Stakeholder Sharing

(CPAW Meeting – November 5, 2020)**

Highlights of news to share and areas discussed at recent Contra Costa Behavioral Health Services (CCBHS) supported stakeholder meetings:

Adult Committee
- No meetings until further notice.

Aging and Older Adult Committee (AOA) (October 15th and 28th)
- We met on 10/15/20. We are continuing to work on developing effective and engaging messaging for older adults related to staying safe during the COVID-19 pandemic and reducing social isolation.
- We are working on developing a television ad campaign, a mask logo, infographic flyers, and a letter writing campaign. We would love to have input from stakeholders!
- Our next meetings are on 10/28/20 from 2pm to 3:30pm, and 11/10/20 from 2pm to 3:30pm.

Alcohol and Other Drugs (AOD) Advisory Board (October 28th) Recovery Champion Award Presentations in honor of National Recovery Month
- Presentation on LQBTQA+ Community and Addiction
- Triennial Sunset Review Preparation
- Annual Report Preparation

Behavioral Health Care Partnership (BHCP) (October 20th)
- Behavioral Health Care Partnership met on October 20th, 2020 from 1:30PM-3:00PM via Zoom online/telephone conference.
- Discussed the need for additional crisis responses in the community.
- Contra Costa Health Services will be facilitating a Value Stream Mapping process involving stakeholders from different cities within our county, people with lived experience navigating crisis responses, and with Behavioral Health staff.
- Executive staff addressed the ongoing concern of needing a separate section for children and youth. Although there is no other option than to bring children to PES at the time executive staff assured the partners that strategies to make changes that would make PES safer for children and youth are still being explored.
- The BHCP received an update that 4D will reopen and provide adult inpatient acute care and treatment.
- Discussed care of those receiving mental health services within our detention centers who are experiencing severe psychosis that they get appropriate medical treatment in a medical space for acute services.
- The BHCP took some time to plan out the structure of our next meeting. BHCP partners will decide on the top three areas of improvement, on which we want to focus efforts to improve.
- The next Behavioral Health Care Partnership meeting is scheduled for Tuesday November 17th, 2020, from 1:30PM – 3:00PM via Zoom online/telephone conference.

Children, Teens and Young Adults Committee

- No meetings until further notice.

Health, Housing and Homeless Services (H3)

- H3 supported Census enumeration of people experiencing homelessness, including providing sheltered data and having CORE outreach support the enumeration in Central and East County.
- COVID: As of 10/28, 6,505 people experiencing homelessness have been tested, 148 positives and have 623 hotel placements. For more information go to https://www.coronavirus.cchealth.org/homeless
- November is Homelessness Awareness Month. Will release a Toolkit and a host a CoC Learning Hub: "Shared Stories" (on 11/19 from 1-3 pm) that will feature stories from people who have moved from homelessness to housing in Contra Costa and the people and agencies who helped them achieve their goals.

  CoC Learning Hub: "Shared Stories
  November 19, 2020
  1pm - 3 pm

  Meeting link:
  https://contracosta.webex.com/contracosta/j.php?MTID=m1133a57f0f791b74aaa59ee937916687
  Join by Phone: +1-408-826-0365 US Toll or 1-844-517-1271 US Toll Free
  Meeting number: 146 221 0796
  Password: ERxeXFF7*42

- Point in Time Count: Will start soliciting for volunteers for homeless Point in Time Count soon! PIT count will take place at the end of January (date TBD).

Innovation Committee (October 26th)

- Meeting canceled
- The next meeting (via Zoom) will be November 23rd from 2:30 – 4:00 pm.

Mental Health Commission (MHC) (October 7th)

- Meeting held via Zoom. Discussed the re-opening of unit 4D (former Contra Costa Regional Medical Center Acute Psychiatric Unit) for adults coming from Psychiatric Emergency Services (PES). Information provided and response to questions by Jaspreet Benepal (Chief Nursing Officer, Contra Costa Regional Medical Center) and Dr. Suzanne Tavano (Director, Behavioral Health Services).
- Announced the 2021 Mental Health Commission Officer and Executive Committee election and formed the Nominating Committee.
- Received the Behavioral Health Director's Report from Dr. Tavano on such topics as updates as to recent legislation, legislation passed for Certified Peer Specialists, collaborative efforts working with Chiefs of Police, City Managers and Mayors regarding crisis intervention and mobile crisis response. Looking at the current situation and working to improve for the future. Also participated in Town Hall events. Completed external quality review audit and received excellent reviews. Impressed that the County was able maintain services during this time of COVID while other counties were not able to do so.

- Hosted the Mental Health Services Act (MHSA) Public Hearing on the MHSA Three Year Program and Expenditure Plan (Fiscal Years 2020-2023).
  - Opening comments by Chair of the Mental Health Commission, Commissioner Barbara Serwin. The public hearing was delayed due to COVID-19. Due to the financial impact of COVID on the County and MHSA budget, the public hearing was delayed until adequate up to date financial data and budget projections could be determined and obtained. The MHSA Plan had to be adjusted due to COVID-19. Due to working in collaboration during these challenging times, the information was collected and obtained.
  - Windy Taylor (Program Manager, Behavioral Health Administration) provided background information on effects of COVID-19 and the resulting effects on the MHSA budget. Three Options were provided for the MHSA budget. One of the Options resulted in a large deficit. Ultimately, Option Three was chosen that provided for using MHSA dollars to make up for lost funds which ensured there were no cuts, MHSA programs would be maintained and continue, there would be MHSA funds remaining and MHSA Prudent Reserves would remain intact.
  - Jennifer Bruggeman (MHSA Program Manager) provided a PowerPoint presentation "MHSA Three Year Program and Expenditure Plan – Revised Proposed programming and Budget Summary for FY 2020-2023). With budget Option Three, MHSA funds would be used to make up for lost realignment dollars. Programs would be preserved. Also permitted some expansion to support priority services (i.e. Suicide Prevention, Early Childhood Mental Health, Workforce, Training and Education, etc.). Can still continue with programs, expand in specific priority areas, still have MHSA funds remaining and be able to preserve MHSA Prudent Reserve funds.
  - Public Comment received. This MHSA Three Year Plan will be presented to the Board of Supervisors for approval.
- The next Mental Health Commission meeting will be via Zoom on November 4, 2020 from 4:30 – 6:30 pm.

- **Quality of Care Committee (MHC QC)** (October 1st and October 15th)
- October 1st
  - Quality of Care Committee met via zoom and continued to develop documentation and surveys for the Mental Health Commission Site Visit Program.
- October 15th (Regular Monthly Meeting)
  - Discussion and planning for case study: Gap analysis of a family seeking an LPS conservatorship and the right care for its seriously mentally ill adult loved one
  - Reviewed highlights on development of documentation for the Site Visit Program
  - Reviewed and discussed documentation for the Program (letters, surveys, questions, etc.) and discussed next steps and schedule
  - The next Quality of Care Committee will be held via Zoom on November 19th from 3:30 – 5:00 pm

Reducing Health Disparities (RHD) (October 5th)
- Finalized RHD Workplan, soon to be CCBHS Equity Committee Workplan.
- Discussed 2020-2023 Cultural Humility Plan. Will hold meeting in November for review.
- Discussed and gathered input for MHSA Cultural Humility Forum.

- Meetings are currently being held every other month (exception in November, will hold meeting to discuss Cultural Humility Plan). The next meeting is scheduled for Monday, November 2nd from 3pm to 4:30pm via Zoom.

Social Inclusion (October 8th)

- The committee learned about the Promotoras Program, which operates within Contra Costa Health Services and offers health education and assistance in navigating healthcare system resources to members of the county's Spanish-speaking community.
- Participants also acknowledged Hispanic/Latino History Month through a group activity focused on identifying prominent Latino figures with lived experience of behavioral health challenges.
- The next Social Inclusion meeting will be Thursday, November 12th from 1:30 to 3:30 PM and will be facilitated once again via Zoom. More details, including the Zoom link, will be available in the coming days. To join the Social Inclusion mailing list, email Roberto.Roman@cchealth.org or call (925) 957-5105.

Suicide Prevention Committee (October 23rd)

- Suicide Prevention Coalition – The past two meetings have focused on two populations (LGBTQI community and Veterans) that are at high risk for suicide.
- In September, the group received a presentation from Kiku Johnson, Executive Director of Rainbow Community Center.
- In October, we received a presentation from Dr. Shauna Springer, an author and national expert on PTSD and trauma who has done extensive work with veterans. Resources were shared with participants.
- The next meeting will be in January (due to Thanksgiving and Christmas holidays).

System of Care Committee (SOC) (October 14th)

- Update was provided on the Loan Repayment Program.
- Update was provided on No Place Like Home (NPLH).
- Update on MHSA Three Year Plan Fiscal Years 2020-2023.
- Discussed planning for topics.
- Meetings are currently being held every other month. Next SOC Committee Meeting is scheduled for Wednesday, December 9th from 10:00am to 11:30am via Zoom.

Training Advisory Workgroup (TAW) (October 6th)

- Update will be provided at the CPAW meeting.

**** (Access to future scheduled Committee meetings may be by Teleconference (Online Video/Telephone). Some meetings may be canceled. At present, there are no in person meetings. To receive updates as to the status of a meeting, please refer to the CPAW Calendar for November 2020 and list of email contacts.)**

(October 28, 2020)

2020 Evolution of Peer Movement Community Forum Summary

Self Identified (Could chose more than one)	RESPONSES: 32	
Peer/Consumer/Client (someone with lived experience)	62.50%	20
Family Member of a Peer/Consumer/Client	37.50%	12
Service Provider (Community Based Organization, Clinician,Psychiatrist, Peer Provider etc.)	40.63%	13
Contra Costa County Behavioral Health Services Staff	28.13%	9
Other (please specify): -Curious CCHP member, received an email and looked interesting -Advocate for Formerly Incarcerated People to help them connect to services when they are released from custody	6.25%	2

Age Range	RESPONSES: 32	
18-25 years	0.00%	0
26-35 years	9.38%	3
36-45 years	37.50%	12
46-55 years	15.63%	5
56-65 years	25.00%	8
66 Years+	12.50%	4

Gender Identity	RESPONSES: 32	
Female	75.00%	24
Male	25.00%	8
Transgender	0.00%	0
Genderqueer	0.00%	0
Questioning	0.00%	0
Decline to State	0.00%	0

Sexual Orientation:	RESPONSES: 32	
Bisexual	12.50%	4
Gay	3.13%	1
Heterosexual or straight	78.13%	25
Lesbian	0.00%	0
Queer	0.00%	0
Questioning	3.13%	1
Decline to State	3.13%	1

Region of the County Participants Identify With:	RESPONSES: 32	
Central	31.25%	10
East	40.63%	13
South	3.13%	1
West	15.63%	5
I do not live in Contra Costa County	9.38%	3

#	Other County or Cities in Attendance:
1	Butte County
2	Solano
3	Contra Costa
4	Concord

Race or Ethnicity (asked to chose one)	RESPONSES: 31	
American Indian/ Native American/Alaska Native	0.00%	0
Black/ African American	19.35%	6
Asian	3.23%	1
Middle Eastern/ North African	0.00%	0
Caucasian/ White	45.16%	14
LatinX/ Hispanic	19.35%	6
Pacific Islander	0.00%	0
Decline to state	3.23%	1
Prefer to Self Describe	9.68%	3

TOTAL

#	PREFER TO SELF-DESCRIBE:
1	White with Cultural Knowledge reggarding the polynesian community and specifically the Tongan Community
2	Puerto Rican
3	Human

Military Member on Reserve Status	RESPONSES: 32	
Yes	3.13%	1
No	96.88%	31
Decline to State	0.00%	0

Veteran Status:	RESPONSES: 32	
Yes	12.50%	4
No	87.50%	28
Decline to State	0.00%	0

0.00 %

Have you ever received services at CCBHS or any other public mental health system?	RESPONSES: 32	
Yes	59.38%	19
No	37.50%	12
Don't Know	3.13%	1
Decline to State	0.00%	0

Has a close family member ever received services at CCBHS or any other public mental health system?	RESPONSES: 32	
Yes	65.63%	21
No	25.00%	8
Don't Know	9.38%	3
Decline to State	0.00%	0

Highest Level of Education:	RESPONSES: 32	
Did not finish High School	0.00%	0
High School Diploma/ GED	21.88%	7
Associates	12.50%	4
Bachelors	43.75%	14
Masters	12.50%	4
Doctoral	3.13%	1
Decline to State	6.25%	2

The objective of the forum was clearly stated.	RESPONSES: 32	
Strongly Agree	59.38%	19
Agree	37.50%	12
Neither Agree nor Disagree	3.13%	1
Disagree	0.00%	0
Strongly Disagree	0.00%	0

The forum met the stated objectives.	RESPONSES: 32	
Strongly Agree	62.50%	20
Agree	34.38%	11
Neither Agree nor Disagree	3.13%	1
Disagree	0.00%	0
Strongly Disagree	0.00%	0

The method of obtaining input in the talking circles was effective.	RESPONSES: 32	
Strongly Agree	50.00%	16
Agree	40.63%	13
Neither Agree nor Disagree	9.38%	3
Disagree	0.00%	0
Strongly Disagree	0.00%	0

I felt comfortable providing input during the forum.	RESPONSES: 32	
Strongly Agree	59.38%	19
Agree	28.13%	9
Neither Agree nor Disagree	9.38%	3
Disagree	0.00%	0
Strongly Disagree	3.13%	1

I enjoyed the presentations and speakers today.	RESPONSES: 32	
Strongly Agree	68.75%	22
Agree	28.13%	9
Neither Agree nor Disagree	0.00%	0
Disagree	3.13%	1
Strongly Disagree	0.00%	0

Q18 I learned from the presenters and was able to relate the information to today's topic.	RESPONSES: 32	
Strongly Agree	56.25%	18
Agree	40.63%	13
Neither Agree nor Disagree	3.13%	1
Disagree	0.00%	0
Strongly Disagree	0.00%	0

Overall, I was satisfied with the experience of today's forum.	RESPONSES: 32	
Strongly Agree	65.63%	21
Agree	31.25%	10
Neither Agree nor Disagree	0.00%	0
Disagree	0.00%	0
Strongly Disagree	3.13%	1

Overall, I was satisfied with the time frame the forum was held.	RESPONSES: 32	
Strongly Agree	56.25%	18
Agree	34.38%	11
Neither Agree nor Disagree	6.25%	2
Disagree	3.13%	1
Strongly Disagree	0.00%	0

Overall, I was satisfied with the length of the forum.	RESPONSES: 32	
Strongly Agree	50.00%	16
Agree	34.38%	11
Neither Agree nor Disagree	12.50%	4
Disagree	3.13%	1
Strongly Disagree	0.00%	0

Overall, I was satisfied with the availability of reasonable accommodations.	RESPONSES: 32	
Strongly Agree	43.75%	14
Agree	37.50%	12
Neither Agree nor Disagree	9.38%	3
Disagree	3.13%	1
Strongly Disagree	6.25%	2

#	What do you feel was the most valuable take away from today? Responses: 32
1	Native American Health Center Videos and Wellness Practices
2	Inspiration and networking
3	I was overjoyed to learn from the Native American Health Center staff and presentations. I could identify with the drum circle in a new way and I love how they call their elders group Wisdom Keepers. I also very much found immeasurable value in learning the history of the Peer Movement from Ray and Anna, people who were there and involved in it. This is so important to preserve this history and know the context of where we are now. Institutional memory is so often lost and it is tragic. We can build upon what has been done and not start from scratch, if we look at the history first. It was also great to see all the participation from a larger county in the community planning process.
4	learning about peer programs
5	The group of people were respectful to time, showed professionalism in conduct.
6	As a family member it was interesting to know that my input in the discussion groups was asked to be limited. On all Community Forums to date no one’s opinion was ever given precedence over another.
7	Understanding
8	Learning about all aspects of Mental Health educating me even about things that I didn't think of
9	... highly relevant information and professionally presented
10	Listening to the individuals come from a peer consumer to a peer provider, awesome
11	The information that was presented was the biggest take away
12	To have the opportunity to even be part of this presentation
13	All the presentations
14	Hearing from Jay and Anna - personal experiences and knowledge. And learning more about Native American Health Center
15	Just learning about the resources and people involved was helpful to me. I am interested in collaborating with agencies who offer Mental Health Resources to support the people I come in contact with. and
16	The presentation by Jay Mahler and Anna Lubarov with the rich history it covered.
17	This history of the peer movement
18	Native American Awareness
19	that i felt a part of
20	being with so many others for the same purpose, so much dedication and passion
21	Conversations during breakout group
22	Breakout "rooms"
23	The overwhelming appreciation for those who paved the way
24	I love the sharing from the Native American Health Center and Jay sharing.
25	I loved learning about Native American Health Center and Supaman. The breakout rooms with the questions was a great experience to connect with one another.
26	The videos and Jay's presentation
27	All the information was new for me, so very valuable
28	Video of Supaman, Jay Mahler's history, and Breakout Group
29	The SPIRIT history

#	Would you have changed something from today's forum? RESPONSES: 29
1	Longer Talking Circles
2	No
3	I wish there was more time to talk one-on-one with participants and to be able to ask questions of presenters.
4	no
5	No
6	Yes, all would have been equally welcomed.
7	No
8	No I wouldn't change anything
9	... Would liked to have seen a longer presentation ...!
10	No
11	No
12	No
13	More time during the talking circles
14	More time for Talking Circle
15	Maybe longer breakout sessions
16	More time for talking circles.
17	Length of breakout rooms :)
18	No
19	nothing
20	no
21	no
22	More time: 3 hours total with 3 brief stretch breaks.
23	Longer break-out room times. Great conversation but too rushed.
24	More time in the talking circles.
25	No
26	No
27	Nothing, Zoom was run very smoothly
28	Longer :)
29	n/a

#	General Comments: RESPONSES 18
1	Great forum. Well organized and very informative.
2	Thank you for all the work that went into this and to the amazing presenters. The forum was fantastic. I was engaged and educated and it didn't drag on like some Zoom presentations can nowadays.
3	Na
4	Felt welcome
5	No comments great job keep doing what you're doing
6	... Excellent ...!
7	None
8	Did a wonderful job speaking
9	The forum I believe was very successful and effective as a virtual event.
10	Thank you for offering this event.
11	A phenomenal event. So many faces I recognize. I am blessed and privileged to call you all my colleagues and friends.
12	Grateful to be part of a forum that reflected such informative and necessary information.
13	Thank you!
14	Worthwhile meeting, aware of different perspectives, esp. cultural (Native American)
15	Great forum
16	Awesome forum today I look forward to attending future ones.
17	Thank you for putting this together
18	Great job!

Contra Costa Behavioral Health Stakeholder Calendar
November 2020

Note: The dates and times below are the regular schedule. Please refer to notations in blue below or refer to email addresses on page two, await email notification or review the Committee website (if applicable) to receive updated information as to the status of a meeting (i.e. Teleconference, in person meeting, etc.). At present, no in person meetings are scheduled.

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2 Reducing Health Disparities (RHD): 3:00 -4:30 pm (Online/Telephone)	3 Training Advisory Workgroup (TAW): 3:00 — 3:45 pm (Online/Telephone) ELECTION DAY	4 Mental Health Commission (MHC): 4:30 — 6:30 pm (Online/Telephone)	5 CPAW: 3:00—5:00 pm (Online/Telephone)	6	7
8	9	10 Aging /Older Adults: 2:00—3:30 pm (Online/Telephone)	11 System of Care: (Next meeting December 9, 10:00—11:30 am. Meet every other month)	12 Children's, Teens & Young Adults: (No meeting this month) Social Inclusion: 1:30—3:30 pm (Online/Telephone)	13	14
15	16 CPAW Membership 3:00 — 4:30 pm (Online/Telephone)	17 Behavioral Health Care Partnership: 1:30—3:00 pm (Online/Telephone)	18	19 CPAW Steering: 2:00 — 3:00 pm (Online/Telephone) MHC Quality of Care: 3:30 — 5:00 pm (Online/Telephone)	20 November 19th: H3 Learning Hub: 1:00 — 3:00 pm (Online/Telephone) ⇦	21
22	23 Innovation: 2:30 — 4:00 pm (Online/Telephone)	24 Adult: (No meeting this month)	25 AOD Advisory Board: 4:00 — 6:15 pm (Online/Telephone)	26	27 Suicide Prevention Committee 9:00 — 10:30 am (No meeting in Nov—Next meeting in January)	28
29	30	31				

Contra Costa Behavioral Health

November 2020

Committee Email Contacts**

Adults	Robert.Thigpen@cchealth.org
Aging and Older Adults	Ellen.Shirgul@cchealth.org
Alcohol & Other Drugs (AOD) Advisory Board	Nazneen.Abdullah@cchealth.org
Behavioral Health Care Partnership (BHCP)	Jennifer.Tuipulotu@cchealth.org
Children, Teens & Young Adults	Candace.Collier@cchealth.org
Consolidated Planning Advisory Workgroup (CPAW)	Audrey.Montana@cchealth.org
Health, Housing & Homeless Services (H3)	Jaime.Jenett@cchealth.org
Innovation	Audrey.Montana@cchealth.org
Membership (CPAW)	Audrey.Montana@cchealth.org
Mental Health Commission (MHC)	Audrey.Montana@cchealth.org
Reducing Health Disparities (RHD)	Genoveva.Zesati@cchealth.org
Social Inclusion	Roberto.Roman@cchealth.org
Steering (CPAW)	Audrey.Montana@cchealth.org
Suicide Prevention	Audrey.Montana@cchealth.org
System of Care	Audrey.Montana@cchealth.org
Training Advisory Workgroup (TAW)	Adam.Down@cchealth.org

** Can also call the Mental Health Services (MHSA) Office at **(925) 957-2617** for committee meeting status updates.

CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Annual PEI Evaluation Report

Contra Costa Behavioral Health Services

Mental Health Services Act

As submitted for MHOAC
FY 2018-2019

Table of Contents

Executive Summary

Prevention and Early Intervention (PEI) is the component of the Three-Year Plan that refers to services designed to prevent mental illnesses from becoming severe and disabling. This means providing outreach and engagement to increase recognition of early signs of mental illness and intervening early in the onset of a mental illness.

First approved in 2009, with an initial State appropriation of $5.5 million, Contra Costa's Prevention and Early Intervention budget has grown incrementally to $8.6 million for FY 2017-18 in commitments to programs and services. The construction and direction of how and where to provide funding for this component began with an extensive and comprehensive community program planning process that was similar to that conducted in 2005-06 for the Community Services and Support component. Underserved and at- risk populations were researched, stakeholders actively participated in identifying and prioritizing mental health needs, and strategies were developed to meet these needs.

The programs and services described below are directly derived from this initial planning process, and expanded by subsequent yearly community program planning processes, to include current year. New regulations and demographic reporting requirements for the PEI component went into effect on October 6, 2015. Programs in this component now focus their programming on one of the following seven PEI categories:

1) Outreach for increasing recognition of early signs of mental illness
2) Prevention
3) Early intervention
4) Access and linkage to treatment
5) Improving timely access to mental health services for underserved populations
6) Stigma and discrimination reduction
7) Suicide prevention

All programs contained in the PEI component help create access and linkage to mental health treatment, with an emphasis on utilizing non-stigmatizing and non- discriminatory strategies, as well as outreach and engagement to those populations who have been identified as traditionally underserved.

Outcome Indicators.

PEI regulations (established October 2015) have data reporting requirements that programs started tracking in FY 2016-2017. In FY 18-19, over 32,000 consumers of all ages were served by PEI programs in Contra Costa County. This report includes updates from each program and is organized by PEI program category.

The information gathered enables CCBHS to report on the following outcome indicators:

- Outreach to Underserved Populations. Demographic data, such as age group, race/ethnicity, primary language and sexual orientation, enable an assessment of the impact of outreach and engagement efforts over time.
- Linkage to Mental Health Care. Number of people connected to care, and average duration of reported untreated mental illness enable an assessment over time of impact of programs on connecting people to mental health care.

Evaluation Component

Contra Costa Behavioral Health Services is committed to evaluating the effective use of funds provided by the Mental Health Services Act. Toward this end, a comprehensive program and fiscal review process has been implemented to: a) improve the services and supports provided; b) more efficiently support the County's MHSA Three Year Program and Expenditure Plan; c) ensure compliance with stature, regulations and policies. Each of the MHSA funded contract and county operated programs undergoes a triennial program and fiscal review. This entails interviews and surveys of individuals both delivering and receiving the services, review of data, case files, program and financial records, and performance history. Key areas of inquiry include:

- Delivering services according to the values of MHSA
- Serving those who need the service
- Providing services for which funding was allocated
- Meeting the needs of the community and/or population
- Serving the number of individuals that have been agreed upon
- Achieving outcomes that have been agreed upon
- Assuring quality of care
- Protecting confidential information
- Providing sufficient and appropriate staff for the program
- Having sufficient resources to deliver the services

- Following generally accepted accounting principles
- Maintaining documentation that supports agreed upon expenditures
- Charging reasonable administrative costs
- Maintaining required insurance policies
- Communicating effectively with community partners

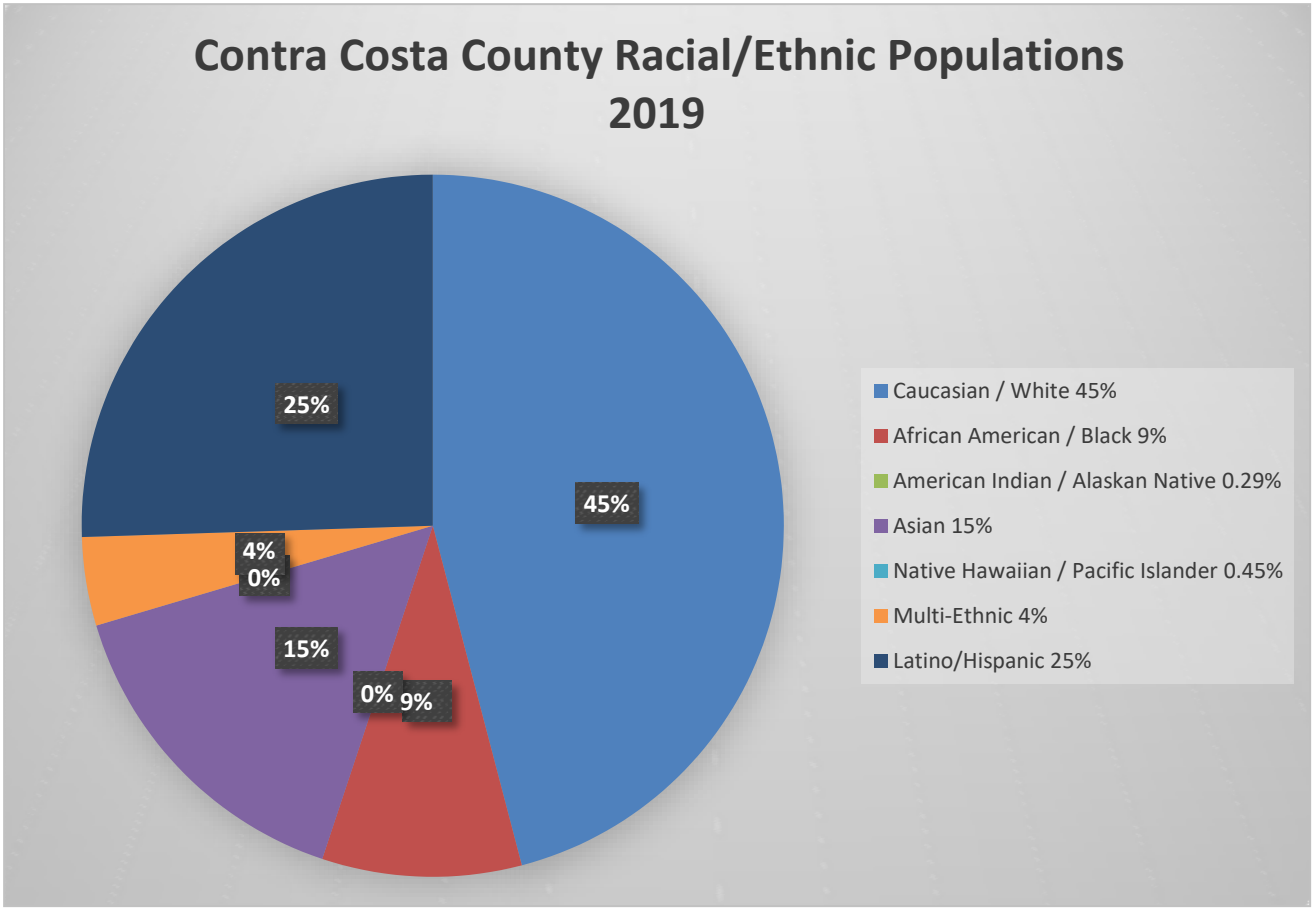
Each program receives a written report that addresses the above areas. Promising practices, opportunities for improvement, and/or areas of concern are noted for sharing or follow-up activity, as appropriate. The emphasis is to establish a culture of continuous improvement of service delivery, and quality feedback for future planning efforts. Completed reports are made available to members of the Consolidated Planning Advisory Workgroup (CPAW) and distributed at the monthly stakeholder meeting, or to the public upon request. Links to PEI program and fiscal reviews can be found here: https://cchealth.org/mentalhealth/mhsa/cpaw/agendas-minutes.php.

During FY2018-19, completed PEI Program and Fiscal Review reports were distributed at the following monthly CPAW meetings: September 2018, February 2019, March 2019, April 2019.

PEI Aggregate Data FY 18-19

Contra Costa is a geographically and culturally diverse county with approximately 1.1 million residents. One of nine counties in the Greater San Francisco Bay Area, we are located in the East Bay region.

According to the United States Census Bureau (https://www.census.gov/quickfacts/fact/table/contracostacountycalifornia), it's estimated that about 9% of people in Contra Costa County are living in poverty and that children, adolescents & young adults (ages 0-25) make up approximately 30% of the population. Roughly 25% of residents are foreign born. The most common languages spoken after English include: Spanish, Chinese languages and Tagolog.



MHSA funded Prevention and Early Intervention (PEI) programs in Contra Costa County served over 32,000 individuals during FY 18-19. For a complete listing of PEI programs,

please see Appendix A. PEI Providers gather quarterly for a Roundtable Meeting facilitated by MHSA staff, and are actively involved in MHSA stakeholder groups including Consolidated Planning and Advisory Workgroup(CPAW) and various sub-committees. In addition, PEI programs engage in the Community Program Planning Process (CPPP) by participating in three annual community forums located in various regions of the county.

The below tables outline PEI Aggregate Data collected for FY 18-19.

Total Served: 32,949
Total Number of Individual Family Members Served: 588

Table 1. Age Group

	# Served
Child (0-15)	2,530
Transition Age Youth (16-25)	5,207
Adult (26-59)	10,831
Older Adult (60+)	2,684
Decline to State	11,700

Table 2. Primary Language

	# Served
English	20,471
Spanish	6,181
Other	642
Decline to State	5,655

Table 3. Race

	# Served
More than one Race	1,014
American Indian/Alaska Native	94
Asian	1,866
Black or African American	3,697
White or Caucasian	11,393
Hispanic or Latino/a	8,377
Native Hawaiian or Other Pacific Islander	103
Other	409
Decline to State	5,996

Table 4. Ethnicity (If Non- Hispanic or Latino/a)

	# Served
African	190
Asian Indian/South Asian	150
Cambodian	7
Chinese	50
Eastern European	29
European	273
Filipino	143
Japanese	8
Korean	13
Middle Eastern	238
Vietnamese	23
More than one Ethnicity	173
Decline to State	3,002
Other	940

Table 5. Ethnicity (If Hispanic or Latino/a)

	# Served
Caribbean	11
Central American	590
Mexican/Mexican American /Chicano	3,784
Puerto Rican	15
South American	162
Other	23

Table 6. Sexual Orientation

	# Served
Heterosexual or Straight	14,997
Gay or Lesbian	220
Bisexual	133
Queer	24
Questioning or Unsure of Sexual Orientation	40
Another Sexual Orientation	168
Decline to State	17,367

Table 7. Gender Assigned at Birth

	# Served
Male	10,289
Female	11,925
Decline to State	18,339

Table 8. Current Gender Identity

	# Served
Man	8,699
Woman	8,801
Transgender	149
Genderqueer	13
Questioning or Unsure of Gender Identity	14
Another Gender Identity	68
Decline to State	15,205

Table 9. Active Military Status

	# Served
Yes	52
No	3,049
Decline to State	29,848

Table 10. Veteran Status

	# Served
Yes	75
No	8,045
Decline to State	24,829

Table 11. Disability Status

	# Served
Yes	360
No	2,660
Decline to State	29,929

Table 12. Description of Disability Status

	# Served
Difficulty Seeing	33
Difficulty Hearing or Having Speech Understood	38
Physical/Mobility	91
Chronic Health Condition	126
Other	406

Table 13. Cognitive Disability

	# Served
Yes	116
No	987

Table 14. Referrals to Services

	# Served
Clients Referred to Mental Health Services	1,850
Clients who Participated/ Engaged at Least Once in Referred Service	1,681

Table 15. External Mental Health Referral

	# Served
Clients Referred to Mental Health Services	18,464
Clients who participated/ engaged at least once in referred service	191

Table 16. Average Duration Without Mental Health Services

	Week Totals
Average Duration for all Clients of Untreated Mental Health Issues (In weeks)	17.6

Table 17. Average Length of Time Until Mental Health Services

	Week Totals
Average Length for all Clients between Mental Health Referral and Services (In weeks)	4.4

PEI Programs by Component

PEI programs are listed within the seven categories delineated in the PEI regulations.

Outreach for Increasing Recognition of Early Signs of Mental Illness

Programs in this category provide outreach to individuals with signs and symptoms of mental illness so they can recognize and respond to their own symptoms. Outreach is engaging, educating and learning from potential primary responders. Primary responders include, but are not limited to, families, employers, law enforcement, school, community service providers, primary health care, social services and faith- based organizations.

Seven programs are included in this category:

1) Asian Family Resource Center provides culturally sensitive education and access to mental health services for immigrant Asian communities, especially the Southeast Asian and Chinese population of Contra Costa County. Staff provides outreach, medication compliance education, community integration skills, and mental health system navigation. Early intervention services are provided to those exhibiting symptoms of mental illness, and participants are assisted in actively managing their own recovery process.

2) The Counseling Options Parenting Education (COPE) Family Support Center utilizes the evidence-based practices of the Positive Parenting Program (Triple P) to help parents develop effective skills to address common child and youth behavioral issues that can lead to serious emotional disturbances. Targeting families residing in underserved communities this program delivers in English and Spanish a number of seminars, training classes and groups throughout the year.

3) First Five of Contra Costa, in partnership with the COPE Family Support Center, takes the lead in training families who have children up to the age of five. First Five also partners with the COPE Family Support Center to provide training in the Positive Parenting Program (Triple P) method to mental health practitioners who serve this at-risk population.

4) Contra Costa Interfaith Housing provides on-site services to formerly homeless families, all with special needs, at the Garden Park Apartments in Pleasant Hill, the Bella Monte Apartments in Bay Point, and Los Medanos Village in Pittsburg. Services

include pre-school and afterschool programs, such as teen and family support groups, assistance with school preparation, and homework clubs. These services are designed to prevent serious mental illness by addressing domestic violence, substance addiction and inadequate life and parenting skills.

5) Jewish Family and Community Services of the East Bay provides culturally grounded, community-directed mental health education and navigation services to refugees and immigrants of all ages in primarily the Afghan, Bosnian, Iranian and Russian communities of Contra Costa County. Outreach and engagement services are provided in the context of group settings and community cultural events that utilize a variety of non-office settings convenient to individuals and families.

6) The Native American Health Center provides a variety of culturally specific methods of outreach and engagement to educate Native Americans throughout the County regarding mental illness, identify those at risk for developing a serious mental illness, and help them access and navigate the human service systems in the County. Methods include an elder support group, a youth wellness group, a traditional arts group, talking circles, Positive Indian Parenting sessions, and Gatherings of Native Americans.

7) The Latina Center serves Latino parents and caregivers in West Contra Costa County by providing culturally and linguistically specific twelve-week parent education classes to high risk families utilizing the evidence-based curriculum of Systematic Training for Effective Parenting (STEP). In addition, the Latina Center trains parents with lived experience to both conduct parenting education classes and to become Parent Partners who can offer mentoring, emotional support and assistance in navigating social service and mental health systems.

The allocation for this category is summarized below:

Program	**Region Served**	**Numbers Served FY 18-19**	**MHSA Funds Allocated for FY 18-19**
Asian Family Resource Center	Countywide	238	142,055
COPE	Countywide	226	245,863
First Five	Countywide	(included in COPE)	81,955

Contra Costa Interfaith Housing	Central and East County	445	80,340
Jewish Family & Children's Services	Central and East County	224	174,485
Native American Health Center	Countywide	101	238,555
The Latina Center	West County	327	111,545
Total		**1,561**	**$1,075,076**

Prevention

Programs in this category provide activities intended to reduce risk factors for developing a potentially serious mental illness, and to increase protective factors. Risk factors may include, but are not limited to, poverty, ongoing stress, trauma, racism, social inequality, substance abuse, domestic violence, previous mental illness, prolonged isolation, and may include relapse prevention for those in recovery from a serious mental illness.

Five programs are included in this category:

1) The Building Blocks for Kids Collaborative, located in the Iron Triangle of Richmond, train family partners from the community with lived mental health experience to reach out and engage at-risk families in activities that address family mental health challenges. Individual and group wellness activities assist participants make and implement plans of action, access community services, and integrate them into higher levels of mental health treatment as needed.

2) Vicente Briones Continuation High School in the Martinez Unified School District provides career academies for at-risk youth that include individualized learning plans, learning projects, internships, and education and counseling support. Students, school staff, parents and community partners work together on projects designed to develop leadership skills, a healthy lifestyle and pursuit of career goals.

3) People Who Care is an after-school program serving the communities of Pittsburg and Bay Point that is designed to accept referrals of at-risk youth from schools, juvenile justice systems and behavioral health treatment programs. Various vocational projects are conducted both on and off the program's premises, with selected participants

receiving stipends to encourage leadership development. A licensed clinical specialist provides emotional, social and behavioral treatment through individual and group therapy.

4) Putnam Clubhouse provides peer-based programming for adults throughout Contra Costa County who are in recovery from a serious mental illness. Following the internationally recognized clubhouse model this structured, work focused programming helps individuals develop support networks, career development skills, and the self-confidence needed to sustain stable, productive and more independent lives. Features of the program provide respite support to family members, peer-to-peer outreach, and special programming for transition age youth and young adults.

5) The RYSE Center provides a constellation of age-appropriate activities that enable at-risk young people in Richmond to effectively cope with the continuous presence of violence and trauma in the community and at home. These trauma informed programs and services include drop-in, recreational and structured activities across areas of health and wellness, media, arts and culture, education and career, technology, and developing youth leadership and organizing capacity. The RYSE Center facilitates a number of city and system-wide training and technical assistance events to educate the community on mental health interventions that can prevent serious mental illness as a result of trauma and violence.

The allocation for this category is summarized below:

Program	**Region Served**	**Numbers Served FY 18-19**	**MHSA Funds Allocated FY 18-19**
Building Blocks for Kids	West County	438	216,897

Vicente Briones High School	Central County	121	185,763
People Who Care	East County	207	223,102
Putnam Clubhouse	Countywide	322	582,859
RYSE	West County	720	503,019
Total		**1,808**	**$1,705,143**

Early Intervention

Early intervention provides mental health treatment for persons with a serious emotional disturbance or mental illness early in its emergence.

One program is included in this category.

The County operated First Hope Program serves youth who show early signs of psychosis or have recently experienced a first psychotic episode. Referrals are accepted from all parts of the County, and through a comprehensive assessment process young people, ages 12-25, and their families are helped to determine whether First Hope is the best treatment to address the psychotic illness and associated disability. A multi-disciplinary team provides intensive care to the individual and their family, and consists of psychiatrists, mental health clinicians, occupational therapists and employment/education specialists. These services are based on the Portland Identification and Early Referral (PIER) Model, and consists of multi-family group therapy, psychiatric care, family psycho-education, education and employment support, and occupational therapy.

The allocation for this program is summarized below:

Program	**Region Served**	**Numbers Served FY 18-19**	**MHSA Funds Allocated for FY 18-19**
First Hope	Countywide	900	2,651,791
Total		**900**	**$2,651,791**
Decline to State			0

Access and Linkage to Treatment

Programs in this category have a primary focus on screening, assessment, and connecting children and adults as early as practicable to necessary mental health care

and treatment.

Three programs are included in this category:

1) The James Morehouse Project at El Cerrito High School, a student health center that partners with community-based organizations, government agencies and local universities, provides a range of youth development groups designed to increase access to mental health services for at-risk high school students. These on-campus groups address coping with anger, violence and bereavement, factors leading to substance abuse, teen parenting and caretaking, peer conflict and immigration acculturation.

2) STAND! For Families Free of Domestic Violence utilizes established curricula to assist youth successfully address the debilitating effects of violence occurring both at home and in teen relationships. Fifteen-week support groups are held for teens throughout the County, and teachers and other school personnel are assisted with education and awareness with which to identify and address unhealthy relationships amongst teens that lead to serious mental health issues.

3) Experiencing the Juvenile Justice System. Within the county operated Children's Services five mental health clinicians support families who are experiencing the juvenile justice system due to their adolescent children's involvement with the law. Three clinicians are out-stationed at juvenile probation offices, and two clinicians work with the Oren Allen Youth Ranch. The clinicians provide direct short-term therapy and coordinate appropriate linkages to services and supports as youth transition back into their communities.

The allocation for this category is summarized below:

Program	**Region Served**	**Numbers Served FY 18-19**	**MHSA Funds Allocated for FY 18-19**
James Morehouse Project	West County	416	102,897
STAND! Against Domestic Violence	Countywide	1903	134,113
Juvenile Justice System – Supporting Youth	Central County	300	695,855
Total		**2,619**	**$932,865**

Improving Timely Access to Mental Health Services for Underserved Populations

Programs in this category provide mental health services as early as possible for individuals and their families from an underserved population. Underserved means not having access due to challenges in the identification of mental health needs, limited language access, or lack of culturally appropriate mental health services. Programs in this category feature cultural and language appropriate services in convenient, accessible settings.

Six programs are included in this category:

1) The Center for Human Development serves the primarily African American population of Bay Point in Eastern Contra Costa County. Services consist of culturally appropriate education on mental health issues through support groups and workshops. Participants at risk for developing a serious mental illness receive assistance with referral and access to County mental health services. In addition, the Center for Human Development provides mental health education and supports for gay, lesbian, bi-sexual, and questioning youth and their supports in East County to work toward more inclusion and acceptance within schools and in the community.

2) The Child Abuse Prevention Council of Contra Costa provides a 23-week curriculum designed to build new parenting skills and alter old behavioral patterns and is intended to strengthen families and support the healthy development of their children. The program is designed to meet the needs of Spanish speaking families in East and Central Counties.

3) La Clinica de la Raza reaches out to at-risk Latina/os in Central and East County to provide behavioral health assessments and culturally appropriate early intervention services to address symptoms of mental illness brought about by trauma, domestic violence and substance abuse. Clinical staff also provide psycho-educational groups that address the stress factors that lead to serious mental illness.

4) Lao Family Community Development provides a comprehensive and culturally sensitive integrated system of care for Asian and Southeast Asian adults and families in West Contra Costa County. Staff provides comprehensive case management services, to include home visits, counseling, parenting classes, and assistance accessing employment, financial management, housing, and other service both within and outside the agency.

5) Lifelong Medical Care provides isolated older adults in West County opportunities for social engagement and access to mental health and social services. A variety of group and one-on-one approaches are employed in three housing developments to engage frail, older adults in social activities, provide screening for depression and other mental and medical health issues, and linking them to appropriate services.

6) Rainbow Community Center provides a community based social support program designed to decrease isolation, depression and suicidal ideation among members who identify as lesbian, gay, bisexual, transgender, or who question their sexual identity. Key activities include reaching out to the community in order to engage those individuals who are at risk, providing mental health support groups that address isolation and stigma and promote wellness and resiliency, and providing clinical mental health treatment and intervention for those individuals who are identified as seriously mentally ill.

The allocation for this category is summarized below:

Program	**Region Served**	**Numbers Served FY 18-19**	**MHSA Funds Allocated for FY 18-19**
Child Abuse Prevention Council	Central and East County	164	125,109
Center for Human Development	East County	342	156,936
La Clinica de la Raza	Central and East County	6960	280,558
Lao Family Community Development	West County	125	190,416
Lifelong Medical Care	West County	138	130,786
Rainbow Community Center	Countywide	1174	759,362
Total		**8,903**	**$1,642,624**

Stigma and Discrimination Reduction

Activities in this category are designed to 1) reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to having a mental illness, 2) increase acceptance, dignity, inclusion and equity for individuals with mental illness and their families, and 3) are culturally congruent with the values of the population for whom changes, attitudes, knowledge and behavior are intended.

The County operated Office for Consumer Empowerment (OCE) provides leadership and staff support to a number of initiatives designed to reduce stigma and discrimination, develop leadership and advocacy skills among consumers of behavioral health services, support the role of peers as providers, and encourage consumers to actively participate in the planning and evaluation of MHSA funded services. Staff from the OCE support the following activities designed to educate the community in order to raise awareness of the stigma that can accompany mental illness.

1) The PhotoVoice Empowerment Project enables consumers to produce artwork that speaks to the prejudice and discrimination that people with behavioral health challenges face. PhotoVoice's vision is to enable people to record and reflect their community's strengths and concerns, promote critical dialogue about personal and community issues, and to reach policymakers to effect change.

2) The Wellness Recovery Education for Acceptance, Choice and Hope (WREACH) Speakers' Bureau forms connections between people in the community and people with lived mental health and co-occurring experiences, using face to face contact by providing stories of recovery and resiliency and current information on health treatment and supports. Other related activities include producing videos, public service announcements and educational materials.

3) The OCE facilitates Wellness Recovery Action Plan (WRAP) groups by providing certified leaders and conducting classes throughout the County. Staff employ the evidence-based WRAP system in enhancing the efforts of consumers to promote and advocate for their own wellness. OCE also supports a writers' group in partnership with the Contra Costa affiliate of the National Alliance on Mental Illness (NAMI).

4) The Committee for Social Inclusion is an ongoing alliance of committee members that work together to promote social inclusion of persons who receive behavioral health services. The Committee is project based, and projects are designed to increase

participation of consumers and family members in the planning, implementation and delivery of services. Current efforts are supporting the integration of mental health and alcohol and other drug services within the Behavioral Health Services Division. In addition, OCE staff assist and support consumers and family members in participating in the various planning committees and sub-committees, Mental Health Commission meetings, community forums, and other opportunities to participate in planning processes.

5) Through the Each Mind Matters initiative California Mental Health Services Authority (CalMHSA) will provide technical assistance to encourage the County's integration of available statewide resources on stigma and discrimination reduction and suicide prevention. For FY 2017-20 CCBHS will partner via Memorandum of Understanding (MOU) with CalMHSA to link county level stigma and discrimination reduction efforts with statewide social marketing programs. This linkage will expand the County's capacity via language specific materials, social media, and subject matter consultation with regional and state experts to reach diverse underserved communities, such as Hispanic, African American, Asian Pacific Islander, LGBTQ, Native American and immigrant communities. Primary focus will be to reach Spanish speaking Latina/o communities via social media and materials adapted specifically for this population.

The allocation for stigma and discrimination efforts are summarized below:

Program	**Region Served**	**Numbers Served FY 18-19**	**MHSA Funds Allocated for FY 18-19**
OCE	County Operated	Countywide	270,628
CalMHSA	MOU	Countywide	78,000
Total			**$348,628**

Suicide Prevention

There are three plan elements that augment the County's efforts to reduce the number of suicides in Contra Costa County. 1) augmenting the Contra Costa Crisis Center, 2) dedicating a clinical specialist to support the County's adult clinics, and 3) supporting a suicide prevention committee.

1) The Contra Costa Crisis Center provides services to prevent suicides by operating a certified 24-hour suicide prevention hotline. The hotline connects with people when they are most vulnerable and at risk for suicide, enhances safety, and builds a bridge to community resources. Staff conduct a lethality assessment on each call, provide support and intervention for the person in crisis and make follow-up calls (with the caller's consent) to persons who are at medium to high risk of suicide. MHSA funds enable additional paid and volunteer staff capacity, most particularly in the hotline's trained multi-lingual, multi-cultural response.

2) The County fields a mental health clinical specialist to augment the adult clinics for responding to those individuals identified as at risk for suicide. This clinician receives referrals from psychiatrists and clinicians of persons deemed to be at risk, and provides a short-term intervention and support response, while assisting in connecting the person to more long-term care.

3) A multi-disciplinary, multi-agency Suicide Prevention Committee has been established, and has published a countywide Suicide Prevention Strategic Plan. This ongoing committee oversees the implementation of the Plan by addressing the strategies outlined in the Plan. These strategies include i) creating a countywide system of suicide prevention, ii) increasing interagency coordination and collaboration, iii) implementing education and training opportunities to prevent suicide, iv) implementing evidence-based practices to prevent suicide, and v) evaluating the effectiveness of the County's suicide prevention efforts.

The allocation for this category is summarized below:

Program	**Region Served**	**Numbers Served FY 18-19**	**MHSA Funds Allocated for FY 18-19**
Contra Costa Crisis Center	Countywide	18,128	310,685
County Clinician	Countywide	NA	133,742
Suicide Prevention	Countywide	NA	Included in PEI administrative cost
Total		**18,128**	**$444,427**

PEI Administrative Support Mental Health Program Supervisor position has been allocated by the County to provide administrative support and evaluation of programs and plan elements that

are funded by MHSA. The allocation for this activity is summarized below:

Program	**Region Served**	**MHSA Funds Allocated for FY 18-19**
Administrative Support	Countywide	135,607
Total		**$135,607**

Prevention and Early Intervention (PEI) Summary for FY 2018-19

Outreach for Increasing Recognition of Early Signs of Mental Illness	$1,075,076
Prevention	$1,705,143
Early Intervention	$2,651,791
Access and Linkage to Treatment	$932,865
Improving Timely Access to Mental Health Services for Underserved Populations	$1,642,624
Stigma and Discrimination Reduction	$348,628
Suicide Prevention	$444,427
Administrative Support	$135,607
Total	**$8,926,161**

Appendix A
Program Profiles

Asian Community Mental Health Services (ACMHS)

www.acmhs.org
Point of Contact: Sun Karnsouvong
Contact Information: Asian Family Resource Center (AFRC), 12240 San Pablo Avenue, Richmond, CA 94805
(510) 970-9750, Sunk@acmhs.org

1. General Description of the Organization

ACMHS provides multicultural and multilingual services, empowering the most vulnerable members of our community to lead healthy, productive and contributing lives.

2. Program: Building Connections (Asian Family Resource Center) - PEI

a. Scope of Services: Asian Family Resource Center (AFRC), a satellite site of Asian Community Mental Health Services (ACMHS), will provide comprehensive and culturally-sensitive education and access to mental health services for Asian and Asian Pacific Islander (API) immigrant and refugee communities, especially the Southeast Asian and Chinese population of Contra Costa County. ACMHS will employ multilingual and multidisciplinary staff from the communities which they serve. Staff will provide the following scope of services:

   i. Outreach and Engagement Services: Individual and/or community outreach and engagement to promote mental health awareness, educate community members on signs and symptoms of mental illness, provide mental health workshops, and promote mental health wellness through community events. Engage community members in various activities to screen and assess for mental illness and/or assist in navigating them into the service systems for appropriate interventions: community integration skills to reduce MH stressors, older adult care giving skills, basic financial management, survival English communication skills, basic life skills, health and safety education and computer education, structured group activities (on topics such as, coping with adolescents, housing issues, aid cut-off, domestic violence, criminal justice issues, health care and disability services), mental health education and awareness, and health/mental health system navigation. ACMHS, in collaboration with community-based organizations, will participate in 3-5 mental health and wellness events to provide wellness and mental health outreach, engagement, and education to immigrants and refugees in the Contra Costa County.

   ii. Individual Mental Health Consultation: This service will also be provided to those who are exhibiting early signs of mental illness, to assess needs, identify signs/symptoms of mental health crisis/trauma, provide linkages/referrals or assist in navigation into the mental health system, provide wellness support groups, access essential community resources, and linkage/referral to mental health services. Peer Navigators will be utilized to support participants in accessing services in a culturally sensitive manner. These services will be provided for a period of less than one year unless psychosis is present. ACMHS will serve a minimum of 75 high risk and underserved Southeast Asian community members within a 12 month period, 25 of which will reside in East County with the balance in West and Central County.

b. Target Population: Asian and Pacific Islander immigrant and refugee communities

(especially Chinese and Southeast Asian population) in Contra Costa County

c. Payment Limit: FY 18-19: $142,054
d. Number served: In FY 17-18: 554 high risk and underserved community members
e. Outcomes:

- All program participants received system navigation support for mental health treatment, Medi-Cal benefits, and other essential benefits.
- Services are offered in the language of the consumer.
- Program hosted two community wellness events and psycho-education workshops for the community.

Building Blocks for Kids (BBK)

www.bbk-richmond.org
Point of Contact: Sheryl Lane
Contact Information: 310 9th Street, Richmond, CA 94804
(510) 232-5812, slane@bbk-richmond.org

1. General Description of the Organization

Building Blocks for Kids Richmond Collaborative is a place-based initiative with the mission of supporting the healthy development and education of all children, and the self-sufficiency of all families, living in the BBK Collaborative zone located in Richmond, California. BBK's theory of change is simple and enduring: we believe that providing effective supportive services and investing in individual transformation serves thriving families, which yields community change.

2. Program: Not Me Without Me - PEI

a. Scope of Services:
Building Blocks for Kids Collaborative, a project of Tides Center, will provide diverse households in Richmond, CA with improved access to mental health education, and mental health support. The *Not About Me Without Me* prevention and early intervention work addresses MHSA's PEI goal of providing Prevention services to increase recognition of early signs of mental illness and intervening early in the onset of a mental illness.

Accordingly, the goals are three-fold: (1) working with BBK Zone families to ensure that they are knowledgeable about and have access to a network of supportive and effective mental health information and services; (2) reduce risk for negative outcomes related to untreated mental illness for parents/primary caregivers and children whose risk of developing a serious mental illness is significantly higher than average including cumulative skills-based training opportunities on effective parenting approaches; and, (3) train and support families to self-advocate and directly engage the services they need.

This work represents an evolution in our *Not About Me Without Me* approach to service provision by working toward a coordinated, comprehensive system that will support families in not just addressing mental illness and recovering from traumatic experiences but will fortify them to create community change. This system will continue to put resident interests and concerns at the fore and additionally be characterized by a model that enables organizations to: work more effectively and responsively with underserved residents in the Richmond community; improve outcomes; reduce barriers to success; increase provider accountability, and create a truly collaborative and healing environment using strategies that are non-stigmatizing and non-discriminatory.

b. Target Population: Children and families living in Central and South Richmond
c. Payment Limit: FY 18-19: $216,897
d. Number served: In FY 17-18: 649 Individuals (includes outreach and education events).

e. Outcomes:

- Over the course of the 17-18 year, BBK Health and Wellness Team met with 33 community organizations, government agencies and individuals around partnering and collaboration.
- BBK held Sanctuary groups and parents who attend have consistently reported that they learned something new about holistic health, and that they intended to follow up with a partner organization that they learned about through BBK sponsored events.
- Summer Program at Belding Garcia Park, and expanded programming to Monterey Pines Apartments in South Richmond. Children participating received at least one healthy meal per day and family members had access to wellness activities and developmental playgroups.
- BBK partnered with COPE and Child Abuse Prevention Council to offer weekly evidence-based parenting classes. Care providers developed a strong knowledge base on child development and positive parenting skills.

Center for Human Development (CHD)

http://chd-prevention.org/
Point of Contact: David Carrillo, Executive Director
Contact Information: 901 Sun Valley Boulevard, Suite 220, Concord, CA 94520
(925) 349-7333, david@chd-prevention.org

1. General Description of the Organization

Center for Human Development (CHD) is a community-based organization that offers a spectrum of Prevention and Wellness services for at-risk youth, individuals, families, and communities in the Bay Area. Since 1972 CHD has provided wellness programs and support aimed at empowering people and promoting positive growth. Volunteers work side-by-side with staff to deliver quality programs in schools, clinics, and community sites throughout Contra Costa as well as nearby counties. CHD is known for innovative programs and is committed to improving the quality of life in the communities it serves.

2. Program: African American Wellness Program and Youth Empowerment Program - PEI

a. Scope of Services: The Center for Human Development will implement the African American Wellness Program (formerly African American Health Conductor Program) and between the four program components will provide a minimum of 150 unduplicated individuals in Bay Point, Pittsburg, and surrounding communities with mental health resources. The purpose is to increase client emotional wellness; reduce client stress and isolation; and link African American clients, who are underserved due to poor identification of needs and lack of outreach and engagement to mental health services. Key activities include: outreach at community events, culturally appropriate education on mental health topics through Mind, Body, and Soul support groups and community health education workshops in accessible and non-stigmatizing settings, and navigation assistance for culturally appropriate mental health referrals as early in the onset as possible.

   The Center for Human Development will implement the Empowerment Program, a Youth Development project, that will provide a minimum of 80 unduplicated LGBTQ youth and their allies in Antioch, Pittsburg, and surrounding East County communities with strength-based educational support services that build on youths' assets, raise awareness of mental health needs identification, and foster resiliency. Key activities will include: a) Three weekly educational support groups that will promote emotional health and well-being, increase positive identity and self-esteem, and reduce isolation through development of concrete life skills; b) one leadership group that will meet a minimum of twice a month to foster community involvement; and c). referral linkage to culturally appropriate mental health services providers in East County as early in the onset as possible.

b. Target Population: Wellness Program: African American residents in East County at risk of developing serious mental illness. Youth Empowerment Program: LGBTQ youth in East County

c. Payment Limit: FY 18-19: $156,936

d. Number served: In FY 17-18: 342 individuals were served in both programs combined. 268 in the African American (AA) Wellness Program and 74 in the

Empowerment Program. Outcomes:

i. Wellness Program

- Mind-Body-Soul support groups in Pittsburg and Bay Point throughout the year with topics such as “Depression and Stress”, “Maintaining Emotional Well Being”, “Guide to Vitamins and Minerals in Fresh Foods”, “Self-Care (Physical, Emotional, Mental and Spiritual)”.
- Several community health / mental health workshops throughout the year.
- 100% of the participants in the Mind-Body-Soul peer health education support groups reported and increased wellness (wellbeing) within fiscal year.
- Participants in AA Wellness Program received navigational support for their service referral needs.

ii. Empowerment Program

- LGBTQ youth empowerment support groups in Pittsburg and Antioch throughout the year with topics such as: “Family and Peer Conflict,” “Challenges to Relationships,” “Community Violence and Loss,” “Queer History and Activism,” “Stress, Anxiety and Depression,” “Identity Development and Coming Out.”
- 85% of the participants in the Empowerment Psycho-Educational Leadership support groups reported an increased sense of emotional health and well-being within fiscal year.
- 100% of participants in Empowerment in need of counseling services were informed and referred to LGBTQ-sensitive resources available to youth.
- 36 LGBTQ Youth Support Groups facilitated at Pittsburg High, 26 at Deer Valley High, and 42 at Rivertown Resource Center.

Child Abuse Prevention Council (CAPC)

www.capc-coco.org
Point of Contact: Carol Carrillo
Contact Information: 2120 Diamond Boulevard #120, Concord, CA 94520
(925) 798-0546, ccarrillo@capc-coco.org

1. General Description of the Organization

The Child Abuse Prevention Council has worked for many years to prevent the maltreatment of children. Through providing education programs and support services, linking families to community resources, mentoring, and steering county-wide collaborative initiatives, CAPC has led Contra Costa County's efforts to protect children. It continually evaluates its programs in order to provide the best possible support to the families of Contra Costa County.

2. Program: The Nurturing Parenting Program - PEI

a. Scope of Services: The Child Abuse Prevention Council of Contra Costa will provide an evidence-based curriculum of culturally, linguistically, and developmentally appropriate, Spanish speaking families in East County, and Central County's Monument Corridor. Four classes will be provided for 12-15 parents each session and approximately 15 children each session 0-12 years of age. The 22-week curriculum will immerse parents in ongoing training, free of charge, designed to build new skills and alter old behavioral patterns intended to strengthen families and support the healthy development of their children in their own neighborhoods. Developmental assessments and referral services will be provided to each family served in the program using strategies that are non-stigmatizing and non-discriminatory. Families will be provided with linkages to mental health and other services as appropriate. Providing the Nurturing Parenting Program in the Monument Corridor of Concord and East County allows underserved parents and children access to mental health support in their own communities and in their primary language.
b. Target Population: Latino children and their families in Central and East County.
c. Payment Limit: FY 18-19: $125,109
d. Number served: In FY 17-18: 140 parents and children
e. Outcomes:

- Four 22-week classes in Central and East County serving parents and their children.
- All parent participants completed pre- and post-tests. All parents improved their scores on at least four out of five 'parenting constructs' (appropriate expectations, empathy, discipline, self-awareness, and empowerment).

Contra Costa Crisis Center

www.crisis-center.org
Point of Contact: Tom Tamura, Executive Director
Contact Information: P.O. Box 3364 Walnut Creek, CA 94598
(925) 939-1916, Ext. 107, TomT@crisis-center.org

1. General Description of the Organization

The mission of the Contra Costa Crisis Center is to keep people alive and safe, help them through crises, and connect them with culturally relevant resources in the community.

2. Program: Suicide Prevention Crisis Line - PEI

a. Scope of Services:

- Contra Costa Crisis Center will provide services to prevent suicides throughout Contra Costa County by operating a nationally certified 24-hour suicide prevention hotline. The hotline lowers the risk of suicide by assuring 24-hour access to real time services rendered by a trained crisis counselor who not only assesses suicide and self-harm lethality and provides intervention, but links callers to numerous mental health treatment options. This linkage occurs via referral to culturally relevant mental health services as well as provides REAL TIME warm transfer to those services when appropriate. Because the hotline operates continuously regardless of time or day, all callers receive timely intervention and access to service WHEN THEY NEED IT and immediately upon their request. The Crisis Center's programs are implemented (including agency program and hiring policies, bylaws, etc.) in a welcoming and intentionally non-discriminatory manner. Much of our outreach activities and staff/volunteer training activities center around increased awareness of myriad mental health issues, as well as mental health services, consumer stigma reduction in an effort to increase community comfort at accessing services and in referring those in need.
- Key activities include: answering local calls to toll-free suicide hotlines, including a Spanish-language hotline; the Crisis Center will maintain an abandonment rate at or below national standard; assisting callers whose primary language other than English or Spanish through use of a tele-interpreter service; conducting a lethality assessment on each crisis call consistent with national standards; making follow-up calls to persons (with their consent) who are at medium to high risk of suicide with the goal of 99% one-month follow up survival rate; and training all crisis line staff and volunteers in a consistent and appropriate model consistent with AAS (American Association of Suicidology) certification. As a result of these service activities, >99% of people who call the crisis line and are assessed to be at medium to high risk of suicide will be survivors one month later; the Crisis Center will continuously recruit and train crisis line volunteers to a minimum pool of 25 multi-lingual/culturally competent individuals within the contract year; Spanish-speaking counselors will be provided 80 hours per week.
- The Crisis Center will provide community outreach and education about how to access crisis services. Priority and vigorous outreach efforts are directed to underserved and hard to reach populations such as youth, elderly, isolated, persons with limited English, LGBQT, etc. and focus changes as community needs emerge and are identified.

- The Crisis Center will liaison with the County Coroner to provide referrals for grieving survivors (and mitigating contagion).
- In Partnership with County Behavioral Health, the Contra Costa Crisis Center will co-chair the Countywide Suicide Prevention Committee.

b. Target Population: Contra Costa County residents in crisis.
c. Payment Limit: FY 18-19: $310,685
d. Number served: In FY17-18: 30,932 crisis calls were fielded.
e. Outcomes:

- Spanish language coverage was provided 80 hours/week
- Call abandonment rate was 1.5%
- Lethality assessments were provided for 100% of callers rated mid to high level risk.
- Responded to 1,345 calls from people in crisis, suicidal or experiencing mental health issues.
- A pool of 25 volunteers was maintained, and 2 volunteer trainings were offered during the year

Contra Costa Interfaith Housing (CCIH)

http://ccinterfaithhousing.org/
Point of Contact: Sara Marsh, Director of Support Services
Contact Information: 399 Taylor Boulevard, Suite 115, Pleasant Hill, CA 94530
(925) 944-2244, Sara@ccinterfaithhousing.org

1. General Description of the Organization

Contra Costa Interfaith Housing (CCIH) provides permanent, affordable housing and vital, on-site support services to homeless and at-risk families and individuals in Contra Costa County. By providing services on-site at the housing programs where individuals and families live, we maximize timeliness and access to services. This model also minimizes the discriminatory barriers to support, due to lack of transportation or other resources.

2. Program: Strengthening Vulnerable Families - PEI

a. Scope of Services:

- Contra Costa Interfaith Housing, Inc. (CCIH) will provide an array of on-site, on-demand, culturally appropriate and evidence-based approaches for its "Strengthening Vulnerable Families" program, which serves formerly homeless families and families at risk for homelessness and for mental illness. CCIH provides services on-site in affordable housing settings and case managers are available fulltime to residents. This structure helps to eliminate barriers to timely access to services. Culturally aware youth enrichment and case management providers assist youth and families to access a multitude of community services, including mental health treatment. By incorporating these services among general support, potential stigma related to mental health referrals is reduced. By providing services to all residents, potential biased or discriminatory service delivery is avoided.
- At Garden Park Apartments in Pleasant Hill, on-site services are delivered to 28 formerly homeless families. Programming at this site is designed to improve parenting skills, child and adult life skills, and family communication skills. Program elements help families stabilize; parents achieve the highest level of self-sufficiency possible and provide early intervention for the youth in these families who are at risk for ongoing problems due to mental illness, domestic violence, substance addiction, poverty and inadequate life skills. Key activities include: case management, family support, harm reduction support, academic 4-day-per-week homework club, early childhood programming, teen support group, and community-building events.
- CCIH will also provide an Afterschool Program and mental health and case management services at two sites in East Contra Costa County: Bella Monte Apartments in Bay Point and Los Medanos Village in Pittsburg. These complexes offer permanent affordable housing to low-income families at risk for homelessness. The total number of households offered services under this grant was 274. Anticipated impact for services at these sites will be improved school performance by the youth and improved parenting skills and mental health for these families due to lowered stress regarding their housing status (eviction prevention) and increased access to resources and benefits. Increased recognition of early signs of mental illness will be achieved as well, due to the on-site case management staff's ability to respond to possible family concerns

about family members' mental health, as they arise. CCIH staff is also able to help community providers be aware of early signs of mental illness in their clients, and support sensitive care and timely treatment for these issues.

b. Target Population: Formerly homeless/at-risk families and youth.
c. Payment Limit: FY 18-19: $80,340
d. Number served: In FY 17-18: 428 clients
e. Outcomes:

- Improved school functioning and regular attendance of school-aged youth in afterschool programs.

- Improved family functioning and confidence as measured by the self-sufficiency matrix (SSM) and individual family goals and eviction prevention. (SSM evaluates 20 life skill areas including mental health, physical health, child custody, employment, housing stability).

Counseling Options Parent Education (C.O.P.E.) Family Support Center

http://copefamilysupport.org/
Point of Contact: Cathy Botello
Contact Information: 2280 Diamond Blvd #460, Concord, Ca 94520. (925) 689-5811
cathy.botello@copefamilysupport.org

1. General Description of the Organization

C.O.P.E.'s mission is to prevent child abuse by providing comprehensive support services to strengthen family relationships and bonds, empower parents, encourage healthy relationships, and cultivate nurturing family units to encourage an optimal environment for the healthy growth and development of parents and children through parent education.

2. Programs: Triple P Positive Parenting Education and Support -PEI

a. Scope of Services:
In partnership with First 5 Contra Costa Children and Families Commission and Contra Costa County Behavioral Health Services, C.O.P.E. is funded to deliver Positive Parenting Program classes to parents of children ages 0–17. The C.O.P.E Family Support Center will provide approximately 21 services using the evidence-based Triple P — Positive Parenting Program Level 2 Seminar, Level 3 Primary Care, Level 4 Group, Level 5 Pathways, Level 5 Enhanced, Level 5 Transitions, Level 5 Lifestyle multi-family support groups, at low or no cost to parents of children two to seventeen years of age.

The program utilizes an evidence based self-regulatory model that focuses on strengthening the positive attachment between parents and children by building a parent's capacity for the following five aspects:

i. **Self-sufficiency** - having the ability to use one's own resources to independently solve problems and decrease reliance on others;
ii. **Self-efficacy** - having the confidence in performing daily parenting tasks;
iii. **Self-management** - having the tools and skills needed to enable change;
iv. **Personal agency** - attributing the changes made in the family to own effort or the effort of one's child;
v. **Problem-solving** - having the ability to apply principles and strategies, including creating parenting plans to manage current or future problems.

All classes are available in Spanish, Arabic, Farsi and/or English. In order to outreach to the community about the curriculum and benefits of Triple P Parenting, C.O.P.E. provides management briefings, orientation and community awareness meetings to partner agencies. C.O.P.E. supports and organizes annual trainings for other partnering agencies, including pre-accreditation trainings, fidelity oversight and clinical and peer support in an effort to build and maintain a pool of Triple P practitioners.

b. Target Population: Contra Costa County parents of children and youth with identified special needs. Our targeted population includes caregivers residing in underserved communities throughout Contra Costa County.
c. Payment Limit: FY 18-19: $245,863 (ages 6–17), through First Five: $81,955 (ages 0–5).
d. Number served: In FY 17-18: 337

e. Outcomes:

- Offered Triple P evidenced based parenting classes at 27 site locations across the county
- Pre and Post Test Survey results indicate program participants showed a 41% decrease in depression, 34% decrease in anxiety, and 33% decrease in overall stress
- Access and linkage to on-going treatment supported through warm hand off referrals for housing, vocational, legal and mental health services
- Program served 246 individuals in parenting classes, and 91 individuals for case management services.

First Five Contra Costa

http://www.first5coco.org/
Point of Contact: Wanda Davis
Contact Information: 1486 Civic Court, Concord CA 94520
(925) 771-7328, wdavis@firstfivecc.org

1. General Description of the Organization

The mission of First 5 Contra Costa is to foster the optimal development of children, prenatal to five years of age. In partnership with parents, caregivers, communities, public and private organizations, advocates, and county government, First Five supports a comprehensive, integrated set of sustainable programs, services, and activities designed to improve the health and well-being of young children, advance their potential to succeed in school, and strengthen the ability of their families and caregivers to provide for their physical, mental, and emotional growth.

2. Programs: Triple P Positive Parenting Program - PEI

a. Scope of Services: First Five Contra Costa and Contra Costa Behavioral Health jointly fund the Triple P Positive Parenting Program that is provided to parents of age 0 - 5 children. The intent is to reduce the maltreatment of children by increasing a family's ability to manage their children's behavior and to normalize the need for support to develop positive parenting skills. The Triple P program provides timely access to service by placing the classes throughout county and offering classes year round. The Program has been proven effective across various cultures, and ethnic groups. Triple P is an evidence based practice that provides preventive and intervention support. First 5 Contra Costa provides over-site of the subcontractor, works closely with the subcontractor on program implementation, identifying, recruiting and on-boarding new Triple P Practitioners, management of the database, review of outcome measurements, and quality improvement efforts. The partnership is intended to provide outreach for increasing recognition of early signs of mental illness.

b. Target Population: Contra Costa County parents of at risk 0–5 children.

c. Payment Limit: FY 18-19: $81,955

d. Number served: In FY 17-18: 182 parents of children age 0–5 yrs. (C.O.P.E.)

e. Outcomes:

- Completed 17 parenting classes for East and West County parents of children age 0–5 (C.O.P.E.)
  i. Clinical Highlights for FY 17-18:
     - **Depression** – parents self-report on symptoms such as hopelessness and dysphoria, decreased by 41% overall
     - **Anxiety** – parents self-report on symptoms such as anxiousness and situational anxiety, decreased by 34% overall
     - **Stress** – parents self-report on symptoms such as nervousness, muscle tension and inability to relax, decreased by 33% overall
     - **Intensity of Behavior Problems** which measures the frequency of each problem behavior, decreased by 19% as indicated by the chart above
     - **Behavior Problems** which reflect parent tolerance of the behaviors and the distress, decreased by 43%

First Hope (Contra Costa Behavioral Health)

http://www.firsthopeccc.org/ Point of Contact: Jude Leung, Mental Health Program Manager
Contact Information: 391 Taylor Boulevard Suite 100, Pleasant Hill, CA 94523
(925) 608-6550, YatMingJude.Leung@CCHealth.org

1. General Description of the Organization

The Behavioral Health Services Division of Contra Costa Health Services combines Mental Health, Alcohol & Other Drugs and Homeless Program into a single system of care. The First Hope program operates within Contra Costa Behavioral Health's Children's System of Care but is a hybrid program serving both children & young adults.

2. Program: First Hope: Early Identification and Intervention in Psychosis - PEI

a. Scope of Service: The mission of the First Hope program is to reduce the incidence of psychosis and the secondary disability of those developing a psychotic disorder in Contra Costa County through:

- Early Identification of young people between ages 12 and 25 who are showing very early signs of psychosis and are determined to be at risk for developing a serious mental illness.
- Engaging and providing immediate treatment to those identified as "at risk", while maintaining progress in school, work and social relationships.
- Providing an integrated, multidisciplinary team approach including psychoeducation, multi-family groups, individual and family therapy, case management, occupational therapy, supported education and vocation, family partnering, and psychiatric services within a single service model.
- Outreach and community education with the following goals: 1) identifying all young people in Contra Costa County who are at risk for developing a psychotic disorder and would benefit from early intervention services; and 2) reducing stigma and barriers that prevent or delay seeking treatment through educational presentations.

b. Target Population: 12-25 year old transition age youth and their families

c. Total Budget: FY 18-19: $2,651,791

d. Staff: 14 FTE full time equivalent multi-disciplinary staff

e. Number served: FY 17-18: 118 clients and their families served (assessments and clinical services). On any given day, between 55 and 70 clients and their families are open to services. Additionally, First Hope provided ongoing outreach education reaching 224 participants in the community and 179 initial phone screenings and consultation to at risk individuals, families, or providers.

f. Outcomes:

- Help clients manage Clinical High Risk symptoms
- Help clients maintain progress in school, work, relationships
- Reduce the stigma associated with symptoms
- Prevent development of psychotic illnesses
- Reduce necessity to access psychiatric emergency services/ inpatient care

g. Long Term Public Health Outcomes:

- Reduce conversion rate from Clinical High Risk symptoms to schizophrenia
- Reduce incidence of psychotic illnesses in Contra Costa County
- Increase community awareness and acceptance of the value and advantages of seeking mental health care early

James Morehouse Project (JMP) at El Cerrito High, YMCA East Bay

http://www.jamesmorehouseproject.org/
Point of Contact: Jenn Rader, Director
Contact Information: 540 Ashbury Avenue, El Cerrito, CA 94530
(510) 231-1437, jenn@jmhop.org

1. **General Description of the Organization**
   The James Morehouse Project (JMP) works to create positive change within El Cerrito High School through health services, counseling, youth leadership projects and campus-wide school climate initiatives. Founded in 1999, the JMP assumes youth have the skills, values and commitments to create change in their own lives and the life of the school community. The JMP partners with community and government agencies, local providers and universities.
2. **Program: James Morehouse Project (JMP) - PEI**

a. Scope of Services: The James Morehouse Project (JMP), a school health center at El Cerrito High School (fiscal sponsor: YMCA of the East Bay), offers access to care and wellness through a wide range of innovative youth development programs for 300 multicultural youth in West Contra Costa County. Through strategic partnerships with community-based agencies, local universities and county programs, JMP offers three main program areas that include: Counseling & Youth Development, Restorative School-Wide Activities, and Medical & Dental Services. Key activities designed to improve students' well-being and success in school include: AOD Prevention; Migrations/Journeys (immigration/acculturation); Bereavement Groups (loss of a loved one); Culture Keepers (youth of color leadership); Discovering the Realities of Our Communities (DROC – environmental and societal factors that contribute to substance abuse); Peer Conflict Mediation; and Dynamic Mindfulness.

   As an on-campus student health center, the JMP is uniquely situated to maximize access and linkage to mental health services for young people from underserved communities. The JMP connects directly with young people at school and provides timely, ongoing and consistent services to youth on-site. Because the JMP also offers a wide range of youth development programs and activities, JMP space has the energy and safety of a youth center. For that reason, students do not experience stigma around coming into the health center or accessing services.

b. Target Population: At-risk students at El Cerrito High School
c. Payment Limit: FY 18-19: $102,897
d. Numbers Served: For FY 17-18: 413
e. Outcomes:

- Stronger connection to caring adults/peers (build relationships with caring adult(s), peers) for participating youth.
- Increased well-being (diminished perceptions of stress/anxiety, improvement in family/loved-one relationships, increased self-confidence, etc.) for participating youth.
- Strengthened connection to school (more positive assessment of teacher/staff relationships, positive peer connections, ties with caring adults) for participating youth.
- Reduced likelihood of ECHS youth being excluded from school.

- Strengthened culture of safety, connectedness and inclusion schoolwide.
  i. Measures of Success
     - 90% of participating students will show an improvement across a range of resiliency indicators, using a resiliency assessment tool that measures change in assets within the academic year, 2017 to 2018.
     - 90% of participating students will report an increase in well-being through self-report on a qualitative evaluation tool within the academic year, 2017 to 2018.
     - ECHS School Climate Index (SCI) score will increase by 15 or more points from 2017 to 2018.

Jewish Family & Community Services East Bay (JFCS East Bay)

https://jfcs-eastbay.org/

Point of Contact: Amy Weiss, Director of Refugee and Immigrant Services
Contact Information: 1855 Olympic Boulevard, #200, Walnut Creek, CA 94596
(925) 927-2000, aweiss@jfcs-eastbay.org, jfcs-eastbay.org

1. General Description of the Organization

Rooted in Jewish values and historical experiences, and inspired by the diverse communities the agency serves, JFCS East Bay promotes the well-being of individuals and families by providing essential mental health and social services to people of all ages, races, and religions. Established in 1877, JFCS East Bay's long tradition of caring directly impacts the lives of approximately 6,000 Alameda and Contra Costa residents each year. The agency provides services in three main program areas: Refugees & Immigrants, Children & Parents, and Adults & Seniors. Woven throughout these services is a comprehensive volunteer program.

2. Program: Community Bridges - PEI

a. Scope of Services: During the term of this contract, Jewish Family & Community Services East Bay will assist Contra Costa Behavioral Health to implement the Mental Health Services Act (MHSA), Prevention and Early Intervention Program "Reducing Risk of Developing Mental Illness" by providing Outreach and Engagement to Underserved Communities with the Community Bridges Program, providing culturally grounded, community-directed mental health education and navigation services to 200 to 300 refugees and immigrants of all ages and sexual orientations in the Afghan, Syrian, Iranian, Iraqi, African, and Russian communities of central Contra Costa County. Prevention and early intervention-oriented program components include culturally and linguistically accessible mental health education; early assessment and intervention for individuals and families; and health and mental health system navigation assistance. Services will be provided in the context of group settings and community cultural events, as well as with individuals and families, using a variety of convenient non-office settings such as schools, senior centers, and client homes. In addition, the program will include mental health training for frontline staff from JFCS East Bay and other community agencies working with diverse cultural populations, especially those who are refugees and immigrants.
b. Target Population: Immigrant and refugee families of Contra Costa County at risk for developing a serious mental illness.
c. Payment Limit: FY 18-19: $174,485
d. Number served: FY 17-18: 330 clients
e. Outcomes:

- Provided assessment and short-term intervention to 141 bilingual clients.
- Provided individual health and mental health navigation services to 141 clients.
- Provided 4 trainings on cross-cultural mental health concepts for 35 to 40 frontline staff from JFCS East Bay and other community agencies.
- Provided 2 (2-hr) mental health education classes to 20-24 Arabic-speaking clients.
- Provided 4 (2-hr) mental health education classes to 10-12 Dari/Farsi-speaking seniors.
- Provided 4 (2-hr) Dari/Farsi-bilingual parenting classes to 10-12 Afghan & Iranian parents
- Provided 4 (2-hour) mental health education classes to 10-12 Russian-speaking seniors.
- Referred 27 high-risk individuals to bilingual therapy services with JFCS East Bay's bilingual therapist.

Juvenile Justice System – Supporting Youth (Contra Costa Behavioral Health)

Point of Contact: Daniel Batiuchok, Mental Health Program Manager
Contact Information: 202 Glacier Drive, Martinez, CA 94553
(925) 957-2739, Daniel.Batiuchok@CCHealth.org

1. General Description of the Organization

The Behavioral Health Services Division of Contra Costa Health Services combines Mental Health, Alcohol & Other Drugs and Homeless Program into a single system of care. The staff working to support youth in the juvenile justice system operate within Contra Costa Behavioral Health's Children's System of Care.

2. Program: Mental Health Probation Liaisons & Orin Allen Youth Ranch Clinicians - PEI

County behavioral health clinicians strive to help youth experiencing the juvenile justice system become emotionally mature and law abiding members of their communities. Services include: screening and assessment, consultation, therapy, and case management for inmates of the Juvenile Detention Facility and juveniles on probation, who are at risk of developing or struggle with mental illness or severe emotional disturbance.

a. Scope of Services:

Orin Allen Youth Rehabilitation Facility (OAYRF): OAYRF provides 100 beds for seriously delinquent boys ages 13-21, who have been committed by the Juvenile Court. OAYRF provides year-round schooling, drug education and treatment, Aggression Replacement Training, and extracurricular activities (gardening, softball). Additionally, the following mental health services are provided at OAYRF: psychological screening and assessment, crisis assessment and intervention, risk assessment, individual therapy and consultation, family therapy, psychiatric, case management and transition planning.

Mental Health Probation Liaison Services (MHPLS): MHPLS has a team of three mental health probation liaisons stationed at each of the three field probation offices (in East, Central, and West Contra Costa County). The mental health probation liaisons are responsible for assisting youth and families as they transition out of detention settings and return to their communities. Services include: providing mental health and social service referrals, short term case management, short term individual therapy, short term family therapy. Additionally, the mental health probation liaisons are responsible for conducting court-ordered mental health assessments for youth within the county detention system.

b. Target Population: Youth in the juvenile justice system in need of mental health support
c. Payment Limit: FY 18-19: $695,855
d. Staff: 5 Mental Health Clinical Specialists: 3 probation liaisons, 2 clinicians at the Ranch
e. Number served: FY 17-18: 300+
f. Outcomes:

- Help youth address mental health & substance abuse issues that may underlie problems with delinquency
- Increased access to mental health services and other community resources for at risk youth
- Decrease of symptoms of mental health disturbance
- Increase of help seeking behavior; decrease stigma associated with mental illness

La Clínica de la Raza

https://www.laclinica.org/
Point of Contact: Whitney Greswold, Planner
Contact Information: P.O. Box 22210, Oakland, CA 94623
(510) 535 2911, wgreswold@laclinica.org

1. General Description of the Organization

With 35 sites spread across Alameda, Contra Costa and Solano Counties, La Clínica delivers culturally and linguistically appropriate health care services to address the needs of the diverse populations it serves. La Clínica is one of the largest community health centers in California.

2. Program: Vías de Salud and Familias Fuertes - PEI

a. Scope of Services: La Clínica de La Raza, Inc. (La Clínica) will implement Vías de Salud (Pathways to Health) to target Latinos residing in Central and East Contra Costa County with: a) 3,000 depression screenings; b) 500 assessment and early intervention services provided by a Behavioral Health Specialist to identify risk of mental illness or emotional distress, or other risk factors such as social isolation; and c) 1,000 follow-up support/brief treatment services to adults covering a variety of topics such as depression, anxiety, isolation, stress, communication and cultural adjustment. La Clínica's PEI program category is Improving Timely Access to Services for Underserved Populations.

Contractor will also implement Familias Fuertes (Strong Families), to educate and support Latino parents and caregivers living in Central and East Contra Costa County so that they can support the strong development of their children and youth. The project activities will include: 1) Screening for risk factors in youth ages 0-18 (750 screenings); 2) 150 Assessments (includes child functioning and parent education/support) with the a Behavioral Health Specialist will be provided to parents/caretakers of children ages 0-18; 3) Two hundred (200) follow up visits with children/families to provide psycho-education/brief treatment regarding behavioral health issues including parent education, psycho-social stressors/risk factors and behavioral health issues. The goal is to be designed and implemented to help create access and linkage to mental health treatment, be designed, implemented and promoted in ways that improve timely access to mental health treatment services for persons and/or families from underserved populations, and be designed, implemented and promoted using strategies that are non-stigmatizing and non- discriminatory.

b. Target Population: Contra Costa County Latino residents at risk for developing a serious mental illness.
c. Payment Limit: FY 18-19: $280,558
d. Number served: In FY 17-18: 7669 consumers
e. Outcomes:
   i. Vías de Salud
      - Participants of support groups reported reduction in isolation and depression
      - Offered 7,153 depression screenings, 633 assessments and early intervention services, 1,554 follow-up services
   ii. Familias Fuertes

- 100% of parents reported increased knowledge about positive family communication
- 100% of parents reported improved skills, behavior, and family relationships
- Offered 955 screenings for youth, 185 assessments for youth, 262 follow-up visits with families

LAO Family Community Development

https://lfcd.org/
Point of Contact: Kathy Chao Rothberg, Chief Executive Officer or Brad Meyer
Contact Information: 1865 Rumrill Boulevard, Suite #B, San Pablo, CA 94806
(510) 215-1220, krothberg@lfcd.org or bmeyer@lfcd.org

1. **General Description of the Organization**

Founded in 1980, Lao Family Community Development, Inc. (LFCD) annually assists more than 15,000 diverse refugee, immigrant, limited English, and low-income U.S. born community members in achieving long-term financial and social self-sufficiency. LFCD operates in 3 Northern California counties delivering timely, linguistically, and culturally appropriate services using an integrated service model that addresses the needs of the entire family unit, with the goal of achieving self-sufficiency in one generation.

2. **Program: Health and Well-Being for Asian Families - PEI**

a. Scope of Services: Lao Family Community Development, Inc. provides a comprehensive and culturally sensitive Prevention and Early Intervention Program that combines an integrated service system approach for serving underserved Asian and South East Asian adults throughout Contra Costa County. The program activities designed and implemented include: comprehensive case management; evidence based educational workshops using the Strengthening Families Curriculum; and peer support groups. Strategies used reflect non-discriminatory and non-stigmatizing values. We will provide outreach, education and support to a diverse underserved population to facilitate increased development of problem solving skills, increase protective factors to ensure families emotional well-being, stability, and resilience. We will provide timely access, referral and linkage to increase client's access to mental health treatment and health care providers in the community based, public and private system. LFCD provides in language outreach, education, and support to develop problem solving skills, and increase families' emotional well-being and stability, and help reduce the stigmas and discriminations associated with experiencing mental health. The staff provides a client centered, family focused, strength based case management and planning process, to include home visits, brief counseling, parenting classes, advocacy and referral to other in-house services such as employment services, financial education, and housing services. These services are provided in clients' homes, other community based settings and the offices of LFCD in San Pablo.

b. Target Population: South Asian and South East Asian Families at risk for developing serious mental illness.

c. Payment Limit: FY 18-19: $190,416

d. Number served: In FY 17-18: 127

e. Outcomes:

- 100% of program participants completed the Lubben Social Networking Scale (LSNS) assessments. Results indicate program participation leads to a decrease in social isolation.
- Held 5 Strengthening Families Program (SFP) Educational Workshops
- Held 4 Thematic Peer Support Group Events – in various locations including outdoor parks and spaces
- 92% of program participants were satisfied with services

The Latina Center

https://thelatinacenter.org/
Point of Contact: Miriam Wong
Contact Information: 3701 Barrett Avenue #12, Richmond, CA 94805
(510) 233-8595, mwong@thelatinacenter.org

1. General Description of the Organization

The Latina Center is an organization of and for Latinas that strives to develop emerging leaders in the San Francisco Bay Area through innovative training, support groups and leadership programs. The mission of The Latina Center is to improve the quality of life and health of the Latino Community by providing leadership and personal development opportunities for Latina women.

2. Program: Our Children First/Primero Nuestros Niños - PEI

a. Scope of Services: The Latina Center (TLC) provides culturally and linguistically specific parenting education and support to at least 300 Latino parents and caregivers in West Contra Costa County that: 1) supports healthy emotional, social and educational development of children and youth ages 0-15, and 2) reduces verbal, physical and emotional abuse. The Latina Center enrolls primarily low-income, immigrant, monolingual/bilingual Latino parents and grandparent caregivers of high-risk families in a 12-week parenting class using the Systematic Training for Effective Parenting (STEP) curriculum or PECES in Spanish (Padres Eficaces con Entrenamiento Eficaz). Parent Advocates are trained to conduct parenting education classes, and Parent Partners are trained to offer mentoring, support and systems navigation. TLC provides family activity nights, creative learning circles, cultural celebrations, and community forums on parenting topics.
b. Target Population: Latino Families and their children in West County at risk for developing serious mental illness.
c. Payment Limit: FY 18-19: $111,545
d. Number served: In FY 17-18: 240 parents, 91 youth
e. Outcomes:

- Workshops reached an additional 67 participants
- Latina Center offered a free summer camp which served 91 children
- A total of 240 parents participated in evidenced based parenting curriculum

Lifelong Medical Care

https://www.lifelongmedical.org/
Point of Contact: Kathryn Stambaugh
Contact Information: 2344 6th Street, Berkeley, CA 94710
(510) 981-4156, kstambaugh@lifelongmedical.org

1. General Description of the Organization

Founded in 1976, LifeLong Medical Care (LifeLong) is a multi-site safety-net provider of comprehensive medical, dental, behavioral health and social services to low-income individuals and families in West Contra Costa and Northern Alameda counties. In 2017, LifeLong provided approximately 300,000 health care visits to 61,000 people of all ages.

2. Program: Senior Network and Activity Program (SNAP) - PEI

a. Scope of Services: LifeLong's PEI program, SNAP, brings therapeutic drama, art, music and wellness programs to isolated and underserved older adults in Richmond. SNAP encourages lifelong learning and creativity, reduces feelings of depression and social isolation, and connects consumers with mental health and social services as needed. All services are designed with consumer input to promote feelings of wellness and self-efficacy, reduce the effects of stigma and discrimination, build community connections, and provide timely access to underserved populations who are reluctant or unable to access other mental health and social services.

   SNAP provides services on-site at three low-income housing locations in West County, including weekly group activities, one-on-one check-ins, and case management. Activities vary based on consumer interests, but may include choir, theater, art, board games, word games, special events, and holiday celebrations. Services also include quarterly outings, screening for depression and isolation, information and referral services, and outreach to invite participation in group activities and develop a rapport with residents.

   Services are designed to improve timely access to mental health treatment services for persons and/or families from underserved populations, utilizing strategies that are non-stigmatizing and non-discriminatory. The expected impact of these services includes: reducing isolation and promoting feelings of wellness and self-efficacy; increasing trust and reducing reluctance to revealing unmet needs or accepting support services; decreasing stigma and discrimination among underserved populations; and improving quality of life by reducing loneliness and promoting friendships and connections with others.

b. Target Population: Seniors in low income housing projects at risk for developing serious mental illness.
c. Payment Limit: FY 18-19: $130,786
d. Number served: In FY 17-18: 154
e. Outcomes:

- More than 50% of participants demonstrated self-efficacy and purpose by successfully completing at least one long-term project.
- 93% of respondents self-reported improvement in mood as a result of participating in SNAP.
- 98% of respondents reported satisfaction with the SNAP program.

b. Total FTE: 4.0 FTE
c. Total MHSA Portion of Budget: $603,230
d. Number Served in FY 17/18: Approximately 700 individuals per year receive permanent or temporary supportive housing by means of MHSA funded housing services.

Native American Health Center (NAHC)

http://www.nativehealth.org/
Point of Contact: Chirag Patel, Catherine Nieva-Duran
Contact Information: 2566 MacDonald Avenue, Richmond, 94804
(510) 434-5483, chiragp@nativehealth.org or catherinen@nativehealth.org

1. General Description of the Organization

The Native American Health Center serves the California Bay Area Native Population and other under-served populations. NAHC has worked at local, state, and federal levels to deliver resources and services for the urban Native American community and other underserved populations, to offer medical, dental, behavioral health, nutrition, perinatal, substance abuse prevention, HIV/HCV care coordination and prevention services.

2. Program: Native American Wellness Center – PEI

a. Scope of Services: Native American Health Center provides outreach for the increasing recognition of early signs of mental illness. To this end, they provide mental health prevention groups and quarterly events for Contra Costa County Community Members. These activities help develop partnerships that bring consumers and mental health professionals together to build a community that reflects the history and values of Native American people in Contra Costa County. Community-building activities done by NAHC staff, community members, and consultants, include: an elder's support group, youth wellness group (including suicide prevention and violence prevention activities). Quarterly cultural events and traditional arts groups including: beading, quilting, shawl making and drumming. Other activities include: Positive Indian Parenting to teach life and parenting skills, Talking Circles that improve communication skills and address issues related to mental health, including domestic violence, individual and historical trauma and Gathering of Native Americans (GONA) to build a sense of belonging and cohesive community. Expected outcomes include increases in social connectedness, communication skills, parenting skills, and knowledge of the human service system in the county.

   Program Staff conduct cultural competency trainings for public officials and other agency personnel. Staff assist with System Navigation including individual peer meetings, referrals to appropriate services (with follow-up), and educational sessions about Contra Costa County's service system.

b. Target Population: Native American residents of Contra Costa County (mainly west region), who are at risk for developing a serious mental illness.
c. Payment Limit: FY 18-19: $238,555
d. Number served: In FY 17-18: 162
e. Outcomes:

- Program participants will increase social connectedness within a twelve month period.
- Program participants will increase family communications.
- Participants that engaged in referrals and leadership training will increase their ability to navigate the mental health/health/education systems.

Office for Consumer Empowerment (OCE)
(Contra Costa Behavioral Health)

Point of Contact: Jennifer Tuipulotu, Program Manager
Contact Information: 1330 Arnold Drive #140, Martinez, CA 94553
(925) 957-5206, Jennifer.Tuipulotu@CCHealth.org

1. General Description of the Organization

The Office for Consumer Empowerment is a County operated program that supports the entire Behavioral Health System and offers a range of trainings and supports by and for individuals who have experience receiving behavioral health services. The goals are to increase access to wellness and empowerment knowledge for participants of the Behavioral Health System.

2. Program: Reducing Stigma and Discrimination – PEI

a. Scope of Services:

- The PhotoVoice Empowerment Project equips individuals with lived mental health and co-occurring experiences with the resources of photography and narrative in confronting internal and external stigma and overcoming prejudice and discrimination in the community.
- The Wellness and Recovery Education for Acceptance, Choice and Hope (WREACH) Speakers' Bureau encourages individuals with lived mental health and co-occurring experiences, as well as family members and providers, to effectively present their recovery and resiliency stories in various formats to a wide range of audiences, such as health providers, academic faculty and students, law enforcement, and other community groups.
- Staff leads and supports the Committee for Social Inclusion. This is an alliance of community members and organizations that meet regularly to promote social inclusion of persons who use behavioral health services. The committee promotes dialogue and guides projects and initiatives designed to reduce stigma and discrimination, and increase inclusion and acceptance in the community.
- Staff provides outreach and support to peers and family members to enable them to actively participate in various committees and sub –committees throughout the system. These include the Mental Health Commission, the Consolidated Planning and Advisory Workgroup and sub-committees, and Behavioral Health Integration planning efforts. Staff provides mentoring and instruction to consumers who wish to learn how to participate in community planning processes or to give public comments to advisory bodies.
- Staff partner with NAMI Contra Costa to offer a writers' group for people diagnosed with mental illness and family members who want to get support and share experiences in a safe environment.

3. Program: Mental Health Career Pathway Program - WET

a. Scope of Services:

- The Mental Health Service Provider Individualized Recovery Intensive Training (SPIRIT) is a recovery-oriented peer led classroom and experientially based college accredited program that prepares individuals to become providers of service. Certification from this program is a requirement for many Community Support Worker positions in Contra Costa Behavioral Health. Staff provide instruction and administrative support, and provide ongoing support to graduates who are employed

by the County.

4. Program: Overcoming Transportation Barriers – INN

a. Scope of Services:

- The Overcoming Transportation Barriers program is a systemic approach to develop an effective consumer-driven transportation infrastructure that supports the entire mental health system of care. The goals of the program are to improve access to mental health services, improve public transit navigation, and improve independent living and self-management skills among peers. The program targets peers and caregivers throughout the mental health system of care.

b. Target Population: Participants of public mental health services and their families; the general public.

c. Total MHSA Funding for FY 2018-19: $270,628

d. Staff: 11 full-time equivalent staff positions.

e. Outcomes:

- Increased access to wellness and empowerment knowledge and skills by participants of mental health services.
- Decrease stigma and discrimination associated with mental illness.
- Increased acceptance and inclusion of mental health peers in all domains of the community.

People Who Care (PWC) Children Association

http://www.peoplewhocarechildrenassociation.org/
Point of Contact: Constance Russell, Executive Director
Contact Information: 2231 Railroad Avenue, Pittsburg, CA 94565
(925) 427-5037, PWC.Cares@comcast.net

1. General Description of the Organization

People Who Care Children Association has provided educational, vocational and employment training programs to children ages 12 through 21 years old, since 2001. Many are at risk of dropping out of school and involved with, or highly at risk of entering, the criminal juvenile justice system. The mission of the organization is to empower children to become productive citizens by promoting educational and vocational opportunities, and by providing training, support and other tools needed to overcome challenging circumstances.

2. Program: PWC Afterschool Program (PEI)

a. Scope of Services: Through its After School Program, People Who Care (PWC) will provide Prevention services through providing work experience for 200 multicultural at-risk youth residing in the Pittsburg/Bay Point and surrounding East Contra Costa County communities, as well as programs aimed at increasing educational success among those who are either at-risk of dropping out of school, or committing a repeat offense. Key activities include job training and job readiness training, mental health support and linkage to mental health counseling, as well as civic and community service activities.
b. Target Population: At risk youth with special needs in East Contra Costa County.
c. Payment Limit: FY 18-19: $223,102
d. Number served: For FY 17-18: 212
e. Outcomes:

- Participants in Youth Green Jobs Training Program increased their knowledge and skills related to entrepreneurship, alternative energy resources and technologies, and Green Economy.
- Participants of the PWC After-School Program showed improved youth resiliency factors (i.e., self-esteem, relationship, and engagement).
- More than 50% of participants did not re-offend during the participation in the program
- Participants in PWC After School Program reported having a caring relationship with an adult in the community or at school.
- Majority of participants showed an increase in school day attendance and decrease in school tardiness.

Putman Clubhouse

https://www.putnamclubhouse.org/
Point of Contact: Tamara Hunter, Executive Director
Contact Information: 3024 Willow Pass Road #230, Concord CA 94519
(925) 691-4276 or (510) 926-0474, tamara@putnamclubhouse.org

1. General Description of the Organization

Putnam Clubhouse provides a safe, welcoming place, where participants (called members), recovering from mental illness, build on personal strengths instead of focusing on illness. Members work as colleagues with peers and a small staff to maintain recovery and prevent relapse through work and work-mediated relationships. Members learn vocational and social skills while doing everything involved in running The Clubhouse.

2. Program: Preventing Relapse of Individuals in Recovery - PEI

a. Scope of Services:
   i. Project Area A: Putnam Clubhouse's peer-based programming helps adults recovering from psychiatric disorders access support networks, social opportunities, wellness tools, employment, housing, and health services. The work-ordered day program helps members gain prevocational, social, and healthy living skills as well as access vocational options within Contra Costa. The Clubhouse teaches skills needed for navigating/accessing the system of care, helps members set goals (including educational, vocational, and wellness), provides opportunities to become involved in stigma reduction and advocacy. Ongoing community outreach is provided throughout the County via presentations and by distributing materials, including a brochure in both English and Spanish. The Young Adult Initiative provides weekly activities and programming planned by younger adult members to attract and retain younger adult members in the under-30 age group. Putnam Clubhouse helps increase family wellness and reduces stress related to caregiving by providing respite through Clubhouse programming and by helping Clubhouse members improve their independence.
   ii. Project Area B: Putnam Clubhouse assists the Office for Consumer Empowerment (OCE) by providing career support through hosting Career Corner, an online career resource for mental health consumers in Contra Costa County, and holding countywide career workshops.
   iii. Project Area C: Putnam Clubhouses assists Contra Costa County Behavioral Health in a number of other projects, including organizing community events and by assisting with administering consumer perception surveys.
   iv. Project Area D: Putnam Clubhouse assists Contra Costa County Behavioral Health in implementing the Portland Identification and Early Referral (PIER) program for individuals at risk of psychosis, First Hope, by providing logistical and operational support.
b. Target Population: Contra Costa County residents with identified mental illness and their families.
c. Payment Limit: FY 18-19: $582,859
d. Number served: In FY 17-18: 308
e. Outcomes (FY17-18):

- 70 new members enrolled and participated in at least one activity
- Held 4 career workshops
- Prepared 9,000 meals for members
- Provided 54,437 hours of Clubhouse programming to members
- Clubhouse membership made a positive impact by decreasing hospitalizations

Rainbow Community Center

https://www.rainbowcc.org/
Point of Contact: Kevin McAllister, Executive Director
Contact Information: 2118 Willow Pass Road, Concord, CA 94520
(925) 692-0090, kevin.mcallister@rainbowcc.org

1. General Description of the Organization

The Rainbow Community Center of Contra Costa County builds community and promotes well-being among Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ) people and our allies. Services are provided in our main office in Concord, our satellite location in West County, and in East County by arrangements with partner organizations.

2. Programs: A.) Outpatient Behavioral Health and Training
B.) Community-based Prevention and Early Intervention - PEI

a. Scope of Services:
   i. Outpatient Services: Rainbow works with LGBTQ mental health consumers to develop a healthy and un-conflicted self-concept by providing individual, group, couples, and family counseling, as well as case management and linkage/brokerage services. Services are available in English, Spanish, and Portuguese.
   ii. Pride and Joy: Three-tiered prevention and early intervention model. Tier One: outreach to hidden groups, isolation reduction and awareness building. Tier Two: Support groups and services for clients with identified mild to moderate mental health needs. Tier Three: Identification and linkage of clients with high levels of need and who require system navigation support. Services are aimed at underserved segments of the LGBTQ community (seniors, people living with HIV, and community members with unrecognized health and mental health disorders).
   iii. Youth Development: Three tiered services (see above) aimed at LGBTQ youth as a particularly vulnerable population. Programming focuses on building resiliency against rejection and bullying, promoting healthy LBGTQ identity, and identifying and referring youth in need of higher levels of care. Services are provided on-site and at local schools.
   iv. Inclusive Schools: Community outreach and training involving school leaders, staff, parents, CBO partners, faith leaders and students to build acceptance of LGBTQ youth in Contra Costa County schools, families, and faith communities.

b. Target Population: LGBTQ community of Contra Costa County who are at risk of developing serious mental illness.
c. Payment Limit: FY 18-19: $759,362 for PEI, including counseling and case management services onsite and at Contra Costa schools.
d. Number served: In FY 17-18: 1460
e. Outcomes:

- Rainbow held 28 trainings during the year
- Rainbow's Inclusive School Coalition served the following four districts: Mt. Diablo, Pittsburg, Acalanes, West Contra Costa Unified
- Youth Support Programming served: 144 youth via outreach; 176 youth in groups; 43 through one on one work; 387 through school-based outreach; 118 through mental health services, and 65 through psycho-social groups
- Pride & Joy program reached 1,054 members of the community through events/groups; 387 through brief intervention; and 204 through individual services

RYSE Center

https://rysecenter.org/
Point of Contact: Kanwarpal Dhaliwal, Co-found and Associate Director
Contact Information: 205 41st Street, Richmond. CA 94805
(925) 374-3401, Kanwarpal@rysecenter.org

1. General Description of the Organization

RYSE is a youth center in Richmond that offers a wide range of activities, programs, and classes for young people including media arts, health education, career and educational support, and youth leadership and advocacy. RYSE operates within a community behavioral health model and employs trauma informed and healing centered approaches in all areas of engagement, including one-on-one, group and larger community efforts. In these areas, RYSE focuses on the conditions, impact, and strategies to name and address community distress, stigma, and mental health inequities linked to historical trauma and racism, as well as complex, chronic trauma. This focus enables RYSE to provide culturally relevant, empathetic, and timely community mental health and wellness services, resources, and supports across all our program areas and levels of engagement.

1. Program: Supporting Youth – PEI

a. Scope of Services:
   i. Trauma Response and Resilience System (TRRS): Develop and implement Trauma and Healing Learning Series for key system partners, facilitate development of a coordinated community response to violence and trauma, evaluate impact of trauma informed practice, provide critical response and crisis relief for young people experiencing acute incidents of violence (individual, group, and community-wide).
   ii. Health and Wellness: Support young people (ages 13 to 21) from the diverse communities of West County to become better informed (health services) consumers and active agents of their own health and wellness, support young people in expressing and addressing the impact of stigma, discrimination, and community distress; and foster healthy peer and youth-adult relationships. Activities include mental health counseling and referrals, outreach to schools, workshops and 'edutainment' activities that promote inclusion, healing, and justice, youth assessment and implementation of partnership plans (Chat it Up Plans).
   iii. Inclusive Schools: Facilitate collaborative work with West Contra Costa schools and organizations working with and in schools aimed at making WCCUSD an environment free of stigma, discrimination, and isolation for LGBTQ students. Activities include assistance in provision of LGBT specific services, conducting organizational assessments, training for adults and students, engaging students in leadership activities, and providing support groups at target schools, etc.
b. Target Population: West County Youth at risk for developing serious mental illness.
c. Payment Limit: FY 18-19: $503,019
d. Unique Number served: In FY 17-18: 680 young people
e. Outcomes:

- 254 RYSE members participated in at least two programs within the integrative

model

- 7 youth-generated videos were created to address health, social inequity and stigma reduction.
- RYSE served 34 youth through the Hospital-Linked Violence Intervention Program (R2P2)
- RYSE reached at least 1105 adults through community-wise and sector specific trauma-informed care trainings, presentations and gatherings.
- RYSE reached at least 500 young people through their Queer Trans Summit
- 75 young people received services through RYSE's school-linked services

STAND! For Families Free of Violence

http://www.standffov.org/
Point of Contact: Reina Sandoval Beverly
Contact Information: 1410 Danzig Plaza #220, Concord, CA 94520
(925) 676-2845, reinasb@standffov.org

1. General Description of the Organization

STAND! For Families Free of Violence is a provider of comprehensive domestic violence and child abuse services in Contra Costa County, offering prevention, intervention, and treatment programs. STAND! builds safe and strong families through early detection, enhanced support services, community prevention and education, and empowerment to help individuals rebuild their lives. STAND! enlists the efforts of local residents, organizations and institutions, all of whom are partners in ending family violence. STAND! is a founding member of the "Zero Tolerance for Domestic Violence Initiative", a cross-sector organization working for fifteen years to help end domestic violence, sexual assault and childhood exposure to violence.

2. Program: "Expect Respect" and "You Never Win With Violence" - PEI

a. Scope of Services: STAND! provides services to address the effects of teen dating violence/domestic violence and helps maintain healthy relationships for at-risk youth throughout Contra Costa County. STAND! uses two evidence-based, best-practice programs: "Expect Respect" and "You Never Win with Violence" to directly impact youth behavior by preventing future violence and enhancing positive mental health outcomes for students already experiencing teen dating violence. Primary prevention activities include educating middle and high school youth about teen dating through the 'You Never Win with Violence' curriculum, and providing school personnel, service providers and parents with knowledge and awareness of the scope and causes of dating violence. The program strives to increase knowledge and awareness around the tenets of a healthy adolescent dating relationship. Secondary prevention activities include supporting youth experiencing, or at-risk for teen dating violence by conducting 20 gender-based, 15-week support groups. Each school site has a system for referring youth to the support groups. As a result of these service activities, youth experiencing or at-risk for teen dating violence will demonstrate an increased knowledge of: 1) the difference between healthy and unhealthy teen dating relationships, 2) an increased sense of belonging to positive peer groups, 3) an enhanced understanding that violence does not have to be "normal", and 4) an increased knowledge of their rights and responsibilities in a dating relationship.
b. Target Population: Middle and high school students at risk of dating violence.
c. Payment Limit: FY 18-19: $134,113
d. Number served: For FY 17-18: 2179 participants
e. Outcomes:

- 77 *You Never Win with Violence* presentations reached 1987 participants
- 18 *Expect Respect* groups reached 192 participants
- Youth Against Violence: 10 youth leaders trained in summer 2017
- Adult Allies: 31 adults trained in two presentations

Vicente Martinez High School - Martinez Unified School District

http://vmhs-martinez-ca.schoolloop.com/
Point of Contact: Lori O'Connor
Contact Information: 925 Susana Street, Martinez, CA 94553
(925) 335-5880, loconnor@martinez.k12.ca.us

1. General Description of the Organization

The program serves Vicente Martinez High School 9-12th grade, at-risk students with a variety of experiential and leadership opportunities that support social, emotional and behavioral health, career exposure and academic growth while also encouraging, linking and increasing student access to direct mental health services. These services are also provided to students of Briones School, an independent study program located on the same campus. The program has been jointly facilitated within a unique partnership between Martinez Unified School District (MUSD) and the New Leaf Collaborative (501c3).

2. Program: Vicente Martinez High School & Briones School- PEI

a. Scope of Services: Vicente Martinez High School and Briones School provide their students of all cultural backgrounds an integrated, mental health focused, learning experience. Key services include student activities that support:

- individualized learning plans
- mindfulness and stress management interventions
- team and community building
- character, leadership, and asset development
- place-based learning, service projects that promote hands-on learning and intergenerational relationships
- career-focused exploration, preparation and internships
- direct mental health counseling
- timely access and linkage to direct mental health counseling

Services support achievement of a high school diploma, transferable career skills, college readiness, post-secondary training and enrollment, democratic participation, social and emotional literacy and mental/behavioral health. All students also have access to a licensed Mental Health Counselor for individual and group counseling.

Students enrolled in Vicente and Briones have access to the variety of programs/services that meet their individual learning goals. Classes have a maximum of 23 students, and are led by teachers and staff who have training in working with at-risk students and using restorative justice techniques. Students regularly monitor their own progress through a comprehensive advisory program designed to assist them in becoming more self-confident through various academic, leadership, communication, career and holistic health activities.

b. Target Population: At-risk high school students in Central County
c. Payment Limit: FY 18-19: $185,763
d. Number served: In FY 17-18: 140 Transition Aged Youth (TAY)
e. Outcomes:

- Goals: Students enrolled in Vicente and Briones will: Develop an

increased ability to overcome social, familial, emotional, psychiatric, and academic challenges and hence work toward academic, vocational, relational, and other life goals
- Increase mental health resiliency
- Participate in four or more different PEI related activities throughout the school year
- Decrease incidents of negative behavior
- Increase attendance rates

ii. Goals: During the 17-18 School Year:
- 95% of Vicente students enrolled during the 17-18 school year participated in PEI related activities.
- PEI services were extended to Briones independent study students; 37% participated in services.
- All seniors participated in a minimum of 15 hours of service learning.
- Staff organized and hosted 70 different types of activities and events to enrich the curricula.
- All students were offered mental health counseling.
- Developmental Assets Profile (DAP) assessment was administered to all students.

Appendix B
Program Annual Reports
FY 18-19

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA BEHAVIORAL HEALTH
1220 MORELLO AVE., STE. 100
MARTINEZ, CA 94553-4707
PH: (925) 957-2611 FAX: (925) 957-2624 E-MAIL: Jbruggem@cchealth.org

PEI ANNUAL REPORTING FORM

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS REPORTING FORM FISCAL YEAR: 18-19

Agency/Program Name:
Asian Community Mental Health Services / Asian Family Resource Center

PEI STRATEGIES:
Please check all strategies that your program employs:
X Provide access and linkage to mental health care
X Improve timely access to mental health services for underserved populations
X Use strategies that are non-stigmatizing and non-discriminatory

SERVICES PROVIDED / STRATEGIES:
Please describe the services you provided in the past reporting period. Please include qualitative and quantitative data depicting: 1) the types and settings of potential responders you reached during the past reporting period; 2) methods used to reach out and engage potential responders; 3) any strategies utilized to provide access and linkage to treatment, and4) strategies utilized to improve timely access to services for underserved populations.

Within the past reporting period, the potential responders we have reached primarily consist of multilingual and multicultural individuals and families (specifically of Chinese, Vietnamese, Laos, Khmu, and Mien backgrounds) currently living in Contra Costa County (with the majority residing in the western region of the county). These groups and individuals are frequently underserved as a result of language barriers and cultural differences. We hold regular group sessions at our offices in Richmond weekly to reach our target audience.

Our primary method of outreach and engagement with potential responders were program brochures. These brochures were printed in several languages, such as Chinese, Vietnamese, Lao, and Mien to reach a wider range of potential responders. These brochures consisted of our mission, the types of services we

offer under this program, the language we speak, and our contact information.

These brochures are placed in areas that attract high concentrations of the APIC population such as public libraries, supermarkets, restaurants, adult schools, housing complexes, the faith community, weekend community events, and distributed to the participants at diverse community activities. In addition, the brochures are distributed to participants who attended our outreach events in previous years.

We also hold collaborative efforts with other community agencies such as the Family Justice Center Richmond and Concord, Regional Center of East Bay, Senior Peer Counseling, Bay Area Legal Aid, local school districts, SSA, and housing corporations for service resources and case referrals in order to further engage with our community.

Furthermore, we hold psychoeducation workshops for community members with regards to the importance of prevention and early intervention relative to mental health, as well as self-care and human wellness. The workshops also touch on cultural/historical issues and family/parenting issues. These workshops also touch on cultural/historical issues and family/parenting issues. These workshops raise the attendees' awareness and understanding of the early signs of mental health issues, increase their knowledge about mental health, and reduce the stigma that surrounds the topic of mental health. Additionally, we provide information about where and how to get help if needed, particularly for those who may feel limited due to language barriers.

Several strategies are utilized to provide access and linkage to treatment. We assess the needs of the individual, set up services goals for them, provide the services required or otherwise refer them to appropriate programs to service their needs. For instance, if there is a potential case that needs mental health assessment and treatment, it would be transferred to another program we offer, Medi-Cal recipients. For those individuals who are not qualified for this treatment program, of immediate risk, or are having difficulties accessing or receiving services in English because of language and cultural barriers, they are encouraged to receive individual/family consultation for up to one year under the PEI program, or participate in wellness support groups in a variety of Asian languages (this program is also under the PEI program.) We regularly follow up with the individual to assess if program is meeting their needs. Internally, we perform quality assurance by periodically meeting with staff and participants to get feedback to incorporate into our best practices.

We perform a variety of things to improve timely access to services for the underserved populations. i) We regularly attend community meetings, to allow our potential client to be aware of our services and accessibility to them. ii) We attend workshops to receive training for new and updated information about laws, public benefits, social services, etc. to be equipped with information that may have an impact on the population we serve. This way we, as providers, can develop a better understanding of the needs and services for underserved populations, and provide more catered and supportive services. iii) Our agency also hosted several events throughout

the year, to allow the community of underserved population to come together, so we may engage

On August 23, 2018, our agency hosted an outdoor event for the community at Alvarado Park in Richmond, CA. People from all backgrounds, young and old, joined us at the picnic. 52 people attended the event, including those from Chinese, Vietnamese, Lao, Khmu, and Mien communities. It was a fun day for all, filled with an abundance of food and activities. Our attendees enjoyed spending quality time talking and eating with good friends and good food. The picnic was a success, bringing many different people together for a day of fun. It was our pleasure to share resources with all.

On November 30, 2018, our agency facilitated a community wellness event at Family Justice Center in Concord, CA. The activities included health screening, community wellness resources, and introduction to our programs and missions, and a workshop on" Understand Financial Literature, How to grow/save money, and Free Eye Exam by Dr. Viet Ho," There were a total of 47 attendees most of them are Vietnamese and Chinese guest that participated in the events.

On June 27, 2019, our agency hosted outdoor event for the community at Alvarado Park Richmond, CA. We had attendance of 47 people including those from the Chinese, Vietnamese, and Laos. We had games activities and raffle for price for the winner. It was our pleasure to share the resources and have fun with the community.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***Include a list of indicators measured, how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

We utilize the Demographics Form to conduct evaluation and measure outcomes. Some questions in the form have been modified to better reflect cultural competency. Some of the qualitative data we collect include primary language spoken, race, ethnicity, gender, sexual orientation. Our quantitative data includes the number of individuals that attend groups, their ages, and the number of hours attended. The Demographics Form does not include the client name so their information will always be confidential. We use one form per individual per contact. The data is compiled at end of the month and analyzed.

DEMOGRAPHIC DATA: ☐ **Not Applicable** ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

Reported on separate form.

VALUES:

Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

Our program reflects the values of wellness, recovery, and resilience. We base our work on our agency's mission statement, which emphasize the need to provide and advocate for multilingual and multicultural family services that empower people in Contra Costa County to lead healthy, contributing and self-sufficient lives. The services we provide always aim to assist, educate, and eliminate the stigmas of mental health-related issues. Our doors are always open to anyone that seeks assistance, regardless of race, color, ethnicity, religion, sexual orientation. With the assistance of our bilingual staff, we are able to provide language-based and culturally competent care and service, something we value deeply. We truly believe we provide a safe place for the underserved population who ESL and need theseservices

VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

Client is a 78 years old female who speaks Mandarin primarily and some limited English. Client is currently living alone in a house especially her husband who was her main support died couple years ago. Client reported having two adult children whom she barely has contact with. Her older son has lived in the Bay Area but she stated she didn't have much contact with since him. She stated, "in Chinese culture, you didn't tell bad news to your family, you only said good news". Her younger son currently is missing, and she stated her son has been suffering from mental health illness. She has been worrying about him. Client is currently living on SSI and SSA with no other types of support.

Client came to AFRC since April 2017 for case management such as senior housing and translation for letters. For about more than a year, client came with only those needs, she often presented herself with a heavy sense of shame about seeking for services and help. She would reject any other services providing to her and stated, "l didn't deserve help". At the group, one of the peers also stated the client has difficulty asking for help. Therefore, the services at AFRC were provided to client based on the client's requests and client often turned down other suggestions from the staff. After a year of services, client started to build up a sense of trust with the staff at AFRC and client would contact and come to the office for seeking help more frequently. For the recent six months, client used the services at AFRC for about 1-5 times a month. Therefore, the service goals at AFRC were 1. Provided case management to meet with client's basic needs such as food stamp, energy bill deduction, SSl renewal process etc. 2. Reduce client's level of anxiety and depressed mood which was triggered by her external stressors. 3. Establish a rapport with the client through case management and assist client to reduce her sense of shame when seeking help. 4. Provide resources and referral for the client

for other services.

The recent services AFRC provided including case management, brief counseling, money management, psychoeducation, wellness education, screening for mental health needs, and providing referral for resources and mental health therapy. In the year 2018-2019, client has responded with an increasing level of trust to the staff and she stated revealing more about her struggles. Client would contact the staff at AFRC asking for assistance and she was more proactive about asking help for her needs. Moreover, AFRC staff assisted client to resolve her SSI penalty and client's level of stress has decreased which client responded "I really appreciate (AFRC] staff for helping me to resolve the issues; otherwise, I couldn't stop thinking about it. And now, I have felt more secure when I come to see you. My worries got lessen because of the help here." Around May to June 2019, staff suggested client to seek for mental health therapy. Client agreed with the suggestions and she will be connected to Medi-care for therapy.

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PEI ANNUAL REPORTING FORM

EARLY INTERVENTION REPORTING FORM **FISCAL YEAR: 2018-2019**

Agency/Program Name: Building Blocks for Kids

PEI STRATEGIES:
Please check all strategies that your program employs:

X Provide access and linkage to mental health care

☐ **Improve timely access to mental health services for underserved populations**

☐ **Use strategies that are non-stigmatizing and non-discriminatory**

SERVICES PROVIDED / ACTIVITIES:
Please describe the services you provided in the past reporting period. Please include types of problems/needs addressed, any activities that address these problems/needs, and any functional outcomes targeted by the services provided.

1) Ensure BBK Zone families are knowledgeable about and have access to a network of supportive and critical health and mental health information and services.

During the 2018-2019 fiscal year Health & Wellness Team members met with 22 community organizations, government agencies and individuals to strengthen our relationships with them and better understand how to connect Richmond residents to their services. The services include: mental health and wellness providers, access to health information, access to low-cost or free food, early literacy support, financial crisis support and housing. Additionally, Health and Wellness team members attended various networking events and trainings offered by community partners. They included: a trauma informed training focused on the effects of trauma on health and on the brain organized by the Family Justice Center and a training on the impact of witnessing family violence on young children and helpful solutions, a trauma informed training on how trauma impacts young children's brain development and strategies on building supportive relationships and nurturing environments organized by Lotus Bloom and Youth Uprising, a training organized by Village Connect on the Culture Based Transformative Coaching model that empowers individuals, families, groups, and community to move beyond embraced

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cultural norms that stand in the way of achieving success. These trainings helped our staff develop a model for the way in which we interact with families that participate in our programming. This fiscal year, our team members attended the Community and Family Engagement Conference. At this conference our staff attended a training on the development of the Growth Mind Set in families, a training on building successful father engagement, and a training on how to build culturally-competent programming.

Summer Program at Belding Garcia Park

In July 2018, Building Blocks for Kids continued the work at our Summer Program at Belding Garcia Park in Richmond. The focus of the summer program was to ensure that children in the Belding Woods neighborhood had access to at least one healthy meal per day and that family members had access to health promoting activities that they can do individually or together as a family. Three times a week we invited different organizations to visit the park and inform families about the services they provide in the community. In the month of July 2018 we served an average of 95 children under the age of 18 at the park. During the program, we collaborated with: Native American Health Center, Child Abuse Prevention Council, Inspiring Communities, YES Nature to Neighborhoods, East Bay Regional Park District, The Watershed Project, West Coast Chess Alliance, the Richmond History Museum and Tandem-Partners in Early Literacy. They facilitated activities with families that focused on health & wellness which included: workshops on healthy eating and living, team building activities, reading circles for children and families. Another component of the summer program was our developmental playgroups for families who had children ages 0-5. In addition to providing playgroups at Belding Garcia we also provided them at the Monterey Pines Apartments in South Richmond. Twice a week for seven weeks, parents received hands-on, bilingual guidance for building language and literacy through everyday activities. In July 2018, a total of 155 unduplicated participants attended a playgroup. Many participants of the playgroups were Nurturing Parenting class parents interested in picking up additional skills. In June 2019, Building Blocks for Kids continued the Summer Program at Belding Garcia Park.
During the first month of programming, we served an average of 87 children under the age of 18. BBK also collaborated with: White Pony Express, SparkPoint Financial Services, East Bay Regional Park District, Fresh Approach, Tandem-Partners in Early Literacy, The Watershed Project and Family Zumba. These partner organizations facilitated activities with families that focused on health & wellness which included: workshops on healthy eating and living, workshops on financial health, free food and produce, family Zumba classes, and family reading circles. This summer we also continued our developmental playgroups for families who had children ages 0-5. In addition to providing playgroups at Belding Garcia we also provided them at the Monterey Pines Apartments in South Richmond. Twice a week for seven weeks, parents received hands-on, bilingual guidance for building language and literacy through everyday activities. In June 2019, a total of 75 unduplicated participants attended a playgroup.

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Sanctuary

From the start of the fiscal calendar year, in July 2018, 93 women participated in a total of 32 Black Women's and Latinx peer sanctuary support groups received facilitated support for self-care, advocacy for self and family, setting personal goals and reclaiming positive cultural practices.

The women report loving the opportunity to have this time to connect with other women in their community. Consequently, they show up regularly and bring other women to participate in these sessions. The Sanctuary has become a space and a community for women to receive emotional support and encouragement during challenging as well as during promising times. During this period, women participating in two groups have created or refined their existing plans to promote and improve their mental health and emotional well-being. They work with Sanctuary facilitators and other group participants to support them with their wellness goals.

2) Train and support families to self-advocate and directly engage the services they need.

The women in the Sanctuary groups continue to build a network that can regularly share information about resources, such as school events, workshops and community events with other group participants. In addition to sharing information within the Sanctuary groups, participants have displayed self-agency and personal empowerment with planning topics that are covered in the groups. In the Latina Sanctuary group, participants have been very clear about the topics and resources they are interested to learn more about, including an informational workshop on financial health given by SparkPoint Financial Services and women's sexual health. Women have shared that they want to learn more about sexual health and are feeling more comfortable talking about it in the group.

3) Provide a range of parent support services for parents/primary caregivers, including cumulative skills-based training opportunities on effective parenting approaches.

Nurturing Parenting

During the 2018-2019 fiscal year, BBK and the Child Abuse Prevention Council continued our Nurturing Parenting program. We continued to offer two classes for Spanish speaking parents called Crianza Con Cariño. These classes were offered at Chavez Elementary School in Central Richmond at our Health & Healing Center. In addition to the Spanish classes, we also offered the Nurturing Parenting class at Monterey Pines Apartments, a housing development in South Richmond. During the last fiscal year, 58 parents/caregivers successfully completed the 22-week program between the three community spaces in Richmond. During the mid-point check-in one parent stated: "I love this class. It has taught me to do something for myself which was something I didn't do it all before I started coming." "I have a really good relationship with my kids now. I try to watch what I say and how I say it."

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When asked how the class had helped them, a parent shared, "This class is teaching me to be more conscious of the words I use when I communicate with my children, criticize less, be more tolerant, and listen better." Another parent shared, "I'm more conscious of my actions, and I'm learning to be more loving to myself. I understand that loving myself first will help me with my kids." Lastly, a parent shared, "I'm more patient, understanding, and most of all a better listener. This class has helped me to pause and take a moment before taking any actions or saying any words that I might regret later. I'm a better person, and a better mother because of this class."

Family Engagement Night (FEN)

During the 2018-2019 fiscal year, FEN remained focused on providing a safe, affirming environment during which families – parents and children together – are able to share a healthy meal and engage in interactive activities with service providers. Each month, a host organization provided information and materials regarding resources available to participating families and answered questions about challenges or needs. Host organizations included: BBK, the Richmond History Museum, Lifelong Medical Care, Wells Fargo, and First 5. Each host organization is a community partner with expertise in some aspect of family engagement and support and other content areas. In addition to Family Engagement Nights, BBK also provided families monthly Family Sanctuary nights. Family Sanctuary is a gathering where we invite families to strengthen their family bond. Families participate in activities that focus on deepening their relationships, strengthen their communication, and build a culture of positive social and emotional well-being within the family unit. Our ultimate goal is to offer a safe space where families feel comfortable spending quality time with their loved ones and build on their social and emotional skills to strengthen their family communication. Topics that were covered in Family Sanctuary included: Celebrating our Family History, Family Game Night, and Family Tree of Positivity. During this reporting period, we hosted 10 Family Engagement Nights at Monterey Pines Apartment with an average attendance of 15 participants at each event for a total of 146 participants. At our BBK location we hosted 11 Family Sanctuary events with an average of 19 participants at each event for a total of 215 participants.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services.

- ***Which mental illness(es) were potentially early onset***
- ***How participant's early onset of a potentially serious mental illness was determined***
- ***List of indicators that measured reduction of prolonged suffering and other negative outcomes, and data to support overall reduction. Include how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

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Outcomes

A. Parents develop knowledge base on child development and positive parenting skills

Since July 2018, 58 adults have successfully participated in a 22-week positive skills parenting class. 155 adults participated in a parent-child, skills development playgroup during the summer months of 2018. In the month of June 2019, 75 adults participated in the parent-child, skills development playgroup.

B. Service providers are responsive to mental health needs and requests of Central Richmond families.

BBK Zone families are increasingly accessing mental health services. In the last year, we have seen an increase in the confidence that Central Richmond families have in our partner mental health organizations' ability to respond to their needs. Many of our partners have improved their responsiveness by following up with us right away when asked for their assistance in guiding or referring a family who needs support. They have also been willing to come to planned activities that put them in front of families where they are able to make important connections and build rapport. We see this is as an important evolution however; it has become apparent that responsiveness doesn't quite capture all that families are looking for in mental and emotional health support. It makes sense that Central Richmond families, especially those who are high need, have a minimum expectation that they're going to be able to connect to a provider who can help them when a need arises. Getting a friendly initial response might even be enough to solve some short-term problems, but many families are looking for more from providers. Responsiveness is what families expect, but resolution is what they really need.

Measures of Success

Sanctuary

Success Measure: 100% of the mothers participating in Sanctuary report a plan for supporting mental wellness for themselves
Result: 100% of the mothers participating in Sanctuary report a plan for supporting mental wellness for themselves

Success Measure: 80% of mothers will report progress on achieving at least one wellness goal.

Result: 100% of mothers reported progress on achieving at least one wellness goal.

All mothers reported that there is at least one other person from the group that they feel comfortable checking in with about their mental and emotional state, which was a goal for all participants.

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Parent Partner

Success Measure: 75% of parents that work with a Parent Partner will report that they feel safe, confident and more knowledgeable about how to advocate for mental health services for themselves, their child or other family members.
Result: Of the parents that responded to this question, 100% reported that they feel safe, confident and more knowledgeable about how to advocate for mental health services for themselves, their child or other family members. However, many of the undocumented Latinx families reported that they still did not know where to go to get services.

Parenting Support Services

Success Measure: 85% of all participants will report an increase in their use of positive parenting skills with their children
Result: At our midpoint check-in for our most recent parenting session, 100% of parents reported that there was an increase in their use of positive parenting skills with their children.

Linkages with Service Providers
BBK will establish procedures for identifying those individuals/families that need more intensive mental health support and hence referrals to other service providers.

Families and individuals were identified from Sanctuary and Parenting Classes and referred for services by members of the Health and Wellness team. It continues to be difficult to refer undocumented families for mental health services because of the dearth of services available to them.

Success Measure: 70% of families identified as needing mental health services will be successfully linked to providers.

It continues to be difficult to refer undocumented families for mental health services because of the dearth of services available to them. During this reporting period, two (2) program participants were referred to external mental health support services. Referral were made to Youth Service Bureau and the Center for Recovery and Empowerment (C.O.R.E).

Many BBK participants were referred to external support services such as those helping with, legal issues, childcare and short term financial crisis. From July 2017 to June 2018, BBK staff made five (5) referrals to internal and external support services. (For a total of 26 unduplicated clients.) Many BBK families consistently experience income volatility and are vulnerable and are negatively impacted when monthly income dips or there are unexpected increases in rent. Gentrification and displacement impacting the Bay Area region are currently impacting Richmond families. For our participants, the well-founded fears of losing their housing or difficulty finding money to cover a $100+ rent increase is extremely stressful and hard to mitigate. These financial pressures greatly impact the emotional and mental well-being of the families we serve.

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DEMOGRAPHIC DATA: ☐ *Not Applicable (Using County form)*

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

Unduplicated BBK program clients
1 July 2018 – 30 June 2019

From July 2018 to June 2019, BBK served a total of 438 unduplicated West Contra Costa County residents. Among the participants, 205 (52.21%) were under the age of 18 and 224 (47.79%) were adults.

Race & Ethnicity

Overall, BBK's participants closely reflect the racial and ethnic demographics of Richmond's Iron Triangle neighborhood. Latinx comprised 73.74% of program participants and 61.1% of residents in the Iron Triangle census tracts. African Americans represent 20.95% of participants in the 2018-2019 fiscal year. and 24% of Iron Triangle residents. According to 2017 U.S. census estimates, ninety-four (94%) percent of South Richmond residents are people of color; 37% are African Americans and 49% are Latinx.

	BBK Clients		Iron Triangle Residents*	South Richmond Residents**
	Count	%		
African American	79	22.19%	24.7%	37.7%
Asian Pacific Islander	2	0.56%	6.9%	7.16%
Caucasian	0	0%	4.6%	4.27%
Latino/a	258	72.47%	61.1%	49.6%
Other Specified	17	4.78%	.5%	1%
Unspecified	0	0%		

*Source: US Census. 2012-2016 American Community Survey 5-year estimates. Includes CT3760, CT3770, CT3790, CT3810, CT3820. (details)

Monthly Client Counts

BBK served on average, between 148 and 278 residents each month — (BBK's large community summertime events make this number difficult to generalize.)

Gender

Most of BBK's clients are women and girls. 269 (72.51%;) percent of participants are female. 102 (27.49%;) percent of participants are male – these are mostly boys in BBK's childcare and family programs. (The gender of 17 clients was unspecified.)

Language Spoken

Because of the changing demographics of the Iron Triangle neighborhood and talents of the bilingual/bicultural staff at BBK, more than 229 (64.87%) of BBK program participants speak Spanish as their preferred language. 123 percent (34.84%); speak English. (The preferred language spoken was categorized unknown or unselected by 85 clients)

BBK's successful Belding-Garcia Park Playgroups and Latina Women's Sanctuary are attended mostly by Spanish-speaking women and the children in their care. This is due largely to the location of the programs at/near Cesar E. Chávez Elementary School. During the school year, eighty-nine percent (89%) of the students at Chávez Elementary are Latinx. Sixty-four percent (64%) of students are English Language Learners. Nearly all (94%) students at Chavez Elementary are low-income based on qualifying for free and reduced lunch. (Source:http://www.ed-data.org)

Justification for Selected Demographics.

1. Collecting extensive demographic information from our drop-in clients has been unfeasible and not suitable or proper in specific programmatic circumstances.

BBK's mental health prevention work is offered only in group settings (both small and large groups.) We have found that collecting detailed demographic information regarding each person's ethnicity, sexual orientation, gender at birth, and disability status using a self-administered MHSA demographic form was not feasible. At the time of BBK program registration, we are consistently limited to less than 1 minute per individual. Adults typically register themselves and each of their children (often up to 4).

It is important for BBK to understand who our clients are and to assess that we equitably serve Richmond families. As detailed in the report above, we routinely collect essential demographic fields (adult/child, race, gender, preferred language) on specially tooled dual-language sign-in sheets. (Available upon request.) Many of our participants are not strong readers in English or in Spanish. All self-administered forms must be simple and easy to understand/complete within a room full of distractions.

With the exception of the adults attending our Nurturing Parenting classes (only during weeks 6 through 22) –all other BBK program participation is on a drop-in basis. Many drop-in clients find even

the most familiar demographic information too personal or immaterial to their attendance. Sometimes it is necessary to piece together a client's demographic profile over time using personal identifiers and sequential sign-in sheets. We view this as part of building a trusting client relationship, and is only possible among clients who continue their group participation.

2. Some demographic information is not pertinent to most of the individuals and families we serve and not an efficient use of time and resources

BBK serves very few or no veterans. They are not excluded from our programs, just uncommon in the populations we serve. As stated above, we serve women and children who live in the Iron Triangle neighborhood (CT3760, CT3770, CT3790) and the nearby Belding-Garcia neighborhood (CT3730.) In these census tracts, the percent of female veterans is estimated U.S. Census Bureau to be 0%-0.7%. We served very few adult men in our programs. Men constitute 80%-100% of U.S. veterans living in our program service area. In FY 2018-2019 BBK can expect to serve fewer than 2 veterans among our total estimated 500+ clients based on Census data.

The inconvenience to clients to request additional information that is not pertinent to them and repetitive data entry for a null value isn't the best use of the limited time that families spend during BBK programs. Therefore, we do not include veteran status among the demographic variables we collect. (Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates)

EVIDENCE-BASED OR PROMISING PRACTICES:
What evidence-based or promising practices are used in your program and how is fidelity to the practice ensured?

The Nurturing Parenting classes that we offer families is an evidence-based program for parents and caregivers and their children to learn positive and caring nurturing skills. Nurturing Parenting is a trauma informed, family-based program designed for the prevention and treatment of child abuse and neglect. Family Development Resources, Inc. provides programmatic materials, training and ongoing technical assistance to support program implementation. Training and support are also provided by Family Nurturing Centers, International which are organizations licensed by the Family Nurturing Center's national office to provide training, technical assistance, and services by nationally and internationally recognized trainers and consultants. Our team meets weekly to plan activities for the children's program and e use the Nurturing Parenting program manual to ensure that all activities are aligned with what is being taught in the parent program.

VALUES:
Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

Since its founding in 2005, BBK has been a community of social innovators working to support Black and Latin families in Central Richmond. We support families to use their voices and experiences to directly inform the systems they interact with and which impact them.

Beginning last fall, BBK launched a strategic planning process to guide our theory of change for the next 3-5 years. We identified programmatic shifts to achieve a values-aligned structure and practices that support our new mission and vision. BBK envisions empowered communities that are wellness-centered and have equitable access to high-quality education, where healthy families blossom to realize their dreams and full potential. An important outcome of our strategic planning process was for BBK to have organizational clarity that allows integration and innovation of community change strategies that result in improved well-being for children and families in Richmond and surrounding West Contra County. Moving forward, our three core strategies are parent-led advocacy, healing-centered care and leadership development. These strategies drive our mission to amplify the voices of parents/caregivers of color and partner with them to advance equitable access and opportunities for all youth to have a quality education and all families to achieve emotional and physical well-being. Our staff will continue to keep families' health & wellbeing at the forefront of our work in all of our programming. Our new approach continues to align with and bolster MHSA's PEI goal of **providing activities intended to reduce risk factors for developing a potentially serious mental illness, and to increase protective factors**.

BBK's theory of change is simple and enduring: by providing healing centered care, leadership development, and activating inclusive parent-led advocacy, we support the personal and collective transformation of parents and caregivers as they reclaim their power. Furthermore, we seek the transformation of education and health systems, so that all youth achieve success and all families experience positive emotional and mental well-being. We collaborate with families to overcome trauma and barriers so that they may strengthen their ability to support their children, family, and community toward healthy, successful development. Efforts focus specifically on ensuring the well-being of parents and supporting parents to determine long term success for their children. We do this by offering nurturing and culturally responsive environments where parents can heal and identify practices that promote well-being. We also help parents make direct linkages to mental health tools and resources that may not otherwise be accessed. Furthermore, we provide skills-based training that develop the leadership capacity of parents/primary caregivers. Our ultimate aim is that Richmond and West County parents/primary caregivers' effect positive changes in home, schools and neighborhoods to ensure that they are responsive to the needs of families and children.

VALUABLE PERSPECTIVES:
Please include the stories and diverse perspectives of program participants, including those

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of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

BBK continues to commit to the growth and development of our program participants such as Rihana Idris and her family. Through our work at Monterey Pines Apartments we had the honor of meeting. Rihana when she registered for Nurturing Parenting classes. Rihana built relationships with BBK staff, fellow classmates and neighbors and became very interested in BBK programming at Monterey Pines and became a regular participant in the Black Women's Sanctuary group and Family Engagement Night. Rihanna always invites family members, friends and neighbors to our events and activities. Recently Rihana shared that, "the Nurturing Parenting Program and the Family Engagement Night events have helped me be closer with my children and devote more quality time to myself and them." "I really value what I have learned in class." "I now take the time to take care of myself and do things to make me feel relaxed, like go to the movies for example." "I feel very excited and motivated to continue to learn. As a result of taking the Nurturing Parenting program, I signed up for English classes at Berkeley Adult School."

We have had the pleasure of working with Claudia Castro another program participant. Claudia was introduced to BBK at Chavez Elementary School, the school her son attended. Claudia is a regular participant of the Latina Sanctuary group and the Crianza Con Cariño classes. She shares that participating in BBK programming has helped her have a better relationship with her family and believe and value herself. She shares that before she participated in BBK programming she felt very depressed and alone because she does not have a lot of family, but now all that has changed. She says that the groups have allowed her to see that there's a world outside of her family, and has learned who she is as an individual. "These programs have helped me value myself and get rid of the negativity." "They've also helped me be a better mom and wife." "I no longer feel alone." As a result of participating in BBK programming and her increased confidence, she is now taking English classes at her son's school. She's gotten a part- time job at a local restaurant, and volunteers at her son's school. She is making positive changes in herself, her family, and her school community.

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PEI ANNUAL REPORTING FORM

Due: August 15, 2019

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR: 18-19

Agency/Program Name: Center for Human Development - African American Wellness Program

PEI STRATEGIES:
Please check all strategies that your program employs:

☐ **Provide access and linkage to mental health care**

☑ **Improve timely access to mental health services for underserved populations**

☐ **Use strategies that are non-stigmatizing and non-discriminatory**

SERVICES PROVIDED / PROGRAM SETTING:
Please describe the services you provided in the past reporting period. Please include who the program has targeted and how your services have helped in improving access to services. Where are services provided and why does your program setting enhance access to services?

Center for Human Development's African American Wellness Program provides prevention and early intervention services that empowers clients to: 1. Increase emotional well-being. 2. Decrease personal stress and isolation. 3. Increase their ability to access culturally appropriate mental health services.

During the course of the contract, staff will provide MHSA-PEI services to African Americans living in Bay Point, Pittsburg and surrounding East County Communities. The annual goal is to reach 200 unduplicated individuals From July 1, 2018 through June 30, 2019.

Key activities included culturally appropriate education on mental health topics through three open ended Mind, Body and Soul support groups; community health education workshops; outreach at health –oriented community events; and navigation assistance for culturally appropriate mental health referrals.

Taylor Morgan, former Community Health Advocate, Risha LaGrande, and Michelle Moorehead, current Community Health Advocates, co facilitated the services listed below from January 1, 2019

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through June 30, 2019. Ms. Morgan was a full-time employee of the Center for Human

Development, working with Risha LaGrande and our participants of the Mind Body and Soul support group. East County Office location is at the Sparkpoint Center in Bay Point. Through collaboration with Sparkpoint and seeing the valuable resources that the African American Wellness Program provides to participants and the local community. We are able to have office space while collaborating with their services.

The program activities during the 6 month period included the following:

Facilitate four Mind, Body, and Soul support groups in four separate locations:

- **Pittsburg Health Center**, Pittsburg, first and third Monday evening, 12 open-ended, ongoing sessions.
- **Ambrose Community Center**, Bay Point, first and third Wednesday afternoon, 12 open-ended, ongoing sessions.
- **Pittsburg Senior Center**, second and fourth Wednesday afternoon, Pittsburg, second and fourth Wednesday afternoons, 12 open-ended, ongoing session.
- **Antioch Library, Antioch**, second and fourth Thursday evening, 12 open-ended, ongoing sessions.

Facilitate Community Mental Health Education workshops based and community-based organizations in East Contra Costa County.

Conduct outreach services at community events in East Contra Costa County.

Provide navigation of health services, including mental health referrals, for new and continuing clients in East Contra Costa County.

The four Mind, Body, and Soul support groups follow the same format. Often the same topics are presented in the different groups. The topics are related to “Emotional Wellness” which is the term that is more welcoming than “Mental Health” for many African Americans. Guest speakers are often featured as well. Besides the topic and discussion, each session includes a “fellowship” time with healthy refreshments. This “fellowship” time is culturally appropriate for African American participants and is an initial “draw” to the groups.

As of January 1, 2019, the African American Wellness Program went through a few changes to the Mind Body and Soul Support Groups that Ms. Morgan and Mrs. LaGrande facilitated. One of Ms.
Taylor’s objectives were to reduce the stigma attached to the label “mental health” for participants in the Mind Body and Soul Support Group. Another objective was to make the support groups more accessible. Morgan and LaGrande attempted to increase the participation young adults from the community. The changes were made to the scheduled meeting times for the Pittsburg Health Clinic. The afternoon group switched to an evening time slot to appeal to a younger demographic who were either at school or work during the day. Also, a group was added to serve the residents of Antioch.

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During this six month period starting January 1, 2019 through June 30, 2019, Taylor Morgan created a curriculum for the support groups to grow in areas of self-worth and knowing their true value.

Curriculum

Always reiterate self-worth, give value to one another and allow them to envision the benefits of taking care of themselves is a necessary part of life. Sharing daily with the group shows they are worth it and reminds them that helping others mean they have to help themselves first.

1. ***Pittsburg Health Clinic, Mind, Body, and Soul Support Group***, first and third Monday evening, seven (7) open-ended, ongoing sessions.

From January 1, 2019 through June 30, 2019, the group met 7 times. Two (2) of the location's group days fell on a Holiday both in the months of January and February which is the reason for minimum groups.

- Topics presented: Life Cycle and the Whole Person; Hypertension Prevention; Social Health; Powerful vs. Un-Powerful People (KYLO chapter 1); Emotional Wellness-Processing Emotions; Spiritual Wellness-How to Fill Your Spiritual Tank; Overall Wellness for "The Whole You"

2. ***Ambrose Community Center, Mind, Body, and Soul Support Group***, first and third Wednesday afternoon, twelve (12) open-ended, ongoing sessions.

From January 1, 2019 through June 30, 2019, the group met 12 times.

- Topics presented: Life Cycle and the Whole Person; Hypertension Prevention; Social Health; Powerful vs. Un-Powerful People (KYLO chapter 1); Emotional Wellness-Processing Emotions; Spiritual Wellness-How to Fill Your Spiritual Tank; Overall Wellness for "The Whole You"

3. ***Pittsburg Senior Center, Mind, Body, and Soul Support Group***, second and fourth Wednesday afternoon, nine (9) open-ended, ongoing sessions.

From January 1, 2019 through June 30, 2019, the group met 10 times. Two of the days missed were due to facilitators out sick and the community center repainting interior building.

- Topics presented: Life Cycle and the Whole Person; Hypertension Prevention; Social Health; Powerful vs. Un-Powerful People (KYLO chapter 1); Emotional Wellness-Processing Emotions; Spiritual Wellness-How to Fill Your Spiritual Tank; Overall Wellness for "The Whole You"

4. ***Antioch Library, Mind Body and Soul Support Group***, second and fourth Thursday evening, six (6) open-ended ongoing sessions.

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From January 1, 2019 through June 30, 2019, the group met 6 times. Some groups during the month of May and June were cancelled due to transitional period between the former Community Health Advocate, Taylor Morgan and the current Community Health Advocate Michelle Moorehead.

The African American Wellness Program has a goal to facilitate Community Mental Health Education Workshops, attend outreach events, and community-based organizations in East Contra Costa County. Unfortunately, no workshops were offered during the first half of the fiscal year. The program made an effort to make up missing workshops in the following six-months of the fiscal year.

From January 1, 2019 through June 30, 2019, one (1) health-oriented workshop event was conducted to educate the community.

- ***Hello Me! Wellness Workshop***- May 11, 2019; Community Awareness Reached 15 people

From January 1, 2019 through June 30, 2019, six (6) community outreach services were conducted Locations and Topics included below.

- ***Job Club Presentation***- February 04, 2019 Reached 7 people
- ***Black History Event***- February 16, 2019 Reached 104 people
- ***Sexual Assault Awareness Event***- February 27, 2019 Reached 18 people
- ***Mother's Day Gala***- May 4, 2019 Reached 35 people
- ***Memorial Celebration***- May 27, 2019 Reached 14 people
- ***Unity In Community***- June 22, 2019 Reached 77 people

The African American Wellness Program provided navigation of health services, including Mental Health referrals, for new and continuing participants in East Contra Costa County, for a minimum of 90 clients.

From January 1, 2019 through June 30, 2019, Mental Health service referrals were provided to 17 new clients.

From January 1, 2019 through June 30, 2019, Community Support Service referrals were provided to 16 new clients. The combined Mental Health referral and community resource/referral total to 33 new client referrals.

Referrals, including mental health referrals, were made to these groups: Crisis Center 211, Contra Costa Mental Health Access Line and community resources. It is important to consider all referrals due to the necessity of immediate needs, such as food, water, shelter, and regular physical medical care being met before mental health can be addressed and maintained.

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OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***How are participants identified as needing mental health assessment or treatment?***
- ***List of indicators measured, including how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***
- ***Average length of time between report of symptom onset and entry into treatment and the methodology used.***

For July 2018 to December 2018, the program served 147 individuals, however only 107 individuals are accounted for on the roster; the data and percentages that were calculated are based on these numbers recognized on the roster. The African American Wellness Program underwent a transition when the previous community health advocate, Cynthia Garrett, left her position at the Center for Human Development in July of 2018 and the new community health advocate, Taylor Morgan, started in the position on September of 2018. Due to the transition there were some missing files/names that were unaccounted resulting in individuals recognized as unduplicated in monthly reports to be unrepresented in the reports and roster. As mentioned before, there were fewer workshops and outreach events completed during the first half of the fiscal year.

Going forward, date will be saved in triplicate on the computer, on a thumb drive, as well as in a hard copy file system according. The numbers reported in this narrative and the reporting forms represent program participants and community members, which were identified as needing Mental Health services and support provided by the African American Wellness Program: the Mind, Body & Soul Psycho-educational Support groups, Community Education Workshops, Community Outreach, including health fairs and similar events, and one-on-one consultations for referrals and system navigation.

CHD has been working with an evaluator to develop Pretest and Posttest surveys to measure the knowledge, awareness, attitude and behavior change for participants in Mind, Body and Soul groups. The instrument has 17 questions, which can be compared after the Posttest has been tabulated.

CHD will use Posttest tabulated to complete results June 2019 for the final results.

DEMOGRAPHIC DATA: ☐ Not Applicable ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form <u>AND</u> have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

African American Wellness Program Roster for Support Groups from July 2018 through June 2019 totals 123 unduplicated attendees. For the year including the workshops and events we totaled 342 people and 114 of our outreach came from our newly added Social Media page on Facebook.

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This was another addition that began in the month of February 2019 to strictly outreach and get the young adults to gather in person for our Mind Body and Soul Support Groups in one of our four locations.

LINKAGE AND FOLLOW-UP:
Please explain how participants are linked to mental health services, including how the PEI program: 1) provides encouragement for individuals to access services; and 2) follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

Participants, who attend the Mind, Body & Soul Support Groups, receive an assessment tool to identify barriers. Participants are individually provided services to help them to address the current issues they are facing. Participants are referred to Contra Costa Crisis Center 211, Mental Health Access Line and community resources. The program manager and resident leader assist participants by helping them to navigate through the systems so that they can receive care and learn to advocate and navigate for themselves in the future. The community health advocate will call the Mental Health Access Line with participant, ensuring participant to get an appointment. The community health advocate also supports clients by attending their doctor's appointments to help in supporting and advocating for the client's care and help to create effective communication and mutual understanding between the client and their provider.

The appointment is scheduled from initial phone call. The time for scheduling an appointment and seeing a therapist or other provider time frame is up to 3 weeks. The program manager and resident leader follow up with participants within a week to check on progress.

The Healthy living questionnaire is administered to every Mind, Body & Soul Support Group participant in the beginning of the year. Based on the assessment this tool provides staff with information about participant's emotional wellness and the need for individual check in and possible referrals.

VALUES:
Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

The African American Wellness Program serves adults ages 18 and older, living in East Contra Costa County. African American Wellness Program supports their clients and participants by empowering them to recognize and achieve inner strengths, use coping strategies to maintain emotional wellness, and providing tools, resources, and referrals for increasing their emotional wellness and reducing client stress and isolation. The program creates a welcoming, safe and confidential environment for their participants.

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The Mind, Body & Soul Support Group helps give the participant hope, while facing challenges by helping them to address and overcome barriers such as; homelessness, no medical coverage, lack of transportation, lack of shelter and lack of food. African American Wellness Program supports their participant's needs by linking clients, who are low income and disadvantaged due to lack of resources. The African American Wellness Program serve the community by reaching out to many people have lack of outreach engagement to Mental Health Services, Community Resources and referring them to the appropriate medical service providers. Participants enter the program through word of mouth, referrals, community outreach and mental health Pittsburg Health Clinic. The key activities are as follows: Outreach at Community Events, Culturally appropriate education on mental health topics through the Mind, Body & Soul Support Groups, Community Health Education Workshops in accessible and non-stigmatizing settings. We offer navigating assistance for the culturally appropriate, Mental Health Referrals as early in the onset as possible.

Participants in Mind Body & Soul Support Groups generally report a feeling of resiliency. In other words, the group is the supportive system they need to begin the healing process from the hardship or trauma that may have encountered their lives unexpectedly. We strive to teach the very tools and techniques that will help to defuse a crisis situation by using some of our self-care practices such as breathing, mindfulness, taking a brief walk, etc. The Mind Body & Soul Support Groups attempted to appeal to young adults ages 18-29 years, with new evening classes as well an online way to inform the community of our services. We got inquiries from numerous interested participants from a Social Media page. Although, we found many were not comfortable with participating in an in-person group setting. We were able to provide linkages to needed resources and referrals. Former Community Health Advocate, Taylor Morgan, conducted one-on-ones to assess health needs and basic needs, collect intake information and follow-ups, and provide navigation and referral information.

Our numbers dropped significantly due to a change of time for the Pittsburg Health Clinic Group and an added, still forming group located in the Antioch area. Community Health Advocate, Michelle Moorehead, reconnected with the Pittsburg Clinic to arrange a new day and time to meet. Now that we have ongoing classes at the clinic, the numbers have picked up again and we are confident that the Mind Body & Soul Support Group will continue to grow. As of September 2019, we have located another site for Antioch group, which we also hope will boost attendance.

VALUABLE PERSPECTIVES:
Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

Success Stories:

Story #1

R.M. is one of our male participants, age range 26-59 years old. He has attended the Mind, Body and Soul (MBS) Support Group. He is a long term participant of the program. R.M. came to the group for support for depression, and heart disease. During his time attending he was diagnosed Diabetes and High blood pressure. He was given referrals for diabetes classes, and hypertension classes. As a result, R.M. has managed to learn how to eat better, and walk more. His health has improved from the changes he has made attending the support group, and using the referrals, tools and techniques learned in our support group.

Story # 2

V.M. is one of our female participants, age range 60+ years old. She has attended the Mind, Body and Soul (MBS) Support Group. She is a long term participant of the program. V.M. came to the group from a referral from another participant. She needed emotional support regarding daughter diagnosed with Cancer. V.M. was given referral to Mental Health Services Access line. V.M. has improved from counseling and attending M.B.S. support group. She also has been walking, and eating healthier, which is helping her a great deal emotionally. She continues to attend the group because of the warm family atmosphere.

Story # 3

V.T. is one of our female participants, age range 26-59 years old. She has attended the Mind, Body and Soul (MBS) Support Group. She is a long term participant of the program. V.T. came to the program for support for anxiety. During her time attending she was diagnosed with High Blood Pressure. She was given a referral for a Hypertension class. V.T was assisted in changing her Primary Care Dr. Her new doctor helped her focus on her current health challenge better. V.T. has improved a great deal attending M.B.S Support group. She has changed her eating habits to a Low-Salt diet, working with her Primary Care doctor and receiving emotional support from the group. She can now face her health challenges.

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PEI ANNUAL REPORTING FORM

Due: August 15, 2019

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR: 18-19

Agency/Program Name: Center for Human Development – Empowerment Program

PEI STRATEGIES:
Please check all strategies that your program employs:

☑ **Provide access and linkage to mental health care**
☑ **Improve timely access to mental health services for underserved populations**
☑ **Use strategies that are non-stigmatizing and non-discriminatory**

SERVICES PROVIDED / PROGRAM SETTING:
Please describe the services you provided in the past reporting period. Please include who the program has targeted and how your services have helped in improving access to services. Where are services provided and why does your program setting enhance access to services?

Center for Human Development's Empowerment Program provides weekly support groups, youth leadership groups, and mental health resources for lesbian, gay, bisexual, transgender, queer, questioning (LGBTQ+) youth and their heterosexual allies, ages 13 – 18, in East Contra Costa.

The annual goal is to reach 80 unduplicated youth from July 1, 2018 through June 30, 2019. During the course of the contract, staff will provide the following services:

Component 1: Facilitate educational support group sessions at Pittsburg High School in Pittsburg, twice per week during the academic school year, totaling at least forty (40) but not more than fifty (50) open-ended group sessions.

Component 2: Facilitate one (1) weekly educational support group sessions at Deer Valley High School, Antioch during the school year; totaling at least twenty (20) but not more than twenty-five (25) sessions.

Component 3: Facilitate one (1) weekly educational support group at Rivertown Resource

Center (or satellite office) in Antioch, Wednesday afternoons totaling at least thirty (30) but not more than thirty-six (36) open-ended ongoing sessions; this group meets year round; educational support groups contain a social-emotional support component along with educational discussions, workshops, activities related to LGBTQ identity, culture, relationships, mental health and wellness.

Component 4: Facilitate twice-monthly youth leadership groups totaling at least sixteen (16) but not more than twenty (20) ongoing sessions at Rivertown Resource Center, Antioch.

Component 5: Facilitate four (4) per year youth-led community service projects and skill-building field trips.

Component 6: Refer youth to culturally appropriate mental health services on an as needed basis including referral support to a minimum of 15 youth.

Component 7: facilitate monthly educational workshops and/or informational speakers at Rivertown Resource Center including nine (9) workshops annually.

Component 8: Facilitate community educational outreach/psycho-educational workshops including four (4) per year.

Kevin Martin, Empowerment Program Coordinator, facilitated the following services from January 1, 2019 through June 30, 2019. Mr. Martin is a full-time employee, working 40 hours per week on the project. During this reporting period, Empowerment has worked with 91 unduplicated youth, for an annual total of 137, which far exceeds our annual goal of 80 unduplicated youth.

Component 1: Facilitate 40 to 50 weekly meetings at Pittsburg High School, Pittsburg for LGBTQ+ youth and their allies to promote emotional health, positive identity, and reduce isolation through life skill development. Providing services at this location helps to increase access in several ways: it eliminates the need for additional transportation, as students are already at school; there is a network of supportive school staff and service providers working at Pittsburg High School, allowing for expedient linkage to additional support services as needed; and youth are more inclined to engage in support services, including Empowerment, when they can do so with, or supported by their peers and with reduced anxiety of being "outed" to their parents, or guardians.

> From January 1 through June 30, 2019, Kevin Martin facilitated 21 sessions of youth support groups on the campus of Pittsburg High School, for an annual total of 31. The number of meetings is below the goal of 40 to 50 sessions for the year. This is primarily due to conflicts with students' class schedules; several students note not being willing or able to be pulled from certain required classes. For this reason, Kevin was not able to form a second group until late in the year. Also, although the school has designated one classroom for support programs to facilitate groups, there is still a shortage of confidential meeting space at this site; service providers and school staff are constantly juggling

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available space and time to meet with students. Even with this challenge, CHD staff continues to receive new referrals from school staff, students and service providers on campus, and, as previously noted, has establish a regular time to meet with a second group at Pittsburg High School, in order to meet this need. The average group attendance for this period was 5. Low attendance was 2 and high attendance was 8. These groups did not meet during "dead week" (final exam prep), during finals week, or while the school was closed for recess in April and June. Staff continued to work closely with school staff and other service providers on campus to secure space for groups, as providing services at Pittsburg High School fills a need for youth who have difficulty with transportation to Antioch, and/or are not "out" in some aspect of their life (i.e. peers, family, or community). CHD also staff conducted 68 individual check-ins and one-on-one assessments with students during this period.

Topics for the Pittsburg group included: group development, establishing group norms, conflict after relationships end, addressing personal boundaries with friends, characteristics of healthy friendships, closing unhealthy relationships, healthy romantic relationships, social group conflict, disconnecting from peers after graduation, closing relationships with friends (how to have difficult conversations), sharing mental health concerns with family, coming out to family, stress management, time management, identity, reconnecting with family after coming out, coming out to extended family, applying for a job, LGBTQ Pride, self-care, end of year concerns, Prom, mental health awareness, group closure.

Component 2: Facilitate 20 to 25 weekly meetings at Deer Valley High School, Antioch for LGBTQ youth and their allies to promote emotional health, positive identity, and reduce isolation through life skill development. Providing services at this location helps to increase access in a few ways: it eliminates the need for additional transportation, as students are already at school; youth are more inclined to engage in support services, including Empowerment, when they can do so with, or supported by their peers and with reduced anxiety of being "outed" to their parents, or guardians; and until very recently, CHD's Empowerment Program has been the only external mental health service providers working with LGBTQ+ youth at Deer Valley High School, allowing LGBTQ+ students access where otherwise there would not be any.

From January 1 through December 30, 2019, Kevin Martin facilitated 17 sessions of youth support groups on the campus of Deer Valley High School, for an annual total of 24. The number of meetings meets our goal of 20 to 25 sessions for the year. This group saw exponential growth during this period, largely due to word of mouth by participants and referrals from school counselors. This school runs on a block schedule, group is held during the final hour of the school day. Staff continued to receive referrals from school staff and students right up to the end of the school year, indicating the high level of need for this population in this area. Average group attendance for this period was 9. Low attendance was 5 and high attendance was 13. This group did not meet during "dead

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week", during finals week, or while the school was closed for recess in March and June. CHD also staff conducted 25 one-on-one meetings with students during this period.

Topics for the Deer Valley group included: group development, highs and lows of winter break, artistic expression, identifying feelings, characteristics of healthy friendships, characteristics of healthy romantic relationships, Queer Black History, gender versus sexual orientation, health issues for youth at Deer Valley High School, stress management, time management, Spring break highs and lows, "Every 15 Minutes" and alcohol awareness, communicating in relationships (asking for what you want), LGBTQ Pride, group closure.

Component 3: Facilitate 30 to 36 weekly meetings at Rivertown Resource Center, Antioch for LGBTQ+ youth and their allies to promote emotional health, positive identity, and reduce isolation through life skill development. Providing services at this location has challenges, but is the only year round, drop-in support program for LGBTQ+ youth in East Contra Costa County, providing access to youth from Bay Point, Pittsburg, Antioch, Oakley, and Brentwood.

From January 1 through June 30, 2019, Kevin Martin facilitated 20 sessions of youth support group in Antioch, for an annual total of 42. The group met at Rivertown Resource Center at 10th and D Streets. The number of meetings exceeds the goal of 30 to 36 sessions for the year. There was a shift in attendance during this period, with a slight increase toward the end of the year. This shift was due to several factors, increased family obligations, a lack of consistent transportation to and from group sessions, after school conflicts, and lack of parental or guardian support. The increase was due to the school year coming to a close and an increase in parental support for help seeking. This group had an average attendance of 5 youth per session for this reporting period. Low attendance was 2 and high attendance was 11. Staff noted that attendance spiked when schools were not in session and when special social events were scheduled. Staff addressed the challenge of transportation by utilizing CHD's agency van to pick up and drop off youth for this group. CHD staff also conducted 50 one-on-one meetings with youth during this period.

Topics for the Rivertown group included: group development, highs and lows of the holidays, creative expression through art, self-care, characteristics of healthy friendships, characteristics of healthy romantic relationships, Queer Black History, stress management, LGBTQ Pride artistic expression, "Love Simon" movie screening, avoiding isolation, mental health awareness, deterrents to seeking mental health support, Empowerment art project, processing grief and loss of a close friend, "The Pride Movement" film screening, LGBTQ Pride, "Milk" film screening, LGBT activism, and highs and lows of the East County LGBTQ+ Youth Pride "Justice" Prom.

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Component 4: Facilitate 16 to 20 twice-monthly youth leadership groups to foster community involvement. These groups meet at Rivertown Resource Center and are held in conjunction with support group meetings discussed in Component 3.

From January 1 through June 30, 2019, the youth leadership group met 3 times, for an annual total of 7 sessions, which is below our goal of 16 to 20 sessions for the year. The group met at Rivertown Resource Center at 10th and D Streets. The average attendance was 2, with 2 being a low and 2 being a high. Consistent attendance to Leadership sessions has been a challenge, so staff is to meet with Leadership around regular Empowerment group meetings at Rivertown Recourse Center. This is exposing more members to Leadership and helping to address challenges associated with jobs, after school schedule conflicts and transportation hurtles, which are also noted challenges for Component 3.

Though engaging a group for Leadership was a challenge, staff was able to identify a dedicated Youth Leader, who was tasked with leading the planning and coordination of our LGBTQ+ Youth Pride "Justice" Prom, with the support of staff and in collaboration with Rainbow Community Center staff. Staff met and worked with this Youth Leader several times, for a total of 31 hour, throughout April, May and June. This Youth Leader was given a stipend for their work and leadership on this project.

When Leadership met, they focused on activities to support and promote our LGBTQ+ Youth Pride "Justice" Prom and our fieldtrip to the Castro District and GLBT History Museum. CHD staff also conducted 4 individual 1-on-1's meetings with youth during this period

Component 5: Facilitate 4 youth-led community service events or fieldtrips to foster community involvement. These events occur in various locations, increasing East Contra Costa County LGBTQ+ youth's knowledge, experience of, and access to a range of surrounding communities, programs and support services.

With 2 youth-led events or fieldtrips during this period, we met our goal of 4 events or fieldtrips for the year.

June 14 - East County LGBTQ+ Youth Pride "Justice" Prom. In collaboration with our community partner, Rainbow Community Center, our Youth Leader and staff planned and hosted the only Pride Prom for LGBTQ+ youth in East Contra Costa County. The event was held at Community Presbyterian Church, and open, welcoming, and LGBT affirming church in Pittsburg. The event was held from 6pm to 10pm and was attended by 58 area youth. This event gives area LGBTQ+ youth an opportunity to celebrate LGBT Pride month locally in a safe and supportive environment. Youth were engaged in group games, music and dancing, an affirmation wall, a photo/selfie booth, and fun contests. All

attendees were given safety/self-care resources and promotional materials for the Empowerment Program and Rainbow Community Center services.

June 26 – Fieldtrip to the Castro District and GLBT History Museum, in San Francisco. Empowerment took 16 youth and 4 adult chaperones to the Castro District, in San Francisco using public transportation. Youth gained knowledge and experience using both BART and MUNI public transit systems. Upon arrival in the Castro District, attendees were treated to lunch at "Harvey's Restaurant", a local bar and restaurant themed to honor San Francisco's first Gay Supervisor, Harvey Milk. Attendees were then taken on a guided walking tour of several of the district's LGBTQ+ historical sites. Guided by a "Cruisin' the Castro" guide, attendees visited the Pink Triangle Garden (a memorial garden honoring the more than 15,000 gay men who were imprisoned and killed during the Holocaust), the building where the Name Project started the Memorial AIDS Quilt, Lyric's youth center, the Harvey Milk Civil Rights Academy (the district's elementary school with a specific focus on civil rights and activism celebrating diversity and inclusion), and the Human Rights Campaign's (HRC) store located in the location of Harvey Milk's camera shop and campaign headquarters. At the conclusion of the walking tour, attendees visited the GLTB History Museum, the country's first dedicated to the LGBTQ+ history and civil rights movement. Here attendees received a tour led by a docent who shared historical information and stories for each of the displays in the museum.

Component 6: Refer youth to culturally appropriate mental health services on an as needed basis, referral support to a minimum of 15 youth.

Specific referrals for new mental health support were made for 3 youth during this period, for a total of 7 for the year. This number is short of our target of 15 annual referrals. One was made for youth at Pittsburg High School, one was made for a youth at Rivertown Resource Center, and one was made for a youth at Hillview Junior High School. Referrals were made to SEEDS for peer conflict mediation, Rainbow Community Center for therapy, and Community Violence Solutions for therapy. All Empowerment participants also receive an emergency phone list with listings for the Contra Costa Crisis Center, Trevor Project, GLBT Youth Talk-line, Planned Parenthood, Homeless Hotline, Run Away Hotline, Community Violence Solutions, and STAND Against Violence.

It is important to acknowledge that many of Empowerment's participants, this year, were referred to CHD's Empowerment program for additional social-emotional support from other mental health providers. Thus, these participants were already connected and engaged in culturally appropriate mental health services, rendering additional referrals unnecessary.

Component 7: Facilitate monthly educational workshops and/or informational speakers at Rivertown Resource Center including nine (9) workshops annually.

As was noted in our semi-annual report, due to the attendance and transportation

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challenges noted in components 3 and 4, staff has held off scheduling outside speakers and presenters this year. As an alternative, staff started a new educational support group at a new school, Hillview Junior High School, in Pittsburg, CA, in response to a call for support from the school's administrators, after a series of bullying incidents. This was not only an opportunity mitigated challenges with transportation to Rivertown Resource Center, in Antioch, but also directly meets current needs in the community while increasing the reach and potential impact of CHD's Empowerment Program serves.

Staff held 9 group sessions, beginning in March, for LGBTQ+ youth and their allies to promote emotional health, positive identity, and reduce isolation through life skill development. Although this is a new group and location, participation grew quickly, with an average attendance of 6. The low attendance was 2 and the high was 10. Participants came to this group primarily through referrals from the school's counseling staff, administrators and teachers, as well as from other service providers working with students at the school, including: CHD's Project Success program, CHD's Four Corners program, Contra Costa Health Services Mobile Clinic staff, Lincoln Children's Services clinicians and JFK University clinicians. CHD staff also conducted 24 one-on-one meetings with youth during this period.

Topics covered in this group include: group development, establishing group agreements, identity development, bullying, grief and loss of loved ones, gender versus sexual orientation, LGBT history and icons, gender transitioning, mental health awareness, appreciations and group closure.

Research is increasingly showing that junior high is a significant period of heightened bullying, stress and trauma related to gender identity/expression and sexual orientation. Staff believes this is an ideal point to introduce Empowerment's prevention and early intervention supports to help manage stress, mitigate trauma, increase social-emotional supports, connectedness, and life skills, reducing the potential development of serious mental health disorders.

Component 8: Facilitate community educational outreach/psycho-educational workshops including four (4) per year.

From January 1 through June 30, 2019, Kevin Martin facilitated 1 educational outreach/psycho-educational workshops, for an annual total of 3. This is just short our goal of 4 workshops for the year.

May 23: Kevin co-facilitated an all-day Inclusive Classrooms training for teachers and staff of Pittsburg Unified School District (PUSD), at the PUSD offices, in collaboration with Rainbow Community Center training staff. Approximately 30 teachers, staff and district administrators, representing all schools in the district, elementary through high school, attended.

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OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***How are participants identified as needing mental health assessment or treatment?***
- ***List of indicators measured, including how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***
- ***Average length of time between report of symptom onset and entry into treatment and the methodology used.***

Information on mental health topics and services comes up "naturally" during the weekly support groups so this is not seen as a "stand alone" component by staff. However, regular, periodic check-ins and occasional one-on-one meetings and assessments are provided when staff identifies possible "red flags", such as symptoms of anxiety, depression, and suicidal ideation, or youth are distressed. During check-ins and one-on-one meetings, staff always inquires as to youth's experiences, interest, and willingness to participate in mental health services, outside and in addition to Empowerment's programming. Staff also periodically administers the Adolescent Mental Health Continuum Short Form (MHC-SF) during one-on-one meetings to help assess need for referral to mental health services. Staff has had 171 individual one-on-one meetings with youth during this reporting period, as noted in the individual components above, for a total of 286 for the year.
As noted in the previous section, specific referrals for new mental health support were made for three (3) youth during the second half of the year. The current average length of time between report of symptoms onset and entry into treatment is 1.4 months; 1 entered treatment after 1 week, 1 was waitlisted due to staff shortage and one did not enter treatment after referral. The methodologies used during treatment are generally unknown to Empowerment staff, as Empowerment staff does not provide therapy, and all mental health referrals are made to external providers.

DEMOGRAPHIC DATA: ☑ Not Applicable ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form <u>AND</u> have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

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LINKAGE AND FOLLOW-UP:

Please explain how participants are linked to mental health services, including how the PEI program: 1) provides encouragement for individuals to access services; and 2) follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

As noted previously, all Empowerment participants receive an emergency services "Phone Tree", including contact information for CHD's Empowerment Program, Contra Costa Crisis Center, The Trevor Project, Planned Parenthood, Community Violence Solutions, STAND Against Violence, Runaway Hotline, Homeless Hotline, as well as having space to add information for trusted adults and friends. Additional referrals and linkages are provided as needed, and upon participant assent. Direct linkages are made via phone, fax or in person, such as during Care Team meetings at school sites.

1) General encouragement of all participants to seek services that could be of support to them is continual during all group sessions. Specific and direct encouragement and referrals are offered to participants during one-on-one check-ins and assessments by Empowerment staff. Staff administers the Adolescent Mental Health Continuum Short Form (MHC-SF) periodically during one-on-one meetings to help assess need for referral to mental health services.

2) Empowerment staff follows up, verbally, with participants regarding referrals to external services on a weekly basis until participant successfully engages in services, or no longer wishes to engage services. Individual check-in and follow ups are provided monthly, or as need arises, thereafter. The current average length of time between referral and entry into treatment is 1.4 months. Methodologies used are determined by participants and the external service provider with whom they enter into treatment.

VALUES:

Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

Empowerment is a social-emotional and educational support program for LGBTQ+ youth, ages 13 to 20, in East Contra Costa County, which is a highly diverse community in regard to ethnic makeup and socio-economic status, with large percentages of Latino/a, black, and low-income families. Youth enter the program through referrals from self, peers, family, school staff, and other service providers. Staff works hard to create safe, welcoming, confidential spaces for all who attend Empowerment. This is facilitated by the development of group norms, which all attendees agree to adhere to. During groups and during one-on-one sessions youth work to identify and process challenges and struggles they face, then identify

and develop internal strengths, coping mechanisms and tools for building resiliency and working through challenges, with the encouragement of Empowerment staff and peers. Through the process noted above, when youth are identified to need or would benefit from support services beyond the capacities of Empowerment staff, referrals and linkages are made to culturally appropriate service providers. All youth in Empowerment are treated with respect as individuals, and staff makes a concerted effort to do so without bias or judgment. All LGBTQ+ youth, ages 13-20, and their heterosexual friends are welcome to join Empowerment's groups and their level of participation is completely voluntary.

In Empowerment, LGBTQ+ youth are engaged in discussions topics, workshops and activities that are common to the LGBTQ+ community, such as: identity development, the process of coming out, rejection and fear of rejection, isolation, harassment, bullying, discrimination, anxiety, depression, suicidality, healthy relationships, relationship violence, community development and engagement, leadership and activism, physical, mental and sexual health and safety.

VALUABLE PERSPECTIVES:
Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

This year, Empowerment staff was approached by administrators at Hillview Junior High School to help them support their LGBTQ+ students after reports were made of several incidents of bullying, "outing" and cultural insensitivity by both students and school staff. Staff has been welcomed into the school's COST team, where staff can share information and support staff and receive referrals for students who might benefit from Empowerment program support. Students have also been receptive to having an Empowerment group and individual support on campus. According to participant comments given on post-survey, participants were very happy to have a safe space to talk about sexual orientation and gender identity without judgement, or fear of being harassed by others. Even though this group only met for a short time, 3 months, participants from diverse backgrounds and social groups were able to come together amicably, were willing to discuss difficult and sensitive topics, and were able to offer support to one another. School administrators, staff, students and service providers all expressed their hope and support for CHD's Empowerment to continue to support Hillview Junior High students in the upcoming year.

RH, is a 15 year old, gay identified male at Pittsburg High School (PHS). He was referred to Empowerment staff by his guidance counselor after a bullying incident. RH was out to his peer at school, but not to his family. Though RH always believed his parents would accept and support him, he held a lot of anxiety that their Hispanic cultural beliefs might cause a negative response. RH first attended group in December, just prior to the winter recess break. He was very quick to develop trust in the group and openly shared his experiences with a former

romantic relationship and the bullying that ensued after the relationship had ended. In March, he shared that thanks to the support he received from the Empowerment group he was able to come out to his parents and family. He was excited that his family accepted him and grateful for the groups support of him. In his post-survey comments, he noted, "This program helped me come out to the people I love."

AW is 16 year old trans-male identified student at Deer Valley High School (DVHS). This is his third year attending Empowerment group at DVHS. AW is out to his family, friends and community; however his parent is not accepting of his trans-identity. AW frequently noted, this year, his frustration that his parent is not accepting and that school, and specifically, Empowerment group is his only opportunity to be himself. Even with the lack of acceptance at home, AW is very well adjusted, intelligent, and is focused on their future. They express excitement about pursuing transition once they turn 18.

DP is senior at DVHS. He identifies as straight. He was referred to Empowerment group by this guidance counselor, who expressed concern that DP might be depressed and thought Empowerment staff might be able to help, noting that DP presented with many stereotypically effeminate mannerisms. DP was adamant that he identifies as straight, but was happy to join the group, noting that he had questioned his sexual orientation in the past. DP attended each weekly group meeting at DVHS since joining in September and was very supportive to other participants. DP also referred several of his friends to the group. In their post survey comments, they noted, "I will work on things as I progress through the real world. Thank you."

YL is a Junior at PHS. She identifies as bisexual, Hispanic and has been attending Empowerment group at PHS for 2 years. The first year that YL attended group, she was reserved. She would often "pass" during check-in and would only share with Empowerment staff in private 1-on-1 meetings. Toward the end of last year, YL asked if she could switch to the second Empowerment group at PHS, suggesting that being in a group with people she does not know might help her to open up more. In the new, smaller, group she expressed being more comfortable. This year, YL was excited for the group to start again at PHS. Staff noticed a shift in their self-confidence and self-esteem. Throughout the year YL became more vocal and opened up more to the group. In March, they too, shared with the group that they "finally" came out to their parent, sibling and extended family. Prior to group closing for the summer, she noted that she now feels very comfortable sharing with her family, and she frequently receives genuine questions from her parent about LGBTQ+ topics.

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PEI SEMI-ANNUAL REPORTING FORM

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS
REPORTING FORM **FISCAL YEAR: 2018 - 2019**

Agency/Program Name: Child Abuse Prevention Council/Nurturing Parenting Program
Reporting Period (Select One): X☐ Semi-Annual Report #1 (July – Dec)
☐ Semi-Annual Report #2 (Jan – June)

PEI STRATEGIES:
Please check all strategies that your program employs:

X Provide access and linkage to mental healthcare

X Improve timely access to mental health services for underserved populations
X Use strategies that are non-stigmatizing and non-discriminatory

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SERVICES PROVIDED / STRATEGIES:
Please describe the services you provided in the past reporting period. Please include qualitative and quantitative data depicting: 1) the types and settings of potential responders you reached during the past reporting period; 2) methods used to reach out and engage potential responders; 3) any strategies utilized to provide access and linkage to treatment, and4) strategies utilized to improve timely access to services for underserved populations.

Child Abuse Prevention Council - CAPC reached out to the Latino community in Central and East County to offer The Nurturing Parenting Program (NPP). From July to December a total of 50 parents and their 42 children enrolled to participate in the 22-week parenting education program offered in the evening at Vintage Parkway Elementary School in East and at the Concord First 5 Center in Central County. NPP collaborated with community based agencies and school districts such as First 5 Center, Head Start, WIC, Antioch Unified and Oakley Elementary School District to promote this program. Parents enrolled in the NPP reported that hearing other parents' opinion and comments about this program motivated them to enroll. A total of 30 parents successfully completed and graduated from the program, 16 shared they were experiencing challenges to participate and dropped, 2 parents transferred to a different NPP to fit his needs and 2 parents partially completed the program, participated less than 50% of the 22 week program due to work schedules. CAPC staff offered education for 22 consecutive weeks following the fidelity of the NPP evidence based curriculum to increase parenting skills, decrease isolation within this population, decrease stigma related to accessing mental health services for self or child.

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Our staff follows and utilizes curriculum and materials recommended by the Nurturing Parenting Program. Parents are given the opportunity to share areas of concerns in accessing community resources; to meet this need each parent received the Surviving Parenthood Guide to facilitate access to community based organizations providing a wide variety of services at no cost or sliding scale to encourage parents to connect and explore preventive/intervention programs. . NPP staff offered guidance to parents by providing the Mental Health access number as well as the process of advocating for services. NPP collaborated with other agencies and welcomed guess speakers to share information and psycho-education to help identify mental health/behavioral challenges that may need professional support. NPP has been enhanced by the collaboration of Dr. Hector Rivera-Lopez. Dr. Rivera's experience working with the Latino community in Contra Costa County offers participants an opportunity to identify possible behavioral/mental health needs that in the past were perceived as just "part of their "cultural beliefs".

The NPP supervisor not only oversees sessions, she also offers direct services to help parents feel more comfortable and confident when accessing resources. NPP evaluates each case to offer linkages to the appropriate resources. Linkage includes but was not limited to the following: Access Line, Medical, Children Mental Health Services, Crisis Center, Food Bank and Community Based Organizations.

At the end of the program the NPP staff meets with parents to explore supportive services that they accessed and/or if they encounter challenges receiving services.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***Include a list of indicators measured, how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

The Nurturing Parenting Program offered two 22 week sessions starting in July, ending in December. Parents were administered the evaluation tool AAPI "A" at the beginning of the program and AAPI "B" at completion of each program. Results of the AAPI forms are entered in a password protected data base (Assessing Parenting) which analyzes the results and provides a chart reflecting variation of participants starting and ending the program. Upon completion of the program staff reviews results which reflect areas of improvement and measures the "risk" of child abuse and neglect in the home. In the event that parents may score as "high risk", an invitation is offered to them to participate in the program one more time as well as additional resources to address their needs. All data entered in the Assessing Parenting site is password protected and only authorized personnel has access to these records.

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The Nurturing Parenting Program focuses and encourages participants in developing skills along five domains of parenting: age appropriate expectations; empathy, bonding/attachment; non-violent discipline; self-awareness and self-worth and empowerment, autonomy, and independence.

Responses to the AAPI provide an index of risk in five parenting constructs:

A - Appropriate Expectations of Children. Understands growth and development. Children are allowed to exhibit normal developmental behaviors. Self-concept as a caregiver and provider is positive. Tends to be supportive of children.

B – High Level of Empathy. Understands and values children's needs. Children are allowed to display normal developmental behaviors. Nurture children and encourage positive growth. Communicates with children. Recognizes feelings of children.

C – Discipline/ VALUES ALTERNATIVES TO CORPORAL PUNISHMENT Understands alternatives to physical force. Utilizes alternatives to corporal punishment. Tends to be democratic in rule making. Rules for family, not just for children. Tends to have respect for children and their needs. Values mutual parent-child relationship.

D - APPROPRIATE FAMILY ROLES tends to have needs met appropriately. Finds comfort, support, companionship from peers. Children are allowed to express developmental needs. Takes ownership of behavior. Tends to feel worthwhile as a person, good awareness of self.

E - VALUES POWER-INDEPENDENCE Places high-value on children's ability to problem solve. Encourages children to express views but expects cooperation. Empowers children to make good choices.

AAPI Results

Construct	*A*	*B*	*C*	*D*	*E*
Form A	*7.50*	*7.33*	*7.50*	*8.67*	*7.42*
Form B	*7.57*	*7.43*	*8.00*	*8.71*	*5.00*

- *Scale 1 – 10 (Higher the score, lower the risk).*

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DEMOGRAPHIC DATA: ☐ **Not Applicable** ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

Form attached

VALUES:

Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

The CAPC Director and The Nurturing Parenting Program Supervisor continue to meet regularly to discuss program outcomes, challenges and to ensure staff offering direct services receive support and guidance thought out the course of the session. We have learned the value of communication and collaboration as we offer this important service to our community. Staff meet regularly to discuss issues parents identify as "triggers" of stress in their daily life. This program offered a safe place to identify staff challenges and receive support to decrease the risk of emotional fatigue which we often experience in this field. Staff brainstormed ideas to address the emotional needs parents are experiencing while maintaining the fidelity of the Nurturing Parenting curriculum.
The Child Abuse Prevention Council staff agreed to continue being proactive in finding resources for the Latino community who has reported challenges accessing mental health services that are culturally appropriate. Staff has learned of challenges parents are facing in trying to connect adults to mental health resources. To support this need staff has worked with parents by linking them to resources as they wait for clinicians to be open to new clients. CAPC links parents to support groups in their area creating opportunity for families to connect with families in their own neighborhood. CAPC strongly believes in building community connections to increase children's safety. Staff recognizes the areas in which they can help in building bridges to connect the underserved population to the services much needed.

VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

CAPC and the NPP valued parents' feedback to help us learn more about the outcomes of this program. Below you will find the translation of just a few letters parents have written for the program. Originals of the following letters and more are available to you upon request.

Parent 1

Grandparents raising 12 year old grandson, expressed finding this program valuable and in great sadness with tear in his eyes grandpa shared "I wished I had this support when I raised my daughter, she would be here with us raising her son".

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PEI ANNUAL REPORTING FORM

Due: August 15, 2019

SUICIDE PREVENTION REPORTING FORM **FISCAL YEAR: 18-19**

Agency/Program Name: Contra Costa Crisis Center

PEI STRATEGIES:

Please check all strategies that your program employs:

X Provide access and linkage to mental health care

X Improve timely access to mental health services for underserved populations

X Use strategies that are non-stigmatizing and non-discriminatory

SERVICES PROVIDED / ACTIVITIES:

Please describe the services you provided in the past reporting period. Please include who the program has targeted and influenced, as well as, any methods or activities used to change attitudes, knowledge and/or behavior.

1) The provision of 24-hour telephone response to mental health crisis calls via all local and toll-free hotlines. Our staff and volunteer Call Specialists are ALL cross trained, silent monitored and supervised in an intervention modality consistent with best practices/industry standards as set by the American Association of Suicidology. Services were provided in the manner agreed upon in the contract – language, follow-up, lethality assessments, etc.
2) Link callers in need to mental health services via referrals and warm transfers as appropriate for each call.
3) Continued staff in-service training regarding stigma and discrimination reduction; addressed service delivery to underserved population – LGBQT, Homeless, people living with mental illness. Focused training was provided around Grief and Loss and Suicide Prevention.
4) Continued to evaluate our repeat caller policies and adherence to providing services based on respective individual needs vs. call volume.
5) Continued to provide trainings for service providers throughout Contra Costa County on the warning signs of suicide, suicide risk assessment, and cultural competency and awareness when assessing for suicide risk.
6) The Crisis Text service continues to be provided and monitored 24/7/365.
7) Continued co-chair responsibilities with MHSA for the monthly Suicide Prevention Committee.
8) Worked closely with MHSA, mental health, and statewide suicide prevention agencies to create a plan to review and update the suicide prevention strategic plan for county administration.
9) Coordinated with the county board of supervisors and other county agencies to organize, promote and facilitate the showing of the "S Word" movie in the Board Chambers.
10) With American Foundation for Suicide Prevention (AFSP), hosted "Survivor Day" at John Muir Hospital to provide support to survivors of suicide loss and to promote suicide prevention awareness.

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OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***Please detail any methods used in evaluating change in attitudes, knowledge and/or behavior, and include frequency of measurement***
- ***How have your selected methods proven successful? Please reference any evidence- based, promising practice or community practice standards used, as well as how fidelity to the practices have been ensured.***
- ***How does the program evaluation reflect cultural competency and protect the integrity and confidentiality of the individuals served?***

- A risk assessment is provided for every suicide call. Callers with a plan to end their life are asked for a self-rating scale of 1-5 for how likely they are to go through with their suicide plan both at the beginning and at the end of the call to help assess the level of risk and if the caller is feeling better at the end of the call.
- Methods of intervention and lethality assessment are done in accordance with industry standards set by AAS. Monitoring of the calls and the data/call records indicates that fidelity to the model is being well maintained. We are happy to report 0% completed suicides by those who are assessed as at risk.
- Confidentiality - Our policies (HIPAA and clinical license standards informed) ensure confidentiality – including use of technology, storage of records, destruction of records, subpoena response, record keeping, report writing, and (non)use of identifying client information on server.
- Competency – Our supervision is informed by ongoing in-service trainings and professional development opportunities regarding multiple populations and social issues. Our staff and volunteers are diverse in regard to country of origin, languages spoken, culture, gender, religion, sexual orientation and class.
- Our core values of compassion, integrity, inclusion, accessibility, and collaboration along with continuous cultural competency development is written, spoken and practiced. Our policies, protocols, and office environment support these values.

DEMOGRAPHIC DATA: X Not Applicable ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form <u>AND</u> have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

See County Aggregate Data Form

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VALUES:
Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

Our services are designed based on the belief that emotional support can make huge difference in a caller's ability to self-manage and minimize psychiatric hospitalization (5150) visits when the support is available any time it is needed 24/7/365. Our vision is that people of all cultures and ethnicities in Contra Costa County are in a safe place emotionally and physically. Because we also provide the entire county with 211 Information and Referral services, we have a well-maintained database from which to refer and link our callers.

VALUABLE PERSPECTIVES:
Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

Call record #264701
The caller was a 21-year old female, crying and extremely distraught when she called the Crisis Line. The Call Specialist quickly developed rapport and was able to calm the caller down enough to understand what she was saying. The caller was feeling stressed about her new job, had an argument with her boyfriend, and then another disagreement with her mother when visiting for emotional support that escalated to the point of the mother telling her to leave the house. The caller was feeling very alone, had thoughts of suicide, and was feeling the way she had felt when she had attempted suicide in the past several years ago. Her mother doesn't understand her feelings, thinks she is "being dramatic" and doesn't realize how much the caller depends on her for emotional support.
The Call Specialist spent time talking with the caller, providing active listening and emotional support and hearing about the caller's past struggles and coping strategies. She asked for the Call Specialist to provide a three-way conference call conversation with her mother since her mother blocked her calls after their fight. The caller, mother, and Call Specialist were able to have a three-way conference call mediation conversation over the phone and the caller agreed to a follow-up call the following evening.

During the follow-up call the Call Specialist learned that the caller is currently feeling safe and that she will work on her relationship with her mother and siblings. She asked for second follow-up call at the end of the week.
On the second follow-up call, the Call Specialist learned that things were going smooth with the caller's new job and that she is still working on her relationship with her mother with the help of her grandmother as an outside mediator. She was grateful for the support of the Crisis Line and will call again for emotional support or when she needs help.

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Call Record #: 296089

The caller was a 56-year old male and began the call very angry. He feels like no one cares for him, he hates his job and his boss, he experienced sexual abuse in the past, and is now questioning his religious faith. After spending time listening and developing rapport with the caller, he confided with the Call Specialist that he was having suicidal thoughts and on a self-rated scale of 1-5 of 5 being the highest, he rated himself as an 8. They spent time talking and the Call Specialist was able to explore his reasons to live and what made him feel happy such as his dog that was 7-years old that he loved dearly, listening to music, being creative, and helping others (especially people who are homeless).

The Call Specialist continued to provide active listening and emotional support throughout the call, and at the end of the call, the caller self-rated his thoughts of suicide was now reduced to a 1, and he was incredibly grateful for our service. His plan for the remainder of the evening was to spend time with his dog, get some rest for work the following day, and begin look for a new job. The caller declined a follow-up call but agreed to stay safe for the evening and to call us call this line again before acting upon thoughts of suicide or anytime he needed support.

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PEI ANNUAL REPORTING FORM

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS REPORTING FORM **FISCAL YEAR: 18-19**

Agency/Program Name:

Contra Costa Interfaith Housing, Strengthening Vulnerable Families

PEI STRATEGIES:
Please check all strategies that your program employs:

X Provide access and linkage to mental health care

X Improve timely access to mental health services for underserved populations

X Use strategies that are non-stigmatizing and non-discriminatory

SERVICES PROVIDED / STRATEGIES:
Please describe the services you provided in the past reporting period. Please include qualitative and quantitative data depicting: 1) the types and settings of potential responders you reached during the past reporting period; 2) methods used to reach out and engage potential responders; 3) any strategies utilized to provide access and linkage to treatment, and4) strategies utilized to improve timely access to services for underserved populations.

During the past contract year (7/18 – 6/19) Contra Costa Interfaith Housing, Inc. (CCIH) has provided an array of on-site, on-demand, culturally appropriate and evidence-based approaches for its "Strengthening Vulnerable Families" program, which serves formerly homeless families and families at risk for homelessness and for mental illness. CCIH has provided these services on-site in 4 affordable housing settings and case managers have been available fulltime to residents. This structure has helped to eliminate barriers to timely access to services. Culturally responsiveness youth enrichment and case management providers have assisted youth and families to access a multitude of community services, including mental health treatment. By incorporating these services among general support, potential stigma related to mental health referrals is reduced. By providing services to all residents living at each site, potential biased or discriminatory service delivery is avoided.

1) Responders that this program reached included affordable housing staff and residents living in 274 units of housing designed for low-income families (235 units of affordable housing) and units designated for formerly homeless families with disabilities (39 units of permanent

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supportive housing). Most of the disabilities identified among the permanent supportive housing households included mental health challenges. With on-site case managers and youth programming and monthly case management meetings with property management at these sites, housing staff, parents and youth in resident families were all potential responders that we reached with offered services. Specifically, 215 families have been served with 4003 hours of case management services across the 4 housing sites.

2) Methods used to reach potential responders were providing on-site service staff in the housing settings where residents live. Case managers were trained and supervised by licensed clinicians to recognize mental health problems and assist residents to access services. Case managers were available 40 hours/week, by appointment or drop in. Additionally, parent support groups were offered at each site, in Spanish and in English as needed, and this allowed residents to get to know the case managers and youth enrichment staff and build the trust needed to share concerns including worries about mental health. Afterschool programming was also offered on-site at these housing settings. Regular contact was maintained with the property managers and if there were behavioral or financial problems that put resident housing at risk, case managers were able to reach out to the households and assess and support them. Some of these problems were based in the need for mental health support, and these referrals were made as needed.

3) Strategies used to provide access and linkage to treatment included forming trusting relationships with the residents to start. When a resident who had come to know the case manager requested mental health resources the case manager would offer to assist the resident to access these services in numerous ways including assisting with calling the ACCESS line to obtain an appointment with a clinician, transportation to appointments, financial support for transportation (bus passes/gas cards) to get to appointments as needed, emotional support and discussion about the value of counseling or other treatment. Staff were trained in the understanding that many populations have concerns about accessing mental health resources due to stigma or other misgivings. With ongoing presence and relationship support these issues could be addressed.

   In the afterschool program parents would approach the youth enrichment coordinator with concerns related to family dynamics or youth behavioral issues or problems at school. The youth enrichment coordinator was available to support the families to access mental health resources as needed. The case manager and youth enrichment coordinator met to discuss resident needs weekly, and issues related to mental health were addressed and plans for how to support residents in this area were made. During the contract year 170 youth have received youth enrichment support with 2095 hours of programming.

4) Strategies used to improve timely access to services that were used included assistance in navigating the system of obtaining a mental health appointment, education about the mental health system and resources available, transportation when needed and emotional support to consider this resource. Financial support was offered for transportation or other relevant expenses as needed. Follow up with residents after referrals were made to mental health

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resources were done to support the residents as well.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***Include a list of indicators measured, how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

Indicators of success for this program include improvements on a standardized assessment tool related to self-sufficiency and improvements in youth academic achievement. These outcomes are reported below. Additionally, stability of housing, stability and improvement of income level and improvements in parental stress levels are all tracked with ongoing logic model goals and evaluated semi-annually. Feedback from residents on satisfaction surveys and at the end of group programming is also solicited. All data related to outcomes is analyzed and discussed among the service delivery teams, and plans for improvements and innovations are made as needed. Resident participants give feedback about desired topics for support groups and activities in monthly resident meetings and in annual satisfaction surveys.

Case managers in these programs over the last year included a licensed psychologist, a licensed Marriage and Family Therapist, two experienced case managers (one of whom is bi-lingual/bi-cultural) and two mental health, post-masters interns. The youth enrichment coordinators are all experienced educators. The racial/ethnic background of the staff include 2 African Americans, 2 Latinas, one bi-racial Latina/African American, 1 Native American, and 2 Caucasian staff members and 1 Asian American. Several of the staff in this program live in the communities they are serving. In addition to working with the families in these affordable housing sites, the Youth Enrichment Coordinators and Case Managers also work with a number of community resources as referring partners and family advocates. In this role, CCIH staff are able to help community providers be aware of early signs of mental illness in their clients, and support sensitive care and timely treatment for these issues.

Cultural responsiveness is an ongoing area of training for all staff, starting with training at hire and continuing with trainings throughout the year. This past year the entire CCIH staff participated in a day long training related to cultural awareness provided by Circle Up. This was funded with a grant obtained for the specific purpose of providing this important training to the organization as a whole.

All staff are trained during their orientation in HIPAA levels of information and record management. Maintaining the confidentiality of resident information is required of all staff. Records are kept in password protected computers and/or locked files in locked offices.

Outcome objectives for the ***Strengthening Vulnerable Families*** program were:

A. At least 75% of the youth regularly attending homework club will achieve six or more academic benchmark skills during the school year ending in June 2019.

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Youth who regularly attend our youth enrichment and afterschool programs have been assessed for reading levels and for base-line academic benchmark skills. 86% (56/65) have achieved at least 6 new academic benchmarks, and have improved in their reading level.

B. At least 75% of the families with children, in residence at Garden Park Apartments, will show improvement in at least one area of self-sufficiency as measured annually on the 20 area, self-sufficiency matrix within the fiscal year, 2018 to 2019.

While this contract outcome focuses on the Garden Park Apartments community, we are reporting on all the residents that engaged in more intensive case management at the 4 housing sites supported by this grant. The Self Sufficiency Matrix (SSM) is an evidence-based assessment tool that gives a score of "crisis to thriving" on a five-point Likert scale for twenty areas of basic life skills including parenting, mental health and child education. All families served with intensive case management in the first six months established a baseline on the SSM. Final outcomes for this measure are 97%, 103/106 improved in at least one SSM category. (Not all families engage in services to the point of filling this measure out. Some are served just once or twice a year with emergency services, especially in the affordable housing sites. Others engage in more ongoing services and this measure is used to assess progress with those families. Most of the residents living in the permanent supportive housing units are reflected in this outcome).

In addition to these outcomes we achieved the following outcomes related to the parent support groups provided at these sites:

Many of the families we serve have histories of inadequate parenting including exposure to domestic violence, out of home placements with foster care, and unstable family support. These parents report that they find the Community Café and other parenting groups very helpful as they work to provide their children with loving, supportive parenting. (Community Café is an evidence-based program promoting initiative and community collaboration among parents. The curriculum is based in Resiliency Theory).

100% of the parents in the Community Café groups (32/32) report that the group is useful. Additionally, we are instituting a new assessment tool called the Parental Stress Index that assesses parental stress in the community and in parent-child relationships. As of the end of the year we had 4 initial assessments and follow up assessments and 3 of the 4 (75%) showed lower stress. Because this is our first year using this tool, we have initial assessments (baseline) for an additional 23 parents. We will use these scores to compare to scores at the end of next year to assess the impact of our programming on parent stress levels.

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Many residents at GPA cope with the challenges of mental health and substance use issues. At this site we offered an 8 week wellness/harm reduction group. The focus of this group was to support parents with coping skills for managing depression and anxiety and cravings/relapse triggers related to substance use. Activities included mindfulness exercises, discussion of triggers and parents gave each other feedback about strengths in a circle. Discussion topics included managing conflicts, parenting challenges, struggles with money and with relationships. 80% (8/10) of the participants in this group reported finding the topics and skills learned in the group useful and also that they used coping skills learned in the group to support their sobriety and/or moderate substance use.

Two (2) family vignettes , showing the improvements and positive outcomes of the work of this project (including GPA, Lakeside, LMV, and BMA communities) are attached with this fiscal year final report.

DEMOGRAPHIC DATA: ☐ Not Applicable ***(Using County form)***
If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

MHSA aggregate reporting form attached with this report.

VALUES:
Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

The Strengthening Vulnerable Families program reflects MHSA values of wellness, recovery and resilience by providing on-site, on-demand support when residents need it. By being available immediately and in a timely manner when problems begin to emerge, we are able to improve the trajectory of problems with early interventions that are embedded in the housing community where residents live. When mental health care is needed support staff in this program are ready and available to assist residents with information about possible resources, with transportation, and with educational

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and emotional support that is culturally responsive and respectful of the concerns different populations have about accessing this type of resource. By providing an array of supports and services

(employment support, financial support, educational support, basic needs like food, healthcare, childcare access, and social/community activities) when the need for mental health support arises the resident is not singled out or identified with this particular need. By having a trusted, long-term relationship with an on-site case manager, residents can develop trust and be able to move past fears of stigma or discrimination as they seek mental health assistance.

VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

Two vignettes are attached, including a talk presented at the MHSA housing forum in San Pablo earlier this year.

Thank you for your support to help us with this program. We look forward to our continued collaboration.

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One Resident's Story

Good afternoon. I have lived at Garden Park Apartments since January 2015. I live there with my girlfriend and her daughter, who was 2 when we got together.

Before I moved to GPA I was homeless, on and off, for most of my life. I left home when I was in my early teens. Sometimes I would move back to my parents' house for a while. Sometimes I would work. Sometimes I had a job while I was homeless. I slept on park benches and in tents. Sometimes I could stay at friends' houses. Nothing lasted too long. I was using drugs, and I wasn't receiving any mental health care, so my life was pretty erratic.

I knew my girlfriend since we were in high school together. We dated a while in our early 20's, but drifted apart. We were both homeless and using drugs. She got her life together when she gave birth to her daughter, and moved to Garden Park. I ran into her again in January of 2015, and we have been together ever since.

I was able to stop using drugs with her help, and after a while I was added to the lease at GPA. I had a daughter, who was 5 when I came to Garden Park, and she was able to visit regularly. She was welcomed in the activities at the property and a year and a half ago I was awarded part-time custody of my daughter.

Since living at GPA I have been able to turn my life around. I stopped using drugs, which I used since my early teens, to self-medicate. I have been able to work in the landscaping field. I got hurt on the job, and when I was applying for disability, I was diagnosed with mental health problems for the first time in my life. I was 30 years old. I have received medications since then that have helped me with my moods.

Garden Park has on-site services that have made a huge difference for me and my family's life. When I feel worried or down about things, I know there is someone we can talk to in the office. I feel safe, knowing someone is always there. The staff is also available to support us in other

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ways. One of the staff took me to homeless court and I cleared up some of my old legal problems.

Most of my friends from my old life are still using, so my girlfriend and I stay to ourselves a lot. But we go to the social events at the property like pumpkin carving and winter holiday bingo and those are a lot of fun. We talk about making happy memories for our daughters, because we didn't have a great childhood ourselves. That is more important than ever now, because a few weeks ago we found out that we are having a baby!
(pause for applause….)

I'm grateful for what we have. I don't know where we'd be without the stable, affordable housing and support that we have at Garden Park. It has made a huge difference for us, and now it will be making a difference for our children. I was reluctant to speak like this in front of a big group, but I wanted you guys to know how important this kind of housing is.
Thank you.

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Lakeside Vignette

Mr. Sai, aged 65, moved to Lakeside Apartments 13 years ago. He was self-sufficient and spent long periods of time with a sister and brother-in-law in San Francisco. He did not access the on-site service support until just a few months ago.

At that time his brother-in-law became ill and he was not able to visit them in SF. With the loss of that structure he had a hard time managing his physical and mental health. At that time he came to the attention of the on-site case manager who received a referral from the property manager. Mr. Sai had complained to property management that there were people coming to his apartment. He described a woman entering his apartment and when questioned about this situation he reported that she would just appear at times. He also reported seeing racoons and cats in his apartment.

The case manager reached out to him and visited his apartment to be sure he had adequate food and other supports. While there Mr. Sai directed the case manager's attention to the floor and asked if she could see the cats and the visitors in the apartment. There were no cats or visitors there at that time.
At that point it was clear that the resident was having hallucinations. The case manager asked if the resident was on medication and he said that he took medication for epilepsy. The Case manager called the mental health crisis line for assistance and they came to assess Mr. Sai. The crisis team said they couldn't 5150 him, but recommended mental health services.

The case manager assisted Mr. Sai to make an appointment with County Mental Health and provided transportation to the appointment. While waiting for this appointment date Mr. Sai continued to come to the case manager's office complaining that people were assaulting him and robbing him. He taped his money to his body to protect himself. He had bruises and bumps on his body.

At the appointment with mental health they found that Mr. Sai had been seen by a therapist in Concord. However, that therapist was not available at the appointment time and Mr. Sai was told that the therapist was retiring. Mr. Sai went through an intake process to be assigned to a new therapist.

At this time the case manager is working with the county to have a public health nurse visit his home to assist with his daily medication. It appears that he is having seizures daily and has many bumps and bruises from falls. A team from mental health came to assess him in his home and he is in line to be assigned a new therapist. The on-site case manager is also working to have the Mr. Sai's mental health counselling offered in his home, and to have an IHSS worker help him with his household tasks.
The case manager has also been able to help Mr. Sai get to an appointment with his primary care physician and his epilepsy medication has been adjusted. The case manager helped Mr. Sai reach out to his sister and brother-in-law and they have been more available to this resident. With this support and with collaboration with the property manager this resident has been stabilized and his housing remains secure, thanks to the on-site case management support partially funded with MHSA funding.

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PEI ANNUAL REPORTING FORM

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS
REPORTING FORM **FISCAL YEAR: 2018-2019**

Agency/Program Name: C.O.P.E. Family Support Center/Triple P, Parent Education

PEI STRATEGIES:
Please check all strategies that your program employs:

- ✓ **Provide access and linkage to mental health care**
- ✓ **Improve timely access to mental health services for underserved populations**
- ✓ **Use strategies that are non-stigmatizing and non-discriminatory**

SERVICES PROVIDED / STRATEGIES:

Please describe the services you provided in the past reporting period. Please include qualitative and quantitative data depicting: 1) the types and settings of potential responders you reached during the past reporting period; 2) methods used to reach out and engage potential responders; 3) any strategies utilized to provide access and linkage to treatment, and4) strategies utilized to improve timely access to services for underserved populations.

Types and Settings of Potential Responders

Demographic Highlights:

- 45% of participants identified as Hispanic/Latino/a; 20% identified as Caucasian; 15% identified as More than One Race/Ethnicity; 12% identified as African American; 4% identified as Asian
- 54% of participants reported household income below the California state poverty level
- 37% of participants reported completing at least two years of college (or more)

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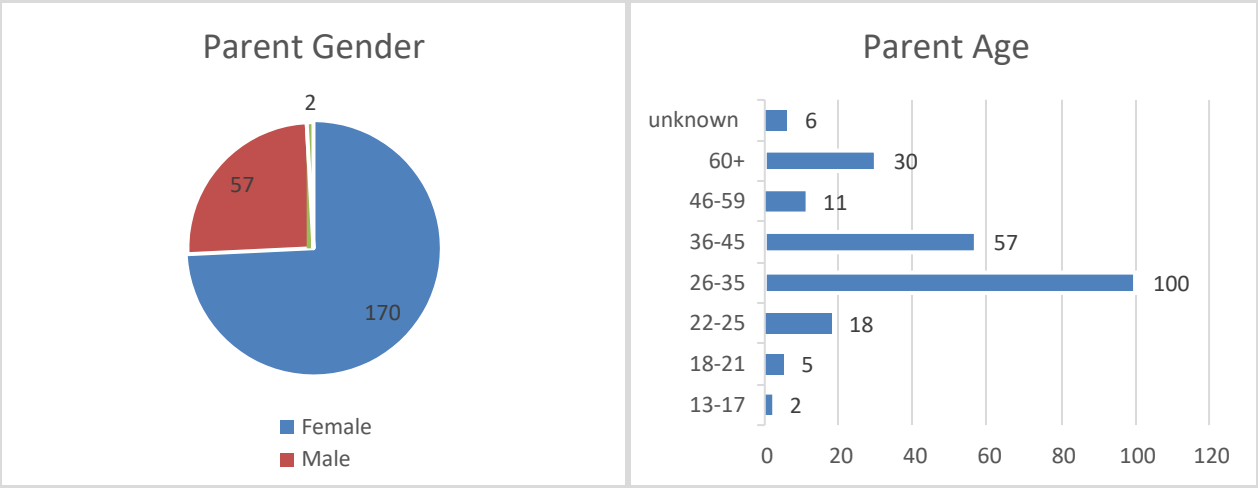
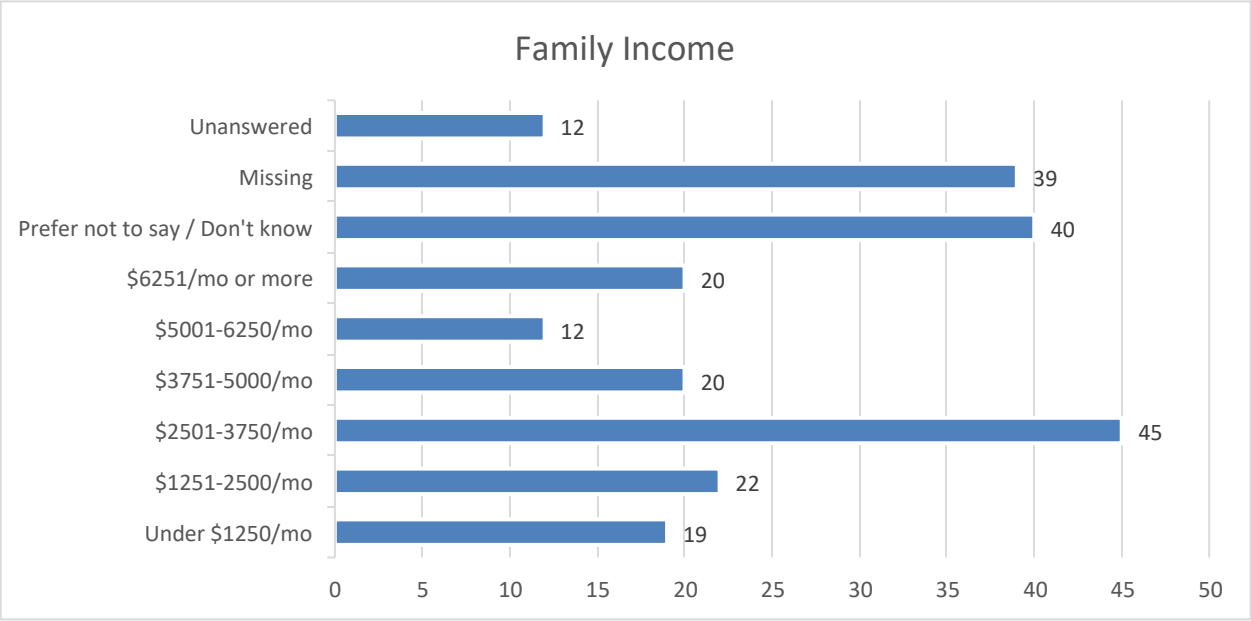
1a) Demographic information below depicts the types of potential responders and is organized by Ethnicity, Gender, Education, Income, Language Age and Location:

First 5 Overall Demographics





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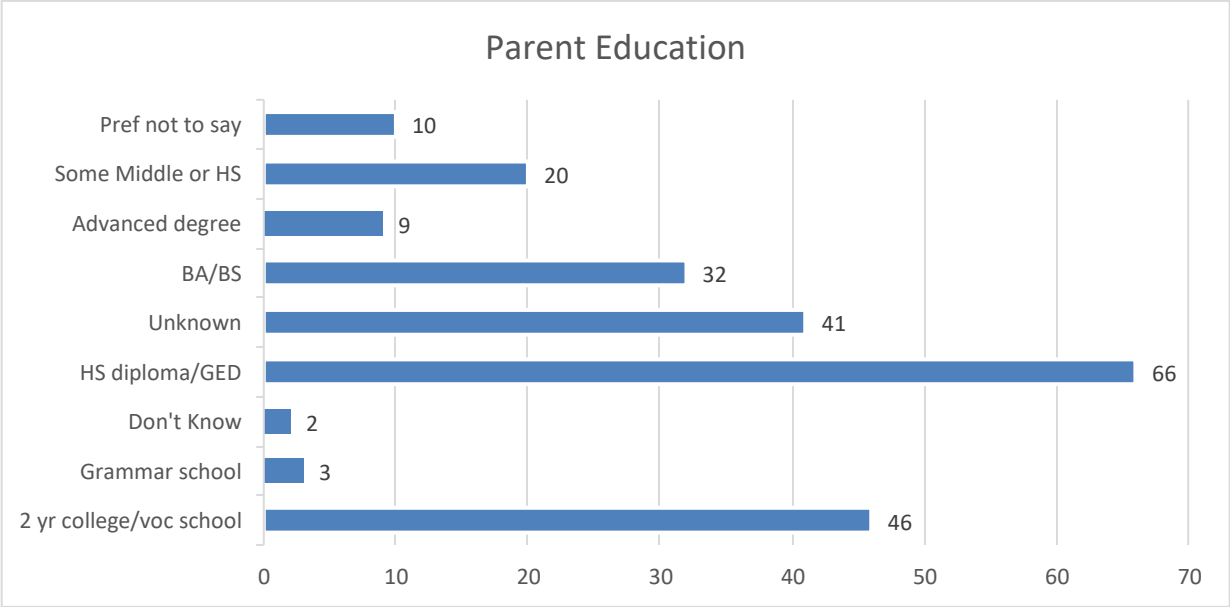
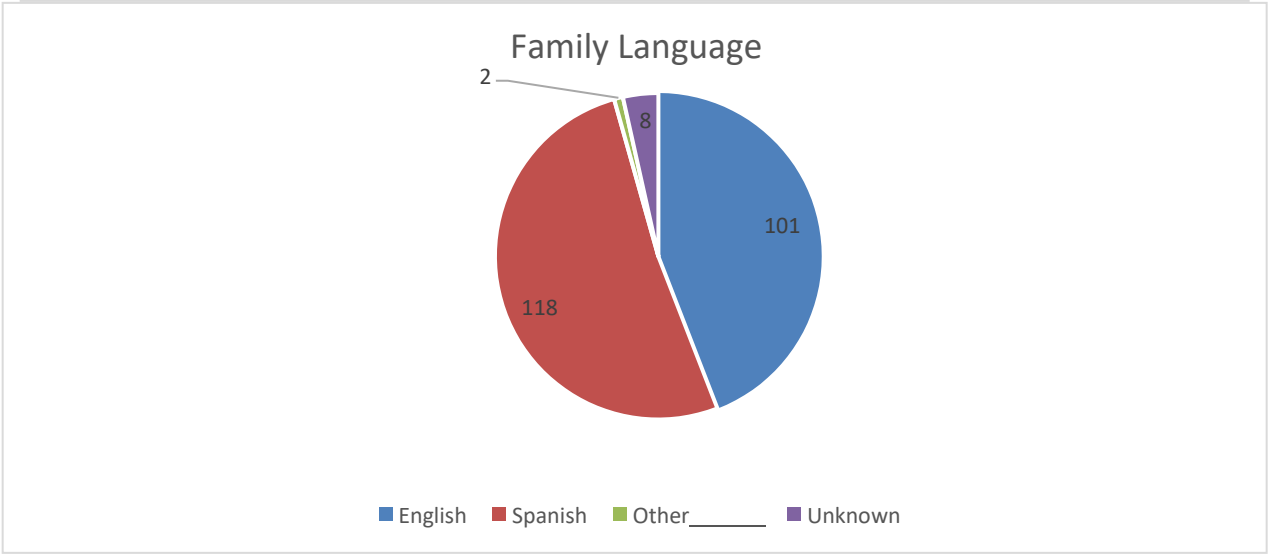
First 5 Overall Demographics, cont.





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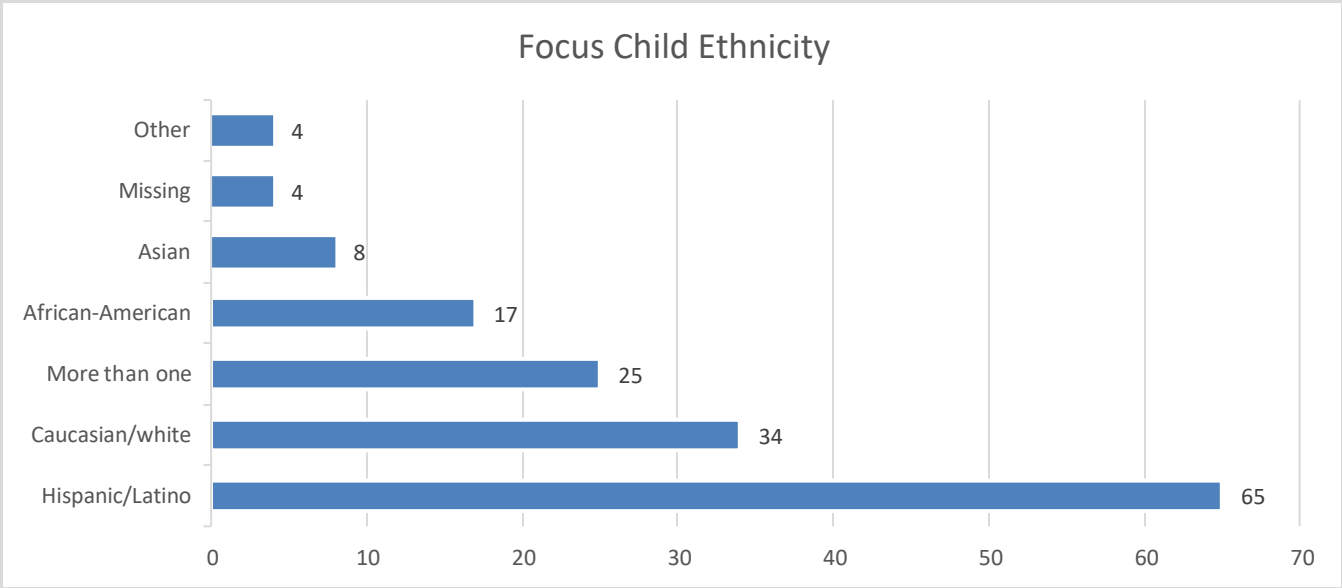

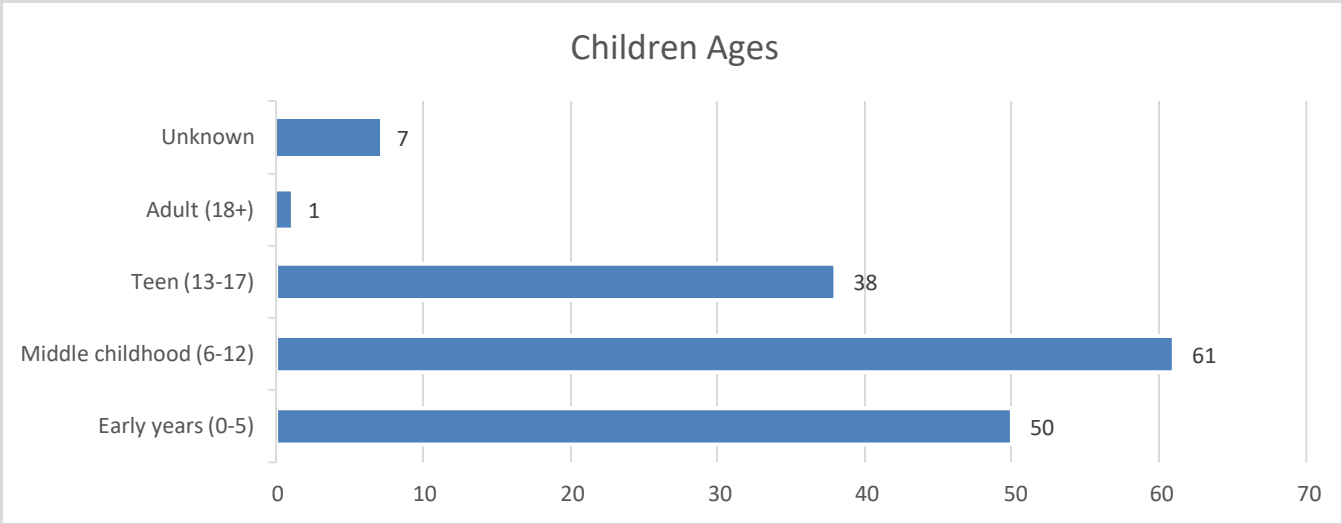

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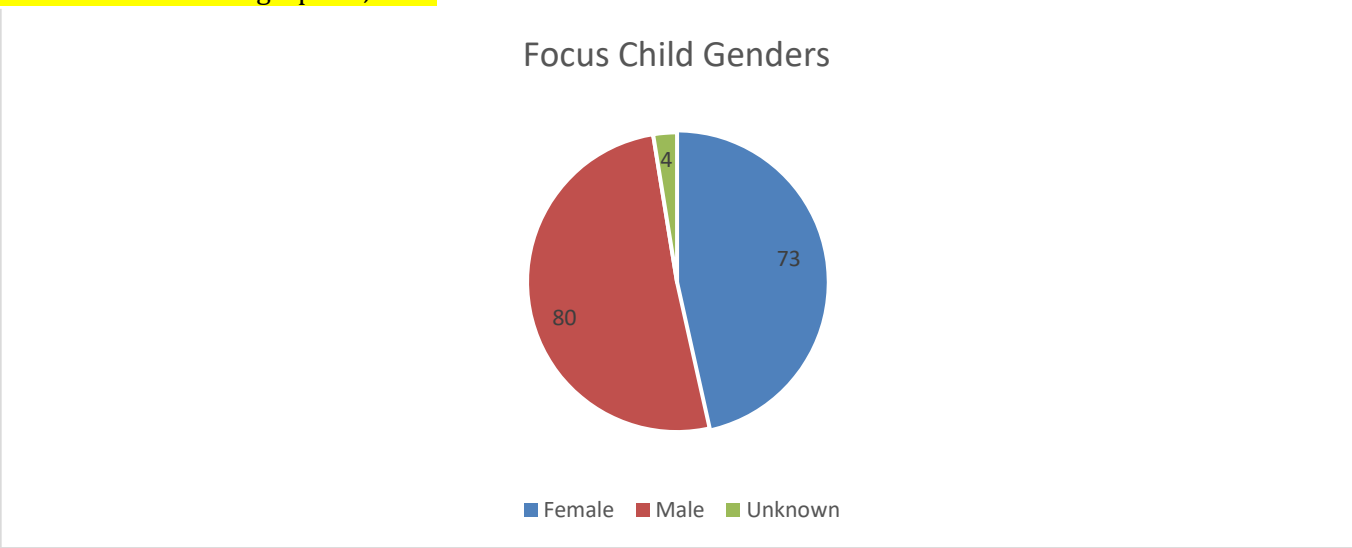

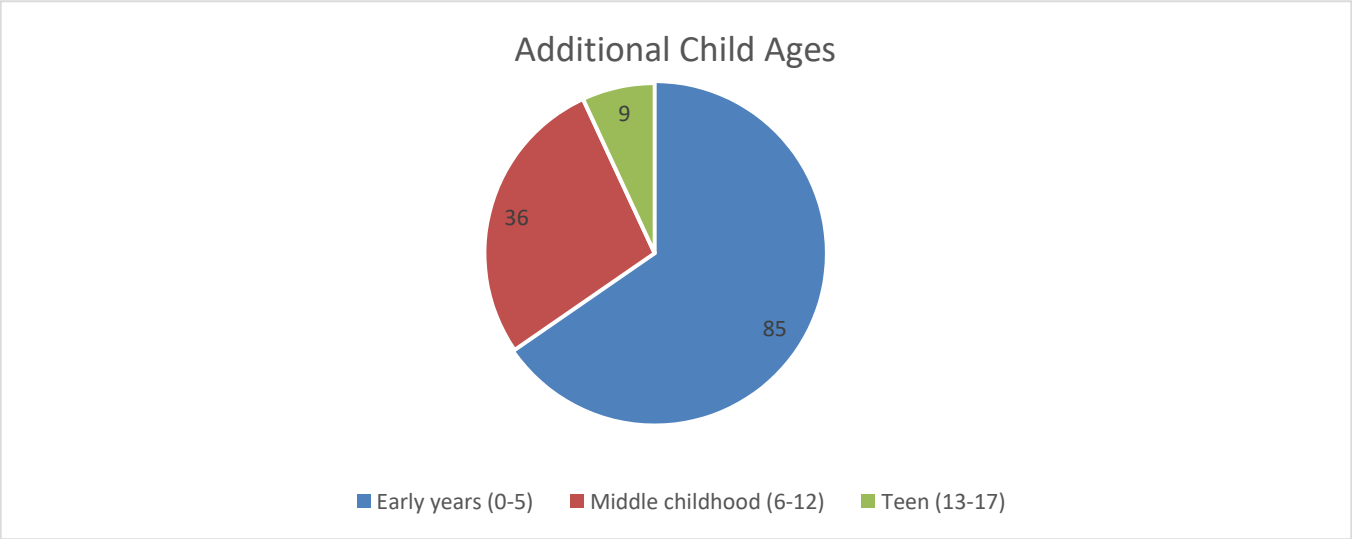

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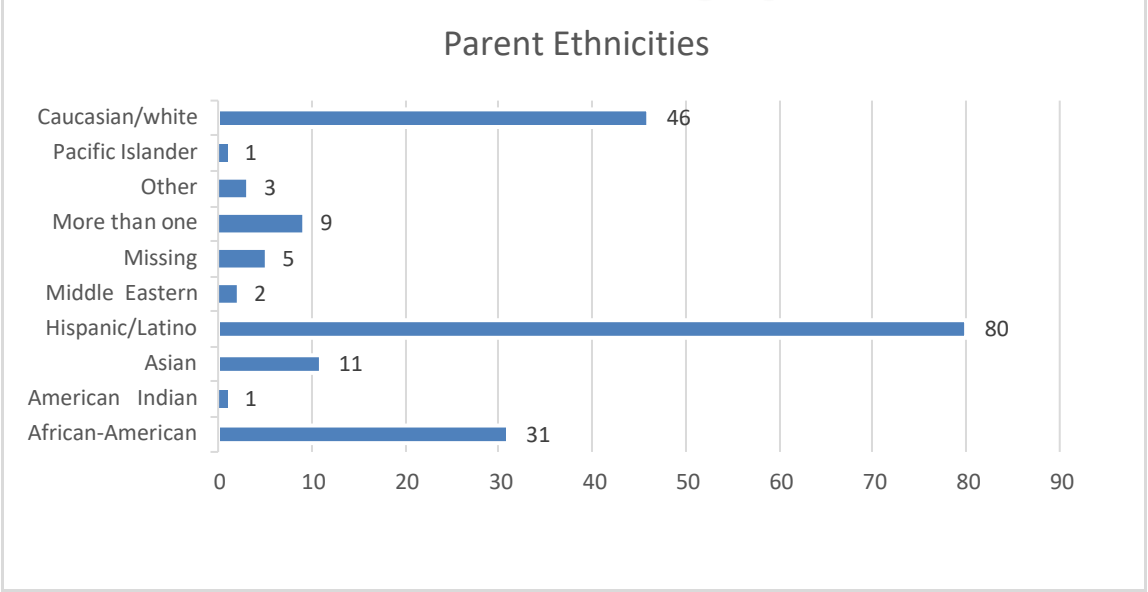
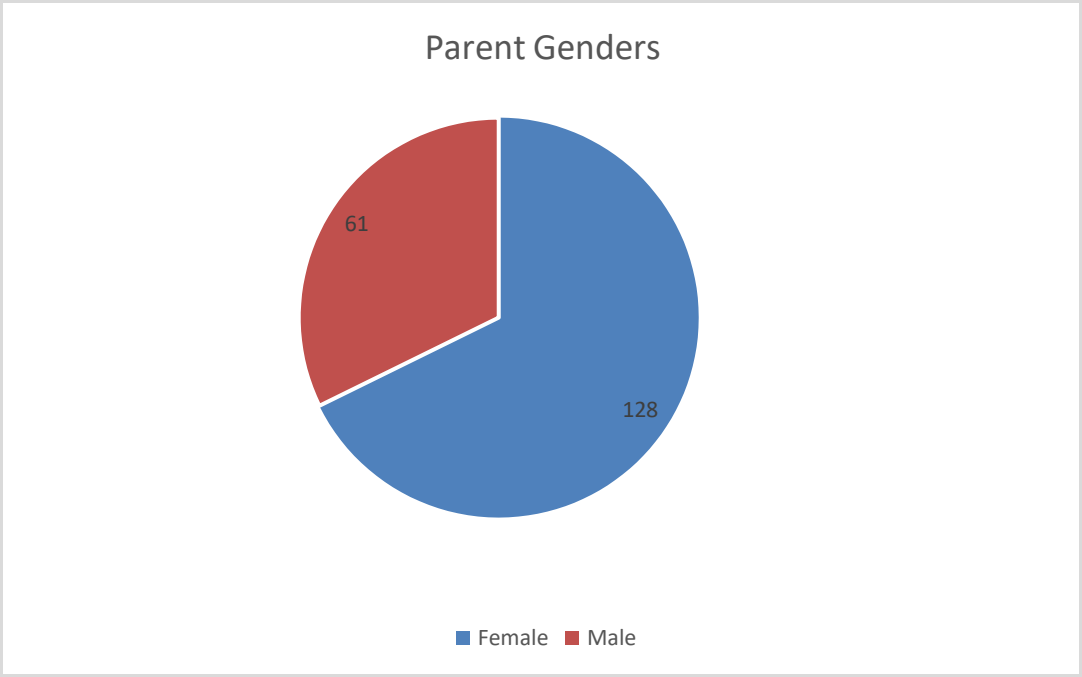
MHSA Overall Demographics





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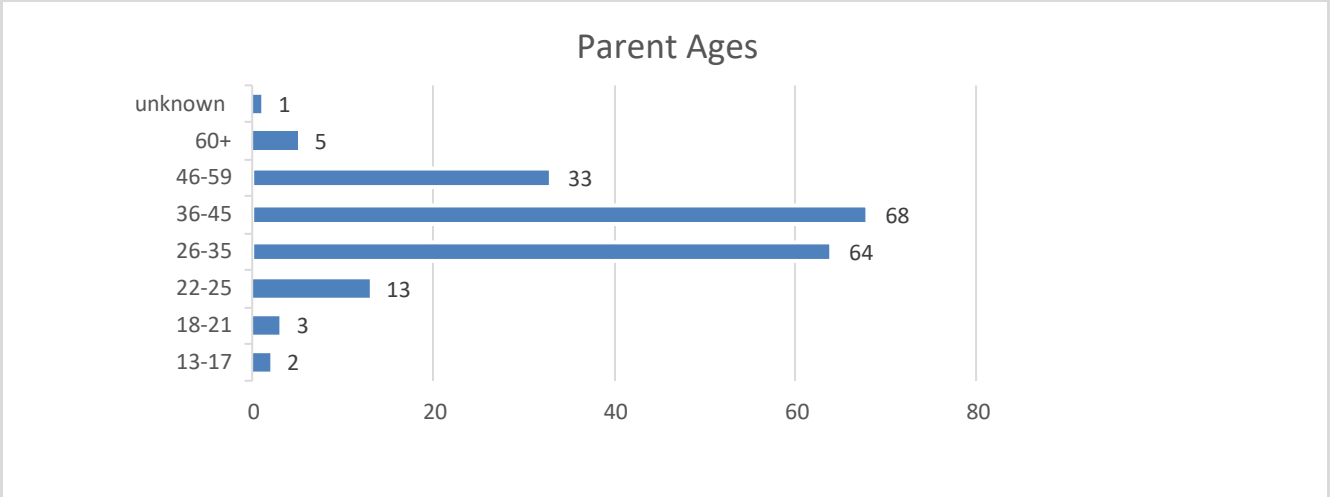

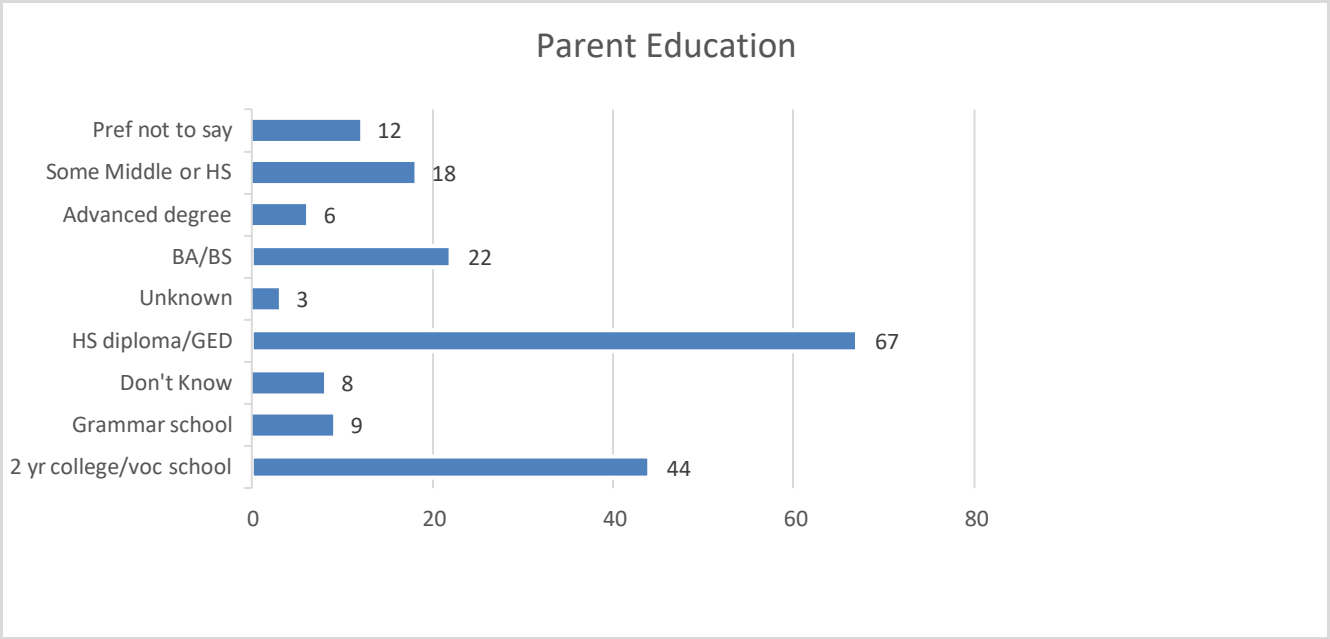

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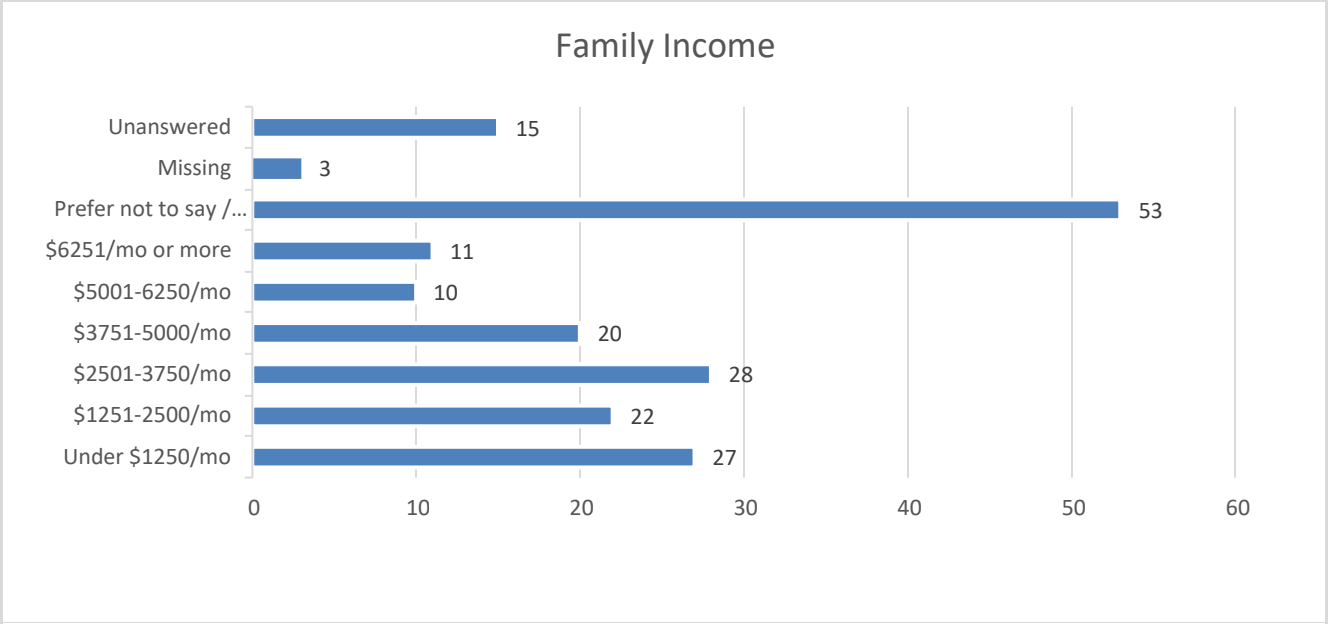

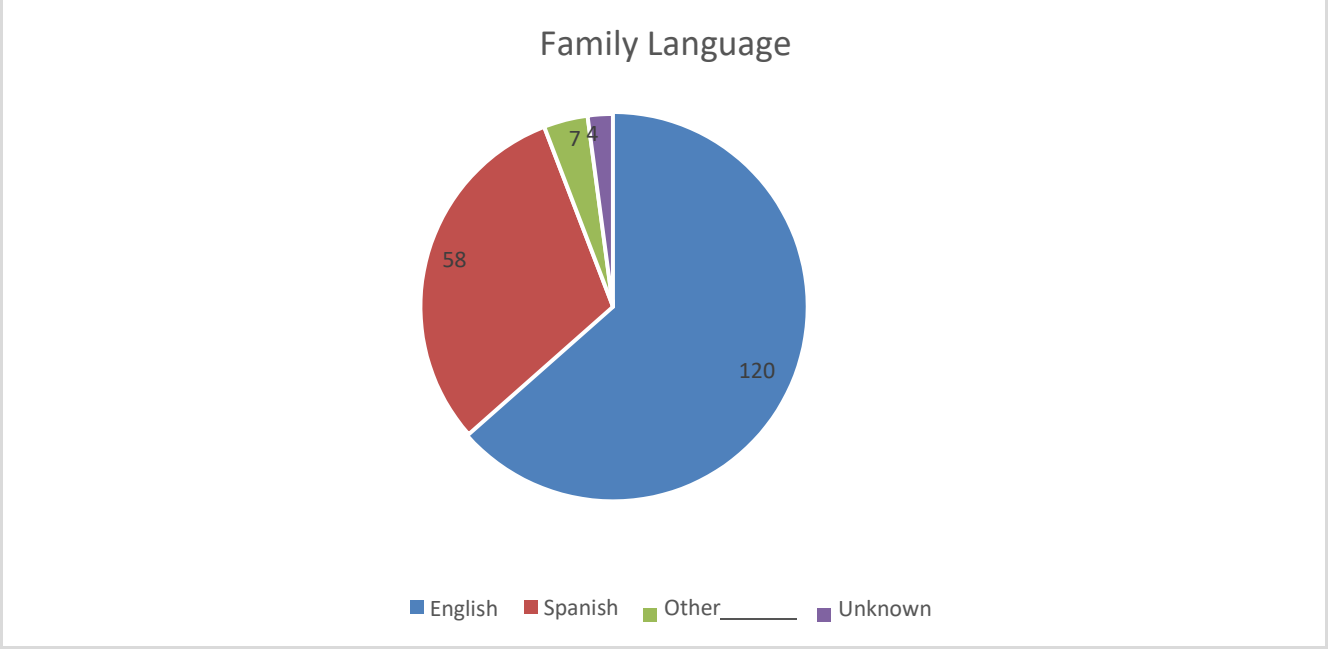

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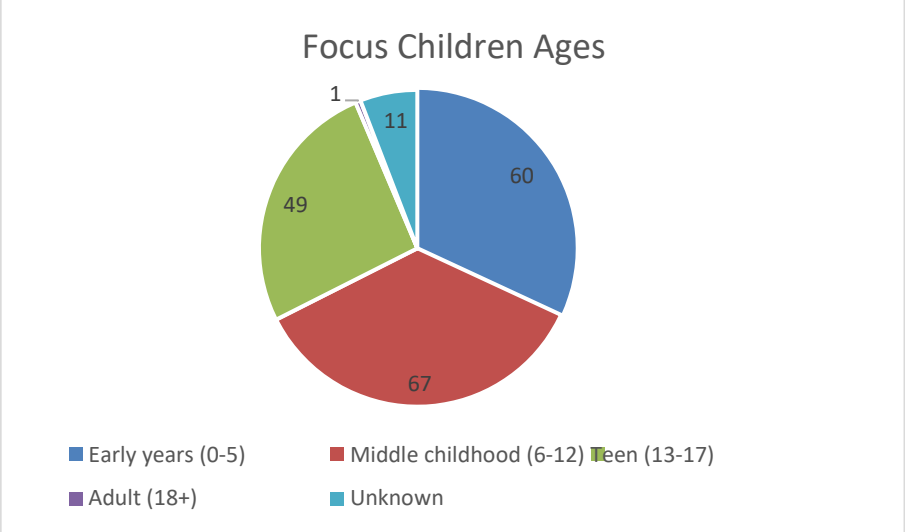
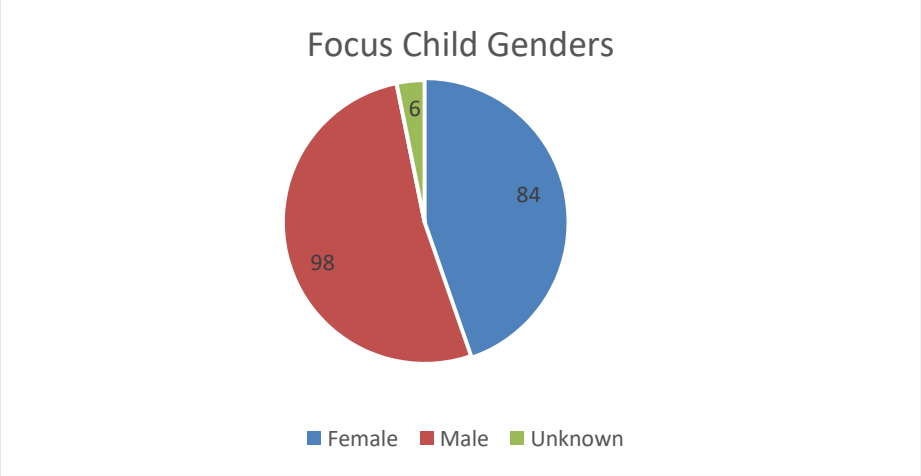
MHSA Overall Demographics, cont.





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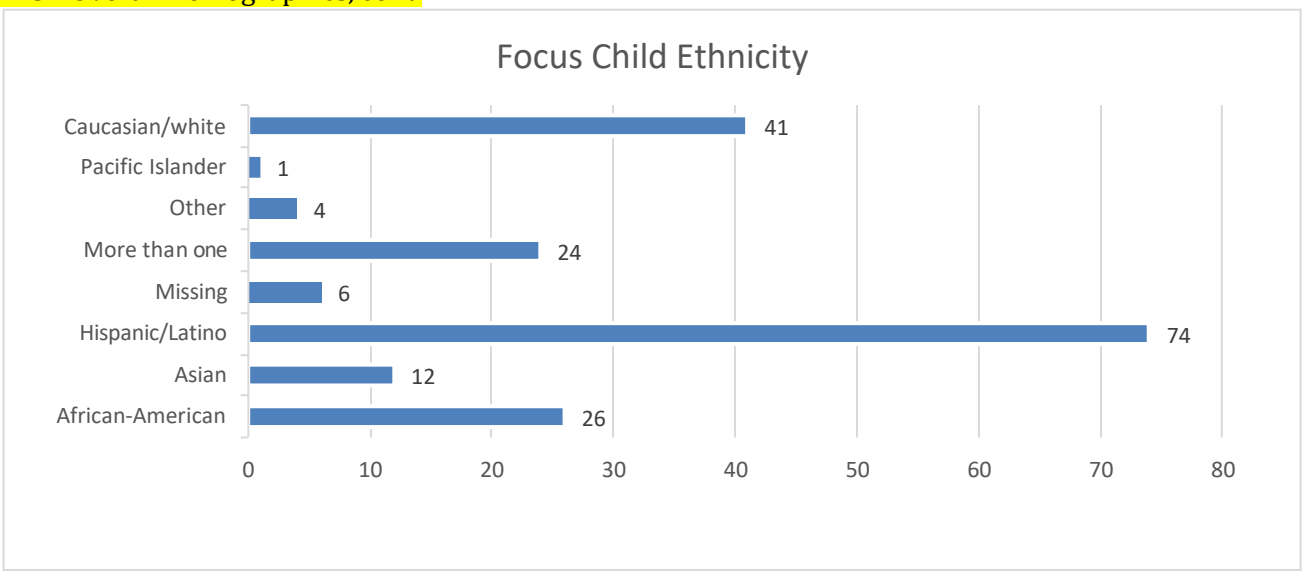
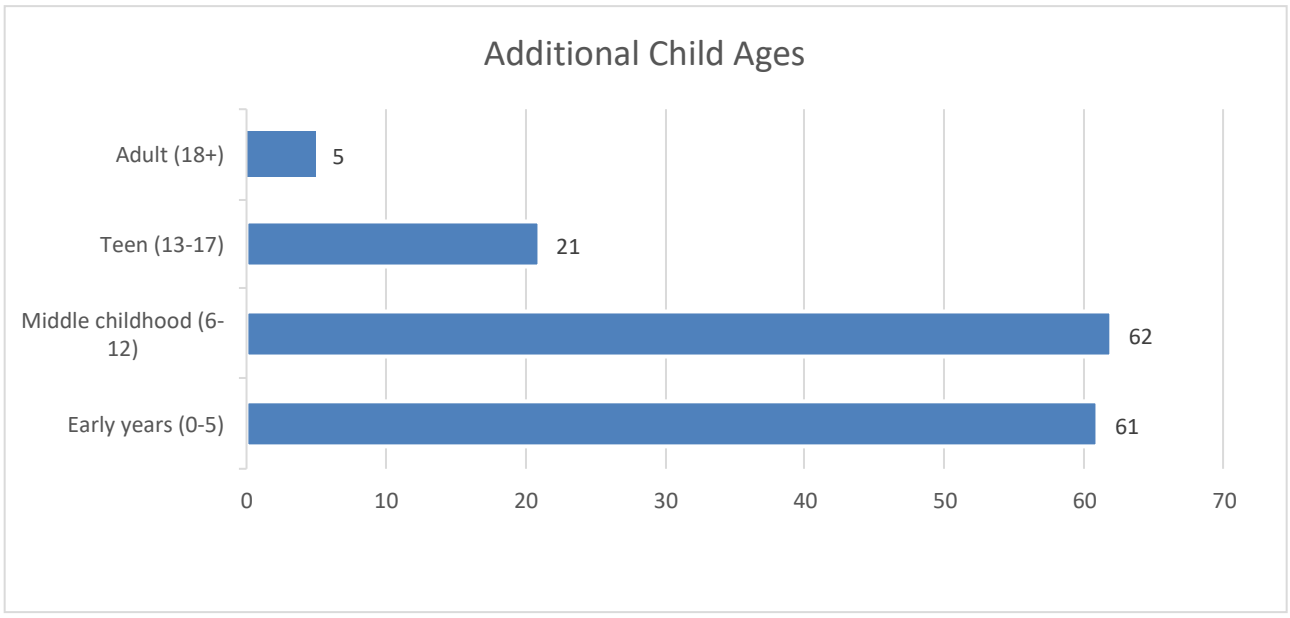
MHSA Overall Demographics, cont.





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1b) Settings of Potential Responders for the 2018-19 FY included elementary, junior and high schools, early education centers, churches, homeless shelters and community-based organizations. Below is a list of class site locations for Triple P:

MHSA Triple P Site Locations
C.O.P.E. Family Support Center – Central County
Family Justice Center – West County
Martin Luther King Jr. High School – East County
Hillview Jr. High School – East County
Cornerstone Fellowship – East County *New partner
Ranchos Medanos Jr. High School – East County
Contra Costa Juvenile Hall – Central County
Shelter Inc. – Central County

First 5 Triple P Site Locations
East County First 5 Center – East County
Martinez Early Childhood Center – Central County
Monument First 5 Center – Central County
West County First 5 Center – West County
Shelter Inc. Mountain View House – Central County
Cornerstone Fellowship – East County *New partner
C.O.P.E. Family Support Center – Central County
Delta First 5 Center – East County
Antioch First 5 Center – East County
Family Justice Center – Central County

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Methods Used to Engage Potential Responders

2) Methods Used to Reach Out and Engage Potential Responders include:

- Distribution of flyers for upcoming classes to community members and other CBOs in both electronic and hard copy
- Attended community events to provide resources (such as school resource fairs and outreach events)
- Collaboration with the Contra Costa Truancy Court, School district SARB (School Attendance Review Board) panels, Contra Costa Family Court and Children and Family Services (CFS) to refer families to parenting classes
- Collaboration with school districts and administrative staff to provide referrals to parents of students within each district
- Case Management referrals for parents working with C.O.P.E. case management staff
- Website advertising of class schedule
- Referrals from community partners such as Contra Costa Juvenile Probation, Family Justice Center, Miller Wellness Center and SHELTER Inc.
- Provided briefing/orientation meetings to community agencies interested in referring members to the Triple P program. During the 2018-19 FY, the following community partners were provided with a briefing/orientation meeting:
    - **West County Children and Family Services**
    - **Contra Costa Leadership Institute (CCLI)**
    - **Scotts Valley TANF**
    - **Acalanes Adult Education Center**
    - **Pittsburg Unified School District**
    - **Court Appointed Special Advocates (CASA)**
    - **Cornerstone Fellowship**
    - **Shelter Inc.**
    - **Lincoln Family Services**
    - **Community Violence Solutions**
    - **Rainbow Community Center**
    - **Center for Human Development**

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Strategies Utilized to Provide Access and Linkage to Treatment

3) Strategies Utilized to Provide Access and Linkage to Treatment include:

- Provide in-depth/clinical assessment of need and case management to community members in need of access to services
- Development of individual case plans (Contract for Wellness) specifically tailored to the needs of each participant
- Collaboration with mental health resources such as Contra Costa Children's Behavioral Health, Contra Costa Regional Center, Mobile Response and Lincoln Family Services
- Collaborate with County agencies to provide court-certified interpreters as needed
- Referrals to community resources such as housing, job training and placement, food banks and family law centers
- Evaluate and provide individual parent consultation for Triple P participants scoring above the clinical-cutoff range in any pre-assessment (DASS, Parenting Scale, ECBI, Conflict Behavior, Relationship Quality Index), providing resources as needed
- Train staff in available resource opportunities to strengthen the support given to each participant
- External referrals to more intensive services (such as AOD, psychiatry, medical providers) as needed
- MHSA & First 5 Resident Case Manager to provide one-on-one assistance with application process for county-related services (such as CAL Fresh, Medi-Cal, MST, MDFT)

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Strategies Utilized to Improve Timely Access to Services for Underserved Populations

4) Strategies Utilized to Improve Timely Access to Services for Underserved Populations included:
   - All First 5 funded classes are free. MHSA Classes free and sliding scale Triple P classes for low-income participants
   - Delivery of classes throughout the county at various times and convenient locations to accommodate transportation barriers (accessible via public transportation)
   - Increased capacity to offer case management services for parents and families with more intensive challenges utilizing master's level MSW interns to provide individualized support
   - Provided classes in English and Spanish and Arabic/Farsi languages in each region of the county
   - Individual assessment, consultations and referrals to county mental health as needed
   - Collaboration with school districts, social workers, other service providers and families to ensure timely access to supports and resources
   - Direct collaboration with Contra Costa County CFS Social Workers II & III to ensure participant Case Plan needs are met
   - Tailored classes that include focus topics that directly address parenting needs (ex. Family Transitions Triple P specifically addresses dysfunction in the co-parent relationship and the impact such dysfunction has on the family unit as a whole)
   - After assessing family needs, we link to other community supports such as county mental health, housing, crisis centers and other resources
   - Utilizing our Clinical Trainee Program to provide immediate services to underserved populations that have had difficulty accessing the system at large (such as Contra Costa County Mental Access Line)
   - Utilizing our Clinical Trainee Program to provide more accessibility to county systems such as Medi-Cal, CAL-Fresh and other consumer benefits

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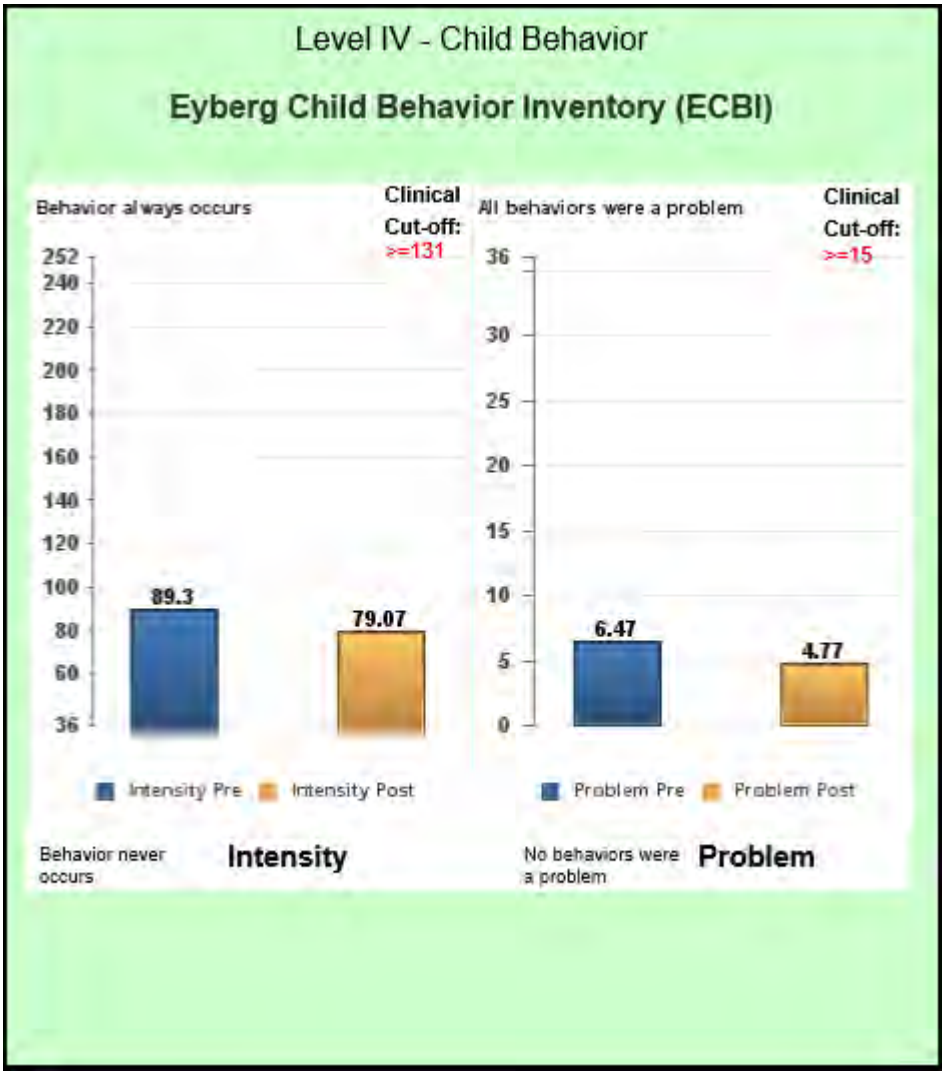
OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***Include a list of indicators measured, how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

MHSA Overall Clinical Outcomes

Eyberg Assessment



Intensity decreased by 11% from pre-test to post-test
Problem measure decreased by 26% f from pre-test to post-test

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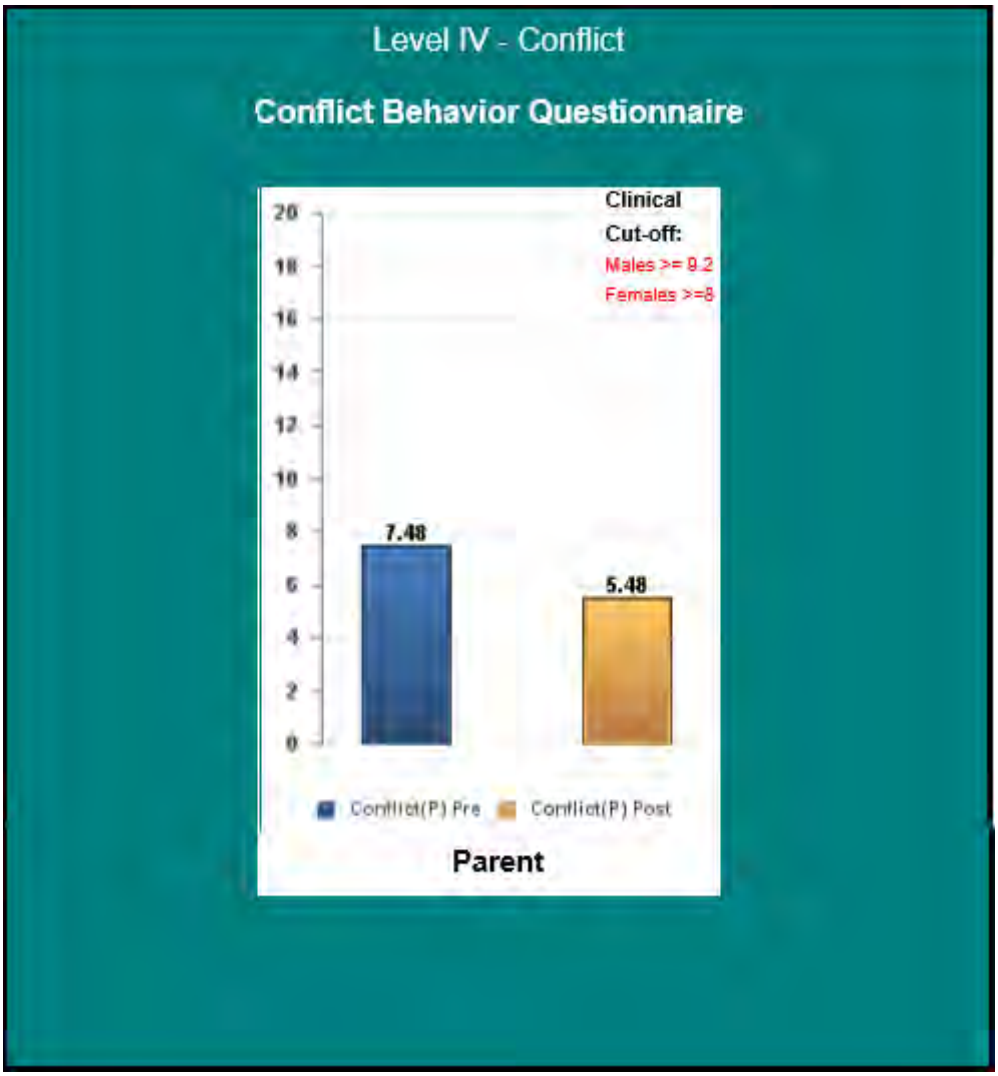
MHSA Overall Clinical Outcomes, cont.

Conflict Behavior Assessment



Conflict measure decreased by 27% from pre-test to post-test

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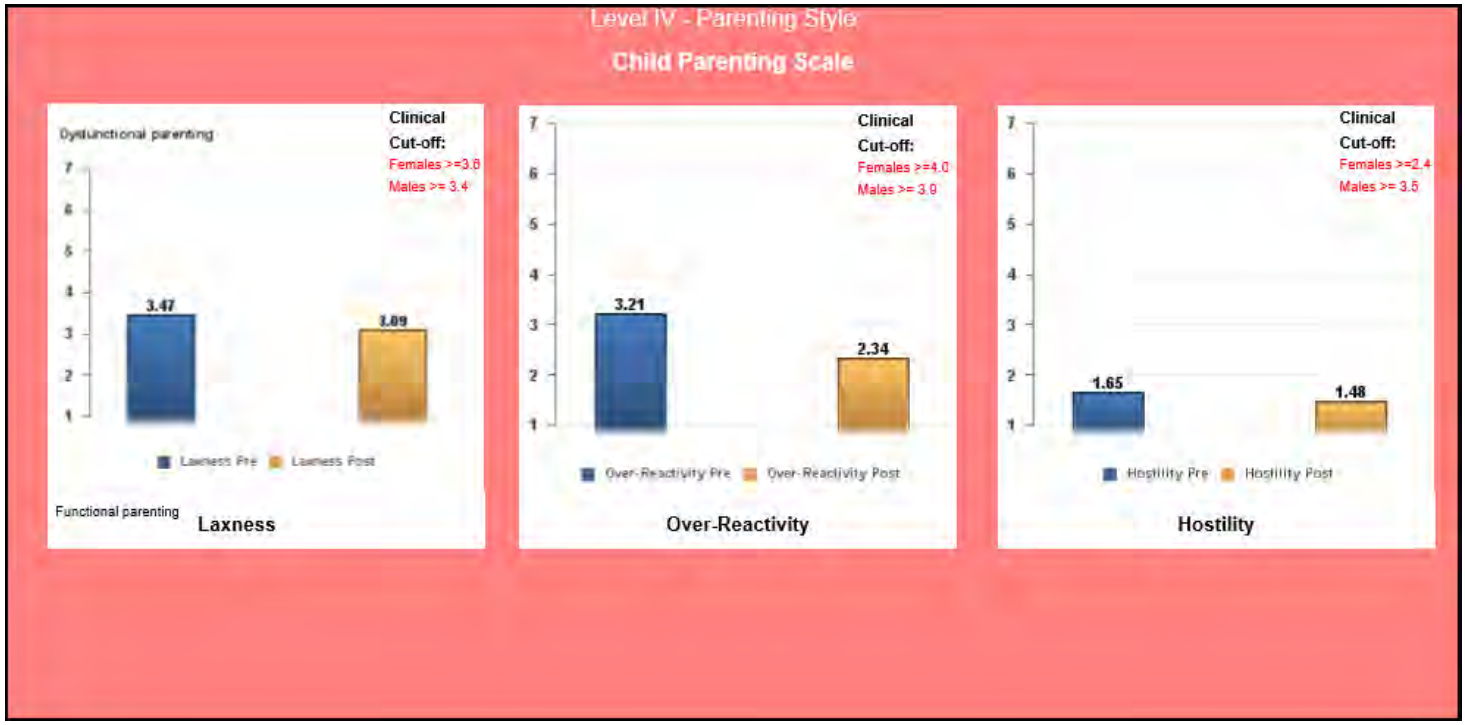
MHSA Overall Clinical Outcomes, cont.

Child Parenting Scale Assessment



Laxness measure decreased by 11% from pre-test to post-test
Over-reactivity decreased by 27% from pre-test to post-test
Hostility decreased by 10% from pre-test to post-test

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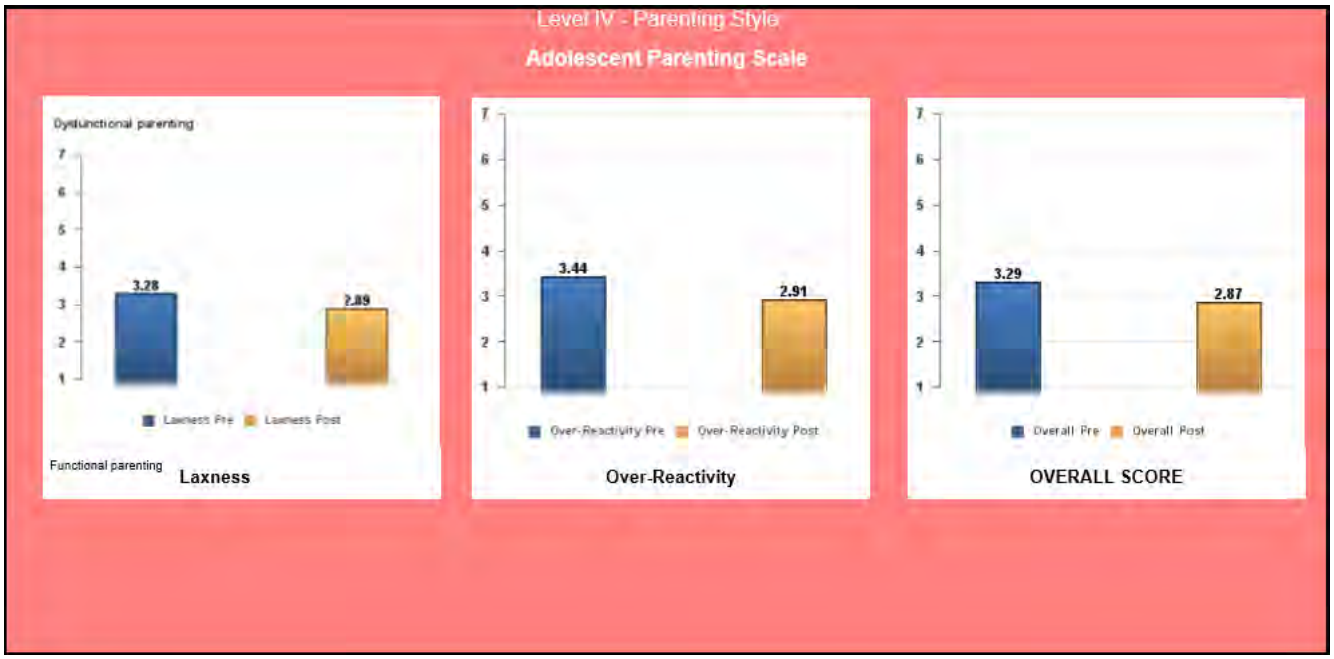
MHSA Overall Clinical Outcomes, cont.

Adolescent Parenting Scale Assessment



Laxness measure decreased by 12% from pre-test to post-test
Over-reactivity decreased by 15% from pre-test to post-test
Hostility decreased by 13% from pre-test to post-test

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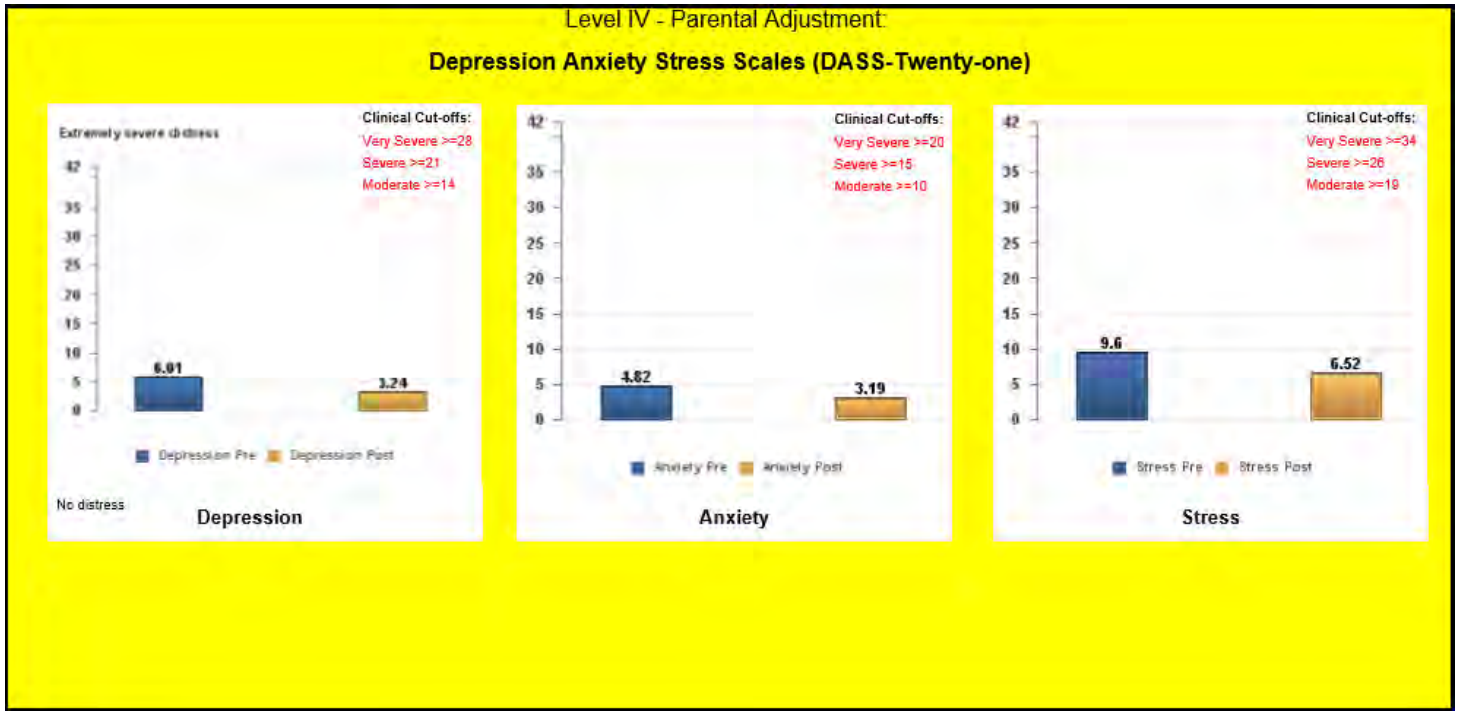
MHSA Overall Clinical Outcomes, cont.

Depression, Anxiety and Stress Scale Assessment



Depression measure decreased by 46% from pre-test to post-test
Anxiety measure decreased by 35% from pre-test to post-test
Stress measure decreased by 32% from pre-test to post-test

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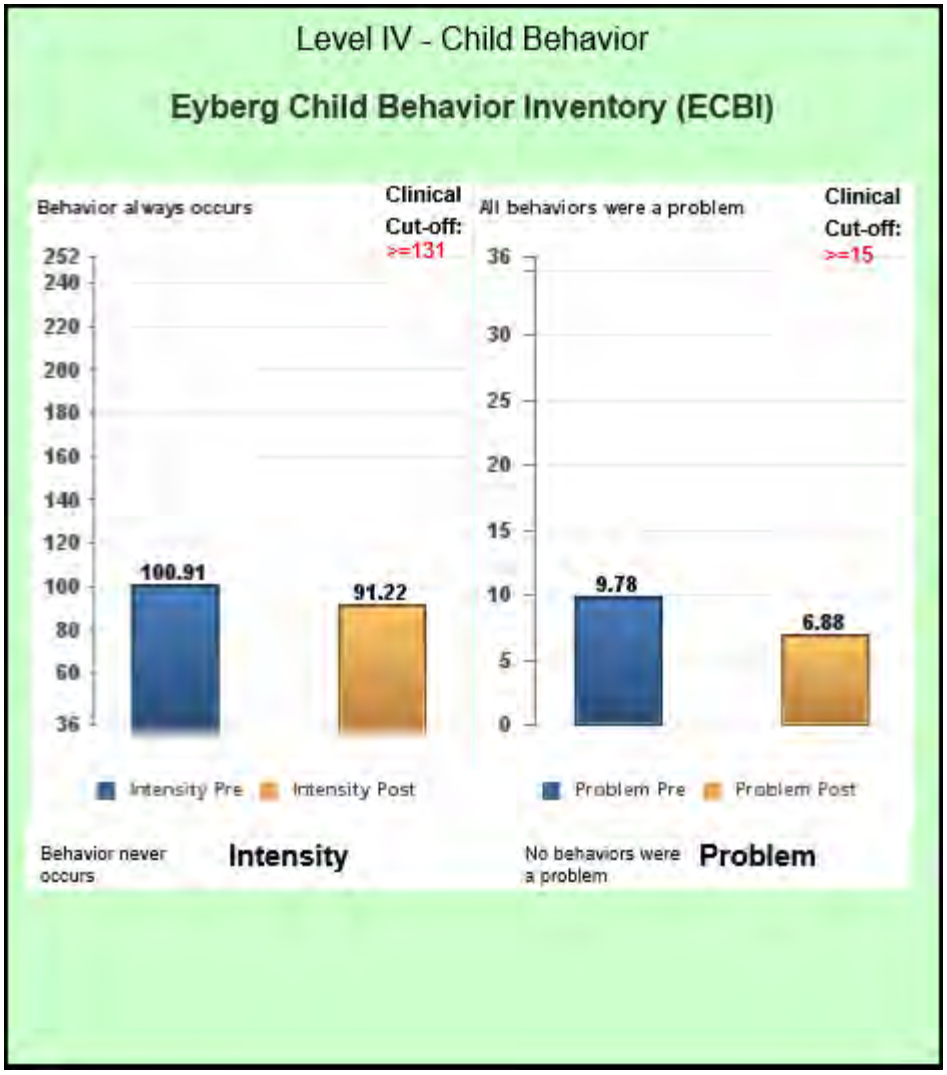
First 5 Overall Clinical Outcomes

Eyberg Assessment



Intensity decreased by 10% from pre-test to post-test
Problem measure decreased by 30% from pre-test to post-test

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First 5 Overall Clinical Outcomes, cont.

Child Parenting Scale Assessment

Laxness measure decreased by 27% from pre-test to post-test
Over-reactivity decreased by 23% from pre-test to post-test
Hostility decreased by 24% from pre-test to post-test

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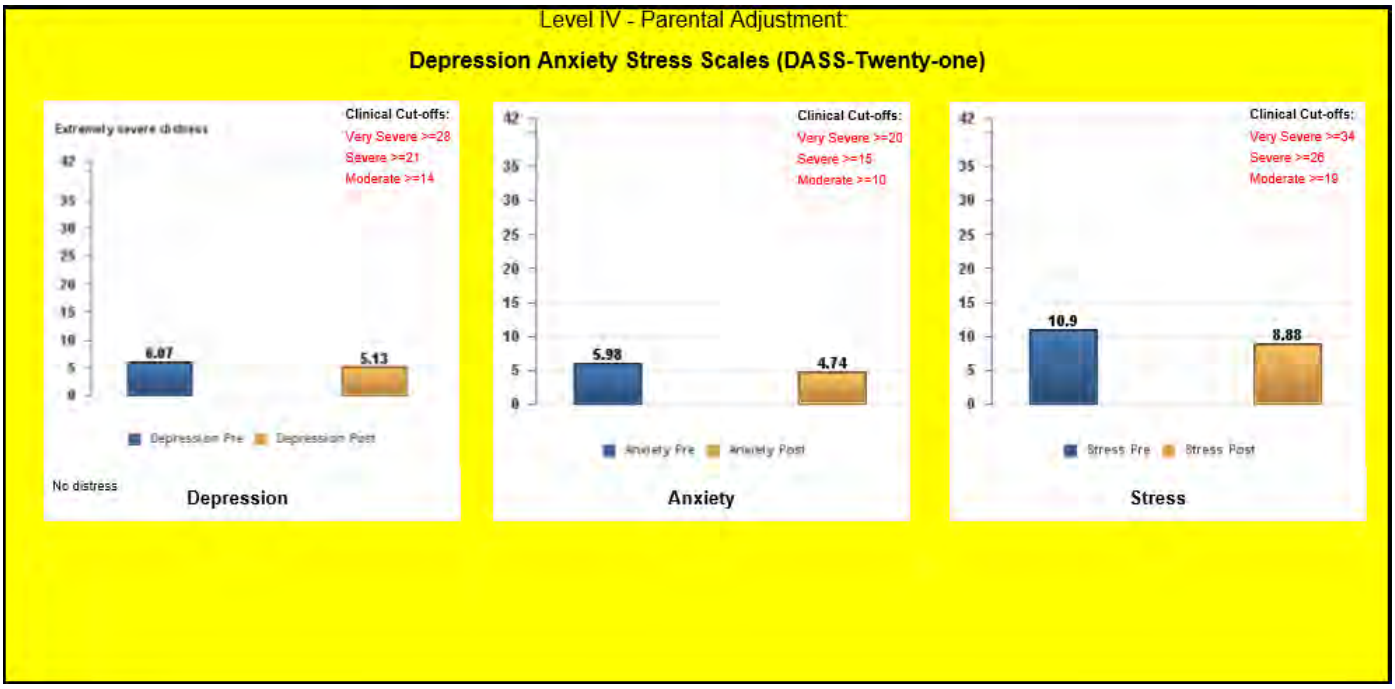
First 5 Overall Clinical Outcomes, cont.

Depression, Anxiety and Stress Scale Assessment



Depression measure decreased by 15% from pre-test to post-test
Anxiety measure decreased by 11% from pre-test to post-test
Stress measure decreased by 19% from pre-test to post-test

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DEMOGRAPHIC DATA: ☐ **Not Applicable** ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

N/A

VALUES:

Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

Values

- C.O.P.E. Family Support Center fosters a holistic approach to family wellness and recovery by providing evidence-based parenting classes along with other augmented services.
- Parents in need of further intervention are identified through their participation in Triple P parenting classes and are linked to supplementary services as needed.
- Participants may express a need for more intensive support and utilize other programs offered such as individual and family counseling, Anger Management and Truancy Intervention.
- By offering a menu of services, C.O.P.E. can provide customized support to families in need as well as identify referrals to additional resources such as county mental health, housing, food banks and family law centers.

Augmented Service: Case Management

Case management is provided to participating families which includes:

- Initial assessments of needs
- Parent/Family coaching
- Resource referrals
- Enrollment into appropriate C.O.P.E. programs
- Weekly check-ins from C.O.P.E. staff
- Preparation of progress reports/attendance verification

C.O.P.E. also provides a comfortable, family-oriented atmosphere for community members visiting the office for services. . In addition, C.O.P.E. employs a culturally diverse administrative staff that is representative of the community in which we serve and allows for a non-judgmental environment for all who see supportive services. C.O.P.E. has a culturally diverse Parent Education facilitation staff, both personally and professionally with sensitivity and training in the needs and characteristics of diverse populations of participants.

C.O.P.E. staff cultivate an inclusive, non-judgmental environment for participants seeking services and are trained in areas such as ACES, trauma-informed care, self-regulation techniques, conflict resolution and other methods for participant communication.

C.O.P.E. provides a culturally inclusive classroom where parents and staff recognize, appreciate and capitalize on diversity to enrich the overall learning experience. Fostering a culturally inclusive learning environment that encourages all individuals – regardless of age, gender, ethnicity, religious affiliation, socioeconomic status, sexual orientation or political beliefs – to develop respectful, effective and consistent parenting skills that nurture the uniqueness so of each family.

VALUABLE PERSPECTIVES:
Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

Participant Testimonials

What about this program was the most helpful?

- Learning new method to speak calmly without shouting
- It helped us to learn to educate the children and how to support them
- Helped us to better educate our children
- Learned strategies to communicate with our children without much difficulty
- I took Triple P English last year, this program is really good
- Received information on how to interact with my adolescent
- Create safe and pleasant places for rewards and contracts to spend time with her
- Helped me to understand my adolescent about his way of thinking, acting, understanding his actions. and how to apply rules and appropriate punishments
- everything
- To apply new methods to treat problems with teenagers
- How to talk with the children and give them advice
- To be able to understand my daughter's feelings
- How to understand my daughter and give more quality time and enforce rules
- Helped me to be more patient with my son, have more conversations
- Share experiences with other parents and the instructor explained very good the subject
- The different experiences shared with all the parents. the ideas shared in the videos and the examples of the teacher are excellent

- Now I have more patience now it is easier for me to talk about the problems now it is easier for me to handle the problems

What could make the Triple P classes better?

- Make the classes longer
- To have more classes to teach us how to treat our children
- Have more Triple P classes
- More time in classes
- I took class years ago, to have classes longer is better
- I think the class is very complete
- Give more exact methods and focus on how to solve problems, not so much on the problem itself
- Everything was good
- Shorter videos and more time to close
- Shorter videos and more time on tips on how to talk moderately to teenagers
- To understand how my son will react in the future helped me a lot to listen to the advice of other mothers
- Maybe a little more time of the program to understand and live more experiences
- For me it was very good class, this is my first time attending this kind of class, for me the teacher was excellent by listening to us and explained everything perfectly

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Class Pictures

Central Family Justice Center

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SHELTER Inc.

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Ranchos Medanos Jr. High School

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West Family Justice Center

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PEI ANNUAL REPORTING FORM

EARLY INTERVENTION REPORTING FORM **FISCAL YEAR: 18-19**

Agency/Program Name: CCCBH/First Hope

PEI STRATEGIES:
Please check all strategies that your program employs:

X **Provide access and linkage to mental health care**

X **Improve timely access to mental health services for underserved populations**

X **Use strategies that are non-stigmatizing and non-discriminatory**

SERVICES PROVIDED / ACTIVITIES:
Please describe the services you provided in the past reporting period. Please include types of problems/needs addressed, any activities that address these problems/needs, and any functional outcomes targeted by the services provided.

For the past six years, First Hope has provided early identification, assessment, and intensive treatment services to youth ages 12-25, and their families, who show signs and symptoms indicating they are at Clinical High Risk (CHR) for psychosis. During this fiscal year, we expanded our program to offer Coordinated Specialty Care (CSC) services to First Episode Psychosis (FEP) young people ages 16-30, and their families, who are within 18 months of their first episode. As part of this expansion, we moved to a new location in Pleasant Hill and hired 13 additional staff, including new positions of program supervisor, a part-time RN, community support worker peer specialist, and a substance use counselor.

Key components of our program include 1) community outreach and education, 2) rapid and easy access to screening and assessment, and 3) intensive treatment services.

1) Community outreach and psychoeducation – The expansion of our First Hope services has provided an opportunity to re-engage with our various community partners and to build relationships with new collaborators. Our outreach presentations focus on the importance of early intervention, how to recognize the early warning signs of psychosis, and how to make a referral to the First Hope program. Some of the organizations we have presented to in fiscal year 2017/2018 include Seneca, Anka, the Mental Health Commission, CCCBH Central Children's Clinic, the SPIRIT program, CCCBH Financial Counselors, Putnam Clubhouse, CCCBH Psychiatrists, the Mental Health Advisory Council, CCBH Forensics Team, St. Mary's, and the Adult System of Care meeting.

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2) Screening and assessment – In order to provide a high level of responsiveness and access to immediate help, First Hope has a Clinician of the Day (COD) who takes screening calls as well as any urgent calls when the primary clinician is not available. The telephone screen helps to determine whether a more extensive SIPS assessment is indicated, whether an individual is eligible for our new FEP services (based on a combination of the potential client's self-report, a medical records review, and collateral information), or whether the caller is referred to more appropriate services. We have also established an Urgent Response Team (URT) that has some capacity to provide an urgent response to those in crisis in inpatient psychiatry or crisis residential treatment. Services are offered in any language using the language line. Services in Spanish are provided by our Spanish-speaking clinicians.

3) Intensive treatment services – Please see section below on Evidence-based or promising practices. Treatment services are offered in any language using the language line. Treatment services in Spanish are provided by our Spanish-speaking clinicians.

Functional outcomes targeted are improved functioning at school and work, improved relationships with family members, decreased need for hospitalization and PES visits, and most importantly preventing conversion to psychosis or a reoccurrence of a psychotic episode.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services.

- ***Which mental illness(es) were potentially early onset***
- ***How participant's early onset of a potentially serious mental illness was determined***
- ***List of indicators that measured reduction of prolonged suffering and other negative outcomes, and data to support overall reduction. Include how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

We work with youth ages 12-30 who are either at Clinical High Risk (CHR) for developing psychosis, or within 18 months of their first episode of psychosis (FEP), as established by the Structured Interview for Psychosis-risk Syndromes (SIPS) assessment, the potential client's self-report, a medical records review, and/or collateral information.

The primary desired outcome for our CHR clients is to prevent conversion to psychosis in a population estimated to carry a 33% chance of conversion within two years. Secondary outcomes include reduction in crises, hospitalization, incarceration and suicide attempts or completions. We had 0 conversions from CHR to psychosis from July 2018 through June 2019. From the inception of our program in 2013, we have had 5 conversions, a conversion rate of less than 5% and a nearly 90% reduction in the predicted conversion rate if no services were provided.

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During the previous fiscal year (2017/2018), we intensified our collaboration with Juvenile Hall and started providing First Hope services to clients while they were still incarcerated, if they otherwise qualified for our program and were scheduled to be discharged from the correctional setting in the near future. This allowed us to implement intervention services even earlier than we had been able to previously. Three of our clients were re-incarcerated during the previous fiscal year (2017/2018), and one was re-incarcerated during the 2018/2019 fiscal year.

We had 3 suicide attempts and 0 suicides from July 2018 through June 2019.

Not enough time has passed since the start of our FEP services to collect needed data to assess whether the rate of PES visits and hospitalization has changed over baseline rates in our clients.

Improvement in age-appropriate functioning is also critical. Our data indicates that at the beginning of treatment the vast majority of clients were failing in school, while at discharge they were stable in school. Many who were work-eligible were now working at least part-time. We also showed a 15 point average increase in GAF for all clients, including those who did not complete the program.

We gather data on outcomes every six months of treatment and at discharge. This data is treated like all other PHI. This data is also entered into a First Hope Database that is housed on the CCC Behavioral Health server and is password protected. Only de-identified/aggregate data is shared with individuals outside of First Hope.

DEMOGRAPHIC DATA: ☐ *Not Applicable (Using County form)*
If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

We use the County form to gather Demographics data for clients who engage in our assessment and treatment services. We gather different data during the outreach and screening components of our program, as described below:

Outreach: We collected different demographics for this component to target the important information needed to assess our outreach goals. The data collected include the type of service provider, the region of the county served, and the number of participants.

Screen Calls: We do not use the county demographic form in order to avoid barriers that may be encountered due to stigma or lack of a release of information. Screen calls are designed for same day conversation with one of our clinicians and in a manner that allows the caller, whether it is the client, family member, or professional, to disclose concerns without requiring background information, unless the caller is able to do so and is willing. Also, since the caller has not engaged in services and may be cautious about disclosure, we only asked pertinent questions about the client's symptoms, important history related to the symptoms, contact information, region of the county, and the referral source. The call allows the caller to inquire about First Hope services and discuss symptoms to determine if an assessment is recommended or if the client is eligible for our FEP services, and allows our clinician to offer an assessment, an intake, or a recommendation of another service. If needed, we also offer advice about how to talk to the client, son, daughter or the family about the need for early intervention.

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EVIDENCE-BASED OR PROMISING PRACTICES:
What evidence-based or promising practices are used in your program and how is fidelity to the practice ensured?

First Hope uses the evidence-based Portland Identification and Early Referral (PIER) and Coordinated Specialty Care (CSC) models, which have been shown to be effective in preventing conversion to psychosis and the subsequent disability associated with psychotic disorders, and in ameliorating psychotic symptoms and promoting functional recovery. Both models provide comprehensive and needs-driven services utilizing the combined skills of a multidisciplinary team. Our First Hope treatment team includes a clinician, occupational therapist, educational and/or employment specialist, community support worker family partner, community support worker peer specialist, substance use counselor, RN, and psychiatrist. In addition to individual therapy, peer groups, case management, educational/employment support, psychosocial rehabilitation, and psychiatric services, clients also benefit from a heavy emphasis on family psychoeducation and engagement in Multifamily Group Treatment (MFGT).

Our clinicians are trained and certified to provide Structured Interview for Psychosis risk Syndrome (SIPS) assessments, Cognitive-Behavioral Therapy for psychosis (CBTp), and MFGT, evidence-based practices for assessing and treating CHR and FEP. Clinicians who have joined our team over the past year participated in intensive training in SIPS in February 2019 with Dr. Barbara Walsh of Yale University, one of the co-authors of the SIPS assessment, and in MFGT in May 2019 with Dr. Alex Kopelowicz of UCLA and Dr. Barbara Stuart of UCSF. Drs. Kopelowicz and Stuart will be conducting monthly supervision over the next year with audiotape review and feedback on MultiFamily Groups. All staff are expected to achieve clinical competence and certification by the end of this supervision period.

Weekly team meetings and weekly supervision meetings with First Hope's program manager and program supervisor provide opportunities to discuss services and assure fidelity to the treatment model. We also hold a weekly consultation call with Dr. Barbara Walsh, one of the co-authors of the SIPS assessment.

VALUES:
Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

First Hope practices a collaborative, strengths-based, and recovery-oriented approach that emphasizes shared decision-making as a means for addressing the unique needs, preferences, and goals of the individuals and families with whom we work. We define family broadly, that is, whoever forms the support team for the client, which may include friends, siblings, extended family, foster parents, significant others, and clergy. We

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also coordinate closely with other mental health and primary medical care service providers, to support our clients' overall mental and physical health.

Much care is taken to provide a welcoming and respectful stance and environment, from the very first contact by phone, to the individual and family's first visit to First Hope, to each and every interaction thereafter. We work closely with our families to identify and problem-solve barriers to accessing care, including childcare and transportation difficulties.

We over-screen so as not to miss any individual in need of service. Any individual who is determined not to be eligible for our program is provided with a referral to more appropriate services. For any individual/family who is found to be eligible for First Hope and accepts our services, treatment begins immediately with engagement (termed Joining sessions) with their assigned clinician.

Services are offered in any language using the language line and in Spanish by our Spanish-speaking clinicians, including a Spanish-language MFG. Our program brochures and psychoeducational materials are available in English and in Spanish.

VALUABLE PERSPECTIVES:
Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

Many of the individuals and families who have graduated from First Hope keep in touch with us, and several have returned as volunteers to speak with new clients and families about their experiences with First Hope. other members of the family. We also had one mother join our outreach presentation at the San Ramon Valley Mental Health Advisory Council on Feb 22, 2019. She spoke movingly about the struggles her daughter had experienced, and how much First Hope helped her daughter recover her life back.

Below is some additional feedback we have received from our clients and families:

"I have sound people who care."

"Talking one on one has been the most helpful thing. Everyone is really nice."

"I'm really happy with the First Hope group, helping my son getting much better. It's helped my son can go back to school regularly and hanging around with family."

"First Hope helped me realize my problem and talking with me to help me improve it."

"[My daughter] got the help she needed to receive home and hospital services from the school."

"The team helped solidify [my] life goals."

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"[My] family understands more."

"It's been better for me going to places with friends and family."

"I like how everyone treats me."

"I love and appreciate the staff here at First Hope. They are helpful, resourceful, caring, and genuinely good people."

"Thank you all for your true commitment to helping families and improving outcomes for young people in crisis."

"El apoyo de Colleen a sido de lo major."

"Para todo esta muy bien. Todos son muy buenos. Gracias por todo personas. Me siento yo imi niña como encasa."

"Lo que mas le ha ayudado es que lo mayoria de tiempo estan disponible"

"A saber entender lo que es siente y saber como mangejar esas situaciones."

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PEI SEMI-ANNUAL REPORTING FORM

ACCESS & LINKAGE TO TREATMENTREPORTING FORM **FISCAL YEAR: 2018-2019**

Agency/Program Name: James Moorehouse Project (at El Cerrito High School)
Reporting Period (Select One): ■Semi-Annual Report #1 (July – Dec)
☐Semi-Annual Report #2 (Jan – June)

PEI STRATEGIES:
Please check all strategies that your program employs:

■ Provide access and linkage to mental health care

☐ Improve timely access to mental health services for underserved populations

☐Use strategies that are non-stigmatizing and non-discriminatory

SERVICES PROVIDED / ACTIVITIES:
Please describe the services you provided in the past reporting period. Please include types of problems/needs addressed, any activities that address these problems/needs, and any functional outcomes targeted by the services provided.

For 2018-2019, the JMP has a team of ten clinical interns. In the fall semester (August – December 2018) interns and staff worked at capacity across our mental/behavioral health programming—this included individual/group counseling, crisis intervention and support, youth leadership/advocacy and youth development. Our groups continue to engage a wide range of young people facing mental health and equity challenges. In the fall semester over 300 young people participated in 20 different groups and/or individual counseling. Targeted outreach and services continue to reach our English Language Learners (ELL) who receive counseling, case management, in-class support and youth development programming. In November, the JMP took 50 ELL students to the Monterey Bay Aquarium for the day. Their joy and excitement to be in community and to see the exhibits and travel outside of the East Bay, was memorable. One of our ELL students was interviewed for a national radio program, Radio Bilingue, and reported that his participation in the JMP Youth ELAC group allowed him to begin to heal from his traumatic history and his long separation from formal schooling and that he now has a family at school and identifies as a leader in his community (link available upon request). The JMP continues our partnership with Niroga to support JMP youth leaders, Culture Keepers, to lead in-class dynamic mindfulness practices in classrooms. The JMP offers ongoing coaching for participating classroom teachers to strengthen their own personal practice and their classroom leadership of dynamic mindfulness practices.

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Twenty – Forty people attend our monthly evening English Language Advisory Committee (ELAC) meetings. Families learn about navigating the school, resources in the community and how to advocate for the rights of their children. Immigrant families also receive case management support connecting them to legal, housing and other family supports in addition to counseling services for youth on-site.

There is a new principal and one new assistant principal at ECHS this year (the third in four years). While it is a challenge to begin over again with a new principal, it is a very welcome change from the previous administration. Our new principal is a strong advocate for the JMP and is enthusiastic around collaboration and shared initiatives. We are eager to capitalize on this support to grow and strengthen our work with teachers around, restorative practices, mindfulness, trauma, structural racism and other school climate initiatives.

The JMP director continues to support school communities and school linked providers to build trauma sensitive disciplinary, community building and instructional practices. She continued her work in Contra Costa and Alameda Counties as a trainer for T2 (T Squared), the Bay Area wide collaboration working to shift public systems toward trauma informed practices. She also continued to offer trainings around racial justice work with teachers and school staff through the CA School Based Health Alliance offering trainings at their annual conference in Sacramento and to school health staff in the Central Valley at a Fresno convening in the fall.

The JMP is excited to play a role in the broader movement to help schools implement more compassionate and effective practices to support trauma impacted young people to be successful in school and to integrate strategies for including racial justice in every conversation around trauma. This fall, the JMP welcomed At ECHS this work included teacher-student restorative conferences, ongoing coaching around trauma sensitive instructional strategies and the second year of a JMP led year-long professional development group with 14 ECHS teachers on race and equity. Participants co-created a safe container to deepen their self-reflection around the ways that white privilege, white supremacy and implicit bias impact their own instructional practices and drive inequitable outcomes on campus. This group will continue for a third year into 2018-2019.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***How are participants identified as needing mental health assessment or treatment?***
- ***List of indicators measured, including how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***
- ***Average length of time between report of symptom onset and entry into treatment and the methodology used.***

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Young people are referred for services by parent/guardians, school staff, peers and themselves.

We measure a range of indicators (see Work Plan for 2017-2018) including connection to caring adults/peers and school, and a sense of well-being (diminished perceptions of stress/anxiety, improvement in family/loved-one relationships, increased self-confidence). The JMP engages in ongoing formative assessments throughout the school year that include participation by JMP staff/interns, school staff and youth participants.

(From 2017-2018 Work Plan)

Outcome Statements

A) Stronger connection to caring adults/peers (build relationships with caring adult(s), peers) for participating youth.
From UCSF evaluation: 96% of participating youth reported feeling like "there is an adult at school I could turn to if I need help." 91% "I get along better with people at my school."

B) Increase in well-being (diminished perceptions of stress/anxiety, improvement in family/loved-one relationships, increased self-confidence, etc.) for participating youth.
From UCSF evaluation: 96% of participating youth "I deal with stress and anxiety better" after program participation.

C) Strengthened connection to school (more positive assessment of teacher/staff relationships, positive peer connections, ties with caring adults) for participating youth.
From UCSF evaluation: 81% of participating students reported they "skip less school/cut fewer classes after program participation.

DEMOGRAPHIC DATA: ☐ Not Applicable ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

We have completed the County Demographic Form with the exception of the following:

Part 2: We import demographic data from PowerSchool (PS), the school district database; PS does not capture the ethnic categories listed in Part 2 of the County form.

Part 3: We capture only 6A, as reported by PS. It is not consonant with our respect for personal sovereignty to ask young people to identify their own sexual orientation, gender identity or disability status based on our need to know. Young people's identity language belongs to them; they can choose to disclose aspects of their identity in ways that feel useful and owned by them. We don't assume a right to that information.

Part 4: #8. We do not ask clients to disclose a "disability status." See Part 3 above.

Part 5: See Part 3 above.

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LINKAGE AND FOLLOW-UP:
Please explain how participants are linked to mental health services, including, how the PEI program follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

Young people are referred to services through a "Resource Request (RR) Form" widely available on the school campus and online through the JMP website. When the JMP receives a RR form, a JMP staff/intern will meet 1:1 with the young person to determine the appropriate level of support services. This can result in participation in on-site mental health services (i.e. individual counseling or therapeutic group support), a youth development/leadership/peer support program or a referral to a community based resource. Because we are an on-site school based program, we are able to easily follow up with students to ensure that they have successfully engaged with (or formally declined) services. If there is a crisis or urgent referral, students are connected with services immediately.

The length of time between referral and entry into services is 1 – 14 days depending on the urgency of the referral and staff/intern caseloads.

VALUES:
Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

The JMP integrates an activist youth centered program with more traditional mental health and health services; we prioritize community change along with positive health outcomes for individual youth participants. Our clinical program and youth centered initiatives challenge the dominant narrative that sees youth as "at risk" or as problems to be fixed. We partner with young people to build their capacity, and connect them with opportunities for meaningful participation in the school community. Students in counseling or a therapeutic group have direct access to wider opportunities for participation in JMP programs. All of these efforts foster resilience and wellness as they engage young people and caring adults in active and robust relationships.

The range of supports and opportunities at the JMP create an energetic field that powerfully mitigates against stigma. Young people come to the JMP for a counseling appointment, to offer peer support through a youth leadership program, to participate in the ELD youth committee, Culture Keepers, Skittles (a group for queer identified youth of color) or a myriad other possibilities. The JMP is a vibrant sanctuary on campus for youth of color and young people from low-income families in a school building where social identity threat is pervasive in other spaces.

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VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

The following quotes are from spring 2018 student evaluations of JMP services and programs:

The JMP is my second family

My counselor helped me understand where my anger is coming from. I don't get into so many conflicts at home like I used to.

The mindfulness exercises that I do with my counselor have helped me a lot with my anxiety. If I feel myself getting overwhelmed, I think about my breath and do that thing with my fingers.

My favorite thing about the JMP is that they keep things confidential. It's the only place I can go where I can say what's really on my mind.

The following quotes are from spring 2019 teacher evaluations of the JMP:

The JMP is the heart and soul of our school. I don't know what we'd do if you all weren't here

I can focus on my teaching, because I know that my students are well cared for when I refer them to the JMP for support.

The Culture Keepers are a gem—please keep them coming to my classroom for presentations, student support and mindfulness! Great stuff!

The work we're doing around racism has given me a whole new way of relating to my students. I feel more awake now, better able to connect to students that before I couldn't connect with.

The JMP on campus is like a sun sending out its warm rays into every classroom. It just feels safer knowing you all are here.

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PEI ANNUAL REPORTING FORM

EARLY INTERVENTION REPORTING FORM **FISCAL YEAR: 18-19**

Agency/Program Name: JFCS East Bay / Prevention Early Intervention

PEI STRATEGIES:
Please check all strategies that your program employs:

☒ **Provide access and linkage to mental health care**

☒ **Improve timely access to mental health services for underserved populations**

☒ **Use strategies that are non-stigmatizing and non-discriminatory**

SERVICES PROVIDED / ACTIVITIES:
Please describe the services you provided in the past reporting period. Please include types of problems/needs addressed, any activities that address these problems/needs, and any functional outcomes targeted by the services provided.

1) We provided culturally appropriate mental health education for client groups in their native languages.
2) We served 224 individual clients – including 81 staff, 46 children, 73 parents, and 24 older adults. Our demographics are based on 133 clients, representing 46 children, 73 parents, and 14 of the older adults. Staff members who attend trainings are not included in demographics. In addition, 10 of the older adults were served in groups at Mt. Diablo Adult Day Health Center and do not provide demographic information due to HIPAA limitations, nor do they receive navigation services.
3) We completed assessment and short-term early intervention with 104 bilingual clients. This number includes 17 children (those over the age of 18), 73 parents, and 14 older adults.
4) We provided individual mental health and health navigation services to 104 clients, as above.
5) We directly provided individual therapy in Dari/Farsi for 21 clients.
6) We provided community outreach and engagement activities in all of our target populations.

1. **Cross-Cultural Mental Health Training Series.** The training series began in August 2018:
    - *August 27, 2018: Living in Fear* – The presenters provided an overview/introduction to U.S. immigration law, information about the recent orders related to immigration, and changes under the new presidential administration. The presenters also provided know-your-rights information for immigrant communities and information regarding local nonprofit organizations for immigration legal assistance. Presenters spoke about the essentials of cultural history, reasons for migration, as well as reasons for staying in the U.S. despite the constant fear of deportation. The presenter also spoke about the mental health impact of immigration enforcement policies on children, families, and communities. Presenters also

discussed the barriers and struggle of living in mixed-status families and communities and the ideas of collective healing practices and culturally appropriate ways to cope and seek support

- *October 3, 2018: Suicide Risk Assessment* – Discussed a simple and easy to use model to help increase awareness, skills, and confidence in suicide risk assessment and management for a variety of providers such as case managers, clinicians, nurses, teachers, volunteers, mentors, and support staff.
- *February 27, 2019: Mandated Reporter* – Presented in collaboration with the Child Abuse Prevention Council. The trainers spoke on California state laws related to suspected child abuse. The training covered indicators and risk factors for child abuse and the legal responsibilities of California's mandated reporters.
- *April 15, 2019: Diversity, Equity & Inclusion* – Presenters cultivated a shared anti-oppression framework and built the foundation for courageous conversations and understanding; initiated a conversation on mindfulness, capacity-building, and accountability for diversity, equity, and inclusion and recognized additional ways to know and support each other in new ways that could break old patterns.

2. JFCS East Bay held **mental health education groups** throughout the year for the Dari-, Farsi-, Arabic-, and Russian-speaking communities.

   Russian psycho-educational senior groups: took place at Mt. Diablo Adult Day Health Center in Pleasant Hill. Katya Vorobeyva, Ph.D, hosted the psycho-educational groups, which were facilitated by JFCS East Bay staff member Lila Katz:

   - *October 15, 2018: Psychoeducation* (14 participants) – focus of the group was to improve mood and socialization by encouraging group participation in positive reminiscing through games and discussion.
   - *December 3, 2018: Psychoeducation* (14 participants) – focus of the group was to improve mood and socialization by encouraging group participation in positive reminiscing through games and discussion.
   - *March 4, 2019: Psychoeducation* (10 participants) – focus of the group was to improve mood and socialization by encouraging group participation in positive reminiscing through games and discussion.
   - *June 10, 2019: Psychoeducation* (13 participants) – focus of the group was to improve mood and socialization by encouraging group participation in positive reminiscing through games and discussion.

   Afghan/Iranian parenting groups: took place in our office and community spaces. Dr. Sohi Lachini facilitated the groups:

   - *November 28, 2018: Parenting Group* (9 participants) – Discussion about parenting issues related to foods and assisting children make healthy eating choices.
   - *February 27, 2019: Parenting Group* (12 participants) – Discussion about parenting issues with children with behavioral needs.
   - *January 28, 2019: Parenting Group* (17 participants) – Discussion about parenting issues related to financial needs and early tax preparation.
   - *June 19, 2019: Parenting Group* (10 participants) – Discussion about parenting issues related to school readiness.

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Afghan/Iranian Senior groups: This year, we had decreased the number of Afghan seniors' groups to two to gradually discontinue offering the group starting in FY20. But even organizing two groups proved to be challenging because the number of Afghan/Iranian seniors who are involved with the Mount Diablo Adult Day Center has decreased significantly in recent years. Many of the seniors have passed and the few who remain active struggle with cognitive issues due to old age. We were able to facilitate one group in June 2019 with 10 participants.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services.

- ***Which mental illness(es) were potentially early onset***
- ***How participant's early onset of a potentially serious mental illness was determined***
- ***List of indicators that measured reduction of prolonged suffering and other negative outcomes, and data to support overall reduction. Include how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

The program used the following tools to evaluate the efficiency of the program.

- Participants/clients evaluation forms for education sessions.
  - Collected after education session.
- Staff and community members' evaluation forms for education sessions.
  - Collected after training session.
- Tracking logs for:
  - Participants/clients associated with clinician and other mental health services.
  - Participants/clients associated with case managers for assessment and early intervention to community mental health services.
  - Number of participants/clients.
  - Number of participants/clients receiving navigation services.
- Pre- and post-assessments to measure progress.
  - Collected once at intake and once at exiting the program.

The indicators measured for this reporting period were:

- Ability to communicate, self-advocate, and see progress.
- Ability to apply for and receive services.
- Understanding rights.
- Access to and ability to navigate mental health system.

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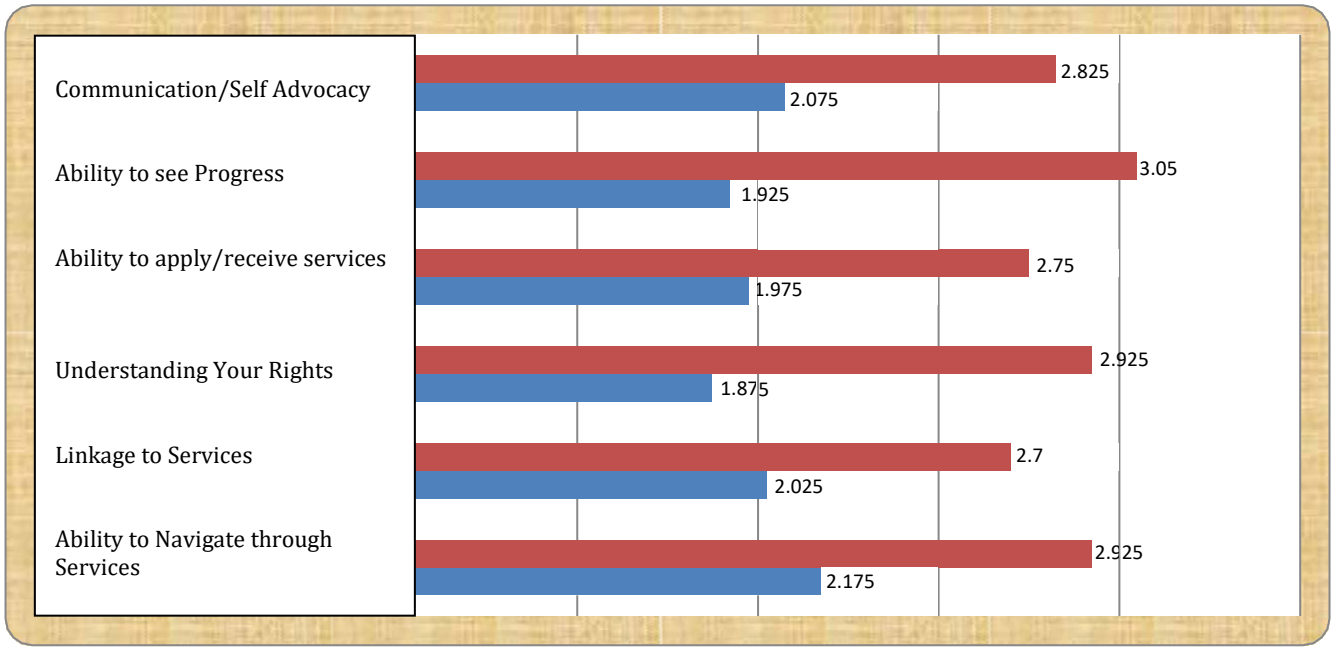
The chart below summarizes the results of client assessments as they entered and exited the program. The blue bar reflects the pre-assessments scores, done during intake. The red bar indicates post-assessments upon exiting. Assessments are on a scale of 1.0 to 4.0, with 1.0 being the lowest ranking and 4.0 the highest



The chart reflects a total of 104 individual adult participants/clients who completed the pre- and post-assessments. All participants increased in their ability to advocate for themselves, understand their rights, link themselves to mental health service, and navigate the system.

Cultural Competency: The case managers and staff are aware of, and responsive to, the cultural and demographic diversity of the population and specific client profiles. Case managers and staff understand relevant cultural information and communicate effectively, respectfully, and sensitively within the client's cultural context. During the grant period, we had Farsi-, Dari-, Arabic-, Russian-, and English-speaking staff.

Integrity & Confidentiality: JFCS East Bay's case managers and staff adhere to applicable local, state, and federal laws, as well as employer policies, governing the client, client privacy, and confidentiality rights, and act in a manner consistent with the client's best interest. Staff has up-to-date knowledge of, and adherence to, applicable laws and regulations concerning confidentiality, privacy, and protection of client medical information issues.

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DEMOGRAPHIC DATA: ☒ *Not Applicable (Using County form)*

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

EVIDENCE-BASED OR PROMISING PRACTICES:
What evidence-based or promising practices are used in your program and how is fidelity to the practice ensured?

The clients served by PEI are primarily survivors of human rights abuse. They have fled war and persecution and have experienced or witnessed violence and trauma. JFCS East Bay staff worked with clients from a holistic and strength-based approach, with a focus on increasing parenting skills and knowledge of child development. In addition, our case managers help families access services to increase family stability. For families exposed to trauma, the additional stress of immigrating and starting new lives can lead to a heightened risk of child abuse and neglect. Stress can become toxic and create strain in family dynamics leading to physical conflict and abuse. By helping families navigate systems as well as attend to their mental health needs, PEI works to effectively support these extremely vulnerable and at-risk families.

Psychotherapy, including family therapy, is provided to newcomer families in Farsi and Dari. These services are inspired by evidence-based modalities such as trauma affect regulation, child-parent psychotherapy, and attachment therapy with a focus on trauma treatment. Therapy services are modified to make the treatment culturally appropriate for our clientele.

This year, case managers were trained in Mental Health First Aid and worked on identifying clients who may need further intervention, and then facilitated connections to internal mental health services and/or to partner organizations. We believe in collaborating and building partnerships to increase access to mental health services.

VALUES:
Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

JFCS East Bay's commitment and dedication to our clients greatly contributed to our success. "Welcoming the stranger" and serving vulnerable people are at the core of our mission. Having linguistically and culturally competent staff enables us to build rapport with clients, helping us better understand and respond to their needs. At JFCS East Bay, we honor our clients' strengths and resiliency and empower them by providing opportunities to identify their needs. Goals and the services provided are evaluated regularly with the client/family to ensure that they have the primary decision-making role. Clients receive wrap-around services at JFCS East Bay's Walnut Creek office; these services include case management, health and mental health navigation, mental health services,

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and parent education classes. We utilize personalized strategies to empower clients in participating in their own lives and taking steps toward self-sufficiency.

VALUABLE PERSPECTIVES:
Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

Shakiba* is a single mother in her early forties from Afghanistan. While she was pregnant, her husband left their home in Kabul one morning and never came back. She believes that he was killed in a suicide attack, but there is no way to prove it.

Shakiba is a college graduate and knows conversational English. She used to work for a U.S. agency's woman empowerment program in Afghanistan. Her daughter is now four years old and her parents have passed away. She has four siblings who have all migrated to countries in Europe. Upon coming to California, Shakiba was feeling very isolated and stressed and did not know how she would provide for her daughter. She was worried about the future and was finding being a mother and navigating a new country extremely overwhelming. This level of stress and anxiety put the family at risk of child abuse and neglect.

JFCS East Bay's volunteer program trained a group of five volunteers as her "Welcome Group," and found her housing with a host family in Lafayette. Our case manager helped her sign up for public benefits, including health insurance. The case manager also provided in-depth cultural orientation, including helping her learn the public transportation system. Shakiba was very eager to work, but her choices were limited since she didn't have enough childcare. Her Welcome Group decided to raise money and was able to fund her childcare for a few months, which eased the stress of having to find one alone. Shakiba was then able to get temporary jobs at a children's gym, as a teacher's aide, and as a babysitter. She finally moved out on her own and JFCS East Bay subsidized her rent for the first month.

Shakiba continues to receive health and mental health navigation from her case manager and is receiving individual therapy from JFCS East Bay's bilingual psychologist. To insure she can facilitate the healthy development of her daughter, she has also attended three of our parenting groups. PEI's combination of case management and mental health services has greatly contributed to the stability and safety of Shakiba's family.

* Name has been changed.

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PEI ANNUAL REPORTING FORM

Due: August 15, 2019

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR: 18-19

Agency/Program Name: La Clinica de la Raza - Vias de Salud and Familias Fuertes

PEI STRATEGIES:
Please check all strategies that your program employs:

X Provide access and linkage to mental health care

X Improve timely access to mental health services for underserved populations

X Use strategies that are non-stigmatizing and non-discriminatory

SERVICES PROVIDED / PROGRAM SETTING:
Please describe the services you provided in the past reporting period. Please include who the program has targeted and how your services have helped in improving access to services. Where are services provided and why does your program setting enhance access to services?

Vías de Salud (Pathways to Health) targets Latinos residing in Central and East Contra Costa County and has provided: a) 5944 depression screenings (198% of yearly target); b) 528 assessments and early intervention services provided by a Behavioral Health Specialists to identify risk of mental illness or emotional distress, or other risk factors such as social isolation (211% of yearly target); and c) 1,185 follow up support/brief treatment services to adults covering a variety of topics such as depression, anxiety, isolation, stress, communication and cultural adjustment (95% of yearly target).

Familias Fuertes (Strong Families) educates and supports Latino parents and caregivers living in Central and East Contra Costa County so that they can support the strong development of their children and youth. This year, the program has provided: 1) 955 screens for risk factors in youth ages 0-17 (127% of yearly target) ; 2) 185 Assessments (includes child functioning and parent education/support) with the a Behavioral Health Specialist were provided to parents/caretakers of children ages 0-17 (247% of yearly target); 262 follow up visits occurred with children/families to provide psycho-education/brief treatment regarding behavioral health issues including parent education, psycho-social stressors/risk factors and behavioral health issues (87% of yearly target).

Services are provided at two primary care sites, La Clínica Monument and La Clínica Pittsburg. The service site enhances access to services because they are provided in a non-stigmatizing environment where many clients

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already come for medical services. As research shows that Latinos are more likely to seek help through primary care (Escobar, et al, 2008), the provision of screening and services in the primary care setting may identify clients who would not otherwise access services. Furthermore, up to 70% of primary care visits involve a psychosocial component (Collins, et al; 2010). Having integrated behavioral health care allows for clients to receive a more comprehensive assessment and treatment, especially those that cannot attain specialty psychological or psychiatric care.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***How are participants identified as needing mental health assessment or treatment?***
- ***List of indicators measured, including how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***
- ***Average length of time between report of symptom onset and entry into treatment and the methodology used.***

Participants are referred to the Integrated Behavioral Health (IBH) team through either their primary medical provider or self-referral. Clients are given an annual behavioral health screen which includes screening for substance use and depression. If these screens yield a positive result, primary care providers discuss with the client and offer a referral to IBH. Additionally, primary care providers may identify behavioral health needs amongst their client population at any visit, discuss with the client and refer to IBH. Clients who self-refer to IBH contact the clinic themselves, or request referral during a primary care visit.

The indicators measured for Vias de Salud are:
A. 3,000 Depression Screenings will be completed annually by clients of La Clínica primary care.
B. 250 assessments and early intervention services will be provided by a Behavioral Health Specialists within the FY 18-19
C. 1,250 support/brief treatment services will be provided by a Behavioral Health Specialists within FY 18-19

The data for A-C are collected at the appointment and captured in La Clínica's Practice Management Computer system and data reports (NextGen or SSRS)

The indicators measured for Familias Fuertes are:

Familias Fuertes program, Project #6:
A. 750 Behavioral Screenings of clients aged 0 – 17 will be completed during the 12-month period by parents (of children 0-12) and adolescents (age 12-17)
B. A total of 75 assessments or visits (including child functioning and parent education/support will be provided for FY 18-19
C. 300 follow-up individual/family visits with Integrated Behavioral Health Clinicians to provide children/caretakers will participate in follow up individual/family education/brief treatment sessions with a Behavioral Health Clinician to provide children/families with psycho-education/brief treatment regarding behavioral health issues including parent education, psycho-social stressors/risk factors and behavioral health issues.

La Clínica strives to reflect cultural competency in the assessment, treatment and evaluation of the program. La

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Clínica utilizes screening and assessment tools that are evidenced-based and have been normed for and researched utilizing a similar client population. Linguistic competence, and cultural competence and humility, are central factors to the new staff hiring process and at the core of La Clínica's program design, the approaches used, and the values demonstrated by all of the staff. An embedded value is to honor participants' traditions and culture and speak the language the participant is most comfortable in. Throughout the initial and continuing training for all IBH staff, cultural and linguistic accessibility and competence is a core element to all topics. Culturally based methods including "dichos" (proverbs) and "Pláticas" or individual/family meetings are used to engage participants and employ culturally familiar stories and discussions with Latino clients. Furthermore, mental health terms are interchanged with language that is less stigmatizing and more comfortable. For example with Latino clients, sadness (tristeza) is a topic used to engage community members, rather than approaching discussions with mental health language terms such as "depression". At the same time, La Clínica strives to understand our unique client population and evaluate data while taking into consideration our unique client population. All of behavioral health providers are bilingual (English/Spanish) and most are bi-cultural. When appropriate, La Clínica utilizes translation services for all other languages.

La Clínica complies with HIPAA regulations and guidelines for all client health information and do not release any client health information to entities outside of the health center.

The average length of time between the report of symptom onset and entry into treatment for Vias de Salud and Familias Fuertes is 244.6 weeks (almost 5 years). This was determined by reviewing a random sample of new appointments for 24 clients and looking at the chart notes which document how long the presenting problem has occurred.

DEMOGRAPHIC DATA: ☐ Not Applicable ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

Data for gender identity, ethnicity and disability will only be collected by clients seen by a behavioral health provider. Other demographic data is already collected and a standard part of the data collection process for all clients during registration for medical care. It would be burdensome and could harm the client relationship to try to collect this data as part of the screening process during a medical appointment.
The Familias Fuertes program serves children and data on veteran status and military status will not be tracked.

For clients under the age of 18, La Clínica collects sexual orientation if it is directly connected to the reason for referral or treatment plan. Given that La Clínica is providing brief treatment, La Clínica wants assessments to be as targeted as possible. La Clínica also wants to be sensitive to the reality that our adolescent population is in the process of forming their identity and sexual preferences and do not think would be appropriate to ask sexual orientation in our entire adolescent client population.

For the Familias Fuertes program, data for gender identity, ethnicity and disability is only collected by clients seen by a behavioral health provider. Other demographic data is already collected and a standard part of the data collection process for all clients during registration for medical care. It would be burdensome and could harm the client relationship to try to collect this data as part of the screening process during a medical appointment.

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LINKAGE AND FOLLOW-UP:

Please explain how participants are linked to mental health services, including how the PEI program: 1) provides encouragement for individuals to access services; and 2) follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

Participants are referred to behavioral health services through their primary care provider or self-referral. Participants are scheduled into our Integrated Behavioral Health Clinicians' (IBHC) schedules directly from their medical appointment. For more urgent need, clients are scheduled for a same-day or 'warm hand-off' appointment with the IBHC. La Clínica encourages all medical providers to discuss the behavioral health referral before it is scheduled to ensure that participant is both interested and motivated to attend the appointment. If the client does not show to the IBHC appointment, the IBHC will call the client to attempt to reschedule the appointment, which may include clarification of purpose of appointment. If the behavioral health clinician assesses participant to need a higher level of care than our program model, La Clínica will work to link the participant to the appropriate services. La Clínica continues to meet with and support the participant until they are linked and follow up with the recommended service.

For clients in the Vias de Salud and Familias Fuertes program, the average length of time between referral and treatment is 20.8 days. This is measured from date of referral from their primary care provider (or self-referral) to the date of the appointment. Please note the next available appointment may be sooner but may not fit in with the client's needs so the appointment is scheduled later.

VALUES:

Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

La Clínica strives to offer quality, consistent behavioral health services to the client population. By locating behavioral health clinicians within primary care facilities, La Clínica provides direct, often same-day behavioral health care to those who need services. Often clients are identified as needing behavioral health support in an early stage, before they have developed severe symptoms. In these cases, services promote client wellness and provide coping skills that prevent the need of a higher level of behavioral health care. For clients with more severe symptoms, La Clínica able to assess them in a timely manner and determine what course of treatment would be most appropriate. La Clínica clinicians work in a team-based approach along with our medical providers to offer holistic care that addresses the intersection between physical and mental health. This team approach is both effective and proves to have the best outcomes for La Clínica's client population. Many of the clients who access behavioral health care at La Clínica would not otherwise have access to behavioral health for a variety of reasons including: transportation difficulties, stigma associated with behavioral health access, and

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inability to navigate the larger behavioral health system due to language barriers and system complexity. La Clínica makes every effort to provide services equally to all clients who are open to receiving care. Staff use non-stigmatizing language by interchanging the terminology of mental health with emotional well-being, allowing for a more receptive message to be communicated. La Clínica emphasizes the improvement in well-being, recognizing disequilibrium, and providing tools and resources for establishing emotional well-being, physical health, and supportive, healthy relationships in one's life. La Clínica also helps normalize mental health issues by pointing out the prevalence of mental health challenges, the availability of a range of treatment services, and the efficacy of support and treatment to help reduce stigma.

VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

Client story #1:
Behavioral Health Clinician began working with a 20 year old female client in May of this year. She presented with moderately-severe depression symptoms and severe anxiety symptoms due to the stress of dealing with a sister with opiate addiction for the past three years. At her initial visit, she described feeling "out of control" with her emotions as a result of the instability and chaos her sister caused her family. Behavioral Health Clinician has worked on the reactivation of behavioral strategies (exercising, spending time with supportive people in her life) and developing mindfulness skills. Currently, they are midway through the course of treatment and client has shown a reduction of symptoms (at last visit reported mild depression symptoms and moderate anxiety symptoms). Despite the continued uncertainty of her family situation, this client has expressed benefit from increased awareness and validation of her own emotions through mindfulness exercises/skills, she stated at last visit that by doing mindfulness exercises, she was able to get in touch with her own emotions without feeling out of control, which led her to acknowledge her own strengths and options for taking care of herself while being a source of support for family members.

Client Story #2:
Female client was referred by her primary care physician for severe depression symptoms that included sadness, passive suicidal ideation, problems with sleep, excess worry, anxious, headaches, nightmares, fatigue, and anhedonia. Client had recently arrived to the US from Mexico and was having difficulties adjusting to a new environment, culture and language. There were other significant stressors that worsened client symptoms such as a recent divorce, her living situation: lived in an old commercial building with no bathroom and kitchen and unstable relationship with her new partner. Client attended IBH sessions for several months, in counseling she developed coping skills and learned strategies to improve her partner relationship. With a strength-based approach in therapy client improved her symptoms, developed self-confidence, started doing community work, and attended ESL classes. With the support of our IBH case manager, client applied for a scholarship that was granted to obtain her certification in a trade school. Client ended IBH services and once in a while stops by to update us with her progress.

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PEI ANNUAL REPORTING FORM

ACCESS & LINKAGE TO TREATMENT REPORTING FORM **FISCAL YEAR: 18-19**

Agency/Program Name: Lao Family Community Development, Inc. (LFCD)
Health and Well-Being for Asian Families

PEI STRATEGIES:
Please check all strategies that your program employs:

☐ **Provide access and linkage to mental health care**

☑ **Improve timely access to mental health services for underserved populations**

☐ **Use strategies that are non-stigmatizing and non-discriminatory**

SERVICES PROVIDED / ACTIVITIES:
Please describe the services you provided in the past reporting period. Please include types of problems/needs addressed, any activities that address these problems/needs, and any functional outcomes targeted by the services provided.

The Lao Family Community Development's (LFCD) Health and Well-Being Program for CCC Asian Families (HWB) continued to focus on delivering PEI services to 125 unique clients targeting South Asian and South East Asian immigrant/refugee/asylee residents living in Contra Costa County. This report covers services provided between July 2018 to June 2019. We served 125 participants from both communities representing a diverse group (Nepali, Tibetan, Bhutanese, Laotian, and Mien) Majority (70%) of the clients were aged 26-59; seniors over 60+ years was approximately 26%; and young adults ages 16 to 25 were (4%). For FY 2018 – 2019, a total of 125 participants were enrolled (104% of enrollment goal for this fiscal year).

We provided navigation and timely access to internal and external services including linkages to mental health and other service providers such as: *a) Partnerships for Trauma Recovery in Berkeley, a community based organization offering linguistically accessible mental health care and clinical services; b) Contra Costa Regional Hospital in Martinez, West County Health Center in San Pablo, Contra Costa County Mental Health Services in San Pablo, California's Employment Development Department, Kaiser Permanente in Richmond, RotaCare Bay Area Richmond Clinic, and Highland Hospital in Oakland, all public health facilities for physical health services and severe mental health access; c) La Clinica Fruitvale Free Clinic in Oakland for free physical medical and mental health service, d) Bay Area Legal Aid in Oakland and Richmond, for related services in family violence, restraining orders, and other civil legal assistance, e) linkages to access the American Bar*

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Association for pro-bono and consultation in legal services (free or low cost consultation), and f) Jewish Family Services – East Bay for naturalization and citizenship services to address our clients' issues affecting their mental health and recovery needs.

For timely access, we escorted high barrier clients such as seniors with visual and physical disabilities; monolingual language barriers, and those with few other options for transportation to 1) mental/physical health evaluations and appointments at to Contra Costa Regional Hospital in Martinez, West County Health Center in San Pablo, Contra Costa County Mental Health Services in San Pablo, Partnerships for Trauma Recovery in Berkeley, Kaiser Permanente in Richmond, RotaCare Bay Area Richmond Clinic, Highland Hospital in Oakland, and La Clinica Fruitvale Free Clinic in Oakland; 2) the USCIS office in San Francisco for immigration assistance; 3) Jewish Family and Community Services – East Bay for onsite legal assistance with naturalization and immigration services 4) Federal SSA offices in Richmond or Oakland for SSI benefits or Temporary Protected Status. These access and linkage services were provided for clients by providers located in both inside and outside CCC county in line with participants' individual service plans.

Enhanced services included: 1) assisting individuals to build connections and links in their cultural communities; 2) strengthening family relationships and communication within their families; 3) reducing stigmas associated with seeking mental health support through education and awareness; and 4) helping individuals learn how to navigate the public and community mental health and well-being systems and in some cases private providers.
The following were activities during the program year:

1. Strengthening Families Program (SFP) Educational Workshops:

LFCD held a total of 18 SFP workshops during the program year. (2 workshops per month from August 2018 to April 2019). We focused on graduation and closing out of cases in June 2019. We continued to conduct SFP workshops for the two population groups separately to accommodate their specific needs. SFP workshops for SA and SEA populations varied from 4-5 hours per month. Weekly 1-2 hour SFP sessions were delivered on an as-need basis. SFP workshops and sessions were delivered in a variety of locations and timeframes. Locations included participants' homes, community parks, community buildings and at LFCD's community-based facilities during the weekday evenings, days and weekends as needed.
For our South Asian population, a 5-hour SFP workshop session was preferred due to personal, work, and school schedules. The top 5 most significant challenges identified by the South Asian population were: 1) parent relationship conflicts 2) mental and health insurance access, 3) behavioral health in areas of alcohol and drug abuse and its relationship to well-being, 4) healthy communication conflict resolution skills within the family, 4) wellbeing and resilience in the areas of immigration status such as Temporary Protected Status (TPS), green cards and citizenship, 5) need for jobs-employment-financial stress. These topics were incorporated into the SFP workshops including having guest trainers and additional ones were provided as requested.

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The Southeast Asian population preferred monthly 5-hour workshops in addition to weekly sessions as needed to allow clients to make up missed workshops. The top 5 most significant challenges identified by the SEA population were: 1) mental health/SSI related assistance, 2) affordable housing assistance, 3) health insurance/mental health access, 4) citizenship and employment, 5) parenting and reducing family conflicts.

Program format for both populations included integration of these identified challenges into each SFP workshop module using discussion and group peer counseling and individual case management and counseling. Linkages and connections to resources were provided to participants in line with their individual goals. Timely access and referral are part of the case management protocol and participants were provided services through internal programs and CBO providers in the community. This timely and relevant menu of linkages are critical in providing positive reputation for successful outreach, engagement and retention of participants, and SFP workshop completion and individual service plan achievement. Program feedback from SFP workshops and/sessions indicated that program participants continue to prefer the following:

- Outdoor settings for peer/individual activities-physical health and mental health benefits including the use of the Health and Well-Being Community Garden at the San Pablo. NOTE: LFCD plans to complete the expansion of the Community Garden to the Community Building located across the street from our San Pablo office.
- Strong preference for community and spiritual related events for building social connections
- Preference for interactive socialization time with other participants and outside groups
- Live music/dancing as therapy to help reduce stress, reduce pain, depression, anxiety
- Interactive activities in workshops/social gatherings

2. Enrollment and Participants Individual and Family Goals

By June 30, 2019, a total of 125 program participants were enrolled for FY 2018/2019. Of the 125 participants, 26 participants (21%) were from East/Central Contra Costa County. Each intake enrollments took 1.5 to 2 hours to complete. Participants developed individual and/or family written goals working closely with case managers. Exits and entrance are on a rolling basis.

Participant goals examples include:

a) To access and obtain treatment for mental healthcare and evaluation for severe mental health issues, PTSD, etc.
b) To access SSI benefits for elderly participants with visual impairment and other disabilities
c) To access health and mental health services through Covered California exchanges or other low-cost health insurance options including County Basic Care, Medical, Medicare, CalFresh and other free services.

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d) To obtain/increase access to preventative health care including annual physical examinations
e) To access permanent affordable housing (public housing, section 8, foreclosure assistance, etc.)
f) To reduce anxiety and depression related to citizenship, naturalization, unemployment and under employment.
g) To reduce stress related to financial hardships and lack of money for basic needs (mental health stress and well-being related illnesses)
h) To develop and maintain healthier lifestyle behaviors
i) To improve their relationships with immediate family members/children/grandchildren
j) To be more engaged and civic oriented within their community
k) To increase integration into US society through citizenship access

Outreaching strategies continue to include word-of-mouth referral from alums, current participants and South Asian/Southeast Asian community members. LFCD has a strong and established reputation among the communities of the targeted population.

Alums are important for outreach, promotion and referrals through their networks to build awareness of the services available and to reduce stigma around mental health. Case managers must still continue to actively do direct outreach at local ethnic events such as community New Year celebrations (e.g. Mien, Khmu, and Nepalese) and social faith-based events. Case managers also conducted outreach at ethnic grocery stores, ethnic community leadership meetings, and other ethnic community gatherings. Outreaching at these events allowed case managers to continue to build awareness of the program services; personally engage and build collaboration and rapport with ethnic group leaders; and to outreach to new community members. The HWB outreach strategy ensured that program staff continue to connect with hard-to-reach populations.

Case managers continued to leverage partner relationships with local service providers for needed service to address needs in the individual service plans. Community building with CBOs and stakeholders has allowed the HWB program to expand deliverable services. An example of this is an MOU signed with Jewish Family Services to provide on-site legal assistance with immigration and citizenship issues at the LFCD San Pablo office once a month. Referral relationships have been valuable in recruiting and retaining program participants by allowing participants to become more aware of different community, public and private resources available to them within Contra Costa County.

3. Thematic Peer Support Groups

The HWB program participated in 8 thematic peer support groups during this reporting period. These events allowed individuals to 1) make connections in the community, 2) become more aware of available public/private services including mental health assistance and how to navigate these systems, 3) communicate with family members across generations and 4) increase timely access to services by making a personal connection with HWB staff. The following

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is a brief summary and highlights of each event.

- September 23, 2018 - A Meet and Greet Event was attended by 44 clients with food provided. A program introduction was provided by LFCD CEO Kathy Chao Rothberg that encouraged participants to take advantage and become engaged in the HWB program. Certified Zumba dance instructor led the group in Zumba activities and ethnic food was provided. Topics presented including Covered California, Census 2020 and community participation. Participants were encouraged to assist each other to reduce stress and isolation. Former clients shared their inspirational success stories including a recent college graduate who has a disability and is continuing her path to self-sufficiency.

- October 28, 2018 - A Halloween BBQ was held at Wildcat Regional Park in Richmond, CA with 21 Southeast Asian attendees participating in Halloween activities such as learning the way Halloween is celebrated in different cultures. Participants introduced themselves and their families in a meet and greet session. A "walk and talk" session followed lunch with participants taking advantage of the local hiking trails.

- October 28, 2018 - A Senior Clients Appreciation event was held in Rodeo, CA with 45 Nepali participants including 12 new participants. Senior clients blessed younger participants. Traditional Nepali songs and chants were played, and health information was provided on Covered California including locations of free or low cost flu vaccinations.

- November 25, 2018 - A Thanksgiving Festival was held at a participant's home in Rodeo, CA with 42 people attending including 15 new clients. The participants celebrated with a traditional Thanksgiving meal plus a special cake for an established family from the program who was moving to Texas and guitar music provided by community members. The HWB Case Manager presented information on Covered California and highlighted mental health access through this program.

- December 16, 2018 - The HWB Christmas Event and Toy Giveaway was held at the Community Building in San Pablo with 71 clients and family members attending in total with 27 of them regarded as new participants. The purpose of the event was to bring clients together to reduce isolation and meet new families. A Covered California representative provided information and answered questions concerning insurance after the meal. The City of San Pablo in partnership with LFCD provided some of the toys provided to the children in attendance.

- April 28, 2019 - A Lao New Year event was held at a community member's residence in San Pablo with 25 family and friends in attendance. The focus of the event was to learn about Lao traditions and culture. Younger attendees participated in a traditional ceremony where they asked for forgiveness and blessings of their elders. The group also participated in a group walk in the surrounding neighborhood as a means to make connections and reduce isolation/fear.

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- April 20, 2019 - A Nepali, Burmese and Lao New Year Celebration was held at a client's residence in Rodeo, CA with 45 clients attending. Activates included tug of war, cultural dances, and yoga from a local yoga guru before the meal. HWB Case Manager provided a presentation to emphasize the need to take time for your own health and well-being including flu vaccinations.

- June 29, 2019 - A Graduation Event from the of the HWB program was held at the Community Building in San Pablo for 51 clients and their family members. Important information was provided about the continued support provided by the program. Certificate of Completions for SFP workshops were presented to graduates of the HWB Program in FY 2018/2019. Ms. Anupama Chapagai of Bay Area Legal Aid presented information on workplace safety and chemical hazards (lead, asbestos, etc.) that has been a concern of many clients living in older rental housing. Other representatives of Every Women Counts and Nepali Association of Northern California provided information about their organizations and service. Other information from the HWB Case Managers included mental health access and health insurance options that are free and low cost. Small group discussions focused on how to access different services and related experiences from clients.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***How are participants identified as needing mental health assessment or treatment?***
- ***List of indicators measured, including how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***
- ***Average length of time between report of symptom onset and entry into treatment and the methodology used.***

Participants were given a Pre and Post Lubben Social Networking Scale (LSNS-6) mental health assessment to help identify mental health needs. The LSNS-6 assessment was administered to each individual program participant at the beginning and end of their time in the program. According to program protocol, clients with initial or final scores that indicate a high level of social isolation and/or a lack of social connectivity are recommended and referred for mental health assistance.

The LSNS-6 assessment is a tool that measures social connectivity and gauges social isolation in adults by analyzing the perceived support that the participant receives from family, friends and neighbors. According to Boston College's School of Social Work, the LSNS-6 "consists of an equally weighted sum of 10 items used to measure size, closeness and frequency of contacts of a respondent's social network." This provided quantitative data that measured the effectiveness of our HWB program within the framework of establishing mental health/well-being through social interaction/community building.

A total of 125 clients completed the Pre LSNS assessment and 125 clients completed the Post LSNS assessments. The average progression was 7 with a high correlation between the

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participant's progression and level of participation in monthly social peer support groups activities and workshops.

Please refer to the table for LSNS results:

	Pre-LSNS	Post-LSNS	Progression
# of Completion:	125	125	-
Average Range:	17	24	7
(Min) Range:	9	16	5
(Max) Range:	23	30	7

In addition, case management provides a continuous contact and monitoring of clients to determine if any trauma or event has affected their mental health status. Referrals to link participants to more rigorous mental health assessments and treatment were provided on an as-needed basis.

Internal evaluation of the program includes reviewing cases to ensure strategies for communication and taking into account the cultural competency of the counselors. Cases are reviewed to ensure participants in the program receive services that are linguistically and socially appropriate. Examples of these services include communicating in their native language (Mien, Lao, Thai, Nepalese, etc.) and understanding the cultural norms in order to address health and well-being issues in an appropriate and effective manner. A thorough review of cases every 6 months ensure that the confidentiality and integrity of the participants' information is protected.

A program activity evaluation form was completed per each activity conducted (e.g. ethnic peer support gatherings and SFP workshops). In each program activity, 5 random participants were asked to complete the activity evaluation form. This process allowed a program staff or volunteer to work one-on-one with the non-English monolingual participant to complete the form. Each set of completed evaluation forms are attached to an activity reflection form for documentation purposed. The evaluation forms are reviewed by the program staff and changes were implemented according to the participants' evaluations. Comments in the evaluations included recommendations for cultural activities, outdoor events including using the recently opened Community Garden at the San Pablo office.

The last evaluation tool used was a general program evaluation form that was created by the program staff to measure the participants' comfort level, participants' engagement and the cultural competency of the program services. The tool was also used to measure the participants' knowledge of accessing services that were related to their mental health and well-being and the impact of stigma on their will to seek services after receive program services. The evaluation was completed via phone by non-program staff that spoke the same languages as the participants.

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The results stated that the 93% (116 of 125 respondents) of the participants were satisfied with the program services, and 7% (9 of 125 respondents) were somewhat satisfied with the program services. Some of the resources the participants listed on the survey were West County Health Center in San Pablo, Contra Costa County Mental Health Services in San Pablo, Community Health for Asian Americans in Richmond, California EDD in Richmond, Department of Rehabilitation in Richmond, Contra Costa Regional Medical Center in Martinez, Highland Hospital in Oakland, La Clinica Fruitvale Free Clinic in Oakland, and East Bay Area Legal Aid in Oakland and Richmond, Law office of Laura A. Craig, Jewish Family Services – East Bay in Walnut Creek, etc.

From July 2018 to June 2019, there were 2 participants that were referred to mental health services as a result of monitoring clients' mental health status. The participants were referred to therapy related to PTSD and expressed symptoms of distress, anxiety and depression. The average length of time between report of symptom onset and entry into treatment was from 2 to 6 weeks depending on availability of services with an average time of about 4 weeks.

One of our continuing challenges is utilizing the county mental health services as it can take up to 16 weeks to get an appointment. By comparison, access to private low-cost and CBO mental health services takes an average of 4 weeks.

DEMOGRAPHIC DATA: ☑ Not Applicable ***(Using County form)***
If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

LINKAGE AND FOLLOW-UP:
Please explain how participants are linked to mental health services, including, how the PEI program follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

Participants were linked to mental health services and other providers depending on their need and goals identified in the individual service plan. From July 2018 to June 2019, this PEI program referred participants to different agencies inside and outside Contra Costa County using the following step-by-step procedure:

1) We carefully, patiently and attentively listen to the participants in a safe confidential setting as they explained their needs. Through our culturally competent counselors, we begin to establish understanding and trust with the participants. The LFCD office in San Pablo was able to add a new confidential private room that is used for intake, counseling, etc.

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2) We gave support to participants while helping them develop their individual service plan with step by step goals and tasks including identifying linkage providers.

3) Then, we encouraged individual participants to access and seek service provided by others. This process can take from 4 to 8 weeks in duration.

4) Once the participant feels strongly that they can trust us with their confidential information, then we escort them (most of the time) to the provider for the warm handoff.

5) If we are not able to do this, we set up a phone conference call to provide an introduction and assure that there is a translator available when they go to their appointments. We also provide the participants with name and address to assist them. If the provider is not available, we send an email and call while the participant is there to witness this.

6) Next, we followed up with the participant and referral partner within the week. Then we stay in contact either weekly, every two weeks, 3 weeks, or monthly depending on the length of time in their treatment and in the program with more attention upfront until the treatment is complete. Average time from the referral to consultation first appointment, evaluations and then entering into the treatment at the referral partners' office is 1 to 8 weeks (depending on availability of interpreters and appointment slots at the outside partners; we have found public providers take longer than CBOs or private).

This is the list of the external services including linkages to mental health and other service providers such as:

1) West County Health Center in San Pablo, Contra Costa County Mental Health Services in San Pablo, Community Health for Asian Americans in Richmond, California EDD in Richmond, Department of Rehabilitation in Richmond, Contra Costa Regional Medical Center in Martinez, Highland Hospital in Oakland, RotaCare Bay Area Richmond Clinic, Kaiser Permanente in Richmond, La Clinica Fruitvale Free Clinic in Oakland, Trauma Recovery in Berkeley, and Regional Center of the East Bay in Concord for physical health services, severe mental health access and/or developmental disability services.

2) Dr. Lee Hee, MD, a private practice medical doctor in Oakland for affordable medical care.

3) Bay Area Legal Aid in Oakland and Richmond, East Bay Sanctuary Covenant in Berkeley, law office of Judith Lott in Oakland for related services in family violence, restraining orders, immigration assistance and other civil legal assistance and linkages to access the American Bar Association for pro-bono and consultation in legal services (free or low cost consultation) for our participants' needs affecting their mental health and recovery needs.

4) Jewish Family Services – East Bay, to assist with naturalization and immigration services on

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site at our San Pablo office at regularly scheduled intervals.

VALUES:

Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

At the end of the 12-month period, we reflect on our work and partner linkages. Our evaluation is that our program values reflect MHSA values in these areas:

1. Our written program policies and agency commitment and practice of providing a safe, trusting, and confidential setting at LFCD and elsewhere engenders feelings that there is no stigma. We patiently listen to understand. Knowing that anything shared is safe and that no one other than who they authorized will know.

2. We have a zero-tolerance policy for discrimination or prejudice on the basis of race, place of origin, gender, religion, disabilities, etc. and our practice gives participants confidence that they are not discriminated upon.

3. Our practice and demonstration of our commitment to timely access for our clients. This results in the high level of satisfaction feedback we get from our clients with service provided in terms of case management, peer support, reduction of isolation, comfort in asking for helping and talking to others about mental health and increased knowledge of services in the community. Our services are provided daytime, nighttime, weekends, and escorted assistance.

4. Our strategy to establish trust first through case management-leads to participants engaging at a higher level and higher graduation from the program and accomplishment of their goals. Our Case Managers are well-respected members of the communities that they serve which allows for an engaging relationship with participants.

5. Providing participants with timely access and warm handoffs to linkages (specific person with the linguistic and cultural competency) to the mental health PEI services and providers helps participants to begin their recovery path sooner. Several mental health providers have provided reflections about the importance of participants trusting our Case Managers that results in a better handoff to services.

Our thematic peer group activities; individual connections to the counselors, linkage providers, and each other; cultural activities, food, music and indoor/outdoor physical activities selected based on participants' wants and needs engenders resiliency and wellness. These activities help participants build their resiliency and their recovery from crisis.

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VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

During this time period, we have had several clients with mental health stress as a result of issues concerning immigration, housing, finances, physical health and death in the family. Here are a few stories related to mental health stress:

Ms. A is a 38-year-old Nepali who was referred to us by Bay Area Legal Aid in July 2018. From monitoring her situation, it became evident she was experiencing a lot of stress and anxiety due to a situation in her home country. Due to her visa requirements, she was separated from her small children and her husband who are back in Nepal. In addition, her in-laws seized her and her husband's property in Nepal which ended up in a prolonged court case. She was also diagnosed with stomach cancer and suffered from extreme anxiety. The HWB Case Manager referred her to the East Bay Trauma Center to provide immediate access to mental and physical health professionals. She is currently in therapy and takes medication to reduce her anxiety, address her stress related conditions and treat her cancer. She has benefitted from participating in the LFCD PEI program activities which has provided more connections in her cultural community to provide her support and comfort while providing access to mental and specialized medical services.

Ms. A is a 58-year-old Laotian woman who came to the US in 2001 and was sponsored by her husband. In 2014, they divorced, and she has struggled to get access to housing, health benefits, etc. For example, she has struggled since 2015 to qualify for Medical because he continues to claim her under his health insurance without her having the ability to use it. The HWB Counselor has helped her navigate the mental and physical health system to get the services she is entitled to receive. She currently receives Medical to address her high blood pressure and sleep amnesia which allows her to continue to work at her job in a local restaurant. She felt a lot of anxiety and stress about losing her job although her employer was flexible with her as she addressed her physical and mental health needs without any MediCal support. Now that her health insurance situation has stabilized, she is working fulltime and receiving medication and health support though MediCal. The HWB Case Manager helped her apply for the CCC Housing Authority Voucher as she is currently renting a room from a friend. The PEI program has provided ongoing support and engagement with other participants as she progresses towards economic and social stability.

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PEI ANNUAL REPORTING FORM

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS REPORTING FORM **FISCAL YEAR: 7/1/2018-12/31/2018**

Agency/Program Name: The Latina Center/*Primero Nuestros Ninos*

PEI STRATEGIES:
Please check all strategies that your program employs:

☐ **XX Provide access and linkage to mental health care**

☐ **XX Improve timely access to mental health services for underserved populations**

☐ **XX Use strategies that are non-stigmatizing and non-discriminatory**

SERVICES PROVIDED / STRATEGIES:
Please describe the services you provided in the past reporting period. Please include qualitative and quantitative data depicting: 1) the types and settings of potential responders you reached during the past reporting period; 2) methods used to reach out and engage potential responders; 3) any strategies utilized to provide access and linkage to treatment; and 4) strategies utilized to improve timely access to services for underserved populations.

Parenting classes: During the period of July 1 to December 31, 2018, The Latina Center provided the 12-week *Primero Nuestros Ninos*/Our Children First, linguistically and culturally relevant parenting classes for parents at 1 school and at The Latina Center in West Contra Costa County. During this period, 47 parents (41 women and 6 men) enrolled. All parents belonged to low-income families. Classes were taught in:

- Lake elementary School 16
- The Latina Center 31

Thirty-six parents (77%) completed all 12 sessions and graduated from the program.

During the period of July – December 2018 we offer 1 workshop for mental health at the first five in San Pablo with 6 people attending this workshop, also 46 clients not participating in parenting classes or the workshop where referred to different services, reaching a total of 99 people attended.

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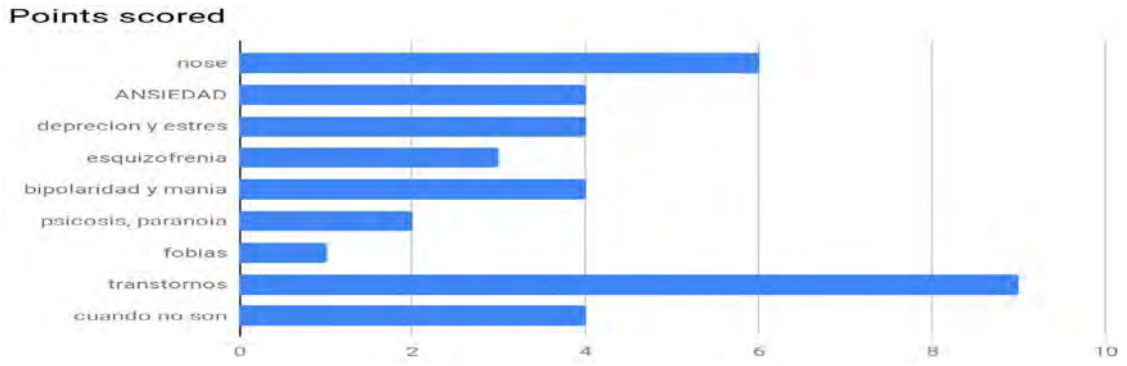
Mental Health Services: During July 1 to December 2018, 42 people participated in mental health workshops. Of these 42 people, 36 were participants and graduated from parenting classes. Pre-survey results indicate that almost 65% of survey respondents did not know what a mental illness was and did not know signs or symptoms, or where or how to seek help for themselves or a family member; most people did not think that a mental illness is a chronic disease.

Post survey results showed that 83% of participants said they could understand more about mental illness, including warning signs and symptoms and where and how to seek help.

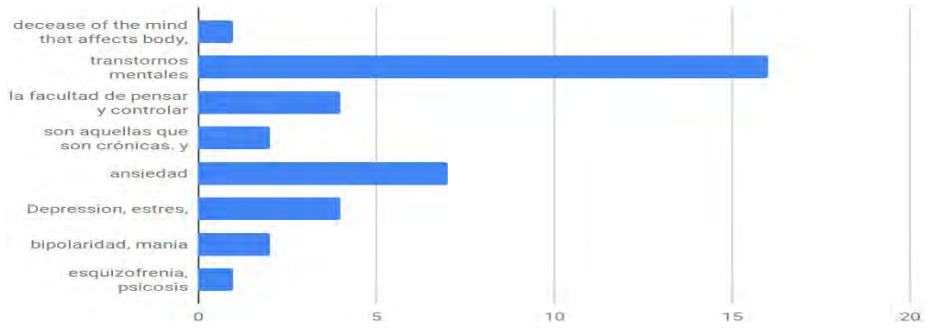
Just as we could see a difference in the percentage of responses in the pre- and post-evaluation in what it is if they have suffered from depression, anxiety and stress. In conclusion at the end of the survey we were able to obtain information that people after the workshops have a more adequate knowledge of what are a mental illness and the steps to follow.

1. What are mental illnesses?

- Pre-survey



- Post- survey



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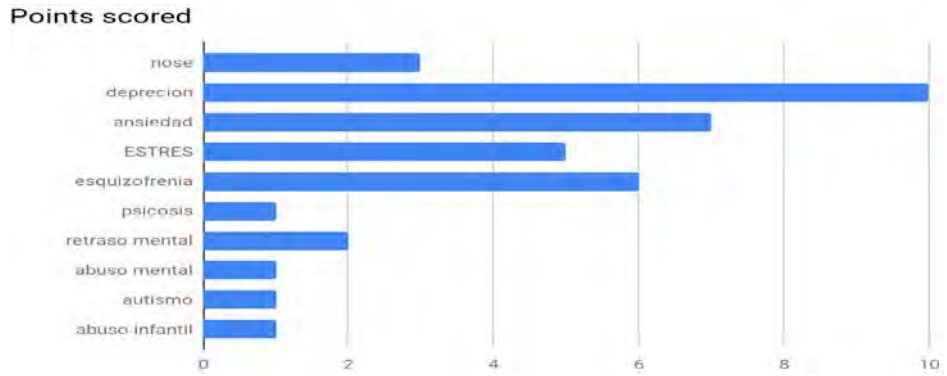
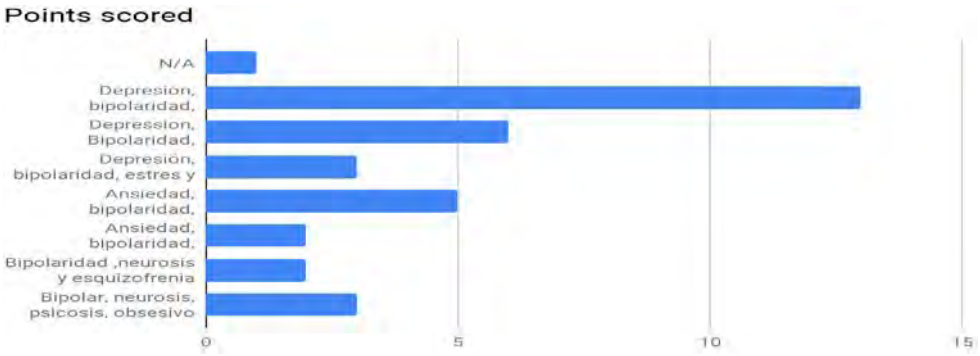
2. What kinds of mental illness do you recognize?

- Pre-survey



- Post- survey



3. Could you recognize some sign or symptom of mental disorder?

Before the workshop, only 34% of participants said that they could recognize the warning signs or symptoms of a mental disorder. However, after the workshop, 83% said that they could.

- Pre- survey

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- Post- survey

4. Do you have depression?

Before the workshop, 32% of survey respondents said that they were or that they had previously been depressed. After the workshop, 41% said that they were or had been previously depressed.

- Pre- survey

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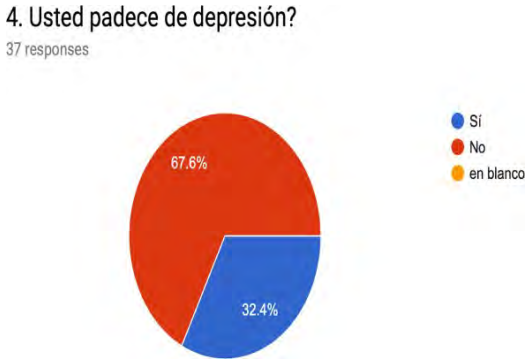

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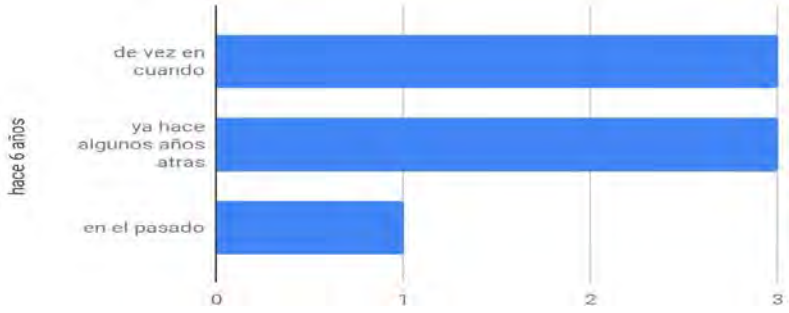

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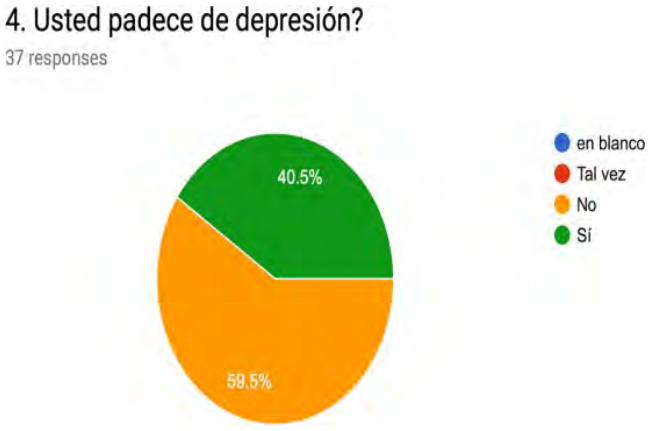

When?

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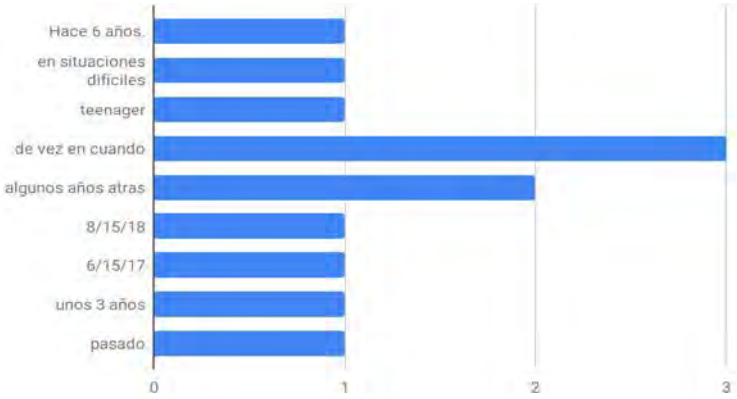
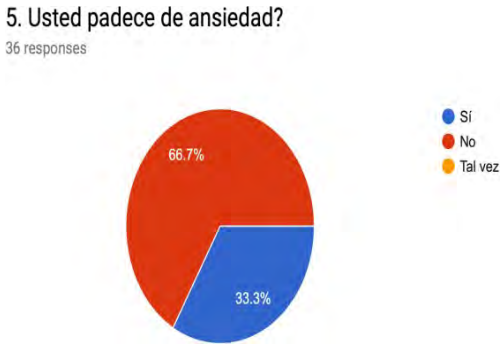


5. Do you suffer from anxiety?

- Pre- survey



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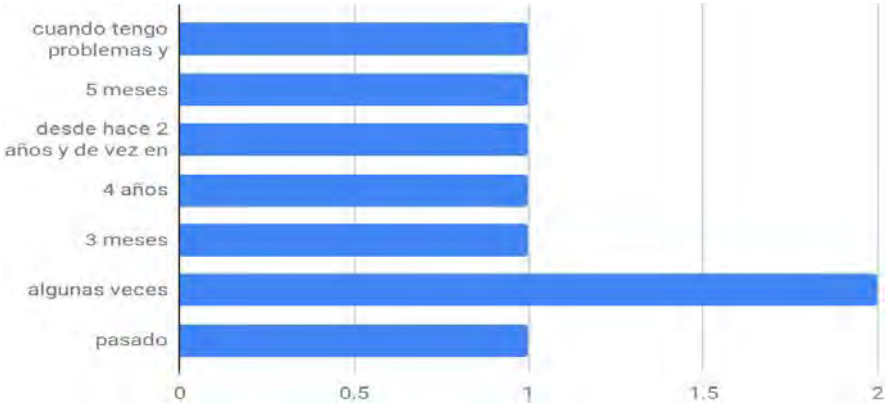

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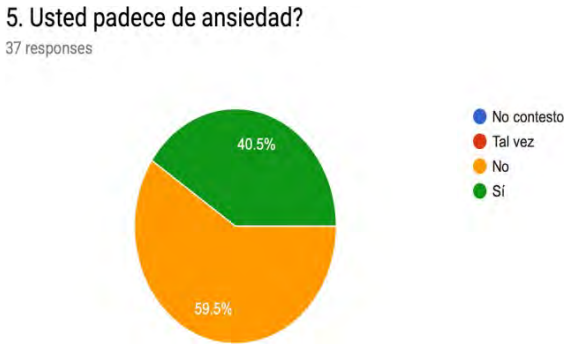

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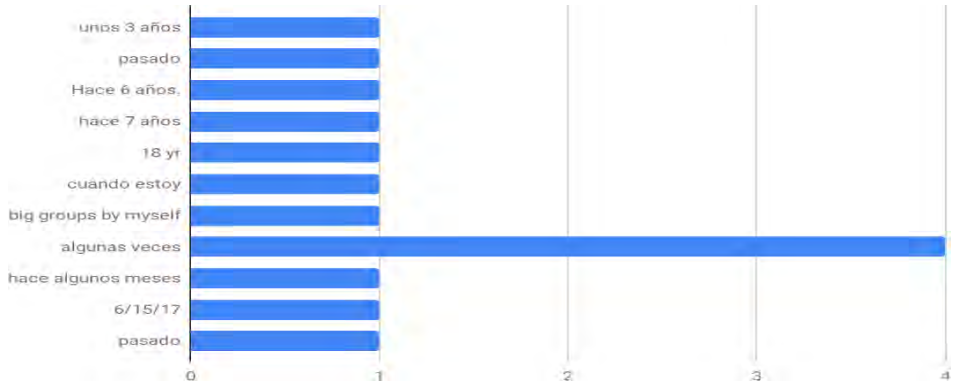

6. Do you suffer from stress?

- Pre- survey

When?

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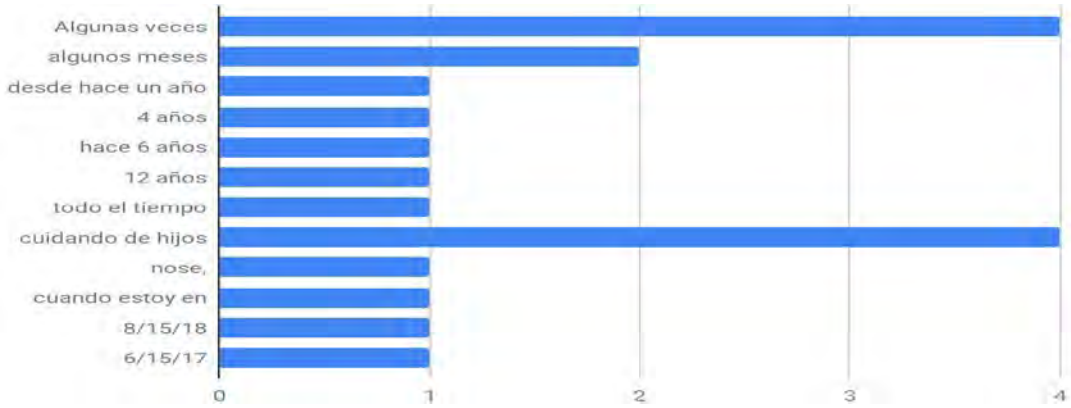

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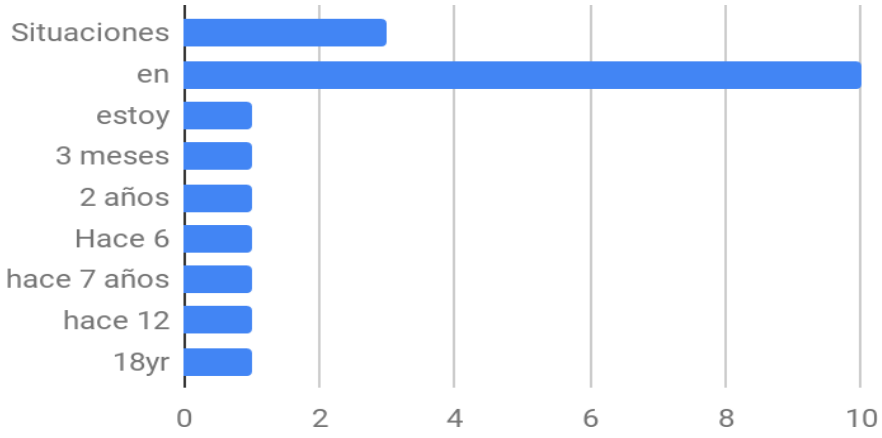

7. Some member of your family has a cognitive disability.

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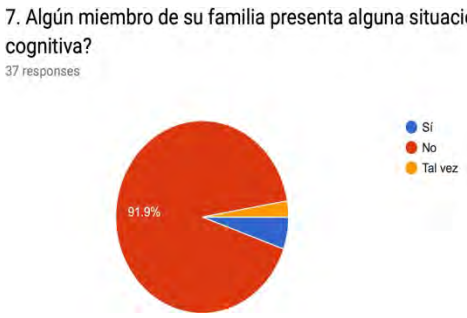

- Post- survey

10. You or the identified person has been diagnosed by a professional?

- Pre- survey

- Post- survey

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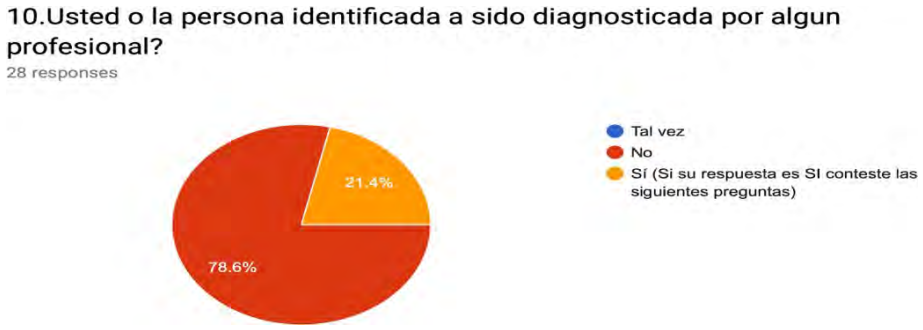
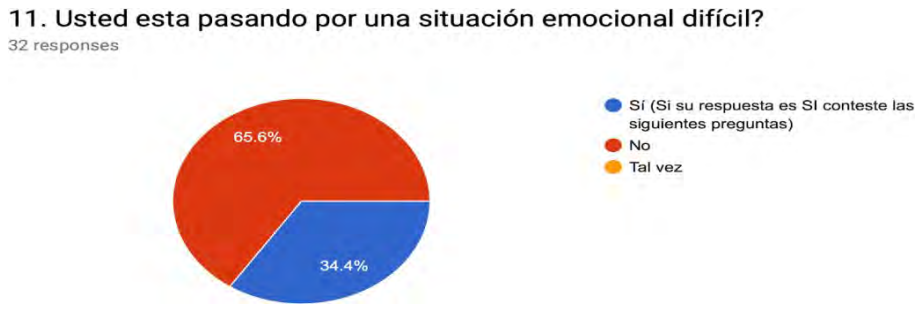


11. You are going through a difficult emotional situation?

- Pre- survey



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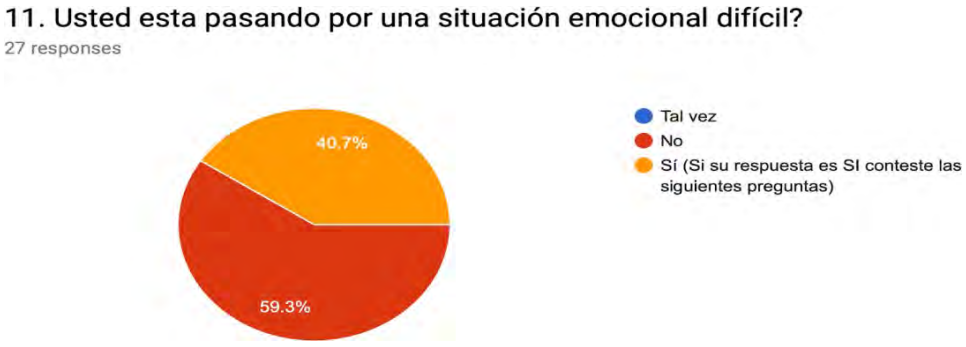

12. Would like to make an appointment with a counselor?

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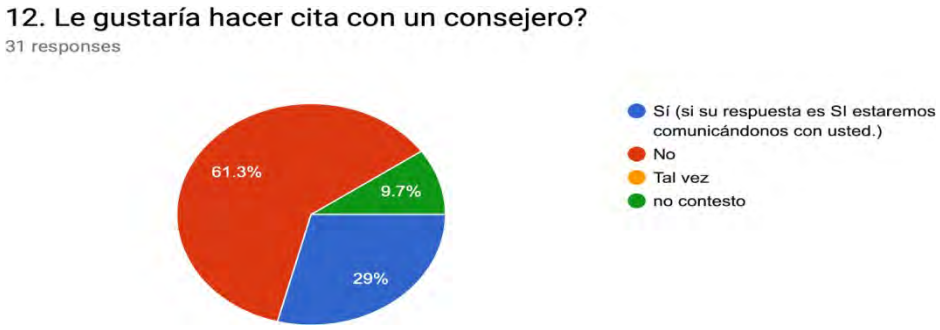
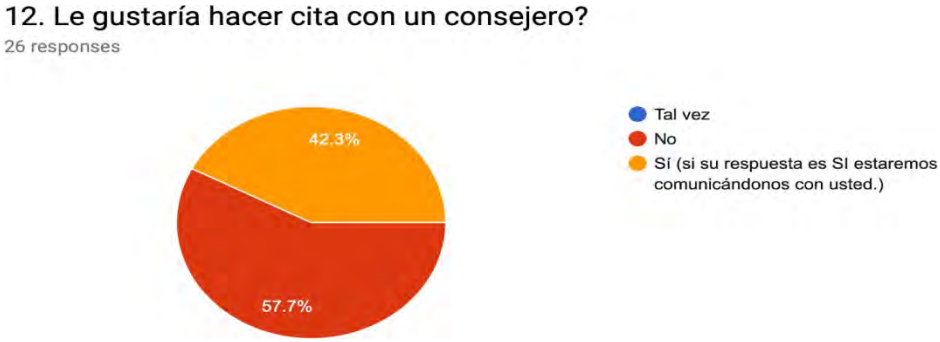
- Pre- survey





- Post- survey

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***Include a list of indicators measured, how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

At the beginning of the program Our Children First, we use a survey that gathered the following information from the parents:

- *41 They wanted to acquire new skills*

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- *33 wanted to improve communication with their children*
- *19 improve couples communications*
- *23 Better relationship with their families*
- *19 learn more about child development*
- *14 learn more about mental health*
- *13 have Access to community resources*

During this survey we could also identify that 44 of them were referred

- *4 Court*
- *4 CPS*
- *18 friends*
- *3 Family*
- *15 by different programs within The Latina Center*

Between the topics they would like to receive more information are the followings

- *11 Individual advise*
- *12 Treatment for depression, anxiety or others*
- *8 Schizophrenia and bipolarity*
- *5 bereavement counseling*
- *4 Domestic violence support group*
- *2 Celebrating the recovery*
- *3 Suicidal prevention*
- *4 child Abuse*
- *22 Techniques of stress reduction*
- *33 Better communication with their children*
- *23 Better communication with their partners*
- *20 Counseling for kids*
- *17 Counseling for youth*
- *2 Counseling for the elderly*
- *17 How to have a better self esteem*
- *3 Legal services*
- *2 housing assistance*
- *3 food assistance*

Some of this information was offered though

- *Individual advise, one on one counseling*
- *Information about deportation , anxiety, Schizophrenia and Bipolarity- Mental health workshop*
- *Referred to the support Group*
- *Referred to celebrating the recuperation*

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- *Techniques to reduce stress – workshop of family harmony about stress*
- *Better communication with their children and their partners thanks to the technics and tools from the STEP guide*
- *How to get a better self-esteem workshop from family harmony and support groups*
- *Giving information about juridical services, housing and food. Referred to difference services*

In this survey we could also identify that 37 participants have lived domestic violence in different phase of their life

- *29 have lived emotional and physical*
- *7 have lived physical, emotional and verbal violence*
- *1 have suffer sexual violence*

During this period we could achieve 86 people from different services being this internal and external, as stated below.

Internal and External referrals

In the following chart we identify the resources to where we have referred our clients

TLC support group for men	*	**Internal**
TLC parenting classes	*	
TLC GETA	*	
MSL	*	
Terapia Javier Northon	*	
Ono a Uno Nancy	*	
1Celebrating the recuperation	*	
Maria clubs	*	
Information on the process for vocation	*	
Lawyer TLC	*	
Support Group VD	*	

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Maria Gamboa business	*	

211	*	External
Service for alcohol and drugs	*	
David defect and character	*	
Family justice center	*	
Nutri sol	*	
Multicultural center	*	
NAMI	*	
DMV	*	
Lifelong medical center	*	
Lawyer Jonathan	*	
Centro cuscatlan	*	
Primeros 5	*	
Support group in English	*	
veteran hall	*	
Early child mental health	*	
Crisis line in Richmond	*	
First Hope	*	
Suicidal line	*	

Referrals in person:

Referrals to different agencies internal and external who came seeking help in person to the installation of THE LATINA CENTER installation of THE LATINA CENTER.

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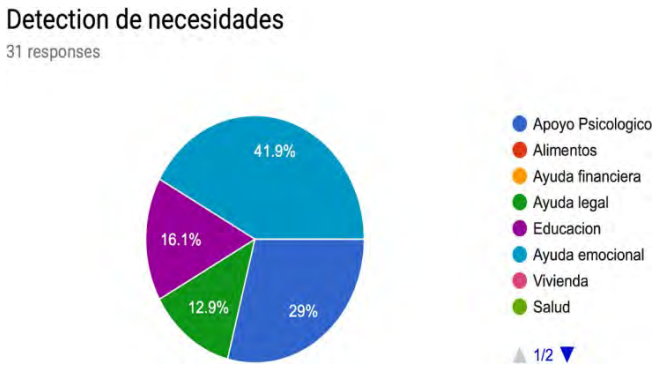
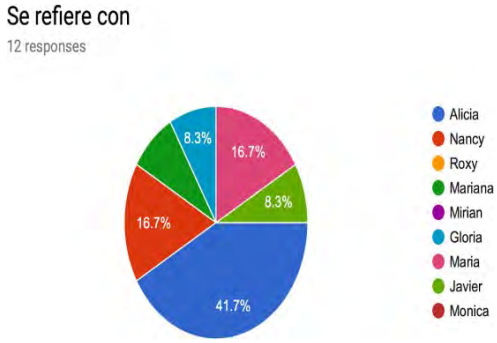
The different necessities and resources vary, even more, psychological and emotional help are the needs from which more resources are sought



Phone referrals:

Similarly, there were referrals to different internal and external agencies that sought help by telephone in THE LATINA CENTER



The different needs of resources also vary, but also the greatest resource that is sought is psychological help and the second is migratory help.

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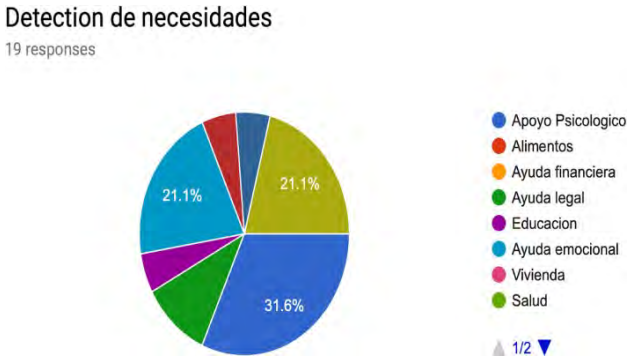

DEMOGRAPHIC DATA: ☐ **Not Applicable** ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

VALUES:

Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

Through the education program for parents (Our Children's First) implemented by THE LATINA CENTER that supports all people with different needs, economic or cultural background. We have been able to identify that if indeed our Latino community has a very large need for different resources of mental health, we still see the deficiency in access to these resources, there are very few resources available to our Latino community because of the cost, the language and the fact of trust between patient (culture) and the professional or the agency, in addition those that exist already have a waiting list, another reason for inaccessibility is the fact that many of our clients are undocumented immigrants and for them to seek help or have access to services means not only putting oneself in a vulnerable situation for their migratory status but also

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economically inaccessible for them since many do not have medical insurance and are low income. Regrettably, this is the biggest problem we face, and it persists year after year, which is reflected in the results of the surveys that have been prepared for the participants of the program, another of the obstacles we have faced is the mental health factor as a result of a sexual abuse, since people with such experience is very difficult to have confidence with a mental health provider, the biggest obstacle for this part of the community is the lack of resources and mental health professionals trained in this area and the few that exist (Ex: violence solution, united families) also have a waiting list.

VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

I am very grateful for the program that has been brought to us at Lake School.
The program our children has helped me to understand my children more, how to helped them, to deal with them, has given me tools to use that are beneficial for the whole family, I have also learned to know myself and discover how much I am worth , also what is the different levels of sexual abuse and what is an abuse of children, what is domestic violence and the strategies to deal with depression, stress and self-esteem, when I started the program I said I wanted to learn all things that they will help me to be a better mother; and with the help of the program I have learned a lot.

Thank you
N. Mora

I really liked the program because I learned many good and positive things for my life, it helps you to tell you about problems that you did not notice before and how to solve them, how to value yourself and be better parents, I recommend these classes because not only You meet new people but they help and de-stress you.

Thanks for your time and dedication.
Beatriz

I like the class because it help me better understand how to communicate with my kids, i liked how it says to let the kids to be part of the decisions making for the family, because we were thinking only adult could solve it, i also like how it says we have to explain why they punishment and how it has to be tie up with what they did, this class is a great benefit and will help me build a better bond with my kids. The first half translation was great but the second half i feel like i missed a lot. This was a great class.

Thank you.

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M. Bortolli

Before I came to this class, I shouted a lot to my children and I had no patience, I was always in a bad mood and on my phone, the truth is that sometimes I treated my daughter badly for no reason. This class helped me so much and it has been noticed, now I talk to my children, I stopped screaming at them and being with my genius always, now I feel with them to do homework and I talk a lot with them I feel very happy to have taken this class.

Thanks
P. Balcazar.

I thank God for giving me the opportunity to get to know the Latin center, my life changed in many ways, first by being able to see myself as a father or mother all the mistakes I had made while raising my children, I could understand how to change my attitudes and ways of be with my children, husband and other family, likewise this course changed my way of feeling about the past, I left the guilt and the condemnation that I felt inside this course made me free, thank God for the classes, teachers and the place, without this teaching I would not have achieved it alone.

Thank you very much and may God continue to use it.
S. Cifuentes

Before this program I was disoriented and I felt bad, now I feel different, in this class they helped me a lot. At first, I was angry I did not want to come, but I really liked it a lot because I learned how to talk to my children. I take many tools to go teach Mexico.
Thanks to God and Latina Center for helping me a lot, thanks to all those who helped me and supported me to be a better person.

A. Vega

The STEP classes helped me to have a better communication not only with my daughter but also with my husband, I learned not to hit or punish, instead of putting consequences, setting limits, messages in me.
From being a frustrated mother, who shouted, depressed and in a bad mood all the time, after classes I learned to smile, I learned to give a discipline without violence and to be a better mother and more communicative.
With the classes for parent educator, I learned many things about myself, for example that I love helping other parents who, like me, did not know how to react to the problems and difficulties that life presents us every day. I know that little by little I will continue to recognize my abilities and strengths as well as strengthen them.

Many thanks to all.

The STEP program helped me to have tools to help my children to be better people and to be able to cooperate, the messages in me have changed the behavior of my children to have meetings in families and say that we like it and that we do not like it, It has taught me how to talk to my children not to shout, to listen reflexively.
I give thanks to this program for giving us tools to raise healthy and happy children, who know how to give and receive love.

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Thanks to
L. Tinajero

For me it is a great experience to participate in this training to be a parent educator, my main impact is my family, now I have much more family harmony especially with my children, until today there is more cooperation, I learned to be tolerant, listen before judging or criticizing, I am excited to continue preparing parents to know this beautiful project and can have the tools that only in these classes are found.

Thank you very much

I thank God, my family and the facilitators, for allowing me to take the courses of parenting classes and mental health, for me personally it has helped me a lot, to know how to identify, solve problems also the inconveniences that arise daily at home, as in any home or family, the children have had significant change but first of all I myself have being changing and I go on the road, fighting day by day and putting into practice everything that we have been taught, such as know how to listen reflexively, make agreements, set rules, be concise and precise, the first 15 seconds are the ones that count, that you do not have to give up to the fire but be wise and get away a moment later on return and talk it over, give I messages, to know who is the owner of the problem. I invite you to continue forward giving more courses, reinforcing the previous ones, since it is very important for other parents to have better families, healthy children living in harmony in a healthy home.

Thanks 1000 thanks
M. Sanches

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PEI ANNUAL REPORTING FORM

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR: FY 2018-19

Agency/Program Name: **LifeLong Medical Care**

Reporting Period (Select One): ☐Semi-Annual Report #1 (July – Dec)
X Semi-Annual Report #2 (Jan – June)

PEI STRATEGIES:

*Please check **all** strategies that your program employs:*

X☐ Provide access and linkage to mental health care

X☐ Improve timely access to mental health services for underserved populations

X☐ Use strategies that are non-stigmatizing and non-discriminatory

SERVICES PROVIDED / PROGRAM SETTING:

Please describe the services you provided in the past reporting period. Please include who the program has targeted and how your services have helped in improving access to services. Where are services provided and why does your program setting enhance access to services?

LifeLong Medical Care's SNAP program creates safe and accessible places for underserved populations to experience community, enjoy meaningful activities, learn new skills, and obtain referrals for needed resources. Program goals include: 1) Increase morale, self-esteem, self-efficacy and sense of purpose; 2) Increase meaningful social engagement and participation in pleasant activities; and 3) Provide referrals to other mental health and support services as appropriate.

SNAP is based on research linking social engagement, a sense of personal control and mastery, access to lifelong learning opportunities, and sustained creative activity with mental and physical well-being in older adults. Social isolation has been linked with negative outcomes, including depressive symptoms, reductions in coping skills, and cognitive decline, while strong social connections and person-centered learning opportunities, tailored to each elder's needs and interests, contribute to improvements in morale, mood, and overall physical and mental health. Research shows that negative outcomes are exacerbated by poverty: about 9% of seniors living in poverty experience depression, more than double the rate of depression among community-dwelling older adults in general (Gum, Arean, & Bostrom, 2007).

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LifeLong's experience working with older adults in West County mirrors these research findings. Seniors facing isolation, depression, and other stressors, benefit from opportunities for lifelong learning, social engagement, and creative activity. Seniors who work with LifeLong's case manager receive needed resources as well as emotional support around grief and loss, family stress, and other challenging issues. Participants have told us that they value SNAP because of the connections they make with others, satisfaction of engaging in positive activities, and practical help obtaining needed supplies and resources.

SNAP ensures timely access by providing services in the community rooms at Nevin Plaza, Friendship Manor, and Harbour View (senior and/or low-income housing sites in Richmond where many program participants reside), and in partnership with the Native American Wellness Center, located across the street from Nevin Plaza. Offering services in convenient and familiar environments encourages participation while also improving the dynamic in public housing buildings by introducing positive activities and reducing disruptive behaviors.

In addition to offering services in highly accessible community locations, SNAP uses programmatic strategies to promote access, including hiring staff who reflect the race/ethnicity of populations served; creating safe and inviting spaces that welcome participants of all different abilities, needs and interests; providing case management to identify and address mental health and other support service needs; and reaching out regularly to encourage participation.

Services Provided:
During FY18-19, SNAP provided social activities and case management as described below:

Social Activities:
This program year, SNAP maintained activity programs once per week at Nevin Plaza, Friendship Manor, and Harbour View. Monthly groups at the Native American Wellness Center (NAWC) provided opportunities for cross-cultural experiences, making excellent use of the NAWC's unique social atmosphere. These social programs created opportunities for building residents to relax and enjoy themselves, support each other through inter-personal connection, try new experiences, and learn and practice new skills -- all of which reduced social isolation and supported long-term mental health, well-being, and quality of life.

Each SNAP location has its own "social personality," and staff employ different approaches to engage residents at each building. At Nevin Plaza, participants especially enjoy BINGO, Uno, Scrabble, and casual movement exercise groups. On-site, one-time activities tend to hold the most community involvement, rather than ongoing projects or excursions. With varied literacy and education levels among Nevin participants, they support each other with mutual encouragement, patience and a unique sense of camaraderie. Friendship Manor residents are an especially relaxed, socially involved group. They enjoy music and conversation, and often sing together. There is a great deal of playful humor alive when the Friendship Manor community is present. Friendship Manor residents are able

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to participate in outings and longer-term projects, such as going out to the movies or learning songs to perform together. Harbour View is more of an intellectual scene: residents enjoy long-term projects like Spanish language classes and arts & crafts projects. Solid relationships have developed within the Native American Wellness Center group. They especially enjoyed Tai Chi exercise and nutrition in-services. All sites enjoyed and welcomed guest speakers and performers.

Some of the highlights of this year include:

- A three-month nutrition series around healthy eating habits.
- An ongoing craft project where residents are making dolls.
- Live drumming with renowned teacher, Roberto Borrell.
- Creative movement and Salsa dancing with Luz Mena.
- Coping with loss, a group oriented around grief and loss of other community members.
- Movie groups hosted in community spaces.
- On-site memorial services organized by SNAP staff for residents who passed away.
- A conversational Spanish group with ongoing language studies curriculum.
- A "Men's Club" that encourages healthy social interaction between male-gender residents.
- Billiards, board games, Bi-lingual BINGO, and scrabble groups.
- Tai Chi classes following an evidence-based program with both physical and emotional benefits.

SNAP participants also enjoyed a variety of special events throughout the year:

Excursions: This year program participants requested popular trips from past years: a ferry ride into San Francisco with a picnic at Fisherman's Wharf (including dancing and singing on the pier!), and a movie outing to Richmond's Hilltop Cinemas. Lunch and transportation were provided for both events. In addition, throughout the year Friendship Manor residents traveled regularly to Harbor View to engage with on-site activities there.

Performances: This year, the SNAP choir got smaller as participants passed away and new participants brought different interests. The group performed twice: at Center for Elders Independence in Berkeley, and a beautiful final performance at LifeLong Medical Care's annual gala. SNAP staff will re-start the choir if participant interest re-emerges; otherwise, we are moving on to new activities based on consumer preferences.

Guest Speakers are always popular; program participants are actively interested in learning about free or low-cost community resources. This year's topics included:

- Food as Medicine
- Nutrition
- Medication Management
- Durable Medical Equipment

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- Vital Link (emergency response)
- Home Health services
- Multipurpose Senior Services (MSSP) of Contra Costa County

Case Management: SNAP provided case management to 79 consumers with a half-time social worker who is a native of Richmond who has extensive experience providing case management services for diverse elderly populations.

SNAP's case management program supports participants with individualized elder care. Frequent wellness checks, including encounters in the community, telephone calls, and home visits, maintain regular contact with clients. Services include follow-up on PHQ-2 depression screening, referrals to behavioral health and social services, and assistance in medical system navigation, including new referrals and follow-up with existing behavioral health providers.

The most common areas of case management support this year included: health insurance navigation, benefit applications (such as ParaTransit and IHSS), food assistance, small DME needs (canes, walkers, heating pads, a raised toilet seat), obtaining eyeglasses, hearing aids and dentures, and support around health issues, grief/loss, and concern about family networks and relationships. The case manager was also available to provide extra help in special situations on a case by case basis. Examples this year included visiting isolated seniors in the hospital, helping a senior find services for his adult daughter with disabilities, and helping a daughter understand and support her mother with advancing Alzheimer's Disease.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- *How are participants identified as needing mental health assessment or treatment?*
- *List of indicators measured, including how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.*
- *Average length of time between report of symptom onset and entry into treatment and the methodology used.*

How are participants identified as needing mental health assessment or treatment?

SNAP program staff provide outreach at Nevin Plaza, Friendship Manor, Harbour View, and the Native American Wellness Center each month with fliers posted in community spaces and delivered to

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residents' doors. Staff go to great lengths to explore SNAP program activities with residents on a personal level, and current program participants are known to encourage other residents to attend. It often takes up to several months before a resident decides to participate, and during that time staff continues to reach out in hopes of building community trust and support. SNAP program staff employ an inclusive "open door policy" to allow for residents to engage with staff on their own terms, in ways that feel comfortable and appropriate to them.

When a resident becomes open to participation, staff ask them to fill out an enrollment form that includes questions about mental health symptoms and whether they would like support to access services. The enrollment form also screens for depression. If the resident is unable to complete a form, then staff asks these questions verbally.

Average length of time between report of symptom onset and entry into treatment: **60 weeks**
At time of enrollment and as issues arise, SNAP staff asks participants about the duration of any mental health symptoms. Most participants refuse to disclose this information to SNAP program staff. The data we were able to capture ranged significantly, from a few months to 3 years, for an average duration of 60 weeks reported during this fiscal year.

List of indicators measured:
The SNAP program measures depression, social isolation, and program satisfaction using a two-page survey we have developed with participant input. In addition to this formal process, we also check in with participants throughout the year to identify emerging issues and to gather feedback. The small size of SNAP allows us to stay connected to participants on a regular basis.

Feedback from participants was very positive overall, with the vast majority reporting high levels of satisfaction and the belief that SNAP helps people develop friendships, feel less isolated, and improve morale. Below, survey results are matched with our contract's "measures of success":

1) *50% of participants will demonstrate self-efficacy and purpose by successfully completing at least one long-term (multi-week or multi-month) project by July 2019*.

   SNAP offered both short and long-term projects to create a variety of experiences: one-time activities designed to be fun and require no long-term commitment (such as games, sing-a-long, and Spanish Bingo), as well as longer projects requiring significant commitment and effort (such as Spanish language classes, the SNAP choir, and multi-week crafts projects). In total, 56 people completed at least one long-term project (65% of the residents who participated in more than one group activity).

2) *75% of respondents will self-report improved feelings of morale as a result of participating in SNAP by July 2019*.

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94.7% of SNAP respondents reported that they agree (50%) or strongly agree (44.7%) with the statement, "SNAP helps improve my mood." 7% responded, "I don't know."

3) *75% of respondents will self-report improved social connections and/or decreased isolation as a result of participating in SNAP by July 2019.*

97.4% of SNAP respondents reported that they agree (50%) or strongly agree (47.4%) with the statement, "SNAP helps me feel more connected to others."

4) *75% of respondents will be satisfied with the engagements and activities provided by staff, volunteers and peers by July 2019.*

97.4 % of SNAP respondents indicated that they agreed (31.6%) or strongly agreed (65.8%) with the statement "I am very satisfied with SNAP." 2.6% responded, "No Opinion."

A summary of these survey responses is provided below:

N= 38	Strongly Agree	Agree	Disagree	Strongly Disagree	No Opinion
I am very satisfied with SNAP.	65.8%	31.6%	0%	0%	2.6%
SNAP helps improve my mood.	44.7%	50%	0%	0%	2.6%
SNAP helps me feel like I can handle my problems.	34.2%	55.3%	0%	0%	10.5%
SNAP helps me feel more connected to others (less isolated).	47.4%	50%	0%	0%	0%
SNAP staff respects me and listens to my ideas.	57.9%	36.8%	0%	0%	5.3%
Case Management has improved my ability to access services	39.5%	44.7%	5.3%	0%	10.5%

DEMOGRAPHIC DATA: X Not Applicable *(Using County form)*

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

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We use the County form.

LINKAGE AND FOLLOW-UP:

Please explain how participants are linked to mental health services, including how the PEI program: 1) provides encouragement for individuals to access services; and 2) follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

Program staff outreach monthly to residents of Nevin Plaza, Friendship Manor and Harbour View Senior Apartments, and to participants at the NAWC, taking time to contact those who express interest in services, appear to be struggling, or who are referred by other residents. In each of the SNAP sites there is community awareness: residents tend to know each other and have a good sense of who might be interested in, or benefit from, the SNAP program. SNAP program staff is also on site frequently, and are able to respond to resident cues about their interests and needs.

As part of SNAP's open-door policy, residents are encouraged to participate in the programs however they can. Residents of SNAP sites are encouraged to engage with the program at any level they would like to, allowing residents to explore by visiting, entering and leaving activities as they please, or otherwise limiting their involvement before they decide to fully engage with the community. All SNAP activities are designed to be highly accessible and welcoming for people with a variety of needs and emotional, physical and cognitive abilities.

The SNAP staff identify those who might benefit from additional mental health services through the program enrollment form, which includes the PHQ-2 patient health questionnaire. In addition, the enrollment form explores a participant's mood with the following question: *"Do you feel mental health symptoms like mood swings, being very angry or mad, sad, anxious, stressed out, isolated, unable to sleep, or something else?*" We also ask the PHQ-2 questions as part of a year-end survey. In addition to these written tools, the SNAP staff interact with program participants often and are able to identify mental health and social service needs.

The participants who describe mental health symptoms to SNAP have had prior access to therapy services about half of the time. In these cases, SNAP program staff partners with those participants around appointments and follow through with service continuation. SNAP program staff may also make referrals to additional mental health resources for more support. If a participant does not

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already work with a therapist, staff will encourage them to speak to their primary care provider, or refer them to county mental health services. SNAP program staff will also ask if participants need support around overcoming barriers to access (such as transportation), and follow up with the participant to ensure they got what they needed.

For participants who chose to pursue enrollment with formal mental health services, this year the average length of time from referral to receipt of services was ten weeks.

VALUES:
Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non-discriminatory?

SNAP promotes MHSA values to the fullest, as described below:

1) Wellness, recovery, resilience: SNAP program staff create inclusive, welcoming, and accepting environments where participants are able to support and encourage each other. Art, music, and language classes encourage participants to expand their skills and experience success with others. These activities lead to resilience and feelings of self-efficacy, all while community presence improves mood and supports personal recovery.

2) Access and linkage: SNAP programming offers highly accessible services in the buildings where our target population lives. SNAP program staff work to get to know and develop the trust of each resident, so that participants have a safe channel to disclose their needs. The SNAP case manager links participants to social services and facilitates referrals to mental health resources as needed. If the participant already sees a mental health provider, staff checks in regularly to encourage them to participate with external care providers.

3) Timely access for underserved populations: Services are provided directly in the building or local neighborhood to promote accessibility for elderly residents; culturally sensitive services are provided for this low-income and primarily African-American population.

4) Non-stigmatizing, non-discriminatory: Residents are accepted into SNAP as they are. SNAP facilitators create group environments that hold space for diverse social thought processes, energy levels, and abilities, allowing each participant's strength to surface and shine.

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Participants can come and go from groups as they need to, and it is perfectly acceptable to participate or not. Participants tend to talk freely about their mental health issues because they are comfortable with SNAP program services, they know they are not being judged.

The SNAP group is largely African-American, with an African-American facilitator and Latina teacher. The half-time case manager is an African-American woman originally from Richmond. Many of the SNAP participants are learning Spanish language songs and greetings because they want to build relationships with Spanish-speaking neighbors. The SNAP program's partnership with the NAWC is similarly based on a shared desire to deconstruct social barriers and fight the discrimination.

VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

We received lots of feedback from SNAP participants through a confidential survey administered in July 2019. Here are some of the responses we received.

SNAP has helped me by…

Being there, especially when I thought no one was there!
Get involved with other seniors
I like SNAP, it makes me happy! I like my case manager very much and I love her very much.
Having activity so I can leave my apartment and having someone to talk to.
By helping me to [interact] with other people with disabilities and age limitations – SNAP helps me remember I'm not by myself.
I am grateful that SNAP offered me the opportunity to have a social worker that helps with my concerns.
It gives me something to do when I don't have anything to do.
Keep having SNAP. We need it.
SNAP help me do a lot of good things by: laugh, cheerful and have fun with others
By taking the stress off and making me happy
Not be depressed
When I'm down and SNAP is around, I come down and join the group and I won't be thinking about what happens on that day.
Having something to do with my neighbors and others
Forget about what I am going through day by day
Getting along with others by playing games and problem-solving games
Keeping us active, and in touch with each other
It helps me feel at ease. I like to be with SNAP people.

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PEI ANNUAL REPORTING FORM

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS REPORTING FORM **FISCAL YEAR: 18-19**

Agency/Program Name: Native American Health Center

PEI STRATEGIES:
Please check all strategies that your program employs:

X Provide access and linkage to mental healthcare

X Improve timely access to mental health services for underserved populations
X Use strategies that are non-stigmatizing and non-discriminatory

SERVICES PROVIDED / STRATEGIES:
Please describe the services you provided in the past reporting period. Please include qualitative and quantitative data depicting: 1) the types and settings of potential responders you reached during the past reporting period; 2) methods used to reach out and engage potential responders; 3) any strategies utilized to provide access and linkage to treatment, and4) strategies utilized to improve timely access to services for underserved populations.

Through the strategy of outreach the Native American Health Center provides prevention and early intervention services to increase the recognition of early signs of mental illness, assist community members to access culturally appropriate mental health services, and host Native American cultural groups, community events, mental health and wellness workshops, and classes that increase social connectedness, cultural connection, and general awareness of community and county resources to improve member's overall well-being. From July 2018 to June 2019, NAHC provided groups and events tailored to the Contra Costa County Native community and the remaining underserved and underrepresented populations. NAHC strongly believes that culture is prevention and integrates Native American cultural practices and traditions throughout our program. In addition to this, we continue to target outside events and activities sponsored by partnering agencies within our community that may serve the Native community. Our goal last year was to further establish our presence throughout Contra Costa County and continue to provide advocacy for the needs of the community that we serve, by doing this we were able to build a strong network of support with partnering organizations within our PEI network and throughout Contra Costa County. This led to partnerships and event collaborations that have allowed us to engage an increased amount of potential responders. NAHC reached a total of 289 unduplicated members by the end of June 2019. In comparison to contract year17-

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18, we had served only 162 unduplicated members and though we had met our goals, this contract year has been a significant improvement and can be attributed to the new/ or improved methods used to engage potential responders. Our dedicated staff worked to improve our network of potential partners and increased collaborations with other organizations. Examples of collaborations include: Lifelong Medical, Building Blocks for Kids, RYSE youth center, the James Morehouse Project, Scotts Valley Tribal TANF, just to name a few. By increasing our presence in the community through outreach booths, attending community events, public hearings and town halls, and a variety of community health committees our staff was able to increase access to services for our members as well as build and arsenal of support and resources that would improve our referral processes moving forward and make warm-handoffs easier for members who may have been unsuccessful in accessing care in the past.

Peer Support for Referrals and Follow-ups:

During intake interviews (either by phone or in person) staff assess members regularly for potential needs for resources or services. Referrals by appointment are encouraged so that staff can dedicate a significant amount of time to ensure the needs of members are fulfilled as well as allowing us the opportunity to conduct wellness surveying to address any other possible concerns they may have. Staff ensures that all referrals issued to members are followed up within a 48-hour window. Referrals are issued to both continuing and new members for services that are offered inter-agency and externally. Inter-agency services include Medical, Dental, youth or transitional- age youth, and behavioral health services. In instances where we cannot provide the members with the resources they are looking for, our goal is to ensure their needs are met in other ways by providing them with information about the services we do provide and connecting them with other local organizations that may have the resources that they need. From July 2017 to June 2018 a total of 23 referrals were issued and completed by staff. Often times, these visits result in multiple referrals issued per member. For example, if a member comes to us looking to be connected with housing support, they may also need resources for food support. The following are brief examples of the referrals processed within this contract period:

Mental Health

1. Member came to us disclosing that she had become severely depressed and was experiencing suicidal thoughts due to a number of contributing factors. The following referral/ Action plan had been discussed: 1. Member was to contact Kaiser's psychiatric department to schedule an appointment with her provider to renew her medications and be connected with a new therapist. Member had also agreed to attend the upcoming Talking Circle and meet with the facilitator for a one on one. NAHC staff had committed to assisting the member with accessing dental services (that had been causing the member extreme pain), IHSS, and working with our partnering Elder Care Coordinator (from LifeLong Medical) to help seek resources that would provide attendant services for the elderly. After about a month of follow-ups the member was able to access everything she needed.

Medical/Dental/Vision

1. Referral was processed for a member who had requested to be seen for vision services by a Native specific provider. Unfortunately, there are no known facilities who provide vision care specifically for Natives. Staff attempted to connect the member with other vision care resources but were declined. The referral was closed. This instance was not the first time a request like this has been made and it does demonstrate a specific need this community has though us as an agency cannot meet it at this time.
2. Member called in seeking dental services and he disclosed that he was a Medi-Cal recipient. A referral was made to a local dentist practice in San Pablo who we were aware accepted Medi-Cal and the

member was able to get an appointment that day.

3. Member came to us seeking assistance with locating a primary care doctor and to get more information about her Medi-Care coverage. She was referred to LifeLong medical and connected with the Patient Service Advocate here in Richmond.

Transportation

Social Services

1. Medi-Cal referral issued and referral was passed on to an intake coordinator at our Oakland facility where client was able to have an in person appointment and was signed up for Medi-Cal

On-Going Prevention Groups

On-going prevention groups are a key component to reaching first responders. NAHC hosts weekly prevention groups to serve the needs, empower, uplift, motivate, and connect with potential first responders. Groups are facilitated by traditional consultants and trained NAHC staff members on site with a focus on traditional arts integrated with mental health and wellness messaging. These groups at the Native Wellness Center are a great resource and foundation for the services that take place here. They allow us to engage community members through culture and help translate mental health concepts in an informal and safe space. These different ways include:

- Exposure to and in-depth practice of Native Culture and Tradition
- Participating in and learning ceremony and etiquette
-Learning skills and various techniques associated with Native American focused crafts
-Community building and social connectedness
-Promotion of health and wellness
-Awareness and destigmatizing of mental health and behavioral health services

It is important to distinguish between the different ways people engage in our groups; our community is vastly diverse in cultural practice. This is why providing services based on the Holistic System of Care for Urban Natives is so important and useful. Being in the Bay Area, most of our clients are a long way from their homelands. Participation here in an Urban setting means that ceremonies and traditions are upheld despite our small numbers, and that makes the resiliency factor that much more important to positive mental health outcomes. Our groups are offered to all and serve a diverse group of individuals. This plays an important role in bridging the gap between people of different cultures and experiences. It allows for the opportunity for non-Natives to learn about the Native community first-hand, reduces misconceptions, corrects misrepresentations, and increases cultural humility. Our ongoing groups are Wisdom Holder's, Traditional Drum Circle and Pow Dance Practice, Beading Circle, Art for Therapy, Quarterly Basket Weaving, Quarterly Quilting, and Health and Fitness Workshop. All these groups share a common goal; to foster learning, connect members to cultural practices, provide a safe space, empower members, all while promoting healthy lifestyles, and both health and wellness education.

Wisdom Holder's Elder Support Group

This group meets on a weekly basis to provide our elders a positive outlet to communicate any issues or concerns that they may be struggling with. There are also opportunities for them to gain knowledge on issues surrounding health and nutrition, Native culture, family support and prevention in regard to depression and isolation. Monthly events are planned by the group to do outreach and interaction within the Native community. With the recent transition of facilitators, the elders support group has made

positive strides toward improvement. We have recently implemented a formal curriculum of goals we hope to accomplish with the elders. The curriculum includes three important components: Formal health and Wellness education- which includes workshops ranging from healthy food demonstration to information on "how to fall" for example. The second component is cultural education- this in particular focuses on teaching Native history, bringing awareness to issues surrounding the Native community, and providing positive entertainment that sparks awareness and constructive conversation within the group. The third component and most recent is the implementation of scheduled activities that focus on exercising the mind. Understanding that elders are commonly diagnosed with Alzheimer's and Dementia, we are more frequently scheduling activities that will help with combatting the diseases. For example, facilitating days dedicated to playing games that are proven to support brain function. In collaboration with Lifelong Medical, we partner once a month to provide our Elder's with additional support and activities they may need or want to have. Our groups combine in an effort for both programs to expand membership and build healthy relationships within the elder community. There is also a social worker with Lifelong who regular attends our elders group to provide additional support and access for wellness outside of our abilities. Throughout programming staff continually assesses attendees for way in which we may provide support or resources and the goal is to support the members to achieve independence and empower them to take control of their own well-being.
Our elders continue to express their gratitude and appreciation for this group specifically. Many of the group members have expressed their dependence on these meetings for support because they either live alone or are facing challenges. They have expressed their need for social connection as a way to combat depression and isolation. The group facilitator also ensures that their needs outside the group are addressed as well as doing regular wellness check-ups when members are not in attendance.
Elder's Fruit Day at NAHC Oakland: Combination of Elder's Support groups from Richmond and Oakland where they gather every second Wednesday of the month. This group uses a similar strategy as the Wisdom Holder's group on a larger scale, while also providing each participant with package of fresh fruit, vegetables, and other nutritious foods.

Traditional Beading Circle
This group has become well established in our Center and in the community. As the group gathers more, the beading skills improve, and they are getting to do more advanced projects. It's been amazing to see members begin the group with no skills at all, and now they are making beautiful jewelry, medicine bags, and accessories with intricate designs that incorporate many traditional techniques. Also, to see people that started with no patience and get frustrated easily, be able to sit for 2 hours in a very calm environment and focus on their beading techniques. While in transition of instructors, this group had remained a drop-in group where members are able to work individually on their own projects in a safe and welcoming space until the new instructor had begun facilitation in February of 2018. Since then she has established a specific curriculum focus on developing the coordination of members necessary to complete beadwork. She also focuses on the therapeutic aspects that beading provides to members and impact that on mental health this class promotes by providing a way in which the Native community can connect to cultural practices they're unable to learn at home. Beadwork is a common practice in the AI/AN community and the skill is typically passed down through familial interaction. For many urban Natives this tradition is not as common and by providing this class we have the opportunity to allow members to relearn lost traditions and promote cultural connectedness.

Traditional Drum Circle and Pow Wow Dance Practice
This group is offered for Men of all ages, and often combines youth and adults. The facilitator teaches various types of songs like Honor Songs, Northern and Southern Drum styles with a focus on learning the

words to the songs which are majority in the Sioux language. This group is important because it exposes members to cultural tradition and practices, promotes healing through traditions and spirituality, and provides a sense of identity and cultural connection to our Urban Native community. The facilitator has been successful in ensuring that the members not only learn songs and drum techniques, but rather they understand the stories and reasons behind specific traditional practices. This speaks to the high importance of the Oral tradition within the Native community. Recently, we have added the Pow Wow dance practice aspect to the group in an effort to attract more women and families to the center because traditionally drumming is a men's practice and the center does not want to encourage disconnection and separation. Through doing this both genders are able to learn about the culture and the reason why certain practices are gender exclusive. This is part of the cultural education component of our work.

Art for Therapy

This group is offered to the community with all ages welcomed. This class was newly established in June of this year with the help of one of our volunteers, a local artist named Juan Nunez. The idea for the class came from his own education and experience. He is currently a psychology student and in thinking of how he could align his education with his interests, we worked to come up with an art class that allows the community an outlet to express their creativity, build community and social connectedness, and reduce stress. This provides members with a therapeutic alternative to traditional clinical settings where they might feel discouraged due to the negative connotations and stigma associated with accessing behavioral health services. It also allows the opportunity for staff to connect with community members and assess for potential needs of members. A few specific examples of the ways in which we've seen this class prove to be effective is the through the demographic of first responders that have attended. There has been families who attended in an effort to strengthen their relationships with their children through bonding, elderly members who suffer from dementia have been brought to participate (arts and crafts have been proven to help relieve patients from symptoms associated with dementia as well as help to calm them during extremely stressful times), and lastly members who seek to participate in paint nights in a sober environment. There has been an increased popularity of "paint nights" due to the recent establishment of "wine and canvas" paint nights at different restaurants and social spaces. This is our alcohol-free alternative for those who seek family and recovery friendly settings. Alternatively, we offer refreshments or community dinner/potlucks where members are still able to engage with one another and learn a new skill in a safe space.

Quarterly Basket Weaving Workshop

Basket Weaving has a similar goal and curriculum as our Beading Circle. Basket Weaving is also an important part of Native history and tradition and we offer a six week course each quarter with the goal that each participant complete one basket project. All the materials are "natural" and either gathered or purchased from specialized stores. Our first workshop of the year took place in April and had a total of 8 participants.

Quarterly Quilting Workshop

The Quilting workshop was also newly established this year and similarly to the basket weaving workshop and lasted for six weeks. Programming was scheduled on Saturdays to address the need for "after-work" hour's programs. The goal of this class was to teach the basic techniques needed for quilting as well as allow community members to work on their own personal projects who may not own the tools and materials necessary to complete the work. This program was significant because it allowed community members to repair quilts that had sentimental value. This led to community members sharing stories about the history of the quilts, family stories, and most importantly community connectedness.

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Health and Fitness Coaching Workshop

This workshop was created to help members address their health concerns and think of creative ways in which they may be able to address those concerns independently. The facilitation was provided by a Native volunteer who was diagnosed with diabetes and was able to change his lifestyle and eating habits. During this workshop members were able to identify reasons that have caused or prevented them from making healthy choices and begin a plan on how they will achieve their health goals in which ensured their accountability. Topics discussed included: diabetes prevention and management, health food alternatives, weight management, etc.

Events

There was a total of 26 events held this year. This includes both in-house and outreach out in the community. Two events I would like to highlight were the September-Suicide Prevention Month event where we brought in a guest speaker and held a video screening and discussion. The other event is the Annual Indigenous Peoples Walk for Sobriety. We partner with a small indigenous organization every year to bring awareness to the effects of substance abuse on our community. All other events include our annual Pow wow's, holiday celebrations, Annual Sage Wrapping ceremony, and Traditional Arts workshops.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***Include a list of indicators measured, how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

Per our contract we had committed to the following measures of success:

a. Engage 150 community members through prevention service programming.
b. 65% of our members utilizing referral services will be successful in accessing (connecting with) services over a 12 month period.
c. Program staff will participate in 20 outreach events or activities throughout the course of the year.
d. 10 participants, including NAHC staff, community members, volunteers and interns, and partner agencies will be trained in Mental Health First Aid.

With the intended outcomes that:

a. Members will have increased access to prevention activities and mental health support.
b. Members will increase their engagement in NAHC mental health prevention and treatment services.
c. NAHC will engage a diverse population of first responders throughout Contra Costa County.
d. Members, Peers, and Staff will be trained in behavioral health related topics including but not limited to Mental Health First Aid.
e.

DEMOGRAPHIC DATA: ☐ Not Applicable ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form AND have chosen

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to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

Please see the MHSA Aggregate Reporting Form submitted in conjunction with this report.

VALUES:

Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

NAHC Richmond staff are specifically trained in Mental Health first aid, Trauma Informed care, Suicide prevention and intervention, and are well versed in identifying outside resources useful to members. A significant portion of our work is dedicated to bridging relationships with local agencies, and ensuring referrals are made to reliable providers. NAHC's programming continues to reflect the MHSA values by providing direct linkages through our Community Health Workers, addressing social determinants of health and serving as system navigators for additional resources. In regard to behavioral health referrals specifically, NAHC Richmond partners with a number of local providers as well as NAHC's own Behavioral Health department which allows us to speak directly with staff regarding appointment scheduling and follow-ups. This reduces barriers and helps to speed up response times.

Embedded in our programming is the philosophy of culture is prevention. Providing services that reflect this philosophy is a key component in our overall mission and the driving force behind our service strategies and goals. Traditional cultural practices provide Native community members with a sense of belonging, identity, and restored pride. These elements are important because they have been historically lost throughout generations due to a number of causes. Exposing members to traditional practices has been proven to reduce stress by providing an outlet as well as played a key role in promoting healing from historical trauma (which we as a community understand causes those to suffer from mental illnesses). Participants report feeling a sense of belonging to community through our groups and events. The social connectedness and pride developed here directly supports wellness and recovery. It allows individual members to build relationships and prevent isolation. Our program builds upon the resiliency of our members to empower them toward the goal of self-sufficiency and self-efficacy.

NAHC also takes an intentional approach to integrating health messaging in our programming, health related topics such as understanding historical trauma, nutrition, diabetes prevention and management, self-care strategies, and insurance eligibility are all discussed in a group or event setting. Topics are covered sensitively and are mindful of language and presentation style. The Native Wellness Center also serves a prevention center by providing information on preventing STD's, providing free condoms on-site and in collaboration with Contra Costa Health Services, we provide free HIV/HEP-C Testing twice a month to members.

The values of NAHC strongly enforce a drug and alcohol-free policy while also encouraging healthy

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lifestyle choices outside the center. We offer events focused celebrating sobriety and recovery as well as referrals to drug and alcohol counselors.

It is important to note that the community we serve suffers from historical trauma as well as continued poverty, substance abuse, mental illness, loss of identity, and distrust of our healthcare system. This is why the work that we do is so important and is specifically tailored the way in which it is. Wellness, recovery, and resilience not only reflect MHSA values but are also key values to keep in mind when serving the Native community.

Lastly, external outreach efforts are targeted toward visibility of our program and advocacy for the community. NAHC ensure our presence on various committees as well as our involvement in a number of cities, county, and overall healthcare events, meetings, and groups. By doing this we provide an outlet for our staff to advocate and provide a voice for our member population. The Native community has a history of misrepresentation and under-representation. This community has its own unique identity and rich history to be proud of and it is our intention to represent so accurately and effectively.

VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

Program participants frequently express their gratitude for the program and staff. They have stated that "without the center they would be alone and have nowhere to go where they feel welcome and safe". In one instance a member has explained how she looks forward to attending our Wednesday luncheons (Wisdom Holder's group), this group is vital to her life for three reasons: 1. It allows her a space for social connection, 2. The staff help to connect her with the resources she needs on a weekly basis, this includes assisting with scheduling medical and dental appointments, finding transportation and food resources, updating her MSSP and paratransit memberships, etc., 3. Lastly, this member also suffers from severe depression and through our Talking Circles she was able to speak out about the her feelings as well as use the tools taught by us to cope and find healthy outlets. Due to the nature of the discussions held at the Talking Circle they are specifically facilitated by Traditional Healers and Native clinicians who have experience working with our population. By doing so we have been able to connect members who are experiencing behavioral health issues sooner and more successfully. The member previously mentioned also disclosed to staff a near suicidal break that she was experiencing last September that led to an extensive follow-up and referral. This disclosure happened during an event that NAHC hosted for Suicide Prevention Awareness month. This is a prime example of why it is so important for us to continue to host events such as these, they not only bring awareness to mental health and reduce stigma but they also provide a safe space for individuals to feel comfortable disclosing their current situations where they typically are hesitant. Understanding that we serve a community that historically has a distrust for medical and behavioral health services (especially those ran by county or governmental bodies) we are serving as a starting point and making connections that foster trust. As an agency we have taken a traditional practice like Talking Circles (which in Native tradition is our way of approaching mental health and wellness) and merged them with the traditional behavioral health approach by providing access to clinicians or referrals, etc., this has proven to be more successful when trying to transition the members into care at other agencies that provide continued behavioral health services:

Passing of an elder member/ a community that has come together to support each other

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Expressions of gratitude regarding the work that we are doing and how we are preventing isolation, improvement in depression, and suicide among our members

Perspectives from community/ CAB regarding the surveys and how we can improve them and our plan on how to move forward

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PEI SEMI-ANNUAL REPORTING FORM

PREVENTION REPORTING FORM FISCAL YEAR: 2018 - 2019

Agency/Program Name: **People Who Care Children Association**
Reporting Period (Select One): □Semi-Annual Report #1 (July – Dec) X Semi-Annual Report #2 (Jan – June)

PEI STRATEGIES:

*Please check **all** strategies that your program employs:*

X Provide access and linkage to mental health care

X Improve timely access to mental health services for underserved populations

X Use strategies that are non-stigmatizing and non-discriminatory

SERVICES PROVIDED / ACTIVITIES:

A. Please describe the services you provided in the past reporting period.

PWC's Clinical Program provides early intervention and prevention intervention utilizing psychotherapy in the following formats: groups, couples, family and individual sessions. We collaborate with other agencies, community-based organizations, and healthcare providers. Our goal is to aid our clients and their families in obtaining the resources/support they need to achieve their goals and thrive. Our groups are primarily prevention based and focus on building and strengthening interpersonal skills necessary for functioning effectively in life. These include the development of healthy coping mechanisms, self/ emotional awareness through mindfulness, anger management, conflict resolution, stress management, and effective communication skills. Other groups focus on team building, community support/peer relationships, creativity and expression, and self-identity/awareness groups. PWC gives our youth a safe and nurturing environment to explore what makes them who they are.

Our goal is to aid our clients and their families in obtaining the resources/support they need to achieve their goals and thrive. This is achieved in part by collaboration with other agencies, community-based organizations, and healthcare providers. Our groups are primarily prevention based and focus on building and strengthening interpersonal skills necessary for functioning effectively in life. These include the development of healthy coping mechanisms, self/emotional awareness through mindfulness, anger management, conflict resolution, stress management, and effective communication skills. Other groups focus on team building, community support/peer relationships, creativity and expression, and self-identity/awareness groups. PWC gives our youth a safe and nurturing environment to explore what

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makes them who they are.

B. Please include types of problems/needs addressed, any activities that address these problems/ needs, and any functional outcomes.

The needs we have seen in the population we serve include: issues with depression, anxiety, and management/regulation of intense complex emotions that are perceived as negative, challenges with resolving internal and external conflicts, struggles to identify and communicate thoughts and feelings when under pressure or dealing with hardships, conflict within the school setting and community setting with peers and family. Many of our clients struggle with their ability to identify their goals, talents, ambitions, along with a lack of understanding regarding their self-identity and how they fit into the world.

Our prevention groups help youth by encouraging and building self-awareness. This enables them to be better attuned to their mental health needs, empowers them to ask questions, identify their needs and seek support. Activities such as group, family, couples, and individual clinical sessions empower our clients by focusing on the creation, development, and maintenance of meaningful relationships to self and others. This also facilitates for the clients to finding who is their support system, or in some circumstances build/create/fortify an effective and strong support system. This gives our youth the keystone to create a stronger and more effective support system. Throughout this process, clients learn about themselves and start the development of a personal growth mindset. These prevention groups foster learning experiences that enhance the individual's self-awareness. This is a motivating factor in cultivating their desire towards caring for their mental health needs and becoming self-sufficient in managing personal/internal challenges and/or external struggles, in conjunction with acquiring the tools for coping through life's sometimes difficult and challenging experiences.

Our mental health program is continuing with the theme of self-discovery and building upon this cornerstone from the previous two years. This year, PWC has transitioned clinicians. Previously, we were using a Pre-Doctoral PsyD trainee, Miss Deborah contracted from the Hume Center and have shifted to a clinician, **Ute Baldwin,** also contracted from the Hume Center with dual credentials. Postmaster Associate Marriage & Family therapist (AMFT), and Associate Professional Clinical Counselor (APCC).

Though there is some overlap between regarding focus, such as both assess and treat clients with a range of problems, but the difference become apparent regarding the clinical focus thus resulting in PWC's orientation to have shifted, due to the differences in our clinician's scope of practice. This transition enabled our program to move from an individual-focused therapy to a more interpersonal relationships-based. Interpersonal relationships are examined for the purpose of achieving more adequate, satisfying interactions therapy, thus concentrating on how our behaviors, thoughts and feelings impact our interactions and their outcomes with others. Our mental health program component continues to provide clients with many opportunities to learn and develop their skills in three crucial areas of strategizing and developing appropriate coping skills to manage, tolerate, understand challenging emotions they experience within themselves and encounter in other individuals and situations, along with continuing to build and enhance communication skills to further develop/maintain and strengthen necessary

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interpersonal relationships with their families, peers, and community members. Thus, helping youth discover ways in which they can learn to manage negative emotions such as anger and hurt that they can respond in a reasonable manner rather than being overtaken by their initial gut reaction, and to find a positive and resolution to whatever conflict they may be experiencing. These concepts provide our clients with learning opportunities. They learn how to resolve issues to create the minimum of negative consequences and hopefully the best outcome for them that is possible.

Our program recognizes the need within the population and community that we serve a trend when specifically focusing on clients' relationship with themselves, their peers, family and community in conjunction with how cultural/subcultures influence how we are perceived by others, and how we deal internally with the concept of self. This ultimately can affect the individuals' emotional wellbeing and mental health. To address this need, we have focused on providing a safe space where clients can discuss and present their emotions to gain understanding how to identify what they are feeling, why the maybe feeling this way, and learn the tools and skill sets to regulate and manage their emotions. This has been especially important in helping to create the awareness needed to understand self/identity. Also, this facilitates client exploration into the depths of who they are and what makes them individuals that are worthwhile and unique. In providing this space, our clients are able to explore what makes them similar and different from others without the stigma of us vs. their mentality of seeking only those who are like them. This assisted in fostering stronger connections within the community and support for those who have been struggling to learn to accept themselves, as well as others who are different from themselves. They are able to discuss and explore a complete range of complex feelings along with thoughts that are specific to themselves and to others as they continue through their adolescent stage of development. PWC seeks to encourage, empower and enable our clients to learn about an important component culture and subcultures contribute and how it culture, and how this interconnects with whom they are. Our clients , where they have been, how it impacts them. These levels and layers of culture influence our values, beliefs and shape our norms. Culture influences the manner we learn, live, and behave to a large degree. In essence, it influences/shapes who we are as individuals, families, and as a community. A lack of cultural awareness by others also creates obstacles and in the case barriers and discrimination our clients may face along the way. By providing a space for them to develop a deeper understanding of the origins in which their emotions/ thoughts are shaped and how that influences their self-concept, identity and in turn creates our clients' reality. Our clients are learning: they are capable and competent in their ability able to manage, control and tolerate any challenges or obstacles they may experience over the course of their lives. Therefore, our goal is to create a mental health program that not only fosters clients' knowledge of themselves and others but also encourages ongoing\continued skill set development. This empowers our clients to strive towards their goals, personal growth and continues self-improvement. This builds a stronger individual, which leads to more resilient families and more cohesive communities. Addressing these needs through groups, individual, and family sessions our youth have demonstrated an increased ability to ask questions, seek support, discuss and explore their internal and external conflicts through communicating with the staff and an increase in their level of

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trust in the staff to help support them through their own challenges. There has also been an improvement in the clients' ability to work together and voice their opinions in ways that are appropriate, productive and helpful to themselves, their peers families, and community.

OUTCOMES & MEASURES OF SUCCESS:

A. Please provide quantitative and qualitative data regarding your services. (See Goals - Appendix)

B. Which mental illnesses were potentially early onset?

Mental illnesses that were detected early by this therapist included: Eating Disorders (Bulimia Nervosa, Bing-Eating Disorder, and Anorexia) in both male and female clients. Anxiety, Depression, Bipolar, Addiction, Conduct Disorder, Reactive Attachment Disorder, and in young adults Borderline Personality Disorder, Intermittent Explosive Disorder, and Antisocial Personality Disorder.

C. How participants' early onset of potentially serious mental illness was determined?

Participants' early onset of a serious mental illness was determined utilizing a combination of our referral process and clinician assessment. These are crucial in providing services, assessing needs, and mental health screening. The Triage Referral Model is utilized to assess and later reassess appropriate levels of treatment and support needed by the client. As a reassessment tool the referral form provides the clinician with additional information that can warrant additional mental health services and/or provides evidence that the client's needs are at a higher level therefore requiring a change in the mental health services being provided. It contains a list of symptoms that the individual identifies and includes a portion for the time and severity of those symptoms as reported by the individual.

PWC's use of a triage model allows us to maintain an open streamline to our mental health services. First, our peer counselor, Gerardo, has a close relationship with clients and their families. He is the person who provides all the initial paperwork for those individuals entering the PWC program. He is Spanish speaking and can create a relationship with the incoming clients and their families by building rapport. Gerardo inquiries about the clients' needs and the needs of the family which allows for him to make an internal referral if needed which is required for any potential mental health services. The next person in line is our mental health resource specialist, Miss Pope, she meets all clients and their families who sign up at PWC, sharing and discussing any possible community resources that may be available to the client and their family. This allows for her to build the necessary relationships needed to discover what each individual client needs are and what their family needs may be as well. When she is able to discover what those needs are, she finds the resources and/ or fills out another internal referral to get the client to the next level of our mental health services. This is determining whether to provide in-house individual and/or group prevention services or provide individual and group therapy and whether to incorporate family therapy into the treatment plan according to their needs level. The clinician then meets with the client to further assess based on their clinical needs and the services provided. Our internal referral system has been a vital part of making our triage model flow smoothly and eliminate as many barriers as possible from mental health services.

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Our peer counselor, Gerardo, then collects as much information as possible from the client and family to get the referral filled out and passed along to our mental health resource specialist, Miss Pope. After reviewing the referral, Miss Pope assesses what resources the client and or their family may need and also collects more information necessary for us to determine the level of care necessary. Once she has done so, she passes the referral along to our clinician to further assess the needs of the client so we will provide them the level of care required for their specific needs. Where clients present symptoms that are indicators of possibly early onset of mental illness such as isolation, social withdrawal, sadness for an extended period, continuous anger or anxiety, along with chronic issues that cause distress, those individuals are flagged for a higher level of care. Once initial referral is made, and signs of early onset are determined. our clinician meets with the client and family to further assess, and if possible, provide individual and/or family therapy services. If the clinician deems a more in-depth assessment is required, and or a higher level of care is warranted the client(s)/family are referred to an outside agency to receive the level of care they need. Besides this referral process, the clinician conducts an assessment on each youth within the program and determines each youth and places that individual in a prevention group, or if they would benefit from a more supportive/intensive therapeutic support in-house program. These dual assessments together aid in the determining if an outside referral should be initiated or if PWC's in-house services are appropriate, the client may be placed into the following pathway which may include: a prevention or therapeutic model, or a combination of both models is the most appropriate level of in-house support PWC can provide to our youth and their families.

D. List indicators that measured reduction of prolonged suffering and other negative outcomes and data to support reduction.

Indicators that measured reduction of client's suffering are parental and client weekly self-reports of feeling happier, and resolution/decrease in presenting problem. Another indicator in addition, clinical behavioral observations are noted by this clinician. For example, this therapist will ask the client a qualitative question, such as "How are you doing this week?" The client is then asked to rank their answer on a scale of intensity from (1 being the lowest to 10 the highest intensity). In conjunction to these aforementioned, this therapist asked the client customer satisfaction questions. These are utilized by this clinician as a balance measure, not a driver for outcomes.

E. Include how often data was collected and analyzed as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served

This clinician utilizes a combination of quantitative and qualitative measures to evaluate effectiveness of individual treatment\prevention sessions. This information is collected at each individual client session, generally on a weekly basis. The data collected is in the form of the client's self-reporting of symptoms, progress, and satisfaction with the session. This is then recorded in a rating/scaling format at ea. individual sessions. This information is noted in the client's progress note, which is stored at an off-site facility in compliance with HIPPA standards.

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DEMOGRAPHIC DATA:

PWC has and continues to utilize the County Demographics Form: However., as previously reported specific demographic domain (i.e., Veterans Status) are not collected due to family dynamics and clients that we serve. ***(See Appendix for additional information)***

EVIDENCE-BASED OR PROMISING PRACTICES:

A. What evidenced-based or promising practices are used in your program?

The evidence-based programs selected to meet the goals, objectives, and performance indicators are presented within our clinical success program. These evidence-based models include promising practices and exemplary programs from the Office of Juvenile Justice and Delinquency Preventions (OJJDP). Specifically, the utilization of a program model with effective proven systems that have shown to work for our at-risk and high-risk clients. This model complements our ongoing strategies and fits well into the underlying program foundation. Thus, the goal within the PWC program is much more than just prevention. Its goal is to foster confidence, character, and competence at school, work and in life, and develop unity with positive peers, family and their community. Specifically, PWC's aim is to empower our clients with the education and training needed to help them make a successful-transition from their current educational status and career paths into a well-adjusted and productive adulthood.

The clinical success program is conducted on site and within the community. Over the past few years and community-based program services, PWC evidence-based practices centered on PWC's knowledge of the community and the clients they serve. These practices or build on success of its community-based programs, and the clients come to improve care processes as well as successful client outcomes. Evidence-based practices are also utilized by this therapist in sessions with our clients. Cognitive-Behavioral Therapy and Dialectical Behavior Therapy are the theoretical realms from which therapy treatment and prevention sessions in groups, family, couples, or individual sessions is conducted. When meeting with individuals, families, or in a group setting, all the information that is discussed and explored during those sessions is data that is utilized for measuring the progress of the people involved, it is also utilized to create goals of continuation of progress, treatment planning, development of focused material to address the individual's needs for continuation of services.

B. And how is fidelity to practice ensured?

The evidence-based practices utilized by this therapist also include Cognitive-Behavioral Therapy and Dialectical Behavior Therapy when working in therapy treatment or prevention sessions in groups, family, couples, or individual sessions. Both PWC and this therapist value and utilized consultation that includes performance feedback is conducted weekly with the team. This serves as oversight with

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adherence and competence to the program. A number of different tools as well as strategies were used in our outreach efforts as well to welcome and identify individuals who would benefit from our program.

VALUES:

A. Reflections on your Work:

1. How does your work reflect MHSA values of wellness, recovery, and resilience?

2. Provide access and linkage to mental health care, Improve timely access to services for underserved populations, Use strategies that are non-stigmatizing and non-discriminatory?

Systemic links to the education system and schools re a particular problem for our clients living in low-income, undeserved communities in Pittsburg, and around the Bay Point communities doe to its overall disengaged and uninterested outcomes for youth facing life struggles.

PWC Clinical Success Program serves as an educational liaison to the school system to help our clients stay engaged and connected to continuation schools. As such, access to community resources is critical for every school. Schools are a primary place for prevention and intervention to occur. Clients who may need additional services are more likely to receive it if teacher and school administrators are aware of the warning signs and have the capacity to link clients to appropriate resources. With the impressive array of excellent innovation programing in the district, there are obvious disconnections in the services continuum relative to the accessible intensive services for the highest at-risk population, I.e., gang involved, drug/alcohol users, and sexual exploited clients. Through partnership, we help to accelerate schools' work to focus on implementing intensive prevention and intervention to serve our high-risk clients. With a practical, affordable model out program encourages our client to become an active contributing member of society. The goals are: (1) individual and family prevention therapy. PWC provides a minimum of four groups per week, one group on both Monday and Tuesdays, along with two groups on Wednesdays, with the addition of providing individual therapy, family therapy and case consultation. 2) Staff peer groups and Peer consultation, a staff support process, facilitated by the Hume Center provides clinical tool and support for working without clients. The peer consultation process emphasizes trust and curious exploration as its primary mechanism f approaching problematic behaviors and maladaptive patterns. Because of the explorative nature that this process engenders, staff and service providers are challenged to abandon preconceived conclusions and assumptions about the client in an effort to understand the root of their suffering from the client's perspective. Doing so allows staff and service providers to approach the clients from non-stigmatizing, non-discriminatory perspective that affects both clinical and managerial functioning on a program level.

PWC's program provides access and linkage to mental health care and improves timely access to services for the undeserved population we served by using strategies that are non-stigmatizing and non-discriminatory. First, based on the clients PWC serves, presentations regarding PWC's goal of empowering at risk youth, resiliency, recovery, and mental wellbeing are addressed to the Martinez, Pittsburgh, Ridgedale, and Brentwood, which are classified as Golden Gate Community School.

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PWC also speaks at Hispanic clubs such as such as Puente and the Latino Unidos, which are clubs located at Pittsburg High School. We continue to reach out to other agencies that can serve our clients' medical and higher level levels of mental health services when needed. La Clinica is one of those agencies we refer frequently. PWC continues to provide community service opportunities at Multi-Cultural, Civic and Community events such as the Cesar Chavez events, community festivals, and local events like the Crab feeds at local Religious centers in Pittsburg, where the population largely Spanish-speaking Youth and their families. This information is shared in Spanish and by our Bi-lingual staff members to ensure the information is shared a language that the population we serve can easily understand. To further de-stigmatize and breakaway barriers to healthcare, PWC offers home visits as a way to provide a space for the client and their family to share in the comfort of their own home. These home visits provide the services in for clients and their families so they can feel emotionally supported and understood in a manner that the stigma is removed/diminished, and they can accept mental health services.

Timely access to mental health services is very important in the treatment and prognosis for the client. PWC's use of a triage model allows us to maintain an open streamline to our mental health services assessment, ensures the most appropriate level of care, whether that is providing in-house services for prevention or therapy groups/individual/family sessions, or providing referrals to outside mental health services in the community. This process also enables PWC to continue breaking down stigmas and barriers of mental health. How we accomplish this is first with our peer counselor, Gerardo. He has a close relationship with clients and their families, as he is the person who provides all the initial paperwork for those individuals entering the PWC program. Gerardo is Spanish speaking and can create a relationship with the incoming clients and their families by building rapport, inquiring about the clients' needs and those of the family as well. This allows for him to make an internal referral if needed, which is required for any potential mental health services. The next person in line is our mental health resource specialist, Miss Pope, she meets all clients and their families who sign up at PWC. Miss Pope shares and discusses possible community resources that may be available to the client and their family. This allows for her to build the necessary relationships needed to discover what each individual client needs are, and what their family needs may be as well. When Miss Pope is able to discover what those needs are, she finds the resources and/ or fills out another internal referral to get the client to the next level of our mental health services. This is determining whether to provide in-house individual and/or group prevention services or provide individual and group therapy and whether to incorporate family therapy into the treatment plan according to their needs level. The clinician then meets with the client to further assess based on their clinical needs and the services provided. Our internal referral system has been a vital part of making our triage model flow smoothly and eliminate as many barriers as possible from mental health services.

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REFLECTION ON YOUR WORK:

A. Valuable Perspectives:

1. Please include the stories and diverse perspectives of program participants, including those of family members. Attach case vignettes and any material that documents your work as you see fit.

On three occasions this year, this process was paramount in aiding the PWC team in determining the level of care appropriate for our clients and their families. For some individuals that face issues of anxiety, depression and/or symptoms of isolation and continued conflict with family were observed and addressed through our assessments of clients through our referral system. When individuals exhibit these types of symptoms, our staff reach out to the individual to seek understanding, provide support, and we can make a referral.

The three instances in which this triage approach was paramount in determining the care level. The first occasion concerned a client who has a dual diagnosis: substance abuse, Bipolar II disorder with psychotic features, this individual was non-medication compliant, had an extensive Hx. of hospitalizations for suicidality, and substance abuse. This adolescent needed more supportive and intensive psychiatric services than PWC could provide, and as a team we made the determination that a referral to county mental health services was the correct pathway to follow. PWC made the following recommendation to the client and her family: she should remain with her primary psychiatric care providers for treatment and seek additional mental health services in the form of therapy with a licensed therapist through county. PWC also encouraged the client to continue partaking in youth activities at PWC. As a team, we felt this has enabled her to be in a structured and safe social environment that promotes and teaches healthy coping mechanisms.

The second occasion where the PWC triage and support services were instrumental in a successful outcome involved a young adult. Through his teen years, he was a client of PWC and when he became an adult, he had left our organization. This client had been affiliated with gang members and then later became estranged from his family. This client later was involved in criminal activity and had been on the run from an outstanding no bail arrest warrant for the last two years. He came in to PWC to speak with Miss Pope. The client and Miss Pope had a good established rapport. He could trust her and shared with Miss Pope what had transpired, along with his dilemma. Miss Pope referred the client to this therapist. Because of the previous rapport and trust this client had established with Miss Pope in conjunction with the privilege of therapist and client confidentiality this client could share his whole story. He could openly discuss his concerns, fears, and hope. After this initial meeting with the client, the PWC triage team (Miss Pope, Peer Counselor—Gerardo, and this therapist, we discussed how we could best support this client in making a decision that would have a profound effect on his life.

Later that week, this therapist and Gerardo meet with the client and openly discuss his options. We addressed the client's fears and worst-case Scenario We, as a team feared because the warrant for this client's arrest was for a past crime that involved a firearm. There is always a chance that something might go horrible wrong depending on the unknown variables of any scenario that might

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ensue. What if he were with any friends or relatives and was stopped by law enforcement for some unrelated reason, they learn that he has a warrant for his arrest, and if one of his friends ran, or resist detainment? We discussed some potential negative outcomes. This therapist, Miss Pope and Gerardo also explored with him the "what if" he processed coped with his fears of incarceration and could turn his life around. "What if you could educate yourself with a trade, earn a decent living wage, and make a difference by being a role model to other young people?
The client decided to surrender to law enforcement. Before he turned himself in, Miss Pope linked this client with Rubicon Programs. This organization provides people with knowledge, resources, and support to break the cycle of poverty. They commit to each program participants for up to three years to help them build a foundation for future success. Gerardo provided moral support and accompanied the client to the Office of the Sheriff Contra Costa County. PWC supported this client through the entire decision-making process, so he could make the decision that in the long-run benefited himself, his family, and the community.

The third case involved a fourteen-year-old Hispanic male. His mother came in asking for help with severe behavioral problems being exhibited by the client (her son). The mother shared with Miss Pope that the client was expelled from school because he brought a knife to school and stabbed a student. The client's mother described events where the client was displaying patterns of episodic excessive anger in response to specific or situational themes. The client's mother is a single parent and does not receive support or has had contact with the client's father since his birth. Mom works long hours and is not receiving any government assistance. She and the client are sharing a residence with multiple family members (uncles, aunts and cousins) who are known to this therapist as gang members.
The relationship between the client and his mother has recently been strained, and she at the initial assessment session with this therapist the following: drastic behavioral changes in her son since the stabbing incident and school expulsion, He also has a repeated history of engaging in passive-aggressive behaviors (e.g., forgetting, pretending not to listen, procrastinating) to frustrate or annoy others, and his academic achievement declined.

Upon this therapist's assessment the client showed the following: cognitive biases associated with anger (e.g. demanding expectations of others, overly generalized labeling of the targets of anger, in response to perceived "slights"). The client described experiencing direct or indirect evidence of physiological arousal related to anger, while displaying body language that suggests anger, including tense muscles, glaring looks, clenched jaw, or refusal to make eye contact. The client demonstrated an angry overreaction to perceived disapproval and criticism. He rationalizes and blames others for his aggressive and abusive behaviors. The client excessively swears when efforts to meet desires are frustrated and when limits are placed on his behavior. He is involved in frequent physical fights with peers. The client consistently fails to accept responsibility for anger control problems by a repeated pattern of blaming other for anger control problems. He also has a repeated history of engaging in passive-aggressive behaviors (e.g., forgetting, pretending not to listen, procrastinating) to frustrate or annoy others and is

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rather proud of this accomplishment. It was determined this client would benefit most by: (1) Providing individual therapy (2) also placing the client in a skill set group where the focus is on building distress tolerance levels and coping mechanisms. (3) Providing support to the client's mother by de-stigmatizing and by normalizing the difficulties with acculturation that many families experience, this removed the stigma that there is something mentally wrong with the child/family, and (3) Providing support in the form of psychoeducation with parenting skills, combined with family therapy. This therapist and Miss Pope have frequently coordinated and collaborated with the client's school therapist to ensure that skill sets, and therapy efforts are not in theoretical conflict therapeutically, and that we are supporting the client and his family. This adolescent can now identify and understand the emotional mechanisms driving their behaviors and impulsivity and can now regulate/control his responses. After approximately 6 months of sessions, Mom is now able to establish and maintain consistent boundaries with the client. She also has learned positive parenting skills that have empowered her in her role as a parent and improved her relationship dramatically with her son. This client has reduced, and some instances the negative behaviors/responses are now extinct. The client is attending classes regularly and made the dean's list at his school. The client mostly completes his chores and is following mom's direction. He is now on a PRN therapy schedule and frequently stops in to talk when something is troubling him or when he wants to share about his accomplishments. The client apparently feels safe and secure at PWC. He interacts with his peers while at PWC. This client has done so well that he is allowed to attend Pittsburg High School this fall semester.

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Appendix

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The PWC Clinical Success After-School Program strives to provide positive outcomes for children and youth by increasing protective factors such as providing structural opportunities and caring relationships with mentors to support education and economic success of at-risk youth, and thereby promote lasting healthy development.

The underlying purpose of the evaluation check/study is to help discern if program elements and activities are resulting in important and meaningful outcomes for targeted youth. The main focus of this study is to track the progress of the objectives that were set for the program at the beginning of the year in accordance with funder expectations as aligned with actual program activities.

Participant surveys

1. A participant pre-/post-test was developed previously in a collaborative effort between PWC program staff and the external evaluators (Hatchuel Tabernik & Associates, & Michael Kee & Associates Architect). This test is designed to measure Entrepreneurial and Environmental knowledge prior to and following exposure to the 8-week Solar and Environmental Training course.

2. A participant pre-/post - survey for this year was replicated as previously approved by Mental Health Administration staff from Contra Costa Health Services. This survey was designed to measure the following: resiliency; community support; recidivism; and program satisfaction.

The pre-survey is designed to be taken at program intake, and the post-survey is to be taken at the end of the 12-week program. As shown in Table 1, the participants were divided into cohorts based on when they started the PWC After-School Program.

It is important to note that many students chose to re-enroll in multiple courses upon completion. To that end, we recorded these students' tests and noted the methodology used for the analysis.

Table 1. Participant Survey Administration (July 1st, 2018 – June 30th, 2019)

Quarters	Participants N	Cohort	Period	Pre-Surveys	Post Surveys
Quarter 0	67	0	July - September	39	29
Quarter 1	47	1	October - December	39	29
Quarter 2	23	2	January - March	35	20
Quarter 3	70	3	April - June	24	19

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School Day Attendance Data from Pittsburg Unified School District (PUSD)

This data is acquired through connections made at PUSD and staff from the schools that our participants attend. Permission was secured from parents/guardians, and every effort was made to collect student records for as many participants as possible. Due to the high-risk nature of our student population, longitudinal attendance records were at times a challenge to collect. For example, a number of students referred to the program were not enrolled in public school due to mental health issues in families that PWC serves, as school attendance is not a top priority within the dysfunctional family unit. This makes it difficult to obtain adequate information in a timely manner for participants for the duration of their involvement in the PWC program (usually lasting 12 weeks).

Through networking efforts with PWC, and the PUSD Director of Student Services, Pittsburg Unified School District (PUSD) staff did provide attendance records for a majority of the Cohort participants attending public schools. Some of the students served by the PWC program are high-risk youth who did not regularly attend school, transferred through multiple schools and districts, participated in alternative school/independent study programs, had issues related to truancy and/or are on record as having dropped out of school. Despite these challenges, school day attendance data was available for **87** participants of which a total of **67** students was referred to the program through the Student Attendance Review Board (SARB) due to attendance and behavior issues.

Probation Data from the Contra Costa County Juvenile Services Department

Data on recidivism is acquired from the Contra Costa County Juvenile Services Division's Director of Field Services. The Director was provided with a list of program participants, and asked to designate which students, if any, had re-offended during the time period for which they were in the PWC program. Due to the sensitive nature of the information, the Director provided aggregated information only; student names were not identified. The Probation Department provided PWC with reporting information for **13** students (6 Cohort 0, 4 Cohort 1, 1 Cohort 2, and 2 Cohort 3).

EVALUATION FINDINGS:

In this year of implementation, PWC continues to make notable progress in assisting at-risk youth to strive for a higher quality of life by providing them with a safe and supportive environment through which they can get vocational training, mentoring, counseling, and peer group support. Clients are encouraged to stay in school, develop goals for their future and lead a purposeful healthy life. The aim of the Solar and Environmental Training Class was to provide youth with environmental education, "green job" training, and opportunities to develop leadership and entrepreneurial skills related to a new "green" economy. Through our dedicated staff, and technology-advances, our success is well documented. The

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following pages summarizes the progress of the program this year as related to its tangible goals and targets.

Outreach and Participation

The target number of unduplicated participants that PWC was prepared to serve in this reporting year was ***200.*** The actual number of unduplicated participants was ***207.*** (See Table 2.)

Table 2. Program Participation by Quarter (July 1st, 2018 – June 30th, 2019)

	July-Sept	Oct-Dec	Jan-March	Apr-June	Total Served
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
# Students (Duplicated) Served Each Quarter	118	160	120	127	525
# New Students Served Each Quarter	67	47	23	70	207

Through careful planning and networking efforts the recruitment process was again an integral part of PWC implementation this year. In August 2018 within the start of the 2018-2019 school year, PWC employed an aggressive recruitment plan that involved the PUSD Director of Student Services, and Probation procedures for referrals to the PWC program during the upcoming school year. PWC also made site visits and presentations to the staff and administrators at Black Diamond and Golden Gate Community Day continuation schools, which resulted in schedules for PWC's staff to meet with the student body to introduce the PWC program, and answer questions. During the months leading up to the start of the program in ***October,*** teachers were supportive in encouraging students to participate in the after-school program.

Once school began, PWC employed their biggest recruitment strategies, the end of the first quarter saw a dramatic upswing of new participants. The first cohort (Cohort 1) began during the first quarter in ***October 2018. A total of 67 students were*** registered for the program, an indicator that recruitment efforts were a success.

Interestingly, the PWC program served the newest students in the first, second, and fourth quarters. This is attributed to the positive pro-social growth of the students wanting to remain in the program, and encouraging peers to be a part of something positive. The third quarter had the lowest number of new participants, as school was back in session, and students transitioning into winter break. A frequent occurrence that was experienced this year was that students had a tendency to remain involved with the program across multiple quarters. Therefore, participants served ***(32%)*** were engaged in program activities for at least two quarters.

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The evaluation for our program consisted with the goal and objective identified are directly linked to the activities and proposed process and outcome measure. Overall, the purpose of this evaluation is to examine specific program activities and service, identify what's working well or not, and enhance our ability to better meet the identified needs and gaps. Working with program manager, the office manager primarily manages the systematic data collection (e.g. pre-and-post clients' surveys, program application, school attendance, and probation data), analyze information, and provide data for the biannual progress reports, ensuring that all the objectives are reached. Additionally, the office manager works closely with the program manager to provide up-to-date data requested by the PEI management team. Our evaluation assesses both clients and environmental level changes (e.g. school-level, systems).

PWC clients consist primarily of Spanish speaking youth and families, who are isolated and social economically segregated from the dominate culture. PWC employee culturally proficient leaders, who must display personal values and behaviors that enable them to engage in effective interactions among students, educators, and the community we serve. Both the peer counselor and the office manager are Spanish speaking Hispanics employed by PWC. Documents combined with PWC's program packet have been translated and revised into Spanish for the support of PWC clients' families. Our data collecting methods help in regard to maintaining clients' confidentiality. Client's confidential personal data are assured by following strict guidelines for collecting and managing client's information. Clinical data are being filed away at the Hume Center while clients' program information is locked in the PWC office in double-locked file cabinets away from reach of our clients.

Participant Demographics:

This year the majority of program participant (n= 207) fell within the 13-17 age range (169), 18-21 age range (29), and 6-12 age range (9). The distribution of gender was 133 male and 74 female. Sexual orientation distribution of program participants was 0 bisexual, 194 heterosexual, 0 lesbian, and 9 declined to state.

The majority of youth participants (76%) were high school aged (9^{th} to 12^{th} grade). The most participants from any one grade level were in the 12^{th} grade.

Of the **207** participants, almost all resided in the city of Pittsburg. One hundred eighty nine (189) participants resided in Pittsburg, three (3) resided in Bay Point, one (1) in Brentwood, one (1) in Oakley, and twelve (12) resided in Antioch. The predominant language of program participants was English (48%). The remaining 52% of participants identified as being primarily English/Spanish speaking.

As there is a large proportion of Spanish speakers in the PWC program, it comes of no surprise, that an examination of the ethnic distribution of PWC participants shows that the majority of all program participants were Hispanic/Latino (73%). The second most represented ethnic group was African American (16%). These two ethnic groups account for 89% of program participants.

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In summary, in this program year:

1. **The majority of the** participants in the program were between the ages of 13 and 17 (**82%)**.
2. **Most** of the participants came from the traditional school system - high schools **(51%).** The second most represented participants (29%) came from alternative school placement.
3. **The majority** of the participants were Latino **(73%).** The next most predominant ethnic groups were African American **(16%)** and **(5%)** White. Asian and "Other" ethnicities represented a smaller part of the participant population **(6% combined)**. This ethnic distribution is similar to that which is found among the students served by the Pittsburg Unified School District as a whole.
4. The above demographic data indicates that the PWC Program is serving the high-risk youth population that it has always intended to serve.

Goal 1: Enhance the Quality of and Access to Resources

Objective 1.1: **65%** of the total number of green jobs program participants will increase their knowledge and skills related to entrepreneurship, alternative energy resources and technologies, and "green economy" according to program curricula for the duration of their program participation.

Result: Of the 8 students hired in Cohort 1 as Green Technicians for the Environmental Studies/ Entrepreneurial course who completed pre and post Knowledge Surveys, 5 participants (95%) demonstrated an increase in knowledge between pre and post survey administrations.

In Cohort 3, for the start of the new Green Technicians for the Environmental Studies/Entrepreneurial, 9 students who were hired and completed pre and post Knowledge Surveys, 7 participants (90%) demonstrated an increase in knowledge between pre and post survey administrations.

An average score between Cohort 1 (95%) and Cohort 3 (90%) resulted in a score of **92.5%.** Indicating that the participants demonstrated an increase in knowledge between pre and post survey administrations. This far exceeds the target objective that **65%** of participants would demonstrate an increase in knowledge.

Between July 2018 and June 2019, PWC enrolled a total of 207 youth participants in their after school program. The Green Jobs Training Program was offered twice this year between July 2018 and June of 2019. Although a number of clients repeated the class multiple times, it is important to note that the class reached a total of 21 (7 duplicated) and (14 unduplicated) clients that applied for the program with a total of 17 participants who completed the class. Students who are struggling with self-esteem in their academic careers, completing this program is evident of pride in their accomplishment.

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Students completed a pre-test and a post-test at the beginning and end of each cohort. For students who were in multiple Cohorts, we used the first cohort pre-test(s) and the final cohort post-test(s). The scores of all other students were taken from the beginning and end of their respective cohorts.

Tests consisted of a total of 17 questions (7 true/false and 10 multiple choice) related to the environment and the future of green job industries. Each answer received a score of 1 if it was answered correctly or 0 if it was answered incorrectly. Totals of all 17 questions were tallied on the pre and post-test of each student and analyzed for any increase or decrease in their scores between the two test administrations. Results are shown in Table 5. Of the students who completed pre and post-tests, all demonstrated improvement **(90%).**

Additionally, when asked to rate their level of knowledge about "green industries" using a 5 point scale (1 being "very low" and 5 being "very high"), the average rating of respondents who answered this question (n= 9) was 3 on the pre-test, and 3.6 on the post-test after the 12-week course. Results by cohort and as a whole are presented in Table 5.

Table 5. Participant Demonstration of Improved Knowledge and Skills

	N	Pre-Mean Score	Post-Mean Score	Change in Mean Test Score
Total # items correct on Knowledge test (Max= 17)	17	30.0	32.3	2.3
Average rating of knowledge about green industries (Max= 5)	17	5.8	7.1	1.3

Goal 2: Develop a safer environment for at-risk youth who are chronically truant or on probation.

Objective 2.1: **65%** of the 200 youth program participants will show improved youth resiliency factors (i.e., self-esteem, relationship, and engagement.)

Result: Of the **207** students enrolled in the after school program who answered all of the resiliency questions on pre-and-post Student Surveys, **77%** demonstrated improved resiliency. This exceeds the target objective that **65%** of participants would demonstrate improved resiliency.

A total of 92 students completed both a pre-and-post Student Surveys. For students who were in multiple Cohorts, we used their first cohort pre-surveys, and the final cohort post-surveys. The results of all other students were analyzed from surveys taken at the beginning and end of their respective cohorts. A total of

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7 questions on the survey directly addressed Youth Resiliency factors. Students were asked about satisfaction with life, stress, levels, future lives. The most positive answers were scored the highest, and the most negative were scored the lowest, utilizing a 1 to 6 point scale per item (depending on the number of answer options) A maximum score of 32 was attainable. Of the **207** student respondents, 92 answered all of the resiliency questions (enabling us to tally a score for them in this area). Overall **82%** demonstrated improved (n= 92), and **18%** showed a decrease in resiliency on the post survey (n= 92).

It is important to note of the 92 students that answered the resiliency questions, 33 participated in multiple Cohorts, of which answers were unchanged from their first cohort surveys and the final cohort post-surveys. The results of each unchanged answer analyzed utilizing the 1 to 6 point scale per item, positive and negative answers were combined in the categories of increased and decreased outcomes.

Responses of "Extremely and Moderately Satisfied" or "Very Little Stress and Some Stress" or "The future looks very bright and The future looks somewhat bright" were considered to be positive.

Objective 2.2: **75%** of the 200 youth program participants will not re-offend for the duration of their program participation.

Result: Of the **13** probation students enrolled in the after school program, **(100%)** did not re-offend during their participation in the PWC After-School Program.

As described in the Methods, the Contra Costa County Juvenile Services Division Director of Field Services was asked to report the number of students on the lists who committed an offense and the number of students who "re-offended" or went to juvenile hall. Of the 13 student names submitted there was 0 new offense, and no new admission to Juvenile Hall. Overall ***(100%)*** of the program participates did not "re-offend."

Objective 2.3: **70%** of 200 youth participants will report that they have a caring relationship with an adult in the community or at school during their program participation.

Result: Of the 207 students enrolled in the after school program who answered all of the survey questions about caring adults on their 12-week post Student Surveys, **(77%)** indicated that they had caring relationships with adults in their lives. This meets the target objective that **70%** of participants would have a caring relationship with an adult in the community or at school during their program participation.

Among the 7 youth resiliency questions were items specifically related to the role of caring adults in the lives of these youth. Four of the questions in particular were related to caring relationships with adults. Students were presented with the following 4-point scale to answer each question (1=Not at all true, 2=A little true, 3=Pretty much true, 4=Very much true).

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To see if students reported that there was a caring adult in their lives, we examined their responses to these 4 questions on their 12-week post Student Surveys. The 12-week post surveys would best capture their feelings after having been served by the PWC program. Responses of "Pretty much true" or "Very much true" were considered to be positive. Results are presented in Table 6.

Table 6. Demonstration of Participant Relationships with Caring Adults

	% of positive responses
	Overall (n=92)
tells me when I do a good job	75%
I trust and could talk to	65%
believes that I will be a success	95%
notices when I am upset about something	74%
Average of all 4 questions	77%

A total of 92 students responded to all 4 questions on the 12-week post survey. Overall, the majority of students did self-report that they had caring relationships with adults in their lives. It is interesting to note that students who participated in more than one cohort had the most positive responses on their surveys. This data could indicate that students who have the most exposure to the program seem to feel more of a connection to the adults in the program.

In addition to the above questions about adult relationships, on the 12-week post survey students were also asked what they liked about PWC.

Students frequently cited the community events and activities, but many respondents also noted the open, familial environment. Some examples are listed below:

"I like how we help people and work hard."

"I like being able to meet new people and experience things that will further my career."

"More jobs."

"The thing that I like best is that I can talk and trust PWC people."

"The way they help me and our community."

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Goal 3: Create a culture of career success among at-risk youth.

Objective 3.1: There will be a **60%** increase in school day attendance among 200 youth participants for the duration of their program participation.

Results: Of the students enrolled in the after school program with attendance data available for their respective cohort periods, **87%** improved or maintained perfect attendance. This exceeds the target objective that there would be a **60%** increase in student's attendance.

Attendance data was collected for the entire 12-week period that each cohort was in session. Student level data was compared between the first week of participation and the last week of participation in each cohort. Attendance was considered to be "perfect" if there was no indication of absence, truancy, tardiness, etc. In order to be considered "perfect" a student had to attend every full period of class for the entire week.

Of the 207 students served attendance data was available for 87 students (not including those who participated in the program for less than 10 days, outreach students, and those attending adult education and/or graduated), 67 were referred through the Pittsburg Student Attendance Review Board (SARB) for attendance and behavior issues. Of the 67 students with attendance data available for their respective cohort periods, **87%** improved or maintained perfect attendance between the beginning and ending weeks of their cohorts.

Objective 3.2: There will be a **60%** decrease in the number of school tardiness among the 200 youth participants for their program participation.

Results: Of the students enrolled in the after school program with attendance data available for their respective cohort periods, **81%** decreased or maintained a rate of 0 tardiness. This exceeds the target objective that **60%** of participants would decrease tardiness.

Of the 207 students served attendance data was available for 87 students (not including those who participated in the program for less than 10 days, outreach students, and those attending adult education and/or graduated), 67 were referred through the Pittsburg Student Attendance Review Board (SARB) for attendance and behavior issues. Of the 67 students with attendance data available for their respective cohort periods, **81%** decreased tardiness between the beginning and ending weeks of their cohorts.

Summary of Findings

Of the six program objectives, all six were fully achieved (increased knowledge, improved resiliency factors, low rates of re-offense, increased school day attendance and decrease tardiness, caring relationships with adults). (See Table 9 and Figure 3)

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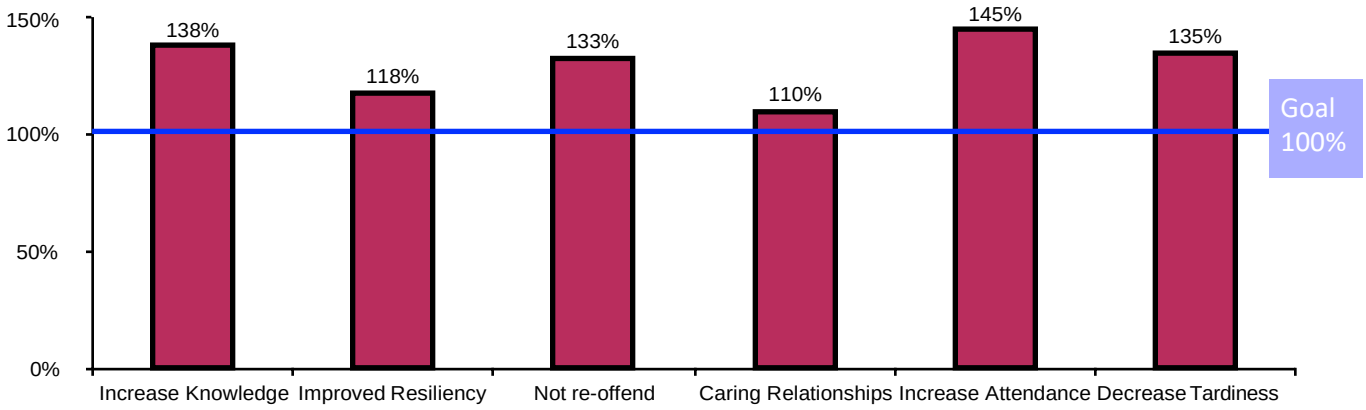
Table 9. Actual Outcomes as Compared to Target: Fiscal Year 2018-2019

Outcome Measure	Target	Actual	Percent
65% *of the total number of* **green jobs program** *participants* will increase their knowledge and skills related to entrepreneurship, alternative energy resources and technologies, and "green economy" according to program curricula for the duration of their program participation.	65%	90%	138%
65% of the youth program participants will show improved youth resiliency factors (i.e., self-esteem, relationship, and engagement.)	65%	77%	118%
75% of the youth program participants will not re-offend for the duration of their program participation.	75%	100%	133%
70% of youth participants will report that they have a caring relationship with an adult in the community or at school during their program participation.	70%	77%	110%
There will be a **60%** increase in school day attendance among youth participants for the duration of their program participation.	60%	87%	145%
There will be a **60%** decrease in the number of school tardiness among the youth participants for their program participation.	60%	81%	135%

Figure 3. Measures of Success Progress Toward Target – Fourth Quarter Report: (July 1st, 2018 – June 30th, 2019)



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Overall, PWC has fully met their targets in regard to the resiliency items in the surveys. One of the biggest tributes to the program is that there are youth who continue to choose PWC to complete their community services hours, despite the ability to complete their hours with other programs, churches or in another city. Another positive is due to PWCs' success, the program has been asked to participate in more new activities in Pittsburg, including volunteering with the Pittsburg Police Department in a human trafficking presentation.

This year PWC After-School Green Jobs Youth Training Program has been a huge success. At this time, we believe we have created a formula for success alongside with learning that will serve our community and our cohorts well, and increase understanding of climate change, renewable energy and conservation. More importantly, we believe we have created a program that helps youth learn real life skills such as cooperation, patience, and caring. Our students realize the program's success is based on their performance on the projects that we set before them. They have responded extremely well and care about the most important goal of all – to believe, achieve, and succeed.

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PREVENTION
END-OF-YEAR REPORTING

FISCAL YEAR: 2018-2019

Reporting Period: Please Select One
☐ Semi-Annual Report #1 (July – Dec)
☐ Semi-Annual Report #2 (Jan – June)

Agency/Program: **The Contra Costa Clubhouses, Inc. DBA Putnam Clubhouse**

PEI STRATEGIES:

Please check all strategies that your program employs:

X Provide access and linkage to mental health care

X Improve timely access to mental health services for underserved populations

X Use strategies that are non-stigmatizing and non-discriminatory

SERVICES PROVIDED / ACTIVITIES:

Please describe the services you provided in the past reporting period. Please include types of problems/needs addressed, any activities that address these problems/needs, and any functional outcomes targeted by the services provided.

For Project A, during the contract year of this report (2018/2019), 322 unduplicated members (target: 300) spent 54,386 hours engaged in Clubhouse programming activities (target: 40,000 hours). 86 newly enrolled Clubhouse members (target: 70) participated in at least one Clubhouse activity; 28 of these new members were young adults aged 18 to 25 years (target: 12 young adults). In addition, at least 46 activities (target: 40) were held specifically for the young adult age group.

Table 1: Clubhouse Membership Activity

	Target Goal	Actual	% of Target
Number of unduplicated members served	300	322	107
Number of Hours spent in Clubhouse programming	40,000	54,386	136
Number of new members participating in at least one Clubhouse activity	70	86	123
Number of young adults (age 18-25 yrs.) participating in at least one Clubhouse Activity	12	28	233
Number of activities specifically for young adults (age 18-25 yrs.)	40	46	115

Other services:

Members helped prepare and eat 9,935 meals at the Clubhouse (target: 9,000). Although a target had not been set for rides, 1,229 rides were provided to members to and from Clubhouse activities, job interviews, medical appointments, and more. During the contract year 103 in-home outreach visits (no target set) were provided by members and staff to members and potential members and numerous outreach calls were made to members on a daily basis

Additionally, under Project B, 165 postings (target 124) were made on the Career Corner Blog and four career workshops were held (target 4). The workshops included "Holiday Blues" on December 14, 2018 (21 attendees), "Cultural Responsiveness" on April 18, 2019 (34 attendees), a "Boundaries Workshop" on May 23, 2019 (53 attendees), and a "Resource Fair" on June 3, 2019 (130 attendees).

Table 2: Other services provided to Clubhouse Members

	Target Goal	Actual	% Target
Number of Meals prepared and eaten at Clubhouse	9,000	9,935	110
Number of Rides to and from Clubhouse Activities	No target set	1,229	N/A
In-home outreach visits	No target set	103	N/A
Number of Blog Postings	124	165	133
Number of Career Workshops	4	4	100

For Project C, the SPIRIT graduation was successfully coordinated by the Clubhouse and attended by 321 people on 7/30/18. The holiday party on 12/20/18 had 377 people in attendance with the collaboration of multiple agencies along with the OCE. The annual Community Picnic was held on 6/7/19 with 315 in attendance. By all accounts, the three events were highly successful.

The final portion of Project C requires the Clubhouse to recruit, coordinate, and supervise volunteer consumers to assist the County with the Adult Consumer Perception Surveys (MHSIP) administration at Contra Costa County mental health clinics twice a year. The first of the two annual MHSIP weeks took place November 12-16, 2018 and the second took place May 13-17, 2019 with the Clubhouse completing all contractual duties.

Under Project D, the Clubhouse assisted County Mental Health in implementing the Portland Identification and Early Referral (PIER) program for individuals at risk of psychosis, First Hope, by providing logistical and operational support as per contract.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services.

List of indicators that measured reduction of risk factors and/or increase in protective factors that may lead to improved mental, emotional and relational functioning. Please include how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.

Project A data is collected upon initial membership in the Clubhouse and then daily through a combination of self-completed forms, surveys and sign-on logs, and phone calls. None of the program outcome data is confidential and it recorded in the program database. Any confidential information provided on intake forms is securely kept in the locked office of the Director of Putnam Clubhouse. Data from annual self-reported member surveys, including the hospitalization survey is collected on Survey Monkey instruments and analyzed by Hatchuel Tabernik and Associates, an external evaluation firm.

In June 2019, members and their family members (called caregivers in this report) were encouraged to complete the annual Clubhouse survey via Survey Monkey, an online survey site. The number of members and caregivers completing the survey was 125 (the target was 120), of whom 31 were caregivers and 94 members. Among members in the survey, 2% were aged 18-21, 6% were 22-25, 18.6% were 26-35, 18.6% were 36-45, 36% were 46-59, and 18.6% were 60 years or older. The age distribution is representative of the age range of Clubhouse members overall.

Because not all respondents answered each item, all survey data reported below reflects the responses of those completing each individual survey item. The survey percentages referenced in this report consist of those who 'Agree' or 'Strongly Agree' with the given statement. Those who responded 'Don't know' or 'No opinion' were not included in the analysis.

Caregiver Respite

The data in this report represents only those caregivers completing the survey who reside in Contra Costa County (N=28). Of the 28 Contra Costa County caregivers who responded to the survey, 75.0% were parents or guardians of a Clubhouse member, 10.7% were siblings, 10.7% were the child of the Clubhouse member, and 3.6% were grandparents.

As in previous years, caregivers who participated in this year's survey reported the highest level of satisfaction with Clubhouse activities and programs that their family member attended (100% satisfied), as well as with the Clubhouse activities/programs that they themselves participated in (97% satisfied). In both areas the target of 75% was exceeded. A large proportion of caregivers (86%) also reported that Clubhouse activities and programs provided them with respite care. Such respite is intended to reduce their stress and also lead to more independence for the Clubhouse members, reflected in the data with 80% of the members agreeing or strongly agreeing that in the last year, their independence had increased. An even higher proportion of the caregivers (89%) also perceived that their family member had become more independent in the last year (target 75%).

Table 3: Caregiver Respite

		GOAL	ACTUAL
Measures of Success	N	%	%
% caregivers reporting Clubhouse activities provided them with respite care	24	75	96
% caregivers reporting high level of satisfaction with Clubhouse activities and programs in which their family member participated	26	75	100
% caregivers reporting high level of satisfaction with Clubhouse activities and programs in which they participated	27	75	96
% caregivers reporting an increase in member's independence	25	75	84
% members reporting an increase in independence	93	75	77

Below are some responses from the caregiver survey to the question of what was liked best about the Clubhouse:

"A place that is safe and welcoming for my loved one and keeps him in a committed active member level that he really enjoys." (caregiver)

"It gives [my family member] the option of being included in social activities, making friends, and participating in special and sporting events." (caregiver)

"My son has grown emotionally, socially and mentally as a result of all of the clubhouse activities. He has now moved from transitional employment to part time independent employment." (caregiver)

"Supportive staff, knowledge about reaching mentally ill adults in a positive way. Important service to the underserved mentally ill adults in our community." (caregiver)

"The fact that it is there gives families an option family member participation in programs." (caregiver)

"The fact that the Clubhouse is here. I wish my loved one was stable enough to attend regularly." (caregiver)

"The friendly open and accepting atmosphere. The vast number of choices for participation." (caregiver)

Member and Caregiver Well-Being

Several survey items addressed improvements to the well-being of the caregivers and the members in terms of emotional, physical, and mental health. When combining responses to self-perceived improvement of their own mental, physical and emotional well-being, 96% of caregivers agreed or strongly agreed their health (emotional, physical, mental well-being) had improved. When asked the same questions about the well-being of their family member, 89% also agreed or strongly agreed that their family members overall health had improved.

The member ratings for their own improvements in these categories averaged 90%, greater than the goal of 75%. The combined family members rated improvement and the member's self-ratings for improvement in these areas in these areas averaged 92%. Additionally, 85% of the members reported that they had more interactions with peers during the year (75% target).

Table 4: Member and Caregiver Well-Being

		GOAL	ACTUAL
Measures of Success	N	%	%
% caregivers reporting increase in their own health (mental, physical, emotional well-being)	25	75	96
% members reporting increase in their own health (mental, physical, emotional well-being)	93	75	90
% members & caregivers combined reporting increase in their health (mental, physical, emotional well-being)	118	75	92
% members reporting an increase in peer interactions	93	75	85

Other comments made on the surveys by members and caregivers include the following:

"Having such a great place to go during the week is vital to my overall well-being." (member)

"They do a good job. Putnam has saved my son giving him guidance and support in his illnesses worst days." (caregiver)

"You helped me quit smoking!! Thank you." (member)

"It is a comfortable place for my son to go and socialize. He feels 'safe' when he is there, and he has a 'purpose.'" (caregiver)

"It's a community that I belong to, a support system." (member)

"It is a safe and supportive community for people with insight into their mental illness." (caregiver)

"The clubhouse gives me a place to be, gives me the opportunity to be heard and also grow. I don't feel like a burden by being here and I'm always greeted by friendly faces." (member)

"The attitude of the staff members, and how it transfers over to the CH members. This is a very healthy program." (caregiver)

"It is so helpful for me to come to the clubhouse. It has kept me out of the hospital." (member)

Hospitalizations

For the ninth year in a row, members were asked to report on their hospitalizations and out-of-home placements (residential treatment) for the three years prior to joining the Clubhouse and for three years since joining the Clubhouse. Data was collected from a total of 67 active members in June 2019. If data had already been collected for the member in the previous year (June 2018) then this data was entered, and information was garnered for the previous reporting year only (since July 1, 2018). Data was not collected from those who had been Clubhouse members for more than four years since the date of their joining, since the period of observation is a six-year span from three years prior to membership to three years post-joining the Clubhouse.

Information on hospitalization was gathered in terms of "episodes" with an episode defined as each time a member was hospitalized or placed in a residential treatment program (NOT including board and cares or other long-term group living situations that are simply where the member lives but don't involve receiving treatment at his or her place of residence). Data was also collected on total number of days hospitalized or in residential care.

Of the 67 members, three were not included in the analysis: one because they showed that they had been hospitalized for an extended time prior to Clubhouse (an extended period comprises at least 1 episode of 800 plus days) and zero episodes/days after; and two because they did not enter anything beyond their demographic information. The final number of members included in the analysis was 64.

The number of hospital days prior to Clubhouse membership for those 64 members included in the analysis ranged from 0 to 228 days, with a mean of 15 days. Post Clubhouse membership, the number of days hospitalized ranged from 0 to 60 days with a mean of 2 days of hospitalization. In terms of episodes of hospitalization prior to Clubhouse membership, the Clubhouse members experienced zero to 9 episodes of hospitalization (a mean of 1.18 episodes). After Clubhouse membership, members experienced on average .10 episodes of hospitalization (range 0 to 1). In terms of change of episodes, 94% of those providing data showed a decrease in hospitalizations or maintained zero hospitalizations, 2% showed no change, and 4% showed an increase in hospitalization episodes from before to after Clubhouse membership.

Table 5: Percentage of # of episode changes before and after Clubhouse Membership

Episode Change (prior & after Clubhouse membership)	N	%
Decrease or maintained 0 prior and after	44	94
No change (1 prior and 1 after)	1	2
Increase	2	4
TOTAL	47	

In terms of number of days (total) that Clubhouse members were hospitalized or in out-of-home placements, paired T-tests were used to look at change in days before Clubhouse membership and

after Clubhouse membership. Findings showed a significant decrease in average number of hospitalization days from 15.34 days (range 0 to 228 days) before Clubhouse membership to 2.02 days (range 0-60 days) after Clubhouse membership ($t=2.817$, $df=61$, $p<.01$).

Hospitalizations were assessed in terms of change in number of episodes and days of hospitalization prior to and since Clubhouse membership, both of which decreased from before to after membership. In conclusion, the program achieved its goal (100%) of reducing hospitalizations in Clubhouse members.

Members were split into three groups according to their number of years as a Clubhouse member (less than 1 year (n=21), 1 to less than 2 years (n=11), and 2 to 3 years, but less than 4 years (n=14) (see Table 6). Although there appears to be a decrease in the proportion of those who showed a decrease or no change in episodes of hospitalization from those who have been Clubhouse members for 1-2 years (100%) to those who have been Club members from 2-3 years but less than 4 (86%), the proportion of those who show a decrease or no change in episodes still remains highest independent of how many years of clubhouse membership.

Table 6: Percentage of # of episode changes before and after Clubhouse Membership

	Years of Membership					
	Less than 1 year		1 to less than 2 years		2-3 years but less than 4 years	
Episode Change (prior and after Clubhouse membership)	N	%	N	%	N	%
Decrease or maintained 0 prior and after	21	95.5	11	100	12	86
No change (1 prior and 1 after)	0	0	0	0	1	7
Increase	1	4.5	0	0	1	7
TOTAL	22		11		14	

When looking at actual number of Hospitalization episodes Before and After Clubhouse membership, although there is a decline in number of episodes independent of how many years of clubhouse membership. This difference was statistically significant for those who had been Clubhouse members for less than one year and those who had been members for 1-2 years. Although there was a decline in episodes for those who had been members longer at Clubhouse (2-3 years but less than 4 years), this was not statistically significant.

Table 7a: Change in number of episodes from before (Prior) to After (Post) Club Membership.

	Years of Membership					
	Less than 1 year		1-2 years		2-3 years but less than 4 years	
Episodes Hospitalization Prior Membership	23	1.30	11	0.45	14	1.64
Episodes Hospitalization After Membership		0.09**		0.09*		0.14

*p<.05;**p<.01;***p<.001

Paired t-tests were also used to look at number of hospitalization days prior to Clubhouse membership compared to number days after clubhouse membership for each membership category (<1 year, 1 to < 2 years, 2-3+ years) (see Table 7b). Although members showed a decrease in number of hospitalization days from prior to post membership for all categories of clubhouse membership (< 1 yr, 1-2 yrs and 2 to <4 years), only those who had been Clubhouse members for less than 1 year demonstrated a statistically significant decrease.

Table 7b: Change in number of days from before (Prior) to After (Post) Club Membership.

	Years of Membership					
	Less than 1 year		1-2 years		2-3 years but less than 4 years	
Days Hospitalization Prior Membership	29	10.31	13	4.08	20	29.95
Days Hospitalization After Membership		0.97***		0.31		4.65

*p<.05;**p<.01;***p<.001

Overall, using the self-report data of Clubhouse members, it would seem that members of Putnam Clubhouse show a decrease in hospitalization in terms of episodes and total days from before to after Clubhouse membership.

Career Development Unit

During the 2018-2019 contract year the Clubhouse made career support services available to all members including the 90 members working in paid employment and the 48 members who attended school during this period. The Clubhouse provided support to all members who worked and attended school during the contract year including the 43 who began jobs during the year and the 21 who returned to school. Of the members completing the member survey who used career services, 88% said they were satisfied or very satisfied with the services related to employment or education (target 75%).

During the contract year Clubhouse members completed personal career plans (17 had employment goals and 16 had education goals). 100% of members who indicated employment as a goal in their career plan successfully completed their goal (target: 80%) and were referred to employers, applied for jobs, and/or has a job interview within three months of indicating goal. In addition, 100% of the members who indicated education in their career plan as a goal (return to school/finish degree/enroll in a certificate program) were referred to appropriate education resources within 14 days (target: 80%)

Table 8: Career/ Educational Development of Clubhouse Members

		GOAL	ACTUAL
Measures of Success:	N	%	%
% members satisfied/very satisfied with services related to employment/education (of those using Career Unit services)	60	75	88
% members referred to appropriate education resources within 14 days (of those indicating education as goal)		80	100
% members referred to appropriate employment resources, applied for a job, or had a job interview within three months (of those indicating employment as goal)		80	100

Importance of Clubhouse programs to Members and Caregivers

Clubhouse Members and Caregivers were asked to indicate how satisfied they were with the different programs and activities provided by Clubhouse during the 2018-2019 contract year.

Table 7 shows the percentage of members and caregivers were satisfied or very satisfied with the program. Those who did not participate in the program or whose family member did not participate did not respond to the survey item. As can be seen from the responses in Table 9, members and caregivers alike were satisfied or highly satisfied with Clubhouse programs, with a satisfaction rate of over 90% for the majority of programs and activities, bar the Rides program (for both caregiver and member) and Career services for the members. Members were most satisfied with the Holiday and Healthy Living Programs whereas Caregivers were most satisfied with the Weekend Activities and Wednesday Night Expressive Arts Programs.

Table 9**: Member and Caregiver Satisfaction with Program Activities** that Member or Caregiver's Member Participated in **(% Satisfied/ Very Satisfied)**

Clubhouse Programs/Activities	Member	Caregiver
	% Satisfied/Very satisfied (N)	% Satisfied/Very satisfied (N)
Meals	97 (86)	96 (23)
Holiday programs	96 (70)	96 (23)
Friday Night Socials/TGIF Fridays	94 (67)	100 (22)
Work-Ordered Day (Monday – Friday daytime activities	92 (85)	96 (24)
Wednesday Nights Expressive Arts Program (music and/or art)	91 (70)	100 (21)
Young Adult Activities	91 (33)	100 (11)
Healthy Living Program	90 (52)	75 (16)
Career Development Unit (assistance with education and/or employment)	88 (60)	90 (21)
Weekend Activities	85 (62)	100 (17)
Rides Program (transportation to/from Clubhouse)	82 (51)	95 (22)

Finally, both members and caregivers were separately asked to rank 10 Clubhouse programs/activities in order of importance to them. For the members the top three ranked activities/programs were Meals, Work-Ordered Days, and TGIF Fridays. For caregivers, the top 3 ranked activities/programs were Work-Ordered Days, followed by the Rides Program, and the Career Development Unit.

Table 10**: Ranking of Program Activities in terms of Importance by Caregiver and Member**

Clubhouse Programs/Activities	Member	Caregiver
Meals	1	8
Work-Ordered Day (Monday – Friday daytime activities)	2	1
TGIF Fridays	3	10
Weekend Activities	4	8
Career Development Unit (assistance with education and/or employment	5	3
Holiday programs	6	4
Wednesday Nights Expressive Arts Program (music and/or art)	7	6
Healthy Living program	8	5
Rides Program (transportation to/from Clubhouse)	9	2
Young Adult Activities	10	6

*program/activities ranked for Members

Overall, the caregivers and members alike had many positive things to say about the Clubhouse programs and activities:

"An absolute gem of an organization that does amazing things to support our family member(s) when they need it the most to be independent & live a useful life while struggling with mental illness. My personal gratitude for all you do!" (caregiver)

"I am grateful for the support that the clubhouse provides for my son. He really needs the social interaction he finds there. It is very good for him to have a schedule to follow. The staff works very hard and tirelessly." (caregiver)

"I REALLY appreciated the outreach. When members came to our house, it encouraged Amelia to go back to the Clubhouse." (caregiver)

"The clubhouse has never been stagnant. It is flexible, it changes in every way, it evolves, it becomes more creative, it challenges, it keeps growing in every way." (caregiver)

"Clubhouse program has enriched my life - added a big social component. Always there no matter when I come in. Always welcoming and receive that kind of support. Humbling to receive all the extras that the clubhouse gives." (member)

"I am on the whole very satisfied with the Clubhouse. The food is excellent, and I love the members and staff, and all that is given to me in time and trouble and friendship." (member)

"The clubhouse could bring anyone out of isolation." (member)

"The Clubhouse has been a tremendous blessing in my life. It gives me a place to go every day and do something meaningful and productive. I am very grateful for the Clubhouse and its presence in my life." (member)

"The clubhouse is like a second home to me. I have met some wonderful people here and I'd highly recommend the clubhouse to anyone who is finding themselves in a difficult place in their lives. Finding this place was one of the best things that's ever happened to me." (member)

The Clubhouse was successful in achieving all contract goals and objectives for the year 2018-19 contract. In addition, they more than made up for the few enrollment shortcomings last year by enrolling 86 new members this year (123% of the target), and engaging 28 young adults in activities (233% of the target)! With many of the prior year's staffing transitions stabilized this year, the Clubhouse was again able to place focus on growth. Revised policies this year also proved to be a successful strategy, as it made it much easier for new members to onboard into the program. Overall, the Clubhouse has demonstrated highly positive outcomes this year while remaining dedicated to its core values and the wellbeing of each and every member, both new and existing. This year's outcomes bode well for a promising future.

DEMOGRAPHIC DATA: X Not Applicable *(Using County form)*

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

N/A – County aggregate data form used.

EVIDENCE-BASED OR PROMISING PRACTICES:

What evidence-based, promising practice, or community practice based standard is used in your program and how is fidelity to the practice ensured?

Since 2011, Putnam Clubhouse has been continuously accredited by Clubhouse International, the SAMHSA-endorsed, evidence-based recovery model for adults with serious mental illness. All Putnam Clubhouse programming meets the 37 standards of Clubhouse International. A rigorous accreditation process and maintaining fidelity to the model require Putnam Clubhouse to provide comprehensive program data to Clubhouse International annually, participate in ongoing external Clubhouse training, conduct structured self-reviews, and receive an onsite reaccreditation review every three years by Clubhouse International faculty. Learning about, discussing, and adhering to the 37 standards of the model are built into the work-ordered day structure. All program staff and program participants of Putnam Clubhouse commit to following the standards during program activities. Program participants are included in all aspects of program evaluation and accreditation.

VALUES:

Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

Putnam Clubhouse is an intentionally formed, non-clinical, working community of adults and young adults diagnosed with SMI. The Clubhouse Model followed has been designed to promote recovery and prevent relapse. Putnam Clubhouse operates under the belief that participants are partners in their own recovery—rather than passive recipients of treatment. That's why Clubhouse participants are intentionally called members rather than patients, clients, or consumers. These members work together as colleagues with peers and a small, trained staff to build on personal strengths, rather than focusing on illness. The term "member" reflects the voluntary, community-based nature of the Clubhouse, making clear that members are significant contributors to both the program and to their own well-being. Thus the term "member" is empowering rather than stigmatizing. Clubhouse membership is voluntary and without time limits. It is offered free of charge to participants. Being a member means that an individual is a valued part of the community and has both shared ownership and shared responsibility for the success of the Clubhouse.

All activities of the Clubhouse are strengths-based, emphasizing teamwork and encouraging peer leadership while providing opportunities for members to contribute to the day-to-day operation of their own program through what's called the work-ordered day. The work-ordered day involves members and staff working side-by-side as colleagues and parallels the typical business hours of the wider community. Work and work-mediated relationships have been proven to be restorative. Clubhouse participation reduces risk factors while increasing protective factors by enhancing social and vocational skill building as well as confidence. The program supports members in gaining access to mainstream employment, education, community-based housing, wellness and health promotion activities, and opportunities for building social relationships.

Putnam Clubhouse operates under the belief that every member has individual strengths they can activate to recover from the effects of mental illness sufficiently to lead a personally satisfying life. Fundamental elements of the Clubhouse Model include the right to membership and meaningful relationships, the need to be needed, choice of when and how much to participate, choice in type of work activities at the Clubhouse, choice in staff selection, and a lifetime right of reentry and access to all Clubhouse programming including employment.

Additional components include evening, weekend, and holiday activities as well as active participation in program decision-making and governance. Peer support and leadership development are an integral part of the Clubhouse. The programming also incorporates a variety of other supports include helping with entitlements, housing and advocacy, promoting healthy lifestyles, as well as assistance in finding quality medical, psychological, pharmacological and substance abuse services in the wider community.

VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

Throughout this report we have included quotes from program participants and family members describing personal experiences and perspectives about the Clubhouse's impact on their lives.

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PEI ANNUAL REPORTING FORM

Due: August 15, 2019

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR: 18/19

Agency/Program Name: Rainbow Community Center of Contra Costa County

PEI STRATEGIES:
Please check all strategies that your program employs:

X Provide access and linkage to mental health care

X Improve timely access to mental health services for underserved populations

X Use strategies that are non-stigmatizing and non-discriminatory

SERVICES PROVIDED / PROGRAM SETTING:
Please describe the services you provided in the past reporting period. Please include who the program has targeted and how your services have helped in improving access to services. Where are services provided and why does your program setting enhance access to services?

During fiscal year 2019, The Rainbow Community Center provided services to members of Contra Costa County's Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) community through the implementation of three different projects: Pride and Joy, LGBTQ Youth Support Programming, and Inclusive Schools Coalitions.

Project #1: Pride and Joy – Pride and Joy, an outreach and early intervention project, targets members of Contra Costa County's LGBTQ community. Special emphasis is placed on reaching LGBTQ seniors, people living with HIV, and community members with unrecognized health and behavioral health disorders. Pride and Joy assists our historically underserved community members in finding culturally affirming health and behavioral health support services, and increasing their ability to cope with oppression when they are required to access health and behavioral health services in less affirming settings. Pride and Joy also raises awareness about existing health/behavioral health disparities within the LGBTQ community (e.g. community members' increased rates of depression, anxiety, suicide, substance abuse, and victimization), delivers health promotion messages, and increases LGBTQ community members' knowledge of local and national behavioral health resources.

Tier 1 (Universal) – Rainbow Community Center organized outreach programming through multiple in-person events/groups such as the weekly HIV+ group for self-identified men and monthly HIV+ group for self-identified women, bi-monthly Senior Luncheon and Gender Voice support group,

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annual Crab Feed Fundraiser, and Concord Pride. Through our email newsletters alone, Rainbow was able to reach and deliver health promotion messages and raise awareness about behavioral health/health disparities throughout Contra Costa County, in addition to Facebook and Instagram.

Tier 2 (Selected) – Rainbow carried out one-on-one brief-intervention services to the target community in our convening group level services, which are designed to support at-risk LGBTQ community members who are HIV+, low-income, coming-out, transgender, diagnosed with a Serious Mental Illness (SMI), and/or in need of early intervention behavioral health and psycho-education services.

Tier 3 (Indicated) – Rainbow provided one-on-one brief-intervention services (Tier 3/Indicated) to the target community in FY18. Tier 3 services are designed to assist at-risk community members in accessing needed care and treatment.

Senior Programming: Rainbow has identified LGBTQ seniors as a particularly vulnerable population. As such, programming for LGBTQ Seniors includes Tier 1, Tier 2, and Tier 3 components. Services include organizing two congregate meals (Outreach/Tier 1) per month, delivering regular in-person and telephonic Social and Support Groups such as Tai Chi, in collaboration with Meals on Wheels (Tier 2), and offering brief-intervention and screening services through the Friendly Visitor Program with the support of Rainbow's Clinical Department (Tier 3).

Project #2: LGBTQ Youth Support Programming – Rainbow has identified LGBTQ+ youth as a particularly at-risk population. As such, programming for this group incorporates components from all three tiers with services provided at Rainbow offices and in school and community-based locations throughout the county. Efforts also include continued development of support services designed to work with youth within a family-based context and transgender/gender nonconforming youth. Efforts reached youth via outreach activities, onsite group-level programming, and one-on-one mentoring. An additional youth were reached through school-based outreach (tabling, guest speaking engagements), the psycho-social group, QscOUTs, and behavioral health services.

Onsite programming consisted of ongoing youth groups, such as: Artistic Expressions, Youth Gender Voice, and Queer Open Mic. In some cases, groups centered around LGBTQ+ awareness and/or celebratory months/days: Day of Silence, LGBTQ+ Pride month. These groups were developed through an educational and empowerment lens to promote self and group development. In order to bring youth to these groups, we outreached to local school Gender and Sexuality Alliance/Queer Straight Alliance (GSA/QSA) clubs, managed resource tables, facilitated trainings, and hosted special events, while posting on social media and mobile outreach. We also promoted our youth program through flyers, email newsletter, and monthly calendars to school staff, health/service providers, GSA/QSAs, contacts within our Inclusive Schools Coalition, and community at large.

Collaborative events helped boost our outreach and advocacy. These events included: trainings/guest speaking engagements such as, "LGBTQ+ 101" at College Park High School and Acalanes High School, "Empowering LGBTQ+ YOUth" at Contra Costa County Office of Education, "Teens Tackle Tobacco" conference, and Gender & Sexuality Alliance Forums (California High School and College Park). In addition to this, we co-hosted an LGBTQ+ inclusive prom in East Contra Costa County with Center for

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Human Development.

Special events included: Gender Affirming Makeup Tutorial, Valentine's Day Party, and two LGBTQ+ Pride Events - Justice Prom and Concord Pride. With the planning and execution of weekly, monthly, and weekend special events, we were able to outreach to youth who may not otherwise attend our program. We collaborated with new and current community partners, to promote and provide services to marginalized LGBTQ+ youth. Overall, these youth groups and special events helped promote resiliency, collectivity, and youth leadership. These outreach efforts, youth groups and special events helped promote resiliency, collectivity, and youth leadership.

Project #3: Inclusive Schools – The Inclusive Schools Coalition continued the work of the MHSA Innovations Project to promote acceptance for LGBTQ+ youth in Contra Costa County schools, families, and faith communities. Rainbow ran the Central/East County Coalition, which focuses on collaborative work with school leaders, staff, and students to expand and solidify a base of action within four of the county's school districts: Mt. Diablo Unified School District, Pittsburg Unified School District/Pittsburg High School, and Acalanes High School District.

The Coalition also contributed to the ongoing development of county-wide collaborative efforts to establish a strong network of schools, faith communities, service providers, parents, and community leaders that will make a commitment to shared values, principles and practices in advancing acceptance of LGBTQ+ youth in Contra Costa County. Target populations included: a) LGBTQ+ students, their peers, and groups of students who were bullied and marginalized due to racial, ethnic, class, sex, gender identity, physical, and emotional differences; b) school boards, school teachers and staff, parents and other adults whose attitudes and behavior are intrinsic to creating an inclusive climate in CCC schools; and c) school and community-based organizations that interface with students and schools on a regular basis in order to create a seamless, no-wrong-door network of supportive services for marginalized students across Contra Costa County.

The Coalition held monthly meetings to plan goals for outreach and advocacy to support LGBTQ+ youth. Efforts have also consisted of reaching out to other faith communities and agencies/organization while supporting local schools, where Rainbow staff and Coalition members attended student club events such as the Gender Sexuality Alliance forums.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***How are participants identified as needing mental health assessment or treatment?***
- ***List of indicators measured, including how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***
- ***Average length of time between report of symptom onset and entry into treatment and the methodology used.***

LGTBQ people are often reluctant to access mainstream services due to experiences of feeling unsafe or unwelcomed by other agencies. As a result, many do not access mainstream services, and some feel

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compelled to hide their HIV status or LGBTQ identities. These fears mean that LGBTQ people, especially those in the aging older adult population, struggle with greater isolation and other discrimination-related health concerns in comparison to their peers who are not living with HIV or do not identify as LGBTQ. Within Rainbow's social and support programming and clinical services, we provide a welcoming, culturally competent environment and various opportunities to identify the needs of the community members who utilize the services that we offer.

One of our primary methods of identifying the need for behavioral health assessment or treatment is through intake. Rainbow has recently implemented new intake procedures to ensure that all who seek services at Rainbow are assessed in a manner that is trauma-informed and culturally appropriate.

In conjunction with Rainbow's new intake process, staff can identify clients who might benefit from further health assessment or treatment through interaction and conversation. For example, if a participant in youth group brings up serious issues with Youth Outreach Counselors (YOC), the YOC will help make sure they have a warm handoff to our intake coordinator.

Sometimes individuals choose to self-disclose their need for further treatment, which is encouraged by the RCC's dedication to a safe, LGBTQ-affirming environment and through our promotion of health/behavioral health services.

We also participate in various intra-agency case rounds and care team meetings. Rainbow clinicians at Ygnacio Valley High School, Las Lomas High School, Campolindo, Acalanes, Mt. Diablo High School, and Concord High School attend care team meetings where they collaborate with other educators. When LGBTQ youth are discussed, clinicians work to connect them to services at Rainbow, other CBOs, and/or county programs. Within adult services, we participate in multi-disciplinary team meetings for human trafficking and domestic violence (as part of Contra Costa's Zero Tolerance for Domestic Violence Initiative). Lastly, we attend the Children's, Teens', and Young Adult's Reducing Health Disparities Meetings and Contra Costa Health Department AIDS Program's case rounds.

We continue to use our Salesforce database to collect data on consumers, including address, name, birthdate, ethnicity, sexual orientation, gender identity, and the types of agency programs that they attend. We also collect service utilization data on every time the consumers attend a program or service. This data is summarized monthly and submitted with our PEI demands for payment. With our new intake procedures we are tracking the amount of time between initial contact and initial assessment. Counseling charts note the amount of time symptoms were present.

DEMOGRAPHIC DATA: x Not Applicable ***(Using County form)***
If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

LINKAGE AND FOLLOW-UP:
Please explain how participants are linked to mental health services, including how the PEI program: 1) provides encouragement for individuals to access services; and 2) follows up with the referral to support successful engagement in services. Additionally, please

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include the average length of time between referral and entry into treatment and the methodology used.

Rainbow uses multiple strategies to link participants into behavioral health services. One strategy is to bring resources directly to Rainbow programming. We routinely include speakers from outside agencies in our community programming. For example, during FY18 we had speakers at Senior Lunch to cover various topics, such as: fraud protection, fall prevention, higher care options.

Additionally, to support LGBTQ+ youth, collaborative events helped boost our outreach and advocacy. These events included: trainings/guest speaking engagements such as, "LGBTQ+ 101" at College Park High School, Acalanes High, "Empowering LGBTQ+ YOUth" at Contra Costa County Office of Education "Teens Tackle Tobacco" conference, and Gender & Sexuality Alliance Forums (California High School and College Park). In addition to this, we co-hosted an LGBTQ+ inclusive prom in East Contra Costa County with Center for Human Development.

Special events included: Gender Affirming Makeup Tutorial, Valentine's Day Party, and two LGBTQ+ Pride Events - Justice Prom and Concord Pride. With the planning and execution of weekly, monthly, and weekend special events, we were able to outreach to youth who may not otherwise attend our program. We collaborated with new and current community partners, to promote and provide services to marginalized LGBTQ+ youth. Overall, these youth groups and special events helped promote resiliency, collectivity, reduction of isolation, and youth leadership.

Another strategy we employ is utilizing our Inclusive Schools Coalition and our training program to outreach to other behavioral health and social service agencies. Rainbow provided a number of trainings, including to Antioch High School, Antioch Unified School District, Pittsburg Unified School District, Seneca Family of Agencies' Catalyst Academy, California State University Sacramento, Diablo Valley College, Pinole Middle School, and Strandwood Elementary School. As we increase our partnerships, referrals for services increase as a result.

Rainbow Community Center staff are trained to understand the importance of meeting people where they are at, in an effort to create a safe, welcoming, and friendly space. Having the 3 Tier Service Model is critical to connecting community members. Staff spend considerable time working to link participants to mainstream services and programs. As brokers for care between our participants and other providers, we are often able to educate providers who may be well-meaning but unsure or unfamiliar with how best to serve LGBTQ Seniors and people living with HIV/AIDS. We also help our community members by encouraging them to use social service programs, as well as inviting providers to partner with us and introduce themselves to our participants.

Once a referral is made to Rainbow's clinical program, we use a brief intake screening tool that is completed over the phone. This tool screens for needs of the individual, couple, or family. A clinician then completes the initial assessment and uses this opportunity to build rapport with community members, as well as share information about the variety of services and programs offered at Rainbow and with our community partners. Through use of the intake screening tool and staff's welcoming approach to engaging with clients, we encourage individuals to access services that are beneficial to

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their immediate and longer term needs.

As stated previously, Rainbow has recently implemented new intake procedures which tracks the amount of time between initial contact and initial assessment.

VALUES:

Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

Rainbow reflects MHSA values of wellness and resilience by providing community members with a safe, inclusive space to build community in a stigma-free environment. Staff are educated on utilizing inclusive and culturally competent language when interacting with the LGBTQ community members. The LGBTQ community often faces discrimination in various aspects of their lives. Providing a safe environment where community members can access services free from fear of this discrimination is integral to the mission of the Rainbow Community Center. Our Community Agreements are designed to ensure that the space is kept welcome to all, and is enforced by all staff and volunteers, and encouragement is given to everyone who enters the space to further enforce these agreements.

In our behavioral health program, we utilize strength-based and trauma informed approaches in all of our interactions with consumers. We believe that our mission to build community and promote well-being is accomplished through providing high quality services while being mindful of the whole person and ways that programming we offer throughout our 3 Tier Service Model may benefit everyone we serve. Through ongoing training and utilization of a team-based approach to the work we do, Rainbow staff provide a safe environment where our clients receive non-judgmental, supportive services that help them feel welcome and accepted.

Our Inclusive Schools Coalition work is focused on creating support networks for LGBTQ youth and providing cultural competency training to other Contra Costa organizations. Through this work, we aim to make behavioral health services for LGBTQ+ people more visible, more accessible, and more culturally competent by providing relevant information, collaboration, and opportunities for networking and connection between providers and consumers alike. For example, during our annual Welcoming Schools & Communities Summit/Rainbow High, we invite several different organizations to run resource tables during the event. As a result we are able to provide appropriate resources, facilitate face-to-face connections, and encourage future collaboration between community members and organizations.

School-based youth programming was implemented through QscOUTs, social-emotional development groups, which were facilitated at El Dorado Middle School, Mt. Diablo High School, Campolindo, Ygnacio Valley High School, Acalanes High School, and Los Lomas High School. The QscOUTs' curriculum provides a safe space for LGBTQ+ students on their campuses and assists youth with identity development, healthy relationships, and team building. In conjunction with QscOUTs, students were provided with one-on-one support from onsite Rainbow interns. This support included behavioral

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health assessments, short-term counseling and case management, and linkage and brokerage services. As a result, youth were able to receive help with short-term issues and be linked into higher levels of 94553care when needed.

VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

"Travis"

"Travis" is an African American, male identified transitional aged youth (25 years old) from Antioch where there are very few LGBTQ+ youth programs. Hoping to find a safe space, to feel less isolated, and become more comfortable with his sexual orientation, he actively searched for a support system and came across the Rainbow Community Center. "Travis" began to attend several youth groups such as Artistic Expressions, Movie Screenings and Queer Open Mic and quickly found Rainbow made him feel "safe in a welcoming, relaxing and respectful environment", falling "in love with the sense of community that attendees, staff and volunteers bring to" Rainbow. As "Travis" attended more youth programming, he sought support from one of our Youth Outreach Counselors, on how to navigate coming out to his family and close friends. Successfully, "Travis" was accepted with open arms and was given a celebratory coming out party. Through attending our youth groups and one-on-one mentoring with a Youth Outreach Counselor, "Travis" was able to work on social-emotional development, build self-esteem, and set goals. He is continuing with his college education, working, and regularly attends youth groups. This past June 2018, he bravely sang at one of our biggest youth program events, Youth Variety Show, and has shown interest on planning and facilitating a youth group. "Travis" feels that youth program is a critical part of our Center because of the genuine, caring, resourceful and very helpful team. He states, "Rainbow Community Center adds value to people's lives and brings them together as one."

"Martin"

"Martin" is a Caucasian identified, transitional aged youth (20 years old), comes from a Mormon family and has struggled with coming out. He was referred to the Rainbow Community Center counseling and youth program by his counselor at Diablo Valley College. "Martin" states that he found our Rainbow Youth Program to be "very warm, open, professional, friendly, accepting and uplifting environment", finding a sense of community, good friends, and resources. "Martin" also sought counseling at Rainbow which helped him work through negative thoughts and learn more about self-care. As a result, working both with Rainbow Clinical Program and meeting one-on-one a Youth Outreach Counselor, he was able to find a job and is currently being promoted to an Assistant Store Manager. Rainbow Youth and Clinical gave him the space and support to navigate safe social settings as well as gain self-confidence, where other youth and Rainbow staff understand his story. He was able to come out to his Mormon family as a drag queen, feeling more accepted.

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MHSA

PREVENTION REPORTING FORM **FISCAL YEAR 18-19**

Agency/Program Name: RYSE

PEI STRATEGIES:
Please check all strategies that your program employs:

X Provide access and linkage to mental health care

X Improve timely access to mental health services for underserved populations

X Use strategies that are non-stigmatizing and non-discriminatory

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SERVICES PROVIDED / ACTIVITIES:
Please describe the services you provided in the past reporting period. Please include types of problems/needs addressed, any activities that address these problems/needs, and any functional outcomes targeted by the services provided.

MHSA services provided by RYSE in the past reporting period continue to facilitate access and linkage to mental health care (through a trauma-informed, healing centered approach), improve timely access to mental health services for young people in West County strategies that non-stigmatizing, non-discriminatory, and which actively address stigma and discrimination that creates physical, mental, and emotional harm and burden for young people in West County. We are pleased to report achievement of and meaningful progress towards key activities:

Direct Service
RYSE engaged young people and community members onsite through drop-in and structured programs and events (on-site and/or online) and offsite through trainings and workshops in high schools, continuation schools, partner agency sites and within juvenile hall:

- 242 new members enrolled, for a total of 542 unduplicated members attending during the reporting period.
- RYSE programming continues to be youth-directed safe spaces that encourage both joy and the difficult work of stepping outside comfort zones. From role-playing games to examine emotions via collective storytelling, to vulnerable letter-writing to themselves and creating life maps, to participating in activities from Boal's Theatre of the Oppressed, to using balloons to learn about trauma responses and triggers—RYSE youth are always modeling for us what it means to be courageous community leaders who continue to learn and grow.
- 87 young people completed Education, Career, Let's Get Free or Case Management Plans. RYSE's Hire Up model has engaged 6 reentry clients to-date, with the following report shared by our Career Pathways Specialist that reflects RYSE's capacity to address young people's needs: *"Yesterday in Hire Up we worked on our career life maps understanding what things in our life have brought about the passions of what we want to do in our lives. It was a very open and vulnerable space members shared aspects of their lives that are truly entangled with deep pains but they have now translated those things to be driving forces to see change in their worlds. Every member wanted to do a type of work that aims towards serving their communities, bringing healing to those in need of it, and implementing justice in our society."*
- RYSE disseminated Spanish-language Sanamente (via Each Mind Matters) mental health awareness and access materials to young people and their families through front desk outreach at RYSE, as community members come into the space, as well as during outreach efforts at local schools and parks.
- Tasty Tuesday programming continued to be held weekly, providing healthy cooking and community-building workshops addressing food scarcity. We continue to receive donations from the food bank, however, must navigate the challenge of receiving an excess of sweet/unhealthy food items rather than nutritious options. Throughout the grant period, we continued to utilize the RYSE garden as a source of fresh healthy food, however in July 2019 the garden will be closed during the construction of RYSE Commons. We are actively seeking new partnerships for healthy and fresh food sources.
- On May 31, 2019, we held a community health resource fair titled, 'Rich in Health'. The event focused on promoting social services that were local and accessible for Spanish speaking families. We had 8 community providers attend with services ranging from mental health, access to primary care, sexual health and STI testing, financial literacy, environmental justice information, free dental screenings, legal consultation, and acupressure/massage therapy demonstrations. One of the purposes of the event was to connect community members with local organizations provide free or low-cost services. We had over 70 community members attend the event.
- The youth-produced RYSE Pride Video was developed to celebrate queer joy at RYSE (June 2019)
- The youth-produced Student Voices Video shared the impact of the arts on young people's wellbeing (March 2019)
- Young people developed original poetry and spoken word, performed at over 15 public and/or youth-led events.
- RYSE members produced the Youthtopia Mixtape, pieces were all components of the May 2019 Multimedia Production.
- 146 Member Liberation Impact Surveys were completed (May 2019)
- 84 Program Impact Surveys were completed in throughout Spring season 2019
- 29 Partner Impact surveys were completed (May 2019)

RYSE continues to receive referrals from the Probation Department and hospital-linked TRRS system following acute or lethal injury. RYSE has been working with youth to provide transitional support and reentry services for youth leaving juvenile hall and the Boy's Ranch and has successfully deepened our relationship with the Contra Costa Probation Department.

- 39 new members were referred through Probation or hospital linkages; case management was provided for all participants, building integration and access to RYSE's full model.
- Services provided this month include, but are not limited to: welcome home care packages; support with transportation to and from court; providing information to incarcerated clients family; clothing support; DMV appointments; transportation; grocery shopping; housing assistance; character letters; community service hours support; anger management programming.
- Individual clinical therapy ranged from 2-5 stabilizing counseling sessions, to continuous relationship and monitoring between the therapist and young person over the entire year. A Spanish-speaking therapist joined RYSE in January 2020, and she has since taken on a caseload of 11 young people who require Spanish for themselves or in communication with their parent/guardian. When we are unable to take a referral, we inquire with the referral site and young person about engaging at RYSE in other capacities until an opening is available.
- Hip Hop Heals, a collaborative educational experience for youth committed by Juvenile Court and staff at the Orion Allen Youth Rehabilitation Facility in Contra Costa County, was piloted over this grant period. The project promoted community, healing, social-emotional learning, creativity, intellectual curiosity, and confidence for young people and staff at the facility.

RYSE continues to raise visibility and promote action on gender justice and queer liberation in WCCUSD as integral to youth leadership and to creating safe space for young people of color. By staying committed to serving young people through all their varied experiences, self-discovery, and changing identity awareness and expression, RYSE served youth identifying as LGBTQ, and maintains an environment that prioritizes queer safety and leadership for all members.

- RYSE Alphabet Group programming utilized art for healing and queer expression.
- Let's Talk about Sex discussion space were held, centering queer and trans experiences and including a trauma informed framework makes accurate sexual health information more accessible and relatable.
- Two Let's Talk About Sex Interns were hired and participated in facilitation and sexual health trainings to develop skills in public health and sexual health education. Completion of this internship ended with a Let's Talk about Sex week of workshops led by peer-health interns, as well as with each receiving a Planned Parenthood endorsed Sexual Health Peer Educator Certification.
- All RYSE Staff were involved in a continued Sex Positivity Training to increase awareness and build collective best practices in supporting young people in navigating conversations around sexuality (including homophobia, transphobia, sexism).
- RYSE members and staff performed and participated in the following community events:
    - 2/4/19, Blacker Side of the Rainbow: Black Queer and Trans Identity dinner and discussion- RYSE Center
    - 3/22/19, Full Bloom Queer Youth Performance Event- Aja & Luris Fierro (member) facilitated cultural opening- Oakland, CA
    - 4/19/19, BlaqOUT Conference- UC Santa Cruz, Black Queer & Trans identity conference
    - 5/28/19, Queer Poetry Slam - Part of the 2019 National Queer Arts Festival- RYSE Center- The Queer Cultural Center (Bay Area) hosted its first Queer Poetry "Cash Prize" SLAM at RYSE. Community members, RYSE members, and RYSE Staff performed.
    - 6/21/19 Rhythms and Rainbows: Queer Pride Party- RYSE Center

- 6/2019: Workshop for AMP Gender/Sexuality and Queer & Trans visibility in music industry- RYSE Center

- In March 2019, RYSE members participated in Grassroots Womxn Rising, the first statewide convening bringing together girls and womxn for social change, self-care, and developing leadership skills, and also attended The California Endowment's Queer and Trans Youth Leadership Summit.

Systems Change

- **Kids First Richmond:** In December 2018 a Director was appointed for the Department & Fund. Since then RYSE has been in deep partnership, alongside the Invest in Youth Coalition and the Richmond Kids First Campaign Committee, ensuring that the vision & goals of the Kids First Initiative is enlivened within the implementation and launching of the Department the community and youth oversight board.

- **John Muir Resident Trainings:** RYSE continued our pilot with John Muir Medical Center, participating as a training site for their Family Residency Program. As part of their rotation, the medical residents come to RYSE to learn how to connect, refer, coordinate supports for patients to RYSE, and to gain a better understanding of the ways in which trauma and violence impact young people of color in our communities, and how they can best support and care for our communities in their roles as doctors.

- **Training and Sharing Praxis:** In May, RYSE presented for Resilient Napa - Resilience, Resistance, and Relationship, the 3 Rs of Systems Change. RYSE developed and provided a two-day training to East Bay Parks and Recreation Department staff about trauma informed and healing centered practices for adults working with youth. The training centered around understanding the correlation between climate and environmental justice work and communities most impacted by health inequities, understanding adolescent brain development and short-term/long term impacts of trauma, and learn strategies for coordinating supports for young people navigating trauma that can be applied to their roles. RYSE is participating in Contra Costa Health Services Strategic Planning Process, including supporting the design of stakeholder convenings. RYSE recently joined the Steering Committee of the California Children's Trust, and participating on the Equity, Accountability, and Outcomes Design Team. RYSE was selected to participate on the Statewide All Children Thrive Initiative, convened by Public Health Advocates. The aim of ACT-CA is to support and move cities to develop and implement child-centered, trauma-informed, healing-based policies, investments, and practice. The Sacramento My Brother's Keeper Initiative launched a Trauma and Healing Learning Series based on RYSE's Series. RYSE presented at the Launch session in May.
  - January 10, 2019 Healing-Centered Organizing for Youth Organize! California Partners
  - January 16, 2019 Contra Costa County Behavioral Health-Community Forum-Focused on Serving the Immigrant Community
  - January 17, 2019 Mental Health Services @ RYSE for Lifelong Medical Care (1 hour)
  - January 31, 2019 Non-Violent Communication and Restorative Practices
  - February 1, 2019 Gender Justice Training
  - February 13-14 Trauma, Healing, and Resilience Training for East Bay Regional Parks District

- **WCCUSD Trainings:** We scheduled a training with the WCCUSD Executive Board to take place in April 2019 to discuss the School-to-Prison Pipeline and the position played by the District in patterns of suspension, expulsion and push-out. The training was cancelled, however, and will be rescheduled for October 2019. RYSE continues to work to connect District administrators with renowned experts in areas of racial trauma and healing with Drs. Ken Hardy and Shawn Ginwright, adolescent brain

development with Dr Joyce Dorado, school to prison pipeline research and policy with Tia Martinez, JD. We plan to continue to hold launch of school-year trainings, are in school-specific conversations across the district about initiatives that support trauma-informed efforts, and continue to offer Listening to Heal as a pathway for building collective capacity to respond to trauma. RYSE is set to conduct new WCCUSD teacher training for the 19-20 school year. This will take place on August 12th and focuses on cultivating Healing-Centered Classrooms.

- **Positive School Climate Resolution:** RYSE continues to build community awareness and promote implementation of the WCCUSD Positive School Climate Resolution, committing to ensuring that positive behavior and restorative practices are embraced, modeled, and reinforced in the District. RYSE began participation in Georgetown's Center for Juvenile Justice Reform 2019 Reducing Racial and Ethnic Disparities working group, which includes the CC County District Attorney office, public defender's office, Office of Reentry and Justice, a school representative and a law enforcement representative, and Probation. During a workshop at Georgetown University the group developed two project ideas: 1) development or enhancement of alternatives to detention and 2) the development of a protocol among police, schools, and juvenile justice officials aimed at reducing arrests of students. Next steps are to hire researchers to evaluate and gather school data that District has about rates of expulsion, suspension and calls to police. This data will be used to make protocol recommendations.

- **Youthtopia: In the Face of Gentrification Multimedia Showcase:** In May 2019, RYSE members produced Youthtopia which premiered at East Bay Center for the Performing Arts and included an interactive audience mapping project of Richmond in the lobby as well as a talk back after each show. Youthtopia featured musical numbers, poetry, and interviews with HERE Action Research Project Interns about systematic workings of gentrification in Richmond and the broader Bay Area.

- **Restorative Justice Diversion Pilot:** In May 2019 RYSE launched a collaborative agreement with the District Attorney's Office to bring restorative justice diversion to Contra Costa County. This is the result of early conversations and coalition-building meetings held over the past 5+ years, as well as ongoing advocacy by young people about the harms of our current system. The program is post-arrest/pre-charge where the young person will be diverted instead of processed through the juvenile legal system. The program will be run by RYSE independent of any law enforcement or systems partner. Staff training in restorative circle-keeping will begin August 29th.

- **RYSE Commons:** RYSE has launched our capital campaign and begun construction to expand into RYSE Commons. RYSE has qualified for and has closed a New Market Tax Credits (NMTC) transaction through the Opportunity Fund, and has been approved for a $5.7 million Bridge Loan from the Raza Development Fund. As part of our sustainability plan, RYSE has acquired our current building as a free and clear asset. Our building and outdoor properties have a current market value of $1,350,000. We also recently acquired another property for the RYSE Commons campus free and clear valued at $465,000. This property will allow RYSE to develop a Health Home for young people of color as a key component of RYSE Commons. A Health Providers Roundtable, youth-participatory action research, and a business/sustainability plan process are each beginning this summer toward the development of this reimagined health system and linkages.

RYSE was also featured on and contributed to the following sites during this reporting period:

- RYSE released a co-authored SF Chronicle Op Ed about the need for more mental health resources in schools and cited radical inquiry research among students in Richmond schools.
- Following our YPAR publication in the Journal of Family Violence, YPAR Intern Leili Lyman authored an article for the Chronicle of Social Change - For Youth In My City, Marijuana is the Go-To Treatment for Trauma.
- Youth Today: https://youthtoday.org/2019/03/how-to-help-youth-activists-change-the-world/
- PACE Funders: YOUTH CIVIC ENGAGEMENT FOR HEALTH EQUITY & COMMUNITY SAFETY
- KQED: If Cities Could Dance
- East Bay Times: https://www.eastbaytimes.com/2019/05/14/contra-costa-explores-an-alternative-to-sending-kids-to-juvenile-hall/
- Opportunity Fund: https://www.opportunityfund.org/media/blog/opportunity-fund-finances-$11mm-expansion-of-youth-center-in-richmond/
- ACES Connection: Program Offers Young Men and Boys a Safe Space to Heal from ACES and Build Connections
- KPFA: Trauma and Healing in Communities
- The Alliance for Media Arts & Culture: Healing through the Arts: LoveTopia
- RYSE continues to engage in advocacy efforts and develop guidance materials and forums for communities to collectively reflect on the opportunities presented by Proposition 64 (2016 marijuana legalization) and to consider their local, regional and statewide application of funds. RYSE co-authored the following report, Recommendations Roadmap for Prop 64
- RYSE's model has been highlighted Fast Company's World Changing Ideas for RYSE Commons; and our Executive Director, Kimberly Aceves-Iñiguez and Associate Director, Kanwarpal Dhaliwal, were recipients of the Jefferson Award for Public Service.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services.

- ***List of indicators that measured reduction of risk factors and/or increase in protective factors that may lead to improved mental, emotional and relational functioning. Please include how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

Health and Wellness

A. 70% of RYSE members report benefits of RYSE programs and services that support mental health and wellness. ACHIEVED.

- 93% report that RYSE has helped them pay more attention to their feelings and emotions
- 97% report that RYSE has helped them feel that it is okay and beneficial to be in programs that support mental health
- On a scale from 1-100, RYSE members selected an average rating of 77 that they feel loved at RYSE, and that however they come in, staff love them.

B. 70% of RYSE members report positive or increased sense of self-efficacy, positive peer relations, youth-adult relations, and agency in impacting change in the community. ACHIEVED

- 97% report positive relationships with RYSE staff
- 90% report positive peer relationships with peers at RYSE
- 92% report positive or increased sense of self-efficacy and agency

C. 70% of members demonstrate progress toward desired skills/goals related to their participation at RYSE (subset of members with a defined plan) ACHIEVED. Results of Spring 2019 Program LITs:

- Digital Storytelling: 100% agree or strongly agree that they learned something new in the workshops and will be able to use what they learned.
- College A-Z: 77% agree or strongly agree that they learned something new in the workshops and 74% will be able to use what they learned.
- Education & Career Case Management: 100% agree or strongly agree that their GPA improved and 100% agree or strongly agree that they reached one or more of their education or career related goals.
- Hire Up: 87%-100% agree or strongly agree that they feel more prepared and confident as job applicants along seven key measures.
- Young Men's Group: 90% agree or strongly agree that they have a better understanding of how social conditions of violence affect individual and community health.
- Transition & Reentry: 100% agree or strongly agree that RYSE supports have helped them know more about their rights and choices when navigating public systems.
- RYOT Leadership Skills Training: 87% - 100% agree or strongly agree that they feel more skilled and prepared as leaders across eight key measures.
- RYOT Political Education: 100% agree or strongly agree that they have a better understanding of issues affecting their local and global communities.

D. RYSE members who are identified as needing more intensive MH services will be linked to culturally competent MH services. ACHIEVED, ongoing.

- Among members engaging in RYSE Intervention/Diversion/Reentry and hospital-linked violence intervention, 100% reported an improved sense of emotional and mental health and destigmatization.
- During this time period, we've referred at least 1 person to receive support through Contra Costa Behavioral Health Services. This client was referred to therapy via the R2P2 program. RYSE supported her in therapy for one year. She was in need of more intensive therapy that included being able to be seen in the home several times/week and support with obtaining and maintaining medication for both Post-Traumatic Stress Disorder and Depression. She is also managing chronic pain due to a bullet in her back from having been shot, which is one of the reasons she was needing in-home supports. She continues to utilize those mental health services and is still connected to RYSE, receiving case management.

Some quotes from our Member LIT (May 2019) - "What makes RYSE Special"

- How accepting they are.
- Inclusive, variety of programs, space for everyone
- No other place like RYSE anywhere, it's like a second home, supports and accepts everyone.
- A safe place to learn, grow, and advocate for your community.
- All the programs it offers for the youth
- Everybody gets along even when they don't like each other they still find ways to work with each other, there's a lot of programs to participate in.

- Different people's happiness and backgrounds
- Good community
- I am accepted for who I am, as I am.

Trauma Response and Resiliency

E. 80% of the total number of stakeholders involved in TRRS series will report increased understanding and capacity to practice trauma-informed youth development. ACHIEVED.

- On a Yelp-like scale about RYSE as a partner, partners gave RYSE an average of 4.9 stars out of 5.
- 89% of surveyed partners agreed or strongly agreed that RYSE has supported them in new ways of thinking and doing their work.
- 94% agreed or strongly agreed that RYSE provided a sense of community.

F. At least 40 stakeholders demonstrate shared commitment to trauma-informed policy that promotes the optimal health and wellness of West Contra Costa youth and young adults.

- RYSE has hosted seven trainings for John Muir residents to-date, with initial evaluation results trending at "strongly agree" related to relevance and value.
- We are still planning a Gender Justice series, pushing timeline back to be mindful of planning for activation of RYSE Commons. In preparation for the space, it feels critical to engage in some of the trainings and praxis that RYSE already does to bring partners together in responding to young people.

Inclusive Schools

A. 70% of RYSE members who self-identify as LGBTQQ report positive sense of safety and belonging at RYSE and positive or increased sense of self-efficacy, positive peer relations, youth-adult relations, and agency in impacting change in the community

- 100% of RYSE members who self-identify as LGBTQQ report positive sense of belonging at RYSE
- 87% of RYSE members who self-identify as LGBTQQ report positive peer relationships at RYSE
- 100% of RYSE members who self-identify as LGBTQQ report positive relationships with staff at RYSE
- 86% of RYSE members who self-identify as LGBTQQ report improved sense of agency and self-efficacy
- 100% of RYSE members who self-identify as LGBTQQ report improved understanding of self and self in relationship to other people, cultures, sexual identities

B. 70% of RYSE members report an understanding and capacity to build community with races, cultures and sexual orientations and genders different from their own.

- 92% of RYSE members report a better understanding of people of different cultures
- 91% of RYSE members have a better understanding of LGBTQ identity
- 98% of RYSE members have a better understanding of how different groups in their schools or communities share common challenges

C. 75% of the total number of adult stakeholders involved in the Inclusive Schools Coalition and/or Trainings will report increased understanding of the priorities and needs of LGBTQQ youth and their peers.

- RYSE conducted trainings for Career Health Pathways staff at various WCC schools in preparation for leading summer student internships, as well as for incoming teachers at WCCUSD. The next training is scheduled for August 12, 2019.
- Audience feedback from Youthtopia: in the Face of Gentrification:
    - *"The cast touched subjects I'm not able to speak about a lot on a serious level."*

- *"It's always a learning experience hearing youth in each generation express their fears, concerns/ hopes. I work in the education sector teaching and seeing how students felt just reinforced the motivation I have to teach and care for our kids."*
- *"I'm inspired by the resilience and talent."*

DEMOGRAPHIC DATA: ☐ Not Applicable ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

- While the total number of youth served during this reporting period is 424, the Race section adds up to more because youth marked both more than one race and the races they identified. Similarly, the Gender Identity and Sexual Orientation sections add up to more because some youth selected multiple responses.
- Part 2 is blank because we collect info on race and ethnicity together and with some differentiated categories than MHSA.
- Part 5 is blank because RYSE does not ask about specific disability on the member application. We noticed that there is no place to document atmospheric trauma and distress our members experience.
- Regarding referrals out for question 9a. We do refer youth to outside services (clinical and non-clinical), however they often report negative or uncomfortable experiences with outside referrals. On occasion, members will inform us that they were unable to make an appointment.
- Regarding Part 7: Item 10 requesting the average duration of untreated mental health issues,

RYSE defines and addresses trauma and distress as historical, structural, and atmospheric, operationalized through racial oppression and dehumanization of young people of color (RYSE Listening Campaign,2013; Hardy, 2013; Leary, 2005; Van der Kolk, 2015). Therefore, RYSE's work is focused on addressing the conditions and systems that induce and perpetuate distress and atmospheric trauma, cultivating and supporting community building for collective healing and mobilization to address the harmful conditions and their generational impacts, and providing tailored supports and services necessary to provide safety, stabilization, and hope for individual young people and as a community.

We measure impacts related to RYSE's core strategies and prioritization of relationships as prevention and early intervention of mental health issues (reflected in our service workplan). We do not measure duration of untreated mental health issues, as it does not fully reflect, and is dismissive of, the context and magnitude of what young people are experiencing and embodying. It falls short of the rigor and dynamism we employ as a community

mental health and healing organization. That said, we work in persistent proximity with individual members to listen to, validate, and hold their lived experiences and articulations of distress, as well as those of resistance and resilience.

EVIDENCE-BASED OR PROMISING PRACTICES:
What evidence-based, promising practice, or community practice based standard is used in your program and how is fidelity to the practice ensured?

Please see previous reports sharing RYSE's Theory of Liberation and Radical Inquiry.

VALUES:
Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

RYSE centers the experience, priorities and needs of young people we work with, believing that they have the expertise to direct the services needed for their wellbeing. With this orientation, RYSE staff form relationships with systems-involved young people to learn about their short and long term goals, their personal relationships and advocates, their familiarity and comfort navigating systems, and learning how their past experiences have impacted the options available to them and existing barriers. When needs and interests have been identified either by a youth participant or by a staff member; the staff member will work to obtain consent from participants to make a referral. Values guiding our approach include:

1. Youth consent: knowing that participants have endured systems harm and non-consensual decisions profoundly affecting their lives, consent is required for referrals to services within and outside of RYSE.
2. Supported self-advocacy: young people are encouraged and supported to take the lead in connecting to services they need and identifying supports that are relevant for them.
3. Relationship-based: RYSE has done the work to build relationships with partner organizations and in and outside of institutions. In this way, we have a clear idea of what they offer that RYSE cannot offer in-house. If desired by participants, RYSE staff accompany youth to first meetings and/or bring partners into Bridge Meetings with probation for a "warm hand off".
4. Culturally-relevant: young people have shared a need for culturally appropriate and culturally-rooted services with strong youth development competency of providers, gender and sexuality affirming services and care, and active countering of implicit and explicit bias among providers.
5. Accessibility: limitations on travel, especially for youth on probation, are taken into account when referring services within our broadly dispersed and public transportation-limited county. While RYSE works to do all we can to provide and coordinate multi-dimensional supports for the dynamic health needs of young people, we experience firsthand the limitations of health systems in providing quality care for them and their families. For example, there is only one psychiatrist for children's mental health in all of Contra Costa County. RYSE is the only mental health provider that will see young people for clinical supports regardless of insurance status.

VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

In June, RYSE held RYSE Pride Month activities, which were shared in our July newsletter. The idea of a chosen family was a theme that young people chose to speak about. They reflected on the safe space and healing relationships that RYSE cultivates and the ways that RYSE sees them in all of their identities, the intersections of being Black and Queer in Richmond:

On the importance of chosen family:
"It doesn't matter what race you are, there are parents that will not accept you. There are people who will not like it and I think that's the main reason why they do Pride, because there's nowhere to turn and I feel like the only way is when you're around people that are in your shoes as well...My chosen family means a lot because most of the people I know are like me, they like girls. There might be a couple of them that's straight, but they still support me. They still support the other people that's in our [Queer] family and they mean a lot to me and that's very important to me."

On growing up in Richmond, CA
"In my experience, growing up it was very difficult to be myself, to show my true self to my family without them lookin' at me crazy or with my family feelin' like I'm not accepted to them and I have to fit their standards of what should be the perfect son and boy. In my family if you cry, you cry. But don't cry for unnecessary things. Growing up in a Black family or an area like Richmond, not many people were very accepting of the LGBTQ [community] or just being them self, but as I got older, I tend to notice most of my friends that were out and about like being LGBTQ. Everybody was cool with them. And I'm just like, a few minutes ago people didn't care and now people are cool with it. And it's a big change, and I'm happy about that I really am. Like I'm happy that people are really accepting people for who them are and love is love no matter what."

On the importance of chosen family:
"...For me, I have a household of five sisters. I'm the baby of the family so I never had a brother or like another male that was my age to hang out with on a constant basis. …having a chosen family especially for me, like Marques. Even though we're not blood related, he is my whole brother. I treat him like he's my whole brother; He's the brother that I never had that I always wanted...He's one of the few straight males that are Black that don't care...who I am as a person and who he is as a person he just don't pay close attention to every particular detail"

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PREVENTION & EARLY INTERVENTION
SEMI-ANNUAL REPORTING FORM

FISCAL YEAR: 2018-2019

Reporting Period: Please Select One
☐ Semi-Annual Report #1 (July – Dec)
☒ Semi-Annual Report #2 (Jan – June)

Agency:	**STAND! For Families Free of Violence**	**Project:**	9

SERVICE PLAN:

Briefly *summarize the Scope of Services as outlined in the Service Work Plan. What did you set out to accomplish?*

For the Fiscal Year 2018-2019 we plan to:

1. Deliver the "You Never Win with Violence" presentations to 500 middle and high school youth in Contra Costa County.
2. Deliver informational presentations to 100 school personnel, service providers and parents on the effects and causes of teen dating violence, including bullying and sexual harassment to increase knowledge and awareness of healthy relationships.
3. Provide secondary prevention activities to 200 youth experiencing, or at risk for teen dating violence.
4. Conduct sixteen (16) gender-based support groups that are fifteen (15) weeks long.

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SERVICES PROVIDED / ACTIVITIES:

Please describe the services you provided in the past reporting period. Please include procedures re: referrals and follow up. Attach case vignettes and any material that documents your work as you see fit.

1. You Never Win with Violence: 1,730 participants served in 70 presentations. **Goal exceeded.**
2. Expect Respect and Promoting Gender Respect Support Groups: 252 participants and 24 groups served. **Goal exceeded.**
3. Twenty-four (24) gender-based support groups that are 10 weeks long each. Goal **Partially achieved.**
4. Adult Allies: 35 teachers and other school personnel trained. Goal **Partially achieved.** (See attached evaluation report)

OUTCOMES, MEASURES OF SUCCESS, DEMOGRAPHIC DATA:

Please provide quantitative data re: your services.

- *For report #1 (half-year report, Jan 15): numbers served year-to-date.*
- *For report # 2 (year-end report, July 15) please include*
  - *a) **year-to-date** demographic information for clients served (see demographic form).*
  - *b) Report on measures of success indicators as defined in Service Work Plan (see separate form)*
  - *c) Narrative of Outcomes*
  - *d) (See evaluation attachment A through H)*

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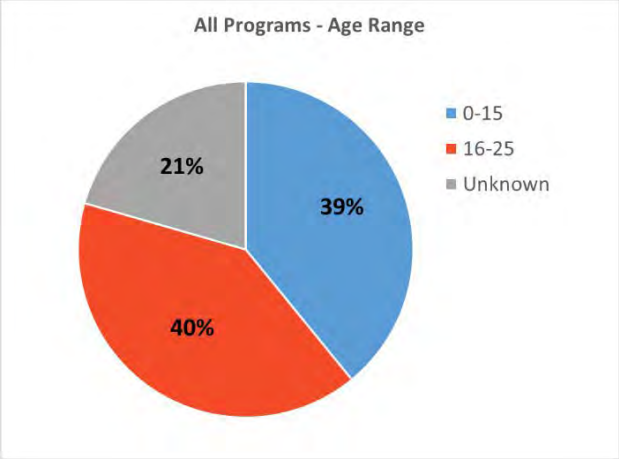
All STAND! Prevention Programs:

Total Clients Served:

We have served a total of **1,903** clients through all our Prevention programs throughout the Fiscal Year.

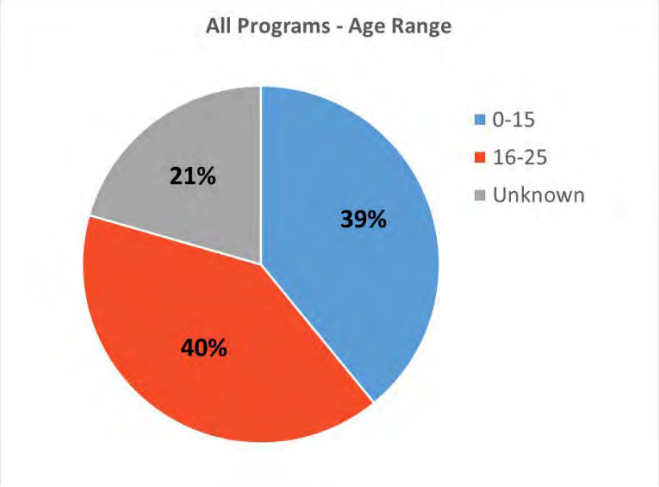
Gender:

Male Identified: 913 clients; Female Identified: 924 clients; Transgender: 9 clients; Unknown/Unreported: 57 clients.



Age:

0-15: 744 participants; 16 – 25: 768 participants; Unknown/Unreported: 391 participants



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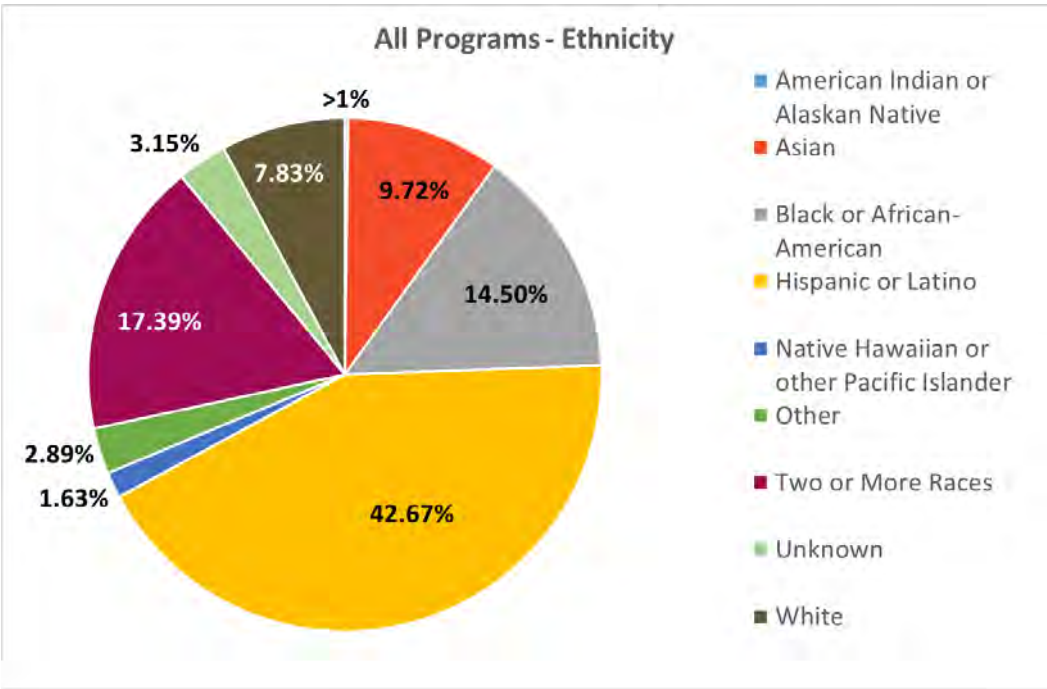
Ethnicity:

African American/Black: 276 participants; American Indian/Alaska Native: 4 participants; Asian: 185 participants; Native Hawaiian/Pacific Islander: 31 participants; Caucasian/White: 149 participants; Hispanic/Latino: 812 participants; Other: 55 participants; Multi-racial: 331 participants; Unknown/Unreported: 60 participants



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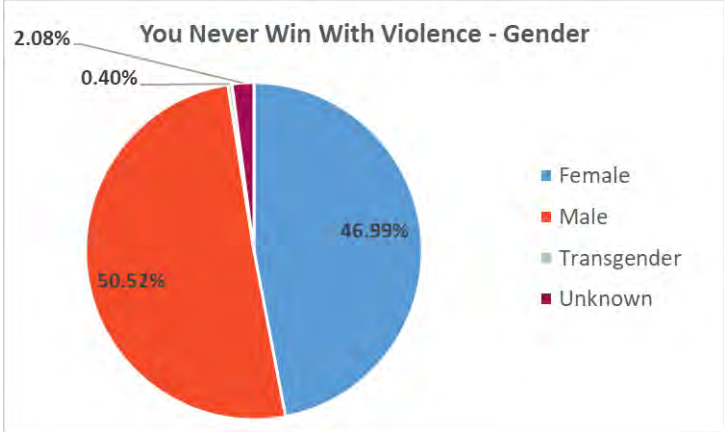
"You Never Win with Violence" and You Never Win with Sexual harassment combined Presentations:

Total Youth Served

We have served a total of **1,730** youth through our YNWWV presentations this Fiscal Year.

Gender

Male Identified: 874 participants; Female Identified: 813 participants; Transgender: 7 participants; Unknown/Unreported: 36 participants



Ages

0-15: 713 participants; 16-25: 644 participants; Unknown/Unreported: 373 participants

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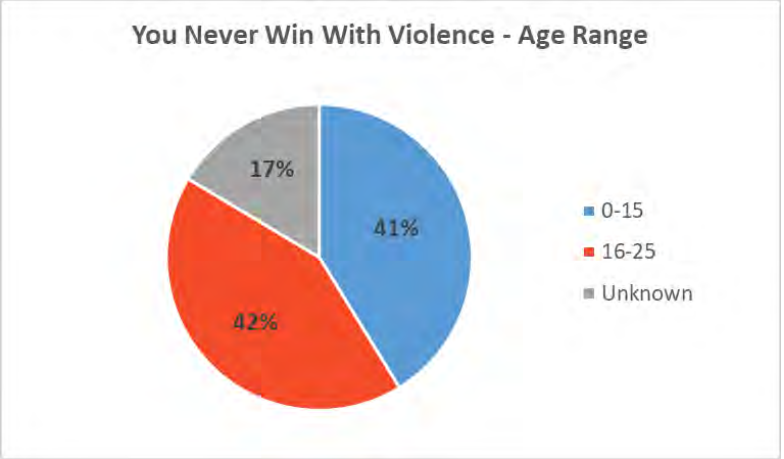

Race/Ethnicity

African American/Black: 246 participants; American Indian/Alaska Native: 4 participants; Asian: 174 participants; Native Hawaiian/Pacific Islander: 27 participants; Caucasian/White: 140 participants; Hispanic/Latino: 772 participants; Other: 53 participants; Multi-racial: 290 participants; Unknown/Unreported: 24 participants

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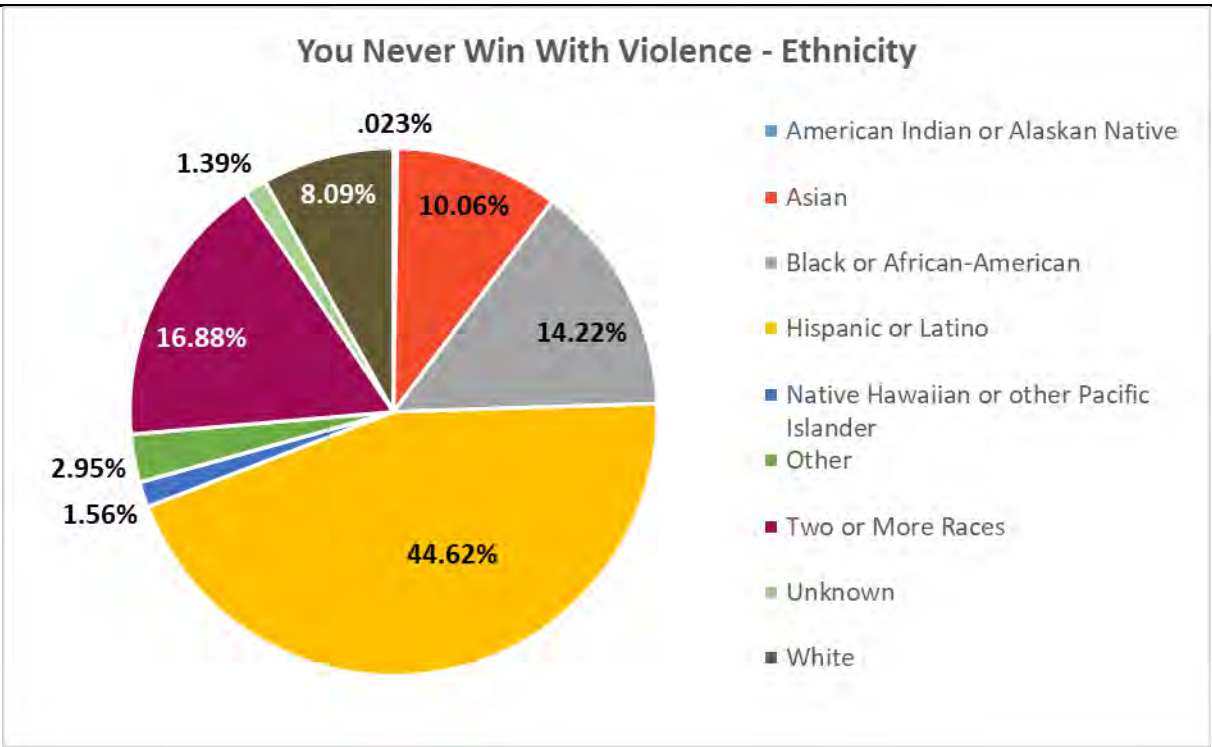

Summary

This year, we served **1,730** students, surpassing our goal of 500 students and resulting in total compliance with this goal. We provided 70 in class workshops throughout West and East Contra Costa County. Our team provided 38 workshops in West County, and 32 workshops in East County. This included reaching most of the Antioch High's Freshman class for the second year in a row. We provided most of our workshops in East County at Pittsburg High. Since Pittsburg High, unlike our West County partners, does not have a health center, we relied entirely on staff contacts and cooperation to schedule workshop presentations. A select number of staff at Pittsburg High have become great resources and on campus support for our team – letting us provide workshops in their classes, providing referrals and even providing us classroom space to conduct our support groups. Throughout the County, our team was able to provide these services with limited staffing and despite significant delays in the contract process with WCCUSD.

The YNWWV workshops continue to be the most successful source of sign-ups for support groups as well as an entry point to a cluster of services offered at STAND! and at each respective school. By

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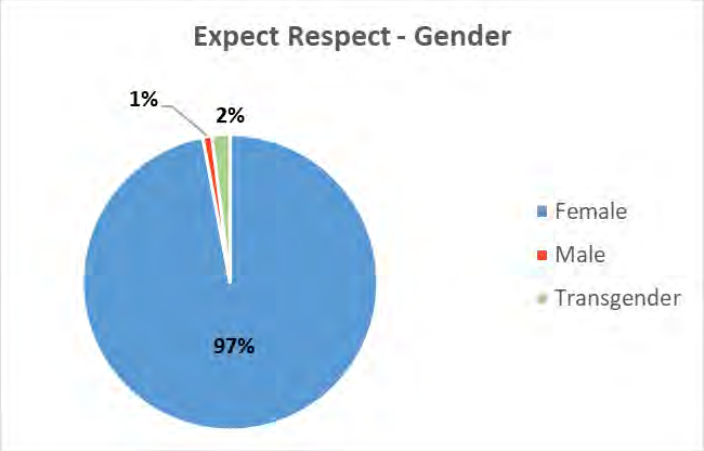
highlighting support groups, crisis line access, and other on-campus services we discretely and safely promoted supportive services. Workshops were also the entry point to accessing intervention services as we had multiple instances where youth asked for advice or reported sexual abuse, sexual harassment, teen dating violence, or domestic violence following a workshop. This year, after a workshop presentation, our prevention staff were approached by a student who thought they might be in an abusive relationship. Our staff were able to meet with her individually in the health center to provide emotional support, safety planning and ultimately assist them to safely leave this unhealthy relationship. Through this interaction and the subsequent follow ups, this youth also enrolled in one of our semester long support groups where they were able to receive continual services, peer support and continue in their journey towards healing.

Expect Respect Total Youth Served

We have served a total of **101** youth through **13** Expect Respect support groups this Fiscal Year.

Gender

Female Identified: 98 participants; Male Identified: 1 participant; Transgender: 2 participants; Unknown/Unreported: 0 participants



Ages

0-15: 29 participants

Unknown/Unreported: 43 participants

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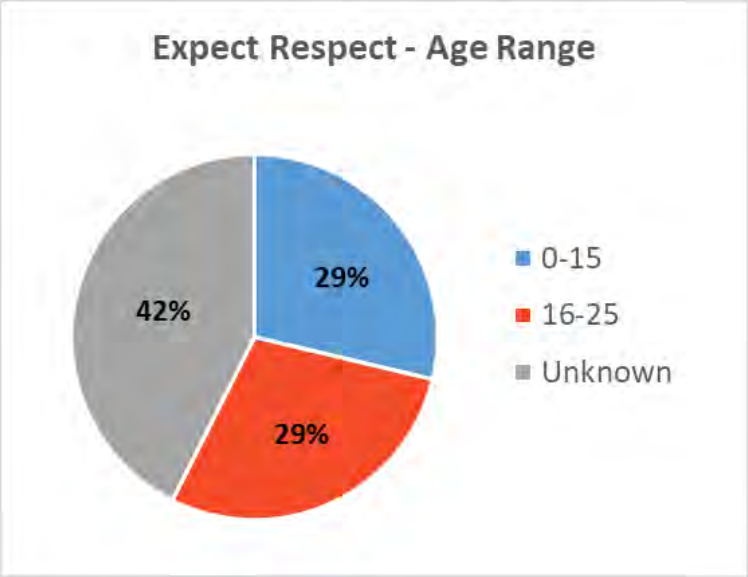

Race/Ethnicity

African American/Black: 22 participants; American Indian/Alaska Native: 0 participants; Asian: 6 participants: Native Hawaiian/Pacific Islander: 3 participants; Caucasian/White: 9 participants; Hispanic/Latino: 30 participants; Other: 0 participants; Multiracial: 31 participants; Unknown/Not reported: 0 participants

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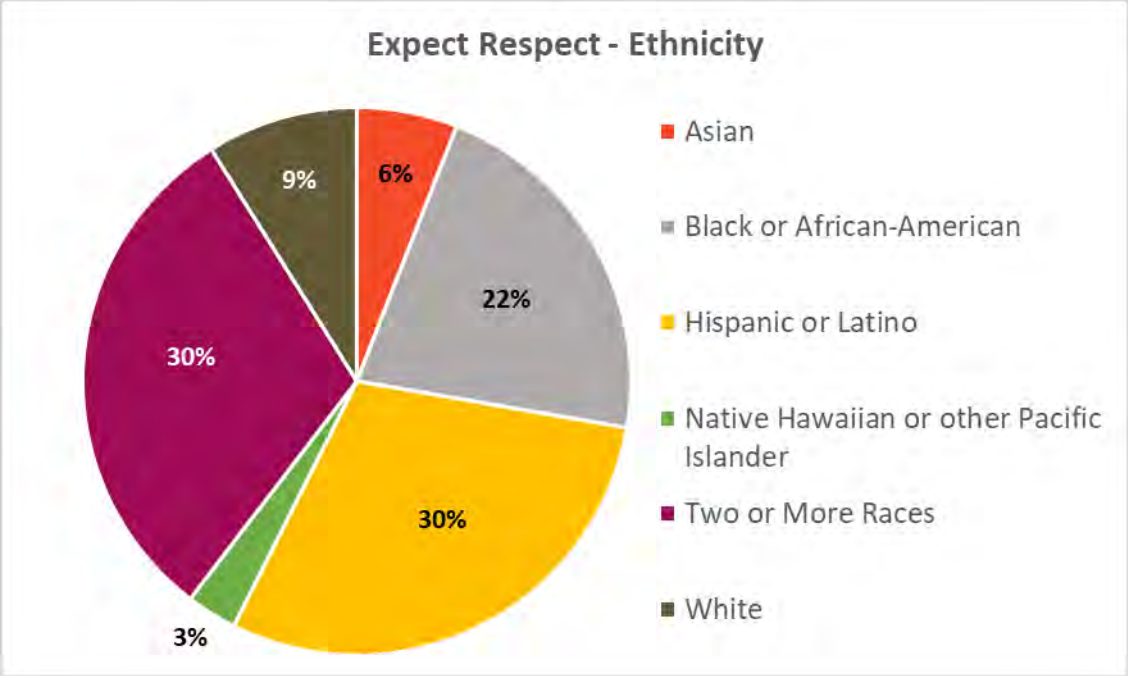

Summary

Our Expect Respect groups served **101** participants in **13** different support groups during this Fiscal Year. When combined with our Promoting Gender Respect Support groups (**151** participants and **11** support groups), which are geared towards male identifying youth, we surpassed our goal of providing 200 gender-based participants, with a total of **252** group participants and **24** support groups. When focusing solely on Expect Respect, we did provide services to less participants than in previous year primarily because there was a staff vacancy with only one remaining facilitator to serve our female-identifying youth. This staff member is also responsible for co-delivering workshops among other direct service efforts. The combination of WCCUSD contract delays and lack of infrastructure in many east county schools (lacking health centers or no full-service community schools) were also factors that reduced our participant numbers this year.

Despite these challenges, we continued to find that smaller support groups are far more effective than previous years' larger groups, thus creating a more intimate forum for youth to learn and share. Smaller groups (10 participants or less) allowed for more natural rapport building and trust.

This year we also found that STAND!'s consistent presence on campuses throughout the County has helped improve external and peer referrals to our programs more than in previous years. In West County Schools, we have been receiving increasing numbers of referrals to our programs than in

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previous years. At De Anza High for example, we had an equal number of students sign up for support groups during our workshop presentations as we had referrals through the health center. These referrals help us provide services to students who might not reach us during our classroom presentations, and signal that health center and school staff have an increased understanding of the services and support that STAND! provides.

Additionally, more and more students on campus recognize our staff and services and are either self-referring to our group or recommending their friends to our services. In one instance, a student who had seen our workshop presentation two semesters previously was in an unhealthy relationship and in need of support. They were able to access their health center and ask to speak with somebody from STAND! That student was then enrolled in a Expect Respect support group where they were a highly active participant and was provided one on one counseling for emotional support, safety planning, and other supportive services. Ultimately, they successfully and safely left their unhealthy relationship.

We are particularly proud of these developments, however subtle, because they signify the continual integration of our agency and our services into school and student culture. We hope that our continued presence and increased recognition on campuses throughout the County will assist us in reaching more and more students who might otherwise be overlooked if left to the traditional pathways to service.

Expect Respect PRE/POST Survey Results

In total, 87 Expect Respect students completed their PRE and POST surveys this Fiscal Year.

Students were surveyed on their general knowledge of the forms and dynamics of abusive relationships. Of the 87 students who completed both surveys **86%** showed improvement or mastery of the subject.

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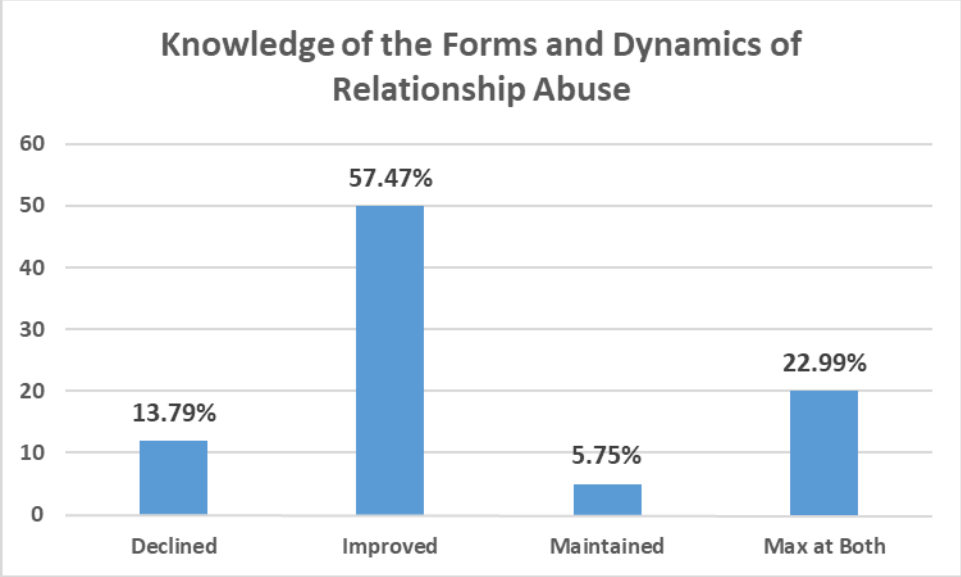
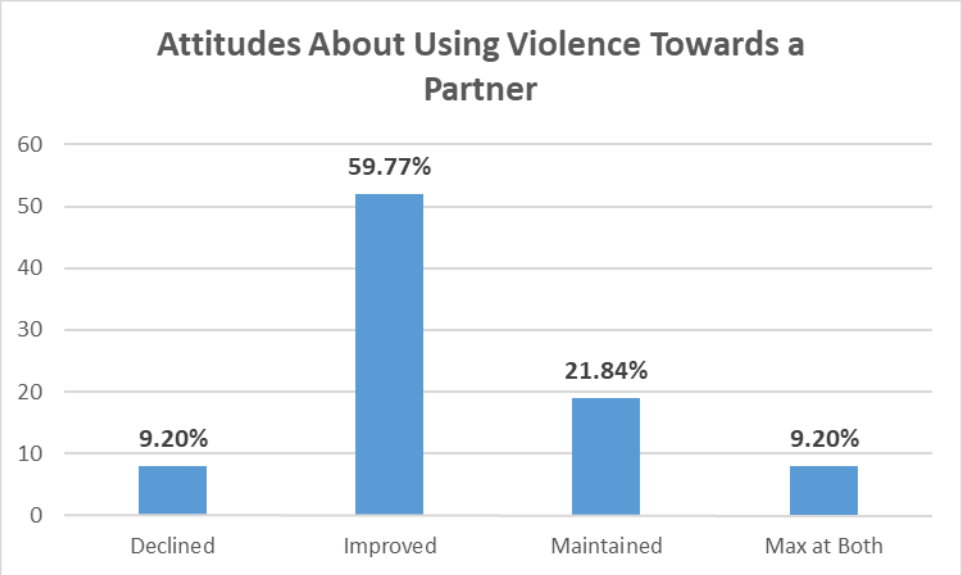


Students were also surveyed on their attitudes about using violence or abuse towards a dating partner. Of the 87 students who completed both surveys **91%** showed improvement or mastery of the subject.



Promoting Gender Respect:

Total Youth Served:

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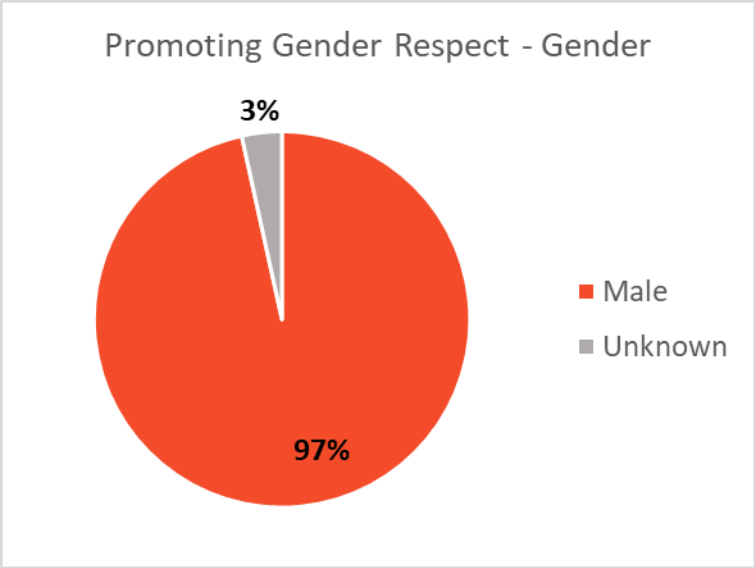
We have served **151** students through **11** Promoting Gender Respect groups this Fiscal Year. **

Gender:

Male Identified: 150 participants; Female Identified: 0 participants; Transgender: 0 participants; Unknown/Unreported: 1 participant.



Age:

0 -15: 2 participants; 16 – 25: 1 participant; Unknown/Unreported: 148 participants.

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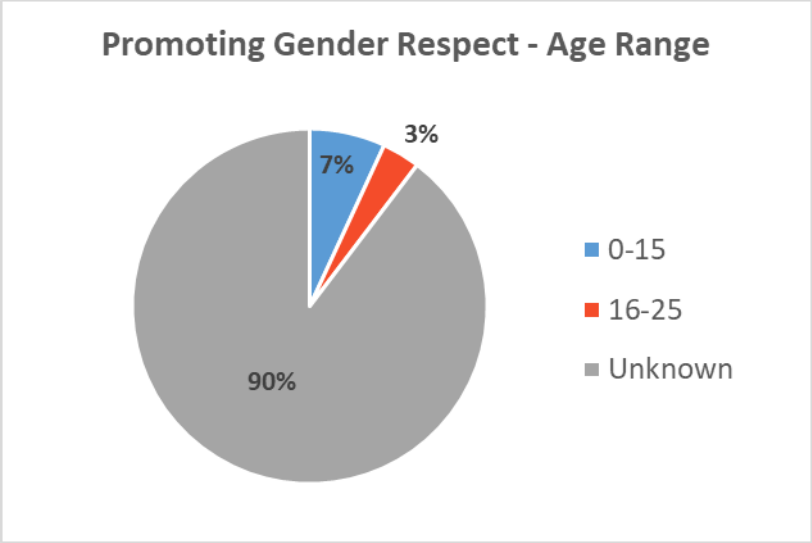
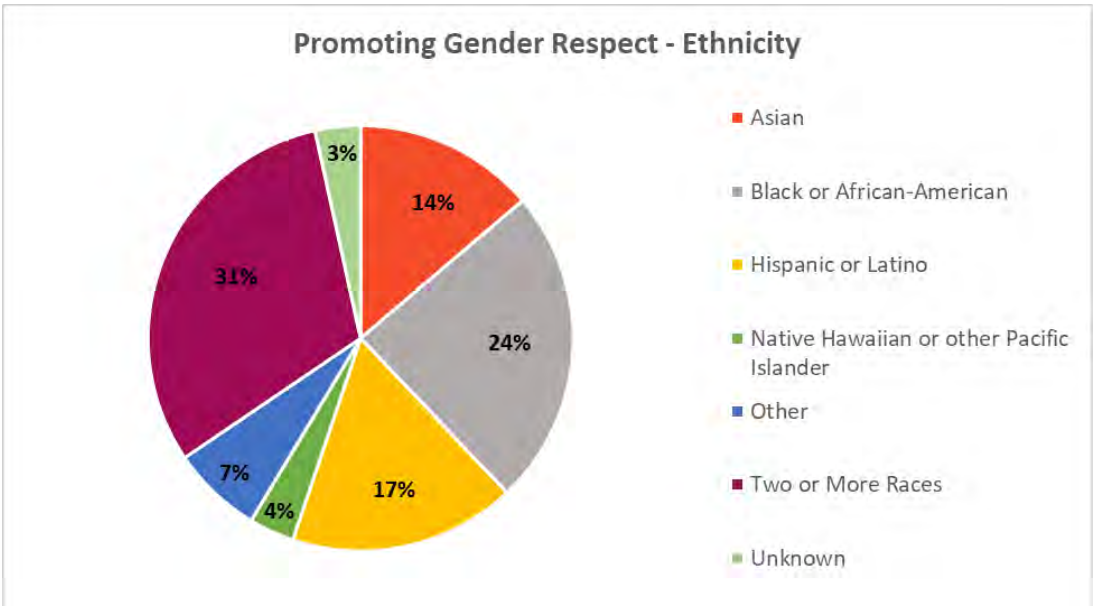


Race/Ethnicity:

African American/Black: 37 participants; American Indian/Alaska Native: 0 participants; Asian: 21 participants: Native Hawaiian/Pacific Islander: 6 participants; Caucasian/White: 0 participants; Hispanic/Latino: 25.5 participants; Other: 10.5 participants; Multiracial: 46.5 participants; Unknown/Not reported: 4.5 participant



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Promoting Gender Respect PRE/POST Survey

Promoting Gender Respect PRE/POST		
Adults at my school teach students how to respect each other	**14.63%**	Improved
Bullying behaviors like name calling, physical fighting, etc. can lead to teen dating violence.	**27.50%**	Improved
Girls always have the right to say no to any sexual activity.	**-1.79%**	Decline
I believe I can prevent teen dating violence.	**5.26%**	Improved
I feel fine telling a boy that it's not ok to hurt girls.	**19.05%**	Improved
If I heard a boy call his girlfriend a name, I would tell him it isn't cool to do that.	**0.00%**	No Change
If I saw a girl hit a boy abusively, I would tell an adult.	**6.98%**	Improved
If I saw a girl yelling at a boy or calling him names, I would try to help him.	**2.00%**	Improved
If I see a boy being bullied by a girl, I would try to stop her.	**15.63%**	Improved
If I see a girl being bullied by a boy, I would try to stop him.	**1.89%**	Improved
I know where I can find help/info on teen dating violence and /or sexual assault.	**25.53%**	Improved
I learned about healthy relationships in middle of school.	**22.86%**	Improved
I would speak out if I knew someone was in an unhealthy relationship.	**13.33%**	Improved
This program will make me a better leader.	**10.20%**	Improved

Summary

In total, **151** students participated in PGR groups. This total combined with the ER total of **101** group participants, provided gender-based support group services to **252** participants. However only **29** PGR in **3** groups students completed their PRE and POST surveys this Fiscal Year. **

These students were surveyed on their attitudes towards relationship abuse, gender norms, campus culture and more. We are most proud to see significant improvement in student's knowledge of where to seek supportive services, with **25%** of those surveyed showing improvement. Additionally, we can see improvement in bystander intervention with **19%** of students stating that they would "tell a boy that it's not ok to hurt girls". Overall, we saw improvements in all but one category.

****(Please note that all 252 participants completed the pre/post survey and were entered in the database; however due to technical difficulties with our database, not all participant survey data is available. We note that we captured our YTD and PGR numbers by manually counting our sign-in rosters for group.*

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Adult Presentations:

Total Clients Served:

We provided trainings to **35** adults through a total of 17 presentations during the fiscal year. This resulted in partial compliance of 35%.

Gender

Male Identified: 8 participants; Female Identified: 7 participants; Unknown/Unreported: 20 participants.

Ages

0-15: 0 participants; 16-25: 0 participants; 26-59: 16 participants; 60+: 4 participants; Unknown/Unreported: 15 participants

Race/Ethnicity

African American/Black: 4 participants; American Indian/Alaska Native: 0 participants; Asian: 0 participants; Caucasian/White:8 participants; Hispanic/Latino: 4 participants; Native Hawaiian/Pacific Islander: 0 participants; Other: 2 participants; Multi-racial: 2 participants; Unknown/Unreported: 15 participants

We served a total of **35** adults through a total of **17** trainings and presentations throughout the fiscal year. 15 of those adults were served through our You Never Win with Violence Presentations. During each presentation, the teacher was present in their classroom and was able to participate, contribute and learn about teen dating violence. In many cases, those teachers have become valuable resources on campus – allowing us to use their classroom for group space and referring students to our groups.

Adults were also reached through trainings run at Pittsburg High aimed to teach school staff about trauma informed practices within school environments.

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Additionally, staff trainings were offered on various occasions to health center and school staff but did not take place due to lack of staff interest and/or lack of time for presentations. Our pre/post surveys were not completed by school staff during these trainings and presentations.

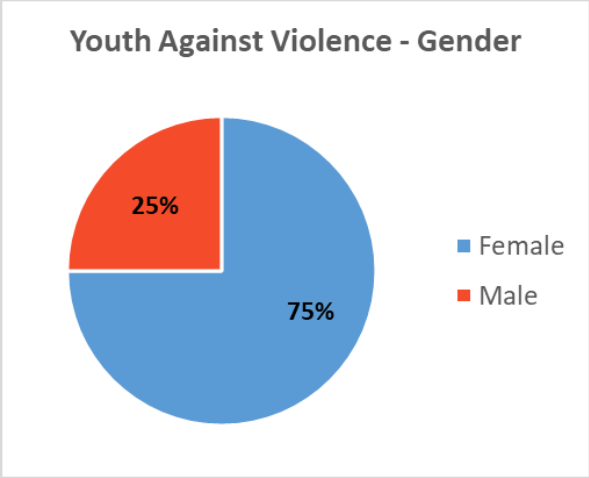
Youth Leadership:

Total Youth Served:

We trained 8 new Youth Against Violence Leaders during the Fiscal Year.

Gender

Male Identified: 2 participants; Female Identified: 6 participants



Ages

0-15: 0 participants; **16-25**: 5 participants; Unknown/Unreported: 3 participants

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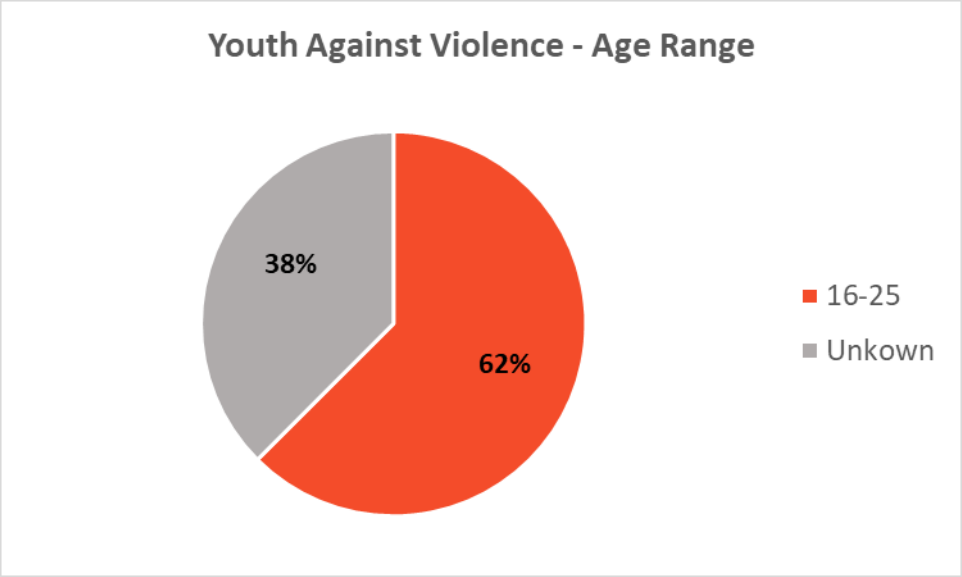
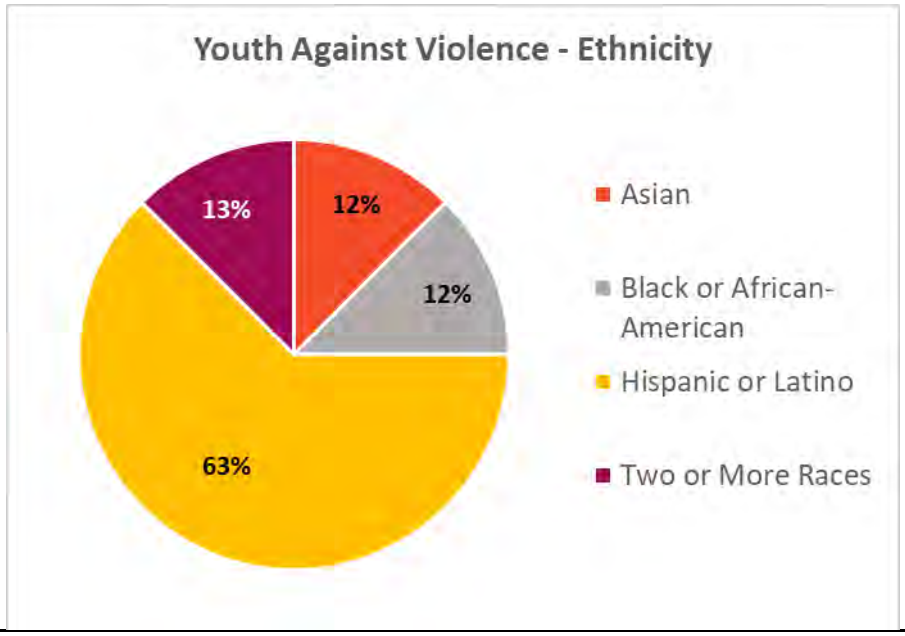


Race/Ethnicity

African American/Black: 1 participant; American Indian/Alaska Native: 0 participants; Asian: 1 participant; Caucasian/White: 0 participants; Hispanic/Latino: 5 participants; Native Hawaiian/Pacific Islander: 0 participants; Other: 0 participants; Multiracial: 1 participant; Unknown/Unreported: 0 participants



CONTRA COSTA HEALTH SERVICES

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Summary:

During the summer of 2018, eight new YAV members were trained in varying levels of leadership (peer presenter trainees, peer facilitator trainees, and community mobilizers.) This summer we had two male and six female youth join our youth leadership training program. All eight participated in our in-class support groups. Youth leaders received training on peer support, community organizing, and awareness campaigning. Our youth leaders were able to visit other domestic violence and advocacy organizations throughout Northern California. These included La Casa de Las Madres and the Women's Building in San Francisco, and CALCASA and the California Partnership to End Domestic Violence in Sacramento. Additionally, the youth leaders visited the Contra Costa animal shelter to highlight the intersections of animal abuse and domestic violence. This led to a social media pet adoption campaign. Throughout the school year, we retained two previous youth leaders who joined our eight new leaders in their year-long work. Five of our previous youth leaders graduated high school the previous spring and are currently attending college.

During Teen Dating Violence Awareness Month (TDVAM) in February, our YAV leaders conducted an awareness campaign titled "Happiness over Relationship History. Our youth leaders created personalized wristbands to give away at school on two specific days – February 12th which is nationally recognized as "Orange Day" for teen dating violence awareness and February 14th for Valentine's Day. On both days, our youth leaders not only gave away over 1400 wristbands and accompanying information cards to their peers, but also got them to write down their own definitions of a healthy relationship. In addition, they created "healthy relationship" valentines goodie bags to give away. (See attached pictures). On each campus, our youth leaders reached out to health center staff, teachers, peers, on campus police officers, morning announcements, clubs and more to spread awareness of their campaign and their message. Following up on their on campus outreach, our youth leaders created a short video (please see link to view) to summarize their campaign and continue sharing their message of "Happiness over Relationship History".

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We were also able to bring this campaign to Pittsburg and Antioch High, two schools where we do not have active youth leaders. There, in addition to our youth led campaign, we were able to bring Teen Dating Violence trivia to youth during lunch time outreach activities.

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FUTURE PLANNING / ADJUSTMENTS:

Reflections on your work: How does it measure up to your goals and the needs of the community? Are you planning any revisions? Lessons learned.

You Never Win with Violence-

We have exceeded our goal of reaching 500 youth. We reached 1730 youth during this Fiscal Year. The presentations were a crucial opportunity for youth to opt into supportive services. Additionally, these workshops afforded us an opportunity to provide secondary follow up services on site. Such was the case for Antioch High. We plan to continue to offer workshops as an entry point to support groups and other comprehensive services.

Expect Respect

We were able to conduct four groups at Pittsburg High School and have re-engaged our Middle School partners in WCCUSD. By working with East County high schools and with WCCUSD middle schools we have expanded our reach to youth that otherwise might not be acknowledged. Smaller groups (10 or less participants) also proved to be much more manageable. In order to travel to various parts of the county and provide support groups, we will have to reduce the overall goal for the number of participants in anticipation of the effort involved in coordinating services at under-resourced schools.

Gender -based Support Groups-

Promoting Gender Respect (PGR) support groups compliment the Expect Respect support groups, making the total count of 252 participants and 24 groups receiving secondary supportive services. PGR targets boys, whereas the Expect respect targets girls. However, participants of any gender can attend both or either group. We will continue to offer these groups, which are effective in discouraging teen dating violence and sexual harassment.

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Adult Presentations-

We did not meet our goal of adult allies trained this year. We trained 35 school personnel. Our school partner's limited availability for hour-long presentations is a challenge for this goal. However, we did a substantial amount of outreach and individual support to adult allies. Outreach and informal information sharing have long been a successful way to provide adults with tools to help youth at-risk or experiencing Teen Dating Violence. Perhaps these efforts as opposed to formal trainings ought to be our measure of success in the upcoming year.

Youth Leadership-

We trained 8 new youth who volunteered during the school year. These new leaders and our five recurring leaders provided critical youth representation in our programs. This cohort spearheaded our Teen Dating Violence awareness campaign and they met bimonthly to execute their year of volunteerism. Their energy and innovative ideas enhanced the outreach and presentations, giving our activities a youthful presence and credibility with the students.

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PEI ANNUAL REPORTING FORM

PREVENTION REPORTING FORM **FISCAL YEAR: 2018-2019**

Agency/Program Name: Vicente Martinez High School

Reporting Period (Select One): ☐Semi-Annual Report #1 (July – Dec)
X Semi-Annual Report #2 (Jan – June)

PEI STRATEGIES:

Please check all strategies that your program employs:

X Provide access and linkage to mental health care

X Improve timely access to mental health services for underserved populations

X Use strategies that are non-stigmatizing and non-discriminatory

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SERVICES PROVIDED / ACTIVITIES:

Please describe the services you provided in the past reporting period. Please include types of problems/needs addressed, any activities that address these problems/needs, and any functional outcomes targeted by the services provided.

The PEI program at Vicente Martinez High School and Briones School is an integrated mental health focused learning experience for 10th-12th grade at-risk students of all cultural backgrounds. The program is facilitated by MUSD and in partnership with NLC within a unique partnership between Martinez Unified School District (MUSD) and the a 503c3, New Leaf Collaborative (NLC) to assist Contra Costa Mental Health in implementing the Mental Health Services Act (MHSA) Prevention and Early Intervention Program. Together we provide 10th-12th grade at-risk students a variety of experiential and leadership opportunities that support social, emotional and behavioral health, career exposure and academic growth while also encouraging, linking and increasing student access to direct mental health services.

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Key services include student activities that support:

1. Individualized learning plans
2. Mindfulness and stress management interventions
3. Team and community building
4. Character, leadership and asset development
5. Place-based learning, service projects that promote hands-on learning, ecological literacy and intergenerational relationships
6. Career-focused preparation and internships
7. Direct mental health counseling

Services support achievement of a high school diploma, transferable career skills, college readiness, post-secondary training and enrollment, democratic participation, social and emotional literacy and mental/behavioral health. PEI services are provided by credentialed teachers and an administrator, qualified office staff, marriage family therapists, a Pupil Personal Services credentialed academic counselor, an internship coordinator, peer mentor, environmental educator and other independently contracted service providers. All students also have access to licensed Mental Health Counselors for individual and group counseling.

All students enrolled in Vicente and Briones have access to the variety of PEI intervention services through in-school choices that meet their individual learning goals. Students sometimes switch between Vicente and Briones schools at different points in the school year. Mental health and social emotional activities and services are offered to all students at both schools and are deeply integrated into the Vicente school day. Data is collected for all students who participate in these programs no matter which school they attend, but demographics and statistics are based upon Vicente total enrollment.

This year the PEI program continued providing students experiential opportunities that fostered a strong sense of positive, personal identity, leadership skills and intergenerational connection to the community and place that they live. These opportunities provided students an alternative to a traditional high school education while they continue to make progress toward earning the necessary credits for an accredited high school diploma. Experiences that enriched the curricula are presented below in the following categories:

- Service Learning
- Team-based Projects
- Career-Focused Internships
- Mental Health Focus
- Leadership Development
- Academic Skills Development
- College and Careers
- Outdoor Appreciation and Field Trips
- Teacher Professional Development
- Outreach

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Service Learning:
Students continue to be involved in short-term, one-day service learning opportunities and team-based, hands-on, service-learning projects that benefit the local community and environment.

Career-Focused Internships:
The internship program continues to be an increasingly important and valuable tool in our efforts to prepare students for rewarding and successful futures as individuals, citizens and community members. To ensure the success of the internships and the growth of the interns, interns learn, present and are evaluated through a series of tiered experiences designed to prepare them for future college and career opportunities. The internship coordinator continues to organize the internships in partnership with community professionals. Academic support is provided by the Vicente teaching staff.

Mental Health Focus:
Students continue to participate in holistic health activities and seminars that support their emotional, social and academic health.

Leadership Development:
Students continue to participate in leadership programs and mentorships that support students needing increased academic or emotional skill development.

Academic Skills Development:
Students continue to receive academic instruction and support from teachers/contracted service providers through integrated, project-based curriculum, specific academic skills instruction and individualized, differentiated instruction.

College and Careers:
Students continue to be exposed to a variety of careers and colleges through guest speakers, introduction to internship seminars and field trips in order to help them prepare for a successful transition into independent adulthood.

Outdoor Appreciation Activities and Field Trips:
Students continue to be exposed to nature and being outdoors in ways that promote a healthy connection to the natural world and encourage students to utilize natural resources to promote environmental and community health. Nature and gardening are also used as a stress management tool and healing agent.

Teacher Professional Development:
Teachers continue to attend professional development opportunities to increase knowledge about supporting at-risk students.

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Outreach:
Vicente Martinez High School continues to advertise the program and to inform the public about the educational opportunities that the school offers for at-risk students and to dispel misconceptions about the school and the population who attend the school. This year Vicente had a waiting list of students wanting to attend due to the focus that is placed on mental and social emotional wellness.

Vicente/Briones staff and outside service providers have worked cooperatively to continue to create opportunities for all students to develop academically, socially, emotionally and mentally through participation in hands-on, place-based learning and experiential projects. Currently, all Vicente teachers and staff are actively engaged in supporting and implementing PEI program services.

In addition, New Leaf Collaborative (NLC) provided two employees working at Vicente/Briones to support the expanding PEI program. They have worked closely with the principal, teachers, counselors and coordinating partners to best fuse the program offerings together.

During the 2018-19 school year a Memorandum of Understanding (MOU) was signed into agreement between MUSD and NLC for PEI services. In short, the two organizations:

1) Continue to provide a variety of services to all students;
2) Continue to encourage a collaborative culture between New Leaf Collaborative staff and Vicente staff;
3) Continue to develop NLC's 501c3 structure to support the implementation of the PEI program and to provide the protocols and agreements necessary to support the differentiation of PEI responsibilities between NLC and MUSD.

Overall Summary of Services:
Throughout the 2018-19 school year the Vicente/Briones staff and New Leaf Collaborative staff organized and hosted over 70 different types of activities and events. Experiences that were found to enrich the curricula are presented below in the following categories: Service Learning, Career-Focused Internships, Mental Health Focus, College and Careers, Career Pathways, Outdoor Appreciation, Academic Support, Student Leadership Development, Teacher Professional Development and Outreach.

Of the 125 students who were enrolled at Vicente over the course of the school year, 97% of the student body or 121 students participated in PEI activities. Students participated in an average of seven different services per individual over the course of the year.

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Service Learning:
One of our PEI fundamental values is Service. To that end, staff place great emphasis upon student participation in service learning opportunities. Vicente and Briones require seniors to volunteer for at least 15 hours their final year and many participate in more than that. Students were involved in short-term, one-day service learning opportunities and team-based, hands-on, service-learning projects that benefited the local community and environment. These activities were organized primarily by the New Leaf Collaborative Internship Coordinator and our Mental Health Counselor and were open to all students of Vicente and Briones.

- ***Alameda Food Bank:*** Over the Thanksgiving holiday break, students worked with the Alameda Food Bank to prepare food packages for those in need.

- ***Coastal Clean Up:*** Students attended a beach clean at the local shoreline.

- ***Dia de Los Muertos:*** Students enjoyed volunteering at the Dia de Los Muertos event in downtown Martinez.

- ***Downtown Martinez Clean-up:*** Students volunteered at the annual Downtown City Clean-up Day to remove graffiti, power wash windows and streets, remove trash, weed and prune trees and bushes in the downtown blocks of Martinez. Students reported an increased sense of connection to and pride in their community.

- ***MEF Run:*** Students and staff volunteered at the Martinez Education Foundation Run for Education, which is a fundraiser for Martinez Unified School District schools.

- ***Service-learning guest speakers & presentations:*** Service-learning focused guest speakers shared their experience, passion and expertise with students. Students were positively engaged, asking questions and some of whom committed to participating in various aspects of the speakers' groups.

Career-Focused Internships:
The internship program continued to grow. All students at Vicente and Briones were given the opportunity to apply, interview and participate in these career-focused internships. The New Leaf Collaborative Internship Coordinator and Vicente teachers organized the internships in partnership with community professionals. Internships for the year included:

- ***Culinary Academy:*** Five students participated in a culinary training program hosted and facilitated by Loaves and Fishes. For ten weeks these students went to Loaves and Fishes headquarters in Martinez to learn culinary skills four days a week after school. Training in a state of the art kitchen provided by Loaves and Fishes has inspired some of our students to move forward in this career pathway. Students reported going long hours or entire days without eating in their homes, and since attending the culinary program they've gained skills to make

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food on their own. The five students who participated and completed the program are now certified food handlers. All students have been hired in the hospitality industry and two are considering enrollment in Diablo Valley College's culinary certificate program.

- ***Martinez Early Intervention Preschool Program:*** Three students held internships with MEIPP. For the first semester of the school year, twice per week they were classroom aides in special needs classrooms at our district's pre-school program.

- ***Martinez Teen Police Academy:*** Four students participated in an eight week teen police academy sponsored by Martinez Police Department. They learned about the work of a police officer and had real life experiences such as working with a police dog, going on a ride along and many other experiences.

- ***National Park Service Cultural Landscapes & Phenology Internship:*** Students were hired for this internship working with an NPS at the John Muir National Historic Site.

- ***Career and Internship Focused Guest Speakers:*** There were a variety of guest speakers throughout the school year.

Mental Health Focus:
All Vicente, Briones and New Leaf Collaborative staff seek to infuse a social emotional and mental health focus into every aspect of each student's experience. Students participate in holistic health activities and seminars that support their emotional, social and academic health. This school year we had two full time mental health counselors on campus daily. When once students were resistant to participating in mental health counseling, now it is the norm among our students. We also had a peer mentor who was a Briones graduate. She also served as our environmental educator.

- ***Basketball Club:*** One of our mental health counselors worked with small groups of our at-risk boys on the basketball court, mixing mental health counseling with athletics and exercise.

- ***Briones Book Club:*** Our mental health counselor created a book club for our independent study students. The students meet weekly to interact and socialize since independent study school can be isolating.

- ***COPE Family Support Services:*** Mid-year, Vicente contacted with COPE Family Support Services. A clinical case manager was on campus four days per week to provide individual counseling, workshops to augment individual counseling, parent coaching and workshops.

- ***Feet First:*** Thanks to a generous donor, a group of our students participated in Feet First through the local FightKore gym. This program promotes discipline, self-awareness, empathy and self-control while building self-confidence and increasing focus.

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- ***Girls' Groups:*** One of our mental health counselors created a Girls Group for each age group: Sophomores, Juniors and Seniors. These groups met weekly to discuss challenges that they were having personally or at school. They also planned some special events to give back to our school community, including a teacher appreciation breakfast and a few spirit days to bring the community together.

- ***Guest Speakers:*** Speakers from Martinez Unified School District presented on their career path and educational experience. Mental Health focused guest speakers included a School Psychologist and Special Needs high school teacher. Various other fields were represented as well.

- ***Lunch & Games Club:*** Before school and at lunch our mental health counselor welcomed students to sit with her and either play board games or get together for lunch. This allowed our students to have group to be a part of and feel a sense of belonging.

- ***MFT Counseling Opportunities:*** Vicente and Briones students have access to individual and group mental health counseling.

- ***Mindful Based Substance Abuse Treatment:*** Our mental health counselor is trained in mindful based substance abuse treatment. Twelve students voluntarily attended this twelve-week group. It was embedded in the school day to draw more students. The group was full, and several other students wished they could have attended. We will be offering this group twice in the coming school year.

- ***NAMI School Workshop:*** Three students attended this workshop to learn how to create a NAMI Club on campus.

- ***Psychology Club:*** Psychology Club met once a week for hour long sessions after school with the mental health counselor. Students created group norms which were reviewed and agreed upon at the beginning of each session. Students were given the opportunity to choose what to learn about along the lines of behavioral health, throughout the year twelve students participated in Psych Club. Topics that were covered in depth included:
    - stigma of mental and behavioral health
    - substance abuse
    - parent child relationships
    - coping strategies

  Allowing students to have a say in what they were learning and using teaching tools they were familiar with created a platform for safe sharing of personal experiences with the content they were learning about simultaneously. Often students had valuable moments of clarity in regard to their past or present experiences. Psychology Club students also took field trips to

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Sacramento to serve on the Mental Health Advisory Workgroup at the California Department of Education that included meeting both the outgoing and incoming State Superintendent. They

were invited to speak at a variety of organizations who were interested in mental health in schools and/or who wanted to learn more. The club also started a weekly pod cast where they would interview professionals in the field of psychology. They also produced a public service announcement about suicide prevention for the Directing Change contest.

- ***Restorative Practices:*** For the second year in a row, Vicente and Briones contracted with Services that Encourage Effective Dialogue and Solutions (SEEDS) for restorative conversations and practices. We began holding restorative circles with students when a wrong needed "righting" and in an effort to remedy challenges on campus instead of turning students away through suspension. Teachers and staff also learned strategies for working with students in the classroom in lieu of sending students to the office.

- ***Sandy Hook Promise:*** Students were trained in the Say Something Program. Students also participated in a variety of Sandy Hook Promise activities that took place throughout the year. The Vicente Psychology Club members were featured in the SAVE Promise Club newsletter.

- ***StrengthsFinder Workshop:*** All Vicente and Briones students and staff completed the Strengths Finder assessment to identify their top five strengths. A Vicente teacher and a certified Strengths Finder facilitator lead eleven workshops through math classes throughout the school year. Students learned about their personal talents and strengths and how to use them in all aspect of their lives. Each participant created and shared a talent map, discussed their strengths with other students and learned how to use their strengths in their personal, academic and professional lives. Seniors included naming their strengths and how they play out in their lives as a part of their senior portfolio and presentations. Staff also engaged in workshops to build professional capacity.

- ***Suicide Prevention:*** A representative from the Contra Costa Crisis Center provided a forty-five minute workshop to all of our students about suicide prevention.

- ***Welcoming Schools Summit:*** Several students attended this summit to learn more about creating an inclusive and accepting school community for LGBTQ students.

Leadership Development:
Many students volunteered for leadership roles in activities and events that were offered.

- ***Get Real Academy:*** A Vicente teacher and counselor took fifteen senior girls to the Get Real Academy. The girls attended various workshops on how to manage their finances, their health, solutions to violence, how to secure a job and insurance.

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- ***Senior Community Service:*** All Vicente and Briones seniors completed a minimum of 15 hours of community service at various events and organizations. Students reported this assignment was pivotal in learning how to work in a professional environment, as well as manage their time.

- ***Teens Tackle Tobacco:*** Ten Vicente students attended this event that took place at UC Berkeley and was hosted by Alameda County Office of Education. Students participated in conversations about tobacco use, presentations about the effects of drug and tobacco on the body and other workshops.

Academic Development:
Students continued to receive common core centered academic instruction and support from their Vicente and Briones teachers. Strategies used included integrated instruction, project/place-based curriculum, specific skill instruction and individualized and differentiated instruction.

- ***Alternative School Setting:*** Vicente Martinez High School and Briones School are both alternative school options. Both schools offer individualized, scaffolded and differentiated instruction, small class sizes, engaging activities, project based learning, skills instruction, on-line courses, self-pacing, flexible scheduling and chunking of instructions and assignments.

- ***History Club:*** Students attended field trips to the Maritime Museum and Rosie the Riveter Museum. These field trips were led by a Vicente teacher who has her master's degree in Museum Studies. Students who attended created presentations for the students who did not attend.

- ***Individual Success Plans:*** Teachers, the academic counselor and principal facilitated weekly appointments with students. Students created goals for academic skills, attendance and self-care. Their ultimate goals were chunked into small weekly goals and adjusted which the student reviewed every Friday.

- ***Multi-Tier System of Support & Response to Intervention:*** Vicente staff met weekly to discuss students of concern and academic progress of students. Staff came up with interventions and supports for each individual student as needed based up their challenges and struggles. The principal developed a shared Google Doc where data was provided on each individual student including attendance, credit accrual and social emotional wellness. Teachers and staff could view the document for insights about each student as well as provide their own comments about what was working for the student.

College and Careers:
Students continued to be exposed to a variety of careers and colleges through guest speakers, introduction to internships, seminars and field trips in order to help them successfully transition to young adulthood.

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- ***College Visits:*** Students had the opportunity to visit and tour Diablo Valley College, UC Davis, Cal State East Bay, Mills College and Chabot College. Diablo Valley College staff visited our campus as well to facilitate a FAFSA Workshop, application workshop and information on summer program offerings.

- ***Concurrent College Enrollment:*** Twelve Vicente students were concurrently enrolled at Diablo Valley College over the course of the school year. Our academic counselor and internship coordinator supported the students who were enrolled by checking in with them weekly. The objective was to provide support for students for them to be able to complete their courses successfully. Discussions took place among students regarding their successes and challenges.

- ***FAFSA Workshop:*** All seniors received a workshop on how to complete and file the Free Application for Federal Student Aid (FAFSA). Most of our students qualify for some level of free assistance for college and most are unaware of this. Once they realize that funding is available this removes the financial obstacle for our students moving on to college.

- ***Internship Coordination*:** The coordinator worked one-on-one with students to develop their resumes, job search, interview tips, volunteer hours and career exploration opportunities. Students have the option to explore individual internships or to join group internships. There were dozens of events and activities throughout the year.

- ***Resume & Cover Letter Workshop:*** In addition to individual appointments with the internship coordinator, students worked in groups to complete their resumes. Support was also given to students to create cover letters for job and internship applications.

- ***Senior Portfolios and Exit Interviews:*** Each senior was required to complete an extensive career portfolio and prepare a written packet and multi-media presentation that then was subsequently presented at an exit interview in front of staff. The internship coordinator supported students with this process and coordinated the presentations.

Outdoor Appreciation Field Trips:
Students continued to enjoy nature and outdoor activities in ways that promoted a healthy connection to the natural world and encouraged them to utilize natural resources for environmental and community health. Students could see that nature is a stress management tool and healing agent.

- ***School Garden:*** Students had opportunities to work in our school garden throughout the school year.

Teacher Professional Development:
Teachers continued to participate and lead professional development opportunities to increase their knowledge about how to better support at-risk students.

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- ***Brief Intervention: An Approach for Substance Using Adolescents:*** Our administrator was trained in this restorative approach and will be implementing it in the coming school year for students who show up to school under the influence of a substance or who are being impacted by substance use.

- ***Restorative Practices:*** Throughout the year, Vicente and Briones contracted with Services that Encourage Effective Dialogue and Solutions (SEEDS) for restorative conversations and practices. We held restorative circles with students when a wrong needed "righting" and in an effort to remedy challenges on campus instead of turning students away through suspension.

- ***StrengthsFinder Workshop:*** All Vicente and Briones students and staff completed the Strengths Finder assessment to identify their top five strengths. Staff worked together to learn how to leverage their talents among their professional peers. A Vicente teacher and a certified Strengths Finder facilitator lead eleven different workshops in math classes throughout the school year. Students learned about their personal talents and strengths and how to use them in all aspect of their lives. Each participant created and shared a talent map, discussed their strengths with other students and learned how to use their strengths in the personal, academic and professional lives.

- ***Training Seminars:*** The Vicente and NLC staff were both trained by the mental health counselor in how to work with at-risk students and conflict management. This was a shared training so there are common responses to students. We also developed universal responses to students around expectations and behaviors which allowed students to know what was expected of them. Teachers and staff were also trained in a variety of child welfare topics, including suicide warning signs and prevention.

Outreach:
Vicente and Briones continued its efforts to promote the program and to inform the public about the PEI opportunities.

- ***Community Events:*** The staff supported the development and student involvement in many community events such as Martinez Run for Education, Earth Day, Dia de Los Muertos, City Clean Up, Kiwanis Club, etc.

- ***Community Organizations:*** The principal and other staff members were invited to present to various groups in our community, such as Kiwanis and Rotary. Vicente hosted the Mental Health Services Act Community Forum. The Vicente-Briones Psychology Club presented to the Martinez Unified School District School Board regarding the mental health services at Vicente-Briones and advocating for services in other schools in the district. Vicente students also presented to the Mental Health Services Act staff, City Council, California Department of Education's Mental Health Workgroup Meetings that included both the outgoing and incoming State Superintendent.

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- ***Mental Wellness Conference:*** Two staff members attended the 2019 California Mental Wellness Conference sponsored by the California Department of Education. They made a presentation entitled: Using Data to Strengthen Your School-Based Mental Health Program.

- ***Model Continuation School Recognition:*** Vicente is a recipient of the Model Continuation High School Recognition through the California Department of Education. The award highlights the mental health focus and other schools have sought guidance from Vicente regarding best practices to support the social emotional growth and development of students.

- ***New Family Orientation:*** The principal meets one-on-one with each family before enrolling a student to orientate the family as to the school program, including the PEI services offered.

- ***Partnerships:*** Staff continued to work in close partnership with National Park Service Park rangers to complete agreed upon partnership goals and items identified in work plan. The Psychology Club worked with Contra Costa Crisis Center to develop a Public Service Announcement regarding their Crisis Line. A Vicente student's art was featured on the Contra Costa Crisis Center posted that was distributed countywide. We continued to work in partnership with Martinez Unified School District personnel and other local organizations to connect to various funding streams to support additional internships and service projects.

- ***Western Association of Schools and Colleges:*** We completed our accreditation process and received another six year term of accreditation. This means that all graduates receive a fully accredited high school diploma.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services.

- ***List of indicators that measured reduction of risk factors and/or increase in protective factors that may lead to improved mental, emotional and relational functioning. Please include how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

The following are our outcome measures of success from the 2018-19 PEI work plan.

Engagement Focus:

- Increase identification of students that have a greater risk of developing a potentially severe mental illness and those who need additional supportive/protective factors.
- Increase engagement of identified Vicente/Briones students in PEI services.

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Engagement Focus Goals:

- At least 70% of enrolling students will receive a) an orientation on program offerings; and b) a self-identified needs assessment targeting risk factors may include, but are not limited to, poverty, ongoing stress, trauma, racism, social inequality, substance abuse, domestic violence, previous mental illness, prolonged isolation.
    - Met. This goal was met at a rate of 95%. The Adverse Childhood Events (ACE) needs assessments showed that Vicente students have an average score of 6. Those with a score of 4 or more are 460% more likely to experience depression and 1220% more likely to attempt suicide.

- At least 85% of identified students will participate in two or more PEI services per quarter that supports their individual learning plan.
    - Met. The average number of PEI activities of those who participated was five.

Short Term Focus:

- Increase timely access and linkage to supportive and mental health service.
- Increase mental health resiliency among Vicente/Briones students.

Short Term Focus Goals:

- At least 85% of students identified as facing risk factors will be referred to supportive services and/or mental health treatment and will participate at least once in referred support service or mental health treatment.
    - Met.

- At least 70% of students participating in two or more services within at least one full semester will report an increase in their Developmental Asset Profile or other risk management tool.

    - Not met. We did not administer the Developmental Asset Profile this year due to shortage in staffing.

Intermediate Focus:

- Increase student ability to overcome social, emotional and academic challenges, by working toward reduction of stigma and discrimination while increasing academic success, vocational awareness relational vitality and the ability to set and achieve other life goals.
- Increase faculty's ability to facilitate agreed upon community practice-based standards of prevention to better ensure an increase of protective factors**.**

Intermediate Focus Goals:

- At least 70% of students who participate in four or more services and who have had chronic absenteeism will increase their attendance rate by 5% as measured at the end of the school year.
    - Met.

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- At least 70% of students who participated in four or more services and who regularly participated in mental health counseling will earn 100% of the expected grade level credits as measured at the end of the school year.
    - Met.

Measurement/Evaluation Tools

1. ACE Assessment
2. Individual Success and Achievement Plan (developed by teacher, internship coordinator and mental health counselor)
3. AERIES (school database) – Attendance, credit accrual and disciplinary data
4. Multi-Tier System of Support Google Spreadsheets
5. Stages of Leadership Character Traits Evaluation Forms
6. Student Work Samples
7. California Healthy Kids Survey
8. Brief Mood Survey

DEMOGRAPHIC DATA: X Not Applicable ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

Not applicable, using county form.

EVIDENCE-BASED OR PROMISING PRACTICES:

What evidence-based, promising practice, or community practice based standard is used in your program and how is fidelity to the practice ensured?

ACE Survey: ACE stands for Adverse Childhood Events. The ACE questionnaire is scored 0-10 based on how many adverse events were experienced before the age of 18. The areas are physical, emotional sexual abuse; physical and emotional neglect; and household dysfunction including mental illness, divorce, incarcerated relative, substance abuse and mental illness.

Brief Mood Survey: Students take this survey before and after counseling sessions to determine if the counseling session eliminated risk factors. Our post counseling session statistics this year include: a 61% decrease in depression, a 65% reduction in anxiety, a 70% reduction in anger and a 100% decrease in suicidality.

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California Healthy Kids Survey: The California Healthy Kids Survey (CHKS) is the largest statewide survey of resiliency, protective factors, risk behaviors and school climate in the nation. Across California the CHKS has led to a better understanding of the relationship between students' health behaviors and academic performance, and is frequently cited by state policymakers and the media as a critical component of school improvement efforts to help guide the development of more effective health, prevention and youth development programs. It provides a means to confidentially obtain data on student knowledge, attitudes and perceptions about the topics it covers. The CHKS, along with its partner surveys, the California School Staff Survey and the California School Parent Survey, is highlighted as a model program in a research document released by the US Department of Education highlighting the research behind the Obama administration's Blueprint for Reform: The Reauthorization of the Elementary and Secondary Education Act (pdf). With the CHKS, schools, districts, counties and the state have a standard tool that promotes the collection of uniform data within and across local education agencies that are also comparable to existing state and national survey datasets.

Cognitive Behavioral Therapy: Our counseling program utilizes Cognitive Behavioral Therapy (CBT) and Mindfulness. CBT is utilized in individual sessions and CBT techniques are taught to our psychology club students. At every counseling session, our head counselor utilizes a brief mood survey and evaluation of therapy form to evaluate student progress and therapist effectiveness. Additionally, our head counselor attends a bimonthly CBT supervision and consultation group as well as yearly workshop trainings. Mindfulness is taught at our weekly workshop on Mindfulness and Substance Abuse. Students also learn mindfulness strategies in individual counseling sessions. Every class period starts with a moment of quiet and reflection.

Expected Schoolwide Learner Outcomes: A requirement of the Western Association of Schools and Colleges (WASC) Accreditation process, these are outcomes determined by the school of what we expect students to learn, know and be able to do when they leave our program. Our outcomes closely align with our work around student wellness, connection to others and post-secondary plans.

Multi-Tier System of Support (MTSS): Formerly Response to Intervention (RTI), a Multi-Tier System of Support is a multi-tier approach to the early identification and support of students with learning and behavior needs. This process begins with high-quality instruction and universal screening of all students in the general education classroom. Vicente teachers, staff and administrator and the NLC internship coordinator work together to provide services that all students receive (Tier 1), such as support with service learning, college applications, senior projects, resume-cover letter writing. If there is a student who needs more supports, whether academic, attendance related or behavioral, than what is offered to all students, the team brainstorms other interventions to support the student (Tier 2). If these supports are not effective and more resources are needed for the student, the team determines the needs and implements the more intensive interventions (Tier 3). If there continue to be needs, then other measures are taken, such as a special education assessment, placement change, etc.

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Schoolwide Expectations: As a schoolwide practice, all students have knowledge of the expectations for them relating to behavior, attendance, credit earning and protocols at our school site. This allows students to be able to know exactly what is expected of them. We hold students to a high level of accountability while providing a high level of support for them to achieve these expectations. This puts all students on a "level playing field" in knowing what is expected of them. Many students rise to the occasion when expectations are clear and consequences are outlined and fair and therefore, can be highly successful while rebuilding confidence and self-esteem in the school setting and beyond.

VALUES:
Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

Our program reflects MHSA values of wellness, recovery and resilience. Our whole staff embraces these values for our students, and we strive to ensure our students are held accountable and are supported in these ways in order for them to thrive. We provide access and linkage to mental health care by providing individual and group services during the school day and referrals to outside mental health services for students needing longer term support and services. The students at Vicente and Briones are some of our most underserved and at-risk students in our school district. Thirty-eight percent of students are on free and reduced lunch which means their families are in a low socio-economic status. The teaching staff, mental health counselor, principal and special education teacher meet regularly to discuss the needs of students and to review and analyze data. We practice the Multi-Tier System of Support or Response to Intervention Model in order to provide students with the individualized supports that they need to be successful. While there are interventions built into the regular school day such as small class sizes, explicit expectations and universal responses to students, those who need something more are discussed, and it is determined what they need. As a staff we also utilize restorative practices and restorative conversations among ourselves and our students.

VALUABLE PERSPECTIVES:
Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

Here is what current students have said about Vicente Martinez High School:

Throughout my academic history I've struggled to thrive or even succeed in a school environment. Every day was a cycle of stress, anxiety, fear, and eventually regret. Even after starting a new year fresh I eventually fell behind. After transferring to Vicente all those problems dissipated. I was finally meeting and surpassing expectations, becoming more involved with extracurricular activities and

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volunteer work, and just in general becoming a better version of myself. Classes were no longer just a chore and I was properly understanding the curriculum. I believe that the experiences I've had at Vicente and the skills that I've learned here have more than properly prepared me for life post-high

school. I am grateful for the opportunities I have been given and, with all of this pushing me forward, I am more than eager to continue my journey through life.

I feel like there are many things about this school that has helped me personally. With that being said, I think that being able to have one on one conversations with teachers is a great way to ask questions. Being at another school where not many teachers really care is sad because they don't pay attention to students as much. Here the teachers ask if "we are ok"? or "How is your day"? This is something you don't see in schools with so many students. I really like how we are still being taught our academics by lectures. We as students also have independence to work freely and be flexible with our work. We can work on our Math independently but still feel comfortable asking our teachers for help. In conclusion this school has helped my mental health in many, many ways which is very important to me. This is why I like this school.

I like Vicente Martinez High School because the small classes have helped my anxiety. The teachers are very welcoming, as well as very helpful. Credits are easy to make up with the teachers' help. Teachers are available to help whenever students need it. If it wasn't for Vicente my grades would still be bad and that goes with my attendance. I love coming to school and talking to the Counselors when I need it. Whenever I leave school I get very sad and can't wait for the next day to get started.

My proposed graduating date is June 2020. Before I went to Vicente Martinez High School, I never liked school. I stopped going to school and I would just stay at home. When I started Vicente I remember being scared, however, I made friends easily and started to catch up on my credits. When I'm in class I feel like I'm being heard and understood. The support the teachers give makes me feel smart, capable and cared for. The thing I like the most is the flexible schedules. I am able to leave school at noon each day. This allows me more time to focus on myself and my goals outside of school.

This school has helped me in many ways. They offer internships and help us apply for jobs. I struggle with school a lot and suffer from anxiety, depression and ADHD. Sometimes these prevent me from working effectively. I would often get overwhelmed and leave class. The teachers here help me to stay motivated and they are very supportive. Not having any homework to bring home each night has helped me majorly. I know at the end of each class that I'm done for the day and I can go home and work on myself and my happiness.

By attending Vicente I've had a much better experience than I have in the past at other schools. The classes are small, and the teachers and counselors are amazing. I actually get up and go to school now. Whereas before while I was attending Alhambra it seemed to make my life worse. The people and energy here at Vicente is much better. I will also get to graduate early if I stay on track. The staff at

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Vicente has also help me to get a job by helping with write my resume and check to see who is hiring. They also offer me many other experiences here that I couldn't get anywhere else.

The things I like about Vicente is I don't have any homework and I can earn my credits faster. This will allow me to start college earlier. Here at Vicente they offer outside activities like kickboxing. I enjoy kickboxing as it is a great way to get rid of stress. The teachers here have helped me with me resume so I could get a job. The teachers are also available to help me whenever I need it. The school also offers Girls Group so we can talk to each other and what is bothering us. This group has helped me a lot and has helped prepare me for the Big World.

Using the brief mood evaluation of therapy form, here are a few comments from students…

"learning how to deal with negative thoughts"
"thinking about the pros of being shy"
"I got helpful tips to help resolve my problems"
"fighting my anxiety"
"the fact that I was able to express myself"
"being able to talk"
"always a good listener and understands"
"evaluating my problems"

Innovation Annual Report FY 18-19

Contra Costa Behavioral Health Services

Mental Health Services Act

CONTRA COSTA
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A Division of Contra Costa Health Services

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Innovation Introduction

Innovation is the component of the Three-Year Program and Expenditure Plan that funds new or different patterns of service that contribute to informing the mental health system of care as to best or promising practices that can be subsequently added or incorporated into the system. Innovative projects for CCBHS are developed by an ongoing community program planning process that is sponsored by the Consolidated Planning Advisory Workgroup through its Innovation Committee.

New Innovation Regulations went into effect in October 2015. As before, innovative projects accomplish one or more of the following objectives; i) increase access to underserved groups, ii) increase the quality of services, to include better outcomes, iii) promote interagency collaboration, and iv) increase access to services. While Innovation projects have always been time-limited, the Innovation Regulations have placed a five-year time limit on Innovation projects. During FYs 2015-16 and 16-17, CCBHS staff and stakeholders reviewed and ensured that all existing and emerging Innovation projects complied with the Innovation Regulations.

Approved Programs

The following programs have been approved, implemented, and funds have been allocated for Fiscal Year 2018-19:

1) Center for Recovery and Empowerment (CORE). CCBHS recognizes substance abuse/dependence in adolescence as it negatively affects physical, social, emotional and cognitive development. Early onset of alcohol or other drug use is one of the strongest predictors of later alcohol dependence. This is a priority because CCBHS does not have a coordinated system of care to provide treatment services to youths with addictions and co- occurring emotional disturbances. The CORE Project will be an intensive outpatient treatment program offering three levels of care; intensive, transitional and continuing care to adolescents dually diagnosed with substance use and mental health disorders. Services will be provided by a multi-disciplinary team, and will include individual, group and family therapy, and linkage to community services. The Center for Recovery and Empowerment project began implementation in FY 2018-19.

2) Coaching to Wellness. Individuals who have experience as a consumer and/or family member of the mental health system have been trained to provide mental health and health wellness coaching to recipients of integrated health and mental health services within CCBHS. These peer providers are part of the County's Behavioral Health Services integration plans that are currently being implemented. Three Wellness Coaches are paired with two Wellness Nurses, and are assigned to the adult mental health clinics. The Coaches have received training specific to the skill sets needed to improve health and wellness outcomes for consumers. The Coaching to Wellness Project began implementation in FY 2015-16.

3) Cognitive Behavioral Social Skills Training (CBSST). Many consumers spend years residing at County augmented board and care facilities with little or no mental health treatment provided, and little or no functional improvement taking place. Often this lack of progress results in multiple admissions to the County's Psychiatric Emergency Services and other, more costly, interventions. Cognitive Behavioral Social Skills Training (CBSST) is an emerging practice with demonstrated positive results for persons with severe and persistent mental illness. The CBSST Project proposes to apply this therapeutic practice to the population of individuals that have been placed in augmented board and care facilities. The CBSST Project will create a clinical team, consisting of a licensed clinician and peer support worker, to lead cognitive behavioral social skills training groups at board and care facilities. Adults with serious mental illness will learn and practice skills that will enable them to achieve and consolidate recovery-based skills. The Cognitive Behavioral Social Skills Training project began implementation in FY 2018-19.

4) Overcoming Transportation Barriers. Transportation challenges provide a constant barrier to accessing mental health services. A comprehensive study was completed via the County's community program planning process, and a number of needs and strategies were documented. Findings indicated a need for multiple strategies to be combined in a systemic and comprehensive manner. These strategies include training consumers to independently navigate public transportation, providing flexible resources to assist with transportation costs, educating consumers regarding schedules, costs and means of various modes of public transportation, and creating a centralized staff response to coordinate efforts and respond to emerging transportation needs. Three Peer Specialists address these needs and provide a means to inform the mental health system of care regarding solutions for improving transportation access to care. The Overcoming Transportation Barriers Project began implementation in FY 2016-17.

5) Partners in Aging. Older adults who are frail, homebound and suffer from mental health issues experience higher rates of isolation, psychiatric emergency interventions, and institutionalization that could be prevented. When fully implemented this project will field three field-based peer support workers to engage older adults who have been identified by their IMPACT clinicians, primary care providers, or Psychiatric Emergency Services as individuals who need additional staff care in order to avoid repeated crises, engage in ongoing mental health treatment, increase their skills in the activities of daily living, and engage appropriate resources and social networks. The Partners in Aging Project began implementation in FY 2016-17.

The allocations for these projects are summarized below:

Project	County/Contract	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 18-19
Coaching to Wellness	County Operated	Countywide	90	474,089
Partners in Aging	County Operated	Countywide	45	181,067
Overcoming Transportation Barriers	County Operated	Countywide	200	241,450
Center for Recovery and Empowerment	County Operated	West	80	600,000
Cognitive Behavioral Social Skills Training	County Operated	Countywide	240	200,000
Administrative Support	County	Countywide	Innovation Support	463,227

The above concepts have been recommended by the Innovation Committee for development and submittal to the Mental Health Services Oversight and Accountability (MHSOAC) for approval. Detailed project descriptions will be submitted to the MHSOAC for approval in a separate document. These concepts have been discussed by stakeholders in this year's community program planning process and are consistent with stakeholder identified priorities.

The Mental Health Services Act states that five percent of MHSA funds will be for Innovation Projects. In order to meet this five percent requirement additional funds will be set aside for the emerging projects listed above.

Innovation (INN) Component Yearly Program Budget Summary for FY 18-19

Projects Implemented			2,159,833
		Total	***$2,159,83***

Appendices

Aggregate Innovation Demographics

In response to the new Innovative Project Regulations issued in July 2015, per California Code of Regulations, Title 9, Section 3580 and 3580.010, Contra Costa County begun collecting new outcome indicators for all innovation projects. Starting in July 2016, projects started capturing demographic data, such as age group, race/ethnicity, primary language and sexual orientation. This data defines outreach to all underserved populations for the current fiscal year. Data not included in this report can be found within the innovation annual reports submitted in this document.

Total Served FY 18/19 = 193

Table 1. Age Group

	# Served	
Child (0-15)	0	
Transition Age Youth (16-25)	0	
Adult (26-59)	3	
Older Adult (60+)	8	
Decline to State	0	

Table 2. Primary Language

	# Served	
English	8	
Spanish	0	
Other	0	
Decline to State	0	

Table 3. Race

	# Served	
More than one Race	1	
American Indian/Alaska Native	0	

Asian	0	
Black or African American	0	
White or Caucasian	6	
Hispanic or Latino/A	3	
Native Hawaiian or Other Pacific Islander	0	
Other	1	
Decline to State	0	

Table 4. Ethnicity (If Non-Hispanic or Latino/A)

	# Served	
African	0	
Asian Indian/South Asian	0	
Cambodian	0	
Chinese	0	
Eastern European	0	
European	5	
Filipino	0	
Japanese	0	
Korean	0	
Middle Eastern	0	
Vietnamese	0	
More than one Ethnicity	0	
Decline to State	1	
Other	0	

Table 5. Ethnicity (If Hispanic or Latino/A)

	# Served	
Caribbean	0	
Central American	0	
Mexican/Mexican American /Chicano	5	
Puerto Rican	0	
South American	0	
Other	0	

Table 6. Sexual Orientation		
	# Served	
Heterosexual or Strait	11	
Gay or Lesbian	0	
Bisexual	0	
Queer	0	
Questioning or Unsure of Sexual Orientation	0	
Another Sexual Orientation	0	
Decline to State	0	

Table 7. Gender Assigned Sex at Birth		
	# Served	
Male	4	
Female	8	
Decline to State	0	

Table 8. Current Gender Identity		
	# Served	
Man	4	
Woman	8	
Transgender	0	
Genderqueer	0	
Questioning or Unsure of Gender Identity	0	
Another Gender Identity	0	
Decline to State	0	

Table 9. Active Military Status

	# Served	
Yes	0	
No	9	
Decline to State	0	

Table 10. Veteran Status

	# Served	
Yes	0	
No	9	
Decline to State	0	

Table 11. Disability Status

	# Served	
Yes	8	
No	3	
Decline to State	0	

Table 12. Description of Disability Status

	# Served	
Difficulty Seeing	0	
Difficulty Hearing or Having Speech Understood	0	
Physical/Mobility	8	
Chronic Health Condition	0	
Other	0	

Table 13. Cognitive Disability

	# Served	
Yes	0	
No	0	

Program Profiles

Program: Center for Recovery and Empowerment (CORE)

The Center for Recovery and Empowerment (CORE) program is an intensive outpatient treatment program that contains three levels of care: intensive, transitional, and continuing care. Because recovery is not linear, teens will be able to move between these levels of care depending on their need. These levels of care involve the following criteria: Intensive Care (6 weeks): During the Intensive Care phase of treatment, teens attend the program four days a week and family members attend twice weekly. An individual treatment plan and attendance contract with the teen is developed, teens are drug tested weekly to encourage honesty and accountability, and through involvement in the 12-step principles of recovery and educational presentations, teens are introduced to the recovery process. Teens also attend weekly individual and group sessions facilitated by therapists and counselors. Teens are linked with Young People's 12-step in the community to begin building connections with a sober peer group that will continue to be a support for ongoing recovery. Phone contact is maintained between CORE staff and client on offsite days.

a. **Target Population:** Adolescents between the ages of 13-19 with substance abuse disorders and co-occurring emotional disturbance will be the targeted group.
b. **Total MHSA Funding for FY 2018/19:** $600,000
c. **MHSA-funded Staff:** 5.0 Full-time 1.0 Part-time equivalents
d. **Total Number served**: For FY 18/19: 28 individuals
e. **Outcomes**: Evaluation of the program included pre- and post-enrollment of T-ASI indicators. Other proposed indicators include utilization rate of involuntary psychiatric emergency admissions and/or acute psychiatric admissions. Child and Adolescent Level of Care Utilization System (CALOCUS).

Program: Coaching to Wellness/Performance Improvement Project

The Coaching to Wellness program provided an additional level of support for adult mental health consumers with certain chronic health conditions through intensive peer and nurse support. With components from intensive peer support coupled with leveraging existing resources in the County, the Coaching to Wellness program provided a holistic team approach to providing care to our consumers. The goals of the program were to: 1) Improve consumer perception of their own wellness and well-being; 2) Increase healthy behaviors and decrease symptoms for consumers; and 3) Increase cross-service collaboration among primary and mental health care staff.

f. **Target Population:** Adults aged 18 years and older who were currently receiving psychiatric-only services at a County-operated Adult clinic; Diagnosed with a serious mental illness (but at a stage to be engaged in recovery); Diagnosed with a chronic health risk condition of cardiac, metabolic, respiratory, and/or have weight issues; Expressed an interest in the program; and indicated a moderate to high composite score on mental health and medical levels of support needed.
g. **Total MHSA Funding for FY 2018/19:** $474,089
h. **MHSA-funded Staff:** 5.0 Full-time equivalents
i. **Total Number served**: For FY 18/19: 46 individuals
j. **Outcomes**: Evaluation of the program included pre- and post-surveys that measured key indicators in areas such as: perceived recovery, functioning, and quality of life. Self-rated health and mental health data is collected by the Wellness Coaches and Nurses at most individual contacts and vitals collected and levels of support assessed by the Wellness Nurses as needed. Satisfaction and achievement on self-identified wellness goals recorded at post-program. Other proposed indicators include primary care and mental health appointment attendance, and utilization rate of involuntary psychiatric emergency admissions and/or acute psychiatric admissions.

Program: Cognitive Behavioral Social Skills Training in Augmented Board and Cares (CBSST)

The CBSST project will involve having a team designed of one Mental Health Clinical Specialist (MHCS) and one Community Support Worker (CSW) whose primary responsibility will be to lead CBSST groups at B& Cs that house CCC consumers. CBSST is a combination of cognitive behavioral therapy (CBT) social skills training (SST) and problem-solving therapy (PST). This differs from traditional CBT because it not only includes the general concepts of CBT, which focus on the relationships between thoughts, but works with improving communication skills through SST and basic problem-solving skills through (PST). This intervention will be new to the public mental health system and currently has only been implemented in private hospitals or universities.

a. **Target Population:** Adults aged 18 years and older who are currently living in Board and Care Homes and are receiving services at a County-operated Adult clinic; Diagnosed with a serious mental illness.
b. **Total MHSA Funding for FY 2018/19:** $200,000
c. **MHSA-funded Staff:** 2.0 Full-time equivalents
d. **Total Number served**: For FY 18/19: 27
e. **Outcomes**: Patient Health Questionnaire (PHQ-9), Generalized Anxiety Disorder (GAD-7) will be given to all group participants. Additional measuring tools would include the Recovery Assessment Scale (RAS) and the Independent Living Skills Survey (ILSS). Clinic and agency case managers will be asked to fill out the Level of Care Utilization System (LOCUS). 5150s will be tracked for pre/post data and length of hospital stay pre/post data

Program: Overcoming Transportation Barriers

a. **Scope of Services:**
   The Overcoming Transportation Barriers program is a systemic approach to develop an effective consumer-driven transportation infrastructure that supports the entire mental health system of care. The goals of the program were to improve access to mental health services, improve public transit navigation, and improve independent living and self-management skills among consumers. The program targeted consumers throughout the mental health system of care.
b. **Target Population:** Consumers of public mental health services and their families; the general public.
c. **Total MHSA Funding for FY 2018/19:** $241,450
d. **MHSA Funded Staff:** 2 full-time equivalent staff positions
e. **Number Served:** For FY 18/19: 46 encounters
f. **Outcomes:**
   - Increased access to wellness and empowerment knowledge and skills by consumers of mental health services.
   - Decreased stigma and discrimination associated with mental illness.
   - Increased acceptance and inclusion of mental health consumers in all domains of the community.

Program: Partners in Aging

Partners in Aging is an Innovation Project that was implemented on September 1st, 2016. Partners in Aging adds up to two Community Support Workers, up to 3 Student Interns and 8 hours/week of Psychiatric Services to the IMPACT program. The project is designed to increase the ability of the IMPACT program to reach out to underserved older adult populations through outreach at the Miller Wellness Center and Psychiatric Emergency Services. Through Partners in Aging, IMPACT has provided more comprehensive services, including providing linkage to Behavioral Health, Ambulatory Care, and Alcohol and Other Drugs services. Peer support, rehab, and in-home and in-community coaching will allow the skills learned through psychotherapy to be practiced in the community. Partners in Aging also to provided SBIRT (Screening, Brief Intervention and Referral to Treatment) services and referrals to IMPACT consumers who screen positive for alcohol or drug misuse.

a. **Scope of Services:** Community Support Workers and Student Interns provided linkage, in-home and in-community peer support, and health/mental health coaching to consumers open to or referred to the IMPACT program. In addition, the CSW and Student Intern provided outreach to staff at Psychiatric Emergency Services and Miller Wellness Center. They were available to meet with consumers at PES and MWC that meet the criteria for IMPACT to provide outreach, and linkage to services. The Student Intern also provide brief AOD screening and referrals, as well as conducting intakes, assessments, and providing individual psychotherapy. Additionally, a Geropsychiatrist will be available 8 hours/week to provide consultation, and in-person evaluations of IMPACT clients.
b. **Target Population:** The target population for the IMPACT Program is adults age 55 years and older who are insured by Medi-Cal, Medi-Cal and MediCare, or are uninsured. The program focused on treating older adults with moderate to severe late-life depression or anxiety and co-occurring physical health impairments, such as cardio-vascular disease, diabetes, or chronic pain. Partners in Aging also focused on providing outreach and services to older adults who are experiencing both mental health symptoms and alcohol or drug misuse.
c. **Total MHSA Funding for FY 2018/19:** $181,067
d. **MHSA Funded Staff:** 2 full-time equivalent staff positions
e. **Number served:** For FY 18/19: 32
f. **Outcomes:** Reductions in Level of Care Utilization System (LOCUS) scores, reductions in Psychiatric Emergency Service visits, reductions in hospitalizations, and decreased Patient Health Questionnaire (PHQ-9) scores would indicate the effectiveness of this program.

Innovation Project Annual and Final Reports

INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: 18/19

Agency/Project Name: **Center for Recovery and Empowerment**

INNOVATIVE PROJECT TYPE:

*Please check **all** that apply:* ☐ PEI – *services for individuals at risk of SMI/SED* **X** CSS – *services for individuals with SMI/SED*

SERVICES PROVIDED:
Please describe the services you provided in the past reporting period.

The Center for Recovery and Empowerment (CORE) Project is an intensive outpatient treatment project located in West Contra Costa County offering three levels of care: intensive, transitional and continuing care to adolescents dually diagnosed with substance use and mental health disorders. CORE follows the disease model of addiction describing addiction as a disease associated with biological and neurological sources of origin. CORE provides a multitude of all-day services to youth that include individual therapy, family therapy, group therapy, nursing, including medication management and toxicology screening, social skills training, high school education support, adventure therapy, connection to community recovery services, transportation, and healthy meal and nutrition education.

CORE's admission process consists of first receiving a referral. Referrals come from psychiatrists, social workers, schools or school nurses, probation, Kaiser, John Muir Behavioral Health Center, community-based organizations or they are self-referrals. When a referral is received the Program Supervisor or other dedicated staff member will discuss client's background over the phone. Client and/or family member will be asked to come in for an assessment to meet with all staff located at the project. To be accepted into the project staff is looking for the client to meet an appropriate mental health diagnosis, SUD level of need and willingness/ability of either client OR family to participate in program.

If client meets admission guidelines they will be enrolled into the program and begin onsite treatment. Day program schedule is as follows:

1) Transportation provided by van pick-up
2) Check-in with teacher for Golden Gate School Program
3) Complete Daily Goals Worksheet

4) School
5) Lunch and social skills integration
6) Individual therapy – clients are pulled from milieu twice a week, or as needed throughout the day.
7) Group therapy: Moral Reconation Therapy - 1xweek, recovery assignments are done in group 5xweek
8) Tox screen and individual consultation with nurse to discuss results 1xweek
9) Adventure Therapy- ecotherapy, mindfulness and recreational activities for youth after lunch
10) Family therapy – Family therapy is conducted 1xweek per client in the late afternoon or evening
11) Community recovery meetings – Clients are transported to and from YPAA meetings 2xweek. They attend with Recovery Coach and process meeting afterwards with Recovery Coach and individual sponsors in YPAA
12) Sober social events – Clients attend social sober events, weekly, in order to develop and establish a sober peer group. These events are sponsored by YPAA and linkage is provided by Recovery Coach. They include events such as sober dances, parties, bowling, dinners, camping, etc.

LESSONS LEARNED:
Please describe any lessons learned (positive and negative) throughout the implementation of this project. If applicable, how have you used these lessons to change the model?

During the development phase of the project a few challenges were discovered. Innovation projects by design are new and different patterns of service. During the implementation process the project encountered barriers. One of these barriers included finding a location for the project outside of inner-city communities and in an area where youth could be removed from settings where they could be easily triggered to use. This made it difficult because the location needed to be close to the client's home and allow for easy access to transportation to and from the program and provides "Safe and Sober" environment critical to an intensive recovery program. The location was eventually identified and secured for a building that had access to trails and parks nearby to allow for Adventure Therapy.

Another obstacle that the project faced was during the hiring process. Many positions didn't meet current County classifications and it was decided to contract out. This ultimately delayed hiring and the opening of the Center. This also influenced decisions on future positions and how to move forward on the process of hiring. The project decided to change some of the staffing pattern to avoid further delay in hiring and promote quicker implementation of opening of the Center.

PROJECT CHANGES: ☐ No changes
Please explain whether any changes were made to the Innovative Project during the reporting period and the reasons for the changes, if applicable.

Upon implementation the staffing pattern changed to meet County policy and requirements. The first change consisted of the Psychiatrist and a Registered Nursing position. These positions proved to be very hard to hire and fill. Neither position required enough hours to justify a part time position and with so few hours required recruitment proved to be difficult. After this evaluation it was proposed to replace this with a Psychiatric Nurse Practitioner (PNP). The PNP was eventually hired and supervised by a Psychiatrist over at the West County Children's Clinic. This position is responsible for providing oversite to clients who need vitals taken, meds reviewed or drug tests. An additional position that was converted was the Recovery Coach. This position was changed to a Community Support Worker because of similar job duties specified under the County classification.

Another staffing change during the onset of the project was a position that was contracted out. This position was for a Substance Abuse Counselor. The position was CADAC certified and held a License of a Professional Clinical Counselor. Eventually, the staff member vacated the position and it was converted to a Mental Health Clinical Specialist. The new person who was hired was working towards her CADAC certification and would meet the guidelines specified in the workplan within the coming year. Finally, it was determined that the project needed additional support with administrative functions. This pushed for the project to hire an experienced-level clerk to support this role which included billing set up and chart organization.

Originally, the project outline consisted of three levels in which the clients would be in each level for 12-week periods. As the project enrolled youth, it was determined that this duration was to be six weeks instead. This would allow for movement into the next phase to be quicker. It would also push for the mentorship portion of the project to be rolled out to increase flow between levels.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- *What are the learning goals of the project?*
- *Which elements of the project are contributing to outcomes?*
- *List of indicators measured; including results and an explanation as to how often data was collected and analyzed.*

The learning goals of the project are to learn if treating adolescents with substance related and co-occurring mental health conditions in an ASAM compliant intensive outpatient program will 1) result in abstinence or reduced use of substance; 2) reduce symptoms of mental illness; 3) reduce/prevent need for/or return to inpatient mental health/substance dependence treatment; 4) increase academic success.

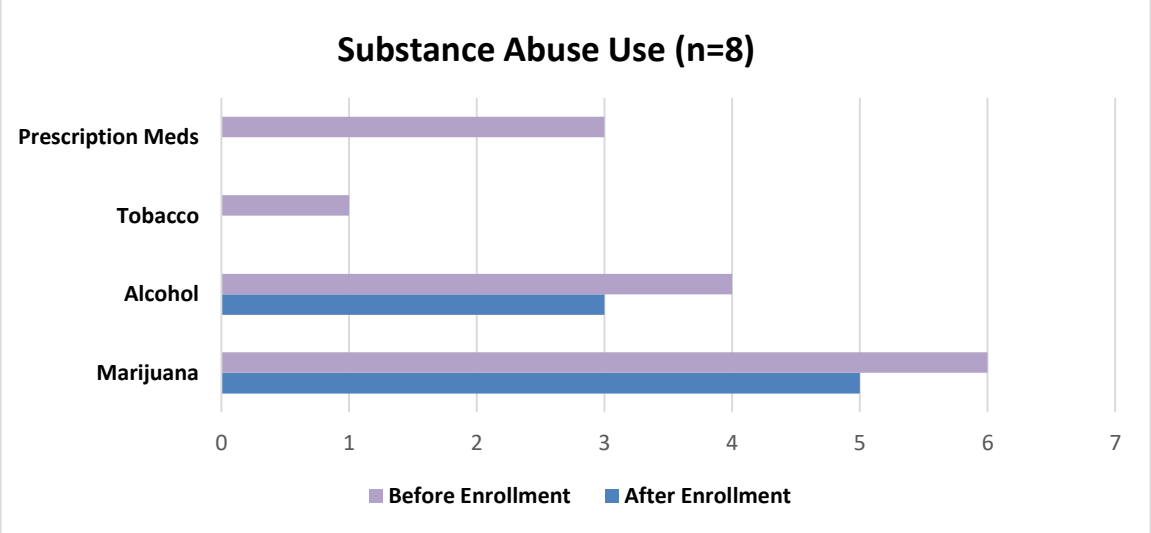
This project used the Teen Addiction Severity Index (T-ASI) to measure many of its outcome goals before enrollment and after discharge. The T-ASI can be defined as a semi-structured interview tool that was developed to fill the need for a reliable, valid, and standardized instrument for a periodic evaluation of adolescent substance abuse. The T-ASI uses a multidimensional approach of assessment as an age-appropriate modification of the Addiction Severity Index. It yields 70 ratings in seven

domains: chemical (substance) use, school status, employment/support status, family relations, peer/social relationships, legal status, and psychiatric status. [i]

The project reported that the average age of drug usage started as early as 12.5. Clients show being in SUD treatment type services 5 times before enrollment with a rate of 63 days total.

The project was able to capture some of the primary goals and respond by the following indicators:

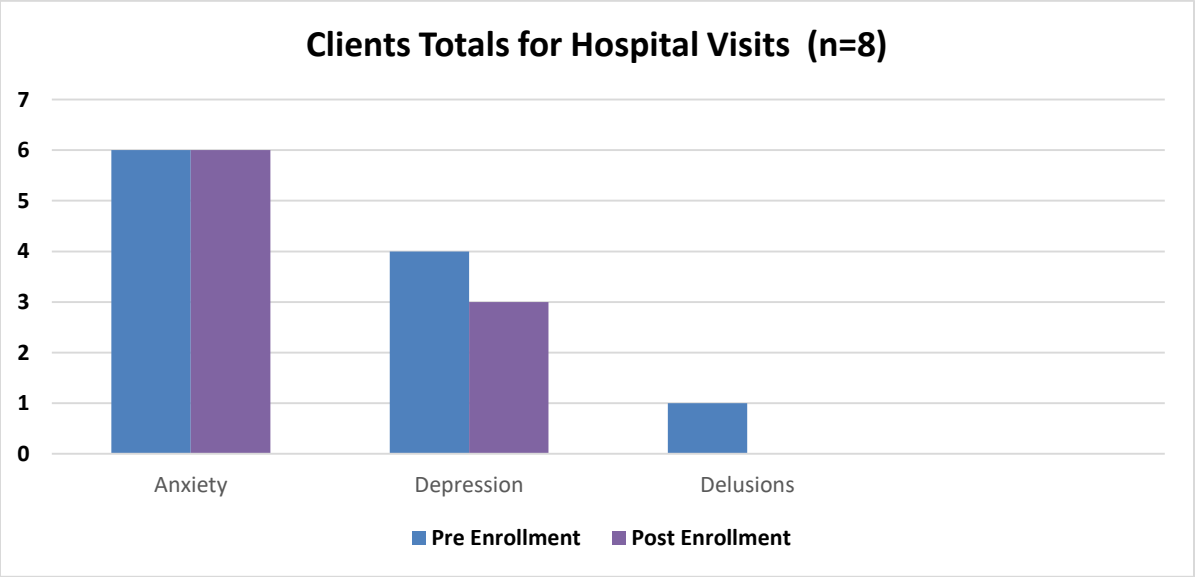
- Reported Drug Usage Impact (pre and post via the Teen Severity Addiction Severity T-ASI Index) Only eight clients completed pre and post data. Both prescription meds and tobacco use show no use after enrollment.



- Reported Mental Health Impact (pre and post via the Teen Severity Addiction Severity T-ASI Index)

This included treatment for any psychological or emotional problems in the hospital for inpatient/outpatient patients. Total visits decreased from 22 to 18 after enrollment.

Table below indicates three clients admitted for anxiety for both pre- and post-enrollment, four pre-enrollment and three post-enrollment for depression, and one pre-enrollment with no post enrollment client for delusions. Admissions decreased overall.



LINKAGE AND FOLLOW-UP: ☐ Not applicable

Please explain how participants are linked to mental health and/or support services, including, how the INN program follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

CORE provides an extensive intake process when client arrives into the center. Upon intake if the program cannot fit the needs of the client then they will be referred out. Besides residential SUD, CORE refers youth and parents/providers on behalf of youth to the following services:

- WCCAS (West County Child & Adolescent Services) mental health
- WCCAS outpatient SUD
- PES
- Seneca Mobile Response Team
- Kaiser CDRC
- John Muir Behavioral Health
- EBYPAA
- Young People NA
- REACH
- Hanna Boys Center (residential but not primarily SUD)
- Rebekah House (residential but not primarily SUD)
- RYSE
- MISSEY (for CSEC youth)

- Golden Gate Schools/County Office of Ed Alternative Education
- Contra Costa County CFS
- First Hope
- James Morehouse Project
- MH Access Line
- West County Health Center
- Richmond Works Program
- West County High Schools Health Centers
- Monument Crisis Center
- Familias Unidas
- Latina Center

If a client is enrolled in the program and needs additional services specifically in phase two then the client could get referrals to activities such as sports, art, dance, summer jobs and other similar programs. There is no lapse in referral time therefore this is not a measured outcome.

VALUABLE PERSPECTIVES:
Please include the stories and diverse perspectives of project participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

Youth within the CORE project were asked how the program has changed their life. This was organized through them providing accounts of how they were affected physically, socially, emotionally and academically. Then they were asked how they would feel without the CORE project being available. Responses were given per the following:

Case Vignette 1: 15-year-old LatinX female, who came to the program just days after returning from the streets, where she had been trafficked. History of runaway and a lot of sexual trauma.

Client Statement:

"When I first came to the program, I was very sick and couldn't stop using. I was using marijuana, vape pens, and popping pills. I was losing a lot of weight and my face was full of acne. All I would do is smoke until I passed out. I lost friends that cared for me because they saw how bad I was doing. Emotionally I experienced a lot of depression and anger issues. My school attendance was really bad, and I would not even show up to classes most of the time. CORE has helped me eat better and stay sober. I am starting to socialize more with people and find good friends. I now communicate better with my family and have raised my grades while achieving more credits for high school. Without CORE I would be lost or even dead. I might even be homeless. I thank CORE for helping me find my higher power.

Case Vignette 2: Male who is 16yrs old. When he came to CORE, he had a severe eating disorder and was hanging out with gang members who were pushing him, daily, to quit program ("Don't be a p***y, no one respects you doing that" etc. He started using at age 12.

Client Statement

"When I first came into the program, I was oppositional about almost everything. I wasn't open at all to take suggestions from anyone. I was using marijuana, alcohol and pills. Physically I was skinny and unhealthy and at times looked like a zombie. Most of the time I would be with a group of friends and we would use drugs together. I quit the baseball team because of drugs. I could be calm because I was high, but if something was to make me mad, I would completely blow it out of proportion. Academically my attendance was horrible because I would be at the park smoking or drinking. CORE helped me recover physically by helping me maintain my sobriety by checking in with me and taking me out to do activities. I built relationships and bonds with other people who had the same goal to stay sober and who were on the right path. CORE has helped me emotionally by helping me find ways to control myself. I also have gotten my credits for school back up to where they are supposed to be and turned all of my F's into A's."

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i. Kaminer, Y., Wagner, E., Plumer, B. & Seifer, R. (1993). Validation of the teen addiction severity index (T-ASI): Preliminary findings. *American Journal on Addictions, 2(3)*, 250-254.

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FINAL INNOVATIVE PROJECT REPORTING FORM

FISCAL YEAR: 2018/19

Agency/Project Name: Contra Costa Behavioral Health/Coaching to Wellness

INNOVATIVE PROJECT TYPE:

*Please check **all** that apply:* ☐ PEI – *services for individuals at risk of SMI/SED services* X CSS – *for individuals with SMI/SED*

INNOVATION:
Please provide a brief summary of the priority issue related to mental illness or to an aspect of the mental health system for which this program/project tests the idea of an innovative concept.

This innovation project was instituted based on a widely recognized disassociation between physical and behavioral health treatment being provided concurrently. The approach was to integrate health care by linking the treatment of physical and mental health to improve the quality of services which lead to better health and mental health outcomes. The innovation project was set in place to test if using Peer Wellness Coaches will improve number of clients that participate in health education and/or wellness activities, improve health outcomes, and enhance recovery and resiliency.

Before the onset of the project it was regarded that mental health clients face physical health problems and engage in risky health behaviors more frequently then the general population. People with severe mental illness (SMI) who receive services from the public mental health systems die, on average, at least 25 years earlier than the general population. Prevalence of diabetes, ischemic heart disease, cerebrovascular disease, arthritis and heart failure is three-times higher among SMI Medi-Cal population compared to general Medi-Cal population. It was decided based on this collective information that it was imperative to utilize peer providers, as a potential solution to overcoming the barriers states above.

This innovation intervention offers a potential solution to determine if using peer providers trained in wellness recovery and self-management promotes positive health outcomes, including mental health recovery and resiliency. It was the idea to determine if a patient at risk received support for both physical health and mental health would this improve the patient's overall health and ability to lead a functional and successful life within the community.

PROJECT OVERVIEW:
Please provide an overview of the innovative project.

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The Coaching to Wellness project provides an additional level of support for adult mental health consumers who are in need of health care management. Support is provided by a Wellness Team that consists of a Nurse, Mental Health Clinical Specialist and a Community Support Worker. With components from intensive peer support coupled with leveraging existing resources in the County, the Coaching to Wellness project provides a holistic team approach to providing care to consumers. The goals of the project are: 1) Improve client perception of their own wellness and well-being; 2) Increase healthy behaviors and decrease symptoms for consumers; and 3) Increase cross-service collaboration among primary and mental health care staff.

The Coaching to Wellness project began enrolling clients in December 2015. Clients were originally enrolled that had comorbid mental health and primary care need. As the project expanded so did the criteria for accessing this service and it was eventually opened to all clients in need of healthcare management. In general services provided included:

- Facing Up To Health: a peer-led group intervention guides participants through identifying and understanding their personal wellness resources and helps them develop an individualized plan to use these resources on a daily basis to manage their mental illness
- Wellness Management related activities including referrals and linkages to primary care and other medical appointments such as nutrition, dental, optometry, ultrasounds, as well as community resources for food, clothing, smoking sensation, health coaching, mindful movement, exercising, linking family members to family support, housing, etc.
- Individual nurse, clinician and peer support in the home, field, and office to work on goal setting, attainment, Injections, medi-sets, whole health education development of self-management skills, and addressing barriers to wellness such as isolation and financial limitations.
- Clinic groups that include a diabetes group, food is medicine and pain managements
- Alumni Group: a peer-led group that provides regular check-ins on progress and need for support goals while promoting the achievement of wellness, recovery, and chronic disease self-management skills.

PROJECT CHANGES: ☐No changes

Please explain whether any changes were made to the Innovative Project during the reporting period and the reasons for the changes, if applicable.

Over the course of the entire innovation project period many features changed to adapt to the specific needs of the clients. The team faced many challenges and made changes as needed. During the last fiscal year, the project made some final changes to see if these changes would allow for the project to learn some additional aspects making the services viable and sustainable.

- The Project Recommendation Form that was once only required to be filled out by a Psychiatrist was made available for other potential providers within the clinic to complete.

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This would allow for more overall referral to be reached by the team.

- Community Access Tickets Service (CATS) is a service provided that allows for a group to access cultural, recreational and education experiences. The project was able to gain access to these tickets and offer the Coaching to Wellness clients the opportunity to experience positive socialization and community integration opportunities. Clients were recently able to attend baseball games and other theater type events. The event lead to positive outcomes and a greater positive response to the project.
- Post surveys were edited to allow for intimate project feedback. Form was separated out to become its own and be mailed in as a separate document. The team decided this would give clients the necessary privacy that would allow for more return on suggestions.
- The project decided to revisit their outreach efforts within the County. This consisted of presenting the project again to the Primary Care Clinics, Shelters, Detention, and other possible sites that would be able to utilize the service.

OUTCOMES AND PROJECT EVALUATION:
Please provide quantitative and qualitative data regarding your services.

- *What is the evaluation methodology?*
- *What are outcomes of the project that focus on what is new or changed compared to established mental health practices?*
- *If applicable, was there any variation in outcomes based on demographics of participants?*
- *List of indicators measured, including how often data was collected and analyzed, as well as how the project evaluation reflects cultural competency and includes stakeholder contribution.*
- *Assessment of any activities or elements of the Innovative Project which contributed to successful outcomes.*

The original learning goals of the project were to learn if and how modifying HARP curriculum and adding peer Wellness Coaches to health integration projects will: 1) improve wellness and health outcomes for consumers; 2) increase primary and mental health care staffs' understanding of mental health "consumer culture" and recovery principles; 3) increase the number of consumers with wellness, recovery, and/or self-management goals; 4) reduce feelings of stigmatization; and 5) enhance recovery. The proposal was written several years before the project was able to be implemented; therefore, the goals were amended by the Coaching to Wellness committee as described in the following.

The Coaching to Wellness pilot has three overarching goals with corresponding indicators:

1. Improve consumer perception of their own wellness and wellbeing.
   - Self-Rated Health and Mental Health (asked at each visit and recorded on Contact Summary Form)

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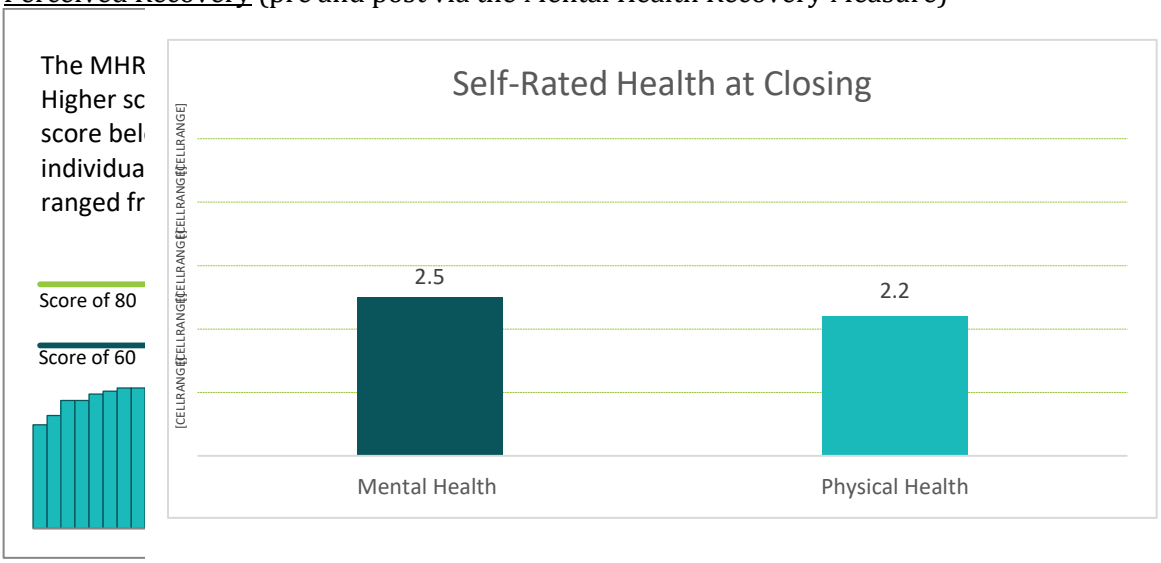
At each individual session, the Wellness Coach and Nurse interviews consumers to ask "In general, would you say your health (5) excellent, (4) very good, (3) good, (2) fair, or (1) poor." This item is used in the National Health Interview Survey and in a number of studies self-rated health has been found to be an excellent predictor of future health.[i] In addition, a similar question is asked regarding mental health, similar to other studies.[ii] Participants were more likely to rate their mental health more positively than their physical health with the majority rating their physical and mental health as "good".

- Perceived Recovery (pre and post via the Mental Health Recovery Measure)



The Mental Health Recovery Measure (MHRM) survey is completed by participants at pre and post and administered by the Wellness Coach. The development of the MHRM involved a grounded theory analysis of qualitative data to develop a model of recovery based upon the experiences of individuals with psychiatric disabilities.[iii] All items are rated using a 5-point Likert scale that ranges from "strongly disagree" to "strongly agree." The MHRM contains 30 items across eight conceptual domains. On average, participants score 8 points lower than the average of most individuals with SMI.

- Functioning (pre and post via the Mental Health Recovery Measure)
  At baseline, participants scored an average of 8.7 points on the Basic Functioning domain of the MHRM, with scores ranging from 0 to 16. Individuals scoring high in this domain are getting their basic needs met and are not depending on others for help.

- Quality of Life (pre and post via the Mental Health Recovery Measure)
  At baseline, participants scored an average of 8.7 points on the Advocacy/Quality of Life domain of the MHRM, with scores ranging from 0 to 16. Individuals scoring high in this domain are making the transition into becoming a role model of recovery; they are becoming confident and comfortable in their journey, so they can share that with others and help them progress along their own path.

2. Increase healthy behaviors and decrease symptoms for consumers.
   - Physical Health Vital Signs and Labs (as needed recorded via Nurse Contact and Lab Summary Form)
     With consumer permission, the Wellness Nurse measures vital signs including height, weight, BMI, blood pressure, pulse, and waist circumference and recorded on a Contact Summary form. In addition,

the Nurse will ask about the number of days and minutes of physical activity engaged in during the week. Labs (e.g., Cholesterol, HgA1C, etc.) are requested as needed; the Wellness Nurse monitors these requests and enters information into a Participant Lab Summary form. There is not enough post data for pre and post analyses. At baseline:

- BMI: Of 8 participants with measurements, all but one (87.5%) were overweight (BMI ≥ 25) or obese (BMI ≥ 30).
- Blood Pressure: Out of 11 participants, 7 (63.6%) have pre-hypertension and hypertension.
- Pulse: Of 15 participants, 0 have a high pulse rate. The average pulse is 81.5 beats per minute.
- Cholesterol: Of 5 participants, 0 have borderline high or high total cholesterol; 60.0% have borderline or very high LDL cholesterol; 100.0% have low HDL cholesterol; and 20.0% have mildly high or high triglycerides.
- HgA1C: Of 5 participants, 60.0 % of scores indicate diabetes.

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FUNDING:
Please explain whether and how the project will be sustained after Innovation funding. Include the source of ongoing funding, if applicable, the reason for the decision, and how stakeholders are involved in the decision-making process.

The project has ended as of August 2019. Overall this project had many challenges throughout the innovation funding period. Initially, the project had a very difficult time hiring a full team and this challenge continued throughout the entire innovation period. While staff were hired many positions still couldn't be filled or staff retention continued as a challenge. The project eventually changed the team's design but by that time the project was already in its third year of funding. Another challenge became when a service that replicated the project in many ways called Community Connect begin its implementation. This created overlap and seemed to support the patients for similar reasons.

Also, what demonstrated to be an additional struggle was the referral and intake process. Many clients didn't meet the criteria and as the innovation period developed it was decided to allow more clients to be able to access the service. Unfortunately, by this time the project was already gearing towards the end of the funding period and the change didn't seem to make a huge improvement. It was decided after the multiple staff left the project it was best to shut the project down. This project will not be sustained.

LEARNING GOALS:
Please explain whether the project achieved its intended outcomes or learning goals and a summary of what was learned.

The learning goals established for the project are as follows:

Process-based learning goals:

- Do consumers develop mental health wellness recovery action plans (WRAP)?
  - Do consumers use them regularly and how can we increase their utilization?
- Do consumers develop self-management goals?
  - Do consumers use them regularly and how can we increase their utilization?
- What elements of Facing up to Health are effective?
- What elements of Facing up to Health are not effective?
- Does the use of Peer Wellness Coaches increase the number of referrals made between consumers and community resources?
- By changing the project's criteria does this increase the number of client's utilizing the project.

Outcomes-based learning goals:

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- Does interacting with Peer Wellness Coaches improve primary and mental care providers understanding of the consumer culture and recovery principles?

    - Do consumers achieve their wellness goals through this intervention?
    - Do consumers permanently change their health-related behaviors through this intervention?
    - Do consumers achieve their recovery goals through this intervention?
    - Do consumer's Self-Rated Health and Mental Health scores change through this intervention?
    - Do consumers have improved health outcomes?
    - Is this approach replicable in other integration settings?
    - If the project establishes a limited timeframe for utilization of services will this increase the overall number of clients served?

Summary:

Overall, consumer outcomes showed improvement, but low caseload counts stayed steady. In the last fiscal year of the project, new referrals became very challenging. Numbers lowered and aggregate outcome information became limited. Learning goals could not be entirely achieved because of low intake counts. According to reports, approximately 55 clients received outreach in FY18-19. 31 clients received more than 3 services from CTW clinicians/nurses/coaches. Three contact attempts were made to engage clients.

INFORMATION SHARING:
Please describe how the results of this Innovative Project have been shared with stakeholders, and if applicable, beneficial to other mental health systems or counties.

During the innovation funding period all innovation projects are scheduled to discuss updates to the Innovation Committee semi-annually. This committee is apprised of County Staff, stakeholders and members of the community in order to provide feedback, comments or suggestions on any current issues, questions or other applicable information that the project may need to consider. The final report for the project was shared at the innovation committee and discussion around what was learned was reported. Finally, this report will be shared with the Mental Health Services Oversight and Accountability Commission for dissemination through the State by its scheduled submission date.

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VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of project participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

The project was able to collect valuable perspectives from two clients who enrolled during the last fiscal year. Both clients felt that the project had a very positive influence on their life and contributed to many positive outcomes making it easier for them to lead successful lives.

Case #1 - A 63-year-old woman who lives alone in the East Region of Contra Costa County, was diagnosed with heart failure, fatty liver, type 2 diabetes, anxiety, depression with psychotic features, agoraphobia, cognitive disorder, and a panic disorder. Client was isolated at her home with only the once weekly support from her nephew who did not know how or what was going on with her care. With the support of the Coaching to Wellness team and having them meet with the client weekly to help with medication management and teaching she was able to get stable mentally and physically. Additionally, the client also attended the social outings with the wellness coach to learn and use social skills. She now is involved with the choir at the senior living where she resides.

Case #2 – A female woman who lives in the West Region of Contra Costa County, was an avid drinker with mobility issues and a hole in her colon. She stated that she was observing clients using the "Facing up to Health" group part of the Coaching to Wellness project. She noticed a few clients enrolled in the project graduating and many of these clients showed positive changes. This made her decide that she wanted to explore the project further. She said it was the best project she could have enrolled in. She learned how to take better care of herself by making her appointments, seeing a substance abuse counselor and just listening to the overall training given in the class. Since attending the class, she has made substantial improvements. She has been clean and sober for 16 months; she attends college classes to hope to provide peer support and uses the many tools she was given to improve her mental and physical care

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INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: 18/19

Agency/Program Name: Contra Costa Behavioral Health/Cognitive Behavioral Social Skills Training in Augmented Board and Cares

INNOVATIVE PROJECT TYPE:

*Please check **all** that apply:* ☐ PEI – *services for individuals at risk of SMI/SED* ☐ CSS – *services for individuals with SMI/SED*

SERVICES PROVIDED:
Please describe the services you provided in the past reporting period.

Cognitive Behavioral Social Skills Training (CBSST) in Augmented Board and Cares can be described as a new emerging practice that consists of a combination of cognitive behavioral therapy (CBT) social skills training (SST) and problem solving therapy (PST) in the County's Board and Care Homes (B&Cs). The project involves a team designed of one Mental Health Clinical Specialist (MHCS) and one Community Support Worker (CSW) whose primary responsibility will be to lead CBSST groups at B&Cs that house CCC consumers.

The project begin implementation in late August 2018 and hired it's first MHCS. The clinician began acclimation of different countywide B&Cs while shadowing the Housing Specialist and other CBSST groups already established within the Mental Health Clinics. In early September, the clinician was pulled away for 11 weeks of Jury Duty, which added to the lengthy process of implementation. Upon return the clinician was able to provide groups but only as a one-person team. Starting early in January, the clinician identified what B&Cs would be a good fit to start and begin groups. After clear assessment of numerous B&Cs the MHCS found approximately five in different regions of the County that would be appropriate.

The CSW was not brought on till May 2019. This was due to original hire falling through and other lengthy hiring processes that were unable to be prevented. The CSW began shadowing the clinician and helping assist with groups already established. This position is now fully implemented within the project and providing peer counseling in a group setting to clients who live in B&Cs.

The CBSST project is designed to enhance the quality of life for those residing in enhanced B&Cs by incorporating meaningful activity and skills into their daily routines and increasing overall functional improvement. As of this fiscal year, the project has provided the following services:

- Served six small (6-bed) ARFs (adult residential facilities)

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- Served 1 large (70-bed) RCFE (residential center for the elderly)
- Provided CBSST individual and group rehabilitation services to 27 individuals
- Support to board and care operators (psychoeducation, partnering on goals utilizing CBSST framework and skills, consultation re: concerns/consumer needs)
- Collateral with Board and Care Operators

LESSONS LEARNED:
Please describe any lessons learned (positive and negative) throughout the implementation of this project. If applicable, how have you used these lessons to change the model?

The project didn't start implementation until August 2018, and even after the initial start it took until January to start seeing clients. This delay resulted in not having a full reporting period in which to learn if the initial set up of the project is operational. During the current fiscal year, the project staff discovered that partnership with the board and care operators/caregivers was an important component. Building trust was gradual and spending time with them separate from the time with the consumers helped with this and allowed room for growth.

Relationships and rapport building with consumer takes time and during engagement after at least four months trust became more evident and secured. Consistence and regularity during engagement was extremely important. Having the two-person team increased ability to be consistent and groups become regular with high client attendance.

Board and cares where the majority of residents are "plugged in" to activities during the day are not always good candidates for onsite CBSST groups. At least three residents are recommended and provided a level of engagement that felt necessary for group modality. Two homes where this was not the case, did not end up being good fits for the project. At one B&C the group was discontinued due to only one resident being present and able to participate. This client was also not a County consumer.

At another B&C continued CBSST was provided individually to one engaged client. This would sometimes be joined by a second client but on a less regular scale. Transitioning such a client to CBSST work with a case manager more quickly when this occurs is definitely something that should be addressed.

PROJECT CHANGES: ☐ No changes
Please explain whether any changes were made to the Innovative Project during the reporting period and the reasons for the changes, if applicable.

The project has experienced some initial changes as it has approached the second module leading up to the end of the fiscal year.

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Initially CBSST was only performed in groups but soon after the MHCS discovered that it could be beneficial to run individual therapy with the clients. The project also decided to decrease the time for groups from 150 min to 70 min. This seemed to be a better fit for the population and helped with keeping the group engaged and present.

OUTCOMES AND PROJECT EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- *What are the learning goals of the project?*
- *Which elements of the project are contributing to outcomes?*
- *List of indicators measured; including results and an explanation as to how often data was collected and analyzed.*

The goals of the project are to learn the following:

1) Will the modality of CBSST have an effect on the consumer's mental stability and growth?
2) Will the intervention lead to a higher overall functionality and quality of life?
3) Will the intervention reduce 5150 involuntary holds within the Crisis Services Unit?
4) Will a consumer have fewer evictions or avoid evictions completely?

In the first stages of this project we explored the use of four surveys to measure impact on participants' symptoms, self-perception and functioning. These include:

- **PHQ-9 (Patient Health Questionnaire)** assessment monitoring presence/severity of depressive symptoms (self-report, self-administer)
- **GAD-7 (Generalized Anxiety Disorder)** assessment monitoring presence/severity of anxiety symptoms (self-report, self-administer)
- **RAS (Recovery Assessment Scale)** assessment measuring aspects of recovery w/ focus on hope and self-determination (self-report)
- **ILSS (Independent Living Skills Survey)** assessment obtaining individual's view of his/her own community adjustment (self-report structured interview)

We adopted the PHQ-9 and GAD-7 to align with the tools utilized within the regional specialty mental health clinics to track symptoms for all clients. Similarly, the use of the ILSS aligns with those clinics' use of this tool to assess functional impairment primarily for individuals with schizophrenia/related diagnoses. Using the RAS aligns with our goal of increasing recovery orientation for project participants. In line with the recovery model this assessment looks beyond "what's wrong" to participants' view of their own capabilities, hopes and sense of self.

We attempted to have participants complete all assessments prior to beginning the program, as well as after completing the program (all 3 modules). We also implemented the PHQ-9/GAD-7/RAS after

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completion of the first and second modules. Some participants declined to complete especially at the beginning of our relationship. In many cases, participants did not take each survey at least two times in this reporting period in order to get scores for comparison. Thus, data from this reporting period is not robust.

Strength of these tools: surveys create an opportunity and platform that has a consistent structure, for more in-depth conversation about participants' well-being. The PHQ-9/GAD-7 in particular seemed most helpful as a way to flag any uptick in symptoms. The RAS provides insight into cognitions/beliefs that may be "unhelpful thoughts" that CBSST participants can work on challenging, while also insight into participants' own view of strengths to tap into. The ILSS identifies issues to tackle and because it is an interview format, can allow for space to discuss where participants hope to make changes/build independent skills. These discussions can relate directly to the goal setting work of CBSST

Lessons learned: these surveys especially PHQ-9/GAD-7 may feel intrusive and are better completed when not linked to group sessions. The responses are less likely to be genuine until trust is gained. Completing with an individual 1:1 and reviewing each question out loud, supports comprehension of the questions, increases completion rate and hopefully validity of responses, and also fosters the aforementioned conversations. For the ILSS, the questions provided are at times outdated and do not capture as wide a range of independent living skills as we observe in participants (e.g., education-related activities). These lessons led to development during 2019-2020 of questions to ask as an addendum to the ILSS, as well as plans for proposing a revision of the ILSS to be tested/validated.

Data samples included in this reporting period were minimal due to the small timeline from the inception of the program until end of the fiscal year. Not included in the sample was Concord Hill Home and Monona Care Home.

Table 1. Percentage Change in Average PHQ 9 Scores, January 1, 2019 through June 30, 2020 shows the change in average PHQ 9 scores.

Table 1: Percent Change in Average PHQ 9 Scores, January 1, 2019 through June 30,2019

Fiscal Year	Average Score of First Survey of the Year	Range	Average Score of Second Survey of the Year	Range	Average Score of Third Survey of the Year	Range	Percentage Change from enrollment
2018/2019 (n=10)	20	(0 to 20)	19	(0 to 18)	11	(0 to 18)	-45%
Board and Care Homes that were not calculated in the totals were missing surveys due to modules not completed.							
PHQ 9 Score Key: 1-4 Minimal depression, 5-9 Mild depression, 10-14 Moderate depression, 15-19 Moderately severe depression, 20-27 Severe depression							

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LINKAGE AND FOLLOW-UP: ☐ Not applicable
Please explain how participants are linked to mental health and/or support services, including, how the INN Project follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

All clients that participate in the CBSST group sessions are clients that are connected to the mental health clinics within the County. Many have psychiatrists and/or case managers and have regularly scheduled visits. If a client is not participating in services and needs to be linked the CBSST provider will proceed with joining the client with necessary services toward improving treatment outcomes. This can include the CBSST provider reaching out to clients' assigned clinic and collaborating to engage client with different types of service connections.

VALUABLE PERSPECTIVES:
Please include the stories and diverse perspectives of Project participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

SC case vignette: the significance of onsite support

SC is a 27 y.o. (at time of admission) Caucasian female who was a resident of Afu's One Voice, 6-bed female board and care facility in Bay Point. She had moved to Afu's in October 2018, shortly before the CBSST program started engaging with the facility. For sixteen months prior, SC lived at Crestwood "The Pathway" enhanced board and care facility in Pleasant Hill, following multiple psychiatric hospitalizations during a time she lived independently. Since SC was 21, she has had multiple stays at both short and longer term residential psychiatric facilities. Afu's One Voice was the first augmented board and care home placement for her, with the idea that more support at this level of care could better help her stabilize vs. being sent again to an enhanced board and care. SC held the goal from the time of arriving at Afu's One Voice, to return to independent living.

During the engagement/assessment period, SC reported quite severe depression symptoms on the PHQ-9 including thoughts of wanting to die. This writer had a further risk assessment interview and intervention with SC to establish ways she could keep herself safe and manage her symptoms. SC was quite fearful that she would be placed on a 5150 hold, be hospitalized and sent back to a higher level of care and that in this happening, she would lose the opportunity to work toward independent living. Based on the risk assessment this did not occur. Having writer present at the home each week provided additional clinical support to help SC maintain at this level of care. Additionally, writer was able to share observations/concerns with SC's case manager, for a richer clinical picture. The case manager had attempted to get therapy approved for SC as part of the step-down plan, but this had not occurred; with writer's advocacy for more support, therapy was approved.

Writer's own alliance with SC felt strong following this event. SC became a motivated, engaged

participant in CBSST group and set a goal of employment, which she felt would help her be more independent and ready to live on her own again. SC did get a job through vocational services, at which point she was a much less frequent participant in CBSST group based on timing. However, she participated intermittently and continued to demonstrate engagement and apparent pride in her ability to set and work toward her goals.

SC is one of the first program participants to step down from the augmented board and care level of placement following CBSST program engagement. The CBSST team was involved in Dec 2019-Jan 2020 in advocating for SC's readiness to accept an MHSA unit when it came available. SC successfully moved to this unit in March 2020 and as of June 2020 continued to be stable with no PES/crisis encounters.

Johnson Care Home: Developing a Recovery Oriented Milieu

Johnson Care Home exemplifies a small board and care that while providing supportive placement for consumers, did not necessarily emphasize the potential for residents to stabilize, develop independent living skills and the capacity to move on to lower levels of care. When our program began working with Johnson Care Home, there was a core group of residents who had lived there for many years; three of the six had been there for over ten years. They were generally psychiatrically stable with no recent psychiatric hospitalizations, and encounters with specialty mental health were mostly limited to medication management. These gentlemen coexisted well, forming a family-like community. As a group however they spent most of their time isolated at home, watching tv or smoking in the yard. The caregivers wanted to establish an expectation for engagement in activities, but struggled to do this in part based on the longstanding culture in the home. Residents identified goals that would require more engagement with the outside world—finishing an associate's degree, returning to employment, stepping down to independent living—but the biggest barrier first and foremost was that they spent their days inside.

We felt the milieu culture would need to change in order to support engagement in any activities outside the home whether the push came from caregiver expectation or from the residents' personal goals. As we developed relationships and the structure for group, we kept this goal of culture change in mind. Having weekly meetings where residents came together began this shift; even just being in community vs. being in their separate spaces other than meals, was a change. CBSST encouraged them to speak openly about goals, modeling for each other that having hope for change is possible. Practicing skills of learning something new reinforced that things *do* change when we act. The social skills module helped participants practicing positive communication and get comfortable looking to others for support. Some residents turned to each other reflecting on the strength of their long-term relationships—noting this as the first time they talked about this.

We also worked with the owner/operator, supporting her efforts to encourage residents to engage in the program at Recovery Innovations-Antioch (RI). Our group became a baseline activity to help remind residents that they could enjoy/benefit from groups or activities. We also linked what they were working on in CBSST, with how they used the program at RI. Five of the six residents at Johnson Care Home in summer 2019 went to RI at least once, with three continuing consistently.

The group also began focusing more on other activities they could do outside of the home. Participants began to take steps on goals that they had held for a long time. One gentleman with high anxiety around leaving the home, got his driver's license renewed and began repairs on his car—both things he had wanted to do for years. These were short term goals on the way to returning to school and finishing his AA. As a group we planned and held on a picnic at a local regional park. For several individuals this meant overcoming significant anxiety about things like being in unknown cars or in unfamiliar places. This picnic was the culmination of the third module on problem solving. We saw it instill hope in the participants that they could engage in the world in a different way. Generally, the home felt more oriented toward hope and the capacity to achieve goals after completing the three modules of CBSST.

EM case vignette: challenging unhelpful thoughts

EM is a 70 y.o. (at time of admission) Caucasian female living at Family Courtyard, a large residential center for the elderly. At time of assessment in Feb 2019 she identified multiple creative talents; EM is a wonderful and prolific painter usually of natural landscapes which she sometimes does from memory of times spent with her mother in bay area hills. In goal setting for CBSST, EM was clear that she would like to sell her artwork—which came across more as the desire to be recognized as an artist, and having an identity expanding beyond the bounds of Family Courtyard. Another goal that evolved during the course of group was to live together with her boyfriend (another resident) in the Marin headlands.

EM also identified writing as a talent, one that she has used throughout her adult life to manage her mood and stay well. This practice is one that she struggled to maintain as consistently as the painting—and she described writing as more of a chosen tool/coping skill that requires effort to remember and utilize; it can fall by the wayside when she is feeling low.
During the first several months of group EM frequently shared about experiencing depressive symptoms. This was wrapped up with having physical ailments, aches and pains; and resulting thoughts about her age, perceived limitations, and living in a facility that places further limitations upon her.

The cognitive skills module of CBSST reinforced how our thoughts/mood/actions are all related, and EM adopted this as a frame of understanding her depressed mood as related to such thoughts. However, she continued to struggle with really having alternative ways to frame her experience or potential. Her gorgeous landscape paintings cover the walls of the activity room where we do group, but sitting at those tables she could not think her way out of her current living situation.
Taking *action*, that third part of the cognitive triangle, had a big impact for EM. We planned an outing to a regional park with views of the bay, for a picnic. This was a huge endeavor for participants who are physically frail (three of the five utilize walkers) and very limited mobility. EM herself had trouble with significant knee pain that day making for an uncomfortable van ride. However, she filmed the scenery out the window the whole ride into the park to our picnic site; she was ecstatic to get the fresh air and time away from the daily routine. This trip was significant for EM. She wrote an essay following the excursion and stood up in group to read aloud, which she did with confidence. EM gave us permission to share her essay which is also included here.

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This experience seemed pivotal to EM. We saw a shift in her focus to be more on making things happen, whether it was taking steps to address issues with social security or supporting her boyfriend as his "manager" while he pursued his own goal of performing publicly as a singer again. With this shift her mood and sense of self-efficacy was also very much improved.

INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: 2018/19

Agency/Project Name: Contra Costa Behavioral Health/Overcoming Transportation Barriers

INNOVATIVE PROJECT TYPE:

*Please check **all** that apply:* ☐ PEI – *services for individuals at risk of SMI/SED* X CSS – *services for individuals with SMI/SED*

SERVICES PROVIDED:

Please describe the services you provided in the past reporting period.

The Overcoming Transportation Barrier (OTB) innovation project began implementation in September 2016 and begin providing services by April 2017. This project was established to help clients build self-sufficiency and apply independent travel skills while increasing access to mental health services. Other goals of the project are to try to find solutions that the clients face when reaching limitations when trying to use types of transportation. As of June 30th, 46 clients accessed help from the OTB team for this fiscal year.

Client services received from the OTB team range from peer support, mapping bus routes, links to resources, referrals, and fare information. Application assistance is provided for discount/disabled transit passes, Regional Transit Connection (RTC), Senior Youth Cards and Paratransit. Clients will typically access some of these services by calling the dedicated phone line for transportation assistance where a Commute Navigation Specialist (CNS) will help with assisting the client's needs. During this call clients will receive one-on-one support on how to access services to get to appointments.

The OTB team presented to the Central Adult and Children's Clinics to provide a project overview and continue outreach within treatment provided services. The presentation offers education about what the project entails and how clinical staff can utilize the project's services to ensure appointment adherence. The project plans on presenting to other regions of the County next fiscal year.

The OTB team presented to the Service Provider Individualized Recovery Intensive Training (SPIRIT) class to provide information on the (RTC) Card. The presentation demonstrated a specific outline around the project's goals, target population, staff roles and tasks. SPIRIT students have lived experience in the mental health field and can use this information in future placements in their careers.

LESSONS LEARNED:

Please describe any lessons learned (positive and negative) throughout the implementation of this project. If applicable, how have you used these lessons to change the model?

The OTB project continues to experience a low volume of calls throughout the year despite numerous outreach efforts. Staff believe this is due to the project not providing direct means of transportation and only putting an emphasis on transportation independence. Although, callers seem appreciative of the additional service provided it doesn't seem to be completely filling the gap for low income households or communities in which public transportation is either vacant or hard to reach. The team finds that there are many other concerns with riding public transportation that callers are still facing, and the hope is that providing more one-on-one peer support might fulfill that need. The team is working towards providing this support for the upcoming fiscal year.

Travel training was initiated during the last fiscal year but provided little to no attendance. The project staff began discussions around hosting a new workshop that would include a training with the possibility of a bike donation. After further deliberation it was decided to postpone training until additional assistance could be provided for clients to attend the training. Staff will address a training for the next fiscal year.

PROJECT CHANGES: ☐No changes

Please explain whether any changes were made to the Innovative Project during the reporting period and the reasons for the changes, if applicable.

The OTB project continues to tackle challenges due to staffing changes. During the end of the last fiscal year the team was impacted by having one CNS leave the project. This put a lot of the project on hold forcing the current CNS to only concentrate on specific immediate needs. It was noted that the hiring process takes a considerable amount of time for these positions. The new CNS started the next fiscal year and began training to cover the East end of the County. The project is working on hiring an additional CSW next fiscal year. This will ensure all regions of the county are covered.

The OTB project started collaborations with another community-based organization to provide flex funding. This funding would cover a one-time cost specific to transportation needs and help provide support to clients who need to get to their appointments. Flexible funds are client specific and are only intended to cover the client lack of funding and/or when there is no traditional payment mechanism available. Flexible funds are for time-limited services or supports; they are not intended to pay for ongoing expenditures. The flex funding will be implemented fully within the behavioral health clinics within the next couple of months. Processes are still being organized and the project is hoping to start by December 2019.

Wallet cards were constructed after feedback that came directly from the transportation sub-committee. Wallet cards are meant to be a tangible item that clients could use when they are

experiencing high stress situations or need a quick relatable reference point. Suggestions on the cards were specific to coping strategies such as: meditation, deep breathing, riding with friends, prayer, listening to music, journaling, reading, and practicing a hobby. Cards were passed out to every clinic and included with bus vouchers upon request.

OUTCOMES AND PROJECT EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- *What are the learning goals of the project?*
- *Which elements of the project are contributing to outcomes?*
- *List of indicators measured; including results and an explanation as to how often data was collected and analyzed.*

The goals of the project are to learn the following:

1) Client education on usage of transportation and encouragement of independent living skills in getting to and from services to improve service access

2) Client support in navigation of the transportation system through education on how to use public transit, read transit schedules, plan travel routes, and apply for discount passes, promoting more efficient use of transportation resources

3) Client application of learned transportation skills to promote productive, meaningful activity, life skills for social engagement, and reduced isolation

4) Reducing no-show rates at county-operated clinics by addressing both physical and emotional safety barriers through development of solutions regarding transportation

5) Reduction of internal stigma among clients through ongoing peer support from Commute Navigation Specialists

The OTB project started collecting data April 25, 2017. The data collected for the project provided outcomes showing the type of support provided by the OTB team and where the referrals originated. The support varied and provided resources, referrals and other types of educational training around different transportation avenues.

Transportation remains to be an ongoing barrier for clients. Table. 1., below defines results from surveys that were administered in November 2018 that detailed modes of transportation for missed appointments, bus/Bart/paratransit, friends/family, drive self, clinic staff, walk, bike, ride services, and

taxi. Also, the table is a breakdown of transportation modes that respondents identified. These preliminary results from the November 2018 Service Improvement Survey related to transportation are as follows:

- 37% of the responses identified transportation as a problem for missing a behavioral health appointment.

Table 1.

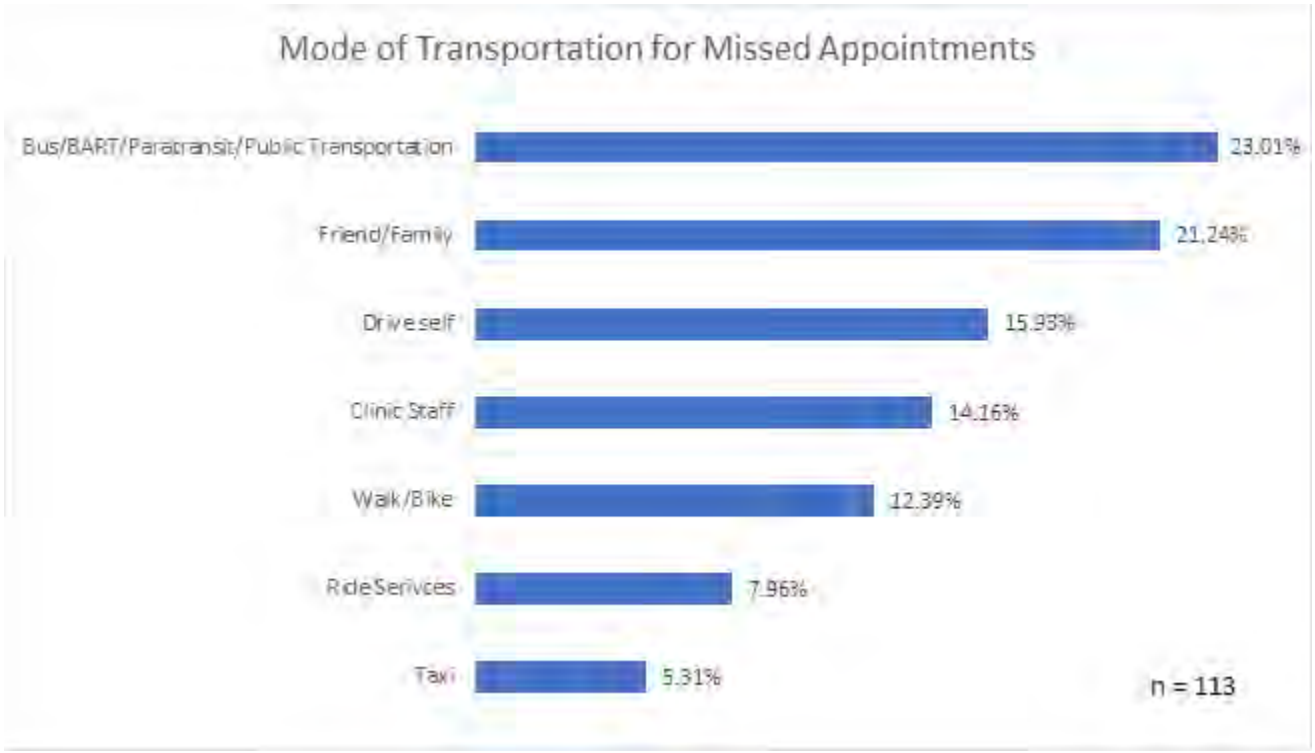

Table 2., below included data for client and staff encounters for the last fiscal year. This table defines the types of services the CNS is providing. Additional types of encounters that were added included

peer support as well as "other" encounters. Other can be explained as contacts that didn't have a specific outcome. Although, the team made numerous attempts to contact clients they were not always able to provide adequate contact or assistance.

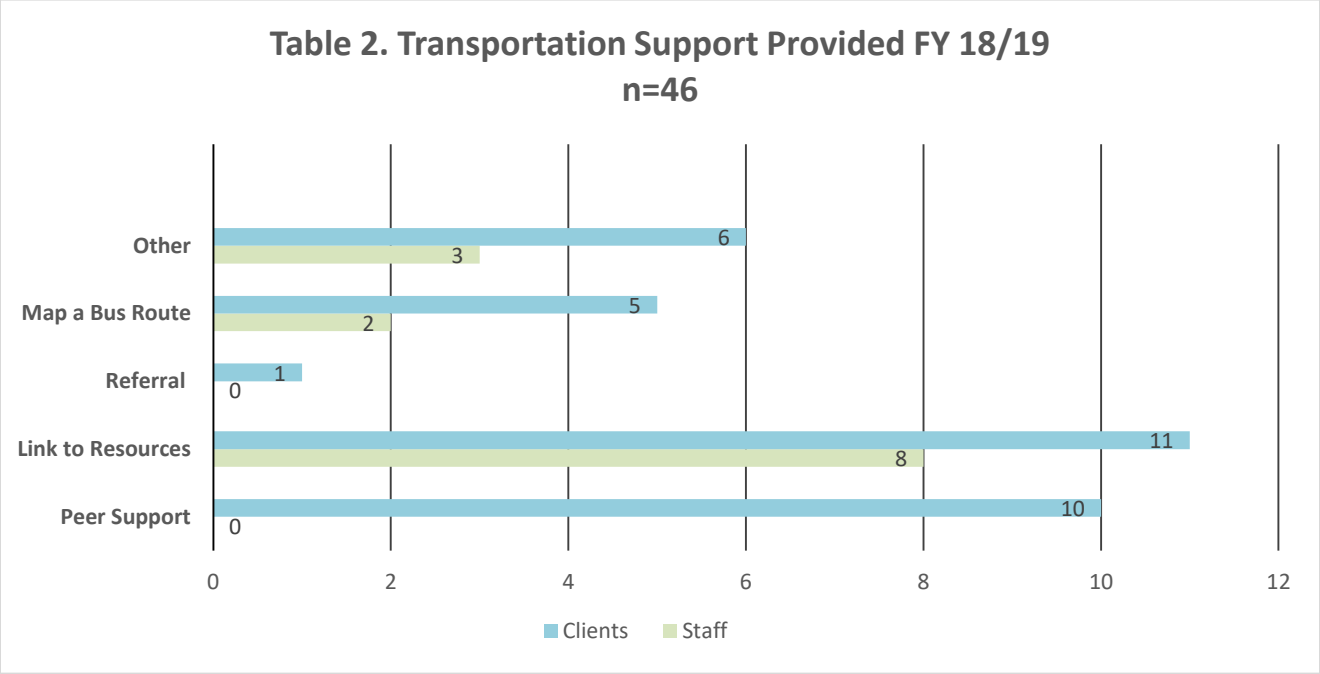

Table 3., below shows total number of calls received by clients and where the referral source originated. Referral source known as "other" describes sources such as family members, friends, word of mouth, presentations or outside therapists.

LINKAGE AND FOLLOW-UP: ☐ Not applicable

Please explain how participants are linked to mental health and/or support services, including, how the INN Project follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

In order to provide support services, the Overcoming Transportation Barriers project reached out to various transportation agencies, and service providers located throughout multiple regions within the County. This action established a process to help in providing a connection between these entities and the project's team. During this process improved access to resources and materials became available for clients and the team was better able to provide further support to clients.

The project also has a system in place that allows the project's staff to follow up on all service contacts if an outcome is not reached. Many times, a client may leave a message after hours and the team will log the contact and then make sure to get the information requested to the client. All client contacts are documented, and extensive outreach is pursued.

VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

The project was able to collect valuable perspectives from clients who called the project for services and for a Focus Group that was held during the Transportation Subcommittee. Both avenues were meant to support the clients with different means of transportation service resources while gaining helpful insight into the client's perspective. Clients commented on different ways in which transportation could be improved and its overall functionality when provided in order to get to and from appointments.

Client Calls:

Caller 1: requested information on how to get a clipper card. The Commute Navigation Specialist was able to assist by providing the information and ended up sending the caller resource information on how to obtain an RTC Clipper Card and bus maps. Client felt services were helpful and would use resources in the future.

Caller 2: Client requested information on the RTC Clipper Card. The Commute Navigation Specialist (CNS) sent over resource information, but client still had a difficult time filling out paperwork. Client was asked to attend the Transportation Subcommittee and get assisted with completing the paperwork. She said the assistance she received from the specialist was very helpful and felt the resources that she received were useful. She recently passed the resource information on to others who are also in need of transportation guidance.

Transportation Subcommittee Focus Group:

The Transportation Subcommittee is composed of behavioral health stakeholders such as consumers of behavioral health services (including both Mental Health and Alcohol and Other Drugs Services), their loved ones, and their providers. It is charged with facilitating community input into the Overcoming Transportation Barriers project.

A focus group was held during the Transportation Subcommittee Meeting to get client feedback. The focus group concentrated on the specific following questions:

1) Did you use any of the transportation related resources provided to you during this meeting?
2) Did you find presentations/activities helpful?
3) Have you used the Overcoming Transportation Barriers services outside of the Transportation Subcommittee?
4) What are the biggest transportation barriers in getting to your behavioral health appointments?

Responses to Question 1

- Caught the bus; went to aquarium. Went to Santa Cruz amusement park. Really nice.
- They changed the 9, 18 and other [County Connection] routes; later buses not running.
- Grabbed bus map; went wrong way; map was helpful; showed direction of bus routes; want to know if [County Connection] Route 18 goes to Amtrak.
- Was getting my first Clipper card; roommate encouraged me.

Responses to Question 2

- Sister bought me punch cards to last me until 2020. Takes an hour and a half between buses.
- I find the information very helpful. I come here to stay updated.
- LINK [County Connection paratransit] charges $5; won't let me ride; want to apply.
- If there is a sidewalk nearly, you're less likely to qualify for paratransit.
- There should be a mental health advocate for transportation.

Responses to Question 3

- Disabled Students Programs and Services at Contra Costa College gave me a free Clipper Card [good to pay fare on any Bay Area transit system].

Responses to Question 4

- Need faster buses, longer times so people can get to work.
- Have difficulty paying fares at the end of the day; transit agency stopped giving transfers.
- At Putnam Clubhouse [mental health community-based organization], members lack knowledge of bus routes, timing of buses. They unknowingly go to bus stops on the wrong side of the street and realize it too late.
- Service available to call for rides to appointments. Can no longer use bus transfers to go the entire loop of the routes.

FISCAL YEAR: 2018/2019

Agency/Program Name: Partners in Aging

INNOVATIVE PROGRAM TYPE:

*Please check **all** that apply:* ☐ PEI – *services for individuals at risk of SMI/SED* ☐ X CSS – *services for individuals with SMI/SED*

SERVICES PROVIDED:

Please describe the services you provided in the past reporting period.

During FY 18/19, we had one Community Support Worker (CSW) leave our program on 1/31/19. She had been working with our program since September 2016. We hired a new CSW for Partners in Aging in early June 2019, and a second CSW in late July 2019. We had an Intern throughout the Fiscal Year. Our Intern began in her position in September 2018 and continued with the program through the remainder of the fiscal year.

Our CSWs and Intern served 32 clients this fiscal year. Our CSWs can build rapport and provide multiple linkage and rehab services. They connect with clients in different ways than our clinicians since they are in the community with the clients and can relate to them as a peer. They collaborate with the clinicians and provide a valuable perspective. The CSWs have provided assistance in linking clients to important resources such as In-Home Support Services, Contra Costa Interfaith Housing, legal services, Social Security Administration, housing resources (including linking to Housing Navigators at Care Centers and linking to organizations that assist with rent payments), Monument Crisis Center, food banks and medical appointments. They also provide several reminder calls to improve attendance at appointments, and link clients to their appointments with their IMPACT clinicians. Our CSWs have become quite knowledgeable on support service resources for older adults. The CSW that was hired in June 2019 maintains an online resource binder that is used by all of the Older Adult Mental Health staff. This has been very valuable and useful!

When our original CSW left the Partners in Aging Program in January 2019 we lost the frequent communication that she was having with the CSWs at Psychiatric Emergency Services (PES). We will work to re-establish this connection. We did not receive referrals from PES during this reporting period.

Our Intern served a caseload of approximately 10 IMPACT clients. She completed intakes and provided psychotherapy. She was able to develop rapport with a range of clients and make progress towards therapeutic goals. Prior to terminating with her clients, she provided them with community referrals, and made recommendations for the next Intern regarding next steps for treatment, or discharge from IMPACT.

LESSONS LEARNED:

Please describe any lessons learned (positive and negative) throughout the implementation of this project. If applicable, how have you used these lessons to change the model?

Throughout FY 18/19 we have steadily received an increase in the number of clients referred to our IMPACT clinicians in all 3 regions of the county. Primary Care Providers now make referrals through the Universal Behavioral Health Referral. Most referrals for clients who are 55 and above are routed to IMPACT. We are

continuing to work to find ways to manage the large number of referrals. Due to their large caseloads IMPACT clinicians usually see their clients once every 2 to 3 weeks. Our CSWs can assist by checking in with clients in between their sessions with their IMPACT clinicians. They provide peer support, coaching, and mental health rehabilitation. We are continuing to explore ways that our CSWs can assist with managing the large number of referrals.

Barriers continue to exist related to developing a collaborative relationship with PES. We have not received referrals from PES during this reporting period. We will continue to work to strengthen this relationship through outreach. PES serves a high volume of clients in a very quick short-term model; thus, it can be challenging to initiate the referral to IMPACT and PIA under the time constraints of their services. We will continue to work to develop these relationships. As stated above, during this Fiscal Year there was a period when we did not have a CSW for Partners in Aging. We need to work to rebuild the collaborative relationship with the CSWs at PES.

We continue to see the incredible benefits of the collaborative relationship between our CSW, Intern and IMPACT clinicians. Our CSW can provide a different perspective on client functioning based on her experiences with clients in the community. This has had a positive impact on client functioning, progress towards treatment goals, and maintaining client safety.

PROJECT CHANGES: ☐ No changes

Please explain whether any changes were made to the Innovative Project during the reporting period and the reasons for the changes, if applicable.

There was one significant change to the project in FY 18/19. We expanded the project to include 2 CSWs instead of one. We began the hiring process for this second CSW during FY 18/19, and this second CSW began working in July 2019.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- *What are the learning goals of the project?*
- *Which elements of the project are contributing to outcomes?*
- *List of indicators measured; including results and an explanation as to how often data was collected and analyzed.*

The goals of the project are to learn the following:

6) Do older adults access IMPACT services with the assistance of peer support workers?

   Yes. Our CSWs successfully provided services to approximately 25 IMPACT clients to improve their access to IMPACT services during FY 18/19.

7) Do older adults engage in SBIRT?

   All patients seen at the health centers engage in SBIRT evaluation.

8) Do older adults develop life skills with the assistance of peer support workers?

Yes, our Partners in Aging clients have developed numerous life skills with the assistance of our CSWs, including obtaining free phones and learning to utilize these phones, ensuring that medical needs are met, being able to utilize transportation resources, working towards financial independence, learning ways to manage clutter and increasing comfort with asking for help from others when needs arise. Our CSWs, in conjunction with the IMPACT clinicians, have been able to empower clients to engage in new activities and activities that they thought were no longer possible for them, and have been able to increase independence.

- Do clients use them regularly and how can we increase utilization?

  Yes, they are using these skills regularly, and our CSW can continue to encourage clients, and provide reminders and support.

9) Do clients develop self-management goals?

Yes, our Partners in Aging clients have been able to identify and carry out self-management goals with the assistance of our CSWs and IMPACT clinicians. For example, clients have been utilizing sleep hygiene tools, are learning to set reminders to eat at regular intervals and also learning the benefits of creating a schedule. CSWs have also been coaching clients in decluttering their homes and organizing paperwork. In addition, clients have been assisted in setting up myccLink profiles to improve communication with their medical providers through their smartphones.

- Do clients use them regularly and how can we increase their utilization?

  Yes, some clients use these skills regularly, including going for walks. We can encourage them, remind them and provide support.

10) Does the use of peer support workers increase the number of linkages made between clients and community resources?

Yes, prior to the implementation of Partners in Aging, IMPACT clients were not being linked to community resources. Referrals were provided, but it was up to the clients to obtain transportation and follow through on these referrals. Our PIA CSW has greatly expanded the scope of the IMPACT Program, and the ability to provide linkage.

11) Does the 60-day recidivism rate of older adults being readmitted to PES decrease?

Yes, our client that was referred from PES in March 2017 has not returned to PES. She was linked to psychotherapy through an IMPACT clinician and participated from June 2017 to June 2018. A review of ccLink indicate that she continues to participate in Health Coaching services.

12) Does social isolation decrease?

Yes, we have observed that social isolation decreases through the support of Partners in Aging. We

began utilizing the PEARLS (Program to Encourage Active and Rewarding LiveS) Questionnaire in approximately August 2017 with Partners in Aging clients. The PEARLS Questionnaire includes the Patient Health Questionnaire-9 (PHQ-9), and also includes questions on general health, social activities, physical activities and pleasant activities. This questionnaire was developed by researchers at the University of Washington to be used in their community-based, evidence-based treatment program designed to reduce depression in physically impaired and socially isolated people. We have requested a report that will demonstrate the differences in scores from the initial PEARLS assessment to the subsequent assessments. We are actively working with the Business Intelligence Team to complete this report.

13) Does quality of life increase?

Yes, we have observed increases in quality of life, including clients feeling more able to engage in activities, and increase the range of activities that are available to them. For example, clients have increased their ability to use transportation independently through coaching and peer support. This greatly increases their ability to engage in social, medical and self-management activities. In addition, we have assisted one client with signing up for classes at a local community college.

14) Do older adults have improved depression scores?

Yes, over the 17/18 fiscal year on average 75.8% of IMPACT clients experienced an improvement in depressive symptoms based on their PHQ-9 scores, and 51.6% of these clients experienced a significant improvement (5 points or more). We are currently in the process of requesting a new report to evaluate the PHQ-9 scores over time. When IMPACT started using the Ambulatory Medicine documentation tools, and the Federally Qualified Health Center model of billing in November 2017, they gradually stopped using a PHQ-9 tracker since this data was entered in ccLink.

We are also in the process of separating out the clients who have received Partners in Aging services to determine if their depression scores show a different pattern than the general trends shown for all IMPACT clients. The PEARLS report referenced above will help to address this question.

The indicators that we have used to assess our learning goals include, PHQ-9 scores, chart review to determine numbers of PES visits, Monthly Service Summaries, and qualitative interviews with our staff. The PHQ-9 are administered frequently by the IMPACT clinicians. The PEARLS has been administered with new Partners in Aging clients beginning in August 2017. The plan is to administer the PEARLS every 6 months, or at closing. The outcomes that we are observing appear to be related to the combined efforts of our CSW, Intern, and IMPACT clinicians. Our CSW has expanded our ability as a program to provide linkage and rehab support, increase the independence of our clients by linking them to resources, and increase their ability to learn and utilize new life skills and self-management tools.

LINKAGE AND FOLLOW-UP: ☐ Not applicable

Please explain how participants are linked to mental health and/or support services, including, how the INN program follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

Participants are linked to mental health and/or support services by the Partners in Aging CSWs. In addition, the CSWs follow up with consumers by phone, email the IMPACT clinicians, and remain in contact with the referral resources they are linking the consumer to in order to ensure successful engagement of services. Housing applications and brochures, transportation resources, assistance with trips to the DMV, assistance with maintenance of benefits, linkage with Community College classes, Senior Center activities, Meals on Wheels information and Contra Costa Continuum of Services are just a few examples of what resources our CSWs provide as far as linkage and follow up. The CSWs continue to establish relationships with outside agencies that will benefit the older adult population we serve. They have attended various meetings and trainings to gather additional resources, including a Forum on Suicide Prevention, training on 211 resources, the Transportation Subcommittee Meeting, Aging and Older Adult Committee and the Social Inclusion Meeting to continue to learn about new resources.

The average length of time between referral and entry to treatment during FY 18/19 is approximately 4.25 days. Most clients were linked with new referrals within 1 day.

VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

We have chosen two case vignettes that demonstrate the successful outcomes of the Partners in Aging Innovation Project. Assistance of the Partners in Aging Project has led to improvements in quality of life, independence, and mental health.

One is a 62-year-old Caucasian male diagnosed with Major Depressive Disorder, Recurrent, Moderate, Generalized Anxiety Disorder, Osteoarthritis, Congestive Heart Failure, Morbid Obesity and a recurrent Wound Infection. He has been receiving brief, short-term therapy through the IMPACT Program and support services through the Partners in Aging Project. Our CSW was able to assist this client through coaching and peer support to achieve the ability to use public transportation independently. He is now able to take himself to medical appointments 3 days a week. He also now goes to the store to get food and to the bank on his own. In addition, he has improved significantly in his ability to advocate for his needs with his medical providers.

Another Partners in Aging client is a 60-year-old Afghani-American female diagnosed with Post-Traumatic Stress Disorder, Back Pain, Insomnia, Hyperlipidemia, and a history of a traumatic brain injury. With the help of our clinician and CSW she has started her road towards financial independence, increasing her feelings of self-worth and self-esteem. This client expressed feeling depressed by depending on her son's family and not being able to provide anything for herself. With CSW support, client has begun the process of obtaining an income, and improving her mental health.