 15, 2019 - (22 individuals attended this training) - Attendees included staff and community partners.

Suicide Prevention and Intervention Skills Building Workshop - January 31, 2020 - (38 individuals attended this training) - Attendees included staff and community partners.

Law and Ethics for Mental Health, Behavioral Health and Health Care Providers - March 4, 2020 - (48 individuals attended this training) Attendees included staff and community partners.

Committees/Groups:

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

Outreach and Engagement:

- Native American Health Center – Indigenous Community
- Black Infant Health –Women & Children
- R.I.S.E. – Youth/Students
- Berkeley Drop-In – Homeless Population
- McGee Baptist Church – African Americans
- The Way Christian Center – African Americans
- Village Connect, Inc., African American & Latino/a/x populations
- Eden Project – LGBTQI2-S – TAY
- Pacific Center – LGBTQI2-S Community
- BAHIA, Inc. – Latino/a/x population
- Healthy Black Families – African American Women & Children Population
- BUSD – Staff, Students, and Families

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 FY20, a total of 109 TAY between the ages of 18-24 were served. Demographics on TAY served were as follows:

CLIENT DEMOGRAPHICS N=109*		
Client Gender	*Number Served*	*% of Total*
Male	65	60%
Female	41	38%
Transgender	2	2%
Questioning or Unsure	1	<1%
Race/Ethnicity		
Client Race/Ethnicity	*Number Served*	*% of Total*
American Indian or Alaska Native	5	4%
African American	52	48%
Asian Pacific Islander	5	4%
Caucasian	27	25%
More than one Race	14	13%
Declined to Answer (or Unknown)	6	6%
Age Category		
Client Age	*Number Served*	*% of Total*
Transition Age Youth	109	100%
Sexual Orientation		
Client Sexual Orientation	*Number Served*	*% of Total*
Gay or Lesbian	6	6%
Heterosexual or Straight	98	90%
Bisexual	5	4%

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

During FY20, 5,248 outreach activities were conducted with a total of 5,408 duplicated contacts. A total of 164 individuals received engagement services and 109 individuals participated in ongoing program services. There were 460 referrals to the following services and supports: 96 Mental Health; 94 Physical Health; 109 Social Services; 61 Housing; and 100 other unspecified services. Per a Satisfaction Survey that was administered, youth participants reported the following: 91% indicated satisfaction with the treatment services they received; 17% exited the program into stable housing; and 39% became employed or entered into school. During the pandemic, services have continued to be provided.

SYSTEM DEVELOPMENT

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

Wellness Recovery System Integration

The BMH Wellness Recovery Team works with staff, stakeholders, community members and clients to advance the goals of Wellness and Recovery on a system wide level. In order to accomplish these goals, some of the various tasks include: recruiting consumers for Division committees; convening committees around Wellness Recovery system initiatives; oversight/administration of peer stipends; convening and conducting meetings for the Berkeley “Pool of Consumer Champions (POCC)”; working with staff to develop various Wellness and Recovery related policy and procedures; and oversight of the Division’s “Wellness Recovery Activities”. The Consumer Liaison is also a resource person around “Mental Health Advance Directives” for consumers desiring to express their treatment preferences in advance of a crisis; and is a participant on a number of local MHSA initiatives. The combination of individual services and system-level initiatives impact all clients and their family members across the system in a given year. In FY20, there were a total of 438 clients in the BMH system.

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

Berkeley Pool of Consumer Champions (POCC)

In FY20, nine Berkeley Pool of Consumer Champions (POCC) meetings were held prior to the pandemic. During the meetings the POCC focused on the following: Giving suggestions for the update to the Berkeley Resource Guide; sponsoring a South Berkeley Art Walk; presenting about their work at the Alameda County POCC Steering Committee; creating a space for people to make cards for people in locked facilities at the POCC Bar-B-Que and honoring people who were not present by placing their name on candles at the Alameda County POCC Cultural Holiday party. The Berkeley POCC focused on creating position for new members and reviewing the mission statement. In the past the POCC committee was involved in other activities such as, tabled at the 8 dimension of wellness 10x10 "We Move for Health" event for Mental Health Awareness month in May. Attending the May is Mental Health event sponsored by Berkeley Mental Health but due to Covid-19 events were cancelled. As a steering committee representative for the Berkley POCC the committee was involved in updating the POCC Action Plan, help revised the Guidelines for respectful engagement for virtual meetings and gave input and managed two- forums on African American Town hall about cultural awareness, voting and covid-19 responses. An average of 4.2 people attended each meeting with a total of 15 unduplicated participants and 38 total number of people.

Wellness Recovery Activities

Designed with, and building on the talents of consumers, the BMH Wellness Recovery activities included workshops, trainings and ongoing health groups. In FY20, a total of 24 groups occurred from before the pandemic. Due to the closing of the facility for Covid-19, the Wellness Recovery activities were cancelled until further notice. During the time period, 20 unduplicated consumers attended this program, facilitating peer led activities, which included:

- Facilitated Discussions - Topics included: Ways to Reduce Stress; Our Values; Watching and Discussing the Video Mind Games; Plans for Summer; What to do When You Are Down; Progress On Your Goals; Things to do to Stay Well.
- Creative Writing - Topics included: Writing a story about a picture; Highs and Lows of Recovery; Description of yourself- Your Wishes and Dreams; Gratitude list; Three Truths and a Lie; What Helps and What Doesn't; Goal Setting; Your Recovery Journey; Recovery Essay; Letters to our Younger Selves; Things You Like About Yourself; What to do When Someone is Rude; The Ups and Downs of the Past Week; Your Most Memorable Walk.
- Creating – Mandalas; Greeting Cards; "Wreck This Paper Art"; Origami Cranes for "Day of the Dead" Altar; Using Dots to Create Art; Choices You Regret and What to do About it; Valentine and Christmas Cards; Cards to our Future Selves.
- Exercise – Yoga; Stretching; Meditation; Catching balls; Chi Gung; Walking to the park, and Mindful walking.

- Games - Wellness Tools Hangman; Moods; Creating a Dinner for Under $30 from Ads; Recovery Hangman; Stress Reduction Hangman; Life Stories; Boggle and Jenga!
- Drawing – Including: Nature scenes; A summer day; Coloring mandalas; Outlining objects to create a composition; Using Lines; Shared Drawing; Creating Art with Stray Lines; Abstract drawing.

Field Trips

In FY20 a total of 6 field trips were offered with 30 participants. Peer led field trips at the museums and in nature incorporating expressive arts included trips to: Berkeley Marina; National NightOut in South Berkeley; the San Francisco Museum Of Modern Art; South Berkeley Art Walk; Berkeley Art Museum; and a trip to 4th Street in Berkeley to see the Holiday lights and the local Open Art studios; and a tour of the Berkeley Main Library.

Card Party Groups

In FY20 a total of 39 Card Party groups were offered to inspire consumers to create inspirational cards for individuals in psychiatric hospitals. This program is modeled after the Do-Send-A-Card program created by the San Francisco Mental Health Association. BMH Wellness Recovery staff partnered with the Alameda Network of Mental Health Clients' Reach Out Program to distribute the cards that were created from the Card Party groups when they visit the hospitals throughout the County. Patients can choose the card they want to receive. Through this program over 360 cards were created and sent to the Reach Out Program. This program was impacted by the pandemic and meetings were moved to virtual platforms such as Zoom. During the reporting timeframe there were approximately 19 unduplicated participants. There was an increase of participants attending, when the groups started meeting virtually, which was an increase in attendance over prior years.

Mood Groups

The Mood Group is designed for people to share their thoughts and feelings in a safe place where support is also offered. In FY20, the weekly support group focused on mood scales and enabled time for participants to share freely among non-judgmental peers. There were 27 groups with a total of 19 attendees. Attendance in this group was impacted due to the Pandemic.

Mental Health Advance Directives

Consultations on Mental Health Advance Directives have generally been offered by phone or on a drop-in basis. Interested individuals can contact the Wellness Recovery Staff to receive information and consultations around Advance Directives. In FY20, 3 sessions were offered and 5 people received consultations.

The Wellness Recovery Team also conducted or participated in the following activities during the reporting timeframe: Developed a monthly color calendar of activities; published a six page newsletter highlighting wellness tools, resources, fun activities, and information about Covid-19; sent these informational documents to approximately 150 individuals via mail and another 130 individuals via email; created an introductory letter about the Wellness Recovery Team to be given to consumers; worked on the development of a Mission Statement for the Wellness Recovery Team:

participated in the planning and implementation of the May is Mental Health Month event in Berkeley; co-facilitated 1 Adult Mental Health First Aid training and 1 Youth Mental Health First Aid training; participated in the Creative Wellness Center Task Force; conducted Consumer Perception surveying in June 2020 by mail, during the State survey period as well as submitted completed surveys to the state; continued work and discussion on the Stipend Policy for the POCC members; assisted consumers with accessing the POCC BBQ and tabled the event with cards and information about Berkeley Mental Health; held a POCC Annual Cultural Holiday celebration, participated in the planning of the Health and Human Resource and Education Center-10x10 8 Dimensions of Wellness, "We move for Health", which was cancelled in person but moved into a #mentalhealth365 virtual campaign; and attended the Spirituality Conference.

Hearing Voices Support Group

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

In FY20, a total of 561 individuals were served through weekly support groups. Demographics on individuals served were as follows:

CLIENT DEMOGRAPHICS N=561*		
Client Gender	*Number Served*	*% of total*
Male	157	28%
Female	338	60%
Declined to Answer (or Unknown)	66	12%
Race/Ethnicity		
Client Race/Ethnicity	*Number Served*	*% of total*
African American	22	4%
Asian Pacific Islander	89	16%
Caucasian	336	60%
Latino/a/x	28	5%
More than one Race	22	4%
Declined to Answer (or Unknown)	64	11%
Age Category		
Client Age Category	*Number Served*	*% of total*
Transition Age Youth	6	1%
Adult	555	99%
Sexual Orientation		
Heterosexual or Straight	313	56%
Bi-Sexual	45	8%
Queer	9	2%
Declined to Answer (or Unknown)	194	35%

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

In FY20 there was an increase in participation for the adult groups. Per program staff report, based on survey responses received from group members, this increase in attendance can be attributed to the increased stress and need for support and community due to the Covid-19 pandemic, and the improved access afforded to participants as groups transitioned to an on-line platform. While some individuals expressed that they missed meeting in-person, many more individuals reported that on-line groups were easier to attend. The following are some comments received on a survey of group members regarding on-line meetings:

"I like the group on line because it is easier for me because I have a disabled husband. If it wasn't online I would probably not be able to attend all of the meetings"

"Since I do not drive, it makes it easy to get there"

"More people are able to take part"

"Not everyone has the Internet"

"It is more accessible to people who don't feel like leaving the house or live in a remote area"

"I only joined it after it was online. Very convenient for me'

"It is better online. It allows a greater audience to attend. Also no car traffic to deal with. And it is aligned with global warming. You need to get folks out of their cars"

"I can do it in the comfort of my own home"

"I don't feel safe to go in person"

There is something freeing about not having to drive and about how intimately we talk. As if Zoom cuts out the small talk".

"Harder to connect not being in the same room".

This increase in attendance was not matched with the Youth Groups and the groups were subsequently put on a hiatus due to low attendance. Per program staff report, the reason for the low attendance in the Youth Groups is that, due to the Covid-19 restrictions, the contractor was unable to do the necessary in-person outreach to schools, parents' organizations, and family support mental health clinics that are so important in getting the word out and building attendance for this new group. Experience shows that group attendance for new groups tends to build over time through word of mouth and increase once mental health professionals, schools, community organizations, and clinics hear about the groups.

Going forward offering groups both on-line and in-person will be explored as well as doing expanded outreach to build attendance and awareness of all of the groups.

Family Support Services

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

The Family Services Specialist serves as a point of contact for family members who are currently accessing or attempting to access services and/or who have questions and concerns about the mental health system, providing them with supports, and as needed, referrals to additional community resources. Outreach is provided to families through existing BMH family support groups, NAMI of the East Bay, community clinics and the Alameda County Family Education Resource Center (FERC). Additionally, the Family Services Specialist coordinates forums for family members to share their experiences with the system; recruit's family members to serve on BMH committees; supports family members through a "Warm line"; conducts a Family Support Group; and creates training opportunities to educate mental health staff on how to effectively work with families. The combination of individual services and system-level initiatives impact all clients and their family members across the system in a given year. In FY20, there were a total of 438 clients in the BMH system.

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

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

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

As the Family Services Specialist position has been vacant since April 2019, the previous position holder has continued the Family Support Group and occasional Warm Line Phone support. In addition, the global COVID-19 pandemic resulted in a pause of the Family Support Group.

During FY20 a total of 41 family members were served. Demographics of individuals served are outlined below:

CLIENT DEMOGRAPHICS N=41*		
Client Gender	*Number Served*	*Percent of Total Number Served*
Male	10	24%
Female	30	73%
Declined to Answer (or Unknown)	1	2%

Race/Ethnicity		
Client Race/Ethnicity	*Number Served*	*Percent of Total Number Served*
African American	4	10%
Asian Pacific Islander	8	20%
Caucasian	23	56%
Latino/a/x	5	12%
Native American	1	2%
Age Category		
Client Age in Years	*Number Served*	*Percent of Total Number Served*
26-55 years	13	32%
56+ years	28	68%

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

Employment Services

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

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

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

Housing Services and Supports

The Housing Specialist provides housing resource services for clients; working with landlords to increase housing opportunities; collaborating with case management staff, landlords, and Board & Care Managers to provide additional supports for clients who are already housed; and working in tandem with the City of Berkeley HHCS Department Hub (which serves as a single entry point into emergency shelter and transitional housing, where clients are triaged based on their housing and service needs). Some of the various places where clients with subsidies are housed are the Berkeley Food and Housing Project Russell Street Residence Board and Care, McKinley House, and Lakehurst Hall.

Benefits Advocacy Services

Through this project a community-based organization, the Homeless Action Center (HAC), assists clients in obtaining public benefits. Services are provided for approximately 10 BMH clients a year. In FY20, 13 clients were served through this agency. Demographics on those served were as follows:

CLIENT DEMOGRAPHICS N=13		
Client Gender	*Number Served*	*Percent of Total Number Served*
Male	7	54%
Female	5	38%
Non-binary	1	8%
Race/Ethnicity		
Client Race/Ethnicity	*Number Served*	*Percent of Total Number Served*
African American	4	31%
Caucasian	5	38%
Latino/a/x	1	8%
Other	3	23%
Age Category		
Client Age	*Number Served*	*Percent of Total Number Served*
18-59	10	77%
Over 59	3	23%

Flexible Funds for Level One Clients

A contract with the community-based organization, Berkeley Food & Housing Project, enables flexible funds to be used with clients across the system for supports such as housing, clothing assistance, food, transportation, etc. This use of flexible funds aids individuals in achieving better stability in areas where they are less capable of addressing their daily living needs. This program is set up to aid any clients in need across the system in a given year. In FY20, there were a total of 438 clients in the BMH system.

Mobile Crisis Team (MCT) Expansion

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

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

Transitional Outreach Team (TOT)

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

In FY20, 302 individuals were served through this project. Demographics on those served were as follows**:**

CLIENT DEMOGRAPHICS N=302*		
Client Gender	*Number Served*	*Percent of Total Number Served*
Male	43	14%
Female	151	50%
Transgender	4	1%
Declined to Answer (or Unknown)	104	34%
Client Race/Ethnicity		
Client Race/Ethnicity	*Number Served*	*Percent of Total Number Served*
African American	104	34%
Asian	24	8%
Caucasian	99	33%
Latino/a/x	16	5%
More than One Race	3	1%
Other	56	19%
Age Category		
Client Age in Years	*Number Served*	*Percent of Total Number Served*
0-15	10	3%

16-25	65	22%
26-59	146	48%
60+	37	12%
Declined to Answer (or Unknown)	44	15%

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

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.

TOT which normally is comprised of two staff, operated on a single staff person for the last seven months of the reporting timeframe, due to staff being out on leave. The redirection of operations and services due to the pandemic also changed what was provided to the public by this team. Additionally, some of the regular collaborative partners such as John George and Herrick Hospital severely reduced contact, referrals, and linkages due to pandemic related changes in service. The remaining TOT staff person was re-deployed to the HOTT team for the last four months of this report period. Systemic issues also hampered the ability to connect agencies to TOT as some institutions and referring parties continued to make contact with the BMH Crisis Assessment Team (CAT) or other clinicians who have been with BMH for long periods of time, instead of the TOT staff.

Outcomes of the program during the reporting timeframe:

- Provided short-term flexible and client centered interface to connect eligible individuals to mental health and other services;
- Connected clients and families to many resources, including mental health, housing, medical, and social services;
- Provided marketing materials and connections to other agencies in order to facilitate education and relationships with TOT;
- Continued building relationships and in-roads with partner agencies where residents coming out of a crisis were being discharged and needed supports in connecting to longer term services; and
- Continued to develop processes and procedures to better communicate with MCT team and provide effective follow-up to mutual clients.

Sub-Representative Payee Program

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

In FY20, Sub-Representative Payee services was contracted out to Building Opportunities for Self Sufficiency (BOSS) who were chosen through a competitive RFP process. BOSS began providing

Sub-Representative Payee Services in April 2019. Approximately 79 individuals receive services a year.

Berkeley Wellness Center

The Berkeley Wellness Center is an MHSA funded collaboration between the City of Berkeley, Mental Health Division and Alameda County BHCS. This program implemented through the community-based organization, Bonita House, provides: mental health and substance abuse counseling; living skills training; community integration and educational activities and opportunities; pre-vocational training; wellness recovery programming; support groups; referrals to community resources; computer training; Art Therapy and other activities.

The main goals of the program are to assist individuals in functioning as highly as possible so they can become integrated into the community. The Berkeley Wellness Center opened in November 2019 and was open for in-person services up until the closure of offices in March 2020 due to the pandemic. From March through June 2020, services continued to be provided via phone or tele-health. Group services, Crisis support and other mental health services were also provided via the Zoom platform.

In FY20, 133 individuals participated in this program. Demographics on individuals served were as follows:

CLIENT DEMOGRAPHICS N=133*		
Client Gender	*Number Served*	*% of total*
Male	54	41%
Female	79	59%
Race/Ethnicity		
Client Race/Ethnicity	*Number Served*	*% of total*
American Indian or Alaska Native	1	1%
African American	10	8%
Asian Pacific Islander	9	7%
Caucasian	101	76%
Other	12	9%
Age Category		
Client Age in Years	*Number Served*	*% of total*
25-44	39	29%
45-54	57	43%
55-61	26	20%
62 and Above	11	8%

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

Results to the following questions on a “Program Satisfaction Survey” that was filled out by participants are outlined below:

- “I am satisfied with the services I have received from this program”.
  Out of 132 responses:
  -51% Strongly Agreed
  -49% Agreed

- "This program's staff treated me with respect".
  Out of 122 responses:
  -100% Strongly Agreed
- "This program helped me make progress towards my goals".
  Out of 122 responses:
  -70% Strongly Agreed
  -30% Agreed
- "This program met my needs".
  Out of 122 responses:
  -75% Strongly Agreed
  -25% Agreed

BMH Peer and Family Member Positions

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

Two additional positions are being proposed through this FY22 Annual Update, to increase the Wellness Recovery work. The addition of peer staff will enable a greater ability to provide a variety of peer led services, and will allow the Wellness Recovery Team to provide activities and supports to individuals in the waiting room, replacing the use of security guards. It is envisioned that this change in practice will create a more welcoming environment for individuals waiting for their appointments.

Homeless Outreach and Treatment Team (HOTT)

The Homeless Outreach and Treatment Team (HOTT) program was established out of an effort to address the homeless crisis, and as a result of input received through various MHSA Community Program Planning processes. Utilizing a portion of PEI and CSS funds, blended with realignment and general funds this pilot program was created to support homeless mentally ill individuals in Berkeley and to connect them into the web of services that currently exist within the system of care. Key program components included the following: Persistent and Consistent Outreach; Supportive Case Management; Linkage to Care; and Treatment. The program was in operation until early FY21, when it was replaced by the Homeless Full Service Partnership.

In FY20, 616 individuals were served through this program. A local consultant, Resource Development Associates (RDA), conducted an evaluation of this project. In late FY20, the

Homeless Outreach and Treatment Team Final Evaluation Report was released. As this program is funded in both the CSS and PEI MHSA components, demographics on individuals served and program outcomes are outlined in the PEI section of this Three Year Plan. In FY21, HOTT continued to be in operation until March 2021, when the Homeless FSP was fully implemented.

Case Management for Youth and Transition Age Youth

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

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

In FY20, a total of 41 youth were served through this project. Demographic data on youth participants is outlined below:

CLIENT DEMOGRAPHICS N=41*		
Client Gender	*Number Served*	*% of total*
Male	17	41%
Female	16	39%
Transgender	7	17%
Declined to answer or Unknown	1	2%
Race/Ethnicity		
Client Race/Ethnicity	*Number Served*	*% of total*
American Indian or Alaska Native	1	2%
African American	28	44%
Asian Pacific Islander	5	12%
Caucasian	6	15%
Latino/a/x	6	15%
More than one Race	5	12%
Age Category		
Client Age Category	*Number Served*	*% of total*
Transition Age Youth	41	100%
Sexual Orientation		
Gay or Lesbian	9	22%
Heterosexual or Straight	20	49%
Bi-Sexual	11	27%
Other	1	2%

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

Of the 41 youth participants:

- 10 were referred to and linked to specialty mental health services (off site therapists);

- 17 were referred to primary care/physical health care and 6 were able to make their appointments;
- 25 worked on their SMART goals at the YSA facility, and
- 1 was linked to housing.

During the pandemic, outreach was conducted through social media and by reaching out to area service providers. While finding new enrollments proved to be a challenge, there were successes in setting up systems and procedures that will be used going forward.

Successes included training staff and youth participants on the use of Zoom for remote conferencing for services, meetings, workshops and laying the groundwork for a larger referral system through outreach and collaborations with the Berkeley schools, County's department of Juvenile Probation, and community based agencies who work with youth. The program was also successful at expanding the use of social media for communications and event announcements. YSA maintains active accounts on Facebook (3,093 followers), Twitter (283 followers), and Instagram (1, 694 followers) that provide information and photographs about services, projects and events.

Through this program youth historically build community and social supports, as they participate in services and projects with other participants. YSA employs Youth Leaders who are adept at creating a welcoming and supportive community. This in-person relationship building was a challenge during the pandemic.

Albany Community Resource Center – Albany CARES

Through previously approved MHSA plans the City of Berkeley allocated funding to support the City of Albany Community Resource Center. The Albany Community Resource Center was initially a short-term pilot project that offered residents a one-stop venue to learn about and receive referrals and resources to assist with a range of social and economic needs. The Community Resource Center was staffed by a half-time Community Resource Center Director. In early 2018, due to a loss of staffing the Albany Community Resource Center closed prematurely. In March 2018, the Albany City Council authorized the development of a Human Services Resource Linkage Program which was subsequently named "Albany CARES."

The Albany CARES program operated through FY20 providing outreach, assistance and referrals to resources and services that supported Albany's most vulnerable and low-income residents. Up through mid-March 2020 (when services were transitioned to tele-health and Zoom) , the programs drop-in hours provided a welcoming environment where services were tailored to each client's unique needs.

In FY20, 337 individuals received services or supports through this program. Demographics on those served were as follows:

CLIENT DEMOGRAPHICS N=337*		
Client Gender	*Number Served*	*Percent of Total Number Served*
Male	121	36%
Female	214	64%
Non-binary	1	<1%

Transgender	1	<1%
Client Race/Ethnicity		
Client Race/Ethnicity	*Number Served*	*Percent of Total Number Served*
African American	33	10%
Asian	31	9%
Caucasian	93	28%
Latino/a/x	22	7%
Other	23	7%
Declined to Answer (or Unknown)	135	40%
Age Category		
Client Age in Years	*Number Served*	*Percent of Total Number Served*
Under 18	6	2%
18-25	4	1%
26-39	28	8%
40-49	21	6%
50-61	28	8%
62-79	103	31%
80+	21	6%
Declined to Answer (or Unknown)	126	38%

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

Albany CARES has been responsive to the needs of vulnerable individuals and families. The number of individuals assisted by this program increased steadily. The program enabled individuals to be connected to resources that they wouldn't normally access. Many individuals made a connection with a mental health professional during the Drop-In hours, which was essential, as a lot of individuals will not follow-up on a mental health referral or appointment.

A Berkeley Mental Health clinician supported the work at Albany Cares providing counseling on-site or by phone to individuals, assisting with a referral to BMH Crisis Services and providing consultation to the Program Director. This support provided critical connections on-site to mental health services for individuals which otherwise, would not have been possible. Having support from BMH allowed critical connections on-site to be made to mental health services that otherwise would have not been possible.

The successes of Albany CARES created its own challenges. The number of clients presenting during Drop In hours, was unpredictable. Approximately 25% of individuals needed assistance beyond the services that could be provided, during Drop In hours. The Program Director spent time outside of the regular hours doing research and gathering information for specific clients, and also finding agencies that could assist with specific needs.

The pandemic also created program challenges as drop in hours came to a halt during the 4th quarter of the Fiscal year. During this time, the Program Director continued to assist and make referrals via phone, and email and conducted Zoom meetings. As the City of Albany transitioned to essential services during the pandemic, the Albany CARES phone line was promoted extensively as the City's hotline for information on social/human services and COVID related services.

Beginning in FY21, the City of Albany was funded under Alameda County's MHSA Plan.

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 two separate RFP processes were executed to find a community partner that the Division could contract with who would provide these services, however the Division was unable to secure a Contractor. As a result, during the Division will be re-assessing the best way to provide additional services and supports for the API population.

Results Based Accountability Evaluation

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

In response to this input, BMH proposed through the previously approved MHSA FY19 Annual Update to allocate CSS System Development funds for a Consultant who will conduct an evaluation on all BMH programs across the system utilizing the “Results Based Accountability” (RBA) framework. The RBA framework will measure how much was done, how well it was done, and whether individuals are better off as a result of the services they received. In FY19 a competitive RFP process was executed, and Resource Development Associates (RDA) was the chosen consultant. In FY21 RDA began working with BMH staff to implement the RBA evaluation framework across the mental health system. Updates on this evaluation will be reported on in future MHSA Plans and Updates.

Counseling Services at Senior Centers

Older Adults who only have Medicare insurance currently have great difficulty accessing mental health services, despite consistent input on the need for mental health services for this population. In an effort to increase mental health services and supports for older adults, the Division allocated up to $150,000 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 Oder Adults. In FY21 a Request For Proposal (RFP) was issued and the Wright Institute, was the chosen contractor to implement these services.

PREVENTION & EARLY INTERVENTION (PEI)

The original City of Berkeley Prevention & Early Intervention (PEI) Plan was approved by DMH in April 2009. Subsequent Plan Updates were approved in October 2010, April 2011, May 2013, May 2014, May 2015, June 2016, January 2017, July 2017, October 2018, July 2019 and December 2020. From the original approved PEI Plan and/or through Plan Updates, the City of Berkeley has provided the following services through this funding component:

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

PEI Reporting Requirements

Per MHSA PEI regulations, all PEI funded programs must collect specified state identified outcome measures and detailed demographic information. MHSA also requires Evaluation Reports for PEI funded programs. Beginning in FY19, PEI Evaluations were required to be included in each MHSA Annual Update or Three Year Plan. See Appendix A for the Fiscal Year 2020 Prevention & Early Intervention 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. Beginning in FY18, this included community agency programs funded through the MHSA Prevention & Early Intervention Community Education & Supports program. Through this initiative the Department worked with each contractor to envision, clarify and develop measures on the outcomes and results each program is seeking to achieve, and used a rigorous framework to begin measuring and enhancing progress towards these results. Page 55 of this Annual Update provides an aggregated summary of some of the results of this initiative. The full report on the Impact Berkeley PEI program results can be accessed on the MHSA website: MHSA Plans and Updates - City of Berkeley, CA

New PEI Regulations

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

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

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

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

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

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

CITY OF BERKELEY PEI PROGRAMS	PEI PRIORITIES	Approximate Projected Funding Per Priority
• Be A Star • Community Based Child & Youth Risk Prevention Program • Supportive Schools	Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.	$227,267
• High School Youth Prevention Project • Mental Health Peer Mentor Program • Dynamic Mindfulness Program • 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. Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis	$851,368 $851,368
• Community Education & Supports	Culturally competent and linguistically appropriate prevention and intervention; Youth Engagement and Outreach Strategies that target secondary school and transition age youth; Strategies targeting the mental health needs of older adults.	$300,000 $32,046 $32,046

Programs and services funded with PEI funds are as follows:

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, eight out of ten local PEI programs provide services for children and youth, 5 of which are in the Berkeley Unified School District (BUSD). Programs are as follows: Behavioral-Emotional Assessment, Screening, Treatment and Referral (BE A STAR); Community-Based Child/Youth Risk Prevention Program; Supportive Schools Project; Mental Emotional Education Team (MEET); Dynamic Mindfulness (DMIND); African American Success Project; High School Youth Prevention Project, and the TAY Trauma Support Project. Additionally, from FY11 through FY20, the City of Berkeley utilized a portion of PEI funds to provide services for children, youth and TAY in the Albany Unified School District, through the Albany Trauma Project.

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

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

In FY20, there were vacancies in staff. A short time after an MHSA program staff was hired, they were deployed to the City's Emergency Operations Center to support work around the pandemic. A minimal level of support enabled continuity with the Pediatric and Alameda County Help Me Grow Collaborative partners to this program. A total of 1,538 screenings were able to be conducted through the area Pediatric partners: Due to the limited program support, the demographic information on individuals served through other programs, in FY20 is not available.

Community-Based Child & Youth Risk Prevention Program

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

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

In FY20, the following services were provided:

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

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

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

Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	67%
Primary Language	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Gender: Assigned sex at birth	
Declined to Answer (or Unknown)	100%
Current Gender Identity	
Declined to Answer (or Unknown)	100%

A major challenge in FY20 was the Shelter in Place that closed the school down for about 3 months. Another challenge was that the Mental Health Consultant and teachers have limited time out of the classroom to create visuals and prompts. Lastly, in general challenges occur when teachers and the Mental Health Consultant attempt to address developmental and or social – emotional needs of a particular student and the family is not ready to accept services. The teachers and the Mental Health Consultant are then limited on how to proceed or support the child in the classroom if the family is not willing to access internal and/or external services/resources.

Berkeley Unified School District PEI Funded Children/Youth Programs

Since the very first MHSA PEI Plan the City of Berkeley has provided MHSA funding to Berkeley Unified School District (BUSD) to implement mental services and supports for children and youth. Currently, MHSA PEI funds, support five programs that provide school-based mental health services and supports for BUSD students. Descriptions of each program and FY20 data are outlined below:

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.

In FY20, Early Intervention Services were provided at all eleven BUSD elementary schools. Funding was allocated at each elementary school to provide early intervention services. BUSD sub-contracted with local agencies to provide early intervention services based upon the standard of evidence-based practices. Bay Area Community Resources (BACR), Child Therapy Institute (CTI), and Lifelong Medical (Lifelong) were subcontracted to provide services at BUSD elementary schools. Additionally, a counselor was provided to support two elementary schools. As a result of

the pandemic, schools finished the year in distance learning. During the academic year, supports were initially provided in-person, before shifting to online. It was reported that the providing remote therapy sessions had its challenges. Supports for each school per each service provider, and numbers served in FY20 were as follows:

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

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

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

Data provided by BUSD, on 268 students that were served from this project, is outlined below:

PARTICIPANT DEMOGRAPHICS N= 268	
Age Group	
0-15 (Children/Youth)	100%
Race	
American Indian or Alaska Native	7%
Asian	4%

Black or African American	34%
Native Hawaiian/Pacific Islander	1%
White	24%
More than one Race	19%
Declined to Answer (or Unknown)	11%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican/Mexican-American/Chicano	22%
Declined to Answer (or Unknown)	5%
Ethnicity: Non-Hispanic or Non- Latino/Latina/Latinx	
Asian Indian/South Asian	1%
Filipino	<1%
More than one Ethnicity	10%
Declined to Answer (or Unknown)	62%
Primary Language Used	
English	13%
Spanish	3%
Other	<1%
Declined to Answer (or Unknown)	84%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)	6%
No Disability	11%
Declined to Answer (or Unknown)	83%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	55%
Female	45%
Current Gender Identity	
Male	55%
Female	45%

Dynamic Mindfulness Program (DMind)

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

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

Due to the pandemic, in FY20 all supports were shifted to online in the second half of the school year. 380 students participated in DMind during the reporting timeframe. Demographics on individuals served were not provided by BUSD.

Mental and Emotional Education Team (MEET)

Through the previously approved MHSA FY19 Annual Update BMH provides PEI funds to support the BUSD MEET Program. This program implements a peer-to-peer mental health education curriculum to 9th graders and an internship program for a cohort of high school students to serve as peers to their fellow students. The goals of the program are to increase student awareness of common mental health difficulties, resources, and healthy coping and intervention skills. Through this program, students are trained by a licensed BUSD clinician to conduct class presentations covering common mental health disorders, on and off campus resources, and basic coping and intervention skills.

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

In FY20, this program was not in operation.

African American Success Project

The African American Success Project (AASP) was first implemented in FY19 in four Berkeley Unified School District Schools (King, Longfellow, Willard and Berkeley High School). Closely aligned with the work of Berkeley's 2020 Vision, the AASP works with African American youth and

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

Following FY19, the project was only going to be implemented at Longfellow. A second key learning was that services could be strengthened if they were integrated into the school day through a class that African American students could elect to take that would provide a safe space to focus on ongoing social and emotional development, skill-building, habits and mindsets that enable self-regulation, interpersonal skills, and perseverance and resilience. The class would be facilitated by a Counselor/Instructor who would follow-up with students in one-on-one counseling sessions on issues of concern that are raised in class and would provide referrals to mental health services and supports as needed. To support the implementation of this additional component, through the FY20 Annual Update the Division allocated PEI funds to support this project.

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

During the FY20 school year students participated/were enrolled in Umoja- a daily elective class offered through the African American Success Project (AASP), at Longfellow Middle School. Umoja provides African American students a safe affinity space to explore their cultural heritage and identity, while building positive peer relationships and establishing relational trust with adults. Umoja provides an ongoing focus on social and emotional development, including building skills, habits and mindsets that enable self-regulation, interpersonal skills, perseverance and resilience.

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

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

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

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

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

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

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

PARTICIPANT DEMOGRAPHICS N=23	
Age Groups	
Children/Youth (0-15)	100%
Race	
Black or African American	74%
More than one Race	26%
Ethnicity: Hispanic or Latino/Latina/Latinx	
More than one Ethnicity	17%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Black/African American	74%
More than one ethnicity	4%
Other	4%
Declined to Answer (or Unknown)	1%
Primary Language	
English	99%
Other	1%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Other	43%

Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	70%
Female	30%
Current Gender Identity	
Male	70%
Female	30%

High School Youth Prevention Program

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

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

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

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

PARTICIPANT DEMOGRAPHICS N=801	
Age Groups	
Youth 14-18 Years	100%
Race	
Asian	6%
Black or African American	19%
White	36%
More than one Race	20%
Declined to Answer (or Unknown)	3%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Declined to Answer (or Unknown)	16%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	84%
Primary Language	
Declined to Answer (or Unknown)	100%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	30%
Female	70%
Current Gender Identity	
Male	30%
Female	68%
Students who identified as either transgender, gender queer, or gender non-conforming	2%

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

Results on a survey from the Alameda County School Health Center Evaluation for Berkeley High School and B-Tech students was as follows:

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

<u>Successes</u>

- Applied for and awarded SB-82 Crisis Triage Grant in order to fund 1.0 FTE Behavioral Health Clinician II position, which enabled more consistent and reliable provision of assessment and crisis assessment services;
- In response to COVID-19, shelter in place restrictions, and transition to virtual learning, the Mental Health team developed and implemented a "Mental Health Warm Line" for students, parents, and school staff;
- Provided ongoing individual Mental Health remote tele-health services from March through June 2020 for all existing Health Center clients;
- Increased awareness and the de-stigmatization of services;
- Increased access to services for historically marginalized student communities;
- Increased BHS campus presence through several tabling events, presentations, and gatherings with students, families, and school staff;
- Successful internal/external linkages to ongoing care;
- Ongoing collaborative partnerships with school administration, teachers, and school-based programs;
- Diverse/eclectic staff backgrounds supported embedding foundational framework of cultural humility across clinical practice; and
- Maintained a 100% staff retention.

<u>Challenges</u>

- Student need continued to exceed clinician/team capacity during the months where in-person learning took place (August 2019 through mid-March 2020);
- Difficulties with external linkages due to fractured nature of larger Mental Health healthcare systems, insurance barriers, etc.;

- Limited staff time to promote prevention and early intervention services due to high volume of Tier 3 therapy services;
- Transition of in-person services and workflows to remote tele-health services and workflows due to the pandemic;
- Utilization of new technology to support remote tele-health services;
- Decline in accessibility and utilization of Mental Health services due to the pandemic;
- Impact of the pandemic on staff;
- Vicarious trauma for staff due to the nature and content of the therapeutic work, high volume, and impact of the pandemic; and
- Limited staff time for team meetings to discuss/plan/review administrative and programmatic considerations.

Adult and Older Adult and Additional TAY PEI Funded Programs

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; Asian Pacific Islanders; Latino/a/x; LGBTQIA+; TAY; and Senior Citizens. All services are conducted through area community-based organizations. In FY20 each of the Community Education & Supports program contractors participated in the HHCS Results-Based Accountability (RBA) Evaluation. RBA implementation results were presented in an aggregated format aggregated across all programs as follows:

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

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

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

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

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

Albany Trauma Project

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

Adult Support Groups: This project used to implement outreach and engagement activities and support groups to Latino immigrant adults dealing with trauma issues, who live and work the backstretch of Golden Gate Field's race track as groomers; exercise jockeys and caretakers of the horses. Over the years this project has migrated to more of a one-on-one engagement project to support individuals in need, with occasional cultural and strength building group activities.

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

In FY20, 18 individuals received supports through one-on-one engagement sessions. Services were not able to continue between March and June due to the pandemic.

Children/Youth Support Groups: Young children and high school youth experiencing trauma are unlikely to seek services at traditional mental health clinics. Schools are an essential vehicle

of treatment for trauma exposed individuals and their families. By aiming psycho-educational interventions for elementary age children and high school youth, it is possible to introduce youth and their families to information about trauma, coping mechanisms, and to combat the isolation that trauma brings.

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

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

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

In FY20, nine support groups were provided to a total of ten participants. Each group met for 1-2 hours in duration. There were seven referrals for additional mental health services, four for Social Services, and one referral to an unspecified service. Thirty-five outreach activities were also conducted. School ended abruptly in mid-March in response to the pandemic. Students who had participated in individual counseling continued to receive weekly services over Zoom.

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

In FY20, twenty-nine support group sessions were held at Albany high School, and served a total of 29 students. Students were assigned to three groups based on racial or ethnic identity: Latinx, African-American, and Asian-American. This was done in order to help promote connection, identification and group cohesion. Students that participated in the trauma groups at Albany High School were initially recommended by counselors, mental health coordinators, or administrators who believed that these selected students may have experienced trauma in their lives. These students were then interviewed individually to assess and determine if they wished to participate in the groups. Each group met weekly for one hour, and were able to continue by Zoom when schools were abruptly closed in March due to the pandemic.

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

PARTICIPANT DEMOGRAPHICS N=65*			
Age Group	Golden Gate Fields Racetrack Supports	Elementary Support Groups	High School Support Groups
Percent of total participants served	28%	15%	57%
0-15		90%	
16-25	6%	10%	100%
26-59	56%		
60+	39%		
Race			
Asian	6%		24%
Black or African American		50%	27%
White	56%	20%	41%
Other	39%	30%	
More than one Race			8%
Ethnicity: Hispanic or Latino/Latina/Latinx			
Mexican/Mexican-American/Chicano	94%	10%	32%
Central American			3%
Puerto Rican		10%	5%

Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	Golden Gate Fields Racetrack Supports	Elementary School Support Groups	High School Support Groups
Asian Indian/South Asian		10%	3%
Chinese			14%
Filipino	6%		5%
Japanese			3%
More than one Ethnicity			35%
Declined to Answer (or Unknown)		70%	
Primary Language Used			
English	17%	100%	100%
Spanish	83%		
Sexual Orientation			
Gay or Lesbian			3%
Heterosexual or Straight	100%	100%	95%
Bisexual			3%
Disability			
Other Disability	22%		
No Disability	78%	30%	100%
Declined to Answer (or Unknown)		70%	
Veterans Status			
No	100%	100%	100%
Gender: Assigned sex at birth			
Male	83%	50%	51%
Female	17%	50%	49%
Current Gender Identity			
Male	83%	50%	51%
Female	17%	50%	49%

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

Beginning in FY21, Albany services will be funded through Alameda County MHSA Funds.

Transition Age Youth Trauma Support Project

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

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

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

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

Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	35%
Asian Indian/South Asian	1%
Chinese	1%
Eastern European	5%
European	15%
Filipino	3%
More than one Ethnicity	17%
Declined to Answer (or Unknown)	2%
Primary Language Used	
English	86%
Spanish	14%
Sexual Orientation	
Gay or Lesbian	8%
Heterosexual or Straight	81%
Bisexual	10%
Disability Status	
Mental (not mental health)	50%
Chronic Health Condition	11%
Other Disability	20%
No Disability	16%
Declined to Answer (or Unknown)	3%
Veteran Status	
Yes	1%
No	99%
Gender: Assigned sex at birth	
Male	33%
Female	26%
Declined to Answer (or Unknown)	41%
Current Gender Identity	
Male	59%
Female	36%

Transgender	2%
Other	2%

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

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

Living Well Project

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

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

In FY20, 63 Living Well workshops were conducted. Each Living Well Workshop series included the following sessions: Orientation; Goal Setting; Problem Solving; Healthy Reactions; Beating the Blues (Depression and Moods); Healthy Communication; Seeking Information; Physical Activity; Eating Well (Nutrition); Advocacy (Self and Systems Change); and Maintenance. Topics of Grief and Loss, Depression, Retirement, and Senior Invisibility were also incorporated into the program. In all 59 Senior Citizens participated in the Living Well Workshops. Demographics of Workshop participants are outlined below:

PARTICIPANT DEMOGRAPHICS N=59*	
Age Groups	
26-59 (Adult)	2%
Age 60+ (Older Adult)	97%

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

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

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

During the reporting timeframe 5 outreach and informational events were conducted reaching 84 individuals, with 235 individuals receiving further engagement services. Services were moved to virtual format providing Tele-workshops and Tele-support services to accommodate the pandemic. There were 653 referrals for additional services and supports. The number and type of referrals was as follows: 115 Mental Health; 147 Physical Health; 112 Social Services; 58 Housing; 221 other unspecified services. A total of 39% of program participants completed a Living Well Workshop Series. Feedback per participant self-report was as follows:

- 100% reported they felt satisfied with the workshops;
- 98% indicated an improvement in feeling satisfied in general;
- 98% had increased feelings of social supports;
- 100% felt prepared to make positive changes; and
- 88% reported they felt less overwhelmed and helpless.

Harnessing Hope Project

Implemented through GOALS for Women this project provides community-based, culturally competent, outreach and support services for African Americans residing in the South and West Berkeley neighborhoods who have experienced traumatic life events including racism and socioeconomic oppression and have unmet mental health support needs. The primary goals of the project are to normalize stress responses and empower families through psycho-education, consciousness raising, strength-based coping skills, and supportive services through the following:

Outreach through community presentations and “Mobile Tenting”; one-on-one supportive engagement services; screening and assessment; psycho-education; family education; support groups such as “Kitchen Table Talk groups (non-stigmatizing, culturally responsive, peer centered groups) and “Just Like Sunday Dinners” (a space for African Americans from all generations to come together to gain supports from one another); workshops and classes; mental health referrals and community linkages; peer counseling and support. A key component of this project is to train and mentor community leaders to become Peer Facilitators of Kitchen Table Talk and Just Like Sunday Dinner groups. This project serves approximately 50-130 individuals a year.
PEI Goals: The goal of this program is to address and promote recovery and related functional outcomes for a mental illness early in its emergence including the prevention of suicide.
In FY20, 22 individuals were served through this project. Demographics on individuals served were as follows:

PARTICIPANT DEMOGRAPHICS N=22*	
Age Groups	
0-15 (Children/Youth)	5%
16-25 (Transition Age Youth)	18%
26-59 (Adult)	73%
Ages 60+ (Older Adult)	5%
Race	
Asian	14%
Black or African American	82%
Other	5%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	77%
Asian Indian/South Asian	9%
Vietnamese	5%
More than one Ethnicity	5%
Declined to Answer (or Unknown)	5%
Primary Language Used	
English	100%
Sexual Orientation	
Heterosexual or Straight	95%
Questioning or Unsure	5%

Disability	
Chronic Health Condition	18%
No Disability	82%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Female	100%
Current Gender Identity	
Female	100%

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

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

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

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

MHSA funded services did not continue with GOALS in FY21, as the program was no longer in operation. A Request For Proposal (RFP) process was executed in April 2021 for these services. In FY22, Trauma Support Services for African Americans will be provided through the chosen vendor of this RFP process.

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

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

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

Puerto Rican	1%
South American	1%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	3%
Asian Indian/South Asian	3%
Chinese	6%
Eastern European	10%
European	27%
Filipino	1%
Japanese	1%
Korean	1%
Middle Eastern	4%
Vietnamese	1%
More than one Ethnicity	7%
Other	2%
Declined to Answer (or Unknown)	24%
Primary Language Used	
English	98%
Spanish	1%
Mandarin	1%
Sexual Orientation	
Gay or Lesbian	23%
Heterosexual or Straight	7%
Bisexual	25%
Questioning or Unsure	2%
Queer	25%
Other	17%

Declined to Answer (or Unknown)	3%
Disability	
Difficulty Seeing	2%
Difficulty Hearing or Having Speech Understood	6%
Mental (not Mental Health)	8%
Physical/Mobility Disability	6%
Chronic Health Condition	9%
Other Disability	1%
No Disability	64%
Declined to Answer (or Unknown)	4%
Veteran Status	
Yes	1%
No	99%
Gender: Assigned sex at birth	
Male	26%
Female	50%
Declined to Answer (or Unknown)	24%
Current Gender Identity	
Male	12%
Female	34%
Transgender	27%
Genderqueer	8%
Questioning or Unsure	3%
Other	13%
Declined to Answer (or Unknown)	4%

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

During the reporting timeframe 25 new Peer Facilitators were trained. The offering of Skills Building Workshops that included trainings on: Nonviolent Communication; Crisis Intervention; and Implicit Bias as it Relates to Race and workshops were provided to 57 Peer Facilitator participants. Services were adjusted to accommodate for the pandemic and Support Group and other services were able to continue virtually on the Zoom platform. There were 93 referrals for additional services and supports. The number and type of referrals was as follows: 45 Mental Health; 11 Physical Health; 3 Housing; 34 other unspecified services. To assess the project services, a self-administered Peer Support Group Survey was distributed to all peer group members. Survey results were as follows:

- 92% indicated they would recommend the organization to a friend or family member;
- 88% felt like staff and facilitators were sensitive to their cultural background;
- 84% reported they deal more effectively with daily problems;
- 76% indicated they have trusted people they can turn to for help;
- 76% felt like they belong in their community.

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

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.

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

PARTICIPANT DEMOGRAPHICS N= 22*	
Age Groups	
26-59 (Adult)	18%
Ages 60+ (Older Adult)	36%
Declined to Answer (0r Unknown)	46%
Race	
American Indian or Alaska Native	9%
Asian	14%
Black or African American	14%
Native Hawaiian or other Pacific Islander	9%
White	32%
Other	9%
Declined to Answer (or Unknown)	13%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican	4%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	96%
Primary Language Used	
English	41%
Declined to Answer (or Unknown)	59%
Sexual Orientation	
Gay or Lesbian	4%
Heterosexual or Straight	27%
Bisexual	4%
Queer	4%
Questionning	9%
Declined to Answer (or Unknown)	52%
Disability	
Difficulty Seeing	9%
Communication (other)	9%
Mental Domain not including a mental illness	9%
Physical Mobility domain	18%

Chronic Health Condition	9%
Declined to Answer (or Unknown)	46%
Veteran Status	
Declined to Answer (or Unknown)	100%
Gender: Assigned sex at birth	
Female	41%
Declined to Answer (or Unknown)	59%
Current Gender Identity	
Female	41%
Declined to Answer (or Unknown)	59%

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

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

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

Homeless Outreach and Treatment Team (HOTT)

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

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

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

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

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

PARTICIPANT DEMOGRAPHICS N= 616	
Age Groups	
16-25 (Transition Age Youth)	2%
26-59 (Adult)	36%
Ages 60+ (Older Adult)	16%
Declined to Answer (or Unknown)	46%
Race	
Asian	4%
Black or African American	36%
White	45%
More than one Race	1%
Other	7%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Hispanic	7%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	100%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%

Veteran Status	
Declined to Answer (or Unknown)	100%
Gender: Assigned sex at birth	
Male	61%
Female	37%
Declined to Answer (or Unknown)	2%
Current Gender Identity	
Male	61%
Female	37%
Declined to Answer (or Unknown)	2%

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

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

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

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

transferred with a pre-existing permanent career status. This resulted in the exit of two staff during this time period who found other employment.

The RDA Homeless Outreach and Treatment Team Final Evaluation Report which covered the timeframe from January 2018 – February 2020, showed the following outcomes:

- A total of 4,435 total encounters were conducted with individuals who were either enrolled or non-enrolled in the program, averaging 171 encounters per month;
- The number of contacts provided in-person in the field was 73%, while 26% were provided by phone;
- A total of 81% of HOTT encounters were with clients who were enrolled in the program;
- Enrolled clients had an average of 20 total encounters with HOTT staff, with an average of 4 encounters per month;
- During encounters, HOTT staff provided at least 1,845 material supports and services (including food, transportation or BART or bus passes, Hygiene Kits, Emergency Housing Vouchers, Blankets, etc.); to respond to clients' immediate and longer-term needs;
- During 488 encounters, HOTT provided emergency or temporary housing vouchers (e.g., for a motel) to individuals who required immediate shelter;
- Approximately three-quarters of enrolled clients (75%) and over a third of non-enrolled individuals (38%) were referred or connected to housing support services;
- In addition to connecting individuals to housing services, HOTT also connected individuals to other supportive services to help reduce or address initial barriers to obtaining housing;
- Approximately 27% of HOTT clients and 6% of non-enrolled individuals successfully enrolled in social service benefits. In comparison, only 9% of HOTT clients and 1% of non-enrolled clients ultimately enrolled in mental health services;
- Over 58% of all HOTT clients, and 9% of non-enrolled individuals obtained emergency or temporary housing (e.g., motel or shelter) at some point during their engagement with HOTT. In comparison, 12% of HOTT clients and 1% of non-enrolled individuals obtained permanent housing;
- To assess changes in self-sufficiency, HOTT staff completed a Client Self-Sufficiency Matrix (SSM) on enrolled clients at program intake, on a quarterly basis after program enrollment, and/or at program discharge. Overall, HOTT clients' SSM scores remained relatively unchanged from baseline to follow-up.

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

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

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

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

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

California Mental Health Services Authority (CalMHSA) PEI Statewide Projects

In 2009, California's counties formed the California Mental Health Services Authority (CalMHSA) as a Joint Powers Authority to implement PEI statewide program initiatives. With an approved combined funding level of $40 million per year for four years during the timeframe of 2011 through 2015, CalMHSA implemented statewide initiatives in the following areas: Suicide Prevention, Stigma and Discrimination Reduction, and Student Mental Health. Following 2015, funding for PEI Statewide projects was generated through pooled contributions from individual counties. Contributing counties are members of a CalMHSA board that provides direction into the types of initiatives that are implemented. In order to continue to sustain programming, CalMHSA previously asked counties to allocate 4% of their annual local PEI allocation each year from FY2018 – FY2020 to these statewide initiatives. In the City of Berkeley, this has varied from year to year to between $42,000 - $66,000 depending on the amount of PEI revenue received. Through the previously approved Three Year Plan the City of Berkeley allocated PEI funds for one year towards this statewide initiative, and for the remaining two years, elected to assess on an annual basis whether or not to continue to allocate funds to this initiative.

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

INNOVATIONS (INN)

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

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

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

In May 2016, the second MHSA INN Plan was approved by the MHSOAC. This plan implemented a Trauma Informed Care project in BUSD for students, educators, and school staff**.** An update to this plan was subsequently approved by the MHSOAC in December 2018 which added funds to the project and switched the initial target population from BUSD students and staff to children, teachers and parents YMCA Head Start sites in Berkeley. In September 2018, BMH also received approval from the MHSOAC for a third INN project that would allocate funds to join the Technology Suite Multi-County Collaborative.

INN Reporting Requirements

Per MHSA INN regulations, all INN funded programs have to collect additional state identified outcome measures and detailed demographic information. Beginning in FY19, INN Evaluations were required to be included in each MHSA Annual Update or Three Year Plan. See Appendix B for the Fiscal Year 2019 Innovations Annual Evaluation Report.

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

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

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

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

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

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

The learning objectives of this project are:

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

In FY20, 197 children received services through this program. An evaluation was conducted during the reporting timeframe by HTA. Below are demographics of individuals impacted by this program. The full evaluation is attached to this report.

PARTICIPANT DEMOGRAPHICS N=197	
Age Groups	
0-15 (Children)	100%
Race	
American Indian or Alaska Native	3%
Asian	4%
Black or African American	47%
White	23%
Other	9%
More than one Race	13%
Declined to Answer (or Unknown)	1%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Caribbean	<1%
Central American	<1%
Mexican/Mexican-American/Chicano	27%
Puerto Rican	<1%
South American	3%
More than one ethnicity	9%
Declined to Answer (or Unknown)	<1%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	37%
Asian Indian/south Asian	2%
Cambodian	1%
Chinese	1%
Eastern European	<1%
European	1%
Japanese	<1%
Middle Eastern	1%
Other	7%
More than one Ethnicity	4%
Declined to Answer (or Unknown)	8%
Primary Language	
English	60%
Spanish	22%
Urdu	1%
Arabic	2%

French	1%
Berber	1%
Punjabi	<1%
Amharic	<1%
Tigrina	<1%
Chinese/Mandarin	<1%
Nepalese	<1%
Declined to Answer (or Unknown)	1%
Disability	
Communication: other, speech/language impairment	10%
Mental domain	1%
Chronic health condition	<1%
Other	2%
No Disability	87%
Gender	
Female	47%
Male	53%

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

Since plan approval the City of Berkeley has been working both internally and with the State collaborative on various aspects of this project to prepare for citywide implementation. In keeping with changes made via the Technology Suite multi-county collaborative, the new name of this project has been changed to “Help@Hand”. As a result of a competitive recruitment process that was conducted in FY20, Resource Development Associates (RDA) was hired to conduct the Project Coordination work on this project. Pre-work for the implementation of this project is currently underway. It is envisioned that the mental health apps will be locally available in early FY22 in Berkeley.

New INN Project

In FY20, the community program planning process for the next round of INN funded Projects was conducted by Resource Development Associates (RDA), who was chosen through a competitive recruitment process to conduct this work. Based on the community input received around the need for additional services and supports for homeless individuals who have mental health needs, the potential new INN project would pilot a Mobile Wellness Center at Homeless encampments in Berkeley.

This project is currently under development. It is envisioned that the project would be implemented for a five year period and have a projected budget amount of a little over 2.8 million, with approximately $560,000 of estimated expenditures in FY22, following project approval. The City is currently working with staff at the MHSOAC on a final draft plan, that will be released to the public for a 30-Day Public Review, and Public Hearing prior to going to the City Council and the MHSOAC for approval.

WORKFORCE, EDUCATION & TRAINING (WET)

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

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

WET programs were funded for an initial period through FY18 and FY19, and per the local MHSA AB114 Reversion Expenditure Plan one WET program (the Graduate Level Training Stipend Program) was extended through FY20.

Greater Bay Area Workforce, Education & Training Regional Partnership

The Office of Statewide Health Planning and Development (OSHPD) is allocating $40 million in Workforce, Education and Training funds for Regional Partnerships across the state for mental health workforce strategies that will be implemented in FY20-FY25. Each Regional Partnership will be able to decide which strategies they want to allocate funds for to benefit the local area. Strategies include:

Pipeline Development: Introduce the public mental health system to kindergarten through 12th grades, community colleges, and universities. Ensure that these programs incorporate developmentally appropriate concepts of mental health needs, self-care, and de-stigmatization and target resources at educational institutions with underrepresented communities. The Regional Partnerships would conduct pipeline activities to identify students as potential scholarship and stipend candidates.

Undergraduate College and University Scholarships: Provide scholarships to undergraduate students in exchange for service learning received in a public mental health system.

Clinical Master and Doctoral Graduate Education Stipends: This program would provide funding for post-graduate clinical master and doctoral education service performed in a local public mental health system.

Loan Repayment Program: Provide educational loan repayment assistance to public mental health system professionals that the local jurisdiction identifies as serving in hard-to-fill and hard-to-retain positions.

Retention: Increase the continued employment of public mental health system personnel identified as high priority by county behavioral health agencies, by increasing and enhancing evidence-based and community-identified practices.

The Division participated in meetings with representatives from the other counties in the Greater Bay Area Regional Partnership. All participating counties chose to allocate these funds for the Loan Repayment program. This program will enable funds in the amount of approximately $12,000 to $15,000 to be made available to repay a portion of student loans for a given number of staff who are in hard-to-fill positions, in exchange for a number of years served in the Public Mental Health system.

OSHPD requested that each Regional Partnership contribute an additional portion of local funds towards this initiative. For the Bay Area Regional Partnership, the total amount of the contribution is $2.6 million, and the proposed contribution from Berkeley is $40,157. Through the previously approved Three Year Plan, the Division proposed to transfer CSS Funds to the WET funding component to participate in this initiative, 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."

It is envisioned that Berkeley will allocate these funds in FY22, to begin participating in the Loan Repayment Program.

A description of the only WET program that was in operation in FY20, and a report on data from that timeframe is outlined below:

Graduate Level Training Stipend Program

Per the original WET Plan, this program offered stipends to Psychologists, Social Workers, Marriage and Family Therapists and other counseling trainees and interns who have cultural and linguistic capabilities. Guidelines were developed and a system was implemented to recruit and provide incentives to those meeting criteria, thereby allowing BMH to attract a more culturally and linguistically diverse pool of graduate level trainees and interns. In FY21 this program provided stipends 5 counseling trainees and interns at BMH and the remaining WET

funds were expended. Funding for Graduate Level Training Stipends will continue through other, non-MHSA Mental Health funds.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

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

The Adult Clinic serves Berkeley's most at-risk and fragile population through crisis intervention, case management, individual/or group therapy, and psychiatric medication support, FSP/Intensive Case Management Teams, Clinical services, Mobile Crisis, and Homeless Outreach. In its previous condition, use of the Adult Clinic space was inefficient and inadequately aligned with MHSA goals, including that of creating welcoming spaces for client and family centered wellness and recovery programs and services. In addition to electrical, HVAC and other environmental upgrades, it was originally envisioned that CFTN funds would be used to re-configure shared work spaces to increase safety; improve clinical, wellness/recovery, support services, and administrative functions; and support the implementation of electronic health records and other emerging technologies. In FY18, renovation on the Adult Clinic was in the design and pre-construction phase. In FY19 construction on the Adult Clinic began and in FY21, the reconstruction of the Adult Clinic was completed. It is anticipated that staff will move back into the Adult Clinic and be re-opened for services in June 2021. The projected amount of remaining CFTN funding will be utilized in FY22 on a plumbing project in an adjacent property to the Adult Clinic where some staff and offices are located.

FY20 AVERAGE COST PER CLIENT*

*(Includes programs that utilized MHSA funds in FY20)

COMMUNITY SERVICES & SUPPORTS			
Program Name	**Approx. # of Clients**	**Cost**	**Average Cost Per Client**
Children and Youth Intensive Support Services FSP	28	$226,288	$8,082
TAY, Adult & Older Adult FSP	82	$1,546,727	$18,862
TAY Support Services	109	$122,856	$1,127
System Development (includes: Wellness Recovery Services; Family Support Services; Benefits Advocacy; Employment/Educational Services; Housing Services and Supports; Crisis Services; HOTT; TOT; TAY Case Management Services; Hearing Voices; Albany CARES; Berkeley Wellness Center)	2,441	$1,200,091	$492
PREVENTION & EARLY INTERVENTION			
Supportive Schools Program	268	$55,000	$205
Albany Trauma Project	65	$64,192	$988
Living Well Project	59	$32,046	$543
Harnessing Hope Project	22	$32,046	$1,457
LGBTQI Trauma Project	151	$32,046	$212
TAY Trauma Project	96	$32,046	$334
High School Youth Prevention Program	801	$506,825	$633
Homeless Outreach and Treatment Team	616	$156,672	$254
Child And Youth at Risk Project	54	$29,711	$550
Dynamic Mindfulness	380	$150,000	$395
African American Success Project	23	$81,250	$3,533
INNOVATION			
Trauma Informed Care Project	197	$138,651	$704

BUDGET NARRATIVE

The enclosed budget provides an update to the estimated revenue and expenditures that were projected for FY22 in the approved Three Year Plan. As with all MHSA Plans and Annual Updates, revenue and expenditures in this Annual Update are estimates.

The Division obtains financial projections from the state on the amount of MHSA revenue to be allocated in a given year. Projections received from the state last year, which were utilized to calculate MHSA revenue the City would receive in the three-year timeframe were included in the approved Three Year Plan. Financial projections last year were provided at a time of great uncertainty of the amount of revenue that would be generated during the pandemic, and were based on a projected downturn of revenue in the MHSA Fund. As has been reflected nationally regarding the wealth divide, there was an increase in MHSA revenue in FY21, and a 43% increase is projected in FY22 in the MHSA Fund. Additionally, the expenditure projections for FY21 in the approved Three Year Plan reflected the total costs of each program if it was fully operable. The actual expenditures in FY21 were less than what was projected, due to several factors including staff attrition and vacancies, and slower start-ups with new programs.

The savings from the FY21 expenditures, and the projected additional revenue in FY21 and FY22, will provide increased monies to support MHSA programs and services over the next couple of years. 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 FY23 Annual Update.

PROGRAM BUDGETS

1B

FY 2021/22 Mental Health Services Act Annual Update
Funding Summary

County: City of Berkeley Date: 5/24/21

	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 FY2021/22 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	6,310,561	1,885,708	1,387,243	40,157	189,599	
2. Estimated New FY2021/21 Funding	6,595,582	1,648,896	433,920			
3. Transfer in FY 2021/22[a/]						
4. Transfer Local Prudent Reserve in FY 2021/22						
5. Estimated Available Funding for FY 2021/22	12,906,143	3,534,604	1,821,163	40,157	189,599	
B. Estimated FY21/22 Expenditures	8,701,483	1,912,904	626,500	40,157	189,599	
G. Estimated FY21/22Fund Balance	4,204,660	1,621,700	1,194,663	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Unspent Local Prudent Reserve on June 30, 2021	1,237,629
2. Contributions to the Local Prudent Reserve in FY2021/22	0
3. Distributions from the Local Prudent Reserve in FY2021/22	0
4. Estimated Local Prudent Reserve balance on June 30, 2022	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 2021/22 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: City of Berkeley Date: 5/24/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. TAY, Adult & Older Adult FSP	2,689,827	2,689,827				
2. Children's FSP	680,239	680,239				
3. Homeless FSP	1,176,437	1,176,437				
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	456,040	456,040				
2. System Development, Wellness & Recovery	2,838,693	2,838,693				
3. Crisis Services	194,653	194,653				
4.						
5.						
6.						
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	665,594	665,594				
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	8,701,483	8,701,483	0	0	0	0
FSP Programs as Percent of Total	52.2%					

FY 2021/22 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: City of Berkeley Date: 5/24/21

	Fiscal Year 2021/22					
	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	258,184	258,184				
2. Social Inclusion	9,000	9,000				
3. African American Success Project	37,500	37,500				
4. CalMHSA	65,956	65,956				
5. Dynamic Mindfulness	71,250	71,250				
6. Mental Health Peer Education Program (MEET)	67,500	67,500				
7. Mental Health Promotion Campaign	100,000	100,000				
8.						
9.	0	0				
10.	0	0				
PEI Programs - Early Intervention						
11. High School Prevention Program	258,184	258,184				
12. African American Success Project	112,500	112,500				
13. BE A STAR	27,903	27,903				
14. Community Based Children & Youth Risk	34,364	34,364				
15. Community Education & Supports	364,092	364,092				
16. Dynamic Mindfulness	23,750	23,750				
17. Mental Health Peer Education Program (MEET)	22,500	22,500				
18. Supportive Schools	110,000	110,000				
19. Specialized Care Unit	68,000	68,000				
20.						
PEI Administration	282,221	282,221				
PEI Assigned Funds						
Total PEI Program Estimated Expenditures	1,912,904	1,912,904	0	0	0	0

FY 2021/22 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: City of Berkeley Date: 5/24/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Help@Hand - Technology Suite Project	66,500	66,500				
2. New INN Homeless Encampment Project	560,000	560,000				
3.						
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration						
Total INN Program Estimated Expenditures	626,500	626,500	0	0	0	0

FY 2021/22 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: City of Berkeley Date: 5/24/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Greater Bay Area Regional Partnership	40,157					
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	40,157	0	0	0	0	0

FY 2021/22 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: City of Berkeley Date: 5/24/21

	Fiscal Year 2021/22					
	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. 2636 MLK Jr. Way - Adult Clinic Office Repai	189,599	189,599				
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
CFTN Programs - Technological Needs Projects						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
CFTN Administration						
Total CFTN Program Estimated Expenditures	189,599	189,599				

APPENDIX A

Fiscal Year 2020

Prevention and Early Intervention

Annual Evaluation Report

City of Berkeley
Mental Health Services Act (MHSA)

Fiscal Year 2020
Prevention and Early Intervention
Annual Evaluation Report

WELLNESS • RECOVERY • RESILIENCE

1B

INTRODUCTION

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

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

Beginning in 2017, per MHSA State requirements, Mental Health jurisdictions must submit a Prevention and Early Intervention (PEI) Evaluation Report to the Mental Health Services Oversight and Accountability Commission (MHSOAC) on an annual basis. Additionally, beginning December 2018, a Three Year PEI Evaluation Report is due to the MHSOAC every three years. Regulations also require mental health jurisdictions to submit either a Three Year Evaluation Report or an Annual Evaluation Report to the State each fiscal year. 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 FY21, the Fiscal Year 2020 (FY20) PEI Annual Evaluation Report that covers data from FY20 is due.

This FY20 PEI Annual Evaluation Report provides descriptions of currently funded MHSA services, and reports on FY20 program and demographic data 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. Since FY18 this has included community agency programs funded through the MHSA Prevention & Early Intervention Community Education & Supports program. Through this initiative the Department worked with each contractor to envision, clarify and develop measures on the outcomes and results each program is seeking to achieve, and used a rigorous framework to begin measuring and enhancing progress towards these results. Page 28 of this Annual Evaluation Report provides an aggregated summary of some of the results of this initiative. The report on the results can be accessed on the MHSA website: MHSA Plans and Updates - City of Berkeley, CA

BACKGROUND

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

Key Community Mental Health Needs:

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

PEI Priority Populations:

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

- Children and Youth at Risk for School Failure – Due to unaddressed emotional and behavioral problems.
- Children and Youth at Risk of or Experiencing Juvenile Justice Involvement – Individuals with signs of behavioral/emotional problems who are at risk of or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through MHSA Community services and Supports funded services.

In April 2009, following a nine-month long Community Planning Process, the original City of Berkeley Prevention and Early Intervention plan was approved. Subsequent updates to the original plan were approved in October 2010, April 2011, May 2013, May 2014, June 2016, January 2017, July 2017, October 2018, July 2019 and December 2020. 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 (originally named "Building Effective Schools Together"-BEST) 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)	➢ Psycho-social Impact of Trauma ➢ Disparities in Access to Mental Health services At-Risk Children, Youth and Young Adult Populations	• Underserved Cultural Populations • Trauma Exposed
Social Inclusion	➢ Stigma and Discrimination Psycho-social Impact of Trauma	• Trauma Exposed Underserved Cultural Populations

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

PREVENTION

Activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors.

EARLY INTERVENTION

Treatment and other services and interventions, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that may result from untreated mental illness.

ACCESS and LINKAGE to TREATMENT

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

STIGMA and DISCRIMINATION REDUCTION

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

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

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

OPTIONAL - SUICIDE PREVENTION

Activities to prevent suicide as a consequence of mental illness.

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

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

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

PEI PROGRAM REQUIREMENTS

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

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

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

PEI Demographic Reporting Requirements

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

(A) The following Age groups:

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

(B) Race by the following categories:

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

(C) Ethnicity by the following categories:

(i) Hispanic or Latino as follows

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

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

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

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

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

(E) Sexual orientation

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

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

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

(G) Veteran Status,

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

(H) Gender

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

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

Effective July 2018 amended PEI regulations 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 to the extent permissible by privacy laws.
- For projects/programs serving minors younger than 12 years of age, demographic information shall be collected and reported, except for sexual orientation, current gender identity, and veteran status.
- Information that cannot be obtained directly from the minor may be obtained from the minor's parent, legal guardian, or other authorized source.

CITY OF BERKELEY PEI PROGRAMS

Upon the release of the 2018 PEI Regulations, the City of Berkeley programs were reviewed to evaluate whether programs that were already funded would fit into the new required PEI Program definitions. As a result, local PEI funded programs were re-classified from the previous construct, into the following:

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

*This project was added through the MHSA FY19 or FY20 Annual Update

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

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

outcomes and results that each program seeks to achieve, and then began implementing a rigorous framework to measure and enhance programs towards these results. The first part of this roll-out included the PEI Community Education & Supports Program contracted services. In FY18, staff began working with PEI funded Contractors both on establishing measures for "Impact Berkeley" and for PEI program requirements. Results of the FY20 RBA Evaluation are captured in this report and will continue to be reported in future PEI Evaluation Reports.

This FY20 Annual PEI Evaluation Report documents program measures and demographic elements to the extent data was available. While, it may be a multi-year process before the City of Berkeley will be able to present a complete data set for each PEI Program on an Annual basis, ongoing efforts will continue towards accomplishing this goal.

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, eight out of 10 local PEI programs provide services for children and youth, 5 of which are in the Berkeley Unified School District (BUSD). Programs are as follows: Behavioral-Emotional Assessment, Screening, Treatment and Referral (BE A STAR); Community-Based Child/Youth Risk Prevention Program; Supportive Schools Project; Mental Emotional Education Team (MEET); Dynamic Mindfulness (DMIND); African American Success Project; High School Youth Prevention Project, and the TAY Trauma Support Project. Additionally, from FY11 through FY20, the City of Berkeley utilized a portion of PEI funds to provide services for children, youth and TAY in the Albany Unified School District, through the Albany Trauma Project.

PREVENTION AND EARLY INTERVENTION

COMBINED PROGRAMS

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

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

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

In FY20, there were vacancies in staff, and shortly after a staff person was hired, they were deployed to work in the City's Emergency Operations Center as a result of the pandemic. A total of 1538 children were able to be screened through community partners.

Community-Based Child & Youth Risk Prevention Program

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

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

In FY20, the following services were provided:

- Over 15 Early Childhood Mental Health Reflective Case Consultation groups for five classrooms. Case consultation meetings allow teachers to develop clear plans and interventions in the classroom for individual children (and families) who have high risk factors including but not limited to complicated family dynamics, trauma, mental health and social-emotional needs as well as overall developmental needs of individual children
- General Classroom Consultations in five classrooms;

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

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

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

Gender: Assigned sex at birth	
Declined to Answer (or Unknown)	100%
Current Gender Identity	
Declined to Answer (or Unknown)	100%

High School Youth Prevention Program

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

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

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

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

PARTICIPANT DEMOGRAPHICS N=801	
Age Groups	
Youth 14-18 Years	100%
Race	
Asian	6%
Black or African American	19%
White	36%
More than one Race	20%
Declined to Answer (or Unknown)	3%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican/Mexican-American/Chicano	16%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	84%
Primary Language	
Declined to Answer (or Unknown)	100%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Male	30%
Female	70%
Current Gender Identity	
Male	30%
Female	68%
Students who identified as either transgender, gender queer, or gender non-conforming	2%

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

Results on a survey from the Alameda County School Health Center Evaluation for Berkeley High School and B-Tech students was as follows:

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

Successes

- Applied for and awarded SB-82 Crisis Triage Grant in order to fund 1.0 FTE Behavioral Health Clinician II position, which enabled more consistent and reliable provision of assessment and crisis assessment services;
- In response to COVID-19, shelter in place restrictions, and transition to virtual learning, the Mental Health team developed and implemented a "Mental Health Warm Line" for students, parents, and school staff;
- Provided ongoing individual Mental Health remote tele-health services from March through June 2020 for all existing Health Center clients;
- Increased awareness and the de-stigmatization of services;
- Increased access to services for historically marginalized student communities;
- Increased BHS campus presence through several tabling events, presentations, and gatherings with students, families, and school staff;
- Successful internal/external linkages to ongoing care;
- Ongoing collaborative partnerships with school administration, teachers, and school-based programs;
- Diverse/eclectic staff backgrounds supported embedding foundational framework of cultural humility across clinical practice; and
- Maintained a 100% staff retention.

Challenges

- Student need continued to exceed clinician/team capacity during the months where in-person learning took place (August 2019 through mid-March 2020);
- Difficulties with external linkages due to fractured nature of larger Mental Health healthcare systems, insurance barriers, etc.;
- Limited staff time to promote prevention and early intervention services due to high volume of Tier 3 therapy services;
- Transition of in-person services and workflows to remote tele-health services and workflows due to the pandemic
- Utilization of new technology to support remote tele-health services;

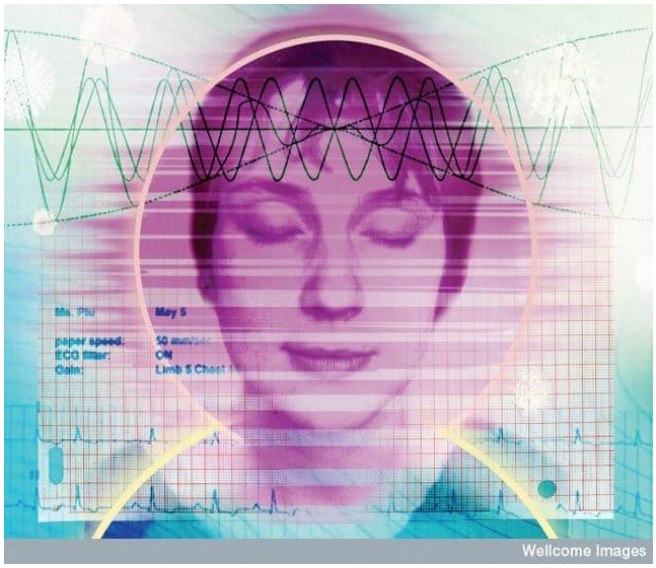
- Decline in accessibility and utilization of Mental Health services due to the pandemic;
- Impact of the pandemic on staff;
- Vicarious trauma for staff due to the nature and content of the therapeutic work, high volume, and impact of the pandemic; and
- Limited staff time for team meetings to discuss/plan/review administrative and programmatic considerations.

Mental Health Peer Education Program

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

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

In FY20, this program was not in operation.



Dynamic Mindfulness Program (DMind)

The Dynamic Mindfulness (DMind) program was added through the MHSA FY19 Annual Update. BUSD partners with the Niroga Institute to provide DMind for students and staff at Berkeley High, Berkeley Technology Academy, Berkeley Independent Study, MLK Jr., Willard, and Longfellow. DMind is an evidence-based trauma-informed program in each of the BUSD middle and high schools. Validated by independent researchers as a transformative program for teaching children and youth, skills for optimal

stress resilience and healing from trauma, the DMind program integrates mindful action, breathing, and centering into an intervention that can be implemented in the classroom in 5-15 minute sessions, 3 to 5 times a week. This program has proven to be successful with vulnerable students who are exhibiting signs of trauma/PTSD from Adverse Childhood Experiences (ACEs), and/or disengagement from school, chronic absences, and significant behavioral challenges, including emotion regulation, impulse control, and anger management. DMind also enables teacher well-being, which has been shown to enhance student learning. The program components include in-class and after-school DMind sessions for students, student peer leadership development, training and coaching of school staff, and program evaluation.

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

Due to the pandemic, in FY20 all supports were shifted to online in the second half of the school year. 380 students participated in DMind during the reporting timeframe. Demographics on individuals served were not provided by BUSD.

African American Success Project

The African American Success Project (AASP) was first implemented in FY19 in four Berkeley Unified School District Schools (King, Longfellow, Willard and Berkeley High School). Closely aligned with the work of Berkeley's 2020 Vision, the AASP works with African American youth and their families to actively engage students in the classroom and school life while creating a pathway for their long-term success. The project implements a three-pronged approach that includes case management and mentorship (which are individualized and tailored to meet each student's needs), community building, and family

engagement. Through this approach a case manager engages and works with each student on school success planning. This work includes establishing student check-ins, family connections, teacher and staff collaborations, advocacy, and community building sessions. The project supports students who have disproportionately faced barriers in Berkeley public schools to promote an individual's learning, mental, and socio-emotional well-being. During the first year the project team worked with 84 students and their families while assessing the effectiveness of the project and identifying ways to strengthen the service model. One key finding was that the project could only have limited impact when staff were spread across four school sites.

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.

During the FY20 school year students participated/were enrolled in Umoja- a daily elective class offered through the African American Success Project (AASP), at Longfellow Middle School. Umoja provides African American students a safe affinity space to explore their cultural heritage and identity, while building positive peer relationships and establishing relational trust with adults. Umoja provides an ongoing focus on social and emotional development, including building skills, habits and mindsets that enable self-regulation, interpersonal skills, perseverance and resilience.

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

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

Direct services for parents and guardians:

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

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

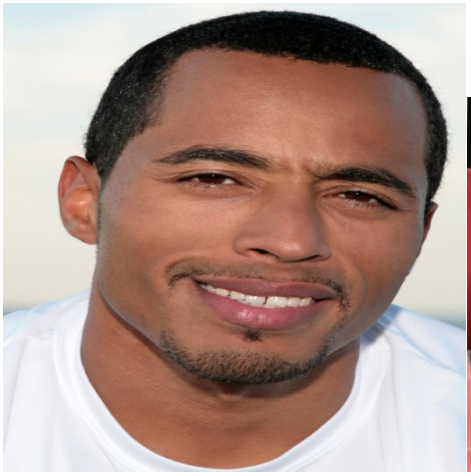
Direct services for students (academic, social, behavioral):

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

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

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

EARLY INTERVENTION (ONLY) PROGRAMS



Supportive Schools Program

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

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

In FY20, Early Intervention Services were provided at all eleven BUSD elementary schools. Funding was allocated at each elementary school to provide early intervention services. BUSD sub-contracted with local agencies to provide early intervention services based upon the standard of evidence-based practices. Bay Area Community Resources (BACR), Child Therapy Institute (CTI), and Lifelong Medical (Lifelong) were subcontracted to provide services at BUSD elementary schools. Additionally, a counselor was provided to support two elementary schools. As a result of the pandemic, schools finished the year in distance learning. During the academic year, supports were initially provided in-person, before shifting to online. It was reported that the providing remote therapy sessions had its challenges. Supports for each school, per service provider, and numbers served in FY20 were as follows:

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

BACR provides services to improve emotional functioning and success in school and life, including individual and group therapy, family consultation, conflict resolution/restorative justice, suicide prevention, check-in/check-out, crisis intervention, and classroom presentations. Additionally, BACR participated on the weekly Coordination of Services (COST) team, Student Success Team (SST), and Individualized Education Program (IEP) meetings for students, providing mental health and trauma informed perspectives. BACR consults with staff on many issues and provides trauma informed coaching for teachers, referrals and

care coordination to outside providers, parenting classes/support groups, crisis hotlines, and other programs.

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

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

PARTICIPANT DEMOGRAPHICS N= 248	
Age Group	
0-15 (Children/Youth)	100%
Race	
American Indian or Alaska Native	7%
Asian	4%
Black or African American	34%
Native Hawaiian/Pacific Islander	1%
White	24%
More than one Race	19%
Declined to Answer (or Unknown)	11%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican/Mexican-American/Chicano	22%
Declined to Answer (or Unknown)	5%
Ethnicity: Non-**Hispanic or Non- Latino/Latina/Latinx**	
Asian Indian/South Asian	1%
Filipino	<1%
More than one Ethnicity	10%
Declined to Answer (or Unknown)	62%
Primary Language Used	
English	13%
Spanish	3%
Other	<1%
Declined to Answer (or Unknown)	84%

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

Community Education & Supports Program

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

In FY20 each of the Community Education & Supports contractors participated in the HHCS Results-Based Accountability (RBA) Evaluation. Some of the results are presented in an aggregated format aggregated across all programs as follows:

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

For additional detail on how various data variables were quantified and for full reporting on other data elements, access the full report on the Impact Berkeley PEI program results on the MHSA website: MHSA Plans and Updates - City of Berkeley, CA

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

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

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

Albany Trauma Project

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

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

Adult Support Groups: This project used to implement outreach and engagement activities and support groups to Latino/Latina/Latinx immigrant adults dealing with trauma issues, who live and work the backstretch of Golden Gate Field's race track as groomers; exercise jockeys and caretakers of the horses. Over the years this project has migrated to more of a one-on-one engagement project to support individuals in need, with occasional cultural and strength building group activities.

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

In FY20, 18 individuals received supports through one-on-one engagement sessions. Services were not able to continue between March and June due to the pandemic.

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

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

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

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

In FY20, nine support groups were provided to a total of ten participants. Each group met for 1-2 hours in duration. There were seven referrals for additional mental health services, four for Social Services, and one referral to an unspecified service. Thirty-five outreach activities were also conducted. School ended abruptly in mid-March in response to the pandemic. Students who had participated in individual counseling continued to receive weekly services over Zoom.

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

In FY20, twenty-nine support group sessions were held at Albany high School, and served a total of 29 students. Students were assigned to three groups based on racial or ethnic identity: Latinx, African-American, and Asian-American. This was done in order to help promote connection, identification and group cohesion. Students that participated in the trauma groups at Albany High School were initially recommended by counselors, mental health coordinators, or administrators who believed that these selected students may have experienced trauma in their lives. These students were then interviewed individually to assess and determine if they wished to participate in the groups. Each group met weekly for one hour, and were able to continue by Zoom when schools were abruptly closed in March due to the pandemic.

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

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

PARTICIPANT DEMOGRAPHICS N=65*			
Age Group	Golden Gate Fields Racetrack Supports	Elementary Support Groups	High School Support Groups
Percent of total participants served	28%	15%	57%
0-15		90%	
16-25	6%	10%	100%
26-59	56%		
60+	39%		
Race			
Asian	6%		24%
Black or African American		50%	27%
White	56%	20%	41%
Other	39%	30%	
More than one Race			8%

Ethnicity: Hispanic or Latino/Latina/Latinx	Golden Gate Fields Racetrack Supports	Elementary School Support Groups	High School Support Groups
Mexican/Mexican-American/Chicano	94%	10%	32%
Central American			3%
Puerto Rican		10%	5%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx			
Asian Indian/South Asian		10%	3%
Chinese			14%
Filipino	6%		5%
Japanese			3%
More than one Ethnicity			35%
Declined to Answer (or Unknown)		70%	
Primary Language Used			
English	17%	100%	100%
Spanish	83%		
Sexual Orientation			
Gay or Lesbian			3%
Heterosexual or Straight	100%	100%	95%
Bisexual			3%
Disability			
Other Disability	22%		
No Disability	78%	30%	100%
Declined to Answer (or Unknown)		70%	
Veterans Status			
No	100%	100%	100%
Gender: Assigned sex at birth			
Male	83%	50%	51%
Female	17%	50%	49%
Current Gender Identity			
Male	83%	50%	51%
Female	17%	50%	49%

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

Beginning in FY21, Albany services will be funded through Alameda County MHSA Funds.

Transition Age Youth Trauma Support Project

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

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

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

CLIENT DEMOGRAPHICS N = 96*	
Age Group	
16-25 (Transition Age Youth)	100%
Race	
American Indian or Alaska Native	5%
Asian	1%
Black or African American	46%
Native Hawaiian or Other Pacific Islander	4%
White	28%
More than one Race	15%
Decline to Answer (or Unknown)	1%

Ethnicity: Hispanic or Latino/Latina/Latinx	
Central American	5%
Mexican/Mexican-American	15%
South American	1%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	35%
Asian Indian/South Asian	1%
Chinese	1%
Eastern European	5%
European	15%
Filipino	3%
More than one Ethnicity	17%
Declined to Answer (or Unknown)	2%
Primary Language Used	
English	86%
Spanish	14%
Sexual Orientation	
Gay or Lesbian	8%
Heterosexual or Straight	81%
Bisexual	10%
Disability	
Mental (not mental health)	50%
Chronic Health Condition	11%
Other Disability	20%
No Disability	16%
Decline to Answer (or Unknown)	3%
Veteran Status	
Yes	1%
No	99%
Gender: Assigned sex at Birth	
Male	33%
Female	26%

Decline to Answer (or Unknown)	41%
Gender Identity	
Male	59%
Female	36%
Transgender	2%
Other	2%

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

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

Living Well Project

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

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

In FY20, 63 Living Well workshops were conducted. Each Living Well Workshop series included the following sessions: Orientation; Goal Setting; Problem Solving; Healthy Reactions; Beating the Blues (Depression and Moods); Healthy Communication; Seeking Information; Physical Activity; Eating Well (Nutrition); Advocacy (Self and Systems Change); and Maintenance. Topics of Grief and Loss, Depression, Retirement, and Senior Invisibility were also incorporated into the program. In all 59 Senior Citizens participated in the Living Well Workshops. Demographics of Workshop participants are outlined below:

PARTICIPANT DEMOGRAPHICS N=59*	
Age Groups	
26-59 (Adult)	2%
Age 60+ (Older Adult)	97%
Declined to Answer (or Unknown)	1%
Race	
American Indian or Alaska Native	2%
Asian	5%
Black or African American	54%
White	29%
Other	2%
More than one Race	5%
Declined to Answer (or Unknown)	3%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	32%
Asian Indian/South Asian	2%
Chinese	2%
European	19%
Filipino	2%
Middle Eastern	3%
More than one Ethnicity	2%
Other	12%
Declined to Answer(or Unknown)	27%
Primary Language Used	
English	92%
Other	3%
Declined to Answer (or Unknown)	5%
Sexual Orientation	
Gay or Lesbian	2%
Heterosexual or Straight	68%
Bisexual	2%
Declined to Answer (or Unknown)	29%

Disability	
Difficulty seeing	5%
Difficulty hearing or Having Speech Understood	8%
Mental (not mental health)	5%
Physical/mobility disability	14%
Chronic health condition	22%
No Disability	31%
Declined to Answer (or Unknown)	15%
Veteran Status	
Yes	2%
No	95%
Declined to Answer (or Unknown)	3%
Gender: Assigned sex at birth	
Male	14%
Female	83%
Declined to Answer (or Unknown)	3%
Current Gender Identity	
Male	14%
Female	71%
Declined to Answer (or Unknown)	15%

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

During the reporting timeframe 5 outreach and informational events were conducted reaching 84 individuals, with 235 individuals receiving further engagement services. Services were moved to virtual format providing Tele-workshops and Tele-support services to accommodate the pandemic. There were 653 referrals for additional services and supports. The number and type of referrals was as follows: 115 Mental Health; 147 Physical Health; 112 Social Services; 58 Housing; 221 other unspecified services. A total of 39% of program participants completed a Living Well Workshop Series. Feedback per participant self-report was as follows:

- 100% reported they felt satisfied with the workshops;
- 98% indicated an improvement in feeling satisfied in general;
- 98% had increased feelings of social supports;
- 100% felt prepared to make positive changes; and
- 88% reported they felt less overwhelmed and helpless.

Harnessing Hope Project

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

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

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

PARTICIPANT DEMOGRAPHICS N=22*	
Age Groups	
0-15 (Children/Youth)	4%
16-25 (Transition Age Youth)	18%
26-59 (Adult)	73%
Ages 60+ (Older Adult)	5%
Race	
Asian	14%
Black or African American	82%
Other	5%

Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	77%
Asian Indian/South Asian	9%
Vietnamese	5%
More than one Ethnicity	5%
Declined to Answer (or Unknown)	5%
Primary Language Used	
English	100%
Sexual Orientation	
Heterosexual or Straight	95%
Questioning or Unsure	5%
Disability	
Chronic Health Condition	18%
No Disability	82%
Veteran Status	
No	100%
Gender: Assigned sex at birth	
Female	100%
Current Gender Identity	
Female	100%

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

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

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

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

MHSA funded services did not continue with GOALS in FY21, as the program was no longer in operation. A Request For Proposal (RFP) process was executed in April 2021 for these services. In FY22, Trauma Support Services for African Americans will be provided through the chosen vendor of this RFP process.

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

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

PARTICIPANT DEMOGRAPHICS N=151*	
Age Groups	
16-25 (Transition Age Youth)	28%
26-59 (Adult)	41%
Ages 60+ (Older Adult)	26%
Declined to Answer (or Unknown)	4%
Race	
American Indian or Alaska Native	1%
Asian	11%
Black or African American	6%
White	57%
Other	3%
More than one Race	12%
Declined to Answer (or Unknown)	11%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Caribbean	1%
Central American	2%
Mexican/Mexican-American/Chicano	5%
Puerto Rican	1%
South American	1%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	3%
Asian Indian/South Asian	3%
Chinese	6%
Eastern European	10%
European	27%
Filipino	1%
Japanese	1%
Korean	1%
Middle Eastern	4%
Vietnamese	1%
More than one Ethnicity	7%

Other	2%
Declined to Answer (or Unknown)	24%
Primary Language Used	
English	98%
Spanish	1%
Mandarin	1%
Sexual Orientation	
Gay or Lesbian	23%
Heterosexual or Straight	7%
Bisexual	25%
Questioning or Unsure	2%
Queer	25%
Other	17%
Declined to Answer (or Unknown)	3%
Disability	
Difficulty Seeing	2%
Difficulty Hearing or Having Speech Understood	6%
Mental (not Mental Health)	8%
Physical/Mobility Disability	6%
Chronic Health Condition	9%
Other Disability	1%
No Disability	64%
Declined to Answer (or Unknown)	4%
Veteran Status	
Yes	1%
No	99%
Gender: Assigned sex at birth	
Male	26%
Female	50%
Declined to Answer (or Unknown)	24%

Current Gender Identity	
Male	12%
Female	34%
Transgender	27%
Genderqueer	8%
Questioning or Unsure	3%
Other	13%
Declined to Answer (or Unknown)	4%

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

During the reporting timeframe 25 new Peer Facilitators were trained. The offering of Skills Building Workshops that included trainings on: Nonviolent Communication; Crisis Intervention; and Implicit Bias as it Relates to Race and workshops were provided to 57 Peer Facilitator participants. Services were adjusted to accommodate for the pandemic and Support Group and other services were able to continue virtually on the Zoom platform. There were 93 referrals for additional services and supports. The number and type of referrals was as follows: 45 Mental Health; 11 Physical Health; 3 Housing; 34 other unspecified services. To assess the project services, a self-administered Peer Support Group Survey was distributed to all peer group members. Survey results were as follows:

- 92% indicated they would recommend the organization to a friend or family member;
- 88% felt like staff and facilitators were sensitive to their cultural background;
- 84% reported they deal more effectively with daily problems;
- 76% indicated they have trusted people they can turn to for help;
- 76% felt like they belong in their community.

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

ACCESS AND LINKAGE TO TREATMENT PROGRAM

Homeless Outreach and Treatment Team (HOTT)

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

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

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

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

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

PARTICIPANT DEMOGRAPHICS N= 616	
Age Groups	
16-25 (Transition Age Youth)	2%
26-59 (Adult)	36%
Ages 60+ (Older Adult)	16%
Declined to Answer (or Unknown)	46%
Race	
Asian	4%
Black or African American	36%
White	45%
More than one Race	1%
Other	7%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Hispanic	7%

Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	100%
Primary Language Used	
Declined to Answer (or Unknown)	100%
Sexual Orientation	
Declined to Answer (or Unknown)	100%
Disability	
Declined to Answer (or Unknown)	100%
Veteran Status	
Declined to Answer (or Unknown)	100%
Gender: Assigned sex at birth	
Male	61%
Female	37%
Declined to Answer (or Unknown)	2%
Current Gender Identity	
Male	61%
Female	37%
Declined to Answer (or Unknown)	2%

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

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

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

A result of the COVID-19 pandemic was a shift from many in-person services to telephonic or tele-health. The incidence of the pandemic changed the face of services and resources throughout the landscape, including systems of care and access to them. The data used for the final HOTT report, for example, was

truncated due to the unavailability of consistent information and the redirection of services as dictated by the City of Berkeley and its Emergency Operation Center. Similarly, data gathered after February 2020 is likely less reflective of the services as planned, but more in the emergency response and shift of focus to emergency support of vulnerable communities and individuals. Maintaining regular staffing was also difficult in this pilot. Since the positions were temporary, project based appointments, any staff persons who were hired for this team did not have job security with the City of Berkeley unless they transferred with a pre-existing permanent career status. This resulted in the exit of two staff during this time period who found other employment.

The RDA Homeless Outreach and Treatment Team Final Evaluation Report which covered the timeframe from January 2018 – February 2020, showed the following outcomes:

- A total of 4,435 total encounters were conducted with individuals who were either enrolled or non-enrolled in the program, averaging 171 encounters per month;
- The number of contacts provided in-person in the field was 73%, while 26% were provided by phone;
- A total of 81% of HOTT encounters were with clients who were enrolled in the program;
- Enrolled clients had an average of 20 total encounters with HOTT staff, with an average of 4 encounters per month;
- During encounters, HOTT staff provided at least 1,845 material supports and services (including food, transportation or BART or bus passes, Hygiene Kits, Emergency Housing Vouchers, Blankets, etc.); to respond to clients' immediate and longer-term needs;
- During 488 encounters, HOTT provided emergency or temporary housing vouchers (e.g., for a motel) to individuals who required immediate shelter;
- Approximately three-quarters of enrolled clients (75%) and over a third of non-enrolled individuals (38%) were referred or connected to housing support services;
- In addition to connecting individuals to housing services, HOTT also connected individuals to other supportive services to help reduce or address initial barriers to obtaining housing;
- Approximately 27% of HOTT clients and 6% of non-enrolled individuals successfully enrolled in social service benefits. In comparison, only 9% of HOTT clients and 1% of non-enrolled clients ultimately enrolled in mental health services;
- Over 58% of all HOTT clients, and 9% of non-enrolled individuals obtained emergency or temporary housing (e.g., motel or shelter) at some point during their engagement with HOTT. In comparison, 12% of HOTT clients and 1% of non-enrolled individuals obtained permanent housing;
- To assess changes in self-sufficiency, HOTT staff completed a Client Self-Sufficiency Matrix (SSM) on enrolled clients at program intake, on a quarterly basis after program enrollment, and/or at program discharge. Overall, HOTT clients' SSM scores remained relatively unchanged from baseline to follow-up.

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

- "They help people, not just me. I introduce people on the street to them, and I say you can talk to the HOTT team and they will help you."
- "I really didn't expect anything, but when I called the City, they said someone [from HOTT] would meet me right then. They got me a hotel room that day. I wasn't expecting the City to help."

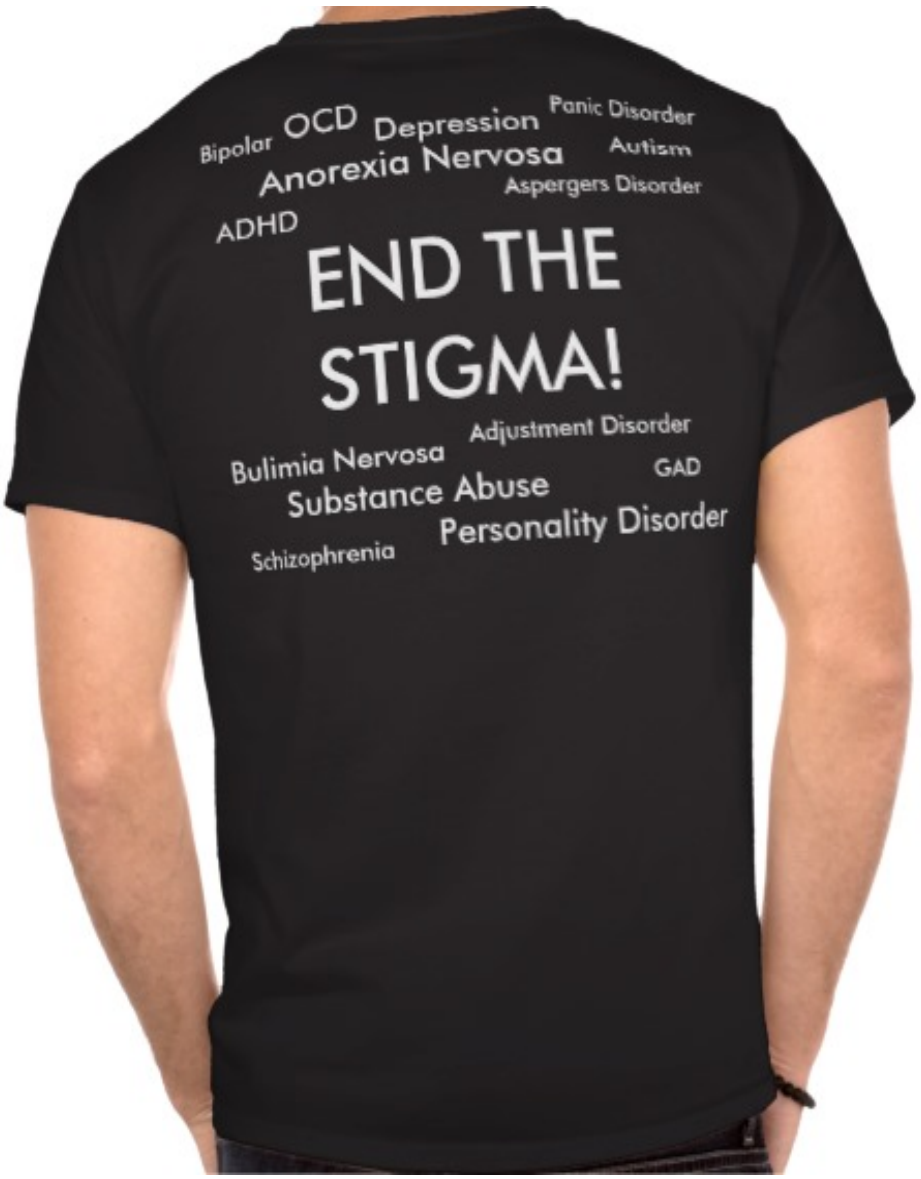
- "They were so helpful. I felt like if I didn't get the hotel room, they would have let me stay at their personal house."

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

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

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

STIGMA AND DISCRIMINATION REDUCTION PROGRAM



Social Inclusion Program

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

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

PARTICIPANT DEMOGRAPHICS N= 22*	
Age Groups	
26-59 (Adult)	18%
Ages 60+ (Older Adult)	36%
Declined to Answer (or Unknown)	46%

Race	
American Indian or Alaska Native	9%
Asian	14%
Black or African American	14%
Native Hawaiian or other Pacific Islander	9%
White	32%
Other	9%
Declined to Answer (or Unknown)	13%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Mexican	4%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
Declined to Answer (or Unknown)	96%
Primary Language Used	
English	41%
Declined to Answer (or Unknown)	59%
Sexual Orientation	
Gay or Lesbian	4%
Heterosexual or Straight	27%
Bisexual	4%
Queer	4%
Questionning	9%
Declined to Answer (or Unknown)	52%
Disability	
Difficulty Seeing	9%
Communication (other)	9%
Mental Domain not including a mental illness	9%
Physical Mobility domain	18%
Chronic Health Condition	9%
Declined to Answer (or Unknown)	46%
Veteran Status	
Declined to Answer (or Unknown)	100%

Gender: Assigned sex at birth	
Female	41%
Declined to Answer (or Unknown)	59%
Current Gender Identity	
Female	41%
Declined to Answer (or Unknown)	59%

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

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

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

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

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

High School Youth Prevention Project

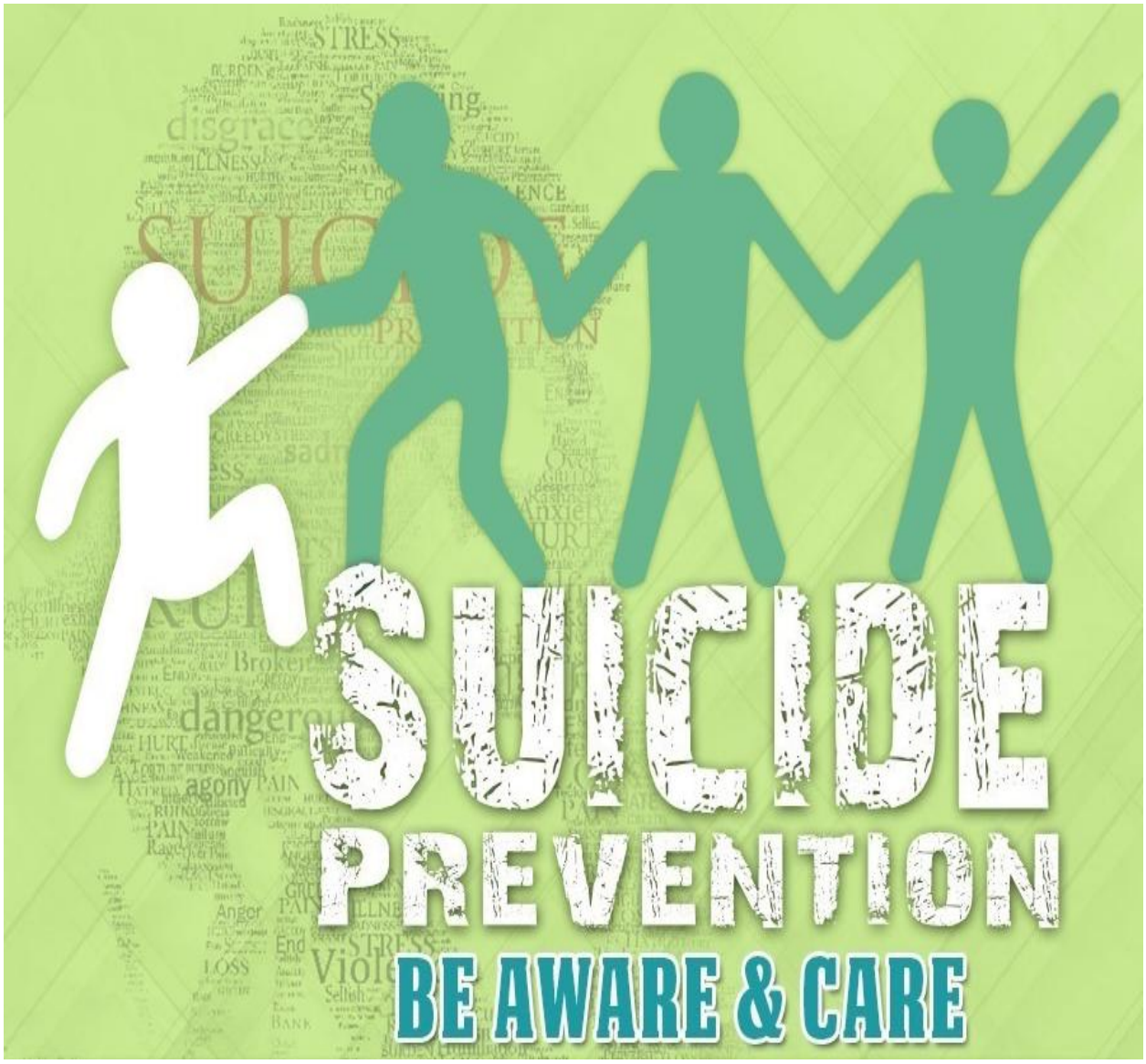
The High School Youth Prevention Project which is also classified as a Prevention and Early Intervention program. The data elements for the "Outreach for Increasing Recognition of Early Signs of Mental Illness" component of this program were not collected in the reporting timeframe.

Mental Health First Aid

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

SUICIDE PREVENTION

(OPTIONAL PEI PROGRAM)



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

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

APPENDIX B

Fiscal Year 2020 Innovation Annual Evaluation Report

City of Berkeley
Mental Health Services Act (MHSA)

Fiscal Year 2020 Innovation Annual Evaluation Report

WELLNESS • RECOVERY • RESILIENCE

INTRODUCTION

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

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

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

Per 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 in 2021, the Fiscal Year 2020 (FY20) INN Annual Evaluation Report that covers data from FY20 is due.

This FY20 INN Annual Evaluation Report provides descriptions of currently funded MHSA INN services, and reports on FY20 program and demographic data to the extent possible. While, it may be a multi-year process before the City of Berkeley will be able to present a complete data set for each INN Program on an Annual basis, ongoing efforts will continue towards accomplishing this goal.

BACKGROUND

On October 6, 2015, updated INN regulations designed by the Mental Health Services Oversight and Accountability Commission (MHSOAC) became effective. The new INN Regulations, included program and demographic data requirements that are to be reported to the MHSOAC through 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 and what changes were made to the Innovative Project during the reporting period and the reasons for the changes.
- Available evaluation data, including outcomes of the Innovative Project and information about which elements of the Project are contributing to outcomes.
- Program information collected during the reporting period, including for applicable Innovative Projects that serve individuals, number of participants served.
- All Demographic Data as applicable per project. (as outlined below)

INN Demographic Reporting Requirements

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

(A) The following Age groups:

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

(B) Race by the following categories:

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

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

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

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

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

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

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

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

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

(E) Sexual orientation

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

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

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

(G) Veteran Status,

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

(H) Gender

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

Effective July 2018 amended INN regulations specified the following:

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

CITY OF BERKELEY INN PROGRAMS

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

Since plan approval the City of Berkeley has been working both internally and with the State collaborative on various aspects of this project to prepare for citywide implementation. In keeping with changes made via the Technology Suite multi-county collaborative, the new name of this project has been changed to "Help@Hand". As a result of a competitive recruitment process that was conducted in FY20, Resource Development Associates (RDA) was hired to conduct the Project Coordination work on this project. Pre-work for the implementation of this project is currently underway. It is envisioned that the mental health apps will be locally available in early FY22 in Berkeley.

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

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

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

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

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

The learning objectives of this project are:

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

In FY20, 197 children received services through this program. An evaluation was conducted during the reporting timeframe by HTA. Below are demographics of individuals impacted by

this program. The full evaluation is attached to this report.

PARTICIPANT DEMOGRAPHICS N=197	
Age Groups	
0-15 (Children)	100%
Race	
American Indian or Alaska Native	3%
Asian	4%
Black or African American	47%
White	23%
Other	9%
More than one Race	13%
Declined to Answer (or Unknown)	1%
Ethnicity: Hispanic or Latino/Latina/Latinx	
Caribbean	<1%
Central American	<1%
Mexican/Mexican-American/Chicano	27%
Puerto Rican	<1%
South American	3%
More than one ethnicity	9%
Declined to Answer (or Unknown)	<1%
Ethnicity: Non-Hispanic or Non-Latino/Latina/Latinx	
African	37%
Asian Indian/south Asian	2%
Cambodian	1%
Chinese	1%
Eastern European	<1%
European	1%
Japanese	<1%
Middle Eastern	1%
Other	7%
More than one ethnicity	4%
Declined to Answer (or Unknown)	8%

Gender	
Female	47%
Male	53%
Primary Language	
English	60%
Spanish	22%
Urdu	1%
Arabic	2%5
French	1%
Berber	1%
Punjabi	<1%
Amharic	<1%
Tigrina	<1%
Chinese?Mandarin	<1%
Nepalese	<1%
Declined to Answer (or Unknown)	1%
Disability	
Communication: other, speech/language impairment	10%
Mental domain	1%
Chronic health condition	<1%
Other	2%
No Disability	87%

Early Childhood Trauma and Resiliency Project (ECTR)

City of Berkeley, Berkeley's 2020 Vision

Year Two Evaluation Report, September 2020

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Hatchuel Tabernik and Associates

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Project Description

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

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

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

Key Partners

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

Theory of Change

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

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

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

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

-Frederick Douglass

Methodology

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

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

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

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

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

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

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

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

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

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

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

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

Table 1. ECTR Data Sources

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

Implementation

Implementation Activities to Date

This report covers program activities and outcomes cumulatively over the past 18 months of program implementation from January 1st 2019 through June 30th, 2020. Head Start kicked off the ECTR project in February 15th, 2019 with its first all-staff (e.g., teachers, counselors, administrators) training, **"Understanding Trauma Informed Practices for Early Childhood Programs: Creating Strength-Based Environments to Support Children's Health and Healing"** (also referred to as "Trauma Informed Care 101"). See Table 3 below for training dates and attendance counts.

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

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

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

Resiliency Champion sessions covered topics including: **Understanding the Neurobiology of Trauma, Foundations of Trauma-Informed Practices for Early Childhood Education** and **Trauma Sensitive Early Childhood Programs**. Participants discussed case studies, including those of an infant and mother in a homeless shelter, a toddler with a history of neglect and three foster care placements, a preschooler with an undocumented father who has been deported, and a child who witnessed a drive-by shooting while at school. The text for these sessions is a book co-authored by Julie Kurtz, Trauma Informed Practices for Early Childhood Educators: Relationship-Based Approaches that Support Healing and Build Resilience in Young Children. The Resiliency Champions also learned and practiced delivering three new staff trainings developed by Ms. Kurtz for this project, each with its own PowerPoint slide deck. A later session covered: **The Importance**

of Self-Care: Taking Care of Yourself in Order to Prevent Burnout, Compassion Fatigue and Secondary Traumatic Stress.

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

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

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

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

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

Pivots to Programming During COVID-19

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

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

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

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

In the midst of this upheaval, the ECTR program continued its work. Julie Kurtz and Lawanda Wesley (of Optimal Brain Integration) were scheduled to lead an in-person Family Engagement Trauma Training on May 18th, 2020. In response to the pandemic, the Head Start team transitioned this planned training into a two-part virtual training over three hours on May 18th and three hours on the 28th. In addition to discussing strategies to engage families from a trauma-based lens, the trainers adjusted the topics to meet the immediate needs of staff, including: anxiety as a result of Covid-19, coping strategies, wellness, and self-care. Staff also discussed what would make them feel safe when Head Start re-opened. Feedback from these trainings was extremely positive based on post-training evaluations. Attendees wanted even more training for staff "to better handle families that are dealing with trauma as they [staff] may be dealing with trauma themselves" and others recommended that families take the training as well. Another attendee reportedly expressed how the training helped her to name the issues she sees with children, "We were always gardening but now we can be better gardeners because we can name the plants."

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

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

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

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

Table 3. Training Sessions and Attendance

Training Name	Date	Length	# Attendees
Year One Trainings			
Understanding Trauma Informed Practices for Early Childhood Programs (All Staff)	Feb 15, 2019	8 hours	62
Kick-off and Leadership Reflective Practices	June 10, 2019	3 hours	17
Resiliency Champion Meeting 1	June 10, 2019	3 hours	15
Resiliency Champion Meeting 2	June 24, 2019	3 hours	15
Year Two Trainings			
Resiliency Champion Meeting 3	July 1, 2019	3 hours	13
Resiliency Champion Meeting 4	July 15, 2019	3 hours	13
Resiliency Champion Meeting 5	Aug 19, 2019	3 hours	11
Trauma-Informed Practices: Self-Care for Early Childhood Providers (All Staff)	Aug 22, 2019	3 hours	86

Resiliency Champion Meeting 6	Sept 9, 2019	3 hours	11
Resiliency Champion Meeting 7	Sept 23, 2019	3 hours	10
Resiliency Champion Meeting 8	Oct 7, 2019	3 hours	10
Resiliency Champion Meeting 9	Oct 21, 2019	3 hours	8
Trauma-Informed Practices: Classroom Strategies (All Staff)	Oct 14, 2019	6 hours	67
Resiliency Champion Meeting 10	Nov 1, 2019	3 hours	7
Self-Care Part 2 (All Staff)	Jan 27, 2020	3 hours	85
Resiliency Circles (site-based)			
South Y	Feb 19, 2020	2 hours	12
Vera Casey	Mar 10, 2020	2 hours	8
Resiliency Circles-virtual (site-based)			
South Y (Self-Care and Wellness During Covid-19)	Apr 9, 2020	1 hour	15
West Y (Self-Care and Wellness During Covid-19)	Apr 15, 2020	1 hour	15
Vera Casey (Self-Care and Wellness During Covid-19)	Apr 23, 2020	1 hour	15
Oceanview (Self-Care and Wellness During Covid-19)	Apr 29, 2020	1 hour	15
South Y (Prioritizing to Minimize Stress & New Normal)	May 13, 2020	1 hour	15
Vera Casey (Prioritizing to Minimize Stress & New Normal)	May 14, 2020	1 hour	15
West Y (Prioritizing to Minimize Stress & New Normal)	Jun 12, 2020	1 hour	15
Oceanview (Prioritizing to Minimize Stress & New Normal)	Jun 19, 2020	1 hour	15
Family Engagement Part 1 -virtual (All Staff)	May 18, 2020	3 hours	65
Leadership Team Peer Support Learning Circle (leadership)	May 21, 2020	1 hour	9
Family Engagement Part 2 -virtual (All Staff)	May 28, 2020	3 hours	65
Peer Support Learning Circle (Inclusion Team)	Jun 4, 2020	1 hour	4

Source: ECTR program documents

Findings

Demographic Data

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

Child (Participant) Demographics

The ECTR program served 197 children at the four program sites in 2018-19 and also 197 in 2019-20 (see Table 4). The majority of children's primary language is English (60%), and 22% primarily speak Spanish. There are slightly more male (53%) than female (47%) children. All children are in the 0-5 age group. The most common disability among the children is a speech/language impairment (10%).

Table 4. ECTR Child Demographics[2]

	n	Y1 (N=197) %	n	Y2 (N=197) %
Site				
Oceanview	49	25%	48	24%
South YMCA	69	35%	63	32%
Vera Casey	16	8%	19	10%
West YMCA	63	32%	67	34%
Total	*197*	*100%*	*197*	*100%*
Gender (assigned at birth)				
Female	97	49%	93	47%
Male	100	51%	104	53%
Total	*197*	*100%*	*197*	*100%*
Age				
0-5	197	100%	197	100%
Primary Language				
English	130	66%	119	60%
Spanish	41	21%	43	22%
Urdu	5	3%	2	1%
Arabic	4	2%	4	2%
French	4	2%	2	1%
American Sign Language	2	1%	0	0%
Berber	2	1%	2	1%
Mongolian	2	1%	0	0%
Punjabi	2	1%	1	<1%
Tigrina	2	1%	1	<1%
Amharic	0	0%	1	<1%
Chinese/Mandarin	1	1%	1	<1%
Laotian	1	1%	0	0%
Nepalese	0	0%	1	<1%
Russian	1	1%	0	0%
Missing	0	0%	20	10%
Total	*197*	*100%*	*197*	*100%*
Disability				
Communication: difficulty seeing	0	0%	0	0%
Communication: difficulty hearing	0	0%	0	0%
Communication: other, speech/language impairment	39	20%	20	10%
Mental domain	4	2%	2	1%
Physical/mobility domain	3	2%	0	0%
Chronic health condition	11	6%	1	<1%
Other	11	6%	3	2%
[No Disability]	129	65%	171	87%
Total	*197*	*100%*	*197*	*100%*

Source: YMCA ChildPlus

A supplemental survey asking only the following race and ethnicity questions was administered to families in May 2020. Black/African American children are the largest ethnic/racial group served (47%) followed by white children (23%). (See Table 5).

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

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

	Year 1 (N=154)		Year 2 (N=158)	
	n	%	n	%
Race				
American Indian or Alaska Native	3	2%	4	3%
Asian	8	5%	6	4%
Black or African American	64	42%	75	47%
Native Hawaiian or other Pacific Islander	0	0%	0	0%
White	17	11%	36	23%
Other	42	27%	15	9%
More than one race	18	12%	20	13%
Declined to answer/Unspecified	2	1%	2	1%
Total	*154*	*100%*	*158*	*100%*
Ethnicity: Hispanic or Latino				
Caribbean	1	<1%	1	<1%
Central American	2	1%	1	<1%
Mexican/Mexican-American/Chicano	46	30%	42	27%
Puerto Rican	1	<1%	1	<1%
South American	1	<1%	2	3%
Other	1	<1%	0	0%
More than one ethnicity	6	4%	15	9%
Declined to answer	4	3%	1	<1%
Total Hispanic or Latino	*62*	*40%*	*63*	*40%*
Ethnicity: Non-Hispanic or Non-Latino				
African	61	40%	59	37%
Asian Indian/ South Asian	2	1%	3	2%
Cambodian	1	1%	2	1%
Chinese	1	1%	2	1%
Eastern European	0	0%	1	<1%
European	1	1%	2	1%
Filipino	1	1%	0	0%
Japanese	0	0%	1	<1%
Korean	4	3%	0	0%
Middle Eastern	8	5%	2	1%
Vietnamese	0	0%	0	0%
Other	5	3%	11	7%
More than one ethnicity	4	3%	0	0%
Declined to answer	8	5%	12	8%
Total Non-Hispanic or Non-Latino	96	62%	95	60%

Source: ECTR Supplemental MHSA Race/Ethnicity Survey

Staff Demographics

A total of 52 staff who work at the four Berkeley YMCA Head Start sites responded to an online survey in the summer of 2020 for the evaluation. The survey was sent to 68 YMCA Head Start staff, including teachers and assistant teachers, managers, directors, coaches, family advocates, mental health consultants, and program assistants. The response rate was 76%.

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

Survey respondents in this second year of the ECTR program work at West YMCA (35%), South YMCA (31%), Oceanview (21%), and Vera Casey (12%) (See Table 6 below). Over half of survey participants have worked at the YMCA for greater than six years (52%), with 42% who have worked for Head Start for over 9 years. About a quarter of respondents have worked at YMCA for 3-5 years (27%) and about one in five have worked there for two years or fewer (22%). Participants include teachers (48%) and teacher assistants (25%), family advocates (8%), and administrative staff including center directors (6%), managers (6%), and other staff (6%). The great majority are female (85%), and nearly half identified as either Hispanic/Latinx (37%) or Black/African-American (17%). About a third of respondents were also Resiliency Champions (35%).

Table 6. Demographics of ECTR Staff Surveyed

	Year 1 %	Year 2 %
Site		
Oceanview	17%	21%
South YMCA	30%	31%
Vera Casey	8%	12%
West YMCA	43%	35%
Other (responses: all sites, admin office)	2%	2%
Length of time at YMCA		
Less than one year	12%	8%
1-2 years	22%	14%
3-5 years	20%	27%
6-8 years	12%	10%
More than 9 years	35%	42%
Job Title/Role		
Teacher Assistant	30%	25%
Teacher/Head Teacher	37%	48%
Area Manager	5%	6%
Center Director	5%	6%
Coach	2%	0%
Family Advocate	5%	8%
Mental Health Consultant	5%	0%
Program Assistant	3%	0%
Other Manager	7%	0%
Other (responses: floater, inclusion manager, kitchen)	2%	6%
Missing	0%	2%
Sex		
Female	77%	85%
Male	5%	0%
Missing/Declined to answer	18%	15%
Race		
American Indian or Alaska Native	2%	0%
Asian	7%	10%
Black or African American	18%	17%
Native Hawaiian or other Pacific Islander	0%	0%
White	5%	8%
Hispanic or Latinx	30%	37%
Other	5%	2%
More than one race	3%	0%
Missing/Declined to answer	30%	27%

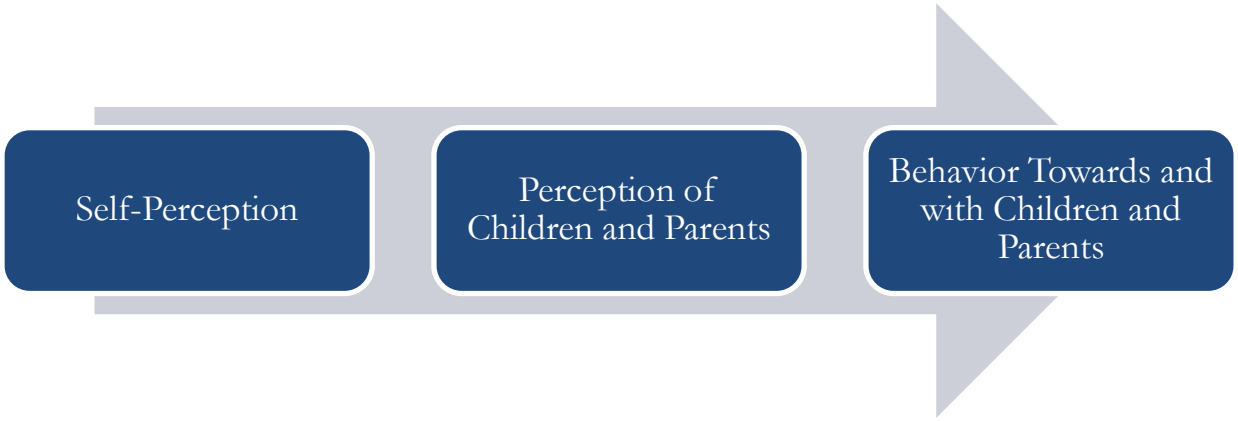
	Year 1 %	Year 2 %
Staff is a Resiliency Champion		
Yes	N/A	35%
No		50%
Missing		15%

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

HTA developed and administered a 39-item online survey to teachers and staff at the four sites in May and June 2020. The survey was developed by HTA in collaboration with ECTR program leaders adapting some questions from the Year 1 survey as well as existing surveys from the City of Berkeley's 2016-17 Trauma-Informed Systems pilot program and a 2016 trauma-informed practices self-assessment from defendingchildhoodoregon.org. The survey is administered annually to assess change in how staff understand how their own past trauma impacts their work, how staff view children and families who have experienced trauma and how that impacts their behavior, and changes in how staff approach the children and families with whom they work. In the first year, the survey was administered in the summer of 2019 and designed slightly differently as a post-retrospective survey. It asked staff how they would have answered questions prior to ECTR trainings began and then how they would answer in the past 30 days.

ECTR's Theory of Change posits that as staff attend trainings and learn about recognizing trauma, their own triggers, and strategies to working with children and families struggling with trauma, staff will change their own perceptions and feelings about trauma through reflections on their own lives and how that affects the way they work with children. Subsequently, they will begin to approach students and parents/guardians from a trauma-informed perspective (including shifting their framing from "What's wrong with you?" to "What happened to you?") and develop more positive, empathic relationships with students and their parents/guardians helping them to better identify trauma in the children/families they serve. Ultimately, staff will then change their actions and behaviors as it relates to children and families, and make more successful and "appropriate" mental health referrals. (See Figure 1 below).

Figure 1. ECTR Theory of Change for Staff



Source: Adapted from the ECTR Theory of Change

While there was incremental growth in the Year 1 survey results across staff views, their perceptions of children and their parents, as well as their behavior working with children and families there is limited growth in this second year. The YMCA and its ECTR project entered unchartered territory as a result of the stay-at-home orders resulting from the Covid-19 pandemic. While the ECTR trainings continued online and staff remained engaged with families, the ECTR project model is built on the premise that staff have day-to-day, intensive, in-person interactions with children throughout the school day, five days a week. Once the Head Start program shifted to virtual, children were no longer in the care of YMCA staff and YMCA staff did not have many opportunities to employ the strategies they continued to learn in trainings and Resiliency Circles. Their work with families was frequently limited to quick phone calls to check in. Likewise, the survey was not designed to measure the impact of a program that is shifting and pivoting to such a degree but rather for a structured and set program. This is important to highlight in order to contextualize the findings in this very unique year of ECTR programming.

The majority (69%) of participants in the staff survey expressed that prior to this year's trainings, they were "somewhat familiar" with trauma-informed approaches while 29% of participants expressed that they were "very" familiar, an increase from 18% who expressed this last year. (See Table 7 below).

Table 7. Staff Familiarity with Trauma Trainings

	Pre		Post Year 2	
How familiar are you with trauma-informed approaches to support children/families?	n	%	n	%
Very familiar	11	18%	15	29%
Somewhat familiar	39	65%	36	69%
Not at all familiar	7	12%	1	2%
Not Sure	1	2%	0	0%
No response	2	3%	0	0%

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

On average, survey respondents attended 2.25 trauma trainings, either among those offered through the ECTR project. See Table 8 below.

Table 8. Number of Trauma Trainings Attended by Staff

	n	%
0 trainings	7	14%
1 training	13	25%
2 trainings	8	15%
3 trainings	10	19%
4 trainings	12	23%
5 trainings	2	4%
Mean # of trainings attended	***2.25***	

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

Staff Views and Perceptions

In the survey, staff were asked about their views and perceptions of their own trauma and triggers, as well as their perceptions of children and families. In this second year of the program, staff felt most confident "that my actions had the ability to help a child who has been exposed to trauma"

(72%) and "in using trauma informed strategies" (67%). (See Table 9 below). Interestingly, all of the questions regarding staff's self-perception of their own trauma and triggers and their sense of being able to use the tools they learned with children fell to rates reported by staff from before the program began (the "pre" survey) or below. It is important to note the timing of the survey: it was conducted approximately three months after the shelter-in-place Covid-19 health order. Head Start teachers and staff were working with families remotely during this period, and were not managing a classroom. This circumstance likely explains the dramatic drop in those who had difficulty maintaining "a positive learning environment because of challenging classroom behavior" (3%). Responses to questions related to reflecting on their own trauma and triggers (29%) and noticing when they felt triggered by a child's behavior (49%) reverted close to the rates at the pre survey.

These results may be related to the fact that staff were not working directly with children at the time of the survey. The results may also be a result of staff themselves being thrust into highly unstable and uncertain circumstances both personally and professionally. Head Start staff are generally low-wage workers, many of whom were likely grappling with their own finances, health, and family issues at this time. In light of these variables, it is not surprising that the survey responses would slip considerably amid these unsettling events.

Table 9. Staff Self-Perception

	Pre % "Often" or "Always"	Post Y1 % "Often" or "Always"	Post Y2 % "Often" or "Always"
I felt I could handle every serious behavioral issue by myself	38%	43%	38%
I reflected on my own trauma and triggers	38%	67%	29%
I noticed when I felt triggered by a child's behavior	51%	70%	49%
I felt confident in using trauma informed strategies	69%	74%	67%
I had difficulty maintaining a positive learning environment because of challenging classroom behavior	21%	26%	3%
I felt confident that my actions had the ability to help a child who has been exposed to trauma	76%	81%	72%

Source: ECTR Evaluation Staff Survey, June/July 2019 (N=60), May/June 2020 (N=52)
Note: Percentages are valid (i.e. exclude missing and N/A responses). Pre and Post Y1 results are among staff who responded to the item for both the Pre and Post time periods. Percentage of missing or N/A responses for perception, behavior, and morale items in the Pre/Post Year 1 survey ranged from 20-36%, and from 15%-44% in the Post Year 2 survey.

For the survey items regarding staff perceptions of students and parents, staff sentiment about children and their future remained generally very positive. (See Table 10 below). Fewer staff "felt that a child's actions/behavior made me irritated" (from 14% in post-Year 1 to 6% in post-Year 2) and most felt generally hopeful about the lives of the children" (78%) and "understood why families may not seek out or accept mental health services/programs they need" (78%). In fact, this last area is the only one with growth since Year 1, likely as a result of increased collaboration between teachers, staff, mental health consultants, and family advocates.

Staff members may have felt like they had less access to observe their students and, therefore, less insight into what students and families were experiencing. About half of the families were available only via telephone (audio only), which did not allow staff to follow visual cues from the parents and children they serve. Contacts were also far more limited in time. While a teacher would typically have a child in her/his classroom for at least 8 hours a day, 5 days a week. Phone calls and other contacts during the pandemic, were both shorter and less frequent.
All of these factors may account for the decrease since Year 1 in a few questions asking about what they directly "saw" such as the percentage of those who "saw how children at my site have been impacted by trauma" (69% to 56%), "saw how parents/families have been impacted by trauma" (66% to 46%), "saw how 'class disruptions' or 'behavior problems' could be related to trauma the child has experienced" (74% to 38%), and "saw improvements in a child's behavior after I used trauma-informed strategies" (59% to 33%).

Table 10. Changes in Perceptions of Students and Parents

	Pre % "Often" or "Always"	Post Y1 % "Often" or "Always"	Post Y2 % "Often" or "Always"
A child's actions/behavior irritated me	11%	14%	6%
I saw how children at my site have been impacted by trauma	67%	69%	56%
I saw how parents/families have been impacted by trauma	66%	66%	46%
I saw how "class disruptions" or "behavior problems" could be related to trauma the child has experienced	67%	74%	38%
I saw improvements in a child's behavior after I used trauma-informed strategies	46%	59%	33%
I felt hopeful about the lives of the children at my site	81%	84%	78%
I understood why families may not seek out or accept mental health services/programs they need	70%	70%	78%

Source: ECTR Evaluation Staff Survey, June/July 2019 (N=60), May/June 2020 (N=52)
Note: Percentages are valid (i.e. exclude missing and N/A responses). Pre and Post Y1 results are among staff who responded to the item for both the Pre and Post time periods. Percentage of missing or N/A responses for perception, behavior, and morale items in the Pre/Post Year 1 survey ranged from 20-36%, and from 15%-44% in the Post Year 2 survey.

Staff Behaviors

Nearly all staff (94%) reported that they kept themselves "calm and regulated in moments working with a student who is challenging." About one in five respondents (21%) "felt hesitant to refer students to mental health resources." (See Table 11 below.) The one area of growth was the percentage of staff who "knew where or to whom to go when I had questions about a child's or parent's mental health" (81% to 85%). Nearly three quarters (74%) "used strategies rooted in trauma informed practices." Staff appear to feel that they have tools to cope with their responses to challenging behaviors.

Looking at change over time, many of the responses to these questions about staff behaviors also reverted to the "pre" survey rates or even decreased. As with the other survey items, it is important to note the timing of the survey took place while teachers and staff were working with families

virtually during an incredibly chaotic and stressful time and were not managing a classroom. Not surprisingly, the results showed no growth on questions about relationship-building with families like "I was able to build rapport with most parents/families" (79% to 66%), "I felt comfortable talking to parents about their child's emotional, developmental, or behavioral issues" (67% to 68%), "I worked with a child's parent/family to support a child's emotional or behavior issues related to trauma" (63% to 53%), "I shared information about trauma and its effects on behavior with parents/caregivers" (50% to 53%), and "I shared ways that I manage challenging trauma-related behavior with parents/caregivers" (51% to 50%).

Some of these early findings were shared with the ECTR project leaders who posited that what may be causing some of the lack of growth is that staff are feeling helpless while working with children and families remotely. They may be seeing children on Zoom and witnessing negative behavior from their parents, but while they may feel confident intervening in person, they have difficulty asserting their allyship virtually. The Project Coordinator and YMCA Executive Director also discussed that because staff are only seeing children for an hour or less rather than every day for a full day, they may be feeling disconnected.

Table 11. Changes in Staff Behaviors

	Pre % "Often" or "Always"	Post Y1 % "Often" or "Always"	Post Y2 % "Often" or "Always"
I was able to build rapport with most parents/families	79%	81%	66%
I felt comfortable talking to parents/families about their child's emotional, developmental, or behavioral issues related to trauma	67%	79%	68%
I worked with a co-worker to support a child with emotional or behavior issues related to trauma	80%	84%	64%
I worked with a child's parent/family to support a child who had emotional or behavior issues related to trauma	63%	75%	53%
I shared information about trauma and its effects on behavior with parents/families	50%	67%	53%
I used strategies rooted in trauma informed practices	67%	79%	74%
I shared ways that I manage challenging trauma-related behavior with parents/families	51%	63%	50%
I felt hesitant to refer a child to mental health resources (e.g., mental health specialist, outside mental health services)	21%	28%	21%
I knew where or to whom to go when I had questions about a child's or parent's mental health	79%	81%	85%
I kept myself calm and regulated when working with a child with challenging behavior	87%	93%	94%

Source: ECTR Evaluation Staff Survey, June/July 2019 (N=60), May/June 2020 (N=52)
Note: Percentages are valid (i.e. exclude missing and N/A responses). Pre and Post Y1 results are among staff who responded to the item for both the Pre and Post time periods. Percentage of missing or N/A responses for perception, behavior, and morale items in the Pre/Post Year 1 survey ranged from 20-36%, and from 15%-44% in the Post Year 2 survey.

In open-ended survey responses, staff described how the trauma trainings and/or resiliency circles impacted how they work with families. (See Appendix for all responses.) Many staff expressed how the trainings allowed them to have a better understanding of families: **"It has made me more understanding of why some families may react to things different and has given me an opportunity to address these families in a more understanding way"** and some felt the trainings allowed them to reflect on their own trauma and triggers: **"I have a better understanding of my own trauma and how I am impacted by others, i.e. triggers, etc."**

They were also asked how the trauma trainings and resiliency circles have changed their relationships with families. Many staff feel more confident about building the relationship with families: **"At first I was nervous about building relationships with parents, because I didn't know what the outcome would be, and I was worried that parents would not like me. Now I have built relationships with parents, and it's easier for me to communicate with them"** and others felt that they have a better relationship with parents, even despite Covid-19: **"The families and I have been more connected, even when this has happened remotely."**

Dr. Anita Smith, ECTR Project Coordinator, expressed that despite the survey results suggesting that staff have not grown in their knowledge and understanding of trauma and how it impacts families, she has seen firsthand how the ECTR trauma trainings have increased staff's ability to work with children and families. "Our teaching staff have exhibited a level of empathy towards the children and families whereas they have purposed themselves to see them differently with the intention to better understand rather than labeling or pathologizing. Another layer to this shift has been their own awareness of their past historical trauma and how close their adverse childhood experiences are to the children and families we serve. With the heightened awareness and knowledge, they too have begun the work towards healing and restoration within their own lives."

Staff Morale

The evaluation also asked two questions to assess staff morale at the YMCA Head Start sites. While not a comprehensive review of the organizational culture of YMCA, the two questions reveal that nearly all staff enjoy working at the school (93%), and staff relationships are consistently positive and supportive (91%). (See Table 12 below).

As the program continues and staff are expected to work together to address children's mental health issues, we anticipate that staff morale and the quality of staff relationships will remain high or even increase. This is also important to monitor as staff morale could help reveal whether there are other issues impeding the program's successful implementation.

Table 12. Staff Morale

	Pre % "Often" or "Always"	Post Y1 % "Often" or "Always"	Post Y2 % "Often" or "Always"
The relationships among the staff at this school were generally positive and supportive	85%	85%	91%
I enjoyed working at this school	98%	94%	93%

Source: ECTR Evaluation Staff Survey, June/July 2019 (N=60), May/June 2020 (N=52)
Note: Percentages are valid (i.e. exclude missing and N/A responses). Pre and Post Y1 results are among staff who responded to the item for both the Pre and Post time periods. Percentage of missing or N/A responses

for perception, behavior, and morale items in the Pre/Post Year 1 survey ranged from 20-36%, and from 15%-44% in the Post Year 2 survey.

In a focus group of seven staff members (five teachers, a family advocate, and an enrollment/childcare specialist) held in November 2019, staff revealed how much they rely on each other, particularly in challenging situations with children and families. (See Appendix for full summary). Teachers rely on each other to take over when they need a break. They are often able to recognize when they need to be separated from the child because they are getting overwhelmed, tired, or too frustrated. They use a team approach in the classroom and "are champions for each other, we feel protective of each other."

Mental Health Referrals

Number of Mental Health Referrals

As a critical component of the MHSA grant, mental health referrals will be tracked every year of the evaluation in order to measure change over time. Based on Program Information Reports (PIR) completed by the Mental Health Consultants and submitted to the Program Manager over the past three years, the number of mental health referrals have slightly increased this school year to five referrals (Table 13). The number of referrals, a longer-term outcome, is expected to increase as more staff understand their role in identifying and supporting access to children's mental health services.

Table 13. Number of Mental Health Referrals

School Year	# Children Referred
2017-18 (baseline)	9
2018-19	4
2019-20	5

Source: YMCA Program Information Reports (PIR) forms

In the focus group, participants described the challenges of getting parents to see the issues with their child and to get them to agree to seek services.

- "It's difficult if families don't agree that there are behavioral issues, they don't want to see it."
- "At the end of the day it's the family's choice to get extra services, and it is frustrating when they decline."
- "Parents don't want their kids labeled"
- "We will put in referrals for extra services, but it's up to the parents to accept."
- "We need to educate the parents."

They also shared best practices and recommendations for how to manage the relationships with families and staff when there is an issue with a child and referral may be necessary:

- Have **mental health consultation meetings** to talk about development of children
    - When families meet with different people who are telling them the same thing, this can help the family get on board
- Try and **learn the personality of the family**, who is the best person/teacher to approach them
- If you're a new teacher, you'll get walked over by the parents. You need to **have a veteran teacher in the room** with you
- **Staff have to be on the same page** and need to have good working relationships

    - Teachers will talk to parents and then they will go to the family advocate, the **family advocate needs to know what's going on** before they talk to the parent
    - Some parents would rather talk to the family advocate, so all teachers and staff need to be aware and on the same page, **family advocates sometimes know more** about what is going on with the family. This may bring up feelings for the teacher who may feel as if families should be comfortable talking to the teacher
- **Inclusion/mental health consultants need to be available** for the one-on-one meetings
- There needs to be a process so that when a referral form is submitted, there is **follow up with the teacher**

Referrals to "Appropriate" Mental Health Services

ECTR project leaders established a mental health consultation process where the teachers start their own early observations of children in collaboration with the observations of Mental Health Consultants/Specialists. They also complete forms that show patterns of behavior which allows for questions, rather than complaints, about a child for whom they would previously have no tangible behavioral examples. These forms provide an opportunity to discuss and initiate Trauma Informed Care strategies within the consultation meetings and classrooms.

Additionally, a new Mental Health Referral form, implemented in the fall of 2019, was initiated to be intentional about outside referrals and determine if they were "appropriate." In other words, documenting whether staff contacted referral agencies before the referral, whether the agency was a thoughtful match for the child, whether families utilized the referral, and whether it met families' needs. These are used by the Mental Health Consultants/Specialist during the parent meetings with their approval, to refer children out for mental health services to appropriate organizations that are trauma-trained and informed. Our Mental Health Consultants/Specialists initiate the connection with organizations and the parents to begin the intake process with the purpose of building rapport with the organization as a secondary contact if they have challenges connecting with the parents afterwards. Mental Health Consultants/Specialists do a 15- to 30-day follow-up with the parents to inquire about the follow through on acquiring services. If the parents have not followed through, then the Mental Health Consultants/Specialist inquires to see if they can help facilitate any further. If it is decided collaboratively with the parents that a therapeutic preschool setting would be a better fit for their child, then a Mental Health Consultant/Specialist would support them by accompanying them on a tour/visit of the new preschool. This initiates the intake process and move.

Four children received five referrals between December 2019 and July 2020. All (5 of 5) referrals were appropriate, in other words, the referral agency had availability to take new clients, is located somewhere accessible to the client, has experience with children age 0-5, is a cultural match for the child, and was given information about the child's needs. Three of the four families utilized the services of the referral, and all families who utilized the services expressed that it met the families' needs. One child/family was referred to the same agency twice but did not utilize the service the first time (February 2020) because of the stay-at-home orders. The second time (July 2020) the family did not utilize the service because the child's mom indicated that she had not been contacted.

The ECTR project leaders have expanded our categorization to include mental health as well as behavioral health referrals. When designing the project, the project team initially thought referring

more families to external mental health specialists would be the ideal scenario. As the project team has come to learn, that may not be the best option in terms of getting the right support to the children who need it. Additionally, getting families to agree that their child requires services and to agree to see a specialist is an ongoing challenge. Based on these learnings, the ECTR project has pivoted to support children who need a higher level of care in a much more appropriate and expeditious manner by bringing specialists directly into the classroom. As described by the project coordinator (See Appendix for full narrative):

"Due to the early establishment of the new procedure which encourages early observations and inquiries, we have been able to have several children placed at two therapeutic preschools in the Bay Area being Maya Angelou Academy in Oakland and EBAC (East Bay Agency for Children) here in Berkeley. This can be seen as a rarity; due to classroom room size being considerably smaller than our classrooms, they fill up very fast. The collaboration with teachers and parents help consider the wellbeing of the child and do not allow for things to be overlooked, ignored or dismissed. We have also had the benefit of working in collaboration with our Inclusion Team to coordinate having Behavioral Aides through Juvo (Autism and Behavioral Health Services) come into our classrooms to work with children who have both behavioral, developmental, and trauma concerns. We have been fortunate to witness the effectiveness of this support for current children within our program that would have otherwise been unmanageable within the classroom setting. These children's parents were not able to benefit from mental health services due to many personal and systemic issues, so to provide these services has been a true turn around for these children."

Conclusion

In this second year of the ECTR program, staff remain in a strong position in terms of feeling confident in their ability to work with the children at the four YMCA sites with trauma-informed strategies and tools. The YMCA program, and likewise the families they serve, faced unprecedented challenges this year with Covid-19 and the sudden closure of their sites. Despite these obstacles, the YMCA managed to quickly pivot to engage with families and children in a virtual setting, provided immediate assistance in the way of diapers, supplies, and other resources, and reached out individually to check in on families and manage crises when necessary.

The Early Childhood Trauma and Resiliency (ECTR) project also made important shifts to ensure staff trainings on trauma as well as Resiliency Circles continued, adapting them to a virtual format. In a survey taken in May and June of 2020 while working remotely, staff felt most confident "that my actions had the ability to help a child who has been exposed to trauma" (72%) and "in using trauma informed strategies" (67%). Fewer staff "felt that a child's actions/behavior made me irritated" (from 14% to 6%) and most felt generally hopeful about the lives of the children" (78%) and "understood why families may not seek out or accept mental health services/programs they need" (78%). Nearly all staff (94%) report that they kept themselves "calm and regulated in moments working with a student who is challenging." About one in five respondents (21%) "felt hesitant to refer students to mental health resources."

Looking at change over time, we do not see the growth that we may have expected, but we must be cautious before drawing conclusions. The survey was conducted while teachers and staff were working with children virtually, rather than in-person in their classrooms, and all of this took place during an incredibly chaotic and stressful time.

As the program continues into its third year, ECTR leaders plan to expand the Resiliency Circles and develop greater leadership from the Resiliency Champions, encouraging them to participate in training new staff on trauma-informed care and in starting to take on more a leadership role in the Resiliency Circles. Also, in the third year, the program will engage parents in these opportunities as well. Given the drastic change of circumstances and the unprecedented challenges facing families during the pandemic, the ECTR project leaders will have to assess the extent to which they need to re-visit knowledge and skills around previously delivered trauma-informed care trainings. The following strategies are in development for year three:

1. Resiliency Champions and Staff Onboarding. Trainings for new staff will continue to be conducted remotely rather than in-person for the foreseeable future. Dr. Smith will work with Resiliency Champions to turn the "Intro to Trauma Informed Care" onboarding training into a webinar which will be shared with new employees. In it, she and Resiliency Champions will provide a high-level overview and consolidation of the trauma trainings. Resiliency Champions will be centered as site-based leaders in trauma-informed care and strategies in order to sustain the program and demonstrate that the entire organization is trauma-informed.
2. Resiliency Champions to co-facilitate Resiliency Circles. Dr. Smith will identify five Resiliency Champions among the four sites to co-facilitate Resiliency Circles with her. These will begin by the first quarter of this next school year.
3. Parent Trainings and Resiliency Circles. Trainings on trauma-informed care will be provided specifically to parents in this third year. These will begin with the parents on the Policy Council as early as either September 25th or October 23rd. Parent Resiliency Circles are also in development with leaders first gathering input on topics of interest in order to garner buy-in.

The pandemic has significantly and unexpectedly impacted the ECTR project. While some of the survey results during the pandemic have been discouraging, at the same time, organizationally, project leaders feel the positive impact of the trauma-informed work. As a result, they are more effectively able to support Head Start staff and families through a devastating time. They are deeply appreciative of the tools, skills, and perspectives that they have acquired through this project and recognize how their growing expertise in trauma-informed care practice is enabling them to work more effectively with each other and the children and families they serve.

As a testament to the successful work of the ECTR program, this coming year (2020-21), the YMCA of the East Bay received federal funding to support and expand their mental health and trauma informed systems. Program leaders were able to submit a well-developed plan based on their current work at these four sites in Berkeley in order to scale the trauma-informed systems training to all of their Bay Area centers from Hayward to Rodeo. Dr. Anita Smith, Melanie Mueller, and other ECTR leaders are looking forward to implementing and expanding the trauma-informed systems developed through MHSA funding across the YMCA's regional programs.

Appendix

Focus Group Notes

Date of Focus Group: 11/27/2019
Facilitator: Sophie Lyons, HTA

Participants:

- Family advocate
- Teacher
- Teacher
- Enrollment and childcare
- Teacher
- Teacher
- Teacher

1. **Tell me about your work with children. What are one or two examples of the MOST challenging behaviors for you and how do you typically handle them?**

- Sometimes kids have not been identified as having or needing an individual family service plan; teachers and staff do not know their diagnosis
    - Teachers are not always equipped to deal with behavior issues, causes strain
    - Need to work with kid one on one to address their individual needs – discipline and positive reinforcement
- Parents are low income, affects the social life of families
    - Some kids are in single parent households
    - Often behavioral issues are physical in the classroom– fighting, pushing, biting
    - Teachers have years of experience and can recognize
- It's the undiagnosed children or kids who have family issues who have behavior issues
    - Children are physical towards the adults, not always towards other kids
    - Teachers take a child development classes, and learn a little bit about how to handle issues, but is it not always enough
    - Personal experience as parent with a child at Head Start - she had a child with behavioral issues, so has learned from that and understands the parent perspective, but it is still very challenging to work with some parents
    - Parents are not as educated (about child development) and are in denial; they also pass down generational trauma
- Difficult if families don't agree that there are behavioral issues, they don't want to see it
    - At the end of the day it's the family's choice to get extra services, and it is frustrating when they decline
    - Parents don't want their kids labeled
- Staff/teachers will put in referrals for extra services, but it's up to the parents to accept
    - Need to educate the parents
- In past 5 years, has seen/experienced more aggression from the kids, but not sure why
    - Kids are impulsive and quick to anger, short tempers, quick to react

Steps teachers and staff take to address issues

- Not allowed to call a parent for pick up, so they have to manage the behavior at school
- Teachers rely on each other to take over when they need a break – They are often able to recognize when they need to be separated from the child because they are getting overwhelmed/tired/too frustrated
    - They use a team approach in the classroom
- Document using ABC charts and they call parents to talk about their child when they complete these forms
    - Teachers try to focus on the positive with the parent when they come pick up the child, but also talk about the challenges with the parent
    - Use parent teacher conferences to talk about the challenges and the help kids need
- Teachers and staff try to drive home the point of safety to parents – help parents understand that they have a goal of keeping classrooms safe, so when one child is having behavioral issues, it means that one teacher has to work individually with them, which can decrease safety in the classroom
- When they talk to parents who blame other kids, they need to help parents see the good and the bad – they try to help parents see that all kids need to and deserve to be here
- Some parents are in denial – say the kid is fine with them and behaviors only happen in school
    - Have to try and get parents to see why that might be the case, that kids behave differently in different environments
- Try to give the kids all the love they can, but there is still a lot of stress
    - Even one challenging behavior kid can be a lot as they need the one on one time with teachers and staff

2. Tell me about your relationships with parents. How do you handle difficult conversations around their child's behavior/needs? What is your process like when working with parents around their child's challenging behavior/needs?

- A lot of times parent issues take priority over the child's issues
    - Talking about the child turns into a conversation about the parents' issues and needs
    - Parents get this help from family advocates, but cannot get out the mindset when they talk to teachers as well
    - The teachers are focused on the child's needs, while the FA is focused more on working with the whole family
- Many parents are in denial – "they don't do this at home…"
    - Or the challenging behavior is normal at home, so parent doesn't see it as an issue
    - Or parents who say they will be involved in finding a solution, but then they avoid the conversation with teachers
- If a parent does come to school to discuss the child during the day, a teacher has to leave the classroom to talk to a parent who is upset and could cause another safety issue
    - Parents say hurtful things to the teachers, sometimes they are discriminatory and disrespectful
    - Parent treat teachers like they are their employees sometimes

What could help the conversations with parents:

- Need a more strictly enforced code of conduct for anyone who comes in – parents need to stick to it, there is no consequence when parents do not follow it
    - At most there is a conversation
    - They just want parents to understand that they are trying to help the child in a school setting, trying to get them ready for bigger schools – teachers need help getting parents to understand what school is, that it's not just childcare
- Parents also experience a lot of trauma – teachers and staff know and recognize this
    - It's important to think about who is talking to the parents, a white staff member telling a parent of color what to do may not be effective

3. What has been your experience with working with colleagues to help a child/family who has challenging behavior issues? What role do you see for yourself in helping families access mental health services? (Have you tried to help a child or family get mental health support? Why or why not?)

- Sometimes there is a misunderstanding – teachers know they are supposed to serve families
    - But sometimes teachers don't feel that they have the support they need from administration – there's a lot of turnover
- Have mental health consultation meetings to talk about development of children
    - When families meet with different people who are telling them the same thing, this can help the family get on board
- Try and learn the personality of the family, who is the best person/teacher to approach them
- Case consultation is important, it's when you get to sit down with families
- Inclusion specialists and speech consultants are very helpful, teachers feel like they can go to them for help with a kid
- If you're a new teacher, you'll get walked over by the parents, need to have a veteran teacher in the room with you
- Staff have to be on the same page, need to have good working relationships
    - Teachers will talk to parents and then they will go to FA, the FA needs to know what's going on before they talk to the parent
    - Some parents would rather talk to the FA, so all teachers and staff need to be aware and on the same page, FAs sometimes know more about what is going on with the family
    - But sometimes it is challenging when parents feel more comfortable talking to the FA (rather than the teacher) – raises a red flag for the teacher, they feel as if families should be comfortable talking to the teacher
- Line of support exists, but sometimes the inclusion/mental health consultants are not available enough or you are too busy to do the one on one with them

- When you do a referral form, but then the ball gets dropped or there is no follow up, this can be very frustrating

4. Some of you may have taken an online survey from us a few months ago. We have some results that we want to share. Are these numbers surprising? Do they sound accurate? Why or why not?
    a. The percentage of staff who reflected on their own trauma and triggers increased from before to after the program started: 38% to 67%.
    b. The percentage of staff who could identify when they felt triggered by a child's behavior or actions increased from before to after the program started: 51% to 70%.

- First statistic is accurate likely – Julie's training could have helped staff see their own trauma and triggers, her introduction about herself was the best thing she presented
    - Not sure about the second stat – may not be accurate

5. Have you attended any of the recent trauma trainings (Understanding Trauma Informed Practices for Early Childhood Programs with Julie Kurtz; Self Care: Getting a PhD in You! with Julie Kurtz; Resiliency Champion trainings)?

- Didn't find the trainings helpful – not agreeable to Julie's approach (*agreement from one other person in the group*)
- Initial story that Julie told about her own background was interesting and helpful, but then the rest of the presentations were not as helpful
    - Would be more helpful to have this person be able to show what they can do in the classroom, not just tell them what might work
- Every situation in the classroom is different, so what they are being trained on will not be the same or work for everyone
    - Training needs to be tweaked for different situations
- The "if you do x, then y will happen" way of training doesn't help as staff knows that kids have differences in what they need
    - Training is too "basic" teachers are more aware of trauma, they know more than the trainers expected
- The trainings are way too long – a multi hour training is hard to pay attention to (*group agreement on this*)
- Maybe the trainings should be done in smaller groups (*group agreement on this*)
    - Not everyone is paying attention, therefore they won't bring what they learned back to the classroom
    - Center by center would be better, smaller group trainings would be more effective
- Some teachers are not ready because they have their own traumas
    - Teachers have to deal with their own traumas
    - Trainings may heighten some people's awareness of traumas

- Anita provides more individualized care for teachers, which has helped
    - Teachers love working with Anita
- There has been progress in getting teachers to understand and recognize trauma, but there is still work to do
- It's the person, not the trainings themselves, that might be the problem
    - Didn't vibe with the style, too lecture based, too long
    - Interactive activities were better, need movement activities

6. **Has anything you learned in trainings changed or helped with your relationships with children? Parents? Colleagues? In your personal life?**

- Learning the physicality of what happens when they are triggered by a child's behavior
    - Smell reminders, etc.
- Talking about the importance of self-care was helpful, now they think about the self-care when a child is exhibiting challenging behavior
- There is a line that parents cross, we can't blame the teachers for reacting poorly sometimes
    - How do you "train" teachers to not have their own reactions, to not take things personally
- Need concrete strategies for how to work with parents
- Teachers are champions for each other, they feel protective of each other
- But parents also need actual consequences when they break the code of conduct, it can't just be
    - Bargaining team with the union is working on the importance of the code of conduct and holding parents accountable

Full Narrative Transcript, ECTR Project Coordinator

1. How did Head Start address trauma in children/families before the ECTR program?

Previous to the City of Berkeley Trauma grant the YMCA of the East Bay had established Mental Health Consulting whereas monthly classroom consultation meetings were conducted with teachers, Center Directors, Family Advocates and Mental Health Consultants/Specialists. Within these meetings, classroom dynamics were discussed which includes those children with what was considered "challenging behaviors" as well as resources that could be utilized to support them. This collaboration meeting would yield mental health consultation strategies and plans that would include social and emotional strategies to support the children on the radar and the classrooms as a whole.

In addition to these meetings individual child consultation meetings would be held with parents in order to gain more developmental and historical information that would help to better understand what was going on with their child and any family dynamics that were attributing to their child's presentation within the classroom. Additionally, within these parent meetings, a Positive Behavioral Support Plan would be established with strategies for the classroom and for the parents to utilize at home. Within these meeting outside resources were discussed like mental health services for the child and family as well as the possibility of a new small therapeutic preschool placement and

possible psychological assessments needed to diagnosis with the intention of effective interventions. Parents would sign this document as an indication of acknowledgement and acceptance of their role and the steps that are necessary to support their child. This was to ensure the parental role in promoting their child's developmental and academic advances not only within the classroom setting but, in their child's, everyday life. This is seen as preventative care rather than intervention. Frederick Douglass stated that "it is easier to build strong children then to repair broken men."

2. What did you change with the ECTR grant? How? Why?

Our intention as The YMCA of the East Bay in applying for and accepting the City of Berkeley Trauma grant, is to empower or teaching staff, administration and management with evidenced based knowledge that is trauma informed with the purpose of changing the lens from what is wrong with this child to what has happened to this child. We believe that this knowledge would empower those within these classroom settings to change their individual understanding, mindset and heart set towards the children and families we serve. Therefore, since the onset of Trauma Informed trainings on the foundations of trauma which include the developmental and neurological effects of trauma, Trauma Informed care strategies, self-care strategies and engaging with families an allowed for a systemic anticipated shift to occur. Our teaching staff have exhibited a level of empathy towards the children and families whereas they have purposed themselves to see them differently with the intention to better understand rather than labeling or pathologizing. Another layer to this shift has been their own awareness of their past historical trauma and how close their adverse childhood experiences are to the children and families we serve. With the heightened awareness and knowledge, they too have begun the work towards healing and restoration within their own lives.

3. What systems, policies, procedures have you put in place in order to better address the mental health and behavioral needs of children?

At the onset of this City of Berkeley Trauma grant, we established a Mental Health consultation procedure whereas the teachers start their own early observations in collaboration with Mental Health Consultants/Specialists observations. They also keep behavioral forms that show patterns of behavior which allows for questions, rather than complaints about a child that they would previously have no tangible behavioral examples of. These forms provide an opportunity to discuss and initiate Trauma Informed Care strategies within the consultation meetings and classrooms.

Newly established Mental Health Referral forms were also initiated to be intentional about outside referrals. These are used by the Mental Health Consultants/Specialist during the parent meetings with their approval, to refer children out for mental health services to appropriate organizations who are Trauma trained and informed. Our Mental Health Consultants/Specialists initiate the connection with organizations and the parents to begin the intake process with the purpose of building rapport with the organization as a secondary contact if they have challenges connecting with the parents afterwards. Our Mental Health Consultants/Specialists do a 15-30 day follow up with the parents to inquire about the follow through on acquiring services. If the parents have not followed through, then the Mental Health Consultants/Specialist inquire to see if they can help facilitate any further. If it is decided collaboratively with the parents that a therapeutic preschool setting would be a better fit for their child, then a Mental Health Consultant/Specialist would support them by accompanying them on a tour/visit of the new preschool which initiates the intake process and move.

4. When did you put these in place and why? What are some examples of children/families these have worked for?

Due to the early establishment of the new procedure which encourages early observations and inquiries, we have been able to have several children placed at two therapeutic preschools in the Bay Area being Maya Angelou Academy in Oakland and EBAC (East Bay Agency for Children) here in Berkeley. This is can been seen as a rarity due to classroom room size begin considerably smaller than our classrooms, they fill up very fast. The collaboration with teachers and parents help consider the wellbeing of the child and not allow for things to be overlooked, ignored or dismissed. We have also had the benefit of working in collaboration with our Inclusion Team to coordinate having Behavioral Aids through JUVO come into our classrooms to work with children who have both behavioral, developmental and trauma concerns. We have been fortunate to witness the effectiveness of this support for current children within our program that would have others wise been unmanageable within the classroom setting. These children's parents were not able to benefit from mental health services due to many personal and systemic issues, so to provide these services has been a true turn around for these children.

We continue to look forward to the work ahead of us with empowering the parents in our program with the same trainings that we have provided for our staff. This is with the hope that it will not only allow them to have a better understanding of their children but to connect the dots on their own adverse childhood experiences along with historical and cultural trauma that has been in the way of their own healing and the work that needs to be done to shift the trajectory of their family with hope leading the way.

Open-Ended Responses from Staff Survey (May/June 2020)

How have the trauma trainings or Resiliency Circles changed how you work with families/children?

- As in apprentice I have learned a lot. The YMCA has taught me a lot in this horrible times of the pandemic the trainings I have taken and how it's preparing me for any guide the children and families will need as a resource or activities children can do for trauma the way they need to be treated to help them to learn and have a healthy and happy growth.
- Channels your inner thought process
- Help me more to get more knowledge to support to families may needed by using different strategies and referred to our mental health supported as well out of the agency mental health supported.
- I can see the difference Corona has impacted families. Some people show how much it effected them and others don't show it. From the training, I get to hear other peoples stories
- I didn't have this experience yet
- I don't work directly with families and children.
- I feel that I understand better how trauma impact children and families
- I got a more detailed understanding of how trauma effects children's learning in the classroom environment.
- I have a better understanding of my own trauma and how I am impacted by others, ie triggers, etc
- I have good relationship with the families

- I have realized that some of the trauma that our children and families have suffered is a lot deeper than what we may be able to handle and that we need to make sure that we have resources for our families.
- I talked to the family weekly and have zoom meeting with kids and families Give one on one time Read book to the kids do so interactive activities through video and zoom
- I understand my own trauma triggers and I can manage them appropriately.
- I will more confident more knowledge and have more resource to handle the traumatize kids or families
- It has made me more understanding of why some families may react to things different and has given me an opportunity to address these families in a more understanding way.
- it really break down the difference between behavior and trauma, and what is really trauma.
- It's easier to communicate with families and support them
- My perspective on impact of trauma has changed and deepened. I see TIC as ongoing tool when supporting all children, families and staff.
- No change, just reassurance
- Teach me more strategies to use.
- teaches me a lot
- The training have been a good review of past trainings I've attended during my years at HS or trainings from the masters credential program. Some things are refreshers and others have built upon previous concepts.
- The trauma add more knowledge to the little experience I have before and I will be confident to help and support a traumatic child.
- The trauma training has changed the way I work with families and children because it gave me a better understanding.
- The Trauma Trainings have helped me to understand the many characteristics of a child's behavior, and of the parent's as well. It also made me realize that it's important for teachers to try to remain calm when dealing with parent's because sometimes parents can be overwhelmed.
- to always support parents with their needs. referring them to specialists
- Trauma trainings during this time have helped understand more the resiliency circles. Also gave me more tools in order to be able to help and support my families and children.
- Understanding a child's behavior in the classroom.
- Using positive strategy that we learn in the training
- We can use strategies we get on training

In what ways has your relationship with families changed since you attended the trauma trainings or resiliency circles, if at all?

- At first I was nervous about building relationships with parents, because I didn't know what the outcome would be, and I was worried that parents would not like me. Now I have built relationships with parents, and it's easier for me to communicate with them.
- Better communication with them
- Better communication with them
- Better understand the families because we all have trauma especially at this time
- depend on the behavior of the child

- Didn't have this experience yet
- I am more compassionate towards myself.
- I feel like my relationships with parents have gotten a lot better.
- I feel more confident.
- I feel more confident talking to families about strategies to cope with trauma
- I have a better understanding of why families sometimes do not accept mental health support. I can also see more clearly generational impact of trauma.
- I Having been trained I can now better handle the kids. With the shelter in place, I proactively guide the parents to be patient with the kids. This help the parents to have an easy happy time at home while the shelter in place is active.
- I'm learning to step back when triggers arise and remain calm until I develop a plan of action.
- it did not change much but i have a better understand on how parents do not share.
- Keep calm and listen to parents and give them positive environment To open up more
- More understanding of the children's situation at home.
- My relationships have changed because I am more knowledgeable of trauma and it gives me the tools to better help the families.
- My relationships with families has not changed science the trauma training.
- My relationships with my parents are positive.
- n/a for now. I will hear and listen to their problems and try to give them suggestions on what to do
- Offering activities to work with kids.
- parents are willing to help child and their needs
- still same
- The families and I have been more connected, even when this has happened remotely.
- The relationships are still good but a little strained by the COVID - 19.
- The training are reminder to remember that experienced shape a person. Not to take a response personally because words, actions, expression can be triggering. Remember to remain calm.
- Understanding more about emotions personal things that can trigger them. Feelings can burst for any reason because trauma can live within them at all times. We must be strong to thrive forward and keep the families healthy and strong.

Additional thoughts and comments

- Am glad to do the trauma trainings on the 18th May and the 28th of May 2020
- I am very grateful with the organization because they have always provided the tools and trainings to grow professionally and improve my practices. THANK YOU for this opportunity!
- I answered questions personally, what I'm experiencing in my own household in this time. As I have not been present in a classroom since 3/16/2020
- I do not have additional thoughts, comments and responses.
- Thank you for provide us those training to reinforce my knowledge and get a new information or resources to support the families as well to us.
- Trauma is harmful and difficult. Only the strong survive.

APPLICATION FOR APPOINTMENT TO
BERKLEY/ALBANY MENTAL HEALTH COMMISSION

RECEIVED
JUN 22 2021
CITY OF BERKELEY
CITY CLERK DEPARTMENT

NAME: Tommy Escarcega

PREFERRED PRONOUN(S): her,her's, she

Residence Address: 830 Allston Way (Street) Berke (City) (Zip)

Business Name/Address: "Get Out The Jail Vote" Campaign

830 Allston Way (Street) Berkeley, C 94710 (City) (Zip)

Occupation/Profession: Community Advocate/Organizer

Business Phone: 510 409 1662 **Home Phone:** 510 845 4622

Email address: tescarcega53@gmail.com

Employer's Name: PFSMed

Name of Spouse's Employer: N/A

(Please note that pursuant to Welfare and Institutions Code Section 5604(d), no member of the City of Berkeley's Mental Health Commission or his or her spouse may be: (a) a full or part time employee of City of Berkeley's mental health division, (b) a full or part time county employee of a county mental health service, (c) an employee of the California Department of Health Care Services, or (d) an employee of, or paid member of the governing body of, a mental health contract agency. If you are unsure whether your employment or your spouse's employment falls within this restriction and are interested in applying for the Commission, please contact the Commission Secretary.)

The following individuals are qualified to comment on my capabilities:

NAME	ADDRESS	PHONE NO.
Mark Toney		
Patricia Loya		

The City of Berkeley's Conflict of Interest Code requires members of all City of Berkeley Commissions except the Youth Commission and Commission on Status of Women to file Statements of Economic Interests – FPPC Form 700. The Form 700 is a public document. For more information, please contact the City Clerk's Department at 981-6900, or visit our website at http://www.cityofberkeley.info/ContentDisplay.aspx?id=4176.

APPLICATION FOR APPOINTMENT TO
BERKLEY/ALBANY MENTAL HEALTH COMMISSION

Name: Tommy Escarcega

I have been a resident of: Berkeley / Albany since: before 2003
(circle one)

I qualify for appointment under the following:

☐ Representative of General Public Interest who shall be persons representing a broad range of disciplines, professions, and fields of knowledge.

☑ Representative of Special Public Interest who shall be consumers who are receiving or have received mental health services or family members (parents, spouses, siblings, or adult children) of consumers. *Please indicate at least one:*

☐ Consumer ☐ Family member

Signature of Applicant: _____ **Date:** 6/15/2021

AFFIDAVIT OF RESIDENCY

I, Tommy Escarcega, hereby declare, under penalty of perjury, that I am a resident of the City of Berkeley. I understand that, with the exception of a temporary relocation outside of Berkeley not to exceed six months, I may no longer serve on a Berkeley Commission should this cease to be true.

Signature of Applicant: _____ Date: 6/15/2021

DEMOGRAPHIC SURVEY (Optional):

Please indicate gender: ☐ **Male** ■ **Female** ☐ **Nonbinary** ☐ **Prefer not to say**
Please indicate whether you are currently a student: ☐ **Yes** ■ **No**
Please indicate the racial / ethnic category which you most closely identify with below (*response optional - please check only one category*):

- ☐ ***WHITE (not of Hispanic or Latino origin):*** All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East
- ☐ ***BLACK or AFRICAN AMERICAN (not of Hispanic or Latino origin):*** All persons having origins in any of the Black racial groups of Africa
- ■ ***HISPANIC or LATINO:*** All persons of Central / South America or other Spanish culture or origin, regardless of race
- ☐ ***ASIAN (not of Hispanic or Latino origin):*** All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent. This includes, Cambodia, China, Japan, India, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam
- ☐ ***AMERICAN INDIAN / ALASKAN NATIVE (not of Hispanic or Latino origin):*** All persons having origins in any of the original peoples of North, Central, and South America, and who maintain cultural identification through tribal affiliation or community recognition.
- ☐ ***NATIVE HAWAIIAN / PACIFIC ISLANDER (not of Hispanic or Latino origin):*** All persons having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- ☐ ***TWO or MORE RACES (not of Hispanic or Latino origin):*** All persons who identify with more than one of the above six races

APPLICATION FOR APPOINTMENT TO
BERKLEY/ALBANY MENTAL HEALTH COMMISSION

Supplemental Questionnaire
Berkeley/Albany Mental Health Commission

In addition to completing the application form, candidates are requested to provide the following information to assist the Mental Health Commission in their process to recommend applicants for appointment by Berkeley City Council. Please use an additional sheet if necessary.

1. Please explain why you are interested serving on the Berkeley/Albany Mental Health Commission.
   Several experiences w/ Berkeley Mental Health Services, throughout long-term homelessness as well as an established ,employed taxpayer and resident.

2. Are you involved in other community activities? If so, which ones?
   S.F. Re Entry Commission,
   All of Us or None
   Get Out The Jail Vote Campaigns

3. What, in your opinion, are the most important mental health issues in Berkeley and/or Albany?
   Using other models of treatment as well as "community" engagement, consumers not only having a voice but a meaningful vote

4. What do you recommend doing about them?
   see #3 above

5. It is important that Berkeley Mental Health be responsive to the needs of our culturally diverse community. What knowledge and experience do you have that could help provide insight on how to make Berkeley Mental Health even more inclusive of under-served communities?
   I am a bilingual/bi-cultural Chicana lesbian with ADHD and brain trauma issues who personally experienced being "under served" and ultimately denied any services.

6. What unique contributions (work experience, education, attributes and training) do you have to make to the Mental Health Commission?
   Long time community advocate some travel, taught ESL in Mexico and Spanish in the United States.

Return this form to the City Clerk Department: 2180 Milvia Street, Berkeley, 94704

Health Housing and
Community Services Department
Mental Health Division

MEMORANDUM

To: Mental Health Commission
From: Steven Grolnic-McClurg, Mental Health Division Manager
Date: July 13, 2021
Subject: Mental Health Manager Report

Mental Health Services Report

Please find the attached report on Mental Health Services for June, 2021.

Record Keeping Systems and Data

The Mental Health Division uses approved data collecting forms from the Alameda County Behavioral Healthcare Plan (ACBH), and enters this data into Clinician's Gateway, the electronic record keeping system utilized by ACBH, and InSyst, an electronic record keeping and billing system that is part of Clinician's Gateway. Clinician's Gateway contains information on client demographics, service history and detail, assessments, and treatment plans. When an open client receives a service from another ACBH provider (Hospital, Sub-Acute Residential, Treatment Team, Psychiatry) that information is available in Clinician's Gateway. All clinical staff have access and use Clinician's Gateway on a regular basis.

For each open client, there is a paper chart compiled, which contains a printout of the Initial and Annual Assessments, Treatment Plan, Releases of Information, Informing Materials, Progress Notes documenting interventions with client and others, and other documentation related to services and client history. This paper chart is also accessed on a regular basis by clinical staff. At program entry, staff complete the "Client Registration Data Entry Form" (attached in packet) and on an annual basis complete an "Annual MH Assessment." I've included the forms for both the registration and annual assessment in the packet as attachments so commission members can see the exact information recorded.

For a number of programs that work primarily with unopened clients, they document their work in the Mobile Crisis Log, a HIPAA secure electronic record keeping system developed by the City of Berkeley. This log tracks demographic information and interventions provided.

The Mental Health Division is working with the City to get approval to participate in the Community Health Record, which provides varying level of information (depending on what releases individuals have signed) about other services provided to clients. We are, at this time, awaiting City Attorney approval of the participation agreements.

Alameda County also provides access to a reporting system, Yellow Fin, that draws information from a variety of sources to provide detailed program level information on services. At this time, Alameda County does not provide access to client level data to community providers such as the City of Berkeley's Mental Health Division. Some programs also keep "registries" – program specific data information of clinically important information that is not accessible through the currently available record keeping systems above.

As you may remember, the Mental Health Division is working with Resource Development Associates to develop Results Based Accountability outcome measures for each internal program. These measures will primarily draw data from the above databases. The Health Equity Committee also is regularly reporting on a variety of health measures, and either uses the above databases or does a manual review of paper charts to develop reports.

Berkeley Mental Health Caseload Statistics
for June 2021

Adult Services	Intended Ratio of staff to clients	Clinical Staff Positions Filled	# of clients open this month	Average Monthly System Cost Previous 12 Months	Fiscal Year 2021 Demographics as of Jan 2021
Adult, Older Adult and TAY Full Service Partnership (AFSP) (Highest level outpatient clinical case management and treatment)	1-10 for clinical staff.	4 Clinicians .5 Team Lead	70	$5,045	79 Clients API: 1 Black or African-American: 21 Hispanic or Latino:4 Other/Unknown: 33 White: 20 Male: 50 Female: 29
Adult FSP Psychiatry	1-100	.75 FTE	59		
AFSP FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff			$2,037,600		
Comprehensive Community Treatment (CCT) (High level outpatient clinical case management and treatment)	1-20	8 Clinicians 1 Manager	177	$2,069	194 Clients API: 4 Black or African-American: 55 Hispanic or Latino:12 Other/Unknown: 82 White: 41 Male: 97 Female: 97
CCT Psychiatry	1-200	1 FTE	140		
CCT FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff			$2,617,010		
Focus on Independence Team (FIT) (Lower level of care, only for individuals previously on FSP or CCT)	1-20 Team Lead, 1-50 Post Masters Clinical 1-30 Non-Degreed Clinical	1 Clinical Supervisor, I Licensed Clinician, 1 CHW Sp./ Non-Degreed Clinical	102	$1,159	105 Clients API: 4 Black or African American: 28 Hispanic or Latino: 2 Other/Unknown: 35 White: 36 Male: 65 Female: 40
FIT Psychiatry	1-200	.5	91		
FIT FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff			$900,451		

Family, Youth and Children's Services	Intended Ratio of staff to clients	Clinical Staff Positions Filled	# of clients open this month	Average Monthly System Cost Last 12 months	Fiscal Year 2021 Demographics as of January 2021
Children's Full Service Partnership (CFSP)	1-8	1.5 Clinical	9	$4,828	18 Clients American Indian: 1 API: 0 Black or African-American:9 Hispanic or Latino: 2 Other/Unknown: 3 White: 3 Male: 13 Female: 5
CFSP FY21 Mental Health Division Estimated Budgeted Personnel Costs			$489,235		
Early and Periodic Screening, Diagnostic and Treatment Prevention (EPSDT) /Educationally Related Mental Health Services (ERMHS)	1-20	2.5 Clinical	51	$1,888	87 Clients American Indian: 1 API: 1 Black or African-American: 29 Hispanic or Latino: 18 Other/Unknown: 16 White: 22 Male: 50 Female: 37
EPSDT/ERMHS FY21 Mental Health Division Estimated Budgeted Personnel Costs			$1,062,409		
High School Health Center and Berkeley Technological Academy (HSHC)	1-6 Clinician (majority of time spent on crisis counseling)	2.5 Clinical	Treatment: 18 Groups offered: 0 Groups conducted: 0 Crisis/Warmline: 7		N/A
HSHC FY21 Mental Health Division Estimated Budgeted Personnel Costs			$396,106		
Children's Psychiatry	1-100	0	4		

Crisis and ACCESS Services	Staff Ratio	Clinical Staff Positions Filled	Total # of Clients/Incidents	MCT Incidents Detail	Fiscal Year 2020 Demographics – From Mobile Crisis Incident Log (through May)
Mobile Crisis (MCT)	N/A	2 Clinician filled at this time	• 90 Incidents • 24 5150 Evals • 5 5150 Evals leading to involuntary transport	• 52 Incidents: Location - Phone • 35 Incidents: Location - Field • 0 Incidents: Location - Home	API: 43 Black or African-American: 156 Hispanic or Latino: 32 Other/Unknown: 215 White: 263 Male: 345 Female: 361 Other: 5 Unknown: 25
MCT FY21 Mental Health Division Estimated Budgeted Personnel Costs			$771,623		
Transitional Outreach Team (TOT)	N/A	1 Licensed Clinician, 1 Case Manager (both sometimes reassigned due to staffing needs in other units)	61 Incidents		
TOT FY21 Mental Health Division Estimated Budgeted Personnel Costs			$272,323		
Community Assessment Team (CAT)	N/A	1 Team Lead, 1 Clinician, 1 Non-Degreed Clinical	65 Incidents		
CAT FY21 Mental Health Division Estimated Budgeted Personnel Costs			$735,075		

Not reflected in above chart is Early Childhood Consultation, Wellness and Recovery Programming, or Family Support.

*Average System Costs come from YellowFin, and per ACBH include all costs to mental health programs, sub-acute residential programs, hospitals, and jail mental health costs.

GUIDELINES/PROMPTS:

1. A Full MH Assessment may not be required for every new episode of care. Use the one-page MH Assessment Update if: importing a full MH Assessment that was done in the past 12 months in your program, or importing a full MH Assessment from a program conducted in the past 6 months.
2. If a full MH Assessment may not be completed by day 60 for clinical reasons, indicate reason and you may continue to claim for unplanned services (crisis, assessment, plan development, case mgt for linkage, meds for urgent need).
3. If a one-page Interim MH Assessment is completed by day 30 of EOD, a full MH Assessment is not due until day 60.
4. If any information is unable to be collected in the MH Assessment, or inappropriate to collect at this time (due to client's individual circumstances) indicate this and when attempts will be made again.
5. Pay special attention to wording such as "when clinically relevant". Examples may be provided, but it is not necessary to inquire into each one—this is determined by the assessor's clinical judgement.
6. Any statements beginning with "PROMPT" are instructions and will not be present in the finalized MH Assessment copy.

Allergies

☐ Yes ☐ No

☐ No new allergies reported

Episode Opening Date: **Birthdate**: **Age:** **Preferred Language**: Choose an item.

Preferred Last Name: **Preferred First Name**:

What is your Pronoun: She/Her: ☐ He/Him: ☐ They/Them: ☐ Unknown/ Not Reported: ☐ Other: ☐

Sex Assigned at Birth: Male: ☐ Female: ☐ Other: ☐

Gender Identity: Unknown: ☐ Male: ☐ Female: ☐ Intersex: ☐ Gender Queer: ☐ Gender non-conforming: ☐

Prefer Not to Answer: ☐ Other: ☐

Transgender: ☐ Male to Female/Transgender Female/Trans Woman ☐ Female to Male/Transgender Male/Trans Man

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SEXUAL ORIENTATION: Unknown: ☐ Bisexual: ☐ Declined to State: ☐ Gay: ☐ Gender Queer: ☐

Heterosexual/Straight: ☐ Lesbian: ☐ Questioning: ☐ Queer: ☐ Other: ☐

Emergency Contact: Relationship:

Contact Address (Street, City, State, Zip): **Contact Phone #:**

☐ Release for Emergency Contact obtained for this time period (or contact is legal representative and release not needed):

ASSESSMENT MENTAL HEALTH

☐ **Initial** ☐ **Update**

☐ **Informing Materials signed (annually)** ☐ **Release of Information Forms signed (annually)**

INITIAL ASSESSMENT SUMMARY

Assessment Sources of Information (Check All that Apply):

Client: ☐ Family Guardian: ☐ Hospital: ☐ Other: ☐

REFERRAL SOURCE/REASON FOR REFERRAL/CLIENT COMPLAINT:

Describe precipitating event(s) for Referral:

Current Symptoms and Behaviors (intensity, duration, onset, frequency; present/new precipitants/stressors; for episodic illnesses describe first episode, onset, precipitants, duration & Rx response; etc.):

Impairments in Life Functioning caused by the MH symptoms/Behaviors (from perspective of client and/or others):

MENTAL HEALTH HISTORY

Psychiatric Hospitalizations / Outpatient Treatment: Yes: ☐ No: ☐ Unable to Assess: ☐

If Yes, describe any known dates, locations, reasons, response to, and satisfaction with treatment:

Prior Mental Health Records Requested: Yes: ☐ No: ☐

(See InSyst Face Sheet for current and history of past services)

Prior Mental Health Records Requested from:

History of Trauma or Exposure to Trauma: Yes: ☐ No: ☐ Unable to Assess: ☐

PROMPT: Describe clinically relevant traumas that may be like: (1) been physically hurt or threatened by another, (2) been raped or had sex against their will, (3) lived through a disaster, (4) been a combat veteran or experienced an act of terrorism, (5) been in severe accident, or been close to death from any cause, (6) witnessed death or violence or the threat of violence to someone else, or (7) been the victim of crime (8) Prolonged separation from parent/caregiver/family? Describe:

Risk factors: Yes ☐ No: ☐ Unable to Assess: ☐

Indicate all clinically relevant risk factors.

PROMPT: DHCS has elaborated the following circumstances as placing the client at higher risk: Current or History of Danger to Self (DTS) or Danger to Others (DTO); Previous inpatient hospitalizations for DTS or DTO; Prior suicide attempts; Lack of family or other support systems; Arrest history; Probation status; History of alcohol/drug abuse; History of trauma or victimization; History of self-harm behaviors (e.g., cutting); History of assaultive behavior; Physical impairments (e.g. limited vision, deaf, wheelchair bound) which makes the beneficiary vulnerable to others; Psychological or intellectual vulnerabilities [e.g., intellectual disability (low IQ), traumatic brain injury, dependent personality]. Describe any relevant factors that increase risk (frustration tolerance, hostility, paranoia, command hallucination, exploitative behaviors and any relevant factors that might lessen such risk such as client's commitment to self-control and involvement in treatment.

Please check if occurred within the last 30 days: ☐ Date of onset:

Safety plan will be completed with Client Plan if any S/I, H/I, or other High Risk in past 90 days. Reports Filed as a result of this Assessment: ☐ N/A ☐ CPS ☐ APS ☐ Other

PSYCHOSOCIAL HISTORY

Family History

Include any clinically relevant factors such as: current family make-up--required; family of origin; family history of: mental illness and suicide--required, substance abuse, domestic or child abuse/neglect (physical, sexual, emotional, etc.); arrests/court proceedings; immigration status, etc.

Cultural Formulation:

PROMPT: Consider any clinically relevant cultural factors which may influence presenting problems as viewed by client/family/caregiver and the clinician. Factors may include ethnicity, race, religion, spiritual practice, sexual orientation, gender identity, caregiver or client socio economic status, living environment. Consider how special treatment issues result from the client's/family diversity AND how it may be a strength for the client.

ADULTS, 18+ yrs. only

Childhood (where, who reared/lived in house where grew up, important/traumatic events, school experience and performance, history of physical/sexual abuse, placement history, etc.).

Adolescence (school and activities, friendships/relationships, sexual experiences, traumas, leaving home, placement history, etc.)

Adulthood (military service, marriage/divorce, children, geographical changes, traumas, current relationship with family/significant other, etc.)

Aging issues (retirement, grandchildren, support systems, sleep changes, losses, etc.)

Education and Vocational History (first job, longest job, current structured activities, type of work, etc.)

Would you like assistance with accessing Education and to have educational supports included in your services?

☐ **Yes** ☐ **No**

Would you like assistance with accessing Employment and to have employment supports included in your services?

☐ **Yes** ☐ **No**

LEGAL HISTORY

Legal History:

PROMPT: Describe any clinically relevant legal encounters for client or family such as: landlord/tenancy; employment; family; criminal; immigration, etc.

MEDICAL HISTORY

	Name	Address	Phone #	Last Date of Service
Primary Physician				
Other medical provider(s):				
Date records requested: From whom, if applicable:				

Relevant Medical History: Indicate or check only those that are relevant

General Information: Reported Weight (lbs.): Reported Height (in):

Height/Weight WNL:

Weight Changes: Describe:

Cardiovascular/Respiratory:	Chest Pain ☐ Hypertension ☐ Hypotension ☐ Palpitation ☐ Smoking ☐
Genital/Urinary/Bladder:	Incontinence ☐ Nocturia ☐ Urinary Tract Infection ☐ Retention ☐ Urgency ☐

Gastrointestinal/Bowel:	Heartburn ☐	Diarrhea ☐	Constipation ☐	Nausea ☐	Vomiting ☐
	Ulcers ☐	Laxative Use ☐	Incontinence ☐		
Nervous System:	Headaches ☐	Dizziness ☐	Seizures ☐	Memory ☐	Concentration ☐
Musculoskeletal:	Back Pain ☐	Stiffness ☐	Arthritis ☐	Mobility/Ambulation ☐	
Gynecology:	Pregnant ☐	Pelvic Inflam. Disease ☐	Menopause ☐	Breast Feeding ☐	
Skin:	Scar ☐	Lesion ☐	Lice ☐	Dermatitis ☐	Cancer ☐
Endocrine:	Diabetes ☐	Thyroid ☐	Other: ☐		
Respiratory:	Bronchitis ☐	Asthma ☐	COPD ☐	Other: ☐	

Optional Comments

☐ **Others (check if relevant and describe):**

Other:

☐ Significant Accident/Injuries/Surgeries:

☐ Hospitalizations:

☐ Physical Disabilities:

☐ Chronic Illness:

☐ HIV disease:

☐ Age of Menarche and Birth Control Method:

☐ History of Head Injury:

☐ Liver Disease:

☐ None of the Above

Alternative healing practice/date (e.g., acupuncture, hypnosis, herbs, supplements, etc.)

Date	Provider / Type	Reason for Treatment	Outcome (was it helpful and why)

MEDICATIONS

CURRENT MEDICATIONS

(include all prescribed, over the counter, and holistic/complimentary/alternative remedies):

	Medication Name	Effectiveness/Side Effects if known	Dosage if known	Date Started if known	Prescriber if known
Psychotropic					
Non- Psychotropic					

PREVIOUS MEDICATIONS

(include all prescribed, over the counter, and holistic/complimentary/alternative remedies):

	Medication Name	Effectiveness/Side Effects if known	Dosage if known	Date Started if known	Prescriber if known
Psychotropic					
Non- Psychotropic					

Date of last physical exam (if known): Date of last dental exam (if known):

Referral made to primary care or specialty: No: ☐ (Yes: ☐ (If yes, list:

Providers, including Address, Phone, E-mail (if known):

Additional Medical Information: If needed, describe any relevant medical conditions.

Therapeutic Foster Care (TFC), Intensive Care Coordination (ICC), And Intensive Home Based Services (IHBS)

All Beneficiaries must be assessed to determine if they qualify and need Therapeutic Foster Care (TFC), Intensive Care Coordination (ICC), and Intensive Home-Based Services (IHBS).

Please check this box to indicate that client has been assessed for these services.

☐ TFC/ICC/IHBS

Check if a referral was made:

☐ TFC ☐ ICC ☐ IHBS

Narrative (Optional):

SUBSTANCE USE SCREENING

18+ yo

	No	Yes
A. Have you felt you should cut down or stop drinking or using substance?	☐	☐
B. Has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using substance?	☐	☐
C. Have you felt guilty or bad about how much you drink or use of substance?	☐	☐
D. Have you been waking up wanting to drink or use substance?	☐	☐

SUBSTANCE USE/EXPOSURE & DISORDERS

Category (indicate if ever used)	Exposure		Past	CURRENT SUBSTANCE USE & PROBLEMS		
	Prenatal	Current	Age at first use (if known)	Current Use	Client-Perceived Problem	
					Yes	No
ALCOHOL	☐	☐		☐	☐	☐
AMPHETAMINES (SPEED/UPPERS, CRANK, ETC)	☐	☐		☐	☐	☐
COCAINE/CRANK	☐	☐		☐	☐	☐
OPIATES (HEROIN, OPIUM, METHADONE)	☐	☐		☐	☐	☐
HALLUCINOGENS (LSD, MUSHROOMS, PEYOTE, ECSTASY)	☐	☐		☐	☐	☐
SLEEPING PILLS, PAIN KILLERS, VALIUM, OR SIMILAR	☐	☐		☐	☐	☐

PCP (PHENCYCLIDINE) OR DESIGNER DRUGS (GHB)	☐	☐		☐	☐	☐
INHALANTS (PAINT, GAS, GLUE, AEROSOLS)	☐	☐		☐	☐	☐
MARIJUANA/ HASHISH	☐	☐		☐	☐	☐
TOBACCO/NICOTINE CAFFEINE (ENGERY DRINKS, SODAS, COFFEE, ETC.)	☐	☐		☐	☐	☐
OVER THE COUNTER	☐	☐		☐	☐	☐
RX MEDS - NOT PRESCRIBED OR TAKEN PER RX	☐	☐		☐	☐	☐
COMPLIMENTARY/ALTERNATIVE MEDICATION	☐	☐		☐	☐	☐
OTHER SUBSTANCE	☐	☐		☐	☐	☐

Is beneficiary receiving alcohol and	Yes, from this provider ☐	Yes, from a different provider ☐	No ☐
Is beneficiary receiving alcohol and drug services?	Residential ☐	Outpatient ☐	Community/ Support Group ☐

SUBSTANCE RISKS, USE, & ATTITUDES/EXPOSURE (Required if "Higher Risk")

	NO	YES	UNABLE TO ASSESS
Were any risk factors identified based on clinical judgment?	☐	☐	☐
Does the client currently appear to be under the influence of alcohol or drugs?	☐	☐	☐
Has the client ever received professional help for his/her use of alcohol or drugs?	☐	☐	☐

Comments on alcohol/drug use (indicate if unable to assess at this time but plan on doing so in the future as treatment proceeds):

How is the mental health impacted by substance use (clinician's perspective)? Must be completed if any services will be directed towards substance Use/Abuse, such as Case Management.

SUBSTANCE ABUSE/SEVERITY ASSESSMENT

A. Beneficiary self-assessment:

☐ Unable to assess at this time but plan on doing so in the future as treatment proceeds.

☐ No alcohol or drug use

☐ Alcohol or drug use with no related problems

☐ Alcohol or drug use with related problems

B. Provider assessment:

☐ Unable to assess at this time but plan on doing so in the future as treatment proceeds.

☐ Use (minimal or no alcohol or drug relation problems)

☐ Substance abuse (frequent and/or periodic use associated with alcohol or drug problems)

☐ Substance dependence in recovery (prior significant, but now minimal or no substance related problems)

☐ Substance dependence not in recovery (uncontrolled use with significant alcohol or drug related problems)

SUD REFERRALS

Check below, for any referral made based on abuse assessment. List specific referral below.

☐ Referral to SUDS (Substance Use Disorder Services) ACCESS line #1-800-491-9099 for:

Self-help groups- groups for consumer's interested in support of sobriety include AA, NA, and Dual Recovery

- ☐ Anonymous. Referral should ideally be to a group known to support clients in psychiatric recovery
- ☐ Alcoholic Anonymous 510-839-8900
- ☐ Moderation Management:paulstayley@comcast.net or www.moderation.org
- ☐ Narcotics Anonymous (www.na.org)
- ☐ Nicotine Anonymous (www.nicotine-anonymous.org)
- ☐ Nicotine Quit Line (www.nobutts.org and 1-800-NO-BUTTS)
- ☐ SMART Recovery (www.SMARTrecovery.org)

☐ Outpatient counseling- for consumer's assessed at abuse level, and who have an environment supportive of recovery.

☐ Residential treatment- for chemically dependent consumer's with a low level of function, requiring an intense level of support to initiate sobriety.

☐ Detoxification- for chemically dependent consumers who are at risk of at least moderate withdrawal symptoms, and who require high level of structure to initiate sobriety.

☐ Other (specify): _____

From the ACBHCS SUD Treatment Referral Guide, www.acbhcs.org/providers/SUD/resources.htm, indicate the specific referrals provided to client. Make a copy for the client to take with them to follow-up with referral.

AGENCY	ADDRESS	TELEPHONE NUMBER

MEDICAL NECESSITY – MENTAL STATUS

MENTAL STATUS (Check and describe if abnormal or impaired)

Appearance/Grooming:	☐ Unremarkable	☐ Remarkable for:		
Behavior/Relatedness:	☐ Unremarkable	☐ Motor Agitated	☐ Inattentive	☐ Avoidant
	☐ Impulsive	☐ Motor Retarded	☐ Hostile	☐ Suspicious/Guarded
	☐ Other:			
Speech:	☐ Unremarkable	☐ Remarkable for:		
Mood/Affect:	☐ Unremarkable	☐ Anxious	☐ Depressed	☐ Elated/Expansive
	☐ Labile	☐ Irritable/Angry	☐ Other	
Thought Processes:	☐ Unremarkable	☐ Concrete	☐ Distorted	☐ Disorganized
	☐ Odd/Idiosyncratic	☐ Blocking	☐ Circumstantial	
	☐ Tangential	☐ Obsessive	☐ Flight of ideas	
	☐ Loosening of Assoc	☐ Other:		
Thought Content:	☐ Unremarkable	☐ Hallucinations	☐ Delusions	
	☐ Other			
Perceptual Content:	☐ Unremarkable	☐ Hallucinations	☐ Homicidal Ideation	☐ Paranoid Reference
	☐ Flashbacks	☐ Depersonalization	☐ Derealization	☐ Dissociation
	☐ Suicidal Ideation	☐ Other:		
Fund of Knowledge:	☐ Unremarkable	☐ Remarkable for:		
Orientation:	☐ Unremarkable	☐ Remarkable for:		
Memory:	☐ Unremarkable	☐ Impaired		
Intellect:	☐ Unremarkable	☐ Remarkable for:		
Insight/Judgment:	☐ Unremarkable	☐ Remarkable for:		

REQUIRED: **Describe all Mental Status Exam abnormal/impaired findings from above:**

FUNCTIONAL IMPAIRMENTS

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Family Relations	☐	☐	☐	☐	**Substance Use/Abuse**	☐	☐	☐	☐

School Performance/Employment	☐	☐	☐	☐	**Activities of Daily Living**	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	**Episodes of decompensation & increase of symptoms, each of extended duration**	☐	☐	☐	☐
Food/Shelter	☐	☐	☐	☐	**Other (Describe):**				
Social/Peer Relations	☐	☐	☐	☐		☐	☐	☐	☐
Physical Health	☐	☐	☐	☐					

REQUIRED, describe Impairments checked above:

TARGETED SYMPTOMS

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Cognition/Memory/Thought	☐	☐	☐	☐	**Perceptual Disturbance**	☐	☐	☐	☐
School Attention/Impulsivity	☐	☐	☐	☐	**Oppositional/Conduct**	☐	☐	☐	☐
Socialization/Communication	☐	☐	☐	☐	**Destructive/Assaultive**	☐	☐	☐	☐
Depressive Symptoms	☐	☐	☐	☐	**Agitation/Lability**				
Anxiety/Phobia/Panic Attack	☐	☐	☐	☐	**Somatic Disturbance**	☐	☐	☐	☐
Affect Regulation	☐	☐	☐	☐	**Other (Describe):**				
						☐	☐	☐	☐

Comments (if any):

BARRIERS / IMPAIRMENTS

Impairment Criteria (must have one of the following): Select A, B, and C as they apply	AND	Intervention Criteria (proposed INTERVENTION will….):
☐ A. Significant impairment in an important area of life function.	**AND**	Significantly diminish impairment
☐ B. Probability of significant deterioration in an important area of functioning.	**AND**	Prevent significant deterioration in an important area of life functioning.
☐ C. (Under 21) Without treatment will not progress developmentally as individually appropriate.	**AND**	(Under 21) Probably allow the child to progress developmentally as individually appropriate.
☐ D. None of the above	**AND**	None of the above

Diagnostic Summary (Optional): (Be sure to include assessment for risk of suicidal/homicidal behaviors, significant

strengths/weaknesses, observations/descriptions, symptoms/impairments in life functioning, i.e. Work, School, Home, Community, Living Arrangements, etc. and justification for diagnosis)

Diagnostic Impression

DSM-5: Mental Health- see Medi-Cal included list

DSM-5 Descriptor	ICD-10	ICD-10 Descriptor	
			PRIMARY

Signs & Symptoms that Support Diagnosis or Per History:

Add Additional Diagnosis

IF DX HAS CHANGED, YOU MUST CORRECT INSYST FOR CORRECT CLAIMING.
Coordinate Diagnoses with other clinicians

Diagnostic Impression

DSM-5: Substance Use- see Medi-Cal included list

DSM-5 Descriptor	ICD-10	ICD-10 Descriptor	
			☐ Rule out

Signs & Symptoms that Support Diagnosis or Per History:

Add Additional Diagnosis

IF DX HAS CHANGED, YOU MUST CORRECT INSYST FOR CORRECT CLAIMING.

Physical Health: General Medical Codes- see general medical code list

General Medical Codes

(code)	**(diagnosis)**	☐ Rule out

Signs & Symptoms that Support Diagnosis or Per History:

Add Additional Diagnosis

IF DX HAS CHANGED, YOU MUST CORRECT INSYST FOR CORRECT CLAIMING.
Coordinate Diagnoses with other clinicians

DSM-5: Psycho Social- See psycho social list

DSM-5 Descriptor	ICD-10	ICD-10 Descriptor

Rule out

Signs & Symptoms that Support Diagnosis or Per History:

Add Additional Diagnosis

Optional Disability Measures (WHODAS, etc.)

Disposition / Recommendations/ Plan (Optional)

Diagnosis Established by:

Date	Staff	Responsible Staff	License (professional suffix)

If established by waivered clinician, also provide licensed supervisor's name and licensure.

Licensed LPHA Co-Signer of Waivered Staff Above License (professional suffix)

Staff member waivered Type:

Mild-Moderate vs Moderate-Severe Level Determination		
List A (Check all that apply)	**List B** (Check all that apply)	**List C**
Impulsivity/Hyperactivity	1 or more psychiatric hospitalization(s) in past year	Substance abuse
Trauma/recent loss	Suicidal/homicidal preoccupations or behaviors in past year	
Withdrawn/Isolative	Self-injurious behaviors	
Mild-moderate depression/anxiety	Paranoia, delusions, hallucinations	
Behavior problems (aggressive/self-destructive/assaultive/bullying/oppositional)	Currently in out-of-home foster care placement	
Significant family stressors *	Juvenile probation supervision with current placement order	
CPS report in the last 6 months	Functionally significant depression/anxiety	

☐ Excessive truancy or failing school	☐ Eating disorder with medical complications	
☐ Difficulty developing and sustaining peer relationships	☐ At risk of losing home, child care, or preschool placement due to mental health issue	
☐ Eating disorder without medical complications		
☐ Court dependent or ward of court		
☐ May not progress developmentally as individually appropriate without mental health intervention		

*** Significant family stressors:** Caretaker(s) with serious physical, mental health, substance use disorders or developmental disabilities, domestic violence, unstable housing or homelessness.

Referral Algorithm		
1	Remains in **PCP care** with Beacon consult or therapy only	☐ 1-2 in List A and none in List B
2	Refer to Beacon Health Strategies- eFax {866) 422-3413)	☐ 3 in list A {2 if ages 18-21) and none in list B OR
		☐ Diagnosis excluded from county MHP
3	Refer to **County Mental Health Plan** for assessment (Phone: 1-800-491-9099 Fax: 510-346-1083)	☐ 4 or more in list A {3 or more if ages 18-21) OR
		☐ 1 or more in list B
4	Refer to County Alcohol & Drug Program (1-800-491-9099)	☐ 1 from list C

Referring Provider Name: _____ **Phone:** _____

Referring/Treating Provider Type: ☐ PCP ☐ MFT/LCSW ☐ ARNP ☐ Psychiatrist ☐ Other: _____

Requested service: ☐ Outpatient therapy ☐ Medication management ☐ Assessment for Specialty Mental Health Services

Health Housing & Community Services
Mental Health Division

CLIENT REGISTRATION DATA ENTRY FORM

RU: _____ Data Entry Initials: _____

Client Registration: ____ New: _____ PFI Update: _____ ___

Client Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Confidential Patient Information
See Welfare & Institutions Code: 5328

Address Verification: Yes ☐ No ☐

PLEASE Print Legibly

Client Name:

(*) Last Name: _____ **(*)** First: _____ Middle: _____

Generation: Ex: Jr, Sr, II __ __ __ __ **(*)** Birth Date: ____ / ____ / _____ **(*)** Sex: _____ **(*)** SSN: __ __ __ - __ __ - __ __ __ __

(*) CIN: __ __ __ __ __ __ __ __ __

1. **(*) (**)** Education: __ __
2. Disability: __ __ __
3. **(*)** Primary Lang: __ **(*)** Preferred Lang: __
4. **(*)** Ethnicity/Race: __ __ __ __ __
5. **(*)** Hispanic Origin: __
6. Marital Status: __
7. **(*) (**)** Care Giver Under 18: __ __ Over 18: __ __
8. Veterans Status___

Aliases Name: (Systems allows multiple alias if applicable)

9. Last Name: _____ First: _____ Middle: _____

Client Birth Name:

10. Last Name: _____ First: _____ Middle: _____

11. Generation (Ex. Jr., Sr., II) 12. Birthplace: County:_____State:_____Country_____

13 Mother's first name: ("UNKN" if unknown) _____

14. **Client Preferred Name** (if different than name of record, i.e. M/C):

Preferred Last Name: _____

Preferred First Name: _____ Preferred Middle Name: _____

Client Sexual Orientation/Gender Identity Info:

15. Sex Assigned at Birth: __
16. Personal (or preferred) Pronoun: __ __ __ __
17. Current Gender Identity: __ __ __ __ __ __ __ __ __
18. Sexual Orientation: __ __ __ __ __ __ __ __ __

Santa Rita Booking Info (data fields for Santa Rita/Forensic Unit staff only):

19. Booking First Name: _____ Booking Last Name: _____
20. PFN # _____
21. SRMR # _____

Child & Youth ONLY Info (data fields for Child and Youth staff only)**:**

22. Child Welfare: __ (Y=yes / N=no)
23. Juvenile Prob: __ (Y=yes / N=no)

Presumptive Transfer or Waivered Presumptive Transfer Info (data fields for Presumptive Transfer staff only)**:**

24. OOC Foster: ___
25. OOC From County: ___
26. OOC Effective Date: _ _ /_ _ /_ _ _ _ (mm/dd/yyyy)
27. ALCO Foster: ____
28. ALCO to County: ___
29. ALCO Effective Date: _ _ /_ _ /_ _ _ _ (mm/dd/yyyy)

Screen 4

30. **Primary Care Physician Info**: Display only fields

PCP First Name: _____
PCP Last Name: _____
PCP NPI: _____
PCP Clinic Name: _____
PCP Telephone #: _____
Last PCP Visit Date: _____
OEA Member ID: _____

Client Category:

31. ERMHS Client: __ (**Y**=yes / **N**=no) Eff Date: _ _/_ _/_ _ _ _ (mm/dd/yyyy) Exp Date: _ _/_ _/_ _ _ _ (mm/dd/yyyy)

32. Therapeutic Foster Care: __ (**Y**=yes / **N**=no) Eff Date: _ _/_ _/_ _ _ _ (mm/dd/yyyy) Exp Date: _ _/_ _/_ _ _ _ (mm/dd/yyyy)

33. Prop47: __ (**Y**=yes / **N**=no) Eff Date: _ _/_ _/_ _ _ _ (mm/dd/yyyy) Exp Date: _ _/_ _/_ _ _ _ (mm/dd/yyyy)
(Has the client been arrested?)

Client Info: Display only field as mm/dd/yyyy

34. Client Date of Death:

Client Address Screen

35. **Client Address:**

Street Number: ___ ___ ___ ___ ___
City: _____
Direction: ___ ___
State: ___ ___
Zip Code: __ __ __ __ __+__ __ __ __
Street Name: _____
Type: ___ ___
Phone Number: (__ __ __) __ __ __ - __ __ __ __ Ext: __ __ __ __
Apartment: __ __ __ __

36. County of Responsibility: **(only use if directed)** ___ ___

Significant Other Screen

37. **Significant Other:** (if applicable)

Last Name: _____ First Name: _____ Eff. Date**:** __ __ / __ __ / __ __ __ __
Relationship to Client: _____ Phone: (__ __ __) __ __ __ - __ __ __ __ Exp. Date: __ __ / __ __ / __ __ __ __
Address: _____ City/State: _____ Zip Code: _____

The intake worker signs and dates the form

Completed by: _____ Date: _____

Highlighted fields are mandatory.
(*) Fields are required for CSI data collection.
(**) CSI Periodic data must be entered on the CSI Periodic Screen in ADDITION to Client Registration Screen.

CLIENT REGISTRATION CODES

1: **Education -** Enter in the number indicating the **highest grade** completed. If the highest grade is greater than 20, enter "20", if the highest grade is unknown then enter "99".

2: **Disability -** Section 503 of the Federal Rehabilitation Act of 1973 defines "disability" as a physical or mental impairment that **substantially** limits one or more of the major life activities of the individual, a record of such impairment, or being regarded as having such an impairment.
Circle and add the number codes to create the sum of all of the client's physical disabilities, as stated by the client, and enter the total in this field.

00	None	04	Speech Impairment	32	Other Physical Impairment
01	Severe Visual Impairment	08	Physical Impairment/Mobility	99	Unknown
02	Severe Hearing Impairment	16	Developmentally Disabled		

3: **Primary Language & Preferred Language**

A	English	I	Sign ASL	Q	Hmong	Y	Arabic	1	Thai
B	Spanish	J	Other Non-English	R	Turkish	Z	Samoan	2	Farsi
C	Chinese Dialect	K	Korean	S	Hebrew			3	Other Sign
D	Japanese	L	Russian	T	French			4	Other Chinese Dialects
E	Filipino Dialect	M	Polish	U	Cantonese			5	Ilocano
F	Vietnamese	N	German	V	Mandarin			6	Hindi
G	Laotian	O	Italian	W	Portuguese			7	Pashto
H	Cambodian	P	Mien	X	Armenian			8	Punjabi

4: **Ethnicity/Race**– Enter up to **FIVE codes** which best represent the client's ethnic group(s) as identified by the client.

A	White	G	Laotian	L	Other Non-White	Q	Korean	W	Mien
B	Black	H	Cambodian	M	Unknown	R	Samoan		
C	Native American	I	Japanese	N	Other Southeast Asian	S	Asian Indian		
E	Chinese	J	Filipino	O	Hmong	T	Hawaiian Native		
F	Vietnamese	K	Other Asian	P	Other Pacific Islander	U	Guamanian		

5: **Hispanic Origin**

1	Not Hispanic	5	Other Latino	N	Nicaraguan
2	Mexican/Mexican American	G	Guatemalan	S	Salvadoran
4	Puerto Rican	M	South American	U	Unknown/Not Reported

6: **Marital Status**–NOTE: Code 1, Never married is used for a single person who does not live with girlfriend/boyfriend and has never been married.

1	Never Married	3	Widowed	5	Separated
2	Married/Live Together	4	Divorced/Dissolved	9	Unknown

7: **Care Giver**- Enter the number of persons the client cares for or is responsible for at least 50% of the time, under the age of 18 and over the age of 18.

00	None	1-98	Number of Persons	99	Unknown

8: **Veteran Status**

1	Yes	2	No	3	Declined to answer

9: **Aliases Last name** - If the client has ever used a different name, type that information here. Systems allows multiple aliases if applicable 28: **Sex Assigned at Birth** – Enter ONE value that applies

1	Male	2	Female	3	Other

16: **Personal (or preferred) Pronoun - What is your Pronoun - Personal or preferred Pronoun?** – Enter up to FIVE codes which best represent the client's Personal (or preferred) Pronoun as identified by the client.

1	He/Him	3	They/Them	5	Prefer Not To Answer
2	She/Her	4	Other Pronoun	U	Unknown

17: **Current Gender Identity –** Enter up to NINE codes which best represent the client's Current Gender Identity as identified by the client.

1	Male	5	Transgender: Male to Female / Transgender Female/Trans Woman	**9**	Prefer Not To Answer
2	Female	6	Transgender: Female to Male / Transgender Male/Trans Man	U	Unknown
3	Intersex	7	Gender non-conforming		
4	Gender Queer (not exclusively male or female)	8	Other Additional Gender Category		

18: **Sexual Orientation –** Enter up to NINE codes which best represent the client's Sexual Orientation as identified by the client.

1	Heterosexual/Straight	4	Bisexual	7	Other Additional Sexual Orientation
2	Gay	5	Queer	8	Prefer Not To Answer
3	Lesbian	6	Questioning	U	Unknown

35: **Client Address**
- Enter the client's **home address** with **Zip Code +4.**
- If the client is homeless, enter **Homeless** as the street name and enter the **Zip Code +4** for the **City Hall** of the city where the client indicates they most often sleep (in a shelter or on the street).

37: **Significant Other** - Enter **name**, **relationship**, **telephone number**, and **address** of any person(s) who has an important relationship with the client. The relationships currently defined are:

Father	Husband	Relative	Friend	Therapist	Probation Officer
Mother	Wife	Guardian	Partner	MD / Physician	Parole Officer
Son	Brother	Conservator	Employer	Board Care	Other
Daughter	Sister	Attorney	Minister	Psych	

From:	Works-Wright, Jamie
To:	Andrea Prichett; boona cheema; Edward Opton (eopton1@gmail.com); Javonna Blanton; Margaret Fine; Maria Moore; Monica Jones; Terry Taplin
Subject:	FW: Pubic Hearing on Mental Health Services Act FY21/22 Annual Update
Date:	Monday, July 12, 2021 1:02:00 PM
Attachments:	image001.png

FYI

Thank you for your time.

Jamie Works-Wright

Consumer Liaison & Mental Health Commission Secretary
City of Berkeley
1521 University
Berkeley, CA 94703
Jworks-wright@cityofberkeley.info
Office: 510-981-7721 ext. 7721
Cell #: 510-423-8365

From: Klatt, Karen
Sent: Monday, July 12, 2021 12:03 PM
To: Klatt, Karen <KKlatt@cityofberkeley.info>
Subject: Pubic Hearing on Mental Health Services Act FY21/22 Annual Update

Greetings!

The City of Berkeley Mental Health Division will be holding a **Public Hearing** on the **Mental Health Services Act (MHSA) Fiscal Year 2021-2022 Annual Update**.

The **Public Hearing** will be held on **Thursday, July 22, 2021, at 7:00pm at the Berkeley Mental Health Commission Meeting, which will be held by Zoom**.
To access the Public Hearing, please click this URL: https://zoom.us/j/96361748103
Or join by phone: Dial (for higher quality, dial a number based on your current location):
US: +1-669-900-6833
+1-346-248-7799
+1 253 215 8782
+1 301 715 8592

+1 312 626 6799
+1 929 205 6099
Webinar ID: 963 6174 8103
International numbers available: https://zoom.us/u/aesRfcwbMt

The Mental Health Services Act (MHSA) FY2021/2022 Annual Update can be reviewed at the following website: https://www.cityofberkeley.info/uploadedFiles/Health_Human_Services/Level_3_-_Mental_Health/Combined%20for%20Posting%20Budget%20Forms-PEI%20Eval-INN%20Eval.pdf

Thanks,

Karen

Karen Klatt, MEd

MHSA Coordinator

City of Berkeley, Mental Health Division

3282 Adeline Street, Berkeley CA 94703

(510) 981-7644 – Office

(510) 849-7541 – Cell

KKlatt@cityofberkeley.info

Thank you for your time.

Jamie Works-Wright
Consumer Liaison & Mental Health Commission Secretary
City of Berkeley
1521 University
Berkeley, CA 94703

Jworks-wright@cityofberkeley.info
Office: 510-981-7721 ext. 7721
Cell #: 510-423-8365

From:	Works-Wright, Jamie
To:	Works-Wright, Jamie
Subject:	FW: Summary Update on Commission Reorganization
Date:	Thursday, July 1, 2021 2:54:16 PM
Attachments:	Memo - Commission Reorganization July 2021.pdf image002.png

FYI

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: Numainville, Mark L.
Sent: Thursday, July 1, 2021 2:21 PM
To: Numainville, Mark L. <MNumainville@cityofberkeley.info>
Subject: Summary Update on Commission Reorganization

Commission Secretaries,

Please share the attached memo with your commission regarding the commission reorganization process adopted by the City Council on June 15, 2021.

Mark Numainville, City Clerk
City of Berkeley
2180 Milvia Street, 1st Floor
Berkeley, CA 94704
(510) 981-6909 direct
mnumainville@cityofberkeley.info

City Clerk Department

July 1, 2021

To: Commission Secretaries

From: Mark Numainville, City Clerk

Subject: Commission Reorganization Update

On June 15, 2021 the City Council took action to direct staff to implement the following reorganization of Berkeley Commissions. Please see the links at the end of this memo for the Council report and the record of the final action taken by the Council.

New Commission Name	**Former Commissions to be Reorganized**
Commission on Climate and the Environment	Energy, Community Environmental Advisory, and Zero Waste (policy issues)
Parks, Recreation, Waterfront (special Marina subcommittee)	Children, Youth, and Recreation, Parks and Waterfront, Animal Care
Peace, Justice, and Human Welfare*	Peace and Justice and Human Welfare, Community Action Commissions
Public Health Commission & Sugar Sweetened Beverage Panel of Experts**	Community Health Commission and Sugar Sweetened Beverage Panel of Experts
Housing Advisory Commission	Measure O and Housing Advisory Commission
Homeless Services Panel of Experts	Homeless Commission and Measure P Homeless Services Panel of Experts
Public Works and Transportation	Public Works, Transportation, and Zero Waste (facilities issues)
Planning	Planning and Cannabis
All other commissions will maintain their current structure: Aging, Civic Arts, Disability, Commission on the Status of Women, Design Review Committee, Disaster and Fire Safety, BIDs, Fair Campaign Practices and Open Government, Redistricting, Landmarks Preservation, Labor, Loan Adjustments Board, Personnel, Police Accountability, Reimagining Public Safety, Mental Health, Zoning Adjustments Board, and Youth	

** Members will be appointed by Council and membership should adhere to Government Code Section 12736(e); 12750(a)(2) and 12751. Membership will not include appointments from Berkeley Unified School District*

*** New commission designated as 18-member commission*

As part of the action, the City Council also referred to the City Manager and the affected commissions to explore the possible consolidation of the Commission on Disability and the Commission on Aging.

The City Council referral requested that staff bring back changes to the enabling legislation to reorganize existing commissions as proposed below in a phased approach.

Phase 1: Prioritize merging the Homeless Commission/Homeless Services Panel of Experts and Housing Advisory Commission/Measure O Bond Oversight Committee first, and request that the City Manager bring back changes to the enabling legislation to implement these consolidated commissions.

Phase 2: All other Commissions as proposed in the report discussed at the June 15, 2021 City Council meeting. As staff is able to make recommendations on consolidation, they can bring those recommendations forward one by one.

Existing commissions impacted by the reorganization will have an opportunity to weigh in on the revisions to the enabling legislation for the new commissions and the charge/responsibilities of merged commissions. Staff will provide direction and support to the existing commissions on the transition process to new consolidated commissions and the effective date of the changes.

Work on Phase 1 will begin in Summer 2021. Staff will coordinate with commission secretaries to schedule any relevant discussions with the commissions for Phase 1 and Phase 2 in the fall of 2021.

Please relay any questions regarding the consolidation process through the commission secretary.

Link to Council Report

Link to Annotated Agenda for Final Action

From:	Works-Wright, Jamie
To:	Works-Wright, Jamie; Andrea Prichett; boona cheema; Edward Opton (eopton1@gmail.com); Javonna Blanton; Margaret Fine; Maria Moore; Monica Jones; Taplin, Terry
Subject:	FW: Updated Low-Income Commissioner Stipend Regulations
Date:	Wednesday, June 30, 2021 2:36:38 PM
Attachments:	Resolution No 69,739.pdf AR 3-2 2021.pdf Commissioner Stipend Update Memo 063021.pdf image002.png

Hello Commissioners,

Please see the information about stipends to see if you qualify

Thank you for your time.

Jamie Works-Wright

Consumer Liaison & Mental Health Commission Secretary
City of Berkeley
1521 University
Berkeley, CA 94703
Jworks-wright@cityofberkeley.info
Office: 510-981-7721 ext. 7721
Cell #: 510-423-8365

From: Numainville, Mark L.
Sent: Wednesday, June 30, 2021 2:22 PM
To: Numainville, Mark L. <MNumainville@cityofberkeley.info>
Subject: Updated Low-Income Commissioner Stipend Regulations

Commission Secretaries,

Please review the attached information and share with your commissioners.

More information on the budget allocation for the stipends will be shared later this month.

Mark Numainville, City Clerk
City of Berkeley
2180 Milvia Street, 1st Floor
Berkeley, CA 94704

RESOLUTION NO. 69,739-N.S.

AUTHORIZING REIMBURSEMENT IN LIEU OF ACTUAL EXPENSES PAID OR INCURRED BY MEMBERS OF CERTAIN BOARDS, COMMISSIONS, COMMITTEES, TASK FORCES, AND JOINT SUBCOMMITTEES, AND AUTHORIZING PAYMENT OF ACTUAL EXPENSES UNDER CERTAIN TERMS AND CONDITIONS AND RESCINDING RESOLUTION NO. 64,831-N.S. AND ALL AMENDMENTS

WHEREAS, it is in the public interest to remove barriers from citizen participation on boards, commissions and committees of the City of Berkeley; and

WHEREAS, the Council of the City of Berkeley finds and determines that it is in the public interest to alleviate this hardship by reimbursing and paying certain minimum allowances for expenses incident to attending official meetings of said bodies; and

WHEREAS, such allowances are determined to be in lieu of actual expenses paid or incurred by said members, except in the case of actual expenses incurred for child care and actual expenses incurred by a member who must employ a paid attendance to provide care for a dependent elderly person while he or she attends meetings; and

WHEREAS, the Council of the City of Berkeley finds and determines that it is in the public interest to reimburse for these support costs when they create and economic hardship for disabled members of boards, commissions and committees; and

WHEREAS, Resolution No. 64,831-N.S., known as the Stipend Resolution, is being rescinded and readopted to change the qualifying household income cap to 50% of Annual Median Income (AMI) for a three-person household in Alameda County, increase the per meeting stipend to $100 per month, and reaffirm the current policy and procedures.

NOW THEREFORE, BE IT RESOLVED by the Council of the City of Berkeley as follows:

Section 1. ELIGIBILITY OF BOARDS, COMMISSIONS, COMMITTEES, TASK FORCES AND JOINT SUBCOMMITTEES

This resolution shall apply to members of Council-appointed boards, commissions and committees, and temporary task forces and joint subcommittees established by Council (collectively "Eligible Recipients"). Payments in lieu of expenses for other than members of Council-appointed boards, commissions, committees, task forces and joint subcommittees, shall be addressed as part of the Council's budgetary process.

Section 2. ANNUAL STATEMENT OF ELIGIBILITY

Eligible recipients desiring said payments shall file annually with the secretary of the board, commission, committee, task force, or joint subcommittee ("secretary"), a statement certifying that their family income for the preceding year was below the limits specified in Section 3.

Eligible recipients listed as dependents on their family's Federal Income Tax, shall file annually with the secretary, a parental statement certifying that the family income for the preceding year was below the limits specified in Section 3.

Section 3. FINANCIAL LIMITATIONS ON ELIGIBILITY

Those eligible recipients whose family gross income as filed jointly for Federal Income Tax purposes is below the Alameda County 50% Area Median Income (AMI) for a three-person household per year shall be entitled to receive payments as set forth in section 5.

When an eligible recipient becomes aware that their annual family income has or will exceed the Alameda County 50% AMI for a three-person household, that member shall immediately notify the secretary, and request that their eligibility to receive payments be cancelled.

When an eligible recipient whose family income for the preceding year was more than the Alameda County 50% AMI for a three-person household finds that their family income for the current year will be below the Alameda County 50% AMI for a three-person household, they may file a certified declaration with the secretary describing the general circumstances which have occurred that resulted in the lower income. Such certified declaration shall make the person again eligible for payments pursuant to Section 5 of this Resolution.

Section 4. DISABLED SUPPORT

Eligible recipients who are disabled and whose incomes fall within the limitations set forth in Section 3, qualify for reimbursement for the costs of readers to help in reviewing written materials in the meeting packets, for attendants to accompany members to meetings, and other support costs that are required in order to allow such disabled members to participate fully in meeting deliberations.

Disabled eligible recipients desiring reimbursement for these costs, will file in addition to the statement of eligibility set forth in Section 2, a statement with the secretary that certifies the support services that the member requires in order to participate fully. If the member's needs change, they will immediately notify the secretary. Otherwise, the statement certifying the need for support services will continue to be in effect for the duration of the eligible recipient's term of appointment.

Section 5. REIMBURSEMENT

Eligible recipients are authorized to receive $100 for each official meeting attended, not to exceed four meetings each month and reimbursement for actual expenses incurred upon presentation of a receipt from the person(s) providing the following services:

a) Child care expenses incurred by a member while they attend meetings;

b) Expenses incurred by a member who must employ a paid attendant to provide care for a dependent elderly person while they attend meetings;

c) Expenses incurred by a disabled member who requires support services in order to participate fully on board, commission or committee meetings.

An "official meeting" is defined as a duly noticed, properly agendized, regular or special meeting of the full board, commission, or committee.

For a meeting that is cancelled, claims may only be submitted if it is for a meeting where the attendees and secretary believed that the meeting would proceed as scheduled, and for which eligible recipients and the secretary actually showed up and waited a reasonable period beyond the meeting start time for the quorum to be met before canceling.

The $100 stipend amount shall be annually adjusted by the Bay Area Consumer Price Index.

Additionally, eligible recipients requesting reimbursement for child care expenses, a paid attendant for elderly care, or expenses incurred for support services as a disabled member, are subject to AB 1234. State law AB 1234 requires completion of an online ethics training course within one year of the first day of service, and every two years thereafter.

The ethics course is available at no cost online on the FPPC website. Upon completion of the course, a printed and signed certificate of participation must be filed with the secretary in order to be eligible for reimbursement,

Section 6. CLAIMS

Claims for reimbursement in lieu of actual expenses paid or incurred shall be filed with the secretary. Said secretary shall process the claim for payment pursuant to procedures established by City Administrative Regulation 3.2 and as amended by the City Manager.

Section 7. REIMBURSEMENT NOT SUBJECT TO FINANCIAL LIMITATIONS

A. Human Welfare and Community Action Commission. The Human Welfare and Community Action Commission provides for alternate representatives of the poor to be elected or appointed when a vacancy occurs. Alternate representatives of the poor shall be eligible for stipend payments when serving in place of the principal member.

B. Commission on Disability. Pursuant to Berkeley Municipal Code Section 3.66.040, low income status for members of the Commission on Disability is not a prerequisite for reimbursement of attendant care expenses.

BE IT FURTHER RESOLVED that the new stipend rate and qualifying threshold shall take effect upon the date which City Council appropriates resources in the General Fund for the increase in the stipend, but no earlier than July 1, 2021.

BE IT FURTHER RESOLVED that Resolution No. 64,831-N.S. and all amending resolutions are hereby rescinded upon the date the new stipend rate and qualifying threshold take effect.

The foregoing Resolution was adopted by the Berkeley City Council on March 9, 2021 by the following vote:

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

Noes: None.

Absent: None.

Jesse Arreguin, Mayor

Attest:
Mark Numainville, City Clerk

CITY OF BERKELEY
ADMINISTRATIVE REGULATIONS

SUBJECT: Stipend and Reimbursement in Lieu of Expenses for Members of Certain Boards, Commissions, Committees, Task Forces, and Joint Subcommittees

PURPOSE

The purpose of this Administrative Regulation is to establish procedures for reimbursing expenses to certain board, commission, committee, task force, and joint subcommittee members (including temporary appointees) who might otherwise incur an economic hardship.

POLICY

The City Council, by Resolution No. 69,739-N.S. (known as the Stipend Resolution March 9, 2021), authorizes payment in lieu of expenses to members of all Council-appointed boards, commissions, committees, task forces and joint subcommittees who meet certain household income criteria in order to remove economic hardship barriers from citizen participation. Subcommittees of commissions, which are designated by the advisory body and not by Council appointment, are not eligible for reimbursement.

An eligible member is authorized to receive:

a) $100 for each official meeting attended, not to exceed four (4) meetings each month;

b) reimbursement for actual child care expenses incurred while he/she attends meetings;

c) reimbursement for actual expenses paid to an attendant to provide care for a dependent elderly person while he/she attends meetings; and

d) reimbursement for actual expenses incurred for disabled support services in order to participate fully in board, commission, or committee meetings.

The $100 stipend amount shall be annually adjusted by the Bay Area Consumer Price Index.

DEFINITIONS AND REGULATIONS

An “official meeting” is defined as a duly noticed, properly agenized, regular meeting or special meeting of the full board or commission at which a quorum of the full membership must be present in order for the meeting to be held.

For a meeting that is cancelled, claims may only be submitted if it is for an official meeting where the attendees and staff Secretary believed that the meeting would proceed as scheduled, and for which Commissioners and the Secretary actually showed up and waited a reasonable period beyond the meeting start time for the quorum to be met before canceling.

A receipt or invoice signed by the person providing such child care, elderly dependent care or disabled support services must accompany a request for reimbursement. Invoices must include date, services provided, vendor contact information, and dollar amount.

The Human Welfare and Community Action Commission provides for alternate representatives of the poor to be elected or to be appointed when a vacancy occurs. Alternate representatives of the poor shall be eligible for stipend payments when serving in place of the principal member.

The City Clerk Department is responsible for keeping this Administrative Regulation up-to-date and shall include notification of this policy with each appointment letter mailed.

COMMISSIONER'S CRITERIA AND RESPONSIBILITIES

1. Eligibility criteria for stipend and reimbursement:

    a) Persons eligible to receive reimbursement in lieu of expenses are those board, commission, committee, task force or joint subcommittee members whose household gross income as filed jointly for federal income tax purposes is below the Alameda County 50% AMI 3-person household ($58,750 as of July 2021) per year.

    b) Commissioners who are minors (under 18 years old) must have eligibility declaration forms co-signed by a parent or legal guardian attesting that the combined 3-person household income is under the Alameda County 50% AMI ($58,750 as of July 2021) per year.

    c) If a commissioner is paid $600 or more in stipend payments in one calendar year, an IRS Form 1099 will be generated by the Finance Department for the commissioner’s tax filing purposes.

2. To establish eligibility, Commissioners must file the Annual Declaration Form (attached) with the secretary of their board, commission, committee, task force or joint subcommittee. Commissioners must file a new declaration form annually prior to May 31st in order to maintain eligibility.

3. In order to pay a Commissioner's attendant directly, a completed IRS Form W-9 must be on file in the Finance Department's Accounts Payable Division. If an attendant, support service, or child care provider is paid $600 or more in one calendar year, a Form 1099 will be generated by Finance. In order to be reimbursed for payments made to an attendant, support service, or child care provider, a Commissioner must be set up as a vendor by Finance - General Services.

4. Eligible members who are disabled and are seeking reimbursement for support services must also complete the support services statement portion on the Annual Declaration Form. If the member's needs change, he/she must immediately notify the secretary. Otherwise, the statement certifying the need for support services will continue to be in effect for the duration of the member's term of appointment.

5. Pursuant to Berkeley Municipal Code Section 3.66.040, low-income status for members of the Commission on Disability is not a prerequisite for reimbursement of attendant care expenses.

6. Additionally, eligible recipients requesting reimbursement for child care expenses, paid attendant services for elderly care, and support services as a disabled member for meeting participation are subject to AB 1234. State law AB 1234 requires completion of an online ethics training course within one year of the first day of service, and every two years thereafter. The ethics course is available online at no cost. Upon completion of the course, a printed and signed certificate of participation must be on file with the secretary in order to be eligible for reimbursement.

RESPONSIBILITIES OF SECRETARY

1. It is the responsibility of the secretary of each board, commission, committee, task force or joint subcommittee to submit quarterly payment forms to the Finance Department, by the 10th of each month (January, April, July, and October). Payment forms for stipends paid for attendance at meetings held pursuant to the Mental Health Services Act are filed monthly. Every submission must include the following:
    a) A.R. 3.2 Payment Form
    b) Invoices for support services, dependent care, and/or child care, if applicable.
    c) Verification that each meeting for which reimbursement or stipend is claimed actually occurred.
    d) A copy of the Annual Declaration Form
    e) A spreadsheet showing the year-to-date payments for each commissioner.

2. The completed forms must be attached to the request for check entry in ERMA and released for review to the Finance Department by the 10th of each specific month so payment can be made. A separate request for check and supporting documentation must be submitted individually for each member.

3. The secretary shall keep copies of all Annual Declaration Forms on file and attach a copy each time a request for check is submitted to the Finance Department, and when submitting quarterly statements.

4. Each secretary will advise the board, commission, committee, task force and joint subcommittee members of this policy and respond promptly to commissioner inquiries regarding payment status. Commissioners should not contact the Finance Department or City Clerk Department for payment status.

RESPONSIBLE DEPARTMENT: **City Clerk** **TO BE REVISED:** Every 1 year	Approved by: /s/ Department Director /s/ City Manager

ANNUAL DECLARATION FORM RESPECTING ELIGIBILITY FOR REIMBURSEMENT OF EXPENSES AS A MEMBER OF THE

_____
(Board/Commission/Committee/Task Force/Joint Subcommittee)

Inasmuch as it is in the public interest to remove barriers, particularly those creating economic hardships for citizens participating on boards, commissions, committees, task forces, and joint subcommittees the City Council has determined that it is in the public interest to alleviate this hardship by authorizing payments in lieu of expenses for certain meetings and under certain conditions as indicated in Stipend Resolution No. 69,739-N.S.

I, _____ certify to the following:

1) That my adjusted gross income reported individually, or as part of a household joint Federal Income Tax Return, was less than the Alameda County 50% AMI 3-person household ($58,750 as of July 2021) per year.

2) I will file this declaration form every year no later than May 31st with the Secretary who will forward copies to the Finance Department; and

3) I will notify the Secretary as soon as I am aware that my household current year income exceeds the Alameda County 50% AMI 3-person household ($58,750 as of July 2021) per year and request that my eligibility be canceled:

_____ _____
Signature Date

_____ _____
Signature of Parent or Legal Guardian if Member is a Minor Date

_____ _____
Signature of Secretary Date

* * *

SUPPORT SERVICES STATEMENT

I, _____, certify I am disabled and require the following support services in order to participate fully in commission meetings:

_____

_____

_____ _____
Signature Date

A.R. 3.2 PAYMENT FORM

Name of Commission: _____

Name of Commissioner: _____

Address of Commissioner: _____

Name of Secretary: _____ Phone: _____

Quarter Covered: Year _____ ☐ Jan - Mar ☐ April - June ☐ July - Sept ☐ Oct – Dec

Date of Meeting	Payment Type*	Amount Due
		$
		$
		$
		$
		$
		$
	Total (this qtr.)**	**$**

* Stipend, Support Services, Dependent Care, or Child Care
**Attach Year-to-Date Spreadsheet to this Form

☐ Please hold check for pick up:_____
(*Commissioner's Signature)*

Prepared by: _____ Date: _____
(Preparer's Signature)

Reviewed by: _____ Date: _____
(Commission Secretary Signature)

CERTIFICATION AND AUTHORIZATION FOR PAYMENT: I hereby certify that the payments for all persons whose names appear herein have been properly authorized; and that the amounts indicated as due said persons are actually due and payable. Payment is approved against the appropriation indicated under delegated authority of the City Manager.

Authorized by: _____ _____
Authorized Department Signature (must be on file with AP) Date

COMMISSIONER STIPEND CHECKLIST

This checklist is provided to expedite the processing of commissioner stipends. The Finance Department requires that all forms are completed and information is accurately prepared and submitted before stipends can be paid. Review the checklist prior to submitting stipend requests.

For Initial Payment to a Commissioner or Service Provider:

☐ Set up the Commissioner as a vendor with Finance - General Services
* Use a W-9 form to set up the Commissioner as a vendor (available on Groupware)

☐ Set up the Vendor (support services, dependent care, or child care) as a vendor with Finance - General Services
* Use a W-9 form to set up the service provider as a vendor

Required Documentation for Every Payment Submission (compile submission in this order):

☐ Request for Check
*In both description areas of the Request for Check screen, list the type of stipend being paid and the period covered (quarterly or monthly)
* Provide the full account code and/or project string (consult your department budget analyst)
* Verify in ERMA that adequate funds are available in the account to pay the voucher
* Clearly document the payment amount
* Obtain all required signatures

☐ A.R. 3.2 Payment Form
* Complete all fields
* Obtain all required signatures

☐ Invoices for Support Service, Dependent Care, and/or Child Care Providers
* Must include date, services provided, vendor contact information, and dollar amount

☐ Attendance Verification
* A copy of the meeting minutes
* Requests for reimbursement for cancelled meetings require written representation from the Commission Secretary

☐ Annual Declaration Form
* The form is completed and signed and dated yearly by the commissioner and the Commission Secretary
* A copy of the form is submitted with each reimbursement voucher

☐ Year-to-Date Summary Spreadsheet
* Documents the fiscal year (year to date) expenditures of the individual commissioner
* Remember that payments of $600 or more result in the issuance of a Form 1099 from the Finance Department and may have tax implications

City Clerk Department

June 30, 2021

To: Commission Secretaries

From: Mark Numainville, City Clerk

Subject: Commission Low-Income Stipend Update

On March 9, 2021, the City Council adopted Resolution No. 69,739-N.S. increasing the qualifying annual household income threshold and the per meeting stipend for eligible members of certain boards, commissions, committees, task forces, and joint subcommittees (eligible recipients). **These changes will go into effect on July 1, 2021.**

The City Clerk Department has updated Administrative Regulation (AR 3.2) to reflect the new stipend amount, the new qualification threshold, and the processing steps in ERMA. Additional funds have been budgeted to cover the expected increase in eligibility and stipend amount. City Clerk staff is working with the Budget Office to determine how departments will access the budget allocation to cover stipend payments and will inform you of the process later in July 2021.

Please share the resolution and A.R. 3.2 with your commissioners.

The qualifying annual household income was adjusted from $20,000 to the Alameda County 50% Area Median Income (AMI) for a three-person household for stipend and reimbursement in lieu of expenses for eligible recipients. The three-person Alameda County AMI was used to set the Mayor's salary for Measure JJ that was approved by Berkeley voters on November 3, 2020.

Persons in Household	**Annual Income Extremely Low (30%)**	**Annual Income Very Low (50%)**	**Annual Low Income (80%)**	**Annual Income Median (100%)**
3	$35,250	$58,750	$94,000	$117,500

The meeting stipend amount was also increased from $40 to $100 per meeting (not to exceed four meetings per month) with an annual Consumer Price Index (CPI) inflator. Reimbursement for actual expenses incurred including child care, paid attendant services for elderly care, and support services as a disabled member for meeting participation remain unchanged.

Additionally, eligible recipients requesting reimbursement for child care expenses, paid attendant services for elderly care, and support services as a disabled member for meeting participation are subject to AB 1234. State law AB 1234 requires completion of an online ethics training course within one year of the first day of service, and every two years thereafter. The ethics course is available online at no cost. Upon completion of the course, a printed and signed certificate of participation must be on file with the secretary in order to be eligible for reimbursement.

To establish eligibility, Commissioners must still file the Annual Declaration Form with the secretary. Claims for reimbursement will still be filed with the secretary and processed pursuant to procedures established in AR 3.2.

If you have any questions, please e-mail the Commission Inbox, commission@cityofberkeley.info.

Attachments:

1. Resolution No. 69,739-N.S.
2. Revised A.R. 3.2

From: Works-Wright, Jamie
To: Works-Wright, Jamie
Subject: Items and topics for July 22, 2021 MHC meeting
Date: Monday, June 28, 2021 3:07:46 PM
Attachments: image001.png

Hello Commissioners,

Please send me any items or topics that you would like to see on the agenda for the July MHC meeting. Please have all items to me by next Tuesday, July 6th , written how you would like it presented on the agenda. Also if you have anything you would like to have in the packet, please have it to me by Monday, July 12, 2021.

Thank you for your time.

Jamie Works-Wright

Consumer Liaison & Mental Health Commission Secretary
City of Berkeley
1521 University
Berkeley, CA 94703
Jworks-wright@cityofberkeley.info
Office: 510-981-7721 ext. 7721
Cell #: 510-423-8365

From: Works-Wright, Jamie
To: Works-Wright, Jamie
Subject: FW: CCJBH Event: Reducing Homelessness for People with Behavioral Health Needs Leaving Jails and Prisons
Date: Monday, June 28, 2021 2:51:44 PM
Attachments: image001.png
image002.png

FYI please see information below

Thank you for your time.

Jamie Works-Wright

Consumer Liaison & Mental Health Commission Secretary
City of Berkeley
1521 University
Berkeley, CA 94703
Jworks-wright@cityofberkeley.info
Office: 510-981-7721 ext. 7721
Cell #: 510-423-8365

From: AFBH Discharge Coordination, ACBH <AFBHDischargeCoordination@acgov.org>
Sent: Friday, June 25, 2021 11:32 AM
Subject: FW: CCJBH Event: Reducing Homelessness for People with Behavioral Health Needs Leaving Jails and Prisons

Sharing this resource.

With thanks and appreciation,

Charleen Stearns, **MA, Rehabilitation Counselor II**

Discharge Coordination Team (afbhdischargecoordination@acgov.org)
Adult Forensic Behavioral Health (AFBH)
Alameda County Behavioral Health (ACBH)
5325 Broder Blvd.
Dublin, CA 94568

Desk: (925) 803 – 7222, TIE LINE 47222
Mobile: (510) 410 – 0291
Email: charleen.stearns@acgov.org
QIC: 80501

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

From: The California Association of Collaborative Courts <communications@cadcp.org>
Sent: Friday, June 25, 2021 8:29 AM
To: Stearns, Charleen, ACBH <Charleen.Stearns@acgov.org>
Subject: CCJBH Event: Reducing Homelessness for People with Behavioral Health Needs Leaving Jails and Prisons

Brought to you courtesy of the CA Association of Collaborative Courts. View this email in your browser

Council on Criminal Justice and Behavioral Health (CCJBH)

Below is information about the upcoming virtual launch event for CCJBH's "Reducing Homelessness for People with Behavioral Health Needs Leaving Jails and Prisons" report:

The Council on Criminal Justice and Behavioral Health and the Council of State Governments Justice Center invite you to join them on **Wednesday, July 14th, from 12-1:30 PM,** for a virtual event to publicly launch their report, Reducing

Homelessness for People with Behavioral Health Needs Leaving Jails and Prisons. Learn about key findings and recommendations to increase housing opportunities, listen to personal stories about the life-changing value of housing, and hear from key state leaders and local partners about why we must prioritize housing for this population with new housing investments. This event will set the stage for future collaborative efforts around this important issue.

Keynote Speakers Include:

- **Corrin Buchanan**, *Assistant Director of Housing and Homelessness, California Department of Social Services (DSS)*
- **Julie Lo**, *Executive officer, Homeless Coordinating and Financing Council (HCFC)*
- **Geoffrey Ross**, *Deputy Director, Housing and Community Development (HCD)*
- **Susan Philip**, *Deputy Director, Department of Health Care Services (DHCS)*

REGISTER HERE!

Learn about the CA Association of Collaborative Courts Annual Conference, Sept. 2-4, 2021, Monterey, CA.

Our mailing address is:
CACC/CADCP
P.O. Box 559
Mentone, CA 92372

From: Works-Wright, Jamie
To: Works-Wright, Jamie
Subject: FW: Follow up from CHR Presentation
Date: Monday, June 28, 2021 1:22:09 PM
Attachments: image001.png

Hello All,

Please see the email below

Thank you for your time.

Jamie Works-Wright

Consumer Liaison & Mental Health Commission Secretary
City of Berkeley
1521 University
Berkeley, CA 94703
Jworks-wright@cityofberkeley.info
Office: 510-981-7721 ext. 7721
Cell #: 510-423-8365

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Sunday, June 27, 2021 2:50 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Fwd: Follow up from CHR Presentation

Hi Jamie,

Can you kindly send this information to the Commissioners? I also believe that all persons who attended last Thursday would have an interest. Please let me know if we need to obtain email addresses.

Best wishes,
Margaret

---------- Forwarded message ---------

From: **Martinez, Jennifer, HCSA** <Jennifer.Martinez@acgov.org>
Date: Fri, Jun 25, 2021 at 2:27 PM
Subject: Follow up from CHR Presentation
To: Margaret Fine <margaretcarolfine@gmail.com>
CC: Iannuzzi, Cristi - CandCAdvisors <cristi@candcadvisors.com>

Hi Margaret-

Thanks again for having us at the commission yesterday. I'm following up on the question about the county-based subsidies for housing. Here is the feedback from our housing team. Feel free to pass it along.

County 'subsidies' are prioritized through Coordinated Entry System (CES), and people countywide can be matched them depending on their priority for housing throughout the system. We do not take geography into account when matching to Permanent Supportive Housing unless that's a requirement of the subsidy itself. Clients also give their preferences for where they want to live when we do the CES assessment so we try to match people to opportunities that honor their geographic preferences.

Thanks,

Jennifer Martinez, MPH
Program Development Director
Early Warning: I will be away on PTO July 6-9
Alameda County Care Connect
Alameda County Health Care Services Agency
1900 Embarcadero, Suite 210
Oakland, CA 94606
Ph: 510-346-1068/x81068
QIC: 28009
www.accareconnect.org

From:	Works-Wright, Jamie
To:	Works-Wright, Jamie
Cc:	Grolnic-McClurg, Steven; Warhuus, Lisa; Katuala, Yvette
Subject:	FW: Invitation 6/24, 7 pm: Whole Person Care & AC Community Health Records, Mental Health Commission Presentation
Date:	Monday, June 21, 2021 11:15:27 AM
Attachments:	CalAIM Medi_Cal Reforms Executive Summary and Summary of Changes 2021.pdf image001.png

Please see the email below from the MHC chair, Margaret Fine

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Friday, June 18, 2021 2:41 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Invitation 6/24, 7 pm: Whole Person Care & AC Community Health Records, Mental Health Commission Presentation

Dear Jamie - Would you kindly please forward this invitation and copy it to Director of Health, Housing and Community Services, Dr. Lisa Warhuus, and Mental Health Division Manager, Mr. Steven Grolnic-McClurg? The email addresses are manager@cityofberkeley.info, pbuddenhagen@cityofberkeley.info, dwhite@cityofberkeley.info

Dear City Manager Ms. Ridley-Williams, Deputy City Manager Paul Buddenhagen and Deputy City Manager David White,

We would like to invite you to our public meeting scheduled for Thursday, June 24 at 7 pm for the Mental Health Commission for the City of Berkeley.

This month we will welcome the Director of Program Development, Ms. Jennifer Martinez, MPH, and the Director of Strategy and Implementation of the Data Exchange Unit, Ms. Cristi Iannuzzi, from Alameda County Care Connect.

We will focus on the whole person care approach and its implementation by Alameda County Care Connect to support people experiencing homelessness with complex medical, behavioral health and social conditions in the county.

Specifically we will focus on whole person care and the "Community Health Records" system. Ms. Martinez will provide an overview of the "Community Health Records" (purpose, definitions, current status) and Ms. Iannuzzi will do a demonstration, including showing the dashboards and how the data sharing platform works. Previously I viewed this demonstration and it was excellent.

They will show how this "whole person care" approach allows for comprehensively integrating information across multiple systems: health, mental health, substance use, crisis response, social, housing and incarceration information. Clients can also access their records through the client portal.

In addition I am attaching the Executive Summary (including summary of changes) for the new California Advancing and Innovating Medi-Cal (CalAIM) which sets forth the framework for new Medi-Cal reforms. It builds upon the whole person care pilots that transpired over three years through December, 2020. "CalAIM has three primary goals:

1. Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health;
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
3. Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems and payment reform (Executive Summary, p. 2)."

After this presentation we will also be addressing the Specialized Care Unit. The Mental Health Commissioners further invite their participation in a discussion about non-police crisis response.

Thanks so much for your consideration. We hope you can join us.

Best wishes,
Margaret

Margaret Fine, PhD, JD
Pronouns: she/her
Chair, Mental Health Commission
Berkeley, CA
Cell: 510-919-4309
margaretcarolfine@gmail.com

California Advancing and Innovating Medi-Cal (CalAIM)
Executive Summary and Summary of Changes

The Department of Health Care Services (DHCS) has developed a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal. CalAIM advances several key priorities of the Administration by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population.

This proposal recognizes the opportunity to provide for non-clinical interventions focused on a whole-person care approach via Medi-Cal that target social determinants of health and reduces health disparities and inequities. Furthermore, the broader system, program, and payment reforms included in CalAIM allow the state to take a population health, person-centered approach to providing services and puts the focus on improving outcomes for all Californians. Attaining such goals will have significant impact on individuals' health and quality of life, and through iterative system transformation, will ultimately reduce per-capita costs over time. DHCS intends to work with the Administration, Legislature and other partners on these proposals and recognizes the important need to discuss these issues and their prioritization within the state budget process. These are updated proposals based on extensive stakeholder feedback. Implementation will ultimately depend on the availability of funding and the requisite federal approvals. The "Summary of Changes" table at the end of this document summarizes major changes to the CalAIM proposal since its original release in October 2019.

CalAIM implementation was originally scheduled to begin in January 2021, but was delayed due the impact of the COVID-19 public health emergency. As a result, DHCS is proposing a new CalAIM start date of January 1, 2022.

Background and Overview

Medi-Cal has significantly expanded and changed over the last ten years, most predominantly because of changes brought by the Affordable Care Act and various federal regulations as well as state-level statutory and policy changes. During this time, the DHCS has also undertaken many initiatives and embarked on innovative demonstration projects to improve the beneficiary experience. In particular, DHCS has increased the number of beneficiaries receiving the majority of their physical health care through Medi-Cal managed care plans. These plans are able to offer more complete care coordination and care management than is possible through a fee-for-service system. They can also provide a broader array of services aimed at stabilizing and supporting the lives of Medi-Cal beneficiaries.

Depending on their needs, some beneficiaries may access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, dental, developmental, In Home Supportive Services, etc.) in order to get their needs addressed. As one would expect, the need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. Therefore, in order to meet the behavioral, developmental, physical, and oral health needs of all members in an integrated, patient centered, whole person fashion, DHCS is seeking to integrate Medi-Cal our delivery systems and align funding, data reporting, quality, and infrastructure to mobilize and incentivize towards common goals.

Together these CalAIM proposals offer solutions designed to ensure the stability of Medi-Cal program and allows the critical successes of waiver demonstrations such as the Whole Person Care Pilots, the Health Homes Program, the Coordinated Care Initiative, and public hospital system delivery transformation, that advance the coordination and delivery of high-quality care for all Medi-Cal enrollees.

Our vision is that people served by our programs should have longer, healthier and happier lives. There will be a whole system, person centered approach to health and social care, in which services are only one element of supporting people to have better health and wellbeing throughout their whole lives. It will be an integrated “wellness” system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.

The whole system, person centered approach will be equitable. Services and supports will deliver the same high quality of care, and achieve more equal health outcomes across the entire continuum of care, for all. It will improve the physical, behavioral, developmental, oral and long term services and supports, throughout their lives, from birth to a dignified end of life.

When people need support, care or treatment they will be able to access a range of services which are made seamless, and delivered as close to home as possible. Services will be designed around the individual and around groups of people, based on their unique need and what matters to them, as well as quality and safety outcomes.

To do this, we must change expectations for our managed care and behavioral health systems. Holding our delivery system partners accountable for a set of programmatic and administrative expectations is no longer enough. We must provide a wider array of services and supports for complex, high need patients whose health outcomes are in part driven by unmet social needs and systemic racism. We must make system changes necessary to close the gap in transitions between delivery systems, create opportunities for appropriate step-down care, and mitigate social determinants of health, all hindering the ability to improve health outcomes and morbidity.

Guiding Principles

In 2018, the Care Coordination Advisory Committee developed a core set of guiding principles that were refined and established as the principles of the CalAIM initiative:

- Improve the member experience.
- Deliver person-centered care that meets the behavioral, developmental, physical, long term services and supports, and oral health needs of all members.
- Work to align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.
- Build a data-driven population health management strategy to achieve full system alignment.
- Identify and mitigate social determinants of health and reduce disparities and inequities.
- Drive system transformation that focuses on value and outcomes.
- Eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation.
- Support community activation and engagement.
- Improve the plan and provider experience by reducing administrative burden when possible.
- Reduce the per-capita cost over time through iterative system transformation.

Key Goals

To achieve such principles, CalAIM has three primary goals:

- Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems and payment reform.

Identify and Manage Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health

California continues to strengthen integration within the state's health care delivery system aimed at achieving better care and better health. In line with these objectives, DHCS is proposing reforms would better identify and manage member risk and need for beneficiaries who may be challenged with medical and behavioral conditions, access to care, as well as chronic illnesses and disabilities, and require multidisciplinary care to regain health and function.

To achieve such goals, DHCS proposes the following whole system, person centered approach

that focuses on addressing the needs of beneficiaries across the system with the overarching goal of improving quality of life and health.

- Development of a statewide **population health management strategy** and require plans to submit local population health management plans.
- Implement a new statewide **enhanced care management benefit**.
- Implement **in lieu of services** (e.g., housing navigation/supporting services, recuperative care, respite, sobering center, etc.).
- Implement **incentive payments** to drive plans and providers to invest in the necessary infrastructure, build appropriate enhanced care management and in lieu of services capacity statewide.
- Pursue participation in the **Serious Mental Illness (SMI) /Serious Emotional Disturbance (SED) demonstration opportunity**.
- Require screening and enrollment for Medi-Cal **prior to release from county jail.**
- **Pilot full integration** of physical health, behavioral health, and oral health under one contracted entity in a county or region.
- Develop a long-term plan for improving health outcomes and delivery of health care for **foster care children and youth**.

Population Health Management

Medi-Cal managed care plans shall develop and maintain a patient-centered population health strategy, which is a cohesive plan of action for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes. Each managed care plan shall include, at a minimum, a description of how it will:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and
- Identify and mitigate social determinants of health and reduce health disparities or inequities.

Enhanced Care Management

DHCS proposes to establish a new, statewide enhanced care management benefit. An enhanced care management benefit would provide a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals. The proposed benefit builds on the current Health Homes Program and Whole Person Care Pilots, and transitions those pilots to this new statewide managed care benefit to provide a broader platform to build on positive outcomes from those programs.

Proposed target populations include:

- Children or youth with complex physical, behavioral, developmental and oral health needs (e.g., California Children Services, foster care, youth with clinical high-risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
- Individuals at risk for institutionalization who are eligible for long-term care services.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with serious mental illness (SMI), children with serious emotional disturbance (SED) or substance use disorder (SUD) with co-occurring chronic health conditions.
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

In Lieu of Services & Incentive Payments

In order to build upon and transition the excellent work done under California's Whole Person Care Pilots, DHCS is proposing to implement in lieu of services, which are flexible wrap-around services that a Medi-Cal managed care plan will integrate into its population health strategy. These services are provided as a substitute to, or to avoid, other covered services, such as a hospital or skilled nursing facility admission or a discharge delay. In lieu of services would be integrated with care management for members at high levels of risk and may fill gaps in state plan benefits to address medical or social determinants of health. The current list of in lieu of services includes:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services

- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

The provision of in lieu of services is voluntary for plans and optional for beneficiaries, but the combination of enhanced care management and in lieu of services allows for a number of integration opportunities, including an incentive for building incremental change to achieve integrated managed long-term services and supports (MLTSS) in the managed care program by 2027 and building the necessary clinically-linked housing continuum for our homeless population. In order to be equipped with the required MLTSS and housing infrastructure, the state must use its ability to provide Medi-Cal managed care plans with financial incentive payments to work with their providers to invest in the necessary delivery and systems infrastructure, build appropriate care management and in lieu of services capacity, and achieve improvements in quality performance and measurement reporting that can inform future policy decisions.

SMI/SED Demonstration Opportunity

With some exceptions, federal Medicaid funding cannot be used to pay for services provided to a Medicaid beneficiary while the beneficiary is residing in an Institutional for Mental Disease (IMD). This is referred to as the IMD exclusion. Generally, an IMD is a hospital, nursing home or other institution with more than 16 beds that is primarily engaged in treating persons with mental diseases. However, the federal government has developed an opportunity for states to seek the ability to receive federal funding for institutional services provided to populations with a Serious Mental Illness or Serious Emotional Disturbance (SMI/SED), similar to the flexibility the state has secured for the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilots. DHCS proposes to assess county interest in pursuing the SMI/SED demonstration opportunity, as long as our systems are positioned to achieve the required goals and outcomes, including building out a full continuum of care to offer beneficiaries community-based care in the least restrictive setting. Counties would voluntarily "opt-in" to participate. The main elements of the proposed SMI/SED demonstration opportunity would include:

- Ensuring quality of care in psychiatric hospitals and residential settings, including required audits;
- Improving care coordination and transitions to community-based care;
- Increasing access to a full continuum of care including crisis stabilization and other clinically enriched forms of housing in the community with robust support services; and
- Earlier identification and engagement in treatment including through increased integration.

In pursuing this waiver opportunity, counties that "opt in" should be prepared to build out a robust continuum so individuals who begin at a higher level of institutional care can be stepped down to a less restrictive, community-based, residential setting.

Mandatory Medi-Cal Application Process upon Release from Jail and County Juvenile Facilities

Justice-involved individuals often receive both medical and behavioral health services while incarcerated. Upon release from jail or county juvenile facilities, proper coordination is needed to ensure the medical and behavioral health needs of an individual continue to be met, and additionally ensure critical non-clinical needs, such as housing, transportation and overall integration back into the community are met. Studies have shown these types of coordination activities reduce unnecessary emergency room and inpatient stays, as well as improve treatment and medication adherence upon release from jail. To ensure all county inmates receive timely access to Medi-Cal services upon release from incarceration, DHCS proposes that California mandate the county inmate pre-release Medi-Cal application process by January 2023. Additionally, DHCS proposes mandating that jails and county juvenile facilities implement a process for facilitated referral and linkage from county institution release to county specialty mental health, Drug Medi-Cal, DMC-ODS, and Medi-Cal managed care plans when the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

Full Integration Plans

DHCS would like to test the effectiveness of an approach to provide full integration of physical health, behavioral health, and oral health under one contracted entity. Due to the complexity of the policy considerations around this concept, DHCS will need to conduct extensive stakeholder engagement around eligibility criteria for entities, administrative requirements across delivery systems, provider network requirements, quality and reporting requirements, as well as complex financial considerations due to realignment and Proposition 30 structure of behavioral health. Given the complexity of this proposal and time needed for consideration and planning, DHCS expects that the first selected plans would not go live no sooner than 2027.

Develop a Long-Term Plan for Foster Care

In June 2020, DHCS launched the Foster Care Model of Care Workgroup to provide an opportunity for stakeholders to weigh in on a long-term plan and strategy for improving health outcomes and the delivery of fully-integrated health care services for foster care children and youth. The workgroup will complete its work in June 2021. Based on input from the workgroup, DHCS and the California Department of Social Services (CDSS) will develop a plan of action, which may involve budget recommendations, waiver amendments, state plan changes or other activities.

Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

Medi-Cal provides services to some of California's most vulnerable and medically complex beneficiaries, but many of the services vary depending on the county one lives in. DHCS is proposing to standardize and reduce complexity by implementing administrative and financial efficiencies across the state and aligning delivery systems to provide more predictability and reduce county-to-county differences. These reforms stretch across managed care, behavioral health, dental, and other county-based services.

To achieve such goals, DHCS proposes the following recommendations.

Managed Care

- Standardize managed care enrollment statewide
- Standardize managed care benefits statewide
- Transition to statewide managed long-term services and supports
- Require Medi-Cal managed care plans be National Committee for Quality Assurance (NCQA) accredited
- Implement regional rates for Medi-Cal managed care plans

Behavioral Health

- Behavioral health payment reform
- Medical necessity criteria
- Administrative behavioral health integration statewide
- Regional contracting
- Drug Medi-Cal Organized Delivery System (DMC-ODS) program renewal and policy improvements

Dental

- New benefit: Caries Risk Assessment Bundle for young children (0 to 6 years of age) and Silver Diamine Fluoride for young children (0 to 6 years of age) and specified high-risk and institutional populations, as described in detail below.
- Pay for Performance for two adult and 11 children preventive services codes and continuity of care through a Dental Home

County-Based Services

- Enhance oversight and monitoring of Medi-Cal Eligibility
- Enhance oversight and monitoring of California Children's Services and the Child Health and Disability Prevention program
- Improving beneficiary contact and demographic information

Managed Care

Managed Care Enrollment

DHCS proposes requiring all non-dual eligible Medi-Cal beneficiaries by January 2022 and requiring all full- and partial-benefit dual beneficiaries by January 2023, statewide, to be enrolled mandatorily in a managed care plan. The one exception is for those for whom managed care enrollment is not appropriate due to limited scope of benefits or limited time enrolled. The goal is to align managed care enrollment practices that currently vary by aid code, population, and geographic location.

Standardize Managed Care Benefit

DHCS proposes to standardize managed care plan benefits, so that all Medi-Cal managed care plans provide the same benefit package by 2023. Some of the most significant changes are to carve-in institutional long-term care and major organ transplants into managed care statewide.

Transition to Statewide Managed Long-Term Services and Supports

To achieve a more standardized approach to comprehensive care coordination for all populations, DHCS is proposing to discontinue the Cal MediConnect pilot program at the end of calendar year 2022. DHCS proposes to transition from the pilot approach of the Coordinated Care Initiative (CCI) to standardized mandatory enrollment of dual eligibles into managed care. The goal is to achieve Medi-Cal benefits integration of long-term care into managed care for all Medi-Cal populations statewide, and to transition Cal MediConnect plans to Medicare Dual-Eligible Special Needs Plans (D-SNPs). This will be done in phases:

January 2022: The Coordinated Care Initiative (CCI) proceeds as today, except that the Multipurpose Senior Services Programs benefit would be carved out of managed care. DHCS will also implement voluntary in lieu of services at this time.

January 2023: Full transition to mandatory enrollment of dual eligibles into managed care. Further, all dual and non-dual fee-for-service Medi-Cal beneficiaries residing in a long-term care facility will be enrolled in a managed care plan effective January 1, 2023. In addition, Medi-Cal managed care plans operating in CCI counties will be required to operate Medicare D-SNPs to transition the Cal MediConnect demonstration to a permanent, ongoing federal authority and to coordinate members' Medi-Cal and Medicare benefits.

January 2025: Medi-Cal managed care plans in non-CCI counties will be required to operate Medicare D-SNPs.

The purpose of these transitions and phases is to achieve a long-term goal of implementing MLTSS statewide in Medi-Cal managed care beginning in 2027, by providing enough time and incentive to develop the needed infrastructure. This will allow many duals to receive needed MLTSS and home and community-based services statewide through their managed care plan, instead of through a variety of 1915(c) HCBS waivers that currently have capped enrollment and

are not statewide.

NCQA Accreditation of Medi-Cal Managed Care Plans

In order to streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS recommends requiring all Medi-Cal managed care plans and their health plan subcontractors to achieve National Committee for Quality Assurance (NCQA) accreditation by 2026. DHCS plans to use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain state and federal Medicaid requirements.

Regional Rates

DHCS proposes to shift the development of Medi-Cal managed care plan rates from a county-based model to a regional rate model. The proposal to move to regional rates has two main benefits. The first benefit is a decrease in the number of distinct actuarial rating cells that are required to be submitted to CMS for review and approval. The reduction in rating cells will simplify the presentation of rates to CMS and allow DHCS to pursue/implement financing advancements and innovations utilizing a more flexible rate model. The second benefit of regional rates is cost averaging across all plans. This will continue to incentivize plan cost efficiencies, as plan rates will be inclusive of the costs within the multi-county region. This shift will produce a larger base for the averaging beyond the experience of plans operating within a single county. This change is fundamental to the ability of DHCS to implement and sustain the other changes proposed in CalAIM.

Behavioral Health

Behavioral Health Payment Reform

The state, in partnership with counties, must take serious steps to continue to invest in and improve access to mental health and substance use disorder (SUD) services for Medi-Cal beneficiaries. Behavioral health transformation is a critical priority for the Governor, the California Health and Human Services Agency, and for DHCS. We recognize that we need to improve quality of and access to care for children and other vulnerable populations. In order to achieve true system transformation, DHCS is committed to first achieving behavioral health payment reform, where DHCS will transition counties from a cost-based reimbursement methodology to a structure more consistent with incentivizing outcomes and quality over volume and cost. This shift is being designed in conjunction with our county partners and will enable counties to participate in broader delivery system transformation efforts and engage in value-based payment arrangements with their health plan partners to support better coordination and integration between physical and behavioral health. This shift will be done thoughtfully with a key focus on ensuring no disruption of services or financial challenges for our county partners.

Behavioral health payment reform is an essential step to other opportunities for the counties around behavioral health integration, regional contracting and delivery system investments needed to advance a high-quality continuum of care for mental health and SUD services in the community.

Revisions to Behavioral Health Medical Necessity

The medical necessity criteria for specialty mental health services is outdated, lacks clarity, and should be re-evaluated. This issue creates confusion, misinterpretation, and could affect beneficiary access to services as well as result in disallowances of claims for specialty mental health and SUD services. DHCS is proposing to update behavioral health medical necessity criteria to more clearly delineate and standardize requirements and to improve access for beneficiaries to appropriate services statewide.

Administrative Behavioral Health Integration

Approximately half of individuals with a serious mental illness (SMI) have co-occurring substance use and those individuals would benefit from integrated treatment. The state covers Medi-Cal SUD and specialty mental health services through separate county contracts, which makes it difficult for counties and contracted providers to offer integrated treatment to individuals with co-occurring disorders. For example, counties are subject to two separate annual quality assessments, two separate post-payment chart audits, and two separate reimbursement and cost reporting methods. In order to comply with these separate processes, providers offering integrated treatment to a Medi-Cal beneficiary must document SUD treatment services separately from specialty mental health services. The purpose of this proposal is to streamline the administrative functions for SUD and specialty mental health services.

Behavioral Health Regional Contracting

Small counties could optimize resources through regional administration and delivery of specialty mental health and SUD services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to provide services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such as the local Medi-Cal managed care plan or County Medical Services Program, to create administrative efficiencies across multiple counties. Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. Furthermore, DHCS encourages counties to join the Drug Medi-Cal Organized Delivery System (DMC-ODS) or provide DMC services through a regional approach. DHCS is committed to working with counties to offer technical assistance to help develop regional contracts and establish innovative partnerships.

DMC-ODS Program Renewal and Policy Improvements

DHCS proposes to update the DMC-ODS program based on experience from the first several years of implementation. Accordingly, DHCS proposes clarifying and/or changing policies to support the goal of improved beneficiary access to care, quality of care, and administrative efficiency.

Dental

The Department set an initial goal to achieve at least a 60 percent dental utilization rate for

eligible Medi-Cal children. To continue progress toward achieving this goal, and based on lessons learned from the Dental Transformation Initiative (DTI), DHCS proposes the following statewide reforms for Medi-Cal dental coverage:

- Add new dental benefits based on the outcomes and successes from the DTI that will provide better care and align with national oral health standards. The proposed new benefits include a Caries Risk Assessment Bundle for young children and Silver Diamine Fluoride for young children and specified high-risk and institutional populations; and

- Continue and expand Pay for Performance Initiatives initiated under the DTI that reward increasing the use of preventive services and establishing/maintaining continuity of care through a dental home. These expanded initiatives would be available statewide for children and adult Medi-Cal enrollees.

County Partners

Enhancing County Oversight and Monitoring: Eligibility

This proposal will help to improve DHCS' oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment and the activities of its contracted partners. This includes implementing additional county oversight activities to increase the integrity of the administration of the Medi-Cal program, as well as implementing the recommendations of the California State Auditor's Office. This proposal will also ensure that DHCS remains compliant with federal and state eligibility and enrollment requirements. These enhancements will be developed and implemented in direct collaboration with our county partners.

Enhancing County Oversight and Monitoring: CCS and CHDP

There are several programs – including California Children's Services, the Medical Therapy Program, and the Child Health and Disability Prevention program – that provide services to over 750,000 children in Medi-Cal. The state delegates certain responsibilities for these high-risk children to California's 58 counties and three (3) cities (Berkeley, Pasadena, and Long Beach). The state needs to enhance the oversight of counties to ensure they comply with applicable state and federal requirements. Enhancing monitoring and oversight will eliminate disparities in care and reduce vulnerabilities to the state and counties, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

Improving Beneficiary Contact and Demographic Information

DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which beneficiary contact and demographic information can be updated by other entities and the means to accomplish this while maintaining compliance with all applicable state and federal privacy laws. The goal of the workgroup will be to determine the best pathway for ensuring that reported data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services programs, Medi-Cal beneficiaries, managed care plans, and the provider community.

Advancing Key Priorities

As DHCS has assessed the changes proposed under CalAIM, it has become apparent that these proposals are critically dependent upon each other -- without one, the others are neither possible nor powerful.

These reforms are fundamental to achieve the overall goals of improving the system and outcomes for Medi-Cal beneficiaries as well as providing long-term fiscal and programmatic sustainability to the Medi-Cal program and delivery system. In developing these recommendations, DHCS has recognized that individual proposals are significantly less likely to be achievable and successful if other key proposals are not pursued. For example, absent the proposed financing changes with respect to both the regional rate setting for Medi-Cal managed care and the structural changes to Medi-Cal behavioral health financing, the ability of our partnered plan and county entities to institute the changes focused on value-based and integrated delivery of care are significantly harder and potentially impossible to achieve.

These fundamental financing changes would not be possible without the elimination of differences across counties with respect to the delivery systems through which Medi-Cal benefits are delivered. Nearly every other proposal contained within CalAIM (such as enhanced care management, in lieu of services, and incentive payments, as well as the possibility of future full integration pilots) is critically dependent on the success of others.

The Medi-Cal program has evolved over the multiple decades since inception with ever-increasing system and fiscal complexities. CalAIM offers DHCS and the entire State of California an opportunity to take a step back to better assess what Medi-Cal beneficiaries need and alter the delivery systems accordingly, while at the same time working to be more effective and efficient with the finite funding available for the program.

CalAIM aligns with and advances several key priorities of the Administration. At its core, CalAIM recognizes the impact of Medi-Cal on the lives of its beneficiaries well beyond just accessing health services in traditional delivery settings. CalAIM establishes a foundation where investments and programs within Medi-Cal can easily integrate, complement and catalyze the Administration’s plan to respond to the state’s homelessness crisis, support reforms of our justice systems for youth and adults who have significant health issues, build a platform for vastly more integrated systems of care, and move toward a level of standardization and streamlined administration required as we explores single payer principles through the Healthy California for All Commission.

Furthermore, CalAIM will translate a number of existing Medi-Cal efforts such as Whole Person Care and the Health Homes Program, the prescription drug Executive Order, improving screenings for children, proliferating the use of value-based payments across our system, including in behavioral health and long-term care into the future of the program. CalAIM will also

support the ongoing need to increase oversight and monitoring of all county-based services, including specialty mental health and substance use disorder services, Medi-Cal eligibility administration, and other key children's programs currently administered by our county partners.

Below is an overview of the impact CalAIM could have on certain populations, if approved and funded as proposed:

Health for All: In addition to focusing on preventive and wellness services, CalAIM will identify patients with high and emerging risk/need and improve the entire continuum of care across Medi-Cal. This will ensure the system more appropriately manages patients over time, through a comprehensive array of health and social services spanning all levels of intensity of care, from birth and early childhood to end of life.

High Utilizers (top 5%): It is well documented that the highest utilizers represent a majority of the costs in Medi-Cal and in Medicaid nationally. CalAIM proposes enhanced care management and in lieu of services (such as housing-related services, transitions, respite and sobering centers) that address the clinical and non-clinical needs of these high-cost Medi-Cal beneficiaries. The initiative envisions a collaborative and interdisciplinary whole person care approach to providing intensive and comprehensive care management services to improve health and mitigate social determinants of health.

Behavioral Health: CalAIM's behavioral health proposals would initiate a fundamental shift in how California organizes and administers specialty mental health and substance use disorder services. It aligns the financing of behavioral health with that of physical health, which provides financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care. Similarly, the reforms in CalAIM simplify administration of, and access to, integrated behavioral health care.

Vulnerable Children: CalAIM is designed to improve and streamline care for medically complex children to ensure they get their physical, behavioral, developmental and oral health needs met. It aims to identify innovative solutions for providing low-barrier, comprehensive care for children and youth in foster care and furthers the efforts already underway to improve preventive services for children, including identifying the complex impacts of trauma, toxic stress and adverse childhood experiences by, among other things, a reexamination of the existing behavioral health medical necessity definition.

Homelessness and Housing: The addition of in lieu of services would build capacity to the clinically-linked housing continuum for our homeless population, and would include housing transitions/navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions, and day habilitation programs.

Justice-Involved: The proposed Medi-Cal pre-release application mandate, enhanced care management and in lieu of services would provide the opportunity to better coordinate medical, behavioral health and non-clinical social services for justice-involved individuals prior to and upon release from county jails and county juvenile facilities. These efforts will support scaling of diversion and re-entry efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities, further aligning with other state hospital efforts to better support care for those who are incompetent to stand trial and other forensic state-responsible populations.

Aging Population: In lieu of services, carving in long-term care statewide, mandatory Medi-Cal managed care enrollment, and aligned enrollment for dual eligible beneficiaries in Medi-Cal and D-SNP plans would allow the state to build infrastructure over time to provide MLTSS statewide by 2027. MLTSS will provide appropriate services and infrastructure for integrated care and home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and is a critical component of California's Master Plan for Aging.

From Medi-Cal 2020 to CalAIM

Through CalAIM, DHCS is undertaking a more targeted approach to consolidating its Medi-Cal benefit package in an attempt to achieve better alignment across the system. While Medicaid Section 1115 authority has historically been the mechanism of choice for states interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating the required budget neutrality for waivers. CMS in recent guidance has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools.

In addition, given that California has significant learnings from our past Section 1115 demonstrations, DHCS believes a primary shift to the use of other authorities is now appropriate to allow us to expand beyond limited pilots to more statewide initiatives. These factors, combined with federal managed care regulations, has encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for delivery system authorities in the Medi-Cal program.

This proposal outlines all elements of the Medi-Cal 2020 waiver and how they will, or will not, be incorporated in to CalAIM. DHCS does not believe California is losing any critical funding or ability to improve and advance the delivery systems and ultimately improve the beneficiary experience and outcomes. In fact, the proposed shift will allow programs or pilots that have traditionally lived outside the core managed care system, where nearly 85% of all Medi-Cal beneficiaries receive care, to be brought into the main fold of managed care delivery system.

In March 2020, as COVID-19 community spread accelerated, the State of California moved quickly to stem the spread by enacting one the nation's earliest stay-at-home orders. This stay-at-home order was accompanied by suspension of non-essential medical procedures, transition to telehealth for many services, transition to telework for administrative staff, and reprioritization of health care resources and training, including infection control measures, to address COVID. While the stay-at-home order and related delivery system changes slowed the spread of the virus, these changes caused significant disruption to the overall health care delivery system, and the economy, in California

As a result, DHCS received multiple requests from organizations representing the state's health care delivery systems (e.g., counties, provider organizations, hospitals, behavioral health directors, and managed care plans). Stakeholders uniformly requested that, since providers and other partners are not able to properly prepare for CalAIM implementation given the focus and attention needed to respond to the COVID-19 emergency, the state request an extension of the Medi-Cal 2020 Section 1115 waiver.

In recognition, the Governor's revision to the state budget released in May 2020 postponed funding for CalAIM. This confluence of events prevented the state from moving ahead with the negotiation and implementation of CalAIM with a January 1, 2021 start. As such, the state prepared a 12-month extension request for the Medi-Cal 2020 Section 1115 demonstration. The request was posted for public comment in June 2020 and submitted to CMS on September 16, 2020. The 12-month extension is meant to serve as a bridge to a 5-year Section 1115 waiver renewal, primarily to continue key programs that require the authority, including the Global Payment Program (GPP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). In addition, DHCS is designing a comprehensive Section 1915(b) managed care waiver request for CMS that would also be for a 5-year period.

We look forward to working in close partnership with our federal CMS colleagues and local partners to ensure that the Medi-Cal program continues to change in ways that ultimately further the goals of improved health and outcomes, as well as cost-effectiveness, of the Medi-Cal/Medicaid program.

CalAIM Stakeholder Engagement

DHCS' released the original CalAIM proposal in October 2019 ahead of an intensive four-month stakeholder engagement process. Between November 2019 and February 2020, five topic-specific workgroups comprised of stakeholders across the state participated in a series of robust in-person meetings. During these discussions, Workgroup members provided real-time feedback on the proposals as they evolved and offered helpful considerations with respect to implementation and operations. The public also had the opportunity to provide feedback on the proposals, both during the workgroup sessions and in writing. This iteration of the CalAIM

proposal incorporates the broad range of feedback received during the stakeholder engagement process. It should be noted that this resulting proposal is dependent on the funding availability through the state budget process, and federal approvals.

Conclusion

CalAIM is an ambitious but necessary proposal to positively affect Medi-Cal beneficiaries' quality of life by improving the entire continuum of care across Medi-Cal, and ensuring the system more appropriately manages patients over time through a comprehensive set of health and social services spanning all levels of intensity of care, from birth to end of life.

CalAIM:

- Keeps all beneficiaries healthy by focusing on preventive and wellness services, while also identifying and assessing member risk and need on an ongoing basis, during transitions in care, and across delivery systems, through effective care coordination.

- Creates a fundamental shift in how California organizes and administers specialty mental health and SUD services, and aligns the financing of behavioral health with physical health, providing financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care.

- Ensures medically complex children and adults get their physical, behavioral, developmental, and oral health needs met.

- Builds capacity in a clinically -linked housing continuum via in lieu of services for California's homeless population, including housing transitions navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions and day habilitation programs.

- Provides the opportunity to better coordinate clinical and non-clinical services for justice-involved individuals prior to and upon release from jail and county juvenile facilities.

- Allows the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide. MLTSS will provide appropriate services and infrastructure for integrated care and home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and is a critical component of the State's Master Plan for Aging.

Summary of Changes from Original Release in October 2019

	Proposal	Key Changes
Identifying and Managing Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health		

2.1	Population Health Management	• Implementation delayed until 1/1/23
		• Adds requirements and clarifications:
		  ○ Managed care plans must partner with community-based providers to address members' needs.
		  ○ Clarification that population health management strategies should be developed in coordination with both county behavioral health and public health departments.
		• Assessment of Risk and Need
		  ○ This section underwent substantial edits based on stakeholder feedback. Detail was added on data collection expectations, risk stratification and segmentation, risk tiering, and development of the IRA tool. Predictive algorithms will incorporate the population needs assessment and the NCQA requirements to identify rising risks and communities.
		• Adds planned learning collaborative topics and continuing areas of policy development.
		• Review main document for additional changes, including an update to population health management strategy requirements based on workgroup feedback.

2.2	Enhanced Care Management	• Enhanced care management will be implemented using a phased-in approach.
		  ○ 1/1/22: Medi-Cal managed care plans in counties with Whole Person Care pilots and/or and Health Homes Programs (HHP) will transition aligning target populations on 1/1/22;
		  ○ 7/1/22:
		  ▪ Medi-Cal managed care plans in counties with WPC and/or HHP will implement additional mandatory target populations
		  ▪ Medi-Cal managed care plans in counties without WPC or

	Proposal	Key Changes
		HHP will begin implementation of mandatory target populations ○ 1/1/23: Full implementation of all target populations in all counties. • Appendix I, describing the enhanced care management benefit, its core concepts, and each target population in detail was developed and finalized based on workgroup feedback and added to the document. The descriptions include the target population descriptions and the services included in the benefit specific to each population. • Clarifies that Local Government Agency Targeted Case Management (TCM) will continue (pending CMS approval). It will be the responsibility of managed care plans to ensure services are not being duplicated. • Clarifies that managed care plans will be required to contract with Health Homes community-based care management entities and Whole Person Care providers. • Changes name of Transition Plan to "Transition and Coordination Plan" and added details around timeline and requirements for the plan and the required Model of Care.
2.3	In Lieu of Services	• Implementation delayed until January 1, 2022. • The ILOS menu was revised extensively based on workgroup feedback. Most notably, a 14th service, Asthma Remediation, was added. The menu is Appendix J of the CalAIM proposal and includes the following for each service: 1) description, 2) eligibility, 3) restrictions and limitations, 4) allowable providers, and 5) state plan services to be avoided.
2.4	Shared Risks, Savings and Incentive Payments	• Updated timeline: ○ 2021: Develop shared savings/risk and plan incentive methodologies and approaches with appropriate stakeholder input. ○ 1/1/22: Begin implementation of managed care plan incentives. ○ No sooner than 1/1/23: Begin implementation of a seniors and persons with disabilities/long-term care blended rate. • Clarifies that the tiered model would be available for three calendar years -- 2023, 2024 and 2025. • Clarifies that a prospective model of shared savings/risk incorporated

	Proposal	Key Changes
		via capitation rate development would be implemented beginning in calendar year 2026 once historical cost and utilization experience is available that would reflect the implementation of in lieu of services, long-term care services, and enhanced care management benefits statewide in managed care.
2.5	SMI/SED Demonstration Opportunity	• Clarifies the implementation timeline and confirms that DHCS will pursue this demonstration opportunity. The waiver proposal would be developed no sooner than 7/1/22, and if approved by CMS, DHCS would work with counties for an expected launch in 2023. • Updates the list of states that have submitted or have an approved 1115 waiver application to CMS. • Updates to the summary of key requirements for the Section 1115 demonstration opportunity.
2.5	Mandatory Medi-Cal Application Process Upon Release from Jail	• Implementation date change to 1/1/23.
2.6	Full Integration Pilots	• Implementation delayed to no sooner than January 2027 to allow sufficient time for planning & preparation, in partnership with counties, plans, and other key stakeholders.
2.7	Develop a Long-term Plan for Foster Care	• Adds details on the workgroup, which launched in June 2020 & will continue to meet until June 2021. DHCS & CDSS will then develop a comprehensive set of recommendations and plan of action based on input from the workgroup. • More information on the workgroup can be found here: https://www.dhcs.ca.gov/provgovpart/Pages/Foster-Care-Model-Workgroup.aspx
Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility		

3.1	Managed Care Benefit Standardization	• Clarifies and revises timeline for carved-out and carved-in benefits
		  ○ Benefits to be carved out:
		  ▪ 4/1/21: Pharmacy benefits or services by a pharmacy billed on a pharmacy claim
		  ▪ 1/1/22:
		  • Specialty mental health services for Kaiser Medi-Cal members in Solano and Sacramento

	Proposal	Key Changes
		Counties • Multipurpose Senior Services Program (MSSP) in the seven Coordinated Care Initiative (CCI) counties ○ Benefits to be carved-in ▪ 1/1/22: All major organ transplants ▪ 1/1/23: Institutional long-term care services ○ 1/1/23 ▪ All Medi-Cal managed care plans provide the same benefit package. • See Appendix F for more details
3.2	Mandatory Managed Care Enrollment	• Implementation date moved to 1/1/22. ○ Transition to mandatory enrollment of all non-dual eligible beneficiaries that are not currently required to enroll in managed care. • 1/1/23:Transition to mandatory enrollment of dual eligibles into managed care
3.3	Transition to Statewide Long-Term Services and Supports, Long-Term Care, & Dual Eligible Special Needs Plans	• Implementation moved to 1/1/27 to align with demonstration renewal periods. • Clarifies the definition of a non-dual, partial dual, and full-dual eligible population. • Clarifies that all dual and non-dual eligible individuals eligible for long-term care services, including long-term care share of cost populations, will transition to Medi-Cal managed care in 2023 (except those already in managed care in COHS and CCI counties). • Per new federal regulations, updated section around limiting Medicare Advantage D-SNP "look-alikes." CMS will not enter into new contracts with look-alikes starting in 2022 and will not renew contracts with look-alikes starting in 2023. DHCS will allow plans in CCI counties with MCP contracts, existing D-SNPs, and existing Medicare Advantage D-SNP look-alikes to transition their dual population enrolled in the look-alike into an existing D-SNP in 2022, prior to the end of CCI. • Clarifies that DHCS will require D-SNPs to use a model of care that supports coordinated care, high-quality care transitions, and information sharing.

	Proposal	Key Changes
		• Adds information on LTC carve-in and intersection with mandatory managed care for dual populations with LTC.
3.4	NCQA Accreditation of Medi-Cal Managed Care Plans	• Accreditation will be required by 2026. • Clarifies that DHCS will not accept accreditation from agencies besides NCQA. • DHCS will require a Long Term Services and Supports (LTSS) Distinction Survey by 2027 ○ The survey will only be required after all MCPs have achieved routine health plan accreditation. • DHCS will not yet require the Medicaid Module but may in the future. • DHCS will not require managed care plans to ensure their non-health plan sub-contractors are NCQA accredited, but may in the future. • Accreditation elements that are selected for potential deeming will be vetted with stakeholders before any final decisions are made.
3.5	Regional Managed Care Capitation Rates	• All implementation timelines moved back a year beginning on 1/1/22. See proposal for more details.
3.6	Behavioral Health Payment Reform	• Earliest start date moved to July 1, 2022. • Adds a proposal to transition from existing HCPCS Level II coding to CPT coding in all cases where a suitable CPT code exists. If a suitable CPT code does not exist, DHCS would identify an appropriate HCPCS Level II code. • Clarifies transition from HCPCS Level II coding to CPT coding for specialty mental health services and SUD services. • Clarifies the rate setting methodology establishing reimbursement rates based on peer grouping. Rates would include a service component as well as an administrative component and a utilization management/quality assurance component, which would be percentages on top of the service component. • Added a bullet to rational "Provide more flexibility to counties to explore provider reimbursement arrangements that incentivize quality and value"
3.7	Medical Necessity Criteria	• Implementation moved to 1/1/22. • Based on extensive stakeholder feedback, this proposal required a full

	Proposal	Key Changes
		re-write. • Proposes to update and clarify medical necessity criteria for specialty mental health services for both adults and children, including allowing reimbursement of treatment before diagnosis and clarifying that treatment in the presence of a co-occurring SUD is appropriate and reimbursable when medical necessity is met. • Proposes to clarify EPSDT protections for beneficiaries under age 21 and create criteria for children to access specialty mental health services based on experience of trauma and risk of developing future mental health conditions, such as involvement in child welfare or experience of homelessness. • Proposes to develop a standardized screening tool to facilitate accurate determinations of when care would be better delivered in the specialty mental health delivery system or in the Medi-Cal managed are or fee for service system. • Proposes to develop a standardized transition tool, for when a beneficiary's condition changes, and they would be better served in the other delivery system. • Proposes to implement a "no wrong door" policy to ensure beneficiaries receive medically necessary treatment regardless of the delivery system where they seek care. • Proposes to simplify and streamline mental health documentation requirements, to align with medical provider requirements, improve efficiency, and decrease provider burnout. • Proposes to update the criteria for psychiatric inpatient medical necessity currently provided in Title 9 of the California Code of Regulations.
3.8	Administrative Integration of Specialty Mental Health and SUD Services	• DHCS's goal is to submit for a single, integrated behavioral health plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and SUD services under the next 1915(b) waiver, effective 2027. • Clarifies the distinction between behavioral health administrative integration and the Full Integration Plan. • Revises "cultural competence plan" to "culturally responsive care".
3.9	Behavioral Health Regional Contracting	• No substantial changes.

	Proposal	Key Changes
3.10	Drug Medi-Cal Organized Delivery System Renewal and Policy Improvements	• Clarifies the timeline, delineating components included in the 12-month extension request (tentative effective date of 1/1/21, if approved) vs. remaining proposals that would go into effect 1/1/22. If these proposed changes are not ultimately approved in the 12-month extension, they will be included in the demonstration renewal request that DHCS will submit in 2021, for a five year renewal from January 1, 2022-December 31, 2026. • Terminology changed from "Substance Use Disorder Managed Care" back to "DMC-ODS" throughout the document to reflect the reversion to the original program name. • Minor update to the background, noting that there are now 37 counties participating in the DMC-ODS. • Announces that DHCS intends to provide non-DMC-ODS counties another opportunity to opt-in. • Notes that the request to remove the number of residential treatment episodes that can be reimbursed in a one-year period was submitted with the 12-month extension request. • Notes that proposed clarifications to recovery services, additional MAT, and tribal services were submitted with the 12-month extension request. • Changes "physician consultation services" to "clinician consultation services" and proposes clarifications related to billing. • Proposes new clarifications related to medical necessity for NTPs • Proposes adding ASAM 0.5 for beneficiaries under 21.
3.11	New Dental Benefits and Pay for Performance	• Implementation date TBD as funding for Designated State Health Programs (DSHP) is not approved in extension of the Medi-Cal 2020 demonstration. • Clarifies that expanded initiatives would be available statewide for children and adult enrollees. • Adds preventative services codes for children and adults • Specifies coverage of Silver Diamine Fluoride for children ages 0-6 years and persons with underlying conditions such that nonrestorative caries treatment may be optimal, which may include adults living in a Skilled Nursing Facility/Intermediate Care Facility. • Adds maximum of four treatments per tooth.

	Proposal	Key Changes
		• Proposes providing an annual flat rate performance payment to a dental service office location that maintains dental continuity of care by establishing a dental home for each patient and perform at least one annual dental exam/evaluation (D0120/D0150/D0145) for two or more years in a row. • Adds Appendix G: Dental in Proposition 56 vs. CalAIM
3.12	Enhancing County Eligibility Oversight and Monitoring	• Revised implementation timeline with initial work beginning 6/1/21 • Given the Executive Order to halt all county renewal processes and negative actions through the duration of the Public Health Emergency (PHE), the implementation timeline reflected in this initiative will shift if the PHE is extended. The dates noted are based on the PHE ending and normal county business processes resuming January 2021, allowing 12 months from the end of the PHE for counties to process and clean-up the resulting backlog. Dates are subject to change once the end of the PHE is established.
3.13	Enhancing County Oversight and Monitoring: CCS and CHDP	• Minor changes to the implementation timeline. Phase I began in August 2020.
3.14	Improving Beneficiary Contact and Demographic Information	• DHCS will engage with partners in 2022-2023.