FY 19-20 MHSA
Prevention & Early Intervention (PEI)
Annual Report

and

FY 19-20 MHSA
Innovation
Annual Report

Annual PEI Evaluation Report

Contra Costa
Behavioral Health
Services

Mental Health Services Act

As submitted for MHOAC
FY 2019-2020

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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 $9.1 million for FY 2019-20 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 like 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 19-20, 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 overtime.
- 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 healthcare.

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

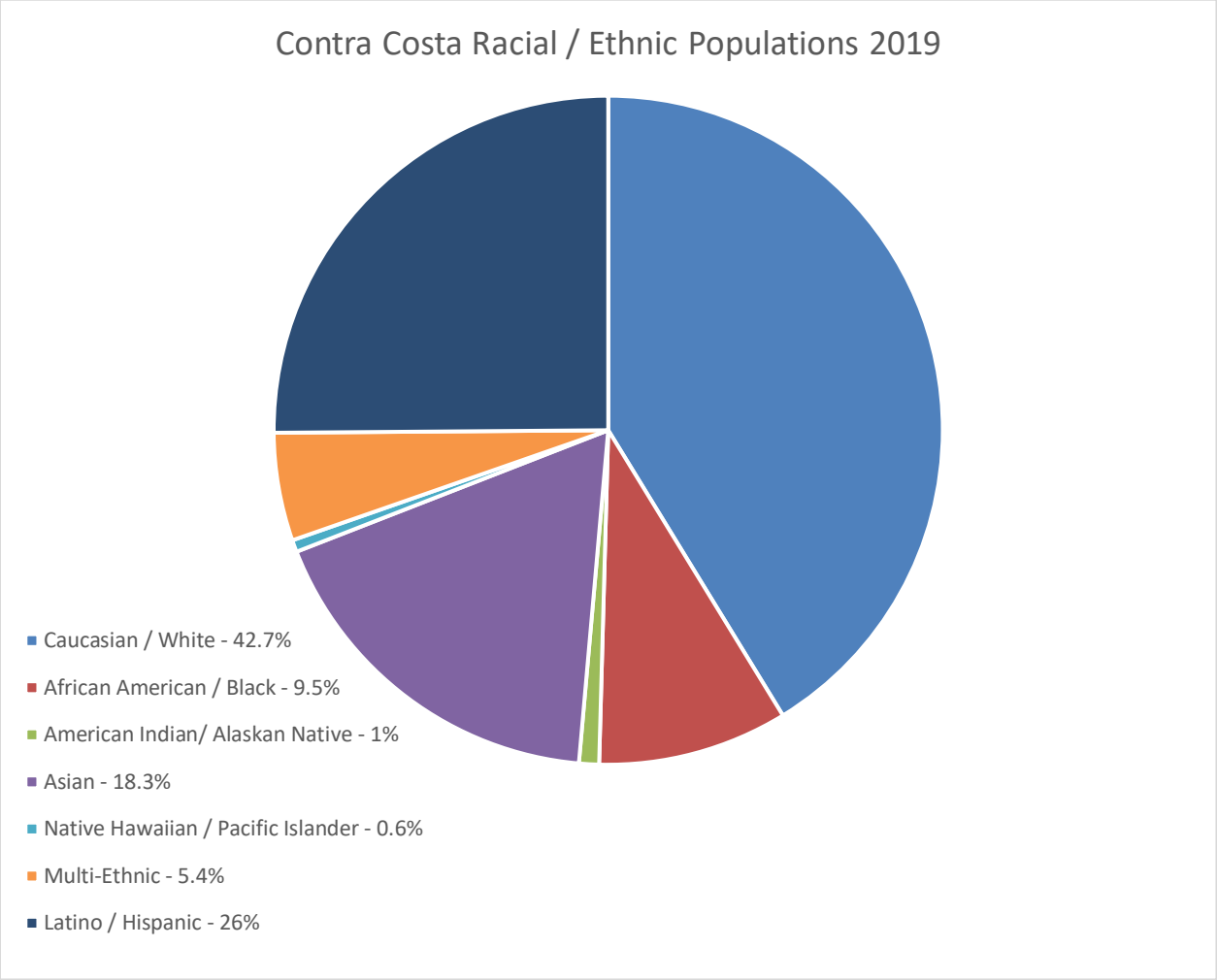
Each program receives a written report that addresses the above areas. Promising practices, opportunities for improvement, and/or areas of concern are noted for sharing or follow-up activity, as appropriate. The emphasis is to establish a culture of continuous improvement of service delivery, and quality 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 FY 2019-20, completed PEI Program and Fiscal Review reports were distributed at the following monthly CPAW meetings: August 1, 2019, January 9, 2020, and February 6, 2020.

PEI AGGREGATE DATA FY 19-20

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, it's estimated that 7.9% 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 Tagalog.



MHSA funded Prevention and Early Intervention (PEI) programs in Contra Costa County served over 32,000 individuals during FY 19-20. 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 19-20.

Total Served: 32,442

Table 1. Age Group

	# Served
Child (0-15)	1,395
Transition Age Youth (16-25)	4,514
Adult (26-59)	9,096
Older Adult (60+)	2,623
Decline to State	14,814

Table 2. Primary Language

	# Served
English	24,071
Spanish	1,959
Other	1,033
Decline to State	5,393

Table 3. Race

	# Served
More than one Race	646
American Indian/Alaska Native	348
Asian	1,932
Black or African American	3,262
White or Caucasian	7,537
Hispanic or Latino/a	3,849
Native Hawaiian or Other Pacific Islander	618
Other	248
Decline to State	14,104

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

	# Served
African	443
Asian Indian/South Asian	1,036
Cambodian	3
Chinese	195
Eastern European	135
European	304
Filipino	33
Japanese	3
Korean	2
Middle Eastern	12
Vietnamese	152
More than one Ethnicity	463
Decline to State	28,453
Other	153

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

	# Served
Caribbean	4
Central American	101
Mexican/Mexican American /Chicano	1,251
Puerto Rican	9
South American	8
Other	23

Table 6. Sexual Orientation

	# Served
Heterosexual or Straight	11,553
Gay or Lesbian	99
Bisexual	156
Queer	18
Questioning or Unsure of Sexual Orientation	25
Another Sexual Orientation	82
Decline to State	20,509

Table 7. Gender Assigned at Birth

	# Served
Male	10,113
Female	11,311
Decline to State	9,495

Table 8. Current Gender Identity

	# Served
Man	10,263
Woman	11,281
Transgender	146
Genderqueer	11
Questioning or Unsure of Gender Identity	8
Another Gender Identity	15
Decline to State	10,718

Table 9. Active Military Status

	# Served
Yes	31
No	2,873
Decline to State	29,073

Table 10. Veteran Status

	# Served
Yes	103
No	3,427
Decline to State	28,912

Table 11. Disability Status

	# Served
Yes	558
No	1,768
Decline to State	30,094

Table 12. Description of Disability Status

	# Served
Difficulty Seeing	88
Difficulty Hearing or Have Speech Understood	77
Physical/Mobility	219
Chronic Health Condition	163
Other	36
Decline to State	25,320

Table 13. Cognitive Disability

	# Served
Yes	144
No	1,327
Decline to State	25,387

Table 14. Referrals to Services

	# Served
Clients Referred to Mental Health Services	1,120
Clients who Participated/ Engaged at Least Once in Referred Service	883

Table 15. External Mental Health Referral

	# Served
Clients Referred to Mental Health Services	22,025
Clients who participated/ engaged at least once in referred service	21,849

Table 16. Average Duration Without Mental Health Services

	# Served
Average Duration for all Clients of Untreated Mental Health Issues (In weeks)	55.9

Table 17. Average Length of Time Until Mental Health Services

	# Served
Average Length for all Clients between Mental Health Referral and Services (In weeks)	4.5

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 (Fiscal sponsor Contra Costa ARC) 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 provide 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 several 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 method to mental health practitioners who serve this at-risk population.
4) Hope Solutions (formerly 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, Los Medanos Village in Pittsburg, and supportive housing sites throughout the County. Services include coordination and assistance with accessing needed community resources, 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 Community Services of the East Bay (JFCS) provides culturally grounded, community-directed mental health education and navigation services to refugees and

immigrants of all ages in the Latino, Afghan, Bosnian, Iranian and Russian communities of Central and East 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 (NAHC) 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.

In addition, additional funding will be added for this Three-Year Plan to provide prevention and early intervention services to families with young children who are experiencing serious emotional disturbances. The Needs Assessment and Community Program Planning Process has identified 0-5 age children with serious emotional disturbances as underserved. The FY 2017-20 MHSA Three Year Plan substantially increased funding for increasing treatment capacity in the Children's System of Care. The FY 2021-22 MHSA Three Year Plan Update dedicates funding to provide outreach, engagement, training, education, and linkage to mental health care for families with young children who are exposed to violence, physical and emotional abuse, parental loss, homelessness, the effects of substance abuse, and other forms of trauma.

The allocation for the Outreach for Increasing Recognition of Early Signs of Mental Illness category is summarized below:

Program	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 21-22
Asian Family Resource Center	Countywide	50	$150,408
COPE	Countywide	210	$253,238
First Five	Countywide	(numbers included in COPE)	$84,214
Hope Solutions	Central and East County	200	$385,477
Jewish Family Community Services	Central and East County	350	$179,720

Native America Health Center	Countywide	150	$250,257
The Latina Center	West County	300	$125,538
0-5 Children Outreach RFP TBD	Countywide	TBD	$125,000
	Total	**1,260**	**$1,553,852**

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 (fiscal sponsor Tides) 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 Alternative High School in the Martinez Unified School District provides career academies for at-risk youth that include individualized learning plans, learning projects, internships, and mental health 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 afterschool 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 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 youth 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 several 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 the Prevention category is summarized below:

Program	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 21-22
Building Blocks for Kids	West County	400	$224,602
Vicente	Central County	80	$191,336
People Who Care	East County	200	$229,795
Putnam Clubhouse	Countywide	300	$631,672
RYSE	West County	2,000	$503,019
	Total	**2,980**	**$1,780,424**

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:

1) 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 psychoeducation, education and employment support, and occupational therapy.

The allocation for the Early Intervention category is summarized below:

Program	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 21-22
First Hope	Countywide	200	$2,587,108
	Total	**200**	**$2,587,108**

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:

2) The James Morehouse Project (fiscal sponsor Bay Area Community Resources -BACR) 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 mindfulness (anger/stress management), violence and bereavement, environmental and societal factors leading to substance abuse, peer conflict mediation and immigration/acculturation.
3) STAND! Against 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.
4) 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. 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 the Access and Linkage to Treatment category is summarized below:

Program	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 21-22
James Morehouse Project	West County	300	$105,987
STAND! Against Domestic Violence	Countywide	750	$138,136
Experiencing Juvenile Justice	Countywide	300	$381,744
	Total	**1,350**	**$625,867**

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 fields two programs under this category. The first is an African American wellness group that serves the Bay Point community in East 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. The second program provides mental health education and supports for LGBTQ 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 Clínica de la Raza reaches out to at-risk LatinX 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 provide 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 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 the Improving Timely Access to Mental Health Services for Underserved Populations category is summarized below:

Program	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 21-22
Child Abuse Prevention Council	Central and East County	120	$128,862
Center for Human Development	East County	230	$161,644
La Clínica de la Raza	Central and East County	3,750	$288,975
Lao Family Community Development	West County	120	$196,128
Lifelong Medical Care	West County	115	$134,710
Rainbow Community Center	Countywide	1,125	$782,141
	Total	**5,460**	**$1,692,460**

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) advocate for services that 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 several 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 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.
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 er 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) provides technical assistance to encourage the County's integration of available statewide resources on stigma and discrimination reduction and suicide prevention. CCBHS partners 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 the Stigma and Discrimination Reduction category is below:

Program	County/Contract	Region Served	MHSA Funds Allocated for FY 21-22
OCE	County Operated	Countywide	$218,861
CalMHSA	MOU	Countywide	$78,000
	Total		**$296,861**

SUICIDE PREVENTION

There are three plan elements that support the County's efforts to reduce the number of suicides in Contra Costa County: 1) augmenting the Contra Costa Crisis Center, and 2) supporting a suicide prevention committee. Additional funds are allocated to dedicate staff trained in suicide prevention to provide countywide trainings, education, and consultation for a host of entities such as schools, social service providers, criminal justice and first responder community-based organizations to know the signs of persons at risk of suicide, assess lethality and respond appropriately.

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) 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. In 2021, a subcommittee was convened to address Youth Suicide Prevention. In the light of the pandemic, school-based providers and people living and working with youth have expressed great concern about their mental health during these challenging times. The group meets in the late afternoon to encourage participation of students and young people.

The allocation for the Suicide Prevention category is summarized below:

Plan Element	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 21-22
Contra Costa Crisis Center	Countywide	25,000	$320,006
Suicide Prevention RFP TBD	Countywide	TBD	$50,000
County Supported	Countywide	N/A	Included in PEI administrative cost
	Total	**25,050**	**$370,006**

PEI ADMINISTRATIVE SUPPORT

Staff time 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 PEI Administration is summarized below:

Plan Element	Region Served	Yearly Funds Allocated
Administrative and Evaluation Support	Countywide	$158,090
	Total	**$158,090**

PREVENTION AND EARLY INTERVENTION (PEI) SUMMARY FOR FY 2021-22

Outreach for Increasing Recognition of Early Signs of Mental Illness	1,553,852
Prevention	1,780,424
Early Intervention	2,587,108
Access and Linkage to Treatment	625,867
Improving Timely Access to Mental Health Services for Underserved Populations	1,692,460
Stigma and Discrimination Reduction	296,861
Suicide Prevention	370,006
Administrative, Evaluation Support	158,090
Total	**$9,064,668**

APPENDIX A - PROGRAM PROFILES

Asian Family Resource Center (AFRC)

Point of Contact: Sun Karnsouvong
Contact Information: Asian Family Resource Center (AFRC), 12240 San Pablo Ave, Richmond, CA
Skarnsouvong@arcofcc.org

1. **General Description of the Organization**
   AFRC 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), under the fiscal sponsorship of Contra Costa ARC, 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. AFRC 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. AFRC, 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 generally be provided for a period of less than one year. AFRC will serve a minimum of 50 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.

iii. Translation and Case Management: AFRC staff will provide translation and case management services to identified mono-lingual consumers in the West County Adult Behavioral Health Clinic in San Pablo, CA. Services will include attending medical appointments, assisting with applications and forms, advocacy, and system navigation.

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 21-22: $150,408

d. Number served: FY 19-20: 583 high risk and underserved community members

e. Outcomes:

- Successful adaptation of services due to COVID-19 including telehealth, social distancing, mask wearing, and connecting participants to resources that were more difficult to access due to the pandemic.
- 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 and outreach is conducted in areas frequented by those they are trying to engage.
- Program collaborated with other service providers via zoom during the pandemic to share resources, information, and support.

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 (BBK) amplifies the voices of parents/caregivers of color and partners 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. We realize our goals through healing centered care, leadership development, and parent-led advocacy. BBK serves parents and primary caregivers living in West Contra Costa County that primarily represent low-income African-American, Latinx and immigrant populations.

2. **Program: Not Me Without Me - PEI**

a. Scope of Services:
   Building Blocks for Kids Collaborative, a project of Tides Center, will provide diverse West County households 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 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 and West Contra Costa 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: Parents and caregivers and their families living in West Contra Costa County
c. Payment Limit: FY 21-22: $224,602
d. Number served: In FY 19-20: 336 Individuals (includes outreach and education events).
e. Outcomes

- During the COVID-19 pandemic, BBK pivoted to continue to engage the community. Staff transitioned into a virtual model. Programs was offered through Zoom meetings, phone calls, and videos on their Facebook page.
- 195 women participated in a total of 28 Black and LatinX Women's Peer Sanctuary groups where they received facilitated support for self-case, advocacy, personal goal setting and reclaiming positive cultural practices.
- Family Engagement activities events, during which families are invited to spend an enjoyable and safe time with their families, were held at Monterey Pines Apartments. 87 people participated in Family Engagement activities, including: an informational session about the Welcome Home Baby Program, Mindfulness practices, Youth Service Bureau, Effective Ways of Communication through Community Circles, Census Information as well family bonding arts & crafts and games.
- At the Health and Wellness free summer program, children under the age of 18 had access to free lunch Monday through Friday, Zumba classes and enrichment activities. BBK staff served an average of 90 children daily and altered their offerings to accommodate virtual programming to follow safety guidelines during the pandemic.
- BBK partnered with Child Abuse Prevention Council to offer weekly evidence-based parenting classes (Nurturing Parenting) in Spanish and English. A total of 26 parents/caregivers graduated from the 22-week program and 146 adults participated in a parent-child skills development playgroup.

Center for Human Development (CHD)

http://chd-prevention.org/
Point of Contact: David Carrillo
Contact Information: 901 Sun Valley Blvd., 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 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 & Youth Empowerment Program - PEI**

a. Scope of Services: The African American Wellness Program (formerly African American Health Conductor Program) serves Bay Point, Pittsburg, and surrounding communities. The purpose is to increase emotional wellness; reduce stress and isolation; and link African American participants, who are underserved due to poor identification of needs and lack of outreach and engagement, to appropriate mental health services. Key activities include: outreach through community events; culturally appropriate education on mental health topics through Mind, Body, and Soul support groups; conduct community health education workshops in accessible and non-stigmatizing settings; and navigation assistance for culturally appropriate mental health referrals.

   The Youth Empowerment Program provides 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 include: a) Three weekly educational support groups that 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 meets a minimum of twice a month to foster community involvement; and c) linkage and referral to culturally appropriate mental health service providers in East County.

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 21-22: $161,644
d. Number served: FY 19-20: 733 individuals were served in both programs combined
e. Outcomes:
   - African American Wellness Program
     - Served 623 participants during FY 2019-20.
     - Moved to telehealth due to COVID-19.
     - Provided 9 clients with mental health referrals.

    - Participants were provided individualized services to help them to address the current issues they are facing
- Youth Empowerment Program
    - 110 individuals were served.
    - Staff facilitated 134 educational group sessions, trainings, and Leadership sessions and staff had 412 individual one-on-one meetings with youth. This is nearly double the number of individual check-ins and one-on-one meetings from the previous year.
    - Successfully Moved to telehealth due to COVID-19
    - Provided 6 clients with mental health referrals.
    - All Empowerment participants receive an emergency services “Safety Phone List”, 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.

Child Abuse Prevention Council (CAPC)

www.capc-coco.org
Point of Contact: Carol Carrillo
Contact Information: 2120 Diamond Blvd #120, Concord, CA 94520
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 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 provides an evidence-based curriculum of culturally, linguistically, and developmentally appropriate, Spanish speaking families in East County, and Central County's Monument Corridor. The 20-week curriculum immerses 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 are provided to each family served in the program using strategies that are non-stigmatizing and non-discriminatory. Families are provided with linkages to mental health and other services as appropriate. Providing the Nurturing Parenting Program (NPP) 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 21-22: $128,862

d. Number served: In FY 19-20: 169 parents and children

e. Outcomes:

- Two 20-week classes in Central and East County serving parents and their children.
- During the first semester of The Nurturing Parenting Program a total of 44 parents and 45 children enrolled in the program. A total of 29 parent and 36 children completed and graduated from the NPP successfully.
- During the second semester of The Nurturing Parenting Program a total of 41 parents and 39 children enrolled in both regions. A total of 31 parents completed and graduated from the program despite the many challenges faced during the COVID-19 Shelter-in-Place.

- Staff modified sessions to meet parents needs during the pandemic and offered resources to families who lost their jobs, linked parents to internet access, and guided them on how to start using zoom to stay connected.
- 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
Contact Information: P.O. Box 3364 Walnut Creek, CA 94598
925 939-1916, x107, 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**

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 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 offer grief support groups and postvention services to the community
- 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 21-22: $320,006
d. Number served: In FY19-20: 21,577 total calls were fielded.
e. Outcomes:
    - Services provided in English and Spanish, and callers have access to the Language Line interpreter services in 240 languages.
    - Upgraded to an advanced web-based phone system software in July 2019, allowing for remote work in case of a disaster, and increased the accuracy of calls answered, average speed to answer (in seconds), and abandonment rate measurements. This allowed calls to the 24-hour crisis lines to continue without interruption with staff and volunteers working either in the office or remotely due to COVID-19.
    - 21,577 referrals were made to mental health services
    - Managed an unprecedented increase in total call volume starting in March 2020 with callers needing referrals for health, food, housing, and financial assistance as well as experiencing feelings of high anxiety and stress.
    - Provided a 54+ hour call center training for new call center staff and volunteers several times throughout the year

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

http://copefamilysupport.org/
Point of Contact: Cathy Botello, Executive Director
Contact Information: 3000 Citrus Circle, Ste. 220, Walnut Creek, CA 94598
(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. **Program: Positive Parenting Program (Triple P) 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 onstrengthening 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 independentlysolve 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 orthe 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. 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 to build and maintain a pool of Triple P practitioners.

b. Target Population: Contra Costa County parents of children and youth withidentified special needs. Our targeted population includes caregivers residing in underserved communities throughout Contra Costa County.

c. Payment Limit: FY 21-22: $253,238
d. Number served: In FY 19-20: 235
e. Outcomes:
   - Provided 21 Triple P Positive Parenting Group classes and seminars to groups in West, Central and East Contra Costa County.
   - Enrolled 235 client family members in Triple P Parenting classes.
   - Provided a Family Transitions Triple P training program and accredited 18 practitioners.
   - Beginning in Mid-March 2020, COPE moved all Triple P classes to online using the Zoom video conferencing platform.
   - Pre and Post Test Survey results indicate program participants showed a 37% decrease in depression, 41% decrease in anxiety, and 24% 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.

First Five Contra Costa

http://www.first5coco.org/
Point of Contact: Wanda Davis
Contact Information: 1486 Civic Ct, 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 21-22: $84,214

d. Number Served: In FY 19-20: 189 client family members enrolled in C.O.P.E. Triple P Parenting classes

e. Outcomes:

- Delivered 15 classes and 2 seminar series throughout the county at various times and convenient locations to accommodate transportation barriers. (through partnership with C.O.P.E.)
- Held 12 presentations and briefings to early childhood organizations as an engagement and recruitment tool
- Offered case management support to parents as appropriate

First Hope
(Contra Costa Behavioral Health Services)

http://www.firsthopeccc.org/
Point of Contact: Jude Leung, Mental Health Program Manager
Contact Information: 391 Taylor Boulevard, Suite 100, Pleasant Hill, CA94523
925-608-6550, yatmingjude.leung@cchealth.org

1. **General Description of the Organization**
   Contra Costa Behavioral 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 and 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 30 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.
   - In FY 18-19, the program expanded 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

b. Target Population: 12–30-year-old young people and their families
c. Total Budget: FY 21-22: $2,587,099
d. Staff: 27 FTE full time equivalent multi-disciplinary staff
e. Number served: FY 19-20: 960
f. Outcomes:
   - Helped clients manage Clinical High-Risk symptoms and maintain progress in school, work, and relationships.
   - One conversion out of 78 from clinical high risk to psychosis.
   - 104 First Hope clients had zero PES visits or hospitalizations.
   - Zero completed suicides in FY 19-20.

- Trained 13 new staff in the Coordinated Specialty Care (CSC) model and trained and certified all staff in MultiFamily Group Treatment (MFGT) and Cognitive Behavioral Therapy for Psychosis (CBTp).
- Reduced the stigma associated with symptoms.
- 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.

Hope Solutions (formerly Contra Costa Interfaith Housing)

https://www.hopesolutions.org/
Point of Contact: Sara Marsh
Contact Information: 399 Taylor Blvd. Ste. 115, Pleasant Hill, CA 94530
(925) 944-2244, smarsh@hopesolutions.org

1. **General Description of the Organization**

   Hope Solutions 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**

a. Scope of Services:

- The Strengthening Vulnerable Families program provides support services at 5 locations. All these locations house vulnerable adults and/or families with histories of homelessness, mental health challenges and/or substance abuse problems. Case management was provided on-site and in-home for all residents requesting this support. Youth enrichment/afterschool programming was provided at all family housing sites. The total number of households offered services under this contract was 286, including the following sites:
  - Garden Park Apartments (Pleasant Hill) – 27 units permanent supportive housing for formerly homeless families with disabilities
  - Lakeside Apartments (Concord) – 124 units of affordable housing for low-income families and individuals (including 12 units of permanent supportive housing for formerly homeless residents with disabilities).
  - Bella Monte Apartments (Bay Point) – 52 units of affordable housing for low-income families and individuals
  - Los Medanos Village (Pittsburg) – 71 units of affordable housing for low-income families and individuals
  - MHSA funded housing (Concord, Pittsburg) - 12 residents in 3 houses.
- In addition to case management, Hope Solutions also provides property management and maintenance for the 12 units of MHSA housing.
- Hope Solutions also agreed to participate with helping to host a community forum on permanent supportive housing during the year.

b. Target Population: Formerly homeless/at-risk families and youth.
c. Payment Limit: FY 21-22: $385,477
d. Number served: In FY 19-20: 433 clients
e. Outcomes:

- Provided 8 parenting support groups, 8 sessions/group at the 4 housing sites for a total of 67 group sessions and least 83 participants.
- Provided 4350 hours of support services with on-site case management to 275 families/433 individuals.
- After the Shelter-in-Place order many residents lost their jobs. Working remotely, case managers assisted 23 residents to access unemployment resources, and 33 residents to access COVID funds to subsidize rents. At Lakeside 12 undocumented families were also assisted to receive the COVID California state funds designated for immigrants.
- Staff also organized food resources for families with limited funds and delivered food to over 100 households to help keep residents safe. Case managers also distributed activity bags to youth including crayons, activity booklets, and hand sanitizer/PPE. Masks were distributed to over 100 families as needed, and education and support was offered regarding the stay-at-home order and the COVID19 virus.
- Provided 2914 hours of service to 181 youth at youth enrichment centers in the four housing sites. Activities included afterschool programming, summer programming, educational advocacy, and a teen support group.
- 99% (277/281) of families maintained their housing. 96% (104/108) of families at risk for eviction remained housed. 98% (243/248) of families requesting assistance with concrete resources had their request fulfilled (e.g., access to food, employment, transportation, healthcare, and mental health resources).
- 100% (8/8) of the residents who attended the wellness/harm-reduction group sessions reported using the coping strategies they learned in the groups.
- 77% (33/43) of youth who were assessed with the Social Skills Index Survey (SSIS) improved their skill score over the year.
- 87% (71/82) of youth that participate in the afterschool academic and tutoring program achieved at least four new CA Academic benchmarks.
- 86% (62/72) of grades K through 5 children achieved progress with their reading skills
- 100% (4/4) of Teen Club youth participants completed end of year surveys and showed improved self-concept/self-esteem.
- 88% (75/85) of parents who received educational advocacy/coaching reported having an improved/positive experience working with school personnel.

James Morehouse Project (JMP) at El Cerrito High (fiscal sponsor of Bay Area Community Resources)

http://www.jamesmorehouseproject.org/
Point of Contact: Jenn Rader
Contact Information: 540 Ashbury Ave, 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: BACR), 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 21-22: $105,987
d. Numbers Served: FY 19-20: 405 young people
e. Outcomes:
   - With the help of a team that included 8 clinical interns, JMP served 405 young people participated in 23 different groups and/or individual counseling.
   - Referred 17 young people to mental health services.

- Altered services to accommodate remote support with COVID-19 including partnering with community-based partners like the Seneca MRT in crisis situations.
- COVID-19 related needs were addressed through case management, including working with young people and families around challenges with distance learning (e.g., accessing Wi-Fi, troubleshooting tech challenges), and securing cash assistance and accessing other resources (e.g., food, legal assistance).
- 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.

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

https://jfcs-eastbay.org/
Point of Contact: Lisa Mulligan
Contact Information: 1855 Olympic Blvd. #200, Walnut Creek, CA 94596
(925) 927-2000, lmulligan@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 21-22: $179,720

d. Number served: FY 19-20: 311

e. Outcomes:

- Provided culturally and linguistically appropriate care to all consumers served
- Served 311 people, including 135 frontline staff and 176 clients.

- Completed three out of four planned trainings for the year. The fourth training was cancelled due to COVID-19. All three trainings were held via Zoom and had high attendance. In total, 135 service providers from the community were trained, exceeding the target of training 75 frontline staff. 96% of respondents reported a better understanding of recognizing stress and risk factors after the training and 91% of respondents reported a better understanding of when to refer clients to specialized services.
- Provided mental health education classes to 16 Russian-speaking seniors, parenting workshops to 16 Afghan parents, bilingual/bicultural case management to 160 clients (including 85 children ages 18 and under and 75 adults ages 18 and older and provided bicultural individual therapy services to 25 Dari-speaking clients.
- 100% of the 75 adult case management clients reported upon exit they were able to independently seek help for mental health services, knew how to link to the appropriate persons within the county health care system or other community resources for resolution of health or mental health issues, and had an increased understanding of health and mental health care systems in Contra Costa County.
- 81% of participants in the Russian Mental Health classes reported a better understanding of when and how to seek help, 93% reported an increased ability to recognize stress and risk factors in themselves and/or family members, and 93% reported feeling more supported after coming to the group.
- 100% of participants in the Afghan Parenting Workshops reported they learned useful skills to become a more effective parent, had a better understanding of when and how to seek help, and felt more supported after coming to the group. 87.5% reported having an increased ability to recognize stress and risk factors in themselves and/or family members.

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

Point of Contact: Steve Blum
Contact Information: 202 Glacier Drive, Martinez, CA 94553
(925) 957-2739, steven.blum@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 and 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)* 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.
b. *Mental Health Probation Liaison Services (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.
c. Target Population: Youth in the juvenile justice system in need of mental health support
d. Payment Limit: FY 21-22: $381,744
e. Staff: 5 Mental Health Clinical Specialists: 3 probation liaisons, 2 clinicians at the Ranch
f. Number Served: FY 19-20: 300+
g. Outcomes:
   - Help youth address mental health and substance abuse issues that may underlie problems with delinquency.

- Increased access to mental health services and other community resources forat risk youth.
- Provide referrals, short-term therapy, and short-term case management tohelp decrease symptoms of mental health disturbance.
- Increase family and youth help-seeking behavior; decrease stigma associated with mental illness.
- Work with Probation, families, and youth to decrease out-of-home placementsand rates of recidivism.
- Help youth and families increase problem-solving skills

La Clínica de la Raza

https://www.laclinica.org/
Point of Contact: Laura Zepeda Torres
Contact Information: PO Box 22210, Oakland, CA, 94623
(510) 535 2911, lztorres@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 goal of: a) 3,000 depression screenings; b) 250 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) 1,250 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) 75 Assessments (includes child functioning and parent education/support) with the Behavioral Health Specialist will be provided to parents/caretakers of children ages 0-18; 3) Three hundred (300) follow up visits with children/families to provide psychoeducation/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 21-22: $288,975
d. Number served: FY 19-20: 922
e. Outcomes:
   - Vías de Salud:
     - Offered 3623 depression screenings (120% of yearly target), 296assessments and early intervention services (118% of yearly target), and 1238 follow-up support/brief treatment services (99% of yearly target).

    - Programming pivoted to telehealth as needed during COVID-19
- Familias Fuertes:
    - Offered 661 screenings for youth (88% of yearly target), 113 assessments for youth (105% of yearly target), and 333 follow-up visits with families (111% of yearly target).
    - Programming pivoted to telehealth as needed during COVID-19

Lao Family Community Development

https://lfcd.org/
Point of Contact: Kathy Chao Rothberg, Brad Meyer
Contact Information: 1865 Rumrill Blvd. Suite #B, San Pablo, Ca 94806
(510) 215-1220 krothberg@lfcd.org ; 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 21-22: $196,128

d. Number served: In FY 19-20: 128

e. Outcomes:

- A total of 125 clients completed the Pre LSNS assessment and 125 clients completed the Post LSNS assessments. The average progression was 8 with a high correlation between

the participant's progression and level of participation in monthly social peer support groups activities and workshops.

- 98% (125 of 128 respondents) of the participants were satisfied with the program services, and 2% (3 of 128 respondents) were somewhat satisfied with the program services.
- 101 clients were referred to mental health services.
- Held 16 Strengthening Families Program (SFP) workshops (2 workshops per month from August 2019 to March 2020). Due to COVID-19 there were no SFP event from April to May 2020.
- Facilitated 6 different thematic peer support groups/events during the FY
- Provided case management and system navigation for 128 community members

The Latina Center

https://thelatinacenter.org/
Point of Contact: Miriam Wong, 3701 Barrett Ave #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 strive 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 fordeveloping serious mental illness.

c. Payment Limit: FY 21-22 $125,538

d. Number served: For FY 19-20: 314

e. Outcomes:

- Served a total of 314 parents (parenting sessions, mental health workshops, psycho-educational therapy, support groups).
- Additionally, provided 30 learning circles with activities reaching 424 children.
- Outreach efforts reached 1,031 individuals and enrolled 42 people into theirprograms.
- Parenting classes were held in 4 community-based locations: Cesar Chavez Elementary School, Mira Vista Elementary, Richmond Charter Academy, and The Latina Center. All classes completed the 10-week sessions, 6 sessions online.
- 286 parents (244 women and 42 men) registered for the parenting class and completed a pre-survey in Spanish.
- Based on the responses to the pre-survey, The Latina Center made at least 28referrals.

- Held 6 Mental Health Workshops in 3 locations (The Latina Center, St Cornelius Catholic Church and Montalvin Elementary School) for 130 participants; 94 participants completed pre- and post-surveys.
- Before the workshop, 65% of parents said they did know what mental illnesses are; 35% did not know. After the workshop, 96.9% understood what mental illnesses are; 3.1% did not understand. Before the workshop, 57.5% knew any symptoms of mental illness and 42.5% did not. After the workshop, 81.3% stated they knew signs and symptoms and 18.8% did not.

Lifelong Medical Care

https://www.lifelongmedical.org/
Point of Contact: Kathryn Stambaugh
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 and cultural backgrounds.

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 primarily African American older adults living 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 21-22: $134,710

d. Number served: FY 19-20: 150

e. Outcomes:

- Prior to Shelter-in-Place, an average of 10 onsite events were held per month (including, creative movement, exercise, bilingual songs, discussion groups, tai chi, walking groups, Spanish classes, and arts & crafts, as well as memorial events for residents who passed away and an outing to visit a participant in the hospital). There was also a health fair held in the fall of 2019. The second planned health fair was cancelled due to COVID-19.
- With COVID-19 services shifted to mainly virtual (telephone and Zoom) interactions and there was an increased emphasis on food distribution. Distribution of masks and PPE, as well as outreach to at-risk older-adult consumers was prioritized.
- Registered 24 people for Meals on Wheels and made 289 deliveries of meals and/or groceries during April-June.
- The Annual survey was adapted to a shorter telephone survey due to COVID-19 and they documented 41 responses. Results were very positive, with all respondents reporting that they were very (79%) or somewhat (21%) satisfied with SNAP overall. 100% were satisfied with the food distribution portion of SNAP during Shelter-in-Place.

Native American Health Center (NAHC)

http://www.nativehealth.org/
Point of Contact: Anthony Guzman, Catherine Nieva-Duran
Contact Information: 2566 MacDonald Ave, Richmond, CA 94804
(510) 434-5483, anthonyg@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 NAHCstaff, 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: basket weaving, beading, quilting, health and fitness coaching 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 westregion), who are at risk for developing a serious mental illness.
c. Payment Limit: FY 21-22: $250,257
d. Number served: FY 19-20: 68
e. Outcomes:

- Hosted weekly prevention groups to serve the needs, empower, uplift, motivate, and connect with potential first responders.
- Made 16 behavioral health related referrals during this contract year.
- Held a total of 11 community-based events and trainings in FY 19-20, including Mental Health First Aid

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

Point of Contact: Jennifer Tuipulotu
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 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.
- The Wellness and 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.
- 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
- 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.

- 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.

b. Target Population: Participants of public mental health services, their families, and the public.
c. Total MHSA Funding for FY 21-22: $218,861
d. Staff: Three
e. Number Served: FY 19-20: 400+
f. Outcomes:
   - Committee for Social Inclusion convened 11 in-person and virtual meetings open to the community
   - PhotoVoice convened 6 subcommittee meetings open to the community, held Recovery Month exhibition, and trained Health, Housing and Homeless Services (H3) staff to facilitate classes for Homelessness Awareness Month exhibition
   - WRAP coordinated recertification of 17 Community Support Workers as facilitators and certification of an additional 11 CSWs as first-time facilitators.
   - WREACH convened 6 subcommittee meetings open to the community

People Who Care (PWC) Children Association

http://www.peoplewhocarechildrenassociation.org/
Point of Contact: Constance Russell
Contact Information: 2231 Railroad Ave, Pittsburg, 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 young people 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 youth 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 21-22: $229,795

d. Number served: FY 19-20: 207

e. Outcomes:

- After Shelter-in-Place started, organized online tournaments to keep students engaged and connected. 40 students participated in each week-long and 2 week-long competition.
- During the Green Jobs Bridge program (virtual adaptation of existing/pre-covid program) a total of 12 unduplicated, and 78 duplicated students participated in the program. More than 50% of participants did not re-offend during the participation in the program
- Students participated in a weeklong simulation in which they had to utilize skills and learning from personal finance lesson taught to make financial and life decisions in an open simulation combining all finance-oriented modules (Budgeting and Saving, finding an apartment, choosing and balancing a bank account, getting a credit card, fixing your credit, online banking, time management and health, paying and filing taxes, intro to investing for retirement, risk vs. return, and diversification). The goal was to have the highest net worth by the end of a week's time. The winner went from $0 and homeless to home-owning, college-educated with 250k in the bank. 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
Contact Information: 3024 Willow Pass Rd #230, Concord CA 94519
(925) 691-4276, (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 several 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 21-22: $631,672
d. Number served: In FY 19-20: 456
e. Outcomes:
   - 456 unduplicated members (target: 300) spent 57,290 hours engaged in Clubhouse programming activities (target: 40,000 hours). 55 newly enrolled Clubhouse members (target: 70) participated in at least one Clubhouse activity
   - Members helped prepare and eat 30,938 meals at the Clubhouse (target: 9,000). This is significantly higher than in past years due in large part to the implementation of a food pantry in response to COVID-19.
   - 1,543 rides were provided to members to and from Clubhouse activities, job interviews, medical appointments, and more.
   - 1,403 in-home outreach visits were provided.
   - 131 postings (target 124) were made on the Career Corner Blog and 4 career workshops were held (target 4).
   - Three community events were held with 378, 389, and 397 people in attendance respectively. The latter was held virtually due to COVID-19.
   - Assisted the implementation of the Portland Identification and Early Referral (PIER) program for individuals at risk of psychosis, First Hope, by providing logistical and operational support.
   - Survey data demonstrated positive outcomes in terms of consumer and caregiver satisfaction, respite, well-being, decreased hospitalizations, increased referrals, etc.

Rainbow Community Center

https://www.rainbowcc.org/
Point of Contact: Kiku Johnson
Contact Information: 2118 Willow Pass Rd, Concord, CA 94520.
(925) 692-0090, kikujohnson@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: Outpatient Behavioral Health and Training, and 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 21-22: $782,141
d. Number served: FY 19-20: 941
e. Outcomes:

- Implemented a Training and Curriculum Manager position with a seasoned SOGIE (Sexual Orientation, Gender Identity and Expression) national trainer and published educational curriculum writer that joined the staff in March 2020. This enabled Rainbow to launch within the two months of the state's Shelter-in-Place orders, a meaningful update to culturally informed work through virtual SOGIE workshops and trainings.
- Rainbow's Inclusive School Coalition served the following four districts: Mt. Diablo, Pittsburg, Acalanes, West Contra Costa Unified.
- Offered services to LGBTQ seniors, adults, and youth through their various tiered services

RYSE Center

https://rysecenter.org/
Point of Contact: Kanwarpal Dhaliwal
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.
2. **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 21-22: $503,019

d. Number served: FY 19-20: 865 young people

e. Outcomes:

- 283 new members enrolled, for a total of 613 unduplicated members attending. Since March 2020. An additional 322 youth participants (not unduplicated) who are not formally enrolled as members took park via virtual program offerings.
- Health and wellness content promoted via social media (Instagram Live videos and TikTok) also engaged youth in the community, with over 2,000 views.
- Supported students across WCCUSD to respond to distance learning policies, surveyed over 282 youth about distance learning needs and ideas, organized a Youth Town Hall for over 100 participants on distance learning, and participated in local, statewide, and national forums to share youth experiences.
- Created a Youth COVID-19 Care Fund, providing direct cash disbursements to nearly 200 youth and their families, as well as assisted the City of Richmond with establishing a community-guided Richmond Rapid Response Fund
- 107 young people completed Education, Career, Let's Get Free or Case Management Plans
- 22 young people completed Community Service requirements with support from RYSE.
- Engaged at least 33 young people who came to RYSE through reentry/transition from juvenile confinement in the Hire Up, Rysing Professionals, and Side Hustle programming
- 23 young men, ages 15-18, completed the Hidden Genius Project (HGP), a 15-month intensive Tech Literacy and Skill-Building program for Black-identified males in the areas of computer science and entrepreneurship.
- Engaged over 326 young people through an arts-based healing program.

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 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 21-22: $138,136
d. Number served: FY 19-20: 1778
e. Outcomes:
   - *You Never Win with Violence* presentations to 1445 middle and high school youth (during 55 presentations) in Contra Costa County
   - 17 *Expect Respect* groups reached 146 participants
   - Offered 17 10-week long gender-based support groups

- Trained adult allies (teachers and other school personnel)

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 PEI program at Vicente Martinez High School and Briones School (co-located on the same campus) offers an integrated mental health focused experience for 10th-12th grade at-risk students of all cultural backgrounds. Students are provided 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.
2. **Program: Vicente Martinez High School & Briones School - PEI**

a. Scope of Services: Vicente Martinez High School and Briones School provide 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 21-22: $191,336
d. Number served: FY 19-20: 245
e. Outcomes:
   - 97% of the Vicente student body and 54% of Briones students participated in PEI

activities.

- All seniors participated in service-learning hours. A minimum of 15 hours is usually required. Due to the school closure because of COVID-19 some students didn't complete all hours but were given a waiver for these hours.
- All students were offered mental health counseling and there was one full time mental health counselor on campus daily.
- Staff organized and hosted 70 different types of activities and events to enrich the curricula.
- Vicente was again a recipient of the Model Continuation High School Recognition through the California Department of Education
- and the California Continuation Education Association.
- All students were given the opportunity to apply, interview and participate in career-focused internships.
- At least 70% of students who participated in four or more services and who had had chronic absenteeism increase their attendance rate by 5%.

APPENDIX B – PROGRAM ANNUAL REPORTS FY 19-20

PEI ANNUAL REPORTING FORM

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS REPORTING FORM

FISCAL YEAR: 19-20

Agency/Program Name: VistAbility/Asian Family Resource Center

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 summarize the Scope of Services as outlined in the Service Work Plan. Please also address any other relevant activities or events that took place during the reporting period.

Our primary method of outreach and engagement with potential responders were program brochures. 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. 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, and community events on the weekend and are also distributed to the participants at diverse community activities. In addition to having 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 to further engage with our community.

Furthermore, we hold psychoeducation workshops for community members regarding the importance of prevention and early intervention relative to mental health, as well as self-care and human wellness. 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. For instance, if there is a potential case that needs mental health assessment and treatment, the case would be transferred to another program we offer, Medi-Cal recipients. For individuals who are not qualified for this treatment program or are having difficulties accessing or receiving services in English because of language and cultural barriers. They would be 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.)

To improve timely access to services for underserved populations, we regularly attend community meetings and workshops. We receive training for new and updated information about laws, public benefits, social services, etc. that may have an impact on the people we serve. This way we, as providers, can develop a better understanding of the needs of services for underserved populations and provide more catered and supportive services.

On September 26, 2019, 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. 68 people attended the event, including those from Chinese, Vietnamese, Lao, Khmu, and Mien communities. Our agency gave out 55 bags of produce and food to the consumers. 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.

Asian Family Resource Center (AFRC), a satellite site of VistAbility/CCARC will provide comprehensive and culturally sensitive, appropriate education and access to Mental Health Services for Asian and Pacific Islander (API) immigrant and refugee communities, especially the Southeast Asians and Chinese population of Contra Costa County. VistAbility/CCARC will employ multilingual and multidisciplinary staff from the communities which they serve. Staff will provide the following scope of service.

Outreach and Engagement Services: individual and/or community outreach and engagement to promote mental health awareness, educate community member on signs and symptoms of

mental illness, provide mental health workshops, and promote mental health wellness through community events. Engage community member in various activities to screen and assess for mental illness and/or assist in navigating them into the service systems for appropriate intervention: community integration skills to reduce MH stressors, senior 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 ,laid off, domestic violence, criminal justice issues, health care and disability services), mental health education and awareness, and health/mental health system navigation. VistAbility/CCARC, 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 API immigrants and refugees in the Contra Costa County.

Individual Mental Health Consultation: will also be provided to those who are exhibiting signs of mental illness early in its manifestation, to assess needs, identify signs/symptoms of mental health crisis/trauma, provide linkages/referrals or assist in navigating them into the mental health system in culturally responsive manner without stigma, and provide wellness support groups to prevent escalations in mental health symptoms or stressors, accessing essential community resources, and linkages/referral to mental health services. Peer navigators will be utilized to support participants to access services in a culturally sensitive manner. These services will be provided for a period of less than one year unless psychosis is present. VistAbility/CCARC will serve a minimum of 55 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.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services. Please include: Numbers served during the fiscal year, describe any adaptation of services due to COVID-19 that may be relevant, include a list of indicators measured, how often data was collected and analyzed.

During this 2019-2020 fiscal year, Asian Family Resource Center served 583 individuals. Due to COVID-19, we regularly called and did home visits with our clients who could not come the office. We would speak to them from the car with our mask on. We bought groceries and necessaries for vulnerable clients who could not go out. We communicated local resources such as rent assistance, meals on wheels, food bank, cleaning supplies, etc. 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's name so their information will always be confidential. We use 1 form per 1 individual per 1 contact. The data is compiled at end of the month and analyzed.

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

Please refer to Aggregate Data Reporting Form Not Applicable

CULTURAL RESPONSIVENESS:

How have services been informed and structured to meet the diverse cultural needs of your clients/members/participants? What is being done by your organization to support cultural responsiveness both within the workforce and for those served by your organization?

Asian Family Resources Center has been able to meet the diverse cultural needs of our clients by providing services in multiple languages to meet the need of these groups. We would go to different areas to distribute brochures to where these groups are at. These areas include other agencies, housing complexes, farmer markets, Chinatown, Asian supermarkets, and community events. We also appeal these diverse groups by promoting and hosting events they are used to. A lot of the groups we work with come from cultures focused on community, so we often host events focused on communal support and community building. Many of these events were unfortunately canceled however due to COVID-19, such as our annual picnic. We focus on the community, which is how we support cultural responsiveness.

COLLABORATIVE PRACTICES:

Describe how you are working with any other agencies or organizations to better serve clients/members/participants? If this is currently not being done, please describe any effort to build relationships with other community service providers?

Asian Family Resources Center used to host the outdoor events, information fair, workshop, and joined other agencies for community events. During pandemic our agency staff joining other agencies in zoom meeting to get or share some information and support on how to help clients who are in need. When the pandemic is over, we will start to work with other agencies to have more events and workshop for the community.

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 and with the assistance of our bilingual staff; we can provide language-based care and services. Being able to provide language-based care is something that we value deeply and believe that it truly provides a safe place for those who are ESL and need services.

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.

AFRC staff helped the head of a household, who lived with his wife and one of their children.

His elderly mother his mentally disabled sister, and his very sick niece lived with him as well. However, in 2018, he suffered from a massive stroke that paralyzed him. Due to his illness and the lack of speech, this family's need was brought to staff attention. The staff went to visit the family and started to engage in assisting the family with medical and physical therapy interpretation and served as a point of contact for his medical needs. AFRC staff had assisted him with his worker disability information and provided emotional support when he was depressed from his illness. Staff visited him and aided him on a weekly basis. AFRC staff was consistently in contact with his physical therapist to update them with his physical mobility progress. He is now much better physically and emotionally but still required physical assistance from his wife.

His wife doesn't drive. So, when he got sick, they had no transportation to and from Doctor appointments, etc. However, staff assisted his wife on studying the driving test and took her to the DMV multiple times to take the written exam. She finally passed her written exam, and hopefully she will pass her driving exam soon. Staff is planning to apply for Paratransit services.

The client's elderly mother has suffered from post-traumatic disorder for years. AFRC staff had the privilege to assist her with emotional support by encourage her to join our life skills group/therapy and church's small group. Her income was limited and due to the illness of her son, they struggled with bills and foods. AFRC staff was able to assist her in applying for food stamp which was a tremendous help to her and her family. In January 2019, his niece passed away and his mentally ill sister was traumatized by the passing of her daughter. Staff was able to be there for the family providing emotional and logistic support since neither one of them were able to communicate with the hospital, funeral home, etc. AFRC staff assisted the family

with funeral arrangements (asking for donations, choosing the casket, arranging for cremation, date, and time, aiding with price negotiation, etc.) and worked with the hospital to obtain the death certificate and assisted the family with locating the deceased bank account, and more.

AFRC staff continues to provide emotional support to this family as of this writing. Stories like the one described above are just one of many successful stories that staff had the privilege to assist in our community through the AFRC agency. The existence of AFRC to serve as a refuge to our Asian community in need and AFRC staff is grateful to represent the agency with pride and dedication.

Thank you to PEI program for your financial support. Without your support this agency would not be able to support our community like the way we are supporting this community now.

PEI ANNUAL REPORTING FORM

EARLY INTERVENTION REPORTING FORM

FISCAL YEAR: 19-20

Agency/Program Name: Building Blocks for Kids

Project (if applicable): Not About Me Without Me

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 summarize the Scope of Services as outlined in the Service Work Plan. Please also address any other relevant activities or events that took place during the reporting period.

The goals of the 2019-2020 scope of work are three-fold: (1) Community and Family Engagement: working with Richmond families to ensure that they are knowledgeable about and have access to a network of supportive and effective mental health information and community services; (2) Social Support and Referral: reduce risk factors for developing a potentially serious mental illness, and to increase protective factors; and, (3) Healthy Parenting Skills: train and support families to self- advocate and directly engage the services they need.

Community and Family Engagement: Ensure Richmond families are knowledgeable about and have access to a network of supportive and critical health and mental health information and services

Linkages with East Bay service providers: In 2019-2020, BBK focused on connecting families to existing mental health and support services that are available within the region. BBK staff connected families to accessible mental health professionals that provide no and low-cost individual, family and group mental health support and prevention services. During the last fiscal year, BBK connected six participants to support services. In 2020, as the COVID-19 pandemic unfolded our staff made check-in phone calls with our program participants and conducted a Needs Assessment. Based on the results, our staff successfully connected 42 families to food resources, financial assistance, and free/reduced internet service options. BBK along with other Richmond-based organizations, launched the Richmond Rapid Response (R3F)

– a wraparound initiative that will meet the immediate and ongoing needs of the community during the COVID-19 pandemic including direct monetary disbursements to residents.

Organizational Support: BBK staff continued to provide support to strengthen services made available by mental health and community wellness providers. In the 2019-2020 fiscal year, BBK continued to partner with the Child Abuse Prevention Council's Nurturing Parenting program. BBK provided logistical support including convening and training space recruitment and evaluation; and offering developmental Child Watch and food for program participants. BBK provided this support to CAPC for two classes during the previous fiscal year.

Family Engagement: Family Engagement activities are events held at Monterey Pines Apartments a 324-unit housing community in South Richmond. At these events, Richmond families are invited to spend an enjoyable and safe time with their families. Each event is hosted by a different organization or multiple organizations intent on engaging families with children from birth to eighteen years of age. In the 2019-2020 fiscal year a total of 87 people participated in Family Engagement Events. Family Engagement activities included: an informational session about the Welcome Home Baby Program, Mindfulness practices, Youth Service Bureau, Effective Ways of Communication through Community Circles, Census Information as well family bonding arts & crafts and games.

Health & Wellness at the Park: In 2019-2020, BBK continued to offer Richmond families a free summer program. During the 2019 summer program, children under the age of 18 had access to free lunch Monday through Friday, Zumba classes and enrichment activities. BBK staff served an average of 90 children daily. As the 2020 summer began, BBK staff decided to continue to offer the summer program but changed our approach as we followed local government social distancing regulations. Our staff offered virtual programming for a total of four weeks in July 2020. Videos were posted daily on our Facebook page. Families had access to two Zumba videos a week, two playgroup videos a week, and once a week we posted a cooking video.

Social Support and Referral: Reduce risk for negative outcomes related to untreated mental illness for parents/primary caregivers whose risk of developing a serious mental illness is significantly higher than average including cumulative skills-based training opportunities on effective parenting approaches.

Sanctuary Peer Support Groups: Through our Sanctuary groups we educated, supported healing, offered mothers the opportunity to share information, build community and worked with moms to develop accessible approaches to maintaining their mental health and that of their families and community. BBK staff continued to host in-person Sanctuary Peer Support Groups at Chavez Elementary School, Monterey Pines housing development in South Richmond, and our office space in the Iron Triangle neighborhood. In April 2020, as we all went into Shelter in Place, our staff conducted check in phone calls with our program participants. Based on responses our staff decided to increase the meetings from once a month to twice a

month. Participants are now able to participate in two virtual meetings a month. In the last year participants were facilitated through different activities related to self-care, meditation, and stress relieving practices. During the 2019-2020 fiscal year, 195 women participated in 28 meetings.

In late 2019, BBK began an equity-centered design thinking approach and process to redesign our parental resilience and emotional wellbeing programs and activities. Our process has included the primary principles of human-centered design. These design principles provide us with the framework to design with the constituents we serve and with whom we are looking to serve. BBK staff has collected 106 e-surveys, spoke with 11 people in 1-1 interviews and another 23 people in focus groups. We are excited about the opportunity to utilize community input to create programs that resonate with community members and meet their needs. We are now beginning to develop program ideas and will work with our Advisory Committee to prioritize these ideas and share them with a smaller subset of community members for feedback.

Healthy Parenting Skills: Train and support families to self-advocate and directly engage the services they need.

Parent Education: In 2019-2020, BBK continued to partner with the Child Abuse Prevention Council to provide evidenced based and informed learning opportunities focused on parents/primary caregivers living within Central and South Richmond. These sessions incorporate curricula for child(ren)/youth that are aligned with learning objectives for parent participants, creating an ongoing mechanism for mutual learning and reinforcement at home. The classes were offered in English and Spanish at two different sites in Richmond. The sites included Highland Elementary, a WCCUSD school in Richmond's Hilltop neighborhood and our office in Central Richmond. During the fiscal year, a total of 26 parents successfully completed the 22-week program.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services. Numbers served during the fiscal year, describe any adaptation of services due to COVID-19 that may be relevant, For PEI - Early Intervention programs, please describe: Which mental illness(es) were potentially early onset, how participant's early onset of a potentially serious mental illness was determined, List of indicators and data that measured reduction of negative outcomes.

Numbers Served:

During the 2019-2020 fiscal year, BBK served a total of 336 unduplicated program participants.

COVID-19 Adaptations:

During the COVID-19 pandemic, BBK has pivoted to continue to engage the community. Our staff has transitioned into a virtual model. All our programs are now offered through Zoom meetings, phone calls, and videos on our Facebook page.

Outcomes:

Care Providers develop strong knowledge base on child development and positive parenting skills

Since July 2019, 26 adults completed a 22-week positive skills parenting class. 146 adults participated in a parent-child, skills development playgroup during the summer months of 2019.

Service providers are responsive to mental health needs and requests of CentralRichmond families. BBK Zone families are increasingly accessing mental health services. In the last year, we have seen an increase in the confidence that 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 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: 80% 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.

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.

Result: It continues to be difficult to refer undocumented families for mental health services because of the dearth of services available to them. During the last fiscal year, BBK connected six participants to support services. In 2020, as the COVID-19 pandemic unfolded our staff made check-in phone calls with our program participants and conducted a Needs Assessment. Along with the stress of the virus, families also shared that they were dealing with financial stress due to the loss of jobs. These financial pressures greatly impact the emotional and mental well-being of the families we serve. As a result, our staff successfully connected 42 families to food resources, financial assistance, and free/reduced internet service options.

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

Please refer to Aggregate Data Reporting Form

CULTURAL RESPONSIVENESS:

How have services been informed and structured to meet the diverse cultural needs of your clients/members/participants? What is being done by your organization to support cultural responsiveness both within the workforce and for those served by your organization?

We are a data-informed organization, and we utilize it to facilitate program development. We take our direction from program participants and residents of the community to then create opportunities for them that continue to inform our work and program implementation. To provide the best service to the community, all flyers and program materials are developed using culturally appropriate English and Spanish. We provide dual translation in Spanish, childcare, and meals for most of our programming, events, and activities. We are increasing our efforts to meet families in community spaces in their neighborhoods to continue to serve African American families, we have expanded our programming to south Richmond because of the density of African American families living in these neighborhoods. In addition, we also schedule our programming to meet the needs of the community. For example, our Latina Sanctuary group was held at Chavez Elementary School in the morning time so that mothers can drop off their children at school and attend the meeting. Our Family Engagement events are scheduled in the evening so that families can attend as kids are out of school and working parents are available.

As an organization rooted in the community, we believe in community representation on our staff and Advisory Board. Our staff is all women of color with deep roots in Richmond and West Contra Costa County through professional and/or personal histories including our executive director who has called Richmond home for most of her life. Similarly, most of our Advisory Board members are people of color, most are from and currently live in Richmond and our expert professional in their fields. BBK has a high standard for work, service, and commitment to the local community. We also have an equally high commitment to the well-being of our colleagues and their families. We believe that supporting the sound maintenance and development of the mind, body and soul of our colleagues is the only way we will effectively serve and support Richmond and West Contra Costa County communities.

COLLABORATIVE PRACTICES:

Describe how you are working with any other agencies or organizations to better serve clients/members/participants? If this is currently not being done, please describe any effort to build relationships with other community service providers?

Collaboration is a key component of our work. As an organization we understand that to be able to make a lasting impact on our community we must work with community partners to serve community members. One of the biggest collaborations have been with WCCUSD. Our

partnership with the school district has allowed us to serve families at two elementary school sites in Richmond. In addition, our partnership with the City of Richmond has allowed BBK to provide our free Health & Wellness Summer Program since 2014. Additionally, through our partnership with the Child Abuse Prevention Council, we were able to free parenting support to several families throughout Richmond.

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 Latinx 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.

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.

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

About two years ago Shawn joined our Nurturing Parenting class. At the time, Shawn was going through hard times. He found himself struggling with parenting and grieving his mother's recent death. Participating in the classes gave him an outlet. He built relationships with other parents and was able to learn from them, share his experiences, and vent. Through the classes, Shawn learned about other BBK programs and began regularly attending Family Engagement Nights. Shawn shares that these events helped him build a stronger relationship with his son and meet other families. Shawn continues to look for different growth opportunities through BBK and other community organizations. He was recently a part of our equity-centered design thinking approach and process to redesign our parental resilience and emotional wellbeing programs and activities. He has provided great feedback and ideas about what our work can look like in the future. BBK is very happy to see how much Shawn has grown over the last two years and is excited to see him continue to develop.

We met Lauren a few years ago when she began participating in our Black Women's Peer Support group. Through the Sanctuary, Lauren was able to build relationships with other participants and BBK staff. As we launched our Community Educational Leadership Institute, Lauren showed interest and applied to the program. Through the four-month program, Lauren learned how to contribute to systems change by serving on a board or commission. As a result, Lauren applied for and is currently on the Rodeo Municipal Advisory Council. She has also decided to run for a board seat on the John Swett Unified School District School Board.

PEI ANNUAL REPORTING FORM

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR: 19-20

Agency/Program Name: THE CENTER FOR HUMAN DEVELOPMENT

Project (if applicable): THE 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 / ACTIVITIES:

Please summarize the Scope of Services as outlined in the Service Work Plan. Please also address any other relevant activities or events that took place during the reporting period.

The African American Wellness Program provides prevention and early intervention services that empowers participants to: Increase emotional well-being, decrease personal stress and isolation, increase their ability to access culturally appropriate mental health services.

Key Activities included culturally appropriate education on mental health topics through Four Mind, Body and Soul support groups: community health education workshops, outreach at health-orientated community events. Also, assistance and navigation for appropriate mental health referrals.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services. Please include: Numbers served during the fiscal year, describe any adaptation of services due to COVID-19 that may be relevant, how are participants identified as needing mental health assessment or treatment?

The African American Wellness Program served 623 participants during 2019-2020 fiscal year. Due to Covid 19 our program was unable to provide in-person support group meetings.

Community Health Advocates Michelle Moorhead and Risha La Grande provided services to participants via telephone. Providing One on One check ins to participant, referrals, and resources according to individual needs. Shelter-In-Place order was placed in effect on March 13, 2020. The Ambrose Community Center was shut down due to the Covid 19 orders. Community Health Advocates Michelle Moorehead and Risha La Grande began to work from home to stay connected to the participants in the program. Risha La Grande resigned on March 31, 2020 to care for her mother full time. At this time, Michelle Moorehead resumed full responsibility of all services for the African American Wellness Program.

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, and 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 211, Mental Health Line, and community resources. Community Health Advocates assist participant by helping them to navigate through the systems, so they can receive care and learn to advocate for themselves in the future. The Community Health Advocate will call the Mental Health Access Line with participant, insuring participant to get an appointment. Community Health Advocate also supports participant by attending their Doctor's appointments to help in supporting and advocating for the participants care, and to help create effective communication and mutual understanding between the participant and provider. The appointment is scheduled from the initial phone call. The time for scheduling an appointment and seeing a Therapist or other provider time frame is up to 3-4 weeks. The Community Health Advocate will follow up with participants within a week to check on progress.

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

Please refer to Aggregate Data Reporting Form

CULTURAL RESPONSIVENESS:

How have services been informed and structured to meet the diverse cultural needs of your clients/members/participants? What is being done by your organization to support cultural responsiveness both within the workforce and for those served by your organization

COLLABORATIVE PRACTICES:

Describe how you are working with any other agencies or organizations to better serve clients/members/participants? If this is currently not being done, please describe any effort to build relationships with other community service providers?

The African American Wellness Program collaborates with other agencies to provide more resources and referrals for our participants. Such as St. Vincent De Paul and their Loaves and Fishes program. Participants were provided with a hot meal and bag of groceries from referral. Pittsburg Senior Center provides our program with referrals for participants that would like to attend the African American Wellness 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?

The African American Wellness Program serves adults 18 years and older, living in East Contra Costa County. African American Wellness Program supports their participants by empowering them to recognize and achieve inner strengths, use coping strategies to maintain emotional wellness, and providing tools, resources, and referrals, to reduce stress, anxiety and isolation. The program provides a welcoming, safe, and confidential environment for their participants. The Mind, Body, and Soul support group helps give the participant hope, while facing life challenges. African American Wellness Program helps participants address and overcome barriers such as homelessness, unemployment no medical coverage, lack of food and transportation. African American Wellness Program supports their participants needs by linking participants, who are low income and disadvantaged due to lack of resources, and referrals to mental health services. Participants enter the program through word of mouth, referrals, community outreach and mental health services at Pittsburg Health Center.

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.

Story #9

E.B. is one of our male participants; age range is 60+ years old. He has attended the Mind, Body, and Soul (M.B.S.) support group for 6 yrs. now. E.B. attended activities at the Pittsburg Senior Center, he saw the flyer on the announcement board regarding the Mind, Body, and Soul support group and decided to attend. E.B. is a U.S. Marine Veteran he suffered from P.T.S.D.,

diabetes, and high blood pressure. Since attending our support group E.B. has developed new friendships, is eating healthier to regulate his diabetes, and high blood pressure. He attends therapy for his P.T.S.D. and is taking his medication regularly now. E.B. has a positive attitude due to practicing self-care tips and techniques provided in Mind, Body, and Soul support groups. E.B. continues the tools he learned and is progressing well. We are proud of his success and with continue to encourage him in the future.

PEI ANNUAL REPORTING FORM

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR: 19-20

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 / ACTIVITIES:

Please summarize the Scope of Services as outlined in the Service Work Plan. Please also address any other relevant activities or events that took place during the reporting period.

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 – 20, in East Contra Costa.

The annual goal is to reach 80 unduplicated youth from July 1, 2019 through June 30, 2020. During 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 one (1) weekly educational support group sessions at Hillview Junior High School, Pittsburg during the school year; totaling at least twenty (20) but not more than twenty-five (25) sessions.

Component 5: 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 6: Facilitate two (2) per year youth-led community service projects and skill-building field trips.

Component 7: Refer youth to culturally appropriate mental health services on an as needed basis including referral support to a minimum of 15 youth.

Component 8: Facilitate community educational outreach/psycho-educational workshops including two (2) per year.

Kevin Martin, Empowerment Program Coordinator, facilitated the following services from July 1, 2019 through June 30, 2020. Mr. Martin is a full-time employee, working 40 hours per week on the project. During this reporting period, Empowerment has worked with 110 unduplicated youth, 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 July 1 through June 30, 2020, Kevin Martin facilitated 46 sessions of youth support groups on the campus of Pittsburg High School. The number of meetings meets goal of 40 to 50

sessions for the year. This was the first year that PHS set a designated room for support groups to meet confidentially. CHD staff continued to receive new referrals from school staff, students, and service providers on campus, and as previously noted, has establish a regular time to meet two groups at Pittsburg High School, to meet this need. The average group attendance for this period was 5. Low attendance was 1 (in April) and high attendance was 10 (in February). These groups did not meet during "dead week" (final exam prep), during finals week, or while the school was closed for recess in December, February, 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 more than 125 individual check-ins and one-on-one assessments with students during this year. More than twice that of previous years.

Topics for the Pittsburg group included: group development, establishing group norms, surviving trauma at home, LGBT terminology, healthy boundaries, jealousy, discrimination by authority figures, coping with stress, writing as a coping method, conflict with friends, Trans awareness, mourning the passing of a teacher, challenges of split family dynamics, symptoms of depression, self-image, affirmations, assumptions, identifying emotions, holiday & family stresses, concerns for Winter break, intentions for 2020, experiences over Winter break, upholding personal boundaries, "4 Pillars of Healthy Relationships", speaking authentically about emotions, questioning gender identity, the process of coming out, managing boundaries and expectations in multilayered relationships, LGBTQ+ Black History Icons, personal stories of identity realization, confronting friends (difficult conversations), initial response to announcement of two week COVID-19 school closure, check-ins, establish telehealth group norms, realities of COVID- 19 Shelter-In-Place order (missed opportunities, stress and mental health), self-care, time management, ending romantic relationships (difficult conversations), tools for changing perspectives (opportunity from victimization), stresses of COVID-19 Shelter-In-Place order, end of school year stresses and excitement, holding grudges, challenges of online learning, openly LGBTQ+ celebrity representation and activism, irrational fear, senior appreciations and advice for underclassmen, anticipating summer during COVID-19.

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 July 1 through June 30, 2020, Kevin Martin facilitated 19 sessions of youth support groups on the campus of Deer Valley High School. The number of meetings is just short of our goal of 20 to 25 sessions for the year. This group saw exponential growth during this year, 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 in-person school year, in March, indicating the high level of need for this population in this area. Staff is weighing the capacity of the program to support a second group at this site, or if capping the number of participants is group sessions is necessary. Average group attendance for this period was 14. Low attendance was 11 and high attendance was 19.

This group did not meet during "dead week", during finals week, or while the school was closed for recess in December, March, May, and June. CHD also staff conducted more than 70 one-on-one meetings with students during this year. This is almost three times the number of previous years.

Topics for the Deer Valley group included: group development, bisexual awareness and myths, LGBTQ+ terminology, National Coming Out Day and the process of coming out, Trans awareness, gender terminology, "safe spaces" to be LGBTQ+, emotion identification, assumptions, intentions for 2020, coming out support, "4 Pillars of Healthy Relationships", grief and shock of student shooting, LGBTQ+ Black History Icons, "friends" speaking negatively about you to others, social and performance anxiety, "Can you remain friends after romantic breakup?", domestic violence, divorce.

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 July 1 through June 30, 2020, Kevin Martin facilitated 40 sessions of youth support group in Antioch. 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 significant decrease after the Shelter-In-Place order began, with a slight increase in June, when staff focused on integrating all participants into one group, in effort to maintain participant enthusiasm. The decrease in attendance was due to several factors, increased family obligations, the inability to meet in person, issues with access to technology, a lack of desire to participants' home environments to be seen and possibly judged

by others, and lack of parental or guardian support. This group had an average attendance of 6 youth per session for this reporting period. Low attendance was 2 (in early May) and high attendance was 9 (in July, January, February, and June). 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 more than 120 one-on-one meetings with youth during this year. This is nearly double that of previous years.

Topics for the Rivertown group included: group development, Pride & Castro field trip, screening of history of LGBTQ+ Pride films, coping with stress, LGBTQ+ representation in media, "Family Dynamics & Personal Boundaries: Choosing to end codependent relationships", positive affirmations, family obligations, suicide awareness "Know the Signs", sadness & mourning, bisexuality awareness & myths, the process of coming out, symptoms of depression, dysphoria, self-care, asking for help, LGBT History Month, peer support, Transgender Day of Remembrance Vigil, gratitude and Thanksgiving, emotional support identification, concerns/stresses relation to holidays, concerns about pharmacological treatments for depression, intentions for 2020, "4 Pillars of Healthy Relationships", LGBTQ+ Black History Icons, trauma, establish telehealth group norms, wellness tips for COVID-19 Shelter-In-Place order, heightened dysphoria during COVID- 19, opportunities for changing perspective (opportunity from victimization), confronting friend/re-establishing boundaries (difficult conversations), poetry as creative outlet for emotional expression, queer celebrities and representation in media, LGBTQ+ Pride history and relations to current civil rights protests, Queer Tech Professionals guest speakers.

Component 4: Facilitate one (1) weekly educational support group sessions at Hillview Junior High School, Pittsburg during the school year; totaling at least twenty (20) but not more than twenty-five (25) sessions.

From July 1 through June 30, 2020, Kevin Martin facilitated 19 sessions of youth support groups on the campus of Hillview Junior High School. The number of meetings is just short of our goal of 20 to 25 sessions for the year. This group saw exponential growth during this year, largely due to word of mouth by participants and referrals from school counselors. Staff decided in January to break the group into two separate groups, one with older students that participated last Spring, and one for younger participants, just beginning participation this year. These smaller groups proved to be more effective for staff working with this age group. Average group attendance for this period was 5. Low attendance was 2 (in February) and the high attendance was 9 (in December). This group did not meet during testing weeks, or while the school was closed for recess in October, November, December, May, and June. Staff also conducted more than 61 one-on-one meetings with students during this year.

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. Staff continued to receive referrals from school staff and students right up to the end of the in-person school year, in March, indicating the high level of need for this population in this area.

Topics covered in this group include: group development, establishing group agreements, identity development, gender versus sexual orientation, bisexuality awareness, supportive tools for coming out, LGBTQ+ terminology, check-ins, instruction manual for parents, LGBTQ+ Black History Icons, Valentines to yourself, LGBTQ+ Women's History Icons, personal stories of coming out.

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 5: 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 July 1 through June 30, 2020, the youth leadership group met 9 times, 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 and stopped being able to meet after the Shelter-In-Place order was implemented. The average attendance was 5, with 2 being a low (in October) and 7 being a high (in January and February). Consistent attendance to Leadership sessions has been a challenge, so staff is meeting with Leadership around regular Empowerment group meetings at Rivertown Recourse Center. This is also 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.

At the time the Shelter-In-Place order was announced, March, staff was preparing to engage two Leadership participants as dedicated Youth Leaders, as was done last year, leading to this not happening this year. Youth Leaders were to be tasked with leading the planning and coordination of our annual LGBTQ+ Youth Pride Prom, throughout April, May, and June, with the support of staff and in collaboration with Rainbow Community Center staff. These Youth Leader were to be given stipends for their work and leadership on this project.

During meetings, Leadership focused on activities to understand principals of leadership, inclusion, and group collaboration. Prior to COVID-19, Leadership began discussing ideas to support and promote our annual LGBTQ+ Youth Pride Prom and our fieldtrip to the Castro

District and GLBT History Museum. CHD staff also conducted 6 individual one-on- one meetings with youth during this period.

Component 6: Facilitate 2 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.

This component was planned to be fulfilled in the month of June. However, the COVID-19 Shelter-In-Place order and health guidelines for the county did not allow for this component to be completed. Planned projects and field trips included our annual Youth Pride Prom and annual field trip to the GLBT History Museum and Historical Castro District, in San Francisco. Staff is exploring alternate opportunities for youth led community service events for the upcoming year, such as voter registration efforts, possible campaigns to educate new voters on impacts of political actions on the LGBTQ+ community or exploring the history of civil disobedience protesting.

Component 7: 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 6 youth throughout the year. This number is short of our target of 15 annual referrals, however, all participants were given Safety Phone Lists and repeatedly encourage to reach out to the Contra Costa County Crisis Center, Trevor Project, as well as any current clinical support during times of stress, anxiety and crisis. Direct mental health referrals were made to Lincoln Child Center, John F. Kennedy University, Contra Costa County Mental Health Access Line, Community Violence Solutions, and SEEDS Community Resolution Center. As noted earlier, all Empowerment participants also receive a Safety Phone List with listings for the Contra Costa Crisis Center, Trevor Project, GLBT Youth Talk-line, Rainbow Community Center, 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, as in previous years, 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 8: Facilitate community educational outreach/psycho-educational workshops including two (2) per year.

From July 1 through June 30, 2020, Kevin Martin facilitated 1 educational outreach/psycho-educational workshops. This is just short our goal of 2 workshops for the year. Prior to the Shelter-In-Place order, Empowerment staff, in collaboration with RCC's training team had been

in conversations with Pittsburg Unified School District for ongoing trainings for all levels of district staff.

October 14: Kevin co-facilitated an all-day Inclusive Classrooms training for the academic counseling staff of Pittsburg Unified School District (PUSD), at the Pittsburg High School, in collaboration with Rainbow Community Center training staff. Approximately 20 academic and clinical counselors representing all schools in the district, elementary through high school, attended.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services. Please include: Numbers served during the fiscal year, describe any adaptation of services due to COVID-19 that may be relevant, how are participants identified as needing mental health assessment or treatment? List of indicators measured, including how often data was collected and analyzed

From July 1 through June 30, 2020, staff facilitated 134 educational group sessions, trainings, and Leadership sessions. 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. Check-ins and one-on-one meetings are held regularly, since COVID-19. 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 412 individual one-on-one meetings with youth during this year. This is nearly double the number of individual check-ins and one-on-one meetings from last year. The sharp increase in this number is primarily to the Shelter-In-Place order, which, as noted in earlier components, have led to many participants being willing to only engage in one-on-one, non- video, communication with staff, and not wanting to participate in groups via telehealth platforms. Telephone communications and secure video conferencing, via Zoom, are the main forms of delivering telehealth support to participant, since COVID-19.

It is important to note that staff also noticed a sharp decline in participant's willingness to engage with CHD staff or the Empowerment Program, in any form once the Shelter-In-Place order was implemented. Staff has continued to attempt to make contact and receive updates on disconnected participants through school staff, counselors, family, and friends, to ensure they are aware that Empowerment is still available to them. Some feedback staff has received is that many do not feel safe to engage with Empowerment while at home, due to lack of privacy

and lack of support or acceptance from family. Many of Empowerment's participants have not shared their identity, or questioning, with their family members.

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 in the previous section, specific referrals for new mental health support were made for six (6) youth during the year. The average length of time between report of symptoms onset and referral for treatment is 5 weeks; 2 entered treatment within 1 week, 1 entered treatment after 4 weeks, due to school closure for Winter recess, 2 unknowns as staff was not able to follow up with them 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.

Also noted previously, all Empowerment participants receive an emergency services "Safety Phone List", 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, or COST meetings at school sites.

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.

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. The current average length of time between referral and entry into treatment is 2 weeks.

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

Please refer to Aggregate Data Reporting Form

CULTURAL RESPONSIVENESS:

How have services been informed and structured to meet the diverse cultural needs of your clients/members/participants? What is being done by your organization to support cultural responsiveness both within the workforce and for those served by your organization?

Empowerment, like CHD, has a history of employing staff and volunteers that represent, and frequently are a member the communities they are employed to represent, embracing diversity in the greatest sense of the word as a fundamental principal of all our agency's work. Desiring to unleash human potential CHD and Empowerment foster an environment of inclusion by encouraging diversity of perspective and opinion, valuing the importance of lived experience as highly as formal education and professional training. CHD staff frequently support other staff, by sharing their unique perspectives and professional expertise. Empowerment staff has often acknowledged its participants educate the staff as much as staff educate participants. Staff also take part in multiple trainings, workshops, coalitions, and other forums throughout the year to stay up to date on issues, research, terminology, laws, diverse perspectives, etc. relevant to the highly diverse LGBTQ+ youth community in East Contra Costa County, incorporating what they learn into the support and education provided to throughout the Empowerment Program.

Empowerment also endeavors to make its support services as accessible as possible to our target population in multiple says. Number one, Empowerment is free of charge to all its participants, to eliminate financial barriers. Number two, Empowerment recognizes that transportation, in general, for youth, and especially in the East part of Contra Costa County is a significant barrier. Due to this, Empowerment has sought to provide support groups in various locations, that will still provide safe and confidential meeting spaces, to permit access to as many LGBTQ+ youth as possible. We currently have offer support groups at one Junior High School, two High Schools, and a centrally located "drop-in" location throughout Pittsburg and Antioch. We currently support youth residing in Pittsburg, Antioch, Oakley, Brentwood, and Discovery Bay. And, number three, fostering an environment and feeling of welcoming inclusion, non-judgement, empathy, honesty, and confidentiality.

Our staff understands and openly acknowledges that the Empowerment Program does not have the capacity to meet all the needs of every person who enters our program, but we always strive to actively listen and empathize with the needs and experiences of all who come our way, so that we can support linkage to other culturally appropriate services, when their needs fall outside our scope of work and capacity. We believe, we do not need to have all the solutions to be able to support someone on their path to finding what they need.

COLLABORATIVE PRACTICES:

Describe how you are working with any other agencies or organizations to better serve clients/members/participants? If this is currently not being done, please describe any effort to build relationships with other community service providers?

Empowerment staff maintains many long-standing collaborative relationships, as references in all earlier components. Our relationships with Pittsburg Unified School District, specifically Pittsburg High School, Hillview Junior High School, as well as Deer Valley High School and Rivertown Resource Center, in Antioch allow us to provide training, education, confidential support, direct referrals and wrap around support to participants and those connected to them in safe, welcoming, and confidential environments.

Staff also maintains collaborative relationships with a variety of mental health and other support service providers for direct referral and wrap around support, such as: Contra Costa Behavioral Health Service, Lincoln Child Center, SEEDS Community Resolution Services, John F. Kennedy University Counseling Services, STAND for Families Against Violence, Community Violence Solutions, Family Purpose, Contra Costa Health Services (mobile clinics), as well as several individual licensed clinicians.

Empowerment staff also continues to foster a multifaceted collaborative relationship with Rainbow Community Center (RCC). Empowerment often collaborate with RCC's youth program to organize a variety of educational and social events for LGBTQ+ youth in Central and East Contra Costa County. Our staff also collaborate to provide training opportunities to other organizations, such as Pittsburg Unified School District. Our staff is active with the Inclusive Coalition, headed by RCC staff. RCC has historically been a culturally appropriate provider of clinical services, including individual and family therapy, case management and wrap around support for Empowerment participants. Our staff are also, currently, facilitating combined youth support groups (one time per month, since May 2020) to support linkage to both agency's support services and expand peer support for participants.

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 regarding ethnic makeup and socio-economic status, with large percentages of LatinX, black, and low- income families. Youth enter the program through referrals from self, peers, family, school staff, and other service providers. Staff works diligently to create safe, welcoming, empathetic,

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 to work through challenges, with the support and encouragement of Empowerment staff and peers. Through this process, when youth are identified to need or would benefit from support services outside the capacities of Empowerment Program, referrals and linkages are made to other 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. As noted earlier, staff also take part in multiple trainings, workshops, coalitions, and other forums, including clinical supervision, throughout the year to stay up to date on issues, research, terminology, laws, possible bias, diverse perspectives, etc. relevant to the highly diverse LGBTQ+ youth community in East Contra Costa County, incorporating what they learn into the support and education provided to throughout the Empowerment Program. 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. We believe that the diversity of our participants is an indication of our success in this endeavor, however, we are always striving to do better.

In Empowerment, LGBTQ+ youth are engaged in discussions of topics, workshops and activities that are common to the broader 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.

It is not an uncommon experience for staff to hear participants and parents/guardians indicated that Empowerment Program is the only source of positive support participants are able to identify, from time to time; especially during times of mental, or emotional struggle related to their identity. This year, staff asked participants to share their personal experiences with Empowerment Program. Here are a couple of their responses:

"Empowerment is a confidential group that is there to help those who don't have emotional support. A couple years ago I was going through a lot and I didn't have anyone to talk to, it felt as if the doors were closed, but once I came to high school and found out about Empowerment

everything changed. During this time, I had come out to my family as bisexual, and everything was bad. As soon as I began to be part of Empowerment everything changed. I began to have the help I needed and the support. During group meetings I felt welcomed and able to be and express my true self without judgement. Empowerment helped me become a stronger version of me. I learned how to cope with emptions a lot better and if it wasn't for Empowerment, I honestly don't know where I would be right now." VCG (17)

"My experience with Empowerment has been one of the greatest so far. This program has helped me in so many ways that most people haven't been able to. Before this program I was insecure about who I was and I was scared to be who I truly am around others, but thanks to my advisor and the help of my peers I was able to overcome my obstacles and I am now free to express myself and be the person I always wanted to be. When life presents a new problem, I know I can always count on my advisor and group because we all strive to help each other, be positive and find solutions to difficult problems. Also, when someone new joins this program, in my experience, everyone was welcoming, and the members were some of the most positive and fun people to be around and they never put anyone down. I highly encourage those who are thinking about joining the group to take advantage of this amazing opportunity." RHV (17)

It is notable that both VCG and RHV are long-term (more than one year) school-based participants of Empowerment Program. They were referred to Empowerment by school staff, each received referrals linking them to additional support services (both school and community based) in conjunction with Empowerment support groups, and this year successfully graduated from high school with healthy goals for their futures. Historically, this has been a common trajectory for most Empowerment Program participants who have not changed schools or relocated making accessing Empowerment support groups impossible.

PEI ANNUAL REPORTING FORM

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS REPORTING FORMFISCAL YEAR: 2019 - 2020

Agency/Program Name: Child Abuse Prevention Council/Nurturing Parenting Program Reporting

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 first semester of The Nurturing Parenting Program a total of 44 parents and 45 children enrolled in the program. A total of 29 parent and 36 children completed and graduated from the NPP successfully. Fifteen parents attended a couple of sessions and dropped out due to scheduling challenges, parents were invited to return when time allows. The first session of the Nurturing Parenting Program, operated as planned and parents expressed gratitude for this type of program, which offered 20 in person sessions and followed curriculum as projected at the beginning of the Fiscal Year. During the second semester of The Nurturing Parenting Program (NPP) a total of 41 parents and 39 children enrolled in both regions (Central and East County). A total of 31 parents completed and graduated from the program despite the many challenges faced during the COVID-19 Shelter in Place, the remaining shared they were experiencing other challenges and dropped out prior to Pandemic The Child Abuse Prevention Council (CAPC) reached out to the Latino community in Central and East County offering The Nurturing Parenting Program (NPP) starting in January, ending June 2020. Parents and their children enrolled to participate in the 20-week parenting education program offered in the evening at Vintage Parkway Elementary School in East County 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. CAPC staff *planned for 20 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 and/or child.

**Sessions were interrupted March 16th and resumed via zoom/phone April 16th following County Health Department orders.*

The Nurturing Parenting Program has faced and overcome many challenges in the past 12 years of serving our communities, and this year has by far being the most challenges. As Shelter-In-Place orders were given our NPP team started working remotely and following direction from our Executive Director, the team was able to adjust our services to continue implementing the program. The NPP staff modified sessions to meet parents needs as the pandemic continue to bring many other challenges for our nation. Staff offered resources to families who lost their jobs, linked parents to internet access and guided them on how to start using zoom to stay connected. During the first two weeks of shelter in place, staff reached parents by phone (more than once a week) to check in and keep them informed. As our communities experienced changes rapidly CAPC offered staff two-week sick leave to emotionally and logistically adjust to the changes we were facing. CAPC provided staff with support and guidance to ensure providers were ready to continue supporting our program participants and linked them to the resources families needed. CAPC resumed sessions via zoom; parents reported feelings "emotionally connected" to the group and appreciated CAPC for "not abandoning them" (as reported by parents).

The Nurturing Parenting Program not only tailored the curriculum to meet parents' needs during the shelter in place, but it also allowed a safe space for parents to express their emotions as their "normal" lifestyle changed and families were spending every day, every hour of the day together (some in very closed quarters and some sharing housing with other family members or friends).

The NPP team was able to continue lessons and utilizing program materials as suggested by curriculum and encouraged parents to use time to implement with their children creating an opportunity to bound and build a stronger relationship with their children whenever possible. CAPC utilized funding to provide meal baskets to families enrolled in the program, providing ingredients and instructions for families to prepare one meal per week as a family and eat together as a family (as suggested by the curriculum).

CAPC offered a safe space for parents to share areas of concerns as they parent their children in very unusual times, parents shared their fears and frustrations of losing patience. Staff discussed creative ways to support parents and monitor any signs of possible abuse or neglect

happening in the home without pushing parents away. The NPP team implemented a “drive by” date to deliver meal baskets and materials with information on accessing community resources to decrease uncertainty and find support in many different areas of needs as discussed during zoom sessions.

Parents received the Surviving Parenthood Resource Guide to facilitate access to community based

organizations providing a wide variety of services at no cost or sliding scale as an effort to encourage parents to connect and explore preventive/intervention programs, in addition NPP offered flyers and other contact information to facilitate families access to services. NPP staff offered guidance on how to access Mental Health support, crisis intervention, EDD services, food banks, low cost, housing, internee support and many others.

To keep a sense of “normalcy” NPP staff continue our program as planned by sharing information and psychoeducation to help identify mental health/behavioral challenges that may need professional support. NPP kept one of the three session with the collaboration of Dr. Hector Rivera-Lopez. Dr. Rivera who has 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” and enhances “how to care for the caregiver” promoting self-care to increase emotional availability for parents caring for their children and decrease the risk of child abuse.

The NPP supervisor not only oversees sessions, but she also offers direct services to help parents feel more comfortable and confident when accessing resources. NPP evaluates each family to offer linkages to the appropriate resources. At the end of the program the NPP staff meets to discuss observations and brainstorm ideas to continue serving our 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 individualsserved.

The Nurturing Parenting Program offered two 20-week sessions starting in July 2019, ending in June 2020. 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 the results which reflect areas of improvement and measures the "risk" of child abuse and neglect in the home. In the event parents score as “high risk”, an invitation is offered to the family to participate in the program one more time as well as offer

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.

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 can 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 can display normal developmental behaviors. Nurture children and encourage 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 can 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.

These five parenting constructs enhance **the Five Protective Factors** that replace risk of abusive behavior with positive parenting skills.

The Five Protective Factors are the foundation of the Strengthen Families Approach: Parental resilience, social connections, concrete support in times of need, knowledge of parenting and child development, and social and emotional competence of children.

Inventory A and B are given to parents at the beginning of the session and at the end. Result per group. Central & East County

AAPI Results Session 1& 2 East County

Construct	*A*	*B*	*C*	*D*	*E*
Form A	*6.19*	*6.06*	*5.75*	*8.00*	*6.25*
Form B	*7.20*	*8.00*	*8.20*	*7.30*	*6.90*
Construct	*A*	*B*	*C*	*D*	*E*
Form A	*6.57*	*6.43*	*7.00*	*7.71*	*6.86*
Form B	*6.67*	*8.67*	*9.50*	*8.67*	*7.67*

AAPI Results Session 1 & 2 Central County

Construct	*A*	*B*	*C*	*D*	*E*
Form A	*6.89*	*6.44*	*5.22*	*8.11*	*5.78*
Form B	*7.40*	*8.40*	*8.00*	*8.80*	*6.00*
Construct	*A*	*B*	*C*	*D*	*E*
Form A	*7.09*	*6.91*	*6.00*	*8.09*	*5.91*
Form B	*7.33*	*8.67*	*9.00*	*9.67*	*8.00*

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

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?

As the world faces the Pandemic, CAPC learned not only the importance of helping others but also the importance of supporting our staff. The population which we served is the most vulnerable and its crucial for us at CAPC to be informed and keep ongoing collaboration with our County as we offer this important service to families who many times feel overwhelmed.

The Pandemic has presented many challenges for us as staff, and we have met regularly to modify our approach and ensure we are taking care of our own Mental Health as we support others. Families have reached out and have opened sharing their fears of COVID-19 and to the unknown of "what comes next". In the mist of all the confusion and frustration our team has continued building bridges between families and community services. We have found the importance of offering psychoeducation to increase awareness and teach parents to monitor themselves as well as their children. Staff utilizes a cultural approach to help them feel comfortable discussing issues parents identify as "triggers" of stress in their daily life. This program offers a safe place for families. We also value importance of identifying our own challenges to support parents in a timely manner and help manage our mental health decreasing the risk of emotional fatigue which has been at a higher level since the Shelter-In-Place and as we go on dealing with the Pandemic. Staff has met several times to brainstorm ideas on how to manage emotional / zoom fatigue and to address the emotional needs parents are experiencing while maintaining the fidelity of the Nurturing Parenting curriculum.

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.

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 values parents' feedback to help us learn how to improve our program. During this Fiscal Year parents shared several points; please see below.

"When I received the meal basket with ingredients and instructions to cook, I felt someone cared for ME, and prepared this basket for me and my family, this made me feel happy and brought a smile to my day"

"Being able to continue the NPP gave me hope and helped me not feel alone"

"During this time of Shelter-In-Place my family and I have had many challenges, being able to continue participating in the NPP has helped me keep moving forward"

"The NPP team has given me resources to access support that our family much needed"

A father's Story

Growing up in a family where role models are present and absent at the same time. Father grew up in a family where children are told what to do and are not heard. Father shared he is a father of 5 children and that in his younger year he made many mistakes; mistakes which helped him realized he wasn't doing things the right way…. And what is the right way? Father asked himself many times. Father enrolled in the Nurturing Parenting Class January 2020. In his search for help to become a "better" father and be the father and role model he didn't have. Father shared having a difficult childhood, as his parents provided the essential to survive but he lacked the attention and guidance he much needed. During his adolescence he made poor choices which led him to lose control of his life, and the loss of loved ones including his children. After finding himself alone and without his children he started to make changes. Father shared he found a church which opened its doors and provided the emotional support he much needed at that time. Father then felt the need to do more for his children, especially for a 13-year-old boy with special needs who has been removed from the mother's home and is currently living in a group home. Father decided to try the Nurturing Parenting to explore his options.

Father enrolled in this program and didn't not miss a session; many times, came straight from work. Often apologized for not coming to class "presentable" as he would be wearing work clothing after a long day of labor. We couldn't help but be amazed by his interest to learn and his questions and comments about what parenting is all about. He interacted with other parents and his curiosity helped him learn new ways and strategies to connect with his children. Father explained he never imagine how much he missed by not "being there" for his children and how now he is enjoying each minute of the time he gets with his kids. "It hasn't been easy", Father says. As we transition to the zoom meetings due to Shelter-In-Place orders, Father continued connecting despite the many challenges he had learning how to use technology. Father explained he has more skills and strategies to parent his children; Father now believes in his potential to be a father and is determined to continue growing as a father.

Father completed the program and has requested CAPC to allow him to continue attending the Nurturing Parenting Program. Father's scores are impressive, the AAPI pre and post inventories show his curiosity has paid off. CAPC will continue to offer support and guidance he requested to continue fighting to reunite with his 13-year-old son. Father shared his past has put him in this situation and he is not giving up, after learning the importance of being a father he is now ready to be the role model he did not have as a child. His 13-year-old might be soon be place up for adoption, and Father is asking for a second chance. CAPC linked Father to Nami, Access Line and other resources to help him continue learning about his child's disability and become familiar with the support needed it to care for him. Father's journey may not end where he would like, but he believes it's all worth it. This is a Father's journey, and we wish the best for him and his son.

PEI ANNUAL REPORTING FORM

SUICIDE PREVENTION REPORTING FORM

FISCAL YEAR: 19-20

Agency/Program Name: Contra Costa Crisis Center

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 summarize the Scope of Services as outlined in the Service Work Plan. Please also address any other relevant activities or events that took place during the reporting period.

Provided active listening, emotional support, and referrals to resources on our 24-hour mental health crisis lines via phone for all local and toll-free hotlines. Crisis text services are also provided 24-hours a day. Lines are answered in English and Spanish, and we have access to the Language Line interpreter services in 240 languages.

Provided callers linkage to mental health services through referrals and warm transfers as appropriate for each call.

Provided supervision, silent monitoring, and consultation for all staff and volunteers in a manner that meets national industry standards and American Association of Suicidology accreditation.

Provided our 54+ hour call center training for new call center staff and volunteers several times throughout the year which included both a classroom education component and one- on-one mentorship with on-the-job skills training.

Provided professional development training and monthly in-services for staff and volunteers throughout the year regarding exploring unconscious bias, ACES trauma training, and increasing our cultural awareness, sensitivity and skills when working with families, youth, children with special needs, and veterans.

Provided 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. Trainings were also conducted for agency partners on ouragency services, grief & loss, and utilizing our 211 Resource Database.

Liaised with the county coroner's office to provide referrals for grieving survivors aswell as collected up to date data of county suicide statistics.

Continued co-chair responsibilities with MHSA for the monthly SuicidePrevention Committee.

Hosted an "International Survivor Day" with American Foundation for Suicide Prevention (AFSP) at John Muir Hospital to provide support to survivors of suicide loss and to promote suicide prevention awareness.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services. Please include: Numbers served during the fiscal year, describe any adaptation of services due to COVID-19 that may be relevant, please detail any methods used in evaluating change in attitudes, knowledge and/or behavior, and include frequency ofmeasurement 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.

We upgraded to an advanced web-based phone system software in July 2019, allowing for remote work in case of a disaster, and increased the accuracy of our calls answered, average speed to answer (in seconds), and abandonment rate measurements.

Due to the COVID-19 Shelter-In-Place county orders beginning March 2020, we conducted all meetings and trainings virtually via Zoom or Microsoft Teams. Calls to our 24-hour crisis lines continued without interruption with staff and volunteers working either in the office or remotely. We created Social Distancing Protocols and implemented Remote Work Policies. We experienced an unprecedented increase in total call volume starting in March 2020 with callers needing referrals for health, food, housing, and financial assistance as well as experiencing feelings of high anxiety and stress.

A suicide risk assessment continues to be conducted for every crisis and suicide call. Methods of intervention and lethality assessment are done in accordance with industry standards set by the American Association of Suicidology (AAS). Monitoring of the calls and call record data indicates that fidelity to the model is being well maintained.

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 regarding country of origin, languages spoken, culture, gender, religion, sexual orientation, and socio-economic class.

Core Values- 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)*

Please refer to Aggregate Data Reporting Form

CULTURAL RESPONSIVENESS:

How have services been informed and structured to meet the diverse cultural needs of your clients/members/participants? What is being done by your organization to support cultural responsiveness both within the workforce and for those served by your organization?

We provided professional development training and monthly in-services for staff and volunteers throughout the year regarding exploring unconscious bias, ACES trauma training, and increasing our cultural awareness, sensitivity and skills when working with families, youth, children with special needs, and veterans. We have planned and organized team bonding activities and events for staff and volunteers to help develop teamwork, cohesiveness, and a cultural of trust (agency luncheons, potlucks, baseball games, hikes, etc.).

We are active participants in meetings that strive to improve cultural sensitivity, awareness, and education to better serve our clients such as CPAW, Historically Marginalized Communities, Special Needs Committee, and the Reducing Heath Disparities Meetings.

We maintain a feedback box in our front lobby for staff, volunteer, and clients, as well as gather feedback and evaluation surveys at the conclusion of every training and grief support group we provide.

COLLABORATIVE PRACTICES:

Describe how you are working with any other agencies or organizations to better serve clients/members/participants? If this is currently not being done, please describe any effort to build relationships with other community service providers?

We provide professional trainings for the community and partner agencies on utilizing our 211 Resource Database, Suicide Prevention & Intervention, and Grief & Loss.

We attend collaborative meetings throughout the county to build our partner relationships and better serve the clients on the crisis lines, which include:

- BASCIA (Bay Area Suicide & Crisis Intervention Alliance)
- Child Death Review Team
- CPAW
- East Contra Costa Networking Meeting
- ECPIC (Early Childhood Prevention & Intervention)
- Fetal Infant Mortality Review Team
- Historically Marginalized Communities
- Human Services Alliance
- NSPL- Local Veteran Suicide Prevention Coordinator
- PEI (Prevention & Early Intervention)
- Reducing Health Disparities Meeting
- San Ramon Valley Mental Health Advisory Council Meeting
- Special Needs Committee Meeting
- Suicide Prevention Committee (Co-chair)
- System of Care Committee
- Volunteer Organizations Active in Disaster (Chair)
- West Contra Costa Networking Meeting

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. We believe every person has a basic right to assistance in life-threatening or other crisis situations. Our mission is to keep people alive and safe, help them through crises, and provide or connect them with culturally relevant resources in the community. Our vision is that people of all cultures and ethnicities in Contra Costa County are in a safe place emotionally and physically. Every resource in our 211 Resource Database is vetted, maintained, and up-to-date and is accessible for agencies partners and members of the community to use throughout the county free of charge.

The Contra Costa Crisis Center holds the following core values:

- Compassion: We are driven by a desire to alleviate the emotional pain, distress, and needs of our clients.
- Integrity: We respect and honor our colleagues and clients through trustworthy actions.

- Inclusion: We affirm the value of differing perspectives and are committed to representation from, and service to, all members of our diverse community.
- Accessibility: We believe that people in need should be able to get help 24:7.
- Collaboration: We are committed to developing strong, lasting partnerships with community members to achieve common goals.

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 #428117

The caller was a 28-year-old black male, in imminent risk at the beginning of the call. He immediately shared with the call specialist that he had a knife, has been trying to stab himself, and is bleeding. The call specialist quickly developed rapport with the caller and asked him to put the knife away out of reach while they were talking. He was agreeable and stated that he needed emergency services and needed to go to the hospital right away. Necessary information was collected for emergency services and a second call specialist contacted Pittsburg Police department.

While waiting for the police, the call specialist remained on the phone line to maintain the connection and keep the caller safe. The caller has had thoughts of suicide since he was a child, had two past attempts, and currently stabbing himself due to his suicidal ideation. His past two attempts have been to try to shoot himself and to overdose on Meth. He stated that he has not told his counselor about the past attempts, or the "voice in his head is always really loud," or that he gets headaches and cannot sleep. He has been homeless for 8 years. He comes from a family with five sisters and his father recently died.

The call specialist remained on the line until police arrived at his home providing active listening and emotional support. The caller consented to a follow-up call in four days when he hopes to return from the hospital. He was reminded that he can call or text the crisis lines 24/7 for emotional support.

Follow Up: Three separate attempts were made to follow up with the caller. Caller is doing well following his hospitalization and has been in contact with the Homeless Coordinated Outreach Referral & Engagement team (CORE) regarding a motel room through Project Roomkey during COVID-19.

PEI ANNUAL REPORTING FORM

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS REPORTING FORM FISCAL YEAR: 19-20

Agency/Program Name: COPE

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 / ACTIVITIES:

Please summarize the Scope of Services as outlined in the Service Work Plan. Please also address any other relevant activities or events that took place during the reporting period.

Program Quality and Standards

COPE completed all provisions of this contract.

COPE ensured that program activities were provided by accredited Triple P qualified staff and focused on parents and/or guardians, expectant parents of children from birth through age 18, and/or early childhood educators of children from birth through age 5.

COPE provided twenty-one (21) Triple P Positive Parenting Group classes and seminars to groups in West, Central and East Contra Costa County. COPE enrolled 235 individuals in these classes and seminars.

Trainers

This year we provided a Family Transitions Triple P training program and accredited 18 practitioners. Clinical interns were provided pre-accreditation training through assisting accredited Triple P practitioners in their classes.

Enrollment

COPE enrolled 235 client family members in Triple P Parenting classes during the fiscal year.

COPE provided case management services for families who asked for additional resources. Additionally, if a parent's assessment indicated a concern, the participant was contacted to

determine if additional community support was needed. Where appropriate, referrals were made for additional mental health services.

Demographic information noted below.

Programs and Outreach

Parenting Classes: We delivered 20 classes and 1 seminar series throughout the county at various times and convenient locations to accommodate transportation barriers. C.O.P.E. provided classes in English and Spanish in East, West and Central County.

Settings of Potential Responders for the 2019-20 FY included elementary, junior, and high schools, early education centers, 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 – Central County
Contra Costa County Juvenile Hall
Family Justice Center- East County
Concord Veterans Center
Black Diamond High School
Hillview Jr High
Martin Luther King Jr. High School
Murwood- Walnut Creek
Ranchos Medanos Jr. High School

We utilized the services of our Clinical interns to address the needs of parents and families with more intensive challenges. Clinical interns are invited to assist accredited Triple P practitioners in the Triple P classes, providing client support and administrative aid.

COPE recorded how parenting classes have supported parents in developing a more positive relationship with their child through vignettes and testimonies. See report below

Outreach

COPE attended the following SARB meetings:

- County Office of Education, Antioch/Acalanes/Pittsburg/Martinez//Walnut Creek Unified School Districts.

COPE attended Parent Truancy Court bi-monthly to promote Triple P System to the courts and outreach to at risk parents with children in Contra Costa County.

COPE provided:

- Case management services for parents interested in or attending Triple P to provide additional supports and linkages.
- Warm-handoff referrals to community resources such as housing, job training and placement, food banks and family law centers, HMG-First 5 Centers.
- Collaboration between staff and a 'point person' at each agency to ensure timely access to resources.
- Evaluations and individual parent consultation for Triple P participants scoring above the clinical-cutoff range in any pre-assessment (DASS, Parenting Scale, ECBI, Conflict Behavior), providing resources as needed.

Data Collection and Tracking

COPE collected data using pre and post assessments in all classes. Data was entered in the ETO system with individual and class results provided to facilitators and participants.

Program Monitoring and Evaluation

COPE worked with Sarah Burke to maintain a secure database containing assessment data for all classes.

COPE maintained quality assessment through regular check-ins by the program manager with the practitioners, weekly review of class checklist and periodic auditing of classes.

Site visit has not been scheduled at this time.

Reporting

C.O.P.E. submitted a report at the half year point on January 15, 2020 and will submit this report by September 15, 2020. Monthly reports are also submitted on Persimmony.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services.

Numbers served during the fiscal year

- 235 individuals enrolled in Triple P classes in MHSA funded programs in Contra Costa County for the 2019-2020 Fiscal Year.
- 46% of participants identified as Hispanic/Latino/a; 22% identified as Caucasian; 6% identified as More than One Race/Ethnicity; 15% identified as African American; 11% identified as Asian
- 43% of participants reported household income below the California state poverty level
- 12% of participants reported completing at least two years of college (or more)
- Additional Demographic information below depicts the types of potential responders and is organized by Ethnicity, Gender, Language, Age, Education, and Income.

Describe any adaptation of services due to COVID-19 that may be relevant

- Beginning in Mid-March 2020, COPE moved all Triple P classes to online using the Zoom video conferencing platform.
- All assessments were recreated on Google Forms to allow participants to complete the assessments on their personal devices (smart phone, tablet, or computer).
- Practitioners followed up with participants by phone to assist them with completing the forms and worked with participants in accessing classes through Zoom.
- Group session times, in some cases, were reduced to one hour and a half and practitioners made additional one-on-one phone calls to the participants.
- Practitioners had to spend additional time assisting participants in how to use the online meeting platform.

For PEI - Early Intervention programs, please describe:

Triple P- Positive Parenting Program *is a* multi-level system of family intervention for parents of children who have or are at risk of developing behavior problems. It is a preventively oriented program which aims to promote positive, caring relationships between parents and their children, and to help parents develop effective management strategies for dealing with a variety of childhood behavior problems and common developmental issues.

PROGRAM OBJECTIVES:

- Increase parents' competence in managing common behavior problems and developmental issues
- Reduce parents' use of coercive and punitive methods of discipline
- Improve parents' communication about parenting issues
- Reduce parenting stress associated with raising children

PRINCIPLES OF TRIPLE P

- Having a safe and interesting environment

- Having a positive learning environment
- Using assertive discipline
- Having realistic expectations
- Taking care of yourself

Which mental illness(es) were potentially early onset?

Our Triple P Practitioners are not clinicians qualified to diagnose mental illness. Every participant is administered the DASS assessment which measures for symptoms of depression, anxiety, and stress in adults.

How participant's early onset of a potentially serious mental illness was determined

All participants were provided the Depression Anxiety Stress Scale as part of the pre and post assessments. Participants who scored above the clinic cutoff on the DASS pre or post assessment for depression, anxiety or stress were contacted individually and referred as necessary to community resources for additional support and services.

List of indicators and data that measured reduction of negative outcomes.

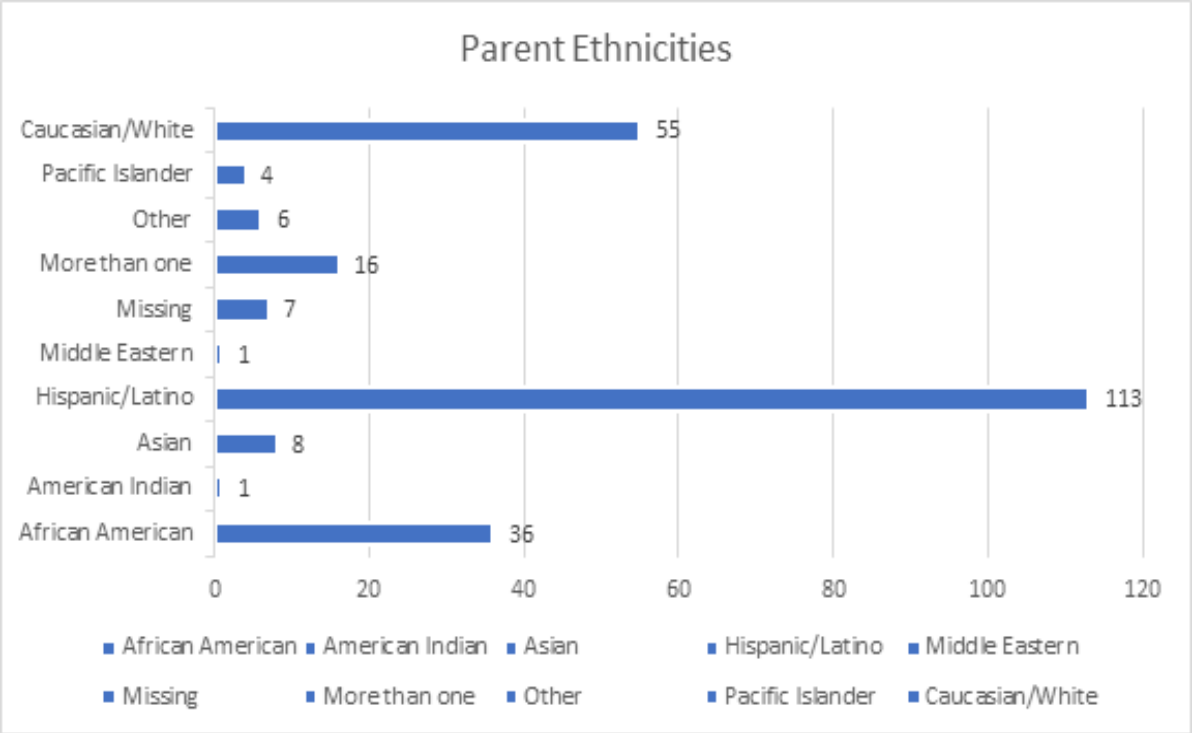
Pre and Post Assessments are completed by all Triple P participants. These assessments are the Parenting Scale, Eyberg Child Behavior Inventory and the DASS

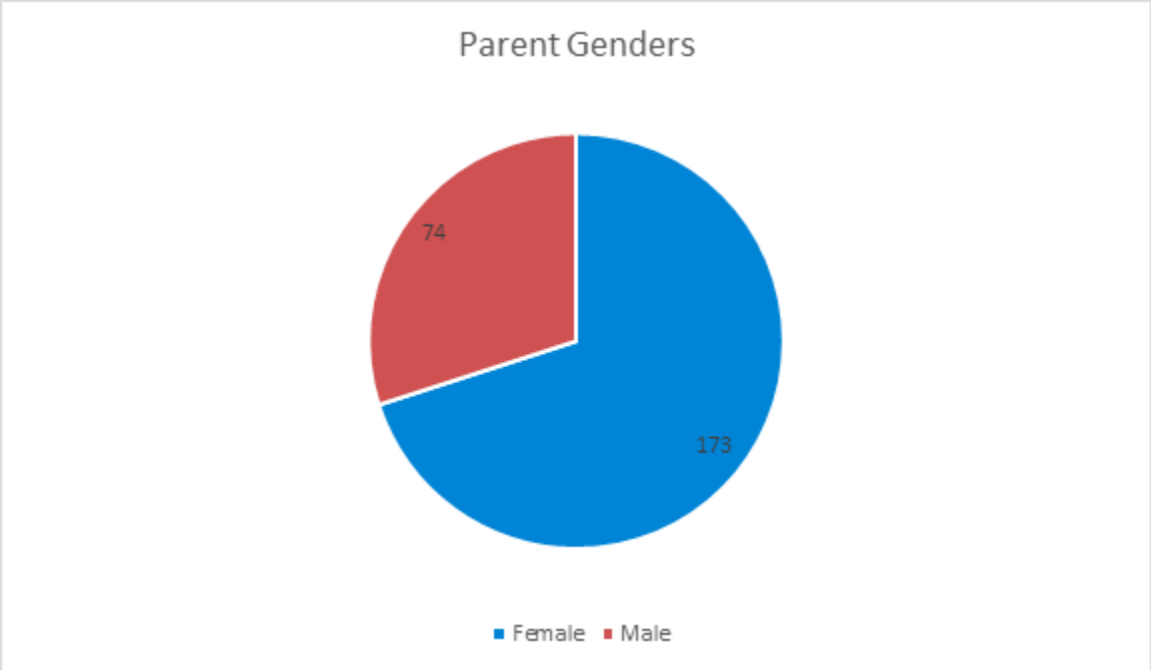
- The Parenting Scale measures dysfunctional discipline practices in parents.
- The Eyberg Child Behavior Inventory measures parental perceptions of disruptive child behavior using both an intensity scale and a problem scale.
    - The Intensity scale measures the frequency of each problem behavior.
    - The Problem scale reflects the parent's tolerance of the behaviors and the distress caused.
- The Depression Anxiety Stress Scale measures symptoms of depression, anxiety, and stress in adults.

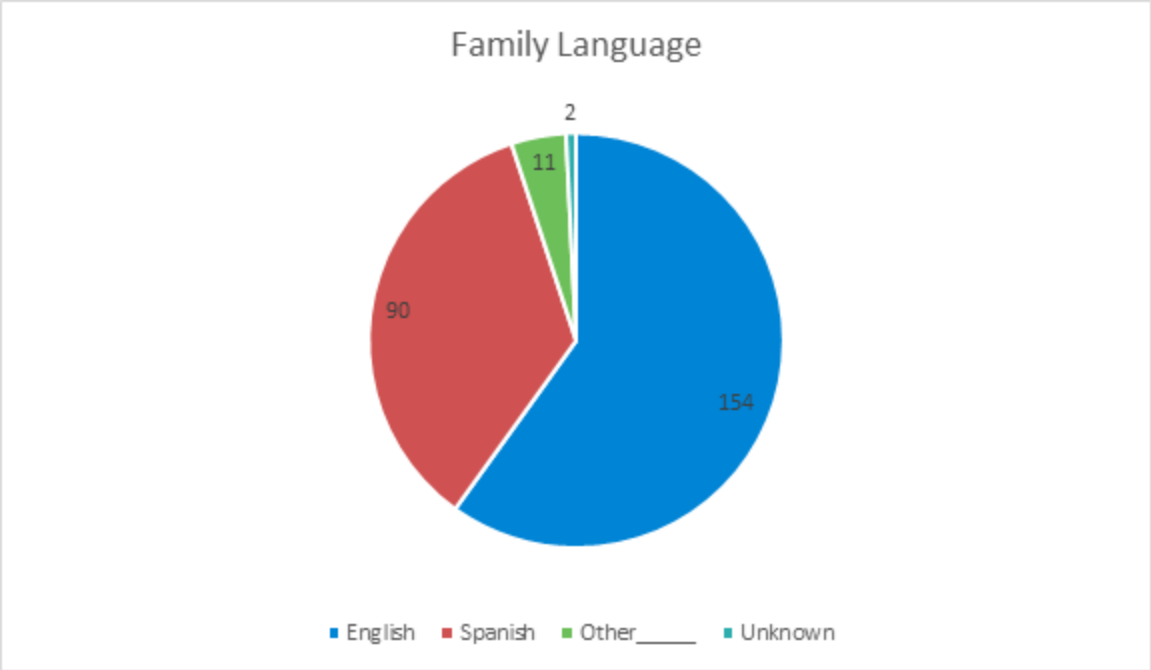
Assessments are administered at the beginning and end of the course. Reports are produced showing the change in results and these reports are reviewed by the practitioner and shared with the individual participants as part of the conclusion of the course. See overall results below.

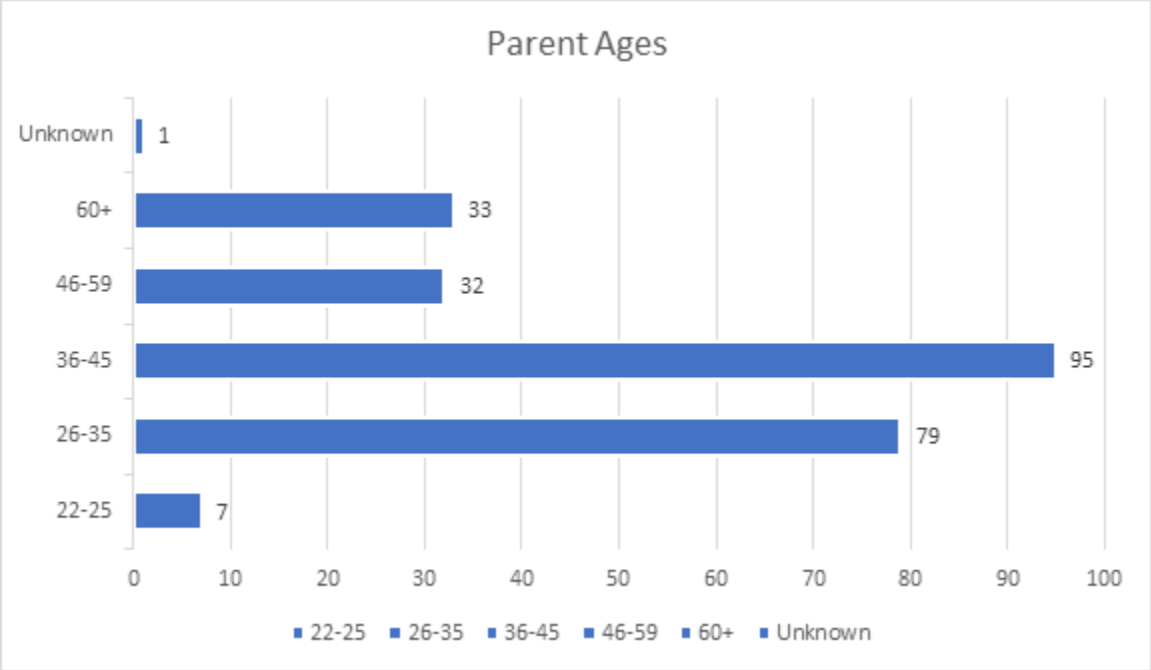
Participants are invited to provide anecdotes of their own successes, both during regular check-ins at each class and at the end of the course.

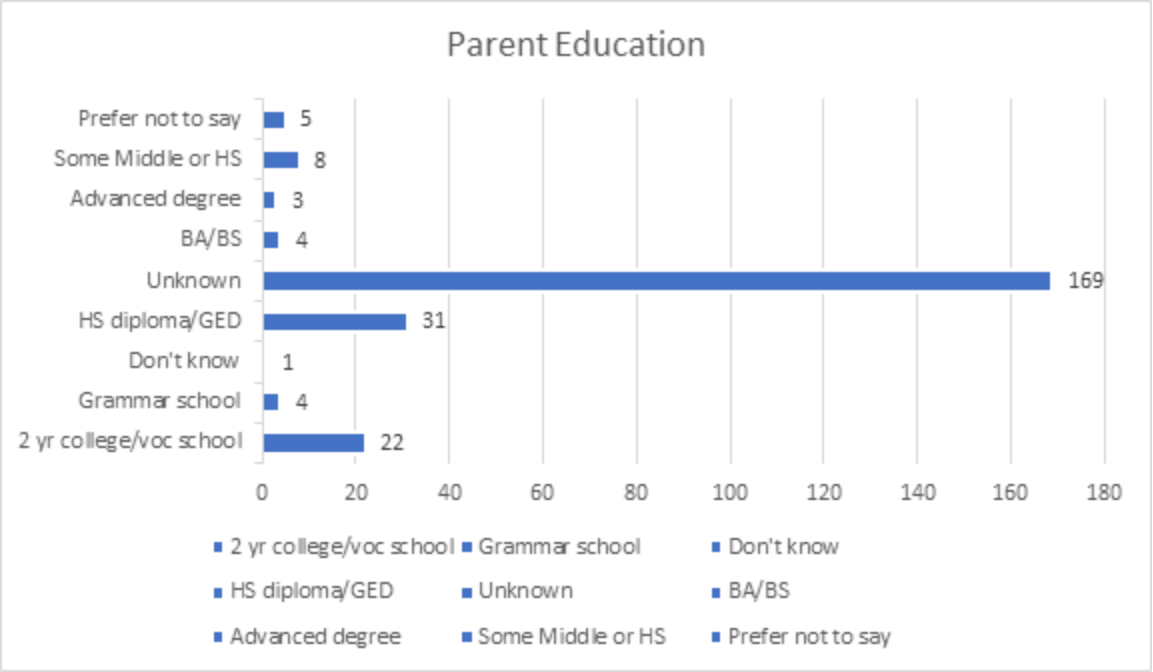
MHSA Demographics for Parents of children 6-17 years of age

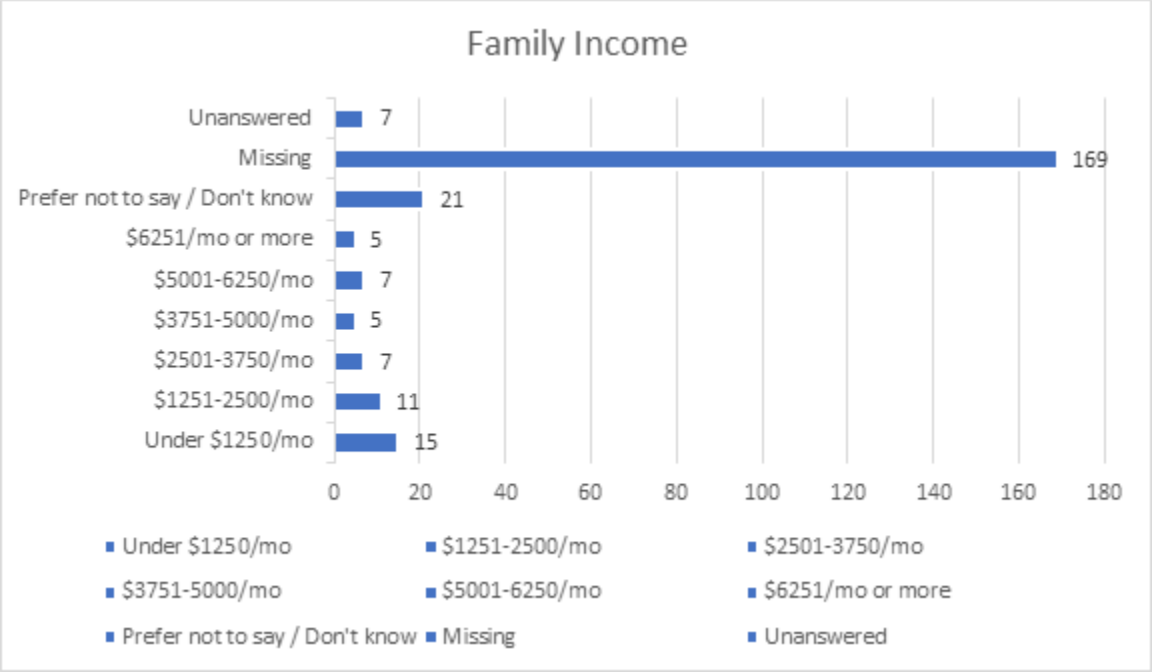


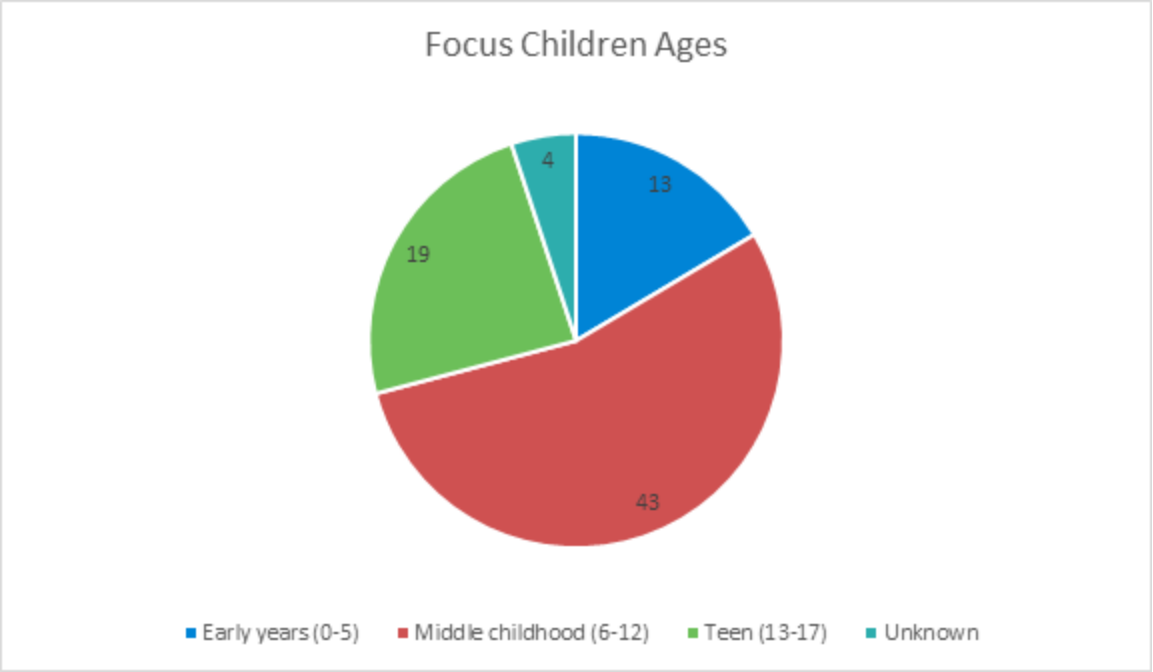


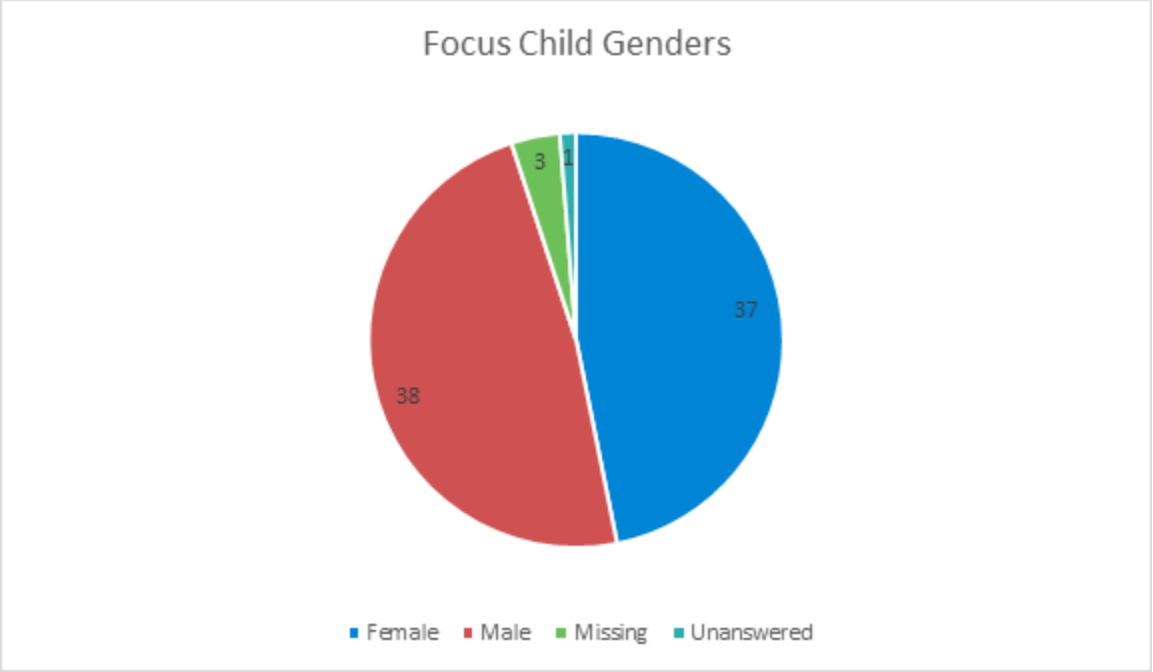

Family Language
2
11
90
154
English
Spanish
Other_____
Unknown

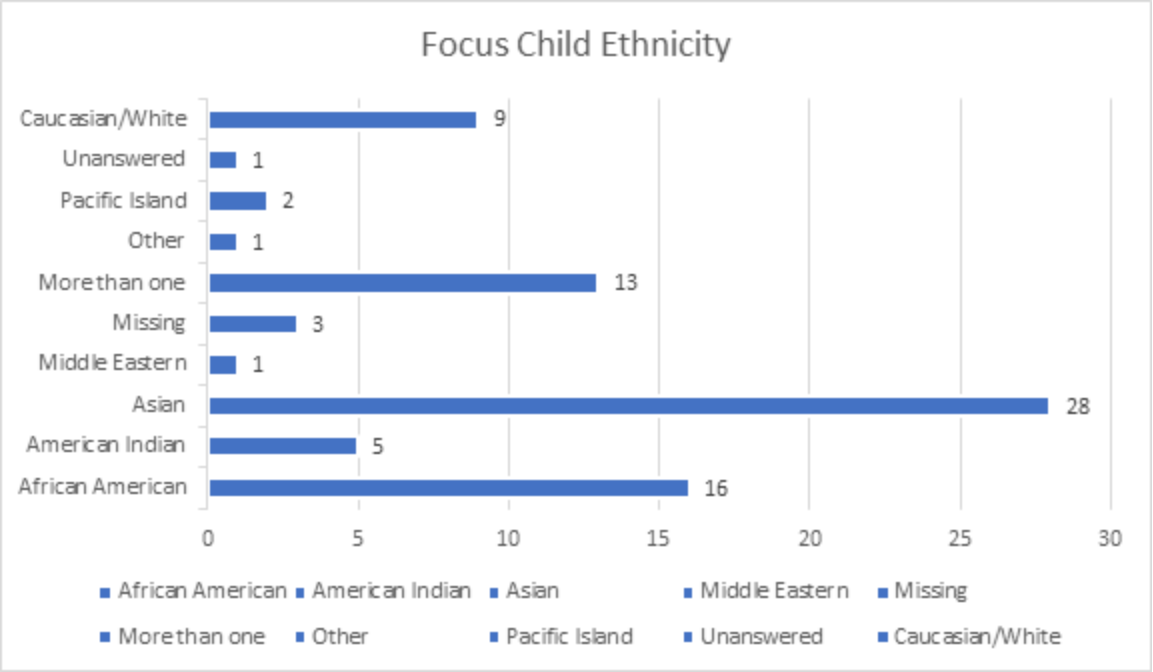

Parent Ages
Unknown
1
60+
33
46-59
32
36-45
95
26-35
79
22-25
7
0
10
20
30
40
50
60
70
80
90
100
22-25
26-35
36-45
46-59
60+
Unknown

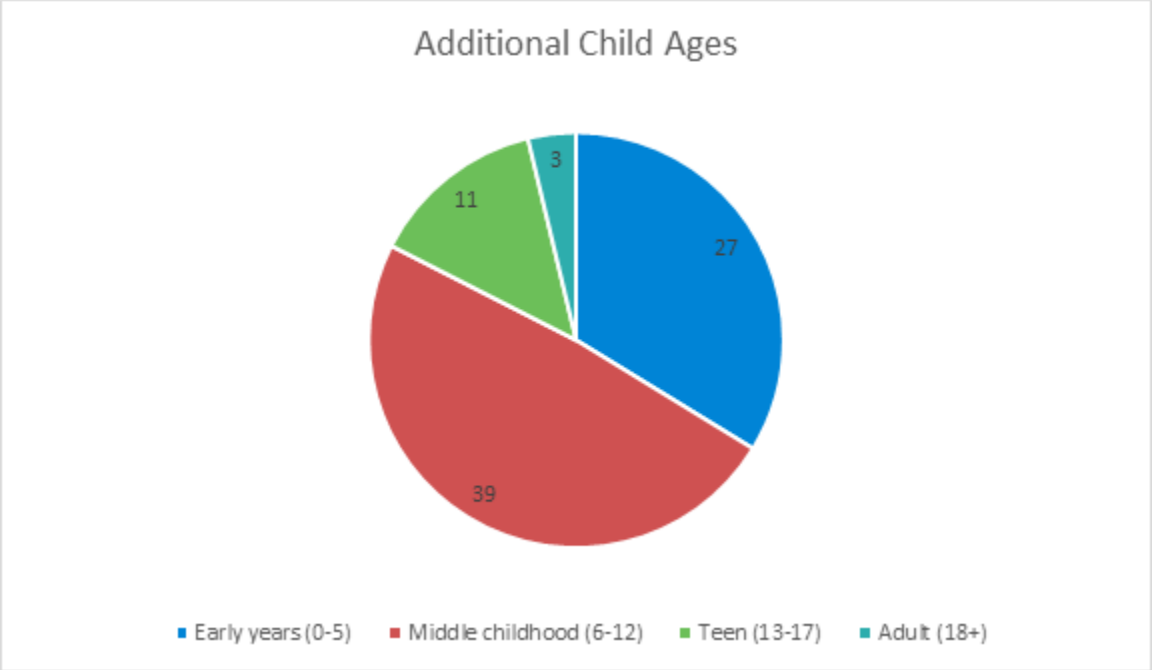

Parent Education
Prefer not to say 5
Some Middle or HS 8
Advanced degree 3
BA/BS 4
Unknown 169
HS diploma/GED 31
Don't know 1
Grammar school 4
2 yr college/voc school 22
0 20 40 60 80 100 120 140 160 180
2 yr college/voc school
Grammar school
Don't know
HS diploma/GED
Unknown
BA/BS
Advanced degree
Some Middle or HS
Prefer not to say


Family Income
Unanswered 7
Missing 169
Prefer not to say / Don't know 21
$6251/mo or more 5
$5001-6250/mo 7
$3751-5000/mo 5
$2501-3750/mo 7
$1251-2500/mo 11
Under $1250/mo 15
0 20 40 60 80 100 120 140 160 180
Under $1250/mo
$1251-2500/mo
$2501-3750/mo
$3751-5000/mo
$5001-6250/mo
$6251/mo or more
Prefer not to say / Don't know
Missing
Unanswered


Focus Children Ages
13
43
19
4
Early years (0-5)
Middle childhood (6-12)
Teen (13-17)
Unknown

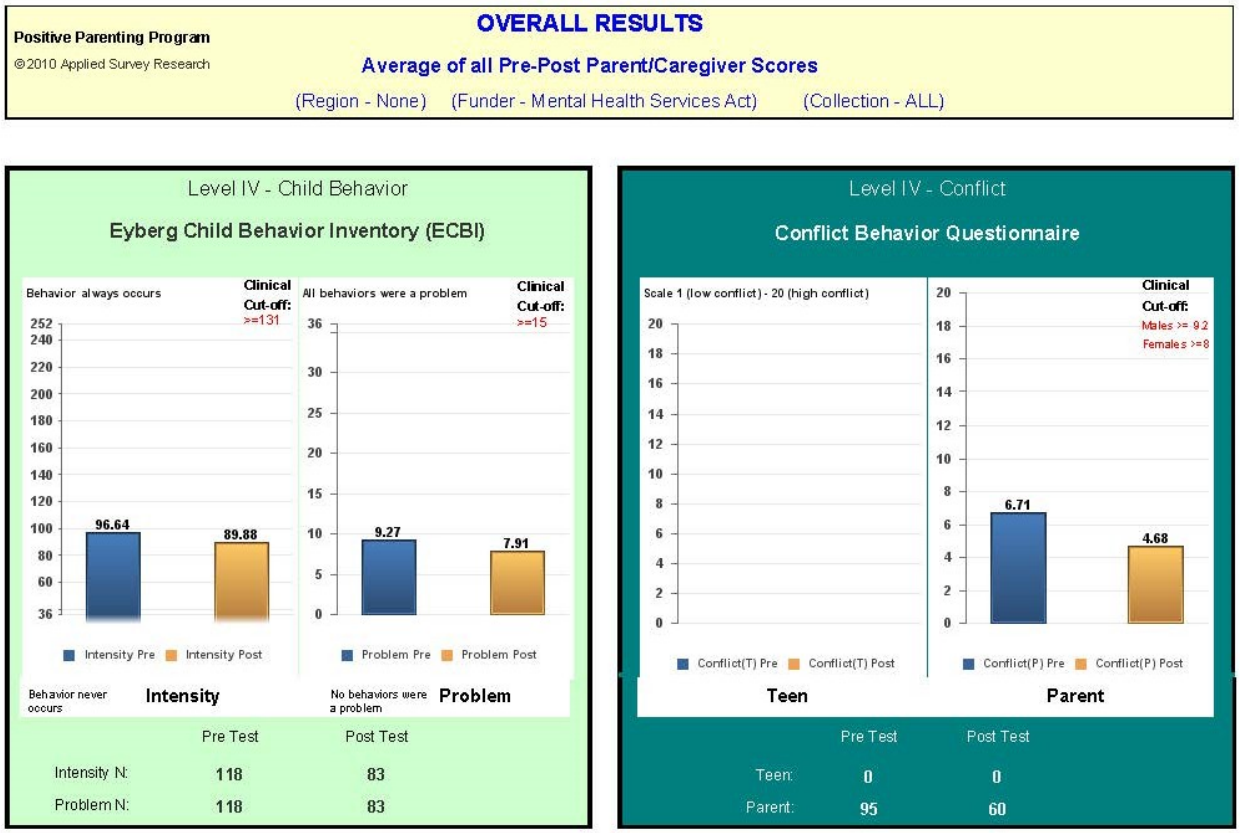

Focus Child Genders
37
38
3
1
Female
Male
Missing
Unanswered


Focus Child Ethnicity
Caucasian/White
Unanswered
Pacific Island
Other
More than one
Missing
Middle Eastern
Asian
American Indian
African American
9
1
2
1
13
3
1
28
5
16
0
5
10
15
20
25
30
African American
American Indian
Asian
Middle Eastern
Missing
More than one
Other
Pacific Island
Unanswered
Caucasian/White


Additional Child Ages
3
11
27
39
Early years (0-5)
Middle childhood (6-12)
Teen (13-17)
Adult (18+)

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.



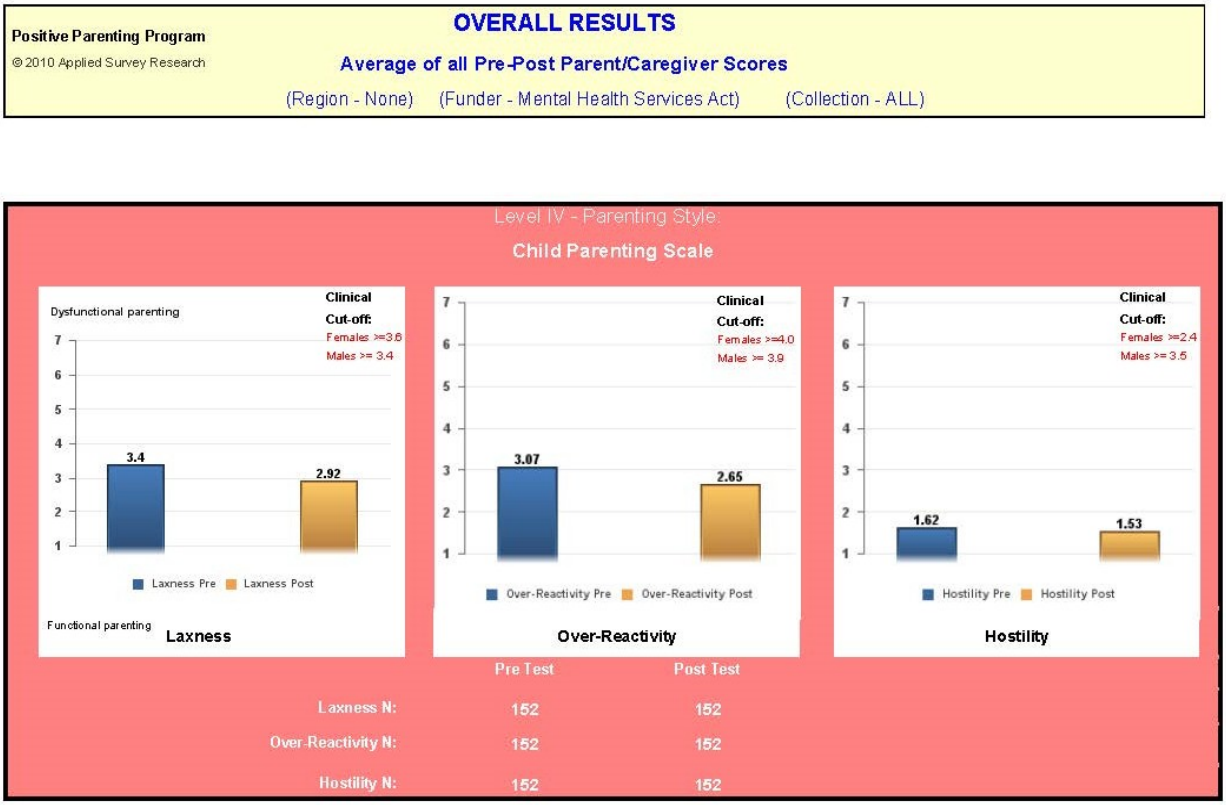
The Eyberg Child Behavior Inventory measures parental perceptions of disruptive child behavior. The Intensity Scale measures the frequency of each problem behavior.

Intensity Scale – 7% reduction in Intensity

The Problem Scale reflects parent's tolerance of the behaviors and the distress caused. Problem – 15% reduction in Problem

The Conflict Behavior Questionnaire is used to measure the level of conflict between a parent and their teenager.

Conflict Levels – 30% reduction in Conflict Levels



The Parenting Scale measures dysfunctional discipline practices in parents. Laxness (Permissive Discipline) – 14% reduction in Laxness

Over-Reactivity (Displays of anger, meanness, and irritability) – 14% reduction in Over-Reactivity

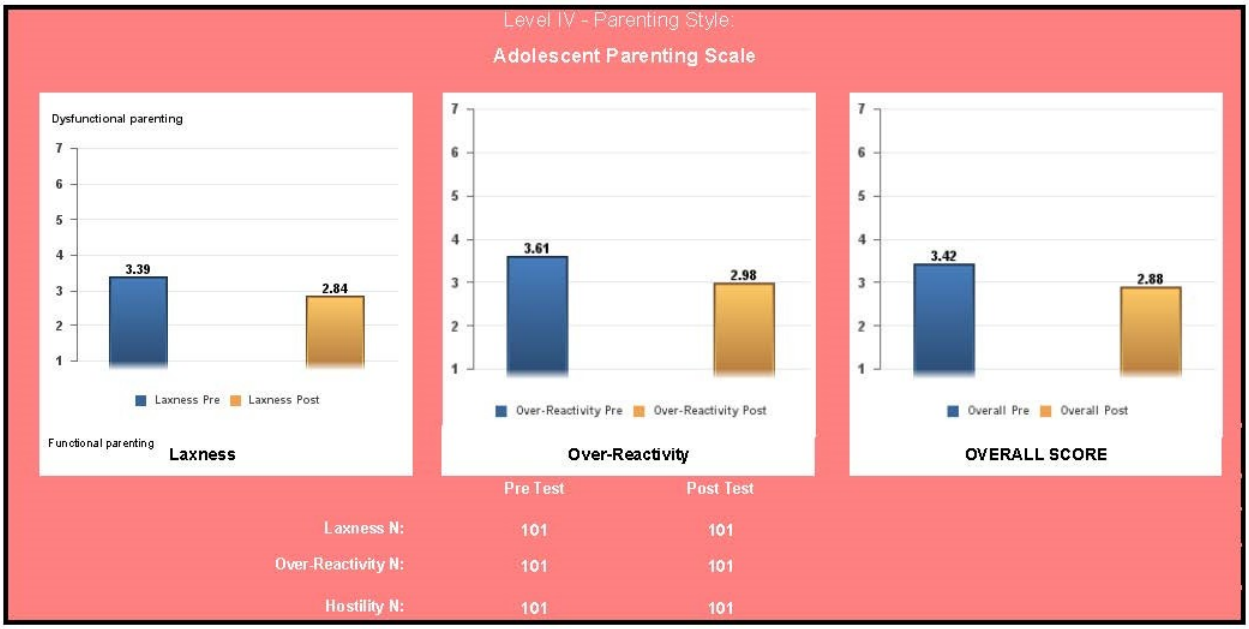
Hostility (Use of verbal or physical force) – 5% reduction in Hostility

Positive Parenting Program

OVERALL RESULTS

Average of all Pre-Post Parent/Caregiver Scores

(Region - None) (Funder - Mental Health Services Act) (Collection - ALL)



The Parenting Scale measures dysfunctional discipline practices in parents. Laxness (Permissive Discipline) – 16% reduction in Laxness

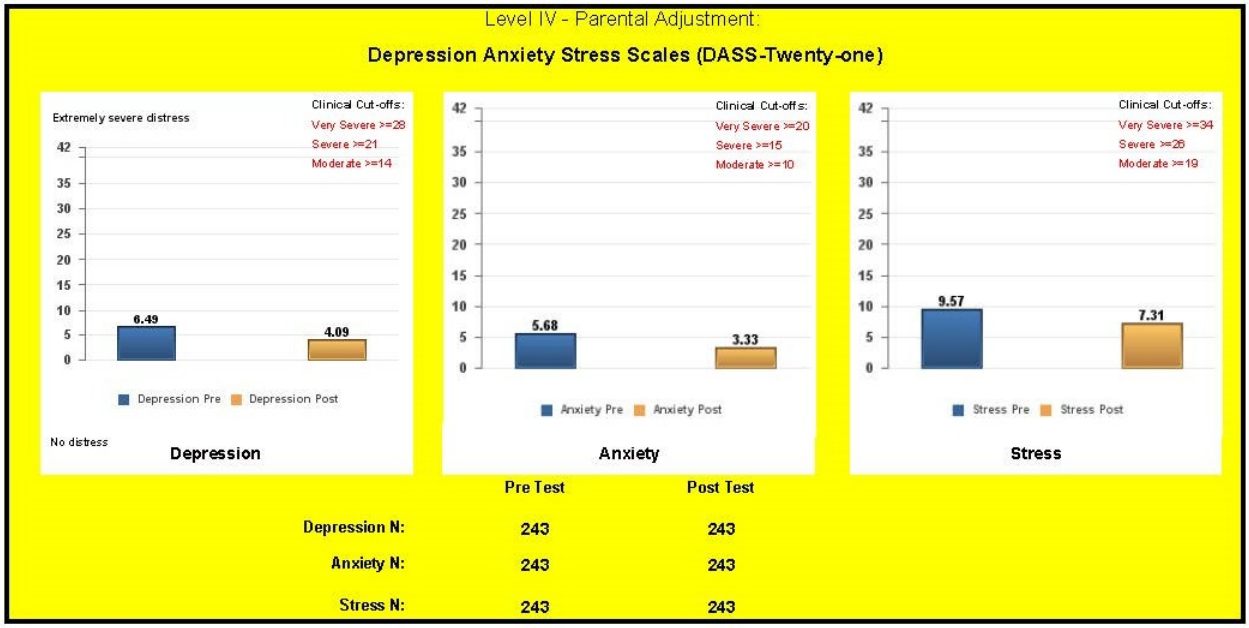
Over-Reactivity (Displays of anger, meanness, and irritability) –17% reduction in Over-Reactivity
Overall Score – 16% reduction

Positive Parenting Program

OVERALL RESULTS

Average of all Pre-Post Parent/Caregiver Scores

(Region - None) (Funder - Mental Health Services Act) (Collection - ALL)



The Depression Anxiety Stress Scale measures symptoms of depression, anxiety, and stress in adults.

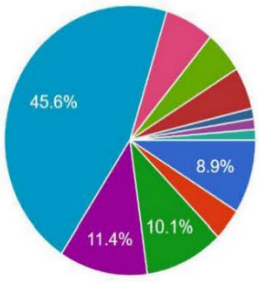
Depression (Dysphoria, hopelessness, devaluation of life, self-depreciation, lack of interest/involvement, anhedonia, and inertia) – 37% reduction

Anxiety (autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious effect) – 41% reduction

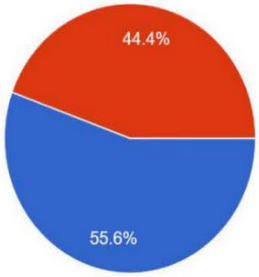
Stress (difficulty relaxing, nervous arousal, and being easily upset/agitated, irritable/over-reactive, and impatient) – 24% reduction

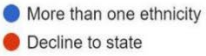
MHSA DEMOGRAPHIC DATA: ☐ Not Applicable *(Using County form)*

Race (please select one.)
79 responses

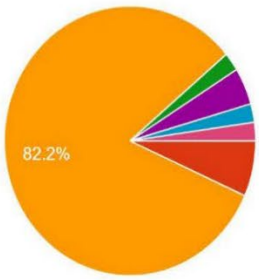


Ethnicity
18 responses



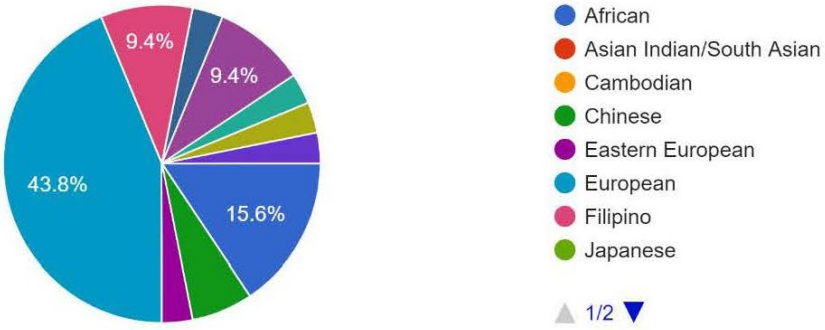


Ethnicity (If Hispanic or Latino/a)
45 responses



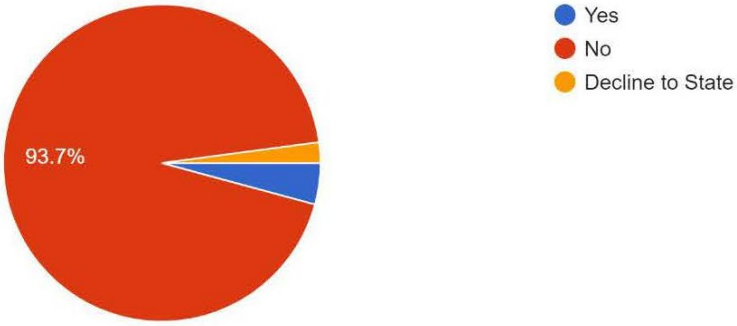
Ethnicity (If Non-Hispanic or Non-Latino/a)

32 responses



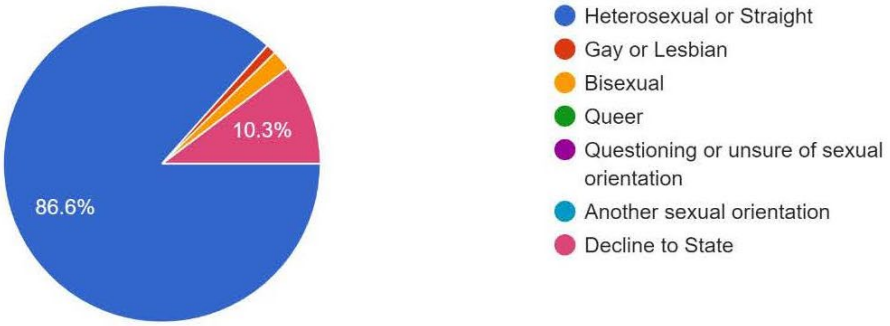
Veteran Status

95 responses



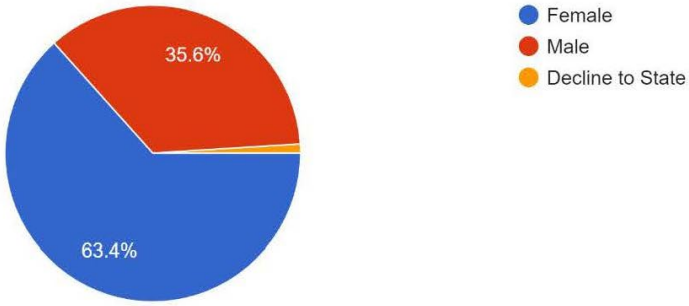
Sexual Orientation

97 responses



Gender (Assigned Sex at Birth)

101 responses

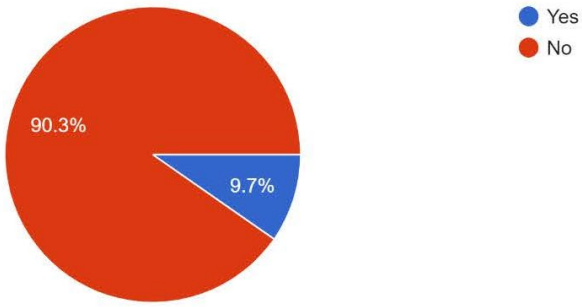


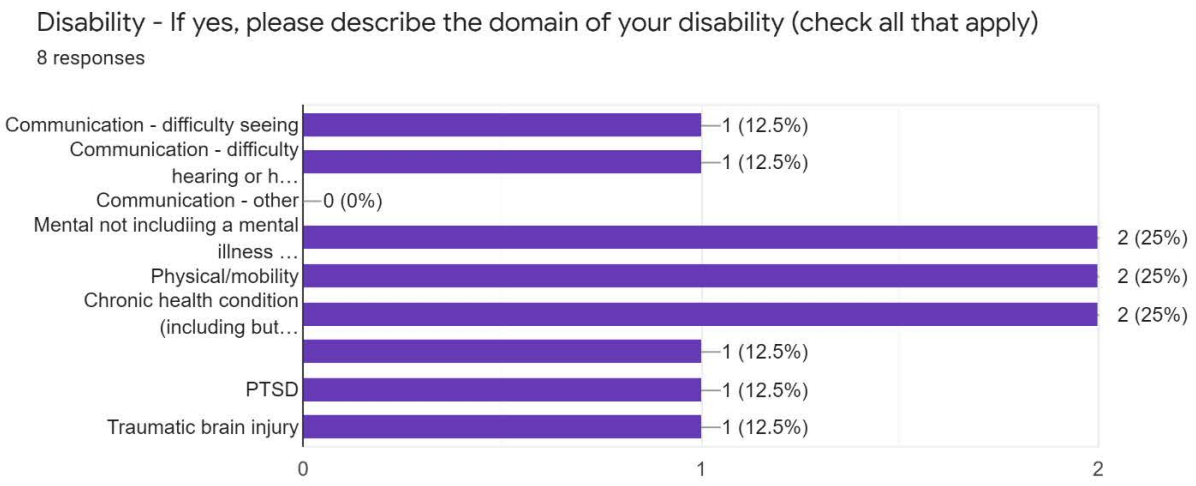
Gender (Current Gender Identity)

93 responses

Disability Status (a disability is a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life acti...y, which is not the result of a severe mental illness)

93 responses





Note: Age Group is not included in the above summary of responses as many respondents incorrectly entered the age group of their children rather than their own age. The questionnaire for 2020-2021 will be modified slightly to make it clear that the respondent's age is what is being asked.

CULTURAL RESPONSIVENESS:

How have services been informed and structured to meet the diverse cultural needs of your clients/members/participants? What is being done by your organization to support cultural responsiveness both within the workforce and for those served by your organization?

C.O.P.E. has a culturally diverse 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 effective and consistent parenting skills that nurture the uniqueness of each family.

COLLABORATIVE PRACTICES:

Describe how you are working with any other agencies or organizations to better serve clients/members/participants? If this is currently not being done, please describe any effort to build relationships with other community service providers?

- Collaboration with the Contra Costa Truancy Court, Probation and CFS to refer families to parenting classes
- Collaboration with school districts and administrative staff to provide referrals to parents of students within each district
- Referrals from community partners such as Family Justice Center, Contra Costa County Juvenile Hall, and Concord Veterans Center.
- Provided briefing/orientation meetings to community agencies interested in referring members to the Triple P program
- Attended community events to provide resources
- Agreement with SPARK to use COPE facility to meet with clients for SIS-SUDS program (Seeking Information & Support – Substance Abuse Disorders)
- Provide classroom to Kinship services to provide classes to foster families

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
- Collaboration with the Contra Costa Truancy Court, Probation and 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 Family Justice Center, Contra Costa County Juvenile Hall, and Concord Veterans Center.
- Provided briefing/orientation meetings to community agencies interested in referring members to the Triple P program

During the 2019-20 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

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?

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 complementary services. Parents in need of further intervention are identified through their participation in Triple P parenting classes and are linked to supplementary services. 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.

C.O.P.E. also provides a comfortable, family-oriented atmosphere for community members visiting the office for services. C.O.P.E. staff pride themselves in

Case management is provided to participating families which includes:

- Initial assessments of program 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 Strategies Utilized to Provide Access and Linkage to Treatment include:
- Provide assessment and case management to community members in need of services
- Warm-handoff referrals to community resources such as housing, job training and placement, food banks and family law centers
- Collaboration between staff and a ‘point person’ at each agency to ensure timely access to resources
- 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), providing resources as needed.

Strategies Utilized to Improve Timely Access to Services for Underserved Populations included:

- 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
- Provided classes in English and Spanish and Arabic in each region of the county
- Individual assessment, consultations and referrals to county mental health as needed
- Collaboration with school districts, family workers, other service providers and families to create a service plan for individuals, to ensure timely access to support and resources.
- Tailored classes that include focus topics that directly address parenting needs (ex. Having a discussion around teen's use of social media in a Group Teen Triple P parenting class where parent have expressed this as a challenge)
- After assessing family needs, we link to other community supports such as county mental health, housing, crisis centers and other resources

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.

Participants feel they are spending more quality time with their children and less conflict. "I spend time with my kids, and I am not yelling at them anymore."

One parent stated she was spending more quality time with her teen which led to less aggression and more conversations between them. She reported her son was "attending school more regularly and not smoking inside the house."

One parent stated, "the behavior charts are working so well that we want to expand them." All parents stated how self-care is important and that they will start to make time for themselves.

"I didn't realize how poorly I was taking care of myself and how that affected my relationship with my child."

"I am working on progress with my mom..." The strategies the students liked were setting goals, stop vaping, and hugging their mom every day.

"I'm recognizing the importance of my time."

One parent reported "learning the difference between underlying issues and expressed issues helped me to identify what I was arguing as opposed to what I should've been arguing."

One parent stated, “spending small amounts of quality time really does make a big difference.” This class helped me to see that I was treating my kids differently.

“I wished I had taken a parent class when my children were young.”

One parent shared that “attending a class does not make you a bad parent. Parent classes should be required.”

“I didn’t realize how poorly I was taking care of myself and how that affected my relationship with my child.”

PEI ANNUAL REPORTING FORM

EARLY INTERVENTION REPORTING FORM

FISCAL YEAR: 19-20

Agency/Program Name: First 5 Contra Costa

Project (if applicable): Contra Costa Triple P

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 / ACTIVITIES:

Please summarize the Scope of Services as outlined in the Service Work Plan. Please also address any other relevant activities or events that took place during the reporting period.

Program Quality and Standards

First 5 Contra Costa completed all provisions of this contract.

First 5 Contra Costa ensured our subcontractor, COPE, utilized accredited Triple P practitioners to implement Triple P services that focused on children from birth through age 5, and/or their parents/guardians, expectant parents, and/or early childhood educators of children from birth through age 5. A year-round "learning community" was provided to support practitioners and a yearly Triple P level training offered for workforce development resulting in eighteen individuals were accredited in the Family Transitions Triple P training.

- First 5 has a secure database containing assessment data for all classes.
- First 5 has an established quality improvement process where our subcontractor COPE maintains quality assessment through regular check-ins with the practitioners, weekly review of class checklist and periodic auditing of classes.
- Quarterly performance progress completed to ensure movement toward all objectives.

Enrollment

189 client family members enrolled in Triple P Parenting classes during the fiscal year.

Enrollment of a subset of families in Case management services who could benefit from additional support in connecting to other community resources.

Demographic information noted below.

Program, Trainers and Outreach

Parenting Classes: We delivered 15 classes and 2 seminar series throughout the county at various times and convenient locations to accommodate transportation barriers. Classes were available in English and Spanish in East, West and Central County. All classes were free to all participants.

The subcontractor used clinical interns to address the needs of parents and families with more intensive challenges.

Our evaluation process captured the effectiveness of the parenting classes including parents" experiences as reflected in vignettes and testimonies. See report below

Program attendance is track in the ETO database to ensure accuracy in reporting participants.

Presentations and briefings to early childhood organizations as an engagement and recruitment tool. This year 12 occurred.

Subcontractor targeted specific key meetings to attend to engage community partners in identifying potential program participants and to expand the reach diverse populations.

Data Collection and Tracking

Collected data using pre and post assessments in all classes offered in First 5 Centers. Data was entered in the ETO system with individual and class results provided to facilitators and participants.

Program Monitoring and Evaluation

The Triple P program is closely monitored. Pre and post evaluation entered on each class. The program data is track quarterly to allow for adjustment and continuous quality improvement. Practitioners received ongoing TA and professional development.

Reporting

The internal database collects quarterly data in preparation for the MHSA annual report.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services.

Numbers served during the fiscal year

- There were 189 individuals enrolled in Triple P classes in First 5 – provided programs in Contra Costa County for the 2019-2020 Fiscal Year.
- 72% of the participants were female.
- 56% of the participants were Latino/a.
- 10% of the participants identified as African American.
- 49% of the participants were either Spanish-speakers or bilingual Spanish/English

Describe any adaptation of services due to COVID-19 that may be relevant

- Beginning in Mid-March 2020, classes moved all Triple P classes to online using the Zoom video conferencing platform.
- All assessments recreated on Google Forms to allow participants to complete the assessments on their personal devices (smart phone, tablet, or computer).
- Practitioners followed up with participants by phone to assist them with completing the forms and worked with participants in accessing classes through Zoom.
- Group session times, in some cases, reduced to one hour and a half and practitioners made additional one-on-one phone calls to the participants.

For PEI - Early Intervention programs, please describe:

Triple P- Positive Parenting Program *is a* multi-level system of family intervention for parents of children who have or are at risk of developing behavior problems. It is a preventively oriented program, which aims to promote positive, caring relationships between parents and their children, and to help parents develop effective management strategies for dealing with a variety of childhood behavior problems and common developmental issues.

<u>PROGRAM OBJECTIVES:</u>

- Increase parents' competence in managing common behavior problems and developmental issues
- Reduce parents' use of coercive and punitive methods of discipline
- Improve parents' communication about parenting issues
- Reduce parenting stress associated with raising children

<u>PRINCIPLES OF TRIPLE P</u>

- Having a safe and interesting environment
- Having a positive learning environment
- Using assertive discipline
- Having realistic expectations
- Taking care of yourself

Which mental illness(es) were potentially early onset?

Our Triple P Practitioners are not clinicians qualified to diagnose mental illness. Every participant is administered the DASS assessment which measures for symptoms of depression, anxiety, and stress in adults.

How participant's early onset of a potentially serious mental illness was determined

All participants are provided the Depression Anxiety Stress Scale as part of the pre and post assessments. Participants who scored above the clinic cutoff on the DASS pre or post assessment for depression, anxiety or stress were contacted individually and referred as necessary to community resources for additional support and services.

List of indicators and data that measured reduction of negative outcomes.

All Triple P participants complete Pre and Post Assessments. These assessments are the Parenting Scale, Eyberg Child Behavior Inventory and the DASS

- The Parenting Scale measures dysfunctional discipline practices in parents.
- The Eyberg Child Behavior Inventory measures parental perceptions of disruptive child behavior using both an intensity scale and a problem scale.
- The Intensity scale measures the frequency of each problem behavior.
- The Problem scale reflects the parent's tolerance of the behaviors and the distress caused.
- The Depression Anxiety Stress Scale measures symptoms of depression, anxiety, and stress in adults.

Assessments are administered at the beginning and end of the course. Reports are produced showing the change in results and these reports are reviewed by the practitioner and shared with the individual participants as part of the conclusion of the course. See overall results below.

Participants are invited to provide anecdotes of their own successes, both during regular check-ins at each class and at the end of the course.

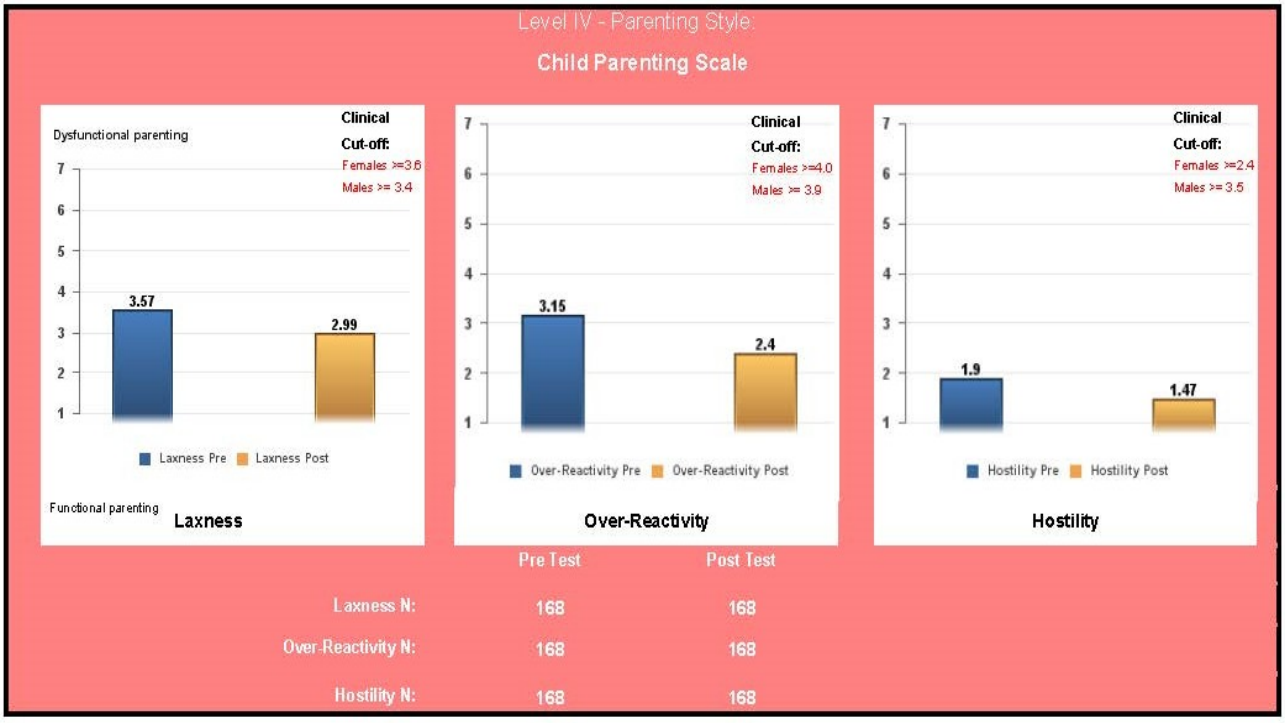
Positive Parenting Program

© 2010 Applied Survey Research

OVERALL RESULTS

Average of all Pre-Post Parent/Caregiver Scores

(Region - None) (Funder - First 5 Contra Costa) (Collection - ALL)



The Parenting Scale measures dysfunctional discipline practices in parents. Laxness (Permissive Discipline) – 16% reduction in Laxness

Over-Reactivity (Displays of anger, meanness, and irritability) – 24% reduction in Over-Reactivity

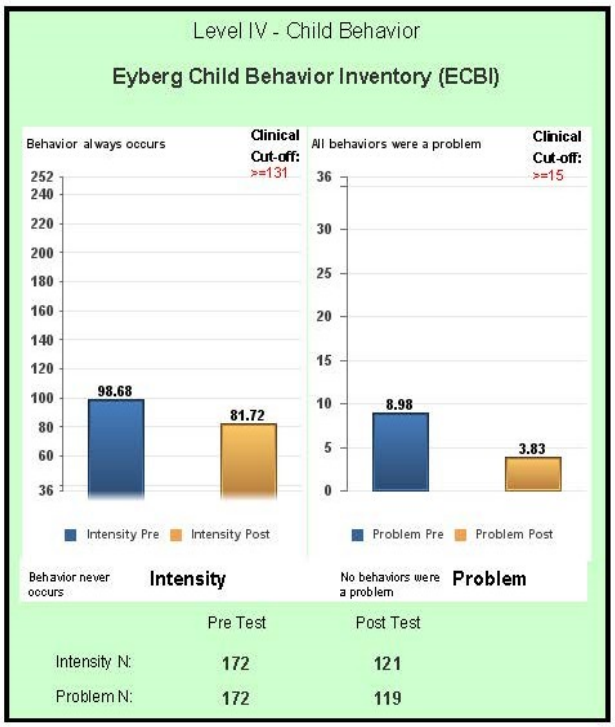
Hostility (Use of verbal or physical force) – 23% reduction in Hostility

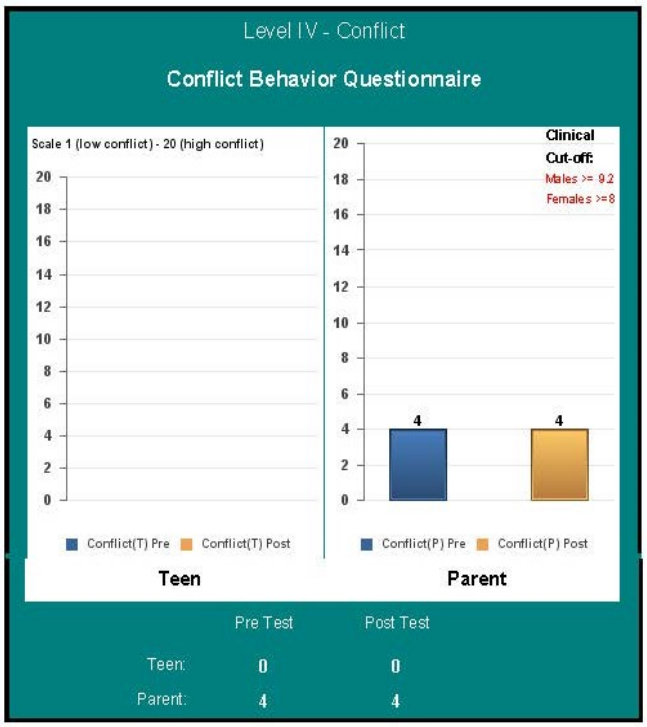
Positive Parenting Program

OVERALL RESULTS

Average of all Pre-Post Parent/Caregiver Scores

(Region - None) (Funder - First 5 Contra Costa) (Collection - ALL)





The Eyberg Child Behavior Inventory measures parental perceptions of disruptive child behavior. The Intensity Scale measures the frequency of each problem behavior.

Intensity Scale – 17% reduction in Intensity

The Problem Scale reflects parent's tolerance of the behaviors and the distress caused. Problem – 57% reduction in Problem

Positive Parenting Program

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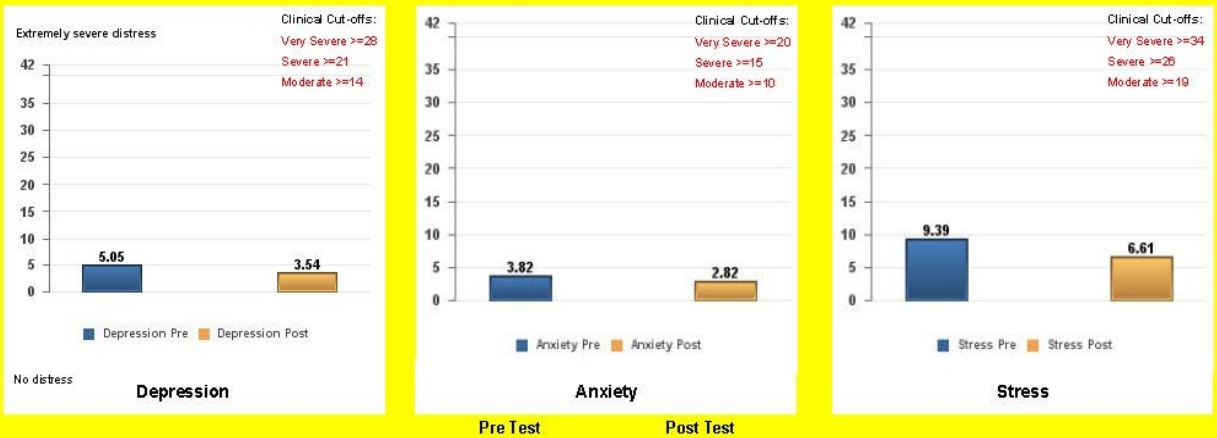
OVERALL RESULTS

Average of all Pre-Post Parent/Caregiver Scores

(Region - None) (Funder - First 5 Contra Costa) (Collection - ALL)

Level IV - Parental Adjustment:

Depression Anxiety Stress Scales (DASS-Twenty-one)



	Pre Test	Post Test
Depression N:	169	169
Anxiety N:	169	169
Stress N:	169	169

The Depression Anxiety Stress Scale measures symptoms of depression, anxiety, and stress in adults.

Depression (Dysphoria, hopelessness, devaluation of life, self-depreciation, lack of interest/involvement, anhedonia, and inertia) – 41% reduction

Anxiety (autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious effect) – 26% reduction

Stress (difficulty relaxing, nervous arousal, and being easily upset/agitated, irritable/over-reactive, and impatient) – 31% reduction

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

Please refer to Aggregate Data Reporting

F5 AGGREGATE REPORTING FORM

Date: FY 19-20

Program Name : COPE FAMILY SUPPORT CENTER - TRIPLE P CC COUNTY

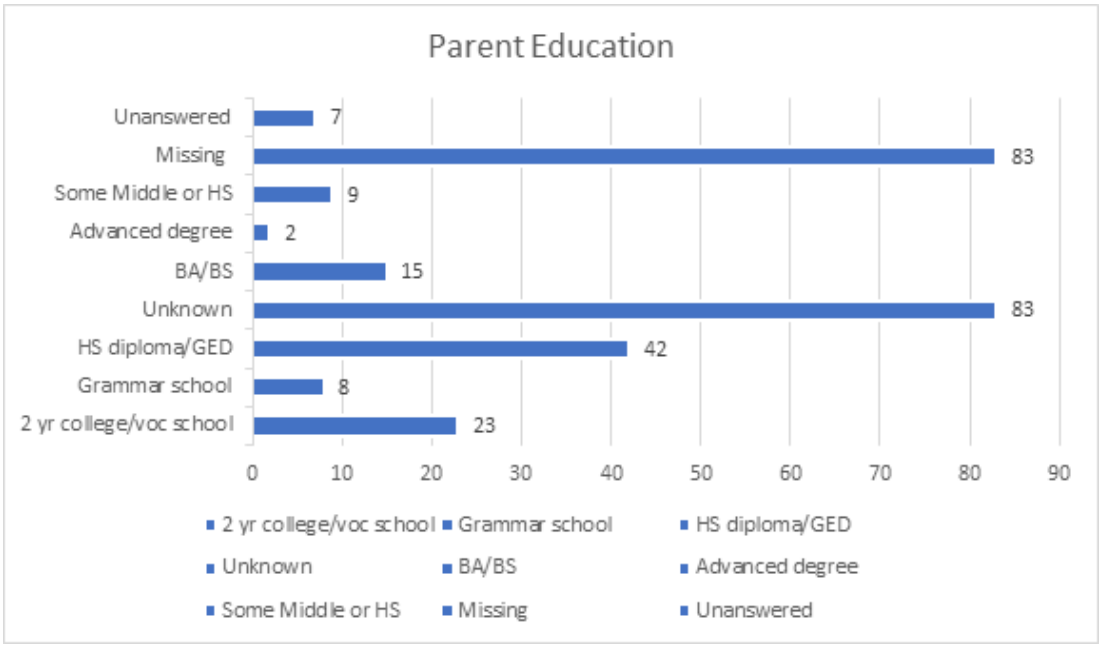
REPORTING PERIOD: ~~FY 19-20~~ *(Example: 06/2016-12/2016)*

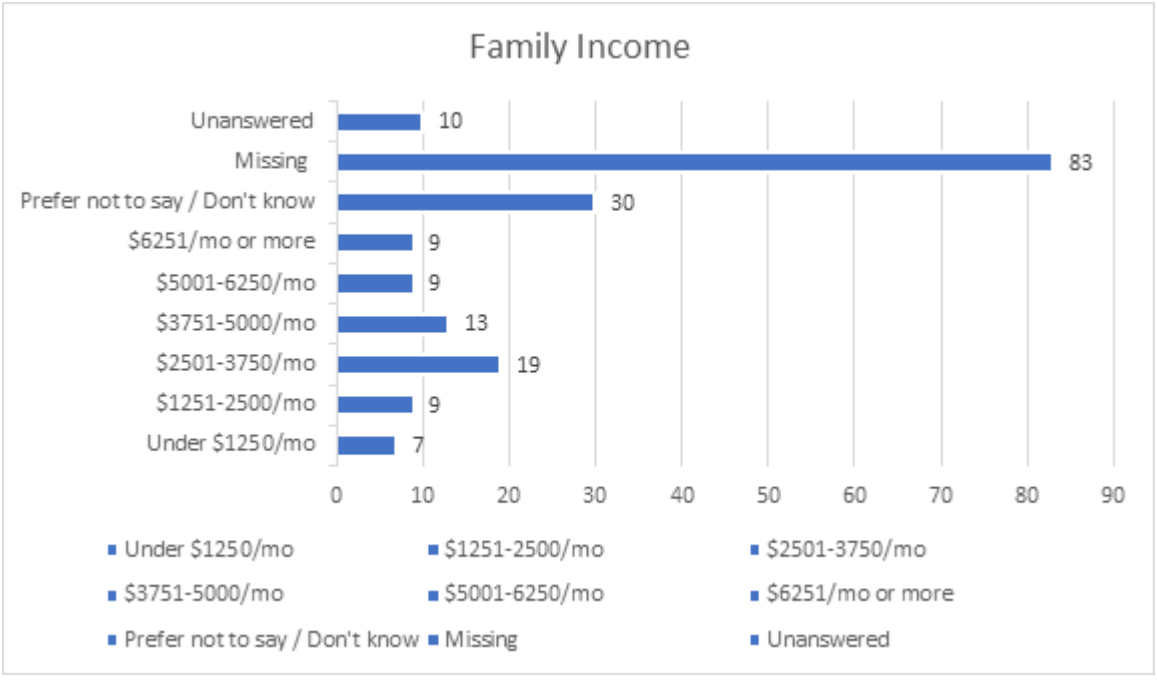
YTD TOTAL NUMBER SERVED: *189*

TOTAL NUMBER OF INDIVIDUAL FAMILY MEMBERS SERVED: 189 *(If applicable)*

PART 1 – FOR ITEMS 1-3, PLEASE RECORD THE TOTAL NUMBER OF CLIENTS IN YOUR PROGRAM FOR THE CURRENT REPORTING PERIOD THAT FIT INTO THE CATEGORIES BELOW.

1. AGE GROUP	#SERVED DURING REPORTING PERIOD	# SERVED DURING FY	2. PRIMARY LANGUAGE	#SERVED DURING REPORTING PERIOD	#SERVED DURING FY	3. RACE	#SERVED DURING REPORTING PERIOD	#SERVED DURING FY
CHILD (0-15)		1	ENGLISH		84	MORE THAN ONE RACE		8
TRANSITION AGE YOUTH (16-25)		22	SPANISH		93	AMERICAN INDIAN/ALASKA NATIVE		3
ADULT (26-59)		147	OTHER		13	ASIAN		14
OLDER ADULT (60+)		19	DECLINE TO STATE		7	BLACK OR AFRICAN AMERICAN		19
DECLINE TO STATE			IF OTHER SPECIFY BELOW:			WHITE OR CAUCASIAN		28
						HISPANIC OR LATINO/A		106
			Arabic			NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER		2
						OTHER		6
						DECLINE TO STATE		3


Parent Education
Unanswered 7
Missing 83
Some Middle or HS 9
Advanced degree 2
BA/BS 15
Unknown 83
HS diploma/GED 42
Grammar school 8
2 yr college/voc school 23
0 10 20 30 40 50 60 70 80 90
2 yr college/voc school
Grammar school
HS diploma/GED
Unknown
BA/BS
Advanced degree
Some Middle or HS
Missing
Unanswered


Family Income
Unanswered 10
Missing 83
Prefer not to say / Don't know 30
$6251/mo or more 9
$5001-6250/mo 9
$3751-5000/mo 13
$2501-3750/mo 19
$1251-2500/mo 9
Under $1250/mo 7
0 10 20 30 40 50 60 70 80 90
Under $1250/mo
$1251-2500/mo
$2501-3750/mo
$3751-5000/mo
$5001-6250/mo
$6251/mo or more
Prefer not to say / Don't know
Missing
Unanswered

CULTURAL RESPONSIVENESS:

How have services been informed and structured to meet the diverse cultural needs of your clients/members/participants? What is being done by your organization to support cultural responsiveness both within the workforce and for those served by your organization?

A Culturally diverse staff is train to response with cultural humility and compassion to the needs and characteristics of diverse populations of participants. Triple P practitioners cultivate, inclusive, and non-judgmental environment for participants seeking services. Practitioners receive training and skill development in a variety of areas (ACES, trauma-informed care, self-regulation techniques, conflict resolution and other methods for participant communication)

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

COLLABORATIVE PRACTICES:

Describe how you are working with any other agencies or organizations to better serve clients/members/participants? If this is currently not being done, please describe any effort to build relationships with other community service providers?

- Collaboration with the Contra Costa Truancy Court, Probation and CFS to refer families to parenting classes
- Collaboration with school districts and administrative staff to provide referrals to parents of students within each district
- Referrals from community partners such as Family Justice Center, Contra Costa County Juvenile Hall, and Concord Veterans Center.
- Provided briefing/orientation meetings to community agencies interested in referring members to the Triple P program
- Attended community events to provide resources
- Agreement with SPARK to use COPE facility to meet with clients for SIS-SUDS program (Seeking Information & Support – Substance Abuse Disorders)
- Provide classroom to Kinship services to provide classes to foster families

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 5 Contra Costa fosters a holistic approach to family wellness and recovery by providing evidence-based parenting classes. Parents in need of further intervention are identify early during assessment and through their participation in Triple P parenting classes. Parents are linked efficiently to additional mental health supports such as individual and family counseling, Anger Management and Truancy Intervention. Practitioners can access case management or use the HMG/211 phone line to obtain referrals to additional resources such as county mental health, housing, food banks and family law centers

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.

Participants feel they are spending more quality time with their children and less conflict. “I spend time with my kids, and I am not yelling at them anymore.”

One parent stated, “The behavior charts are working so well that we want to expand them.” All parents stated how self-care is important and that they will start to make time for themselves.

“I didn’t realize how poorly I was taking care of myself and how that affected my relationship with my child.”

“I’m recognizing the importance of my time.”

One parent reported “learning the difference between underlying issues and expressed issues helped me to identify what I was arguing as opposed to what I should’ve been arguing.”

One parent stated, “Spending small amounts of quality time really does make a big difference.” This class helped me to see that I was treating my kids differently.

One parent shared that “attending a class does not make you a bad parent. Parent classes should be required.”

“I didn’t realize how poorly I was taking care of myself and how that affected my relationship with my child.”

PEI ANNUAL REPORTING FORM

EARLY INTERVENTION REPORTING FORM

FISCAL YEAR: 19-20

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

XImprove timely access to mental health services for underserved populations

XUse strategies that are non-stigmatizing and non-discriminatory

SERVICES PROVIDED / ACTIVITIES:

Please summarize the Scope of Services as outlined in the Service Work Plan. Please also address any other relevant activities or events that took place during the reporting period.

First Hope provides 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. Just over a year ago (June 10, 2019), we also significantly expanded our First Episode Psychosis (FEP) program. We trained our 13 new staff in the Coordinated Specialty Care (CSC) model to treat FEP clients between 16-30 years old and within 18 months of their first episode. In addition, our staff were trained and certified in MultiFamily Group Treatment (MFGT) and Cognitive Behavioral Therapy for Psychosis (CBTp).

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.

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. This past fiscal year 2019/2020 we provided 21 outreach presentations/trainings in early intervention in psychosis. We reached 518 attendees that included staff from schools, community-based mental health agencies such as Familias Unidas, other community organizations such as Rainbow Center, and hospitals, as well as community members at NAMI meetings and at Putnam Clubhouse. On 9/17/19, we also held an Open House at First Hope where 14 of our community partners attended.

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. Our 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.

Intensive treatment services – 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, rehab counselor with a specialization in substance use disorders, RN, and psychiatrist. 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. 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). 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. Numbers served during the fiscal year, describe any adaptation of services due to COVID-19 that may be relevant For PEI - Early Intervention programs, please describe: Which mental illness(es) were potentially early onset, how participant's early onset of a potentially serious mental illness was determined. List of indicators and data that measured reduction of negative outcomes.

Please refer to Aggregate Data Reporting Form for Numbers served during the fiscal year.

Due to COVID-19, most of our services, including group therapy, have moved to telehealth. Throughout the pandemic, we have continued to offer a limited number of in-person appointments to clients when clinically indicated – on average we see about 5 clients in person each week. Our in-person clinic hours are reduced to 11am-4pm Mon-Fri.

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. We had 1 conversion from CHR to psychosis from July 2019 through June 2020, out of 78 CHR clients served.

Desired functional outcomes for both our CHR and FEP clients include reduction in crises, hospitalization, incarceration and suicide attempts or completions.

From July 2019 through June 2020, 104 First Hope clients had 0 PES visits or hospitalizations; 17 First Hope clients had a combined total of 46 visits to the psychiatric emergency room, 21 of which resulted in an inpatient hospital stay. Three First Hope clients represented 43% of the PES visits (20/46). We are still analyzing data to assess whether the rates of PES visits and hospitalization improve over baseline rates for our clients.

Three of our clients were arrested, one of whom was charged and served jail time, during the time period of July 2019 through June 2020. One additional client of ours was sadly killed during an attempted burglary.

We had 4 suicide attempts and 0 completed suicides from July 2019 through June 2020.

Improvement in age-appropriate functioning is also critical. Our data indicates that at the beginning of treatment most First Hope 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.

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

Please refer to Aggregate Data Reporting Form

Also, Screen Calls: We do not use the county demographic form for our screening calls 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 can 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.

CULTURAL RESPONSIVENESS:

How have services been informed and structured to meet the diverse cultural needs of your clients/members/participants? What is being done by your organization to support cultural responsiveness both within the workforce and for those served by your organization?

We have been highly successful in reaching the Hispanic/Latinx community who represent 25% of our county's population but are typically underrepresented within mental health services. One-third of our client population identify as Hispanic or Latinx. One-third of our clinical staff speak Spanish, making services especially inviting to families with monolingual members. All materials are available in Spanish and Psychoeducation Workshops are also conducted in Spanish. Our Multifamily groups have consistently included at least one (currently two) Spanish-language groups.

Contra Costa County Mental Health Division has a well-developed language line to address other language needs.

We have made significant strides over the past few years in engaging with African-American clients and families, and their enrollment rates into our services (13% of our client population) are now reflective of our county's demographics (9% of county's population). Some of the steps that we've implemented over the past few years were key in strengthening our engagement with this community. These steps included hiring additional staff who identify as African-American and conducting outreach to faith communities.

While we have served several Asian-American clients who have been very satisfied with services once engaged, we perceive a continued underutilization of services at the level of seeking services. Asian- Americans make up 8% of our client population, and 14% of our county's population. While we continue to see increases in the enrollment of Asian-American clients over the past year, we plan to continue to focus on ways to reach this community, including addressing stigma and providing culturally friendly services.

Currently two of our staff identify as Asian-American (psychiatrist and program manager).

In addition, about 20% of our client population identify as LGBTQ+. Currently one of our staff identifies as LGBTQ+ (psychiatrist). On 10/31/19, we hosted a Rainbow Center training for our entire First Hope team on Sexual Orientation, Gender Identity, and Expression to further our focus on fostering a welcoming environment for our LGBTQ+ youth and family members.

COLLABORATIVE PRACTICES:

Describe how you are working with any other agencies or organizations to better serve clients/members/participants? If this is currently not being done, please describe any effort to build relationships with other community service providers?

As noted above, we regularly offer trainings on early intervention in psychosis to our community partners. Whenever possible, we engage in a mutual training exchange, where we provide training in early psychosis to their staff, while they provide training to our staff in their area of expertise. The two partners with which we participated in such an exchange during this past year are Familias Unidas and Rainbow Center.

In addition, the First Hope program manager attends a weekly meeting with staff from the inpatient unit at Contra Costa Regional Medical Center to better identify potential referrals and coordinate care. Staff from the John Muir Behavioral Health inpatient units also attends this meeting once a month.

Finally, First Hope frequently refers to, receives referrals from, and coordinates care with other community providers such as Seneca, COFY, Regional Center, RYSE, Fred Finch, Discovery House, Rainbow Center, La Clínica, CFS, Youth Homes, probation, school-based mental health, teaching, and administrative staff, primary care physicians, and private practice providers.

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 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

interaction thereafter. We work closely with our families to identify and problem-solve barriers to accessing care, including childcare, transportation difficulties, and challenges with accessing technology.

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

“Staff is helpful and understanding.”

“I really appreciate this program and all of its services.”

“The new facility is more secure and connected to technology. I feel safer in the location.”

“The program has helped me get back up on my feet. Slowly I learned to open up to others and have confidence to speak up for myself. This program has made me clear my mind and understand what is reality and what’s not actually there. I’m thankful for being in this program because I got to learn about new things and knowing I wasn’t alone made me feel slightly better. I got to learn from so many people, it was sad listening from what everyone went through, but I’m glad I wasn’t alone. We can get through an obstacle but with help from this program.”

PEI ANNUAL REPORTING FORM

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS REPORTING FORM FISCAL YEAR: 19-20

Agency/Program Name: Hope Solutions (formerly Contra Costa Interfaith Housing)

Project (if applicable): 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 / ACTIVITIES:

Please summarize the Scope of Services as outlined in the Service Work Plan. Please also address any other relevant activities or events that took place during the reporting period.

Hope Solutions Strengthening Vulnerable Families program provided the following services to assist the Behavioral Health Division of Contra Costa County to implement the Mental Health Services Act, Prevention and Early Intervention Program. The following is a summary of the services and activities delivered during the past fiscal year 2019-2020.

SCOPE OF WORK

The Strengthening Vulnerable Families program provides support services at 5 locations. All these locations house vulnerable adults and/or families with histories of homelessness, mental health challenges and/or substance abuse problems. Case management was provided on-site and in-home for all residents requesting this support. Youth enrichment/afterschool programming was provided at all family housing sites. The total number of households offered services under this contract was 286, including the following sites:

- Garden Park Apartments (Pleasant Hill) – 27 units permanent supportive housing for formerly homeless families with disabilities
- Lakeside Apartments (Concord) – 124 units of affordable housing for low-income families and individuals (including 12 units of permanent supportive housing for formerly homeless residents with disabilities).
- Bella Monte Apartments (Bay Point) – 52 units of affordable housing for low-income families and individuals

- Los Medanos Village (Pittsburg) – 71 units of affordable housing for low-income families and individuals
- MHSA funded housing (Concord, Pittsburg) - 12 residents in 3 houses.

In addition to case management, Hope Solutions also provides property management and maintenance for the 12 units of MHSA housing.

Hope Solutions also agreed to participate with helping to host a community forum on permanent supportive housing during the year.

ACTIVITIES AND OUTCOMES:

Parent and Life Skills Education and Support

Hope Solutions provided 8 parenting support groups, 8 sessions/group at the 4 housing sites for a total of 67 group sessions and least 83 participants.

Support groups included two community café groups at the two East County sites, two community café groups in Central County (one in Spanish), and a wellness support group, community café group, harm reduction group and parent-toddler group at Garden Park Apartments. These parent support groups were offered with food and childcare as needed. Some of the groups were interrupted by the stay- at-home order, but staff were able to re-organize and offer the continued groups remotely.

- Topics in parenting support included:
- Setting Life goals
- Creating Vision Boards
- Maintaining good health
- disaster readiness/awareness
- Creating Emergency kits
- Exercise and fitness Yoga
- Computer skills
- Mindful eating and nutrition
- Budgeting and making wallets
- Self-care and mindfulness
- Positive discipline for children
- Resilience in our lives
- Adverse Childhood Experiences
- Coping with news of police brutality – talking to children about racial justice
- Coping with COVID
- Managing children at home under stay-home order

EARLY INTERVENTION, CASE MANAGEMENT AND MENTAL HEALTH SERVICES

Hope Solutions provided 4350 hours of support services with on-site case management to 275 families/433 individuals.

Licensed clinicians and mental health interns provided case management/mental health support at Garden Park Apartments where the population is 100% special needs (formerly homeless with most parents coping with mental health/substance abuse challenges). Lakeside Apartments and East County families have average incomes lower that 50% of the area median income and struggle with limited resources. Case managers at these sites are members of the communities they serve, providing on-site assessment, information and referral, and eviction prevention to the families of the East County housing programs (LMV, BMA) and to Lakeside Apartments. Staff at Lakeside are both bi-lingual/bi- cultural, serving this predominantly LatinX community.

Services provided include resource referrals to obtain concrete resources (food, clothing, furniture, financial support, health, and mental health care) as well as referrals and support for educational and employment needs. Case managers work closely with property management at the housing sites to prevent housing instability or eviction with financial and behavioral support. With on- site, fulltime availability, residents develop trusting relationships with staff and are comfortable seeking mental health resources when necessary. Staff are also able to reach out and educate and advocate for residents when mental health challenges arise.

On-site case management and property management were also provided for 12 residents in MHSA funded housing in Central and East County. Case managers supported residents coping with mental health challenges to maintain shared housing relations with housemates, remain engaged with mental health supports and access other critical resources during the stay-home orders. This support enabled residents to stay safe and maintain their housing.

After the Shelter-in-Place order many residents lost their jobs. Working remotely, case managers assisted 23 residents to access unemployment resources, and 33 residents to access COVID funds to subsidize rents. At Lakeside 12 undocumented families were also assisted to receive the COVID California state funds designated for immigrants.

Hope Solutions staff also organized food resources for families with limited funds and delivered food to over 100 households to help keep residents safe. Case managers also distributed activity bags to youth including crayons, activity booklets, and hand sanitizer/PPE. Masks were distributed to over 100 families as needed, and education and support was offered regarding the stay-at-home order and the COVID19 virus.

Hope Solutions also developed procedures to stay connected to residents with weekly outreach via phone, text, facetime and zoom. At first staff were concerned that residents would not want that much contact, but it turned out that the families actually appreciated the contact and said

it made them feel less isolated and that “someone cares”. Hope Solutions also received donations from the community to allow isolated residents to have the technological tools they needed to stay connected, including computers, phones, and internet access.

After the killing of George Floyd, Hope Solutions also provided support and education for staff to be able to manage their distress related to the fight for racial justice. The organization offers monthly town hall style meetings for all staff to come together to share support and learnings in this area. Study groups and action groups were formed to address racial justice efforts within the organization and within the homeless services/housing community. At parents’ requests, one of the resources put together is information about how to address the pandemic and the civil rights protests with children.

Academic Support and Youth Enrichment

Hope Solutions provided 2,914 hours of service to 181 youth at youth enrichment centers in the four housing sites. Activities included afterschool programming, summer programming, educational advocacy, and a teen support group.

During the Shelter-In-Place period academic and mental health supports were offered via zoom and with telehealth. Attached is a picture of one of our first zoom meetings at Lakeside Apartments. Youth Enrichment Coordinators and volunteers coordinated their efforts to help youth be able to finish their school year with support.

During the month of July Youth Enrichment Coordinators put a 4-week summer camp schedule together on zoom, collaborating across all 3 programs. This was a big success with many volunteers and youth participating. The Coordinators are now planning a similar effort for supporting remote learning in the fall. (Summer Schedule attached)

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services. Please include: Numbers served during the fiscal year (see above), describe any adaptation of services due to COVID-19 that may be relevant (see above), include a list of indicators measured, how often data was collected and analyzed.

Specific Goals and Outcomes for the 19.20 fiscal year:

Goal: 95% of families will retain safe, permanent housing.

Outcome: 99% (277/281) of families maintained their housing.

Goal: 95% of families referred for eviction prevention will retain housing.

Outcome: 96% (104/108) of families at risk for eviction remained housed.

The four families that left the program were offered support and referrals to alternate housing/treatment resources. Problems with violent behaviors caused them to be asked to leave the programs.

Goal: 95% of families accessing case management for assistance with concrete resources will have request fulfilled successfully.

Outcome: 98% (243/248) of families requesting assistance with concrete resources had their request fulfilled.

Examples of their requests included access to food, employment, transportation, healthcare, and mental health resources.

Goal: 75% of parents attending wellness support group will report using relapse prevention and/or harm reduction skills learned in group.

Outcome: 100% (8/8) of the residents who attended the wellness/harm-reduction group sessions reported using the coping strategies they learned in the groups.

A wellness group and a harm-reduction group were offered at GPA. The focus of these groups was to support parents with coping skills for managing depression and anxiety and cravings/relapse triggers related to substance use. Activities offered included mindfulness exercises, discussion of triggers and giving each other feedback about strengths in a circle.

Goal: 75% of children and youth that participate in the daily social skill group and afterschool programming will demonstrate an increased sense of competence and mastery in social skills. (SSIS)

Outcome: 77% (33/43) of youth who were assessed with the Social Skills Index Survey (SSIS) improved their skill score over the year. A social skills discussion is facilitated with the youth in the afterschool programs each day. Topics at these discussions include managing anger, addressing bullying, conflict resolution and other helpful topics for youth in their challenges at school and at home.

Goal: 75% of youth that participate in the afterschool academic and tutoring program will achieve at least four (4) new CA Academic benchmarks.

Outcome: 87% (71/82) youth achieved at least 4 benchmarks.

Due to the remote learning mandate at the end of the school year report cards did not include a final benchmark report. The numbers cited for this outcome are based on our internal assessments and observations by our Academic Supervisor, a credentialed, bi-lingual teacher.

Goal: 75% of grades K through 5 children will show progress on reading- level.

Outcome: 86% (62/72) achieved progress with their reading skills.

These results are based on our internal assessments at the start and end of the school year.

Goal: 75% of Teen Club participants will show improved self-esteem after attending regularly.

Outcome: 100% (4/4) youth completed end of year surveys and showed improved self-concept/self-esteem. Four more baselines were set for next year.

These results are based on the Piers-Harris self-esteem assessment tool. This is a statistically reliable and valid tool we have used for the past few years.

Goal: 80% of parents receiving educational advocacy coaching will report they had a positive experience with school personnel.

Outcome: 88% (75/85) of parents who received educational advocacy/coaching reported having an improved/positive experience working with school personnel.

Examples of educational advocacy include staff attendance and support at parent/teacher conferences, IEP meetings and meetings related to accessing educational supports. Twenty-eight of the families served were mono-lingual and worked with Hope Solutions staff who provided translation support. Families were given support for helping children with remote learning after the stay-at-home order.

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

Please refer to Aggregate Data Reporting Form Attached

CULTURAL RESPONSIVENESS:

How have services been informed and structured to meet the diverse cultural needs of your clients/members/participants? What is being done by your organization to support cultural responsiveness both within the workforce and for those served by your organization?

Hope Solutions offers support provided on-site in the housing sites where people live. In this way we seek to address barriers to access to services created by lack of transportation, education, and trust. Staff are hired for their awareness and interest in working with a diverse population of under-served citizens.

Materials are provided in Spanish and English as needed, and advocacy with a variety of resources is maintained to ease the access of residents to receive resources. Support groups are offered in the evenings for working residents and during the days for families who are available while children are in school.

Hope Solutions seeks the input and promotes the leadership of the residents in the many housing settings. We ask for feedback annually with satisfaction surveys. We hire residents in paid resident monitor positions and train residents in paid Resident Empowerment Program positions, supporting their voice in the community to address housing needs.

Ongoing staff training is offered monthly at Hope Solutions on topics that include trauma-informed case management, motivational interviewing and working with substance use/harm reduction. Cultural aspects of all educational trainings are addressed as a regular expectation of the organization. HR is also available to help whenever anyone feels that bias or prejudice is being exhibited in the workplace. Training on successful communication across levels of privilege is offered and supported.

Since the killing of George Floyd, staff have met to discuss the support needs of African American staff and residents during this challenging time. Hope Solutions has also instituted a monthly Town Hall Racial Justice Learning meeting, several study groups and several action groups addressing issues of racial injustice in history, in housing, and in the organization. We have also contracted with LeaderSpring to do a full year of training with all staff and the board on Racial Justice Training.

Hope Solutions has a policy of hiring people with lived experience and with racial/ethnic experience that benefits the populations we serve.

COLLABORATIVE PRACTICES:

Describe how you are working with any other agencies or organizations to better serve clients/members/participants? If this is currently not being done, please describe any effort to build relationships with other community service providers?

Hope Solutions is grateful to collaborate with many community partners. We couldn't support residents without an array of resources. We collaborate with the CC Food bank and many faith communities to access food, we collaborate with CC health and behavioral health services to access physical and mental health resources, we regularly work with the mobile crisis response teams that serve children and adults, we work with NAMI, Putnam Club House, Monument

Crisis Center, GRIP, H3, Family Justice Center, 211, and the Continuum of Care for housing. We also have ongoing collaborative relationships with property owners and landlords and property managers where we provide services and from whom we master- lease properties. We collaborate with the public-school systems where youth attend, and the community and 4-year colleges to access higher education and to share educational resources. We collaborate with multiple faith communities who provide donations and volunteer hours. When needed we collaborate with Child and Family Services and local police departments to ensure that residents receive the support and respect they deserve. We are active in the provider community with many coalitions of service providers including CPAW and the Human Services Alliance. We collaborated this past year with the PEI committee to help provided a community wide training on Permanent Supportive Housing. We continually work to improve the quality of services from the micro to the macro level to benefit the populations we serve.

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 and where residents need it. By being available immediately and in a timely manner when problems emerge, we can improve the trajectory of those 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 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) we lower stress and help people avoid the need for formal mental health supports. We host activities and events that build community, supporting resilience and community self-reliance. When the need for mental health support arises, an individual can make this request in the context of other resources and thus is not singled out or identified with this need. By having a trusted, long-term relationship with an on-site case manager, residents are be able to move past fears of stigma or discrimination as they seek mental health assistance.

MHSA values parallel well with Hope Solutions values:

Values

Hope Solutions is committed to excellence and we accomplish our work with integrity, respect, compassion, and humility.

Mission

Hope Solutions heals the effects of poverty and homelessness by providing permanent housing solutions and vital support services to highly vulnerable families and individuals.

Vision

Hope Solutions envisions a world in which everyone has a place to call home and the support of a strong community so that they can live with dignity and reach their full potential.

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.

Josephine Returns

Josephine lived in a shared housing setting for many years in permanent supportive housing. She is 80 years old and was not in touch with her doctors or her family for over a year. When Hope Solutions began to manage the house where she lives, she conflicted with her 3 housemates, and had several troubling behaviors. Josephine stayed up late at night, rhythmically pounding her cane on the floor, poured oil and ammonia on the furniture, and sprayed toxic bug spray in the refrigerator. Her housemates complained.

James, the new case manager, spoke with Josephine about these behaviors, asking her about her thoughts. Josephine agreed to stop doing these things but was not able to follow through with that agreement. She also thought James might be the devil or a doctor. James offered to take Josephine to see her doctor, and she declined the offer.

James reached out to collaborate with community behavioral health providers, and eventually was able to support Josephine to enter a brief residential program where she received a new medication and was able to stabilize. During her time in the program her grown daughter visited her from out of state and they were able to re-connect after a long period of no contact.

Josephine had a small refrigerator in her room, and when James cleaned it out to keep the food from spoiling, he found many sharp knives and garden sheers propped on the windowsills in Josephine's room. James carefully placed them aside when Josephine re-entered the house. Josephine's housing was held for her while she received treatment.

After a few weeks Josephine returned to her home. At first her housemates were wary and fearful after the problems they had before. James worked with all the housemates and now

they are living together without conflict. Josephine's daughter is continuing to stay in touch with her mother, which they both enjoy.

Claudia needs a break

Claudia lived on the streets for the first few years of her adult life. She became addicted to drugs, but when she learned she was pregnant at age 23, she went into a rehab program. Her daughter was born there and shortly after that Claudia and her baby moved to permanent supportive housing. Claudia maintained her sobriety and was diagnosed with a thought disorder and helped with medication. She lived a quiet life at her apartment with her daughter.

Claudia ran into an old friend from the streets, David. He had also gotten sober, and they soon decided to move in together. They planned to marry. Claudia applied to her housing manager and her fiancé was able to move in at the housing program. He had a job for a year but hurt his back and had to go on disability.

David and Claudia became community leaders, helping others and speaking in public about the importance of housing. They reported that having housing had made all the difference in their lives, and they worked with the support staff when they needed emotional or practical resources.

Claudia became pregnant with her second child and worked with her doctors to change her medications to protect the baby. The pregnancy and the medication were challenging for Claudia, but she gave birth to a healthy baby boy.

When COVID stay home orders were issued, Claudia was managing her new baby, her toddler daughter and transitioning with her medication again. It was too much. She began to hallucinate, and David called 911. Claudia voluntarily went into the hospital and is now having her medications adjusted. David is receiving support from the PSH staff as he cares for his two young children. Claudia and David report that they never worried about their housing, even though this has been a difficult time. Knowing that the housing and the support is there for them has again made a hard time better for this young family.

PEI SEMI-ANNUAL REPORTING FORM

ACCESS & LINKAGE TO TREATMENTREPORTING FORM

FISCAL YEAR: 2019-2020

Agency/Program Name: James Morehouse Project

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.

In 2019-2020, the JMP had a team of eight clinical interns. Through March 2020, interns and staff worked at capacity across JMP mental/behavioral health programming—this included individual/group counseling, crisis intervention and support, youth leadership/advocacy and youth development. JMP groups engaged a wide range of young people facing mental health and equity challenges. In 2019-2020 405 young people participated in 23 different groups and/or individual counseling. Targeted outreach and services supported our English Language Learners (ELL) who participated in counseling, case management, in-class support, and youth development programming.

JMP's work changed dramatically with the school closure on March 13. We were able to ramp up our telehealth capacity and to continue individual, group and crisis intervention/support remotely. This included partnering with community-based partners like the Seneca MRT in crisis situations. Our case management work with young people and families around challenges with distance learning (e.g., accessing Wi-Fi, troubleshooting tech challenges), securing cash assistance and accessing other resources (e.g., food, legal assistance) in the community became the focus of quarter 4 activities. As the school community shifted from the school building to a virtual environment, the JMP scrambled to stay connected with school staff, young people, and families. Our crisis work continued in quarter 4 as families and school community members reached out to connect young people in crisis with JMP support. Students with sub-acute needs

were more difficult to identify and connect with in the absence of in-person contact with teachers, peers, and others likely to refer a struggling student for services.

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.

Young people are referred for services by parent/guardians, school staff, peers, and themselves. The JMP measures a range of indicators (see Work Plan for 2019-2020) 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.

Outcome Statements

- Stronger connection to caring adults/peers (build relationships with caring adult(s), peers) for participating youth.
- Increase in 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.
- Strengthened culture of safety, connectedness, and inclusion schoolwide.

In Quarter 4, the JMP focused on formative assessments to create capacity for connecting with young people in a remote environment. Given the sudden changes in service delivery, our evaluation partner (UCSF) was not able to pivot to an online evaluation tool. So, while we were effective in not having a break in services for young people and families, we were not successful in refashioning our evaluation tools, and thus have no summative data for 2019-2020.

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 except for 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.

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.

When we are in the school building, young people are referred to services through a "Resource Request (RR) Form" widely available on the school campus and online through the JMP website. In Quarter 4, this became more of an on-the-fly process with school staff, students, and families texting, emailing, and calling JMP staff to connect young people with services. Typically, as an on-site school-based program, we can 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 relate to services immediately. If there is a need to discern if the student needs to be hospitalized, the JMP partners with the Seneca MRT in that determination. During COVID, MRT staff are also virtual, and we have enlisted the participation of local police departments to solicit a wellness check in-person in students' homes if we are unsure of a student in crisis' status.

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. The JMP clinical program and youth centered initiatives challenge

the dominant narrative that sees youth as “at risk” or as problems to be fixed. JMP staff/interns 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 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 creates 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 of 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 often pervasive in other spaces.

In a virtual environment, we are striving to sustain these values in our work with young people. We are in constant conversation among our JMP staff, with school administrators, teachers, and young people to explore new opportunities to partner and be in relationship over this time.

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 2018-2019 JMP student voices. We were unable to complete our formal evaluation for 2019-2020.

I never imagined that I could say things that matter in front of other people. Now I talk in front of entire classes or give presentations to a room full of adults. I know my stories and opinions touch people.

An English Language Learner student who participated in a JMP field trip to the Monterey Bay Aquarium shared, when asked if he had ever visited the Aquarium, “Since I have been in this country, I have not been anywhere but my house.” His face was shining with joy and excitement. He explained that since his family arrived in the United States, they are all working and cannot afford to go anywhere. His story is not unique. Even for ELL students who have grown up here, going to places like the Monterey Bay Aquarium is expensive and out of reach for their families. A student shared that this experience meant so much because in his country, El Salvador, they do not have these types of places. For almost all the students, this was a unique opportunity to travel outside of the Bay Area and access an enrichment resource that, for many of their peers, is a normative part of their childhood and youth.

PEI ANNUAL REPORTING FORM

PREVENTION REPORTING FORM

FISCAL YEAR: 19-20

Agency/Program Name: Jewish Family & Community Services East Bay

Project (if applicable): Community Bridges

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 summarize the Scope of Services as outlined in the Service Work Plan. Please also address any other relevant activities or events that took place during the reporting period.

- In total, we served 311 people. This number includes 135 frontline staff and 176 clients. Clients included 80 children (ages 0-15); 13 transition-aged youth (ages 16-25); 63 adults (ages 26-59); and 20 older adults (ages 60+).
- We completed 75 pre-post assessments with adult case management clients (ages 18+).
- We provided cross-cultural mental health trainings to 135 frontline staff.
- We provided 16 Russian-speaking seniors with mental health education classes.
- We provided 16 Afghan parents with parenting workshops.
- We provided 160 clients with bilingual/bicultural case management. Case management clients include 85 children (ages 18 and under) and 75 adults (ages 18 and older).
- We provided bicultural individual therapy services to 25 Dari-speaking clients.

Cross-Cultural Mental Health Training Series: We completed three of the planned trainings for the year. Our fourth trainer declined to hold a virtual training during the pandemic. All three of our trainings were held via Zoom and had high attendance. In total, we trained 135 service providers from the community, exceeding our target of training 75 frontline staff.

- April 24, 2020: Domestic Violence—Serving South Asian Survivors (Presenter: Bindu Fernandez, Executive Director of Narika). Participants learned about:

    - The types of abuse faced by immigrants and survivors of South Asian communities.
    - Trends in the South Asian landscape regarding domestic violence.
    - Recommendations on how to support South Asian survivors and those with identities different from our own.
- May 14, 2020: Suicide Prevention with a Brief Overview of Risk Assessment (Presenter: Scott Chavez, Outreach and Training Lead at Contra Costa Crisis Center). Participants learned about:
    - Suicide-related statistics and myths.
    - Suicide risk factors and protective factors.
    - How to access risk lethality.
    - How to identify an action plan to increase safety.
- June 17, 2020: Cultural Sensitivity and Clinical Practice - Working with Muslim Clients (Presenter: Dr. Rania Awaad, Director of the Muslim Mental Health Lab at Stanford University School of Medicine). Participants learned about:
    - Issues faced by Muslim clients, including discrimination based on ethnicity, cultural background, or faith, and the potential fear of deportation.
    - Assessment considerations for working with Muslim clients.
    - A brief overview of Muslim history.

Mental Health Education Groups: JFCS East Bay held groups throughout the year for Dari- and Russian-speaking communities of Contra Costa County.

Mental Health Classes for Russian-Speaking Seniors: Due to the pandemic, the decision was made to do individual (30-minute) mental health classes via phone with 16 Russian-speaking seniors. Zoom was not used because the Russian seniors engaged with our agency stated they were more comfortable using the phone. The topic was the same for all 16 individualized classes: “Anticipatory Grief and Other New Pandemic-related Emotions.” The one-on-one format also allowed each Russian senior to get more individualized attention and personalized support from our Russian Case Manager.

Afghan Parenting Workshops: The first parenting workshop for Afghan mothers was held in our office in February. Due to the pandemic, our parenting workshops were then moved onto Zoom. For these virtual offerings, we selected the same four families (husbands and wives) to participate in a series of three workshops. These new-arrival families were identified as being highly vulnerable by our Resettlement Program Coordinator. The small group size was advantageous because it gave these new-arrival families the chance to have more of their questions answered. In addition, it gave them the opportunity to connect with other new-arrival families and build a sense of community during shelter-in-place. A total of 16 unduplicated clients participated in Afghan Parenting Workshops.

- February 28, 2020, How to Discipline with Dignity & How to Promote Healthy Child Development (8 participants). The purpose of this workshop was to promote positive parenting techniques and to help parents understand how to promote healthy child brain development.
- April 29, 2020: How to Talk to Your Children about Covid-19 (6 participants). This workshop covered Covid-19 symptoms, steps to prevent Covid-19, and how to have a conversation about Covid-19 with your children.
- May 6, 2020: Building Children's Socioemotional Skills through Play (7 participants). This workshop focused on teaching parents games that they can play with their children at home during shelter-in-place. All games that were taught are known to help build children's vocabulary, math, and/or socioemotional skills.
- May 13, 2020: Parenting Relaxation Techniques (8 participants). This workshop focused on at-home relaxation techniques for parents, such as deep breathing. Parents were also introduced to other JFCS East Bay Afghan staff that they can reach out to with questions about resettlement and life in the U.S.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services. Numbers served during the fiscal year, describe any adaptation of services due to COVID-19 that may be relevant, For PEI – Prevention programs, please describe: 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.

CLIENTS SERVED DURING FISCAL YEAR

- In total, we served 311 people. This number includes 135 frontline staff and 176 clients. Clients included 80 children (ages 0-15); 13 transition-aged youth (ages 16-25); 63 adults (ages 26-59); and 20 older adults (ages 60+).
- We completed 75 pre-post assessments with adult case management clients (ages 18+).
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- We provided 160 clients with bilingual/bicultural case management. Case management clients include 85 children (ages 18 and under) and 75 adults (ages 18 and older).
- We provided bicultural individual therapy services to 25 Dari-speaking clients.

QUANTITATIVE DATA

Please note that *qualitative* information regarding our services, along with how our services were adapted due to Covid, are addressed in the section "Services Provided/Activities."

Health and Mental Health System Navigation (Case Management)

- 100% of the 75 adult case management clients reported upon exit that they were able to independently seek help for mental health services. At entry, 90% of clients reported that they did not know how to do this.
- 100% of the 75 adult case management clients reported upon exit that they knew how to link to the appropriate persons within the county health care system or other community resources for resolution of health or mental health issues. At entry, 89% of clients reported that they did not know how to do this.
- 100% of the 75adult case management clients reported upon exit that they had an increased understanding of health and mental health care systems in Contra Costa County. At entry, 78% of clients reported that they did not understand care systems.

*****_Data was collected by case managers at intake and exit of case management services._

Cross-Cultural Trainings

- 96% of respondents from our cross-cultural staff trainings reported that they had a better
- understanding of recognizing stress and risk factors after the training.
- 91% of respondents from our cross-cultural staff trainings reported that they had a better understanding of when to refer clients to specialized services.

*_Data was collected using anonymous surveys via Zoom._

Russian Mental Health Classes

- 81% of participants reported that they had a better understanding of when and how to seek help.
- 93% of participants reported that they have an increased ability to recognize stress and risk factors in themselves and/or family members.
- 93% of participants reported that they felt more supported after coming to the group.

*_Data was collected by instructor after each class._

Afghan Parenting Workshops

- 100% of participants reported that they learned useful skills to become a more effective parent.
- 100% of participants reported that they had a better understanding of when and how to seek help.
- 100% of participants reported that they felt more supported after coming to the group.

- 87.5% of participants reported that they have an increased ability to recognize stress and risk factors in themselves and/or family members.

**Data was collected by staff who did not lead workshops to prevent bias. Surveys were anonymous.*

HOW DATA WAS COLLECTED AND ANALYZED

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

- Participants/clients mental health evaluation forms for mental health education sessions.
    - Collected after each mental health education session.
- Staff and community members' anonymous evaluation forms for training sessions.
    - Collected after each training session.
- Pre- and post-assessments case management (health and mental health navigation assistance) progress.
    - Collected once at intake and once at exiting the program.

LIST OF INDICATORS

Case Management Services Indicators (Likert Scale: Not Applicable, Strongly Agree, Disagree, Strongly Disagree):

- Can independently seek help for mental health services.
- Can be linked to the appropriate person(s) within the county health care system or other community resources for resolution of health or mental health issue.
- Understands consumer rights in relation to medical care, including the right to seek a second opinion.
- Can apply for health benefits when eligible.
- Has the ability to communicate with doctors and providers about medical and mental health issues.
- Understands health and mental health care systems in Contra Costa County.
- Has a healthy/expanding support network; household is stable, and communication is open.
- Has adapted to American culture.
- For parents: has well-developed parenting skills.
- For parents: can name at least one parenting skill they can apply at home.

Mental Health Education Indicators (Yes/Neutral/No):

- I have an increased ability to recognize stress and risk factors in myself or my family.
- I have a better understanding of when and how to seek help if I need it.

- I feel more supported after attending the group.
- I have a better understanding of the concepts discussed today.
- For parents: I understand the parenting topics presented in the parenting class.
- For parents: I understand at least 75% of the parenting concepts presented in the parenting class.
- For parents: I have learned useful skills to be a more effective parent.
- For parents: I can name at least one parenting skill that I can apply at home.

Provider Trainings Indicators (Likert Scale: Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree):

- I will apply what I learned today with my work with clients.
- Training gave me a better understanding of when to refer clients for specialized services.
- Training will help me improve my professional effectiveness.
- The presenter and/or presentation was effective.
- The content of the training was relevant to my professional needs.
- Training increased my ability to recognize stress and risk factors.

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

Please refer to Aggregate Data Reporting Form

CULTURAL RESPONSIVENESS:

How have services been informed and structured to meet the diverse cultural needs of your clients/members/participants? What is being done by your organization to support cultural responsiveness both within the workforce and for those served by your organization?

General Services and Case Management: The clients served by PEI are primarily survivors of state- sponsored persecution and/or war and experienced or witnessed numerous incidents of violence and trauma before arriving in the United States. For families exposed to such trauma, starting a new life in the U.S. can be an additional stressor. The unique type of trauma exposure experienced by some refugees is called the "Triple Trauma Paradigm," coined for refugees who have been exposed to 1) trauma in their home country; 2) trauma during flight (i.e., while escaping their home country); and 3) trauma in resettlement (i.e., language barriers, cultural barriers, discrimination, and marginalization.) It is during resettlement, when stress is heightened, that a refugee client may be reminded of other traumatic events in their lives. Resettlement, therefore, is an opportunity for our staff to intervene and start to reverse the effects of compound trauma by providing clients with culturally sensitive care and support. This is done by providing clients wrap-around case management services and attending to their mental health needs.

JFCS East Bay's culturally attuned staff is anchored by our 7 Afghan case workers, representing four distinct regions and cultures of Afghanistan. All staff speak both Dari and Farsi, with some also speaking Pashtu, Urdu, and Punjabi. Most staff are former refugees who entered under the federal government refugee resettlement program. All are recent arrivals. This level of understanding of Afghan culture and the refugee experience allows staff to build a strong rapport with clients and to better understand and respond to client needs.

In addition to language and cultural competency, staff attend frequent trainings. This year, trainings included "Trauma-Informed Care within the Refugee Context" and "Preventing Crises Within Resettlement: De-escalation with a Trauma Awareness." Fidelity to Trauma-Informed Care (TIC) was ensured by taking a strengths-based approach to case management. In other words, staff ensured that clients were always the primary-decision makers when it came to making choices about their own lives. This proves especially important for those who may not have had the opportunity of self- agency in decision-making while fleeing persecution and awaiting resettlement. Fidelity to TIC was also ensured not only by upholding and honoring clients' autonomy over their own lives, but by regularly checking in on clients' emotional well-being to see if they need additional emotional support. Any client exhibiting signs of need for support receives immediate referral to internal or external trauma-informed mental health providers.

Psychotherapy: JFCS East Bay provides psychotherapy to refugees in-house as needed. Services are modified to make treatment culturally appropriate for clientele and are based on evidence-based modalities including Trauma Affect Regulation, Solution Focused Therapy, and Cognitive Behavioral Therapy. JFCS East Bay's therapist also has a background in Global Mental Health from Harvard's Program in Refugee Trauma and incorporates the program's H5 model into treatment. Co-created by Dr. Richard Mollica, a world-renowned refugee mental health expert, the H5 model explores five overlapping dimensions essential to trauma recovery by highlighting findings from studies of refugee populations. In-house therapy services are specifically geared for refugee clientele with an emphasis on client strengths, post-traumatic growth, and resiliency.

Parent Education Workshops: Given that stress during resettlement can potentially become overwhelming and create strain on family dynamics, our agency's Parenting Education Workshops for new-arrival families aim to mitigate the potential negative effects of such stress through the teaching of positive parenting skills. This is done through the adaptation of the International Rescue Committee/USAID's "Parenting Skills Curriculum: Ages 6-11" designed specifically for refugee parents. This parenting skills curriculum is based on "more than three decades of the effectiveness of parent training programs to improve child behavior, eliminate behavior problems and prevent and mediate child abuse and neglect." (IRC, Parenting Skills Curriculum, page 13.) Fidelity is ensured by sticking to the core elements of the Parenting Skills

Curriculum, such as the recommended workshop activities, and building on the strengths of individual families.

Advancing Racial Justice: Since the beginning of the summer, JFCS East Bay has had weekly all-staff meetings on advancing racial justice. These meetings allow staff to discuss racial inequities openly and to find ways to advocate for racial equity within and outside of JFCS East Bay. A Racial Justice Advisory Team has also been formed at our agency, made up of non-leadership and leadership staff. In addition, JFCS East Bay plans on hiring an anti-racism consultant to train all staff.

COLLABORATIVE PRACTICES:

Describe how you are working with any other agencies or organizations to better serve clients/members/participants? If this is currently not being done, please describe any effort to build relationships with other community service providers?

This year, JFCS East Bay collaborated with the Contra Costa Crisis Center, Narika (a domestic violence services agency), and Dr. Rania Awaad, the Director of the Muslim Mental Health Lab at Stanford University School of Medicine, to provide three expert trainings to community-based providers. These three trainings allowed experts to share their knowledge with other providers to improve participants' ability to respond to client needs, especially those from minority backgrounds.

These trainings also created a space for community providers to connect and become familiar with each other's work in Contra Costa County. Following each training, various community providers reached out to JFCS East Bay's Refugee Mental Health Coordinator to discuss ways to improve client care/referrals/and cultural responsiveness. In total, 135 community providers participated in the trainings.

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. The value of "Welcoming the Stranger" and serving vulnerable people are at the core of our mission. Clients receive wrap-around services including case management, health and mental health navigation, mental health services, and parent education classes. JFCS East Bay is also deeply committed to taking a strengths-based approach in everything we do. Given this, goals and services are regularly evaluated with the client/family to ensure that they have the primary decision-making role. Staff also expand upon clients' existing strengths and play to them when

creating personalized case management plans and throughout the entirety of service delivery. In this way, JFCS East Bay helps to empower clients on their paths to self-sufficiency.

As an agency, we also recognize that new arrivals come from countries in which there may not be programs in place for mental health and well-being or, if a program exists, it is only for those who are severely mentally ill. To combat any potential stigma, staff provide clients with education about programs that may not have been available abroad.

Because JFCS East Bay is in frequent contact with clients during the early, stressful resettlement period, we can provide timely linkages to other needed services. Universally, clients agree that getting settled and learning all new systems brings a level of hope, but also high anxiety. Link to care through our trusted case managers is offered as a bonus type of support, which many are eager to seize.

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.

Ahray* Family (Wrap-Around Case Management and Parenting Workshops)

The Ahray family of four came to the United States in the early months of 2020 after fleeing persecution by the Taliban in Afghanistan. Before being granted Special Immigrant Visa (SIV) status, the parents had been waiting in Russia for seven years. During their time in Russia, the family had two children. The youngest, now age five, was born with a life-threatening medical condition that requires constant, lifelong treatment. The family came to the United States without an official resettlement agency. After being here for almost a month without support, they were referred to JFCS East Bay by a community member.

JFCS East Bay immediately took the Ahray family on as clients. At the time, both parents were unemployed, and the family didn't have housing. Our team quickly found them a two-bedroom apartment and covered their rent via our rent subsidy program. The agency also provided all the essentials, including furniture and household supplies.

After two months of building a trusting relationship, the family divulged that the youngest child had high medical needs and needed specialty care. They had kept their child's condition a secret for fear of being turned away if any special need became known. In addition, the family revealed that they are members of a religious minority group in Afghanistan and were fearful of judgment by the agency's Muslim staff. After working closely with staff, the family felt safe enough to reveal this new background information. Staff immediately responded by linking the child to care at the only facility prepared to serve pediatric patients with this condition: Lucille Packard Children's Hospital in Palo Alto. In subsequent months, the agency staff worked to

connect the family to California Children's Services (CCS), taught the family how to send in the home testing required to monitor the child's condition, and demonstrated how to connect to virtual medical appointments through an agency-donated Chromebook. Additionally, staff linked the family to a pharmacy that carries the specialized medicine covered through CCS, which was otherwise cost-prohibitive.

To prevent social isolation during the pandemic, staff also connected the family to a faith-based Zoom group (based on the family's minority faith). Staff also helped both parents enroll in online community college ESL classes, which they participate in regularly.

For parenting support, the family engaged in the agency's parenting workshops, where they learned about Covid-19 prevention and games that can use at home with their children to support healthy child development during shelter-in-place. The family was also introduced to the staff therapist and informed that they can always reach out if they want additional mental health support. Both parents are currently interviewing for jobs and are consistently receiving wrap-around support from our dedicated team as they work towards self-sufficiency. Mr. Ahray dreams of running his own business one day, and Ms. Ahray hopes to go to school to become a nurse.

Fatima* (Therapy, and Parenting Workshops)

Fatima is a mother of four in her forties from Afghanistan. During childhood, she experienced child abuse and ever since has had trouble speaking up to anyone who violates her boundaries. When Fatima first came to therapy, she stated that she suffered from low self-confidence rating it a "10" (10 being the worst it's ever been) and that she had an inability to speak up and be assertive with others. Her male family members also made her feel unimportant as a young girl, and even told her once, "Don't bother coming home." Fatima said despite this, her aunt was the only consistent loving figure in her life and encouraged her to pursue her dreams and get an education, which she did.

In the initial phases of treatment, Fatima emphasized her strong desire to be assertive in situations. For example, she had the experience of being discriminated against by a store owner based on her race. Fatima's initial self-identified goals of improving her assertiveness skills and low-self-confidence were her first targets in therapy.

Early in treatment, Fatima shared how her maladaptive cognitions stemmed from her childhood trauma and worked with her therapist to come up with alternative, more positive cognitions. Fatima engaged in assertiveness training, which included role-play that required her to speak up for herself in a safe environment (in therapy). Approximately three months into treatment, the client self-reported that her confidence and assertiveness were both now a "0" (meaning the best it's ever been). She also then shared real-life examples of being able to be assertive in her new life in the United States with friends, family, and strangers. Fatima stated

in session, “I feel I have overcome that . . . I was lacking confidence, now I know I have confidence.”

Fatima’s secondary goal was to improve upon her parenting skills. Given this, Fatima was invited to a JFCS East Bay parenting workshop, where she said she learned about positive parenting techniques such as timeouts and positive reinforcement. Fatima stated she was grateful for learning these techniques especially since they did not use any form of physical discipline, which she stated she experienced in her own childhood. Fatima now regularly incorporates positive parenting techniques into her own child-rearing.

Part-way through treatment, Fatima also experienced a major car accident on the same day she found out she was pregnant with her fourth child. After this incident, Fatima expressed she was terrified of driving and asked her therapist to help her manage her anxiety so that she could make it to her pregnancy check-in appointments. Fatima was then taught mindfulness and grounding techniques and within four sessions exclaimed happily that her fear around driving had dissipated and she could now drive without fear and make it to her medical appointments.

Within weeks of her car accident, Fatima found out that her aunt, who is her role model and biggest cheerleader, had gone into a coma after being diagnosed with coronavirus in Afghanistan. During this time, a rumor also had spread in Afghanistan that the coronavirus was the sign of the apocalypse.

Fatima believed whole-heartedly that this was true. She was devastated by her aunt’s sickness and the belief the coronavirus was the apocalypse, but she knew she still needed to be present for her own young children. Fatima expressed in therapy that she had become too scared to bring her children outside to play—fearful that they may also catch Covid-19 and become fatally ill.

In treatment, Fatima then worked with her therapist on finding safe ways to get outside of the house to play with her kids. She was also taught to focus on what she can control rather than what she cannot regarding her aunt’s illness. For times of stress, she was also taught relaxation techniques such as progressive-muscle relaxation and deep-breathing. Drawing from CBT techniques, Fatima’s therapist helped her rationalize her way to believing coronavirus was not the apocalypse, but something she may be able to prevent by routine handwashing and mask-wearing. She was also comforted by the fact that she knew how and where to receive medical support if her or her children caught Covid-19. Following this, Fatima’s outlook started to become more positive, and she expressed feeling empowered to create a healthy environment for her children to grow in, despite the pandemic.

Both JFCS East Bay’s parenting workshops and intensive therapy have helped Fatima improve her confidence and ability to parent despite a history of childhood trauma and pandemic-

related grief. Fatima now looks toward creating a safe life full of opportunity and contentment for her and her children in the United States and has the confidence to achieve her goals.

** Names, ages, genders, and minor details have been changed to protect client confidentiality.*

PEI ANNUAL REPORTING FORM

ACCESS & LINKAGE TO TREATMENTREPORTING FORM

FISCAL YEAR: 19-20

Agency/Program Name: La Clínica de La Raza, Inc./ 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 / ACTIVITIES:

Please summarize the Scope of Services as outlined in the Service Work Plan. Please also address any other relevant activities or events that took place during the reporting period.

Vías de Salud (Pathways to Health) targets Latinos residing in Central and East Contra Costa County and has provided: a) 3623 depression screenings (120% of yearly target); b) 296 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 (118% of yearly target); and c) 1238 follow up support/brief treatment services to adults covering a variety of topics such as depression, anxiety, isolation, stress, communication and cultural adjustment (99% 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) 661 screens for risk factors in youth ages 0-17 (88% of yearly target) ; 2) 113 Assessments (includes child functioning and parent education/support) with the a Behavioral Health Specialist were provided to parents/caretakers of children ages 0-17 (150% of yearly target); 333 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 (111% 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 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 MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services. Please include: Numbers served during the fiscal year, describe any adaptation of services due to COVID-19 that may be relevant

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.

La Clínica provided the following services for Vias de Salud:

- 3623 out of 3,000 Depression Screenings at La Clínica's primary care sites.
- 296 out of 250 assessments and early intervention services were provided by a Behavioral Health Specialists within the FY 19-20
- 1,238 out of 1,250 support/brief treatment services were provided by a Behavioral Health Specialists within FY 19-20

La Clínica provided the following services for Familias Fuertes:

- 661 out of 750 Behavioral Screenings of clients aged 0 – 17 were completed during the 12-month period by parents (of children 0-12) and adolescents (age 12-17)
- A total of 113 out of 75 assessments or visits (including child functioning and parent education/support were provided for FY 19-20
- 333 out of 300 follow-up individual/family visits with Integrated Behavioral Health Clinicians were provided with children/caretakers. This includes psychoeducation/brief treatment regarding behavioral health issues including parent education, psycho-social stressors/risk factors and behavioral health issues.

La Clínica's services have been adapted to maintain the safety and well-being of both patients and staff, while ensuring the continued provision of essential care. To maintain social distancing during the Shelter-In-Place orders and to serve patients who may be quarantined, La Clínica's

behavioral health clinicians are primarily providing services via telehealth to continue offering essential services to clients. La Clínica is currently able to conduct telephone-based and video conference appointments via a secure platform. Given the remote work at the sites, La Clínica's medical assistants halted the provision of behavioral health screenings but are currently implementing new workflows to resume these services in a safe manner.

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

Please refer to Aggregate Data Reporting Form

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.

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 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 19.8 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.

CULTURAL RESPONSIVENESS:

How have services been informed and structured to meet the diverse cultural needs of your clients/members/participants? What is being done by your organization to support cultural responsiveness both within the workforce and for those served by your organization?

La Clínica strives to reflect cultural competency in the assessment, treatment, and evaluation of the program. La 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 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 behavioral health providers are bilingual (English/Spanish), and most are bi-cultural. When appropriate, La Clínica utilizes translation services for all other languages.

COLLABORATIVE PRACTICES:

Describe how you are working with any other agencies or organizations to better serve clients/members/participants? If this is currently not being done, please describe any effort to build relationships with other community service providers?

IBH Clinicians are currently building relationships with First 5 to collaborate on the ACES screenings and trauma informed care for patients and staff. Clinicians are also working to build relationships with Contra Costa Crisis Center to refer patients to the grief services program. Additionally, the clinicians currently have a trauma group and partner with Agency A Window between Worlds who provides trainings and curriculum for clinicians to use with patients individually and with the group. La Clínica's case Manager refers patients to a variety of community organizations i.e., first 5, shelter inc., senior centers, Putnam clubhouse, contra costa county access services, bay area legal aid, contra costa food bank, family justice center, rainbow community center, contra costa crisis center, STAND, Covia Home match, CORE homeless Outreach.

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 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.

An 81-year-old male patient was referred to Behavioral Health for moderate depression symptoms. Client had a poor relationship with his family, felt unsupported, unloved, and lonely. Despite being in the US for several years, client continued having difficulties with acculturation. Client was also going through a phase of life problem where his lack of self-sufficiency significantly affected him.

Client has been actively in treatment with behavioral health at La Clínica and has stated that this is his only emotional support system. In treatment, client has been learning about coping skills, has been processing the phase of life he currently is in, has been supported with linkage to community resources to improve self-sufficiency and is also provided with a space where he is supported emotionally. Client plans to continue treatment with brief treatment in behavioral health.

PEI ANNUAL REPORTING FORM

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR: 2019-2020

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

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

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

SERVICES PROVIDED / ACTIVITIES:

Please summarize the Scope of Services as outlined in the Service Work Plan. Please also address any other relevant activities or events that took place during the reporting period.

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 128 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 2019 to June 2020. We served 128 participants from both communities representing a diverse group (Nepali, Tibetan, Bhutanese, Laotian, and Mien) Majority 66% of the clients were aged 26-59; seniors over 60+ years was approximately 31%; and young adults ages 16 to 25 were 2%. For FY 2019 – 2020, a total of 128 participants were enrolled 98% 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; 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 Clínica 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 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 Clínica 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 service 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 with building 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:

Strengthening Families Program (SFP) Educational Workshops:

LFCD held a total of 16 SFP workshops during the program year. (2 workshops per month from August 2019 to March 2020). Due to the COVID 19 pandemic we didn't host SFP event from April to May 2020, being that those were the early stages of the pandemic and we wanted to wait until Contra Costa County suggested the number of attendees an event could hold. So, we focused on graduation and closing out of cases in June 2020. For the graduation again, due to the COVID 19 pandemic we had incentive of PPE supplies personally brought to participants who completed the program. 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.

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.

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

<u>Enrollment and Participants Individual and Family Goals</u>

By June 30, 2020, a total of 128 program participants were enrolled for FY 2019/2020. Of the 128 participants, 16 participants 13% 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:

- To access and obtain treatment for mental healthcare and evaluation for severe mental health issues, PTSD, etc.
- To access SSI benefits for elderly participants with visual impairment and other disabilities
- 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.
- To obtain/increase access to preventative health care including annual physical examinations
- To access permanent affordable housing (public housing, section 8, foreclosure assistance, etc.)
- To reduce anxiety and depression related to citizenship, naturalization, unemployment and under employment.
- To reduce stress related to financial hardships and lack of money for basic needs (mental health stress and well-being related illnesses)
- To develop and maintain healthier lifestyle behaviors
- To improve their relationships with immediate family members/children/grandchildren
- To be more engaged and civic oriented within their community
- 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 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.

Thematic Peer Support Groups

The HWB program participated in 6 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 is a summary and highlights of each event.

- September 29, 2019 - 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 Ms. Uma Maharjan 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 Mrs. Sharada Parajuli who is disabled person shared her inspirational success story. She was graduated from the Lincoln University in Oakland California majoring in Human resource management. She got her driving license and job at the Peralta College district. She was continuing to her path to self-sufficiency. There were cultural dances from the community students. The participants were happily enjoying the activities.
- November 24, 2019 - A Thanksgiving Festival was held at Lao Family San Pablo office location with 60 people attending including 25 new clients. The participants celebrated with a traditional Thanksgiving meal plus a special cake for an established family from the program. Two presenters Mr. Surendra Prakash Malla and Mrs. Anupama Chapagai presented about the Cover California through power point. Similarly, Anupama Chapagai has presented about other social benefits such as how to receive services if you have no proper insurance. She also focused on women empowerment as well. Similarly, our former client Prem Pariyar has presented about ongoing mental health problem in the Asian community.
- December 22nd, 2019 - The HWB Christmas New year and Toys Giveaway event was held at the Community Building in San Pablo with 70 clients and family members attending in total with 25 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 Mr. Surendra Malla and Kileshor Malla provided a

power point presentation about the cover California benefit. Similarly, Lao Family CEO Kathy Chao Ruthberg highlighted various aspects of benefits and opportunity in Lao Family. She also congratulated to all participants for joining the HWB program to become self-sufficient. There was a cultural dances and songs by the local student artists. The City of San Pablo in partnership with LFCD provided some of the toys provided to the children in attendance. Many participants also received some gifts after being raffled by the HWB case managers.

- On March 8th and March 15th, 2020, there were a census related workshops and social gathering in San Pablo and Rodeo California with 50 participants due to COVID-19 pandemic. Case manager had enrolled more than 150 people to register census even during the pandemic time. Case manager had continued its efforts to call the clients over the phone and remind them to register in census to count themselves. Many community members and prospective clients were benefited by this effort.
- On April 9th, 2020, a Zoom meeting and presentation was initiated from 5PM-8 PM, by case manager by inviting health professional such as Dr. Pushkar Raj Pandey (General physician), Dr. Sharmila S. Bhatta (Mental health specialist), Mr. Yagya Prasad Nepal (Immigration attorney), Dr. Tika Lamsal (prof. University of San Francisco) , Mr. Tanka Rayachhetri (Tax expert), Mr.Tirtha Dong (Tax expert) and Mr. Suraj Pakhrin (Real Estate agent). They all had presented in their respective topics and extended their helping hands if anybody needs any kind of support at all times. In this way, case manager had connected many clients who were facing difficulties to apply EDD and pandemic EDD benefits. Similarly, health experts also promised to help the community members any COVID-19 related problems at any time and shared their contact information. Immigration attorney also promised help community members who need to extend their visas at no cost. Similarly, professor Tika Lamsal presented problem facing by the international students during the COVID-19 pandemic. He requested more help and support from the community. Finally, realtor Suraj Pakhrin who was our client during 2013-14 HWB program had presented about the current real estate market, gave some update how we can apply for loan forbiddance with the lenders, how we can write a letter to the apartment owners to request an extension. Many people watched this zoom video via Facebook. They highly appreciated our joint efforts for the community.
- Bay Area Nepali community had formed a new Group “COVID-19, Nepali Help Center” under my coordinator ship on April 16th, 2020. It was a coalition of 10 various CBOs and Ethnic organizations in Bay Area. We opened online and offline donation links for the support of victims of COVID-19. We have raised around 20,000 dollars and collected PPE from various sectors of society to help newly arrived immigrant’s family, international students, and senior citizen.
- On May 9th, 2020, case manager again participated in the ZOOM meeting with the various community leaders. The main goal of that meeting was how we were addressing

needs of community members, students, newly arrived immigrants, and elderly people who were stocked in USA due to COVID-19 pandemic. We have distributed cash donation of $250.00 and PPE to each of 50 international students who did not qualify for the stimulus benefit. Similarly, we helped 15 new immigrant families $350.00 each plus PPE, and we also provided financial support and PPE to 12 senior citizens $250.00 each. Most of them were our clients. In this way, we were able to maintain very good relationship with the needy community members during the difficult time.

HWB Graduation Event:

Due to COVID-19 pandemic, HWB graduation event was completely different this year. We used to celebrate this event as a festival during our past 9 years in this program. We used to have big crowd of people (about 100-120). We used to have a cultural event, guest speakers and more informative presentation during the graduation event. However, due to CDC guidelines, our personal safety and client's safety our HWB team had decided drive throw incentive and certificates distribution event. On June 27th and 28th HWB graduation drive throw certificates and incentives distribution program were organized by both case managers individually. Case manager from South and South East Asian community distributed certificates and incentives to 101 clients from El Cerrito, San Pablo, Richmond, Rodeo, Martinez, Concord, Pittsburg, Bay Point, and Walnut Creek California who were still available in Bay area. The pocket of incentive consists of one hand sanitizer, 10, gloves, one KN95 mask, and dry food. For the clients who were not available by that time or had moved from the location on file. The Case manager sent their gifts and certificates via mail in their new addresses.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services. Please include: Numbers served during the fiscal year, describe any adaptation of services due to COVID-19 that may be relevant, how are participants identified as needing mental health assessment or treatment? List of indicators measured, including how often data was collected and analyzed

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 8 with a high correlation between the 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:	16	24	8
(Min) Range:	13	18	6
(Max) Range:	28	30	5

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 considering 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 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 wellbeing 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.

The results stated that the 98% (125 of 128 respondents) of the participants were satisfied with the program services, and 2% (3 of 128 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 Clínica 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 2019 to June 2020, there were 11 participants that were referred to mental health services because 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. Specifically, through experience our case managers have found the Contra Costa Mental Health Access Line to be extremely difficult to navigate. Being that clients who are Medi-Cal recipients through the county, case managers have been directed to the access line to assist their clients. Unfortunately, the access line doesn't have a quick call back turnaround and often clients have been left without service. By comparison, access to private low-cost and CBO mental health services takes an average of 4 weeks. Which in many cases, clients have reported a more efficient way to access western mental health resources.

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 have been linked to mental health services and other providers depending on their need and goals identified in the individual service plan. From July 2019 to June 2020, this PEI program referred participants to different agencies inside and outside Contra Costa County using the following step-by-step procedure:

- 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, prior to linking them with traditional western mental health resources. The LFCD office in San Pablo was able to add a new confidential private room that is used for intake, counseling, etc.
- We provided support to participants while helping them develop their individual service plan with step-by-step goals and tasks including identifying linkage providers.
- Then, we encouraged individual participants to access and seek service provided by others. This process can take from 4 to 8 weeks in duration.
- Once the participant feels confident in our relationship with their confidential information, then we escort them (most of the time) to the provider for the warm handoff.
- 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.
- 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 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:

- 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 Clínica 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.

- Dr. Lee Hee, MD, a private practice medical doctor in Oakland for affordable medical care.
- 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.
- Jewish Family Services – East Bay, to assist with naturalization and immigration services on site at our San Pablo office at regularly scheduled intervals.

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

Please refer to Aggregate Data Reporting Form

CULTURAL RESPONSIVENESS:

How have services been informed and structured to meet the diverse cultural needs of your clients/members/participants? What is being done by your organization to support cultural responsiveness both within the workforce and for those served by your organization?

Services have been designed and structured to meet the diverse cultural needs of our clients and participants by developing a strong sense of cultural informed services. For example, during a SFP Social Gathering last year a Nepalese participant raised a valid concern about the food being served at the event. The client informed the case managers that they were unable to consume food during the event. Which was due to the participant undergoing a fasting period for a religious ceremony. Being that the event was going to be centered around the meal, the case managers were able to shift the focus of the event from the meal to the overall importance of the gathering. The organization has supported the cultural responsiveness and awareness in the agency by staffing individuals from backgrounds like those being served in the program. For example, both HWB case managers are from either South Asia or South East Asia. Therefore, these individuals meet the cultural perspective requirement necessary to serve participants in the program. Also, the organization has adopted the practice of cultural informed trainings throughout the organization. By doing so, our clients and participants can receive cultural aware services across our organization.

COLLABORATIVE PRACTICES:

Describe how you are working with any other agencies or organizations to better serve clients/members/participants? If this is currently not being done, please describe any effort to build relationships with other community service providers?

Collaboration and referrals are a major aspect of the program through traditional and non-traditional channels. Currently, we leverage our partners and mental health providers in the community. For example, during this reporting period our program coordinator established a new partnership with the Contra Costa County Assisted Outpatient Treatment program. This program, like our HWB focuses on the importance of linking these underserved individuals to mental health treatment. Additional to leveraging outside partners and service providers, case managers refer clients within our organization for services such as employment, victim services, and immigration. With the collaboration within the organization, we have seen an increase in positive results and experiences from the clients. To build more relationships with partners and service providers, our coordinator has implemented the importance of outreaching for mental health service providers.

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:

- 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.
- We have a zero-tolerance policy for discrimination or prejudice based on race, place of origin, gender, religion, disabilities, etc. and our practice gives participants confidence that they are not discriminated upon.
- 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.

- 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.
- 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.

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, we have had several clients with mental health stress because 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 2019. 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 Medi- Cal support. Now that her health insurance situation has stabilized, she is working fulltime and receiving medication and health support though Medi-Cal. 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.

PEI ANNUAL REPORTING FORM

Stigma and Discrimination Reduction Reporting Form

Fiscal Year: Jul 2019-August 2020

Agency/Program Name: The Latina Center/Our Children First (Primero Nuestros Niños)

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 summarize the Scope of Services as outlined in the Service Work Plan. Please also address any other relevant activities or events that took place during the reporting period.

The Latina Center offered culturally and linguistically relevant parenting classes and mental health workshops in community-based settings (schools, churches, The Latina Center's office) in West Contra Costa County and made referrals to mental health services, as well as providing educational and therapeutic services in house. During FY July 1, 2019 – June 30, 2020, we served a total of 314 parents (parenting sessions, mental health workshops, psycho-educational therapy, support groups) and provided 30 learning circles with activities reaching 424 children.

The Latina Center conducted outreach to recruit and engage parents to participate in our programs using flyers, phone calls, Facebook, referrals from intakes by The Latina Center staff, and referrals from West Contra Costa County schools, health clinics, Child Protective Services (CPS), churches, and courts.

During this annual reporting period, our outreach efforts reached 1,031 individuals, and enrolled 42 people into our programs.

To improve timely access to services, our staff provided one-on-one case management and follow-up to ensure that people were connected to the services they need. Staff also provided access to phone service and help clients develop a personalized action plan.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services. Please include:

Numbers served during the fiscal year:

During the fiscal year we served a total of 314 parents.

Describe any adaptation of services due to COVID-19 that may be relevant

In the second period of the year COVID-19 unexpectedly paralyzed our programs. First, we had to understand what was happening and how it affected not only our programs but the parents in our community. For most families, the pandemic has devastated their lives in many ways. In addition to the severe economic consequences, anxiety, depression, and fear are the primary mental health effects that we have seen in the last six months. After ensuring that all staff had the necessary skills and equipment (e.g., technology) they needed, we converted all our outreach and education programs to virtual platforms and provided families with supports as needed to access our new online programming. In addition, we received several grants that enabled us to distribute emergency relief funds and PPE to families in our community most in need. Eligibility criteria were identified, and systems were developed to track funds. $189,000 was distributed.

Please detail any methods used to change attitudes, knowledge and/or behavior, and include frequency of measurement.

Our focus was on helping parents with their primary (basic/survival) needs while at the same time talking to them about the importance of learning to use technology that will allow them and us to share information and strategies about parenting that can help provide them with tools to manage their stress levels and avoid abuse and violence with their children, especially in this time of crisis. The methods we use include dynamic sessions that are culturally and linguistically relevant where parents can share their experiences and ask questions; homework that gives parents specific tools to practice parenting techniques; and feedback sessions where parents can support each other. We continued to administer surveys to measure changes in knowledge, attitudes and behavior and gather testimonies about their experiences.

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.

<u>PARENTING CLASSES</u>

<u>Primero Nuestros Niños</u> (Our Children First) is an evidence-based 10-week culturally appropriate and linguistically specific parenting education program. We converted our in-person classes to virtual classes due to the pandemic doing our best under the circumstances to maintain not just the course content (fidelity) but the in-person dialogue and support that parents receive. During the fiscal year, we successfully provided the following:

- 286 parents (244 women and 42 men) registered for the parenting class and completed a pre-survey in Spanish.
- Parenting classes were held in 4 community-based locations: Cesar Chavez Elementary School, Mira Vista Elementary, Richmond Charter Academy, and The Latina Center. All classes completed the 10-week sessions 6 sessions online.

Parenting Class Pre-Survey Results

- 100% of parents wanted to acquire new skills
- 61% of parents wanted to improve their communication with their children
- 54% of parents wanted to improve their relationship with their family
- 23% of parents wanted to learn more about child development
- 15% of parents wanted to learn more about mental health

At least 73% of participants identified as a survivor of some form of violence (physical, emotional, and verbal abuse) including current or experience with domestic violence (as teenagers or adults), child abuse. Many said their children have witnessed domestic violence in their own home.

Parents learned about our parenting program from other programs at The Latina Center, friends or other "word of mouth", their children's school, CPS, or the courts.

More than 1000 calls to reach parents that got help from the emergency fund COVID-19

Referrals for Services

Based on the responses to the pre-survey, The Latina Center made at least 28 referrals to:

- Ya Basta, a domestic violence support group at The Latina Center (5)
- Amor y Servicio !Liberate!, a support group for people with substance use or addiction problems (5)
- Family Justice Center (7)
- Familias Unidas (1)
- Caridades Catolicas (1)
- Life Long Medical Clinic (7)
- Early Childhood Mental Health Services (2)

Mental Health Workshop (in partnership with NAMI)

During July 1, 2019 - August 31, 2020, 324 individuals received educational and direct mental health services from the Our Children First Program. The Latina Center staff 6 Mental Health Workshops in 3 locations (The Latina Center, St Cornelius Catholic Church and Montalvin Elementary School) for 130 participants; 94 participants completed pre and post-surveys.

Before the workshop, 65% of parents said they did know what mental illnesses are; 35% did not know. After the workshop, 96.9% understood what mental illnesses are; 3.1% did not understand.

Can you recognize any signs or symptoms of mental health?

- Before: 57.5% know of any symptoms or mental illness and 42.5% do not. After: 81.3% know more of the signs and symptoms; 18.8% did not.

Do you suffer from depression?

- Before: 39.5% consider themselves to be depressed; 60.5% say they do not have depression. After: 40.6% recognized that they have depression, 50.4% say they do not.

Do you suffer from anxiety?

- Before: 51.2% admit they have anxiety, 48.8% say they do not. After: 50% acknowledged having anxiety; 50% say they do not.

Do you suffer from stress?

- Before: 76.2% say they have stress, and 23.8% say they do not have stress. After: 78.1% now admit to having stress, and 21.9% say they do not have stress.

Does any member of your family have a cognitive disability?

- Before: 20.9% say they have a family member with cognitive disabilities (i.e., dementia, learning disabilities); 29% say they did not.

Does a family member need emotional support?

- After: 71% acknowledged needing emotional support, and 29% say they do not need it.

Are you going through a difficult emotional situation?

- 39.5% answered yes and 60.5% answered no.

Would you like to make an appointment with a counselor?

- 47.6% answered yes and 52.4% answered no.

<u>Referrals to Mental Health Services</u>

During the fiscal year, The Latina Center served 64 parents as follows:

- 20 parents received psycho-educational support/counseling from our onsite therapist Javier Nunton, MSW (see report)
- 8 parents were referred to therapy with Eleana Coll, MSW (see report)

- 36 mothers were referred to The Latina Center's support group Celebrating Recovery (Facilitator, Beneranda Lara)

Activities for Children

Learning Circles: In addition to Our Children First parenting classes, The Latina Center provided 30 learning circles with activities reaching 424 children as follows:

- Ages 0-5 74 girls and 131 boys
- Ages 6-15 73 girls and 146 boys

DEMOGRAPHIC DATA: ***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

CULTURAL RESPONSIVENESS:

How have services been informed and structured to meet the diverse cultural needs of your client, members, or participants? What is being done by your organization to support cultural responsiveness both within the workforce and for those served by your organization?

The Latina Center serves the Latino community with culturally and linguistically relevant parenting classes structured to support our clients by giving them the tools to thrive in their lives. The Latina Center also ensures that staff, Parent Educators, volunteers, and parents participate in training. During 2019-2020, we provided the following training opportunities:

- Vision y Compromiso' 2-day conference in Los Angeles: training related to parenting and support
- NAMI: basic mental health first aid training for facilitators
- SISTAS/HIV education and awareness training informing teenagers

During COVID-19, our staff participated in many webinars and training online including:

- VISIÓN Y COMPROMISO: Answers from a community promoter to confront the pandemic, how to deal with stress and manage with kids at home
- California Work & Family: Understanding paid family leave during COVID-19
- Family Justice Center: Young children impacted by violence; Unlawful Detainers 101; Elder Abuse
- WCCUSD: Careers Training Fellowship
- Seminary from Lima, Peru: Physiotherapy training in mental health support techniques

COLLABORATIVE PRACTICES:

Describe how you are working with any other agencies or organizations to better serve clients, members, or participants? If this is currently not being done, please describe any effort to build relationships with other community service providers?

The Latina Center works with organizations such as Familias Unidas, Early Childhood Mental Health, West Contra Costa County Children and Adolescent Mental Health Services, Family Justice Center, NAMI, Fred Finch Youth Center, among others.

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 Primero Nuestros Niños (Our Children First) parenting education and early intervention program, we identify community members with mental health issues and refer them to local mental health services and programs. Our culturally and linguistically relevant program reaches people where they are with strategies that are neither non-stigmatizing nor discriminatory including a warm hand off, one on one coaching, assistance with the process of contacting a crisis line or other program for assistance, case management, and ongoing follow up to ensure that people get connected and stay connected to the referrals we make.

The needs of immigrant families in our community are much greater than what we can provide and there remains much work to do to improve the emotional health and well-being in our community. Many Latino residents, especially those who are immigrants, are experiencing high levels of depression, anxiety, and stress, now more than ever due to the pandemic. Teenagers, children, and older adults all need resources including counseling and peer support groups but waiting lists are long and not everyone has access to the technology to make virtual programs work.

We refer people to our partners such as Familias Unidas, Early Childhood Mental Health, and West County Children and Adolescent Mental Health Services. Unfortunately, too many people tell us that they are not able to receive the help they need because they do not have medical insurance, the cost of mental health services is too high, the waiting list is long, and/or there is a shortage of bilingual providers. As a result, we have partnered with 2-3 bilingual therapists to refer monolingual Latina women with different mental health needs for appropriate levels of intervention. As a result, more Latina women in West County are being assisted via weekly, one on one sessions by phone based on pandemic protocols. They are receiving psychoeducation and case management for a limited period (12 weeks or 3 months). The array of conditions include:

- Individuals with traumatic experiences due to exposure to different levels of abuse.
- Mood disorders, self-esteem, and dependency issues.
- Parenting challenges; and grief.
- Assistance with the mental health effects of being diagnosed with COVID-19, the effects of the quarantine and/or other pandemic-related mental health issues.
- Clients are receiving case management to facilitate linkages to medical care and psychotherapy as well as immigration services, housing assistance, food banks, and crisis hotlines.

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.

A selection of testimonies from our participants are included below:

I learned to identify bad behavior in my daughters, and I have learned how to do it with love and patience and a lot of dedication. I give them precise instructions if they break them there will be consequences. Communication with my husband has increased in the agreements for them and neither of us disavowed each other. Sometimes he also applies ignoring, it is a good technique for them to find their own answers and make good decisions. We have a style of educating and disciplining, however, the tools of the classes (not punishing, encouraging, speaking with soft and firm words) have helped us a lot.

In my work I have applied I messages when there is a problem, and in my personal life it has helped me a lot in making internal changes and in my family. The dynamics of the heart helps me reflect on the damage that it caused to my loved ones and from now on I will use the tools from the classes to improve my relationship with my family**.**

I learned that using alternatives and consequences, and setting limits are better for disciplining my children. Before, I used methods by which I was educated (screaming, snapping fingers). But my beliefs have now changed with the STEP tools and thus my way of educating and understanding myself better with my family has improved.

There are many things that as a mother one sometimes does wrong, at least it has happened to me. With my children when they have bad behavior, I have spoken out loud to them or I do things for them without showing authority and that gives them power over me. So today I learned that it is better to go out for a moment and try to understand why they act that way and talk to them calmly.

My son suffered a lot from bullying at school. I noticed that he no longer wanted to go to school and showed an attitude of incompetence. I talked to him and applied what I learned in the

motivating classes to highlight the good things he is and that he can do. Little by little, he has been changing.

My children tend to throw tantrums every time we go out for something they want, and we don't give it to them. Now, I have set my limits and speak with them very firmly before leaving, explaining to them that we will go out and that they will not be given everything they ask for and that way they already know how they should behave.

I got desperate when a situation arose with my children and even yelled at them. Now with the tools of the parenting classes, I try to control my anger. I started treating them differently and not yelling at them.

After the class on the four objectives of bad behavior I have been able to identify what my son's objective is: attention and power. We have talked in my family about giving options and looking for alternatives.

And at the same time, we are improving communication.

In my work there are people who treat people very badly. After taking the Mental Health workshop, I understand that there are people who are not well and live with Mental Illnesses all their lives. Now I see them in a different way and with respect. The classes helped me reflect on my behavior and recognize that just as they hurt me, I also did a lot of damage. The tools from the classes I have begun to implement and I have seen that my environment is changing but because first I started to work on myself.

We had an exercise of the heart and I understood that I cannot harm someone because afterwards they are no longer the same, they have already hurt themselves and their heart will not be the same. I learned that reflective listening is a way to understand my family and understand their feelings, that they feel supported by me, and that they count on me.

I like parenting classes because they give me homework. My son is motivated to do it with me, and we bond more.

I've learned to identify my daughter's bad behavior. When I want her to cooperate and she misbehaves, I ignore her, and let her finish with the chores.

I have my daughter in sports, and I encourage her to continue because sometimes she doesn't want to attend, and I motivate her to get good grades so she will continue on the team. I also like to talk with my children, and I learned to listen to them reflectively.

I have learned to show respect for myself and to motivate my children to cooperate.

As a mother, I have learned to reflect and calm down in every situation so that I can think better and take things calmly to be able to solve them and not get out of control.

I really liked the idea of homework and family meetings because it helped me have more time with my children and give them the attention they need.

I learned that reflective listening to my children has helped me a lot in understanding them and improving communication. I also liked the I messages that helped me to listen to them and understand them more.

Reflective listening has helped me understand the needs of my children and my wife, I hope in the future that my wife will also take these classes so that we can agree on the education of our children.

INDIVIDUAL THERAPY REPORTS

Eleana Coll LCSW 87111

During August 2019-August 2020, I have provided mental health services to 9 clients (12 individual sessions per client). This report presents information about their demographics, symptoms, pre and post test results, instruments used, interventions, and outcomes.

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Identifying Information: Client is a 49-year-old, female, Latina, married, with children.

Reason for referral: Symptoms of sadness, lack of sleep, and acute stress due to family changes and after being a victim of crime. Patient reported history of sexual abuse, emotional abandonment, and immigration issues.

Method of Assessment: Clinical Observations, Self-Report, and Mental health Screening Measures: Patient Health Questionnaire (PHQ-9), a depression screener that is in widespread use in medical settings; and General Anxiety Disorder (GAD-7), an anxiety screener that is in widespread use in medical settings.

Pre-test: To quantify client's symptoms of depression, I administered the PHQ-9. She scored 13 out of 27 on this measure, suggesting *moderate* depressive symptoms. To quantify her symptoms of anxiety, I administered the GAD-7. She scored 13 out of 21 on this measure, suggesting *moderately severe* anxiety symptoms.

Post-test: To quantify client's symptoms after 12 individual sessions, I re applied the PHQ-9 and GAD-7 screeners. Patient scored 9 in PHQ-9, suggesting *mild* depressive symptoms and 5 in GAD-7, suggesting mild anxiety symptoms.

Interventions: Gestalt therapy, Motivational interviewing, NLP (Neuro Linguistic Programming).

Outcome: Client attended her 12 individual sessions and actively engaged in each session. Client's current behavior and screeners scores suggest that her symptomatic behaviors have improved.

****

Identifying Information: Client is a 38-year-old, female, Latina, married, with children.

Reason for referral: Symptoms of anxiety and depression due to history of trauma as a child and current issues with her partner in their relationship and conflicts in their parenting styles.

Method of Assessment: Clinical Observations, Self-Report, and Mental health Screening Measures: Patient Health Questionnaire (PHQ-9),), a depression screener that is in widespread use in medical settings; and General Anxiety Disorder (GAD-7), an anxiety screener that is in widespread use in medical settings.

Pre-test: To quantify client's symptoms of depression, I administered the PHQ-9. She scored 21 out of 27 on this measure, suggesting *severe* depressive symptoms. To quantify her symptoms of anxiety, I administered the GAD-7. She scored 15 out of 21 on this measure, suggesting *moderately severe* anxiety symptoms.

Post-test: To quantify client's symptoms after 12 individual sessions, I re applied the PHQ-9 and GAD-7 screeners. Patient scored 14 in PHQ-9, suggesting *moderate* depressive symptoms and 7 in GAD-7, suggesting moderate anxiety symptoms.

Interventions: Gestalt therapy, Motivational interviewing, NLP (Neuro Linguistic Programming).

Outcome: Client attended her 12 individual sessions. She actively engaged in each session, and her anxiety and depression symptoms have decreased.

****

Identifying Information: Client is a 32-year-old, female, married, with children.

Reason for referral: Symptoms of anxiety and depression due to history of domestic violence in her country of origin, and current issues with her children's father.

Method of Assessment: Clinical Observations, Self-Report, and Mental health Screening Measures: Patient Health Questionnaire (PHQ-9), a depression screener that is in widespread use in medical settings; and General Anxiety Disorder (GAD-7), an anxiety screener that is in widespread use in medical settings.

Pre-test: To quantify client's symptoms of depression, I administered the PHQ-9. She scored 19 out of 27 on this measure, suggesting *moderate severe* depressive symptoms. To quantify her

symptoms of anxiety, I administered the GAD-7. She scored 15 out of 21 on this measure, suggesting *moderately severe* anxiety symptoms.

Post-test: To quantify client's symptoms after 12 individual sessions, I re applied the PHQ-9 and GAD-7 screeners. Patient scored 9 in PHQ-9, suggesting *mild* depressive symptoms; and 7 in GAD-7, suggesting *moderate* anxiety symptoms.

Interventions: Gestalt therapy, Motivational interviewing, NLP (Neuro Linguistic Programming).

Outcome: Client attended her 12 individual sessions. She actively engaged in each session. Client's behavior and the screeners score suggest that her anxiety and depression symptoms have decreased.

****

Identifying Information: Client is a 49-year-old, male, Latino, single, with children.

Reason for referral: Client reported lack of energy and concentration, constant worry about his children wellbeing. History of homelessness and substance abuse.

Method of Assessment: Clinical Observations, Self-Report, and Mental health Screening Measures: Patient Health Questionnaire (PHQ-9),), a depression screener that is in widespread use in medical settings; and General Anxiety Disorder (GAD-7), an anxiety screener that is in widespread use in medical settings.

Pre-test: To quantify client's symptoms of depression, I administered the PHQ-9. He scored 14 out of 27 on this measure, suggesting *moderate* depressive symptoms. To quantify his symptoms of anxiety, I administered the GAD-7. He scored 13 out of 21 on this measure, suggesting *moderately severe* anxiety symptoms.

Post-test: Not able to do a post-test due to client participated only in his two first sessions.

Interventions: Initial assessment.

Outcome: Client stopped participating in the individual sessions due to conflict with his work schedule.

****

Identifying Information: 60-year-old, male, Latino, married, with children.

Reason for referral: Due to symptoms of anxiety after a change in family situation.

Method of Assessment: Clinical Observations, Self-Report, and Mental health Screening Measures: Patient Health Questionnaire (PHQ-9), a depression screener that is in widespread

use in medical settings; and General Anxiety Disorder (GAD-7), an anxiety screener that is in widespread use in medical settings.

Pre-test: To quantify client's symptoms of depression, I administered the PHQ-9. He scored 12 out of 27 on this measure, suggesting *moderate* depressive symptoms. To quantify his symptoms of anxiety, I administered the GAD-7. He scored 16 out of 21 on this measure, suggesting *severe* anxiety symptoms.

Post-test: To quantify client's symptoms after 12 individual sessions, I re applied the PHQ-9 and GAD-7 screeners. Patient scored 4 in PHQ-9, suggesting no depressive symptoms and 5 in GAD-7, suggesting *mild* anxiety symptoms.

Interventions: Gestalt therapy, Motivational interviewing, NLP (Neuro Linguistic Programming).

Outcome: Client attended his 12 individual sessions. He actively engaged in each session. Client's behavior and the screeners score suggest that his referral symptoms have decreased.

****

Identifying Information: Client is a 43-year-old, female, Latina, single, with children.

Reason for referral: Symptoms of depression and anxiety that are impacting her self-esteem.

Method of Assessment: Clinical Observations, Self-Report, and Mental health Screening Measures: Patient Health Questionnaire (PHQ-9), a depression screener that is in widespread use in medical settings; and General Anxiety Disorder (GAD-7), an anxiety screener that is in widespread use in medical settings.

Pre-test: To quantify client's symptoms of depression, I administered the PHQ-9. She scored 14 out of 27 on this measure, suggesting *moderate* depressive symptoms. To quantify her symptoms of anxiety, I administered the GAD-7. She scored 8 out of 21 on this measure, suggesting *moderate* anxiety symptoms.

Post-test: In process

Interventions: Gestalt therapy, Motivational interviewing, NLP (Neuro Linguistic Programming).

Outcome: Client has only participated in 8 of her 12 sessions. Outcome is in process.

****

Identifying Information: 33-year-old, female, Latina, single, with children.

Reason for referral: Client with symptoms of anxiety and depression due to family separation and immigration issues.

Method of Assessment: Clinical Observations, Self-Report, and Mental health Screening Measures: Patient Health Questionnaire (PHQ-9), a depression screener that is in widespread use in medical settings; and General Anxiety Disorder (GAD-7), an anxiety screener that is in widespread use in medical settings.

Pre-test: To quantify client's symptoms of depression, I administered the PHQ-9. She scored 16 out of 27 on this measure, suggesting *moderately severe* depressive symptoms. To quantify her symptoms of anxiety, I administered the GAD-7. She scored 15 out of 21 on this measure, suggesting *moderately severe* anxiety symptoms.

Post-test: In process

Intervention: Initial assessment

Outcome: Client has participated only in the assessment session. Outcome is in process.

****

Identifying Information: 31-year-old, female, Latina, single, with children.

Reason for referral: Client with symptoms of anxiety and depression due to changes in her family situation.

Method of Assessment: Clinical Observations, Self-Report, and Mental health Screening Measures: Patient Health Questionnaire (PHQ-9), a depression screener that is in widespread use in medical settings; and General Anxiety Disorder (GAD-7), an anxiety screener that is in widespread use in medical settings.

Pre-test: To quantify client's symptoms of depression, I administered the PHQ-9. She scored 17 out of 27 on this measure, suggesting *moderately severe* depressive symptoms. To quantify her symptoms of anxiety, I administered the GAD-7. She scored 11 out of 21 on this measure, suggesting *moderately severe* anxiety symptoms.

Post-test: In process

Intervention: Initial assessment.

Outcome: Client has participated only in the assessment sessions. Outcome is in process.

****

Identifying Information: 17-year-old, female, Latina, single.

Reason for referral: Client complaints of symptoms of anxiety and depression.

Method of Assessment: Clinical Observations, Self-Report, and Mental health Screening Measures: Patient Health Questionnaire (PHQ-9), a depression screener that is in widespread

use in medical settings; and General Anxiety Disorder (GAD-7), an anxiety screener that is in widespread use in medical settings.

Pre-test: In process. Client has not completed the screeners

Post-test: In process.

Intervention: Initial assessment in process.

Outcome: Outcome is in process.

MENTAL HEALTH: PSYCHO EDUCATIONAL SERVICES

INDIVIDUAL SERVICES PROVIDED BY JAVIER NUNTON, MSW

August 2019 to August 2020

A total of 20 participants were assisted in the following manner:

MM: Starting Date: 8/1/2019

- Elderly woman from Mexico; Issues presented: Possible Post-Traumatic Stress Disorder due to witnessing her adult sons being murdered.
    - Intervention: Trauma Centered Approach
    - Outcome: Participant went to live with her son in another city and had to interrupt services.
    - Please note that same participant completed some of the Psycho-educational Groups provided as well.

DG: Starting Date: 9/28/2019

- Woman in her 50's from Mexico; Issues presented: Constantly worried about her daughter's best intervention for her disability and her future.
    - Intervention: Client was assisted to understand the main issues related to her daughter's diagnosis since her confusion worsened her apparent symptoms of anxiety. Client was also assisted to understand her role as a parent of a disabled girl and the importance to assume better care of her. Client was psycho-educated on relaxation strategies, other lifestyle changes and mindfulness. Client was also referred for possible medication management.
    - Outcome: Levels of anxiety decreased, and client made decisions on issues she felt she had gotten stuck related to her daughter's best type of intervention.

BP: Starting: 10/5/2019

- Woman in her 60's from Puerto Rico; Issues presented: Possible Trauma, Possible Major Depression Disorder; Possible Personality Disorder. Unable to forgive herself since she had to disconnect her son's life support machine.
    - Intervention: Identification of main symptoms by providing education on what Trauma and Depression represents; Identification of healthy alternatives; Psychoeducation on medication role and its importance toward her recovery. Referrals were also provided for possible medication management. Client was helped to find an ex-Psychiatrist provider from San Francisco as she said she had a good relationship with him.
    - Outcome: Client interrupted sessions. No respond to messages.
    - Please note that client refused other types of intervention as she indicated she did not trust the system and she believed that no one could help her.

LC: Starting Date: 10/5/2019

- Woman in her 50's from Mexico; Issues presented: Robbed at gun point at her workplace; possible Trauma.
    - Intervention: Trauma Centered Approach; Relaxation strategies; client learned how certain thoughts can also contribute to exacerbate trauma. Mindfulness approach to develop awareness of her immediate psychological and physical symptoms and act on prevention strategies. Exercises were recreated to help client switch focus of attention when becoming frustrated. She used recollection of daughter's plans in her career which made her feel immensely proud. Client got referrals to other mental health providers and medication management.
    - Outcome: Client responded very well to interventions and verbalized progress and changes of interpretation to what she had experienced.

RT: Starting Date: 9/16/2019

- Woman in her 40's from Belize' Issues presented: Sudden recollection of past traumatic event; possible anxiety and trauma.
    - Intervention: Psychoeducation of trauma; anxiety, main symptoms and effects on her mood and self-esteem. Psychoeducation on self-esteem issues was also provided as client requested to be the same as she was before.
    - Outcome: Levels of anxiety and trauma decreased per client's verbalization as she identified the types of thoughts, she realized only exacerbated her mood challenges. Client practiced suggested exercises via videos, music, and audio books to enhance her self-esteem and decrease symptoms of anxiety and fear.

ER: Staring Date: 1/6/2020

- Woman in her 30's from Mexico; Issues presented: Separation process and past Domestic Violence; Possible Bulimia.
    - Intervention: Individual onsite services were changed. Due to COVID 19 state's Shelter-In-Place laws, client agreed to be assisted over weekly phone calls. Client is being assisted with Psychoeducation on Separation and mood challenges, main symptoms; self-esteem and main definition of what Bulimia represents.
    - Client was provided with referrals to address specific issues such as Bulimia and medication management. Client has been provided with support by helping her to improve her self-care awareness; self-esteem re-definition by reading audio books of topics related: Do not be codependent by Melody Beatty; Change your life by healing your mind by Louise Hay; The power of the Word by Louise Hay; relaxation and guided meditation.
    - Outcome: In process. Client has been able to move on and her initial lack of confidence, anger and sadness have decreased considerably. Client made an important decision: quit her job and started working for a Community Agency to pursue her dreams to help people. Per client, she stating this process helped her to make decisive decisions about her life and to love herself. Client was also referred to programs where she could get further assistance if Bulimia symptoms would relapse.

LM: Staring Date: 1/28/2020

- Woman in her 30's from Mexico: Issues presented: Lack of assertive skills; past severe depressive episodes. Client wishes to be able to face her loneliness and become more independent.
    - Intervention: Individual onsite services were changed. Due to COVID 19 state's Shelter-In-Place laws, client agreed to be assisted over weekly phone calls. Client is being assisted to learn main types of communication and be more assertive; self-esteem enhancement strategies explained. Client was also assisted to identify main components of a relationship and what is healthy and what is not; assistance on how to set goals and organize herself to achieve them.
    - Possible referrals for therapeutic intervention and medication management will be provided. Explanation of importance of medication compliance.
    - Outcome: In process. Client's engagement into a new relationship triggers her emotions to relapse. Although she has developed more awareness about her immediate goals, she may need more emotional support and assistance as she identifies negative elements in her new relationship she feels "attracted" to but

hates it at the same time. Client was referred to Life Coaching services, continuation of Mental Health therapy and Support Groups such as CODA.

LC: Starting Date: 4/14/2020

- Woman in her 40's from Mexico; Issues presented: how to better manage her anxiety and anger that is causing conflict with her only 20-year-old daughter. Client wants to prevent escalation of arguments and bad relationship with her daughter.
    - Intervention: Due to COVID 19 state's Shelter-In-Place laws, client agreed to be assisted over weekly phone calls. Psychoeducation about emotions such as anxiety and anger; identification of her main characteristics that define her anxiety (type) and anger; assertive type of communication. Strategies to de-escalate her anger and develop new ways of communication; explanation of the types of communication to identify the one she uses more frequently (passive-assertive -aggressive).
    - Outcome: communication with daughter improved considerably to the point that client's daughter had a smooth housing transition back with client. Client reports she was able to control her anger and anxiety successfully.
    - According to client her daughter told her she had changed a lot and felt more at ease with her.

AM: Starting Date: 4/17/2020

- Woman in her 40's from Mexico; Issues presented: emotional decompensation, anxiety and fear reaction after witnessing murder of a man in the street.
    - Intervention: Due to COVID 19 state's Shelter-In-Place laws, client agreed to be assisted over weekly phone calls. Psychoeducation to differentiate Acute Stress Disorder and Post Traumatic Stress Disorder; symptom awareness; prevention of escalation of main symptoms associated with anxiety reaction. Coping skills, strategies to reduce stress, Conflict resolution at workplace.
    - Outcome: In progress: Symptoms decreased after 3rd session. Topic switched over conflict resolution to assist client reduce other parallel sources of stress that could exacerbate her condition. Client responded well to interventions as she put in practice ideas to reduce stress.

MS: Starting Date: 5/1/2020

- Woman in her 30's from Mexico, requested assistance due to strengthen her emotions and response to divorce process. Client presented symptoms of anxiety and depression. Difficulties with decision making process.
    - Intervention: Due to COVID 19 state's Shelter-In-Place laws, client agreed to be assisted over weekly phone calls. Client was assisted by providing

psychoeducation about Depression and Anxiety; identification of symptoms and development of strategies to cope with them effectively. Client was also supported in her decision-making process and develop a new sense of identity/concept about herself because of the divorce process.

- Outcome: Client's level of anxiety and depression decreased although it fluctuates due to length of divorce process. Client was assisted to identify specific strategies to use when dealing with perception of legal process and her response to it. Development of self-esteem and decrease symptoms of dependency may require further Mental Health assistance for which she was referred to these services.

AT: Starting Date: 5/1/2020

- Man, in his 30's from Guatemala. Client was referred due to grief issues related to the sudden death of one of his younger brothers. However, client did not follow through due to dealing with parallel challenges: brother arrested by ICE, injury at work.
    - Intervention: Due to COVID 19 state's Shelter-In-Place laws, client agreed to be assisted over weekly phone calls. Client was assisted to vent his problems and identify specific goals to work on. Client was initially motivated to pursue his own goals but then he changed and requested assistance for his brother because he was under house arrest and had a harder time accepting the death of their brother. Client was also provided with referrals to: Brookside Clinic, Immigration Emergency Benefit Services, Latina Center Food Bank.
    - Outcome: Client and brother did not complete services. They stopped returning phone calls.

KJ: Starting Date: 5/25/2020

- Woman in her late 20's from Mexico, was referred due to having Post-partum Depression symptoms. Client, in effect stated she wanted to overcome deeply sad symptoms and negative thoughts that were affecting her relationship with husband and older son.
    - Intervention: Due to COVID 19 state's Shelter-In-Place laws, client agreed to be assisted over weekly phone calls. Psychoeducation about Post-partum depression; identification of symptoms and pattern of distorted thoughts. Client was assisted to vent negative thoughts and learn how to challenge them. Client was also helped to understand the importance to identify gradual list of activities she could use to balance moments of sadness/anger with moments of relaxation, entertainment. Motivational approach was also used to help client develop positive self-affirmations. Parenting issues addressed.
    - Outcome: Services still in process.

HA: Starting Date: 6/6/2020

- Female in her 30's from El Salvador, looked for assistance to better cope with symptoms of anxiety and constant worry. During process client was also infected with COVID 19.
    - Intervention: Due to COVID 19 state's Shelter-In-Place laws, client agreed to be assisted over weekly phone calls. Supportive services to help client understand what anxiety is and identify immediate symptoms and coping strategies. Explanation on how thoughts influence on mood changes and behavior. Referral to medical assistance for medication management. Client was also assisted to deal with COVID 19 diagnosis; find coping strategies to mitigate anxiety symptoms.
    - Outcome: Client was able to follow recommendations to cope with anxiety and defeat distorted thoughts. She was also able to start medication treatment. Client was diagnosed with COVID 19 but was asymptomatic. Client was able to follow medical recommendations and avoided anxiety relapse. Client indicated that this process was very helpful as she felt supported to defeat her fears and especially better cope with the pandemic.

RT: Starting Date: 6/22/2020

- Female client from Belize. She was referred for the second time as she was having a hard time grieving the loss of her Mother.
    - Intervention: Due to COVID 19 state's Shelter-In-Place laws, client agreed to be assisted over weekly phone calls. Emotional support: psychoeducation of what grief represents and validation of array of emotions experienced during this process. Client was weekly assisted to avoid self-criticism and be aware of constant changes of mood and energy. Client was provided with suggestions to grief by practicing cultural/family rituals, vent about her loss and importance of her Mother in her life.
    - Outcome: Client has started to express she is becoming more adapted to the loss of her Mother by accepting the changes she is facing. Services still in process.

AR: Starting Date: 6/29/2020

- Female in her 50's from EL Salvador. Client requested assistance to overcome separation process and get back on her feet.
    - Intervention: Due to COVID 19 state's Shelter-In-Place laws, client agreed to be assisted over weekly phone calls. Client was helped to identify immediate goals and mood changes as well as patten of thoughts. Client was helped to identify possible pattern of dependency issues that sabotage her immediate goals.

- Outcome: client has started to respond effectively by focusing on her self-worth and on the goals, she deserves to achieve. Services still in process.

MM: Starting Date: 7/14/2020

- Female in her 40's from Mexico. Client was referred due to constant worries and possible anxiety symptoms.
  - Intervention: Due to COVID 19 state's Shelter-In-Place laws, client agreed to be assisted over weekly phone calls. Client was assisted to identify her symptoms to determine any mood challenges. Client was able to identify psychological as well as medical issues that needed clarification to provide better assistance. Client was referred with her doctor to rule out thyroid problems. Client can follow recommendations weekly.
  - Outcome: Service still in process.

PC: Starting date: 7/14/2020

- Female in her 30's from Mexico, was referred to services due to problems with her teenage daughter.
  - Intervention: Due to COVID 19 state's Shelter-In-Place laws, client agreed to be assisted over weekly phone calls. Client was assisted to identify immediate challenges with her daughter; psychoeducation on parenting issues: types of communication; how to talk to teenagers, determination of healthy time to interact with teenagers and issues to discuss.
  - Outcome: Client has started to share that her communication with her daughter has improved tremendously as her daughter thanks her for her change and dedication to her needs. Services still in process.

MA: Starting Date: 7/14/2020

- Female in her 50's. Client was referred due to possible depressive symptoms as client lives by herself.
  - Intervention: Due to COVID 19 state's Shelter-In-Place laws, client agreed to be assisted over weekly phone calls. Client was assisted to identify symptoms, psychoeducation on depression and coping strategies. Client was offered emotional support and case management to identify medical assistance and importance to maintain a healthy diet, medication intake and housing /food bank alternatives.
  - Outcome: Client was able to follow recommendations and symptoms of depression started to decrease. Client was also able to follow a better diet pattern and medication intake.

- During the past 2 weeks client stopped answering phone calls. Possible home visit will take place.

RT: Starting Date: 7/29/2020

- Female in her 40's from Mexico. Client was referred for possible PTSD.
  - Intervention: Due to COVID 19 state's Shelter-In-Place laws, client agreed to be assisted over weekly phone calls. During assessment it was determined that client may have Chronic PTSD and Major depression Disorder. She was assisted to find scale fee therapeutic services in the area; referral to medical evaluation in Richmond Clinic located in Macdonald Ave. Client was also referred to food bank assistance with Latina Center. While she waits for mental health services, client is being assisted to understand what PTSD and Depression mean; psychoeducational approach as well as motivational approach is being used to help client.
  - Outcome: Services still in progress.

GR: Starting Date: 7/31/2020

- Female in her 50's from El Salvador. Client requested assistance due to feelings of depression due to separation process. Client is an ex-participant in the circles of therapy provided at Latina Center.
  - Intervention: Due to COVID 19 state's Shelter-In-Place laws, client agreed to be assisted over weekly phone calls. Client is being assisted to identify main issues, symptoms, and goals. Psychoeducation on Depression and PTSD (client disclosed systems of multiple exposure of sexual abuse since teen years to adulthood).
  - Outcome: Services still in process.
- Woman in her 40's from Mexico; Issues presented: possible depression due to having parental issues with her daughter.
  - Intervention: Psychoeducation on what depression represents; self-esteem and what forgiveness means; parental tips.
  - Outcome: Case was transferred to therapist Eleana Coll due to conflict with schedule.
- Woman in her 30's from Venezuela; Issues presented: mood challenges (possible depression and anxiety due to changes in her environment); low self-esteem
  - Intervention: Definition of mood challenges because of important changes in life; alternative coping skills; Definition of what self-esteem is and its effect on her mood as well. Possible referral to the providers will be taken into consideration.
  - Outcome: Case was transferred to therapist Eleana Coll due to conflict with schedule.

PEI ANNUAL REPORTING FORM

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR: 19-20

Agency/Program Name: LifeLong Medical Care

Project (if applicable): SNAP

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 summarize the Scope of Services as outlined in the Service Work Plan. Please also address any other relevant activities or events that took place during the reporting period.

LifeLong Medical Care's SNAP program provides seniors in Richmond with opportunities for social engagement, creative expression, lifelong learning, and case management support. Program goals include reducing isolation and promoting feelings of wellness and self-efficacy; increasing trust and reducing reluctance to revealing unmet needs or accepting support services; improving quality of life by reducing loneliness and promoting friendships and connections with others; and improving access to mental health and social services for underserved populations.

Prior to COVID, our service model created safe and accessible spaces for seniors to come together for group activities and to meet in-person with a case manager. From July 2019 to March 2020, we provided case management, congregate activities, and referrals to mental health and community resources on-site at three housing developments: Nevin Plaza, Friendship Manor, and Harbour View Senior Apartments, as well as at the Native American Health Center. We offered an average of 10 on- site events per month. When COVID hit in March, we shifted to mainly virtual (telephone and Zoom) interactions and increased our emphasis on food distribution (described below).

Throughout the year, seniors facing isolation, depression, and other stressors benefited from opportunities for creative activities and supportive interactions with staff, whether face-to-face or over the phone. Highlights of pre-COVID group activities included creative movement, exercise, bilingual songs, discussion groups, tai chi, walking groups, Spanish classes, and arts & crafts, as well as memorial events for residents who passed away and an outing to visit a participant in the hospital.

Participants in the craft class enjoyed a fancy tea party in September, as well as a trip to the African American Museum for a special dollmaking event. Other special events included holiday music and crafts in December and shopping outings in February to FoodsCo, the 99 Cents store, Goodwill and the food pantry. All activities were based on interests expressed by participants.

Seniors who worked with LifeLong's case manager received needed resources as well as emotional support around grief and loss, family stress, medical issues, and other challenges. Common resource requests included food, durable medical equipment, glasses, and Vial of Life kits (used for advance care planning). The case manager also organized health education events, including a health fair in October and presentations by Vital Link, ACE Home Health & Hospice and Contra Costa Crisis Center. A second health fair organized in collaboration with the Native American Health Center was cancelled at the last minute due to Shelter-In-Place orders in March.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services. Please include:

Numbers served during the fiscal year:

SNAP served 150 people during FY 19-20.

Describe any adaptation of services due to COVID-19 that may be relevant:

Due to the Coronavirus pandemic, we made the following changes:

- Cancelled all in-person group activities and case management.
- Started weekly Zoom case management "office hours;"
- Distributed masks, gloves and toilet paper to those in need.
- Started weekly "check in" calls to SNAP consumers to assess physical, mental, and emotional well-being and offer companionship and supportive services.
- Partnered with the behavioral health team at the William Jenkins Health Center in Richmond (operated by SNAP's parent organization) to conduct outreach calls to high-risk older adult consumers, to assess well-being and offer support.
- Designed and delivered activity packets based on consumer interests (craft projects, books, Spanish language workbooks, etc.).

- Increased food distribution efforts - We have always provided groceries to consumers facing food insecurity, and when Shelter-In-Place started those numbers increased significantly. In March and early April, we helped consumers register for Senior Center meals, which we picked up and delivered weekly. We also purchased and delivered bags of groceries and registered 24 people for Meals on Wheels. Then, as more resources became available in April, we began offering meals weekly in partnership with Fare Community Kitchen and Bridge Kitchen, as well as groceries in partnership with Sojourner Church Presbyterian Church. In total, we made 289 deliveries of meals and/or groceries during April – June.
- Started "socially distanced" wellness checks during food and supply drop-offs; and
- Adapted our annual satisfaction survey from a confidential paper form to a telephone call (conducted by a colleague not associated with SNAP).

How are participants identified as needing mental health assessment or treatment?

The SNAP enrollment form includes questions about mental health symptoms and whether they would like support to access services. The enrollment form also screens for depression using the PHQ-2. If the resident is unable to complete a form, then staff asks these questions verbally. In addition to this formal process, we also check in with participants throughout the year to identify emerging issues.

List of indicators measured, including how often data was collected and analyzed:

SNAP measures mood, isolation, and program satisfaction using an annual survey that we developed with consumer input. Due to Shelter-In-Place orders, we adapted our paper form into a shorter telephone survey conducted by an independent colleague (unknown to consumers and not associated with SNAP).

We documented 41 responses to the telephone survey. Results were very positive, with all respondents reporting that they were very (79%) or somewhat (21%) satisfied with SNAP overall. 100% were satisfied with the food distribution portion of SNAP during Shelter-in- Place.

A summary of survey responses is provided below:

	Yes (Goal = 75%)	No	Maybe / Not Sure
Before COVID, would you say that SNAP helped improve your mood? *(N=34 people who participated prior to S-I-P)*	79%	12%	9%

Before COVID, do you think that SNAP helped you feel more connected to others (less isolated)? *(N=32 people who participated prior to S-I-P)*	88%	6%	13%
Now, during COVID, do you feel that SNAP helps with your mood and feeling connected to other people? *(N=42)*	74%	7%	19%

Consumer comments gathered during the survey are included below, under "Valuable Perspectives."

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.

Pre-COVID, SNAP staff outreached to all residents of Nevin Plaza, Friendship Manor and Harbour View each month with fliers posted in public areas and delivered door-to-door. Staff talked to residents about the program, and current participants encouraged others to attend or told staff when they thought someone might be interested or could benefit. It often took up to several months before a resident decided to attend, and during that time staff continued to reach out to build trust and offer support. These informal outreach strategies worked well given the contained nature of the community and the preferences of residents. Now, during Shelter-in-Place, this outreach happens through SNAP's weekly food distribution, which draws SNAP members as well as residents who were not previously involved with SNAP.

Once a resident is willing, we 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.

For residents who are open to mental health or community support referrals, the SNAP case manager checks in regularly to determine if the referral was met. She also checks in with participants with established mental health services, to offer support should barriers to access arise.

The average length of time between referral and engagement with mental health resources was approximately eight weeks. This estimate is based on the date a referral was made and the date that a consumer reported to the SNAP Case Manager that they followed up with the referral (n=7).

Another eight consumers declined mental health referrals suggested by SNAP staff.

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

Please refer to Aggregate Data Reporting Form

CULTURAL RESPONSIVENESS:

How have services been informed and structured to meet the diverse cultural needs of your clients/members/participants? What is being done by your organization to support cultural responsiveness both within the workforce and for those served by your organization?

LifeLong is very intentional about hiring employees and contractors that reflect the racial identities, and to some extent lived experience, of the populations who utilize our programs. SNAP works with mainly African-American consumers, and our staff this year included an African-American Activity Coordinator, Case Manager (originally from Richmond), craft teacher and men's group facilitator, as well as a Latina music and movement teacher. Staff develops the program based on consumer preferences, which we gather through informal focus groups (pre-COVID) and surveys.

SNAP's manager, who is white, is participating in a program called "Whiteness at Work," designed to identify and address personal and organizational bias including white-dominant workplace culture.

As an organization, LifeLong has launched a racial equity initiative to identify and eliminate polices, practices and cultural norms that reinforce differences in workplace opportunities and experiences based on race.

COLLABORATIVE PRACTICES:

Describe how you are working with any other agencies or organizations to better serve clients/members/participants? If this is currently not being done, please describe any effort to build relationships with other community service providers?

SNAP collaborates with the following agencies and organizations:

- Native American Wellness Center: activity programs (monthly pre-COVID).
- Nevin Plaza Resident Council: to identify needs in the community and coordinate around programming.

- William Jenkins Health Center: outreach to isolated older adult behavioral health consumers in West County during the COVID-10 pandemic.
- Sojourner Truth Presbyterian Church: food resources for consumers.
- Fare Community Kitchen: food resources for consumers.
- Bridge Community Kitchen: food resources for consumers.
- Contra Costa Adult Protective Services Multidisciplinary Team: multidisciplinary support in high-risk cases.

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:

Wellness, recovery, resilience: SNAP staff create inclusive, welcoming, and accepting environments where participants 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. During COVID-19, in-person activities are limited but SNAP staff are still able to check in via telephone and during on-site food distribution.

Access and linkage: SNAP offers highly accessible services in the buildings where our target population lives, with extensive telephone contact added during Shelter in Place. Staff 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 andfacilitates 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.

Timely access for underserved populations: Services are provided directly in the building or local neighborhood (and now over the phone) to promote accessibility for elderly residents; culturally sensitive services are provided for this low-income and primarily African-American population.

Non-stigmatizing, non-discriminatory: Residents are accepted into SNAP as they are. When we operated in-person services, SNAP facilitators created group environments that supported diverse social thought processes, energy levels, and abilities, allowing each participant's strength to surface and shine. Participants could come and go from groups as they needed to, and it was perfectly acceptable to participate or not. Participants tended to talk

freely about their mental health issues because they were comfortable and knew they are not being judged. While we are mainly “remote” now, we continue to support consumers in a manner than is non-stigmatizing and non-discriminatory (and have normalized food distribution to reduce stigma around food insecurity).

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 the following comments from SNAP participants in this year’s annual satisfaction survey.

Prompt: Is there anything else you’d like to say about benefits of SNAP (how SNAP has helped you)?

I am very satisfied about SNAP services. It has been very helpful to me especially during this time when my daughter can't visit. Juana and Luz always check on me and help get food.
SNAP has been very helpful. I've received food from La Juana, and a pair of glasses from Rosilyne when I can't see. I participate in SNAP every week or every other week unless I have a doctor's appointment.
I really enjoy the social activities with La Juana and Luz, especially that one time when we took ferry to San Francisco. It was my first time getting on a ferry and it'd been a while since I went to San Francisco! I also enjoyed when we went to the buffet.
I love all the social activities with La Juana and Luz like arts, music, and outings to different places. Sometimes we would go to nursing homes and visit other disabled seniors, and they would ask us to go back! I did not work with Rosilyne a lot, but she always talked with us. I am very satisfied with SNAP.
SNAP has helped me so many ways. It helps me have good exercises and feel less lonely. I used to have anxiety and was taking medication for that. I miss the social activities so much like bingo and singing.
SNAP helps me get along with other people. Learn to do different activities. We went to movies and ferry to San Francisco etc. My caregiver and I miss everyone at SNAP.

I like the team - they are sensitive and personable. SNAP helps me do more physical activities with La Juana, exercise my brain and learn Spanish with Luz, and do arts and craft - doll making is my favorite thing! We also went to movies and trips.
All of staff are very helpful.
I am not very involved with SNAP but have worked with Rosilyne to solve different problems. She is very nice and welcoming. I like her a lot.
I appreciate this program especially it is for us senior citizens. I moved here for 4 years and knew only a few people. Through SNAP I can meet other people in the same building.
SNAP helps me tremendously. The staff are amazing and always reaching out to us. Especially during this time with COVID-19, they still come and reach out, making sure everyone is taken care of.
I am very satisfied with the program. The staff are amazing, especially Rosilyne. She is very wonderful. She helped me so much. She helped me get into the hospital when I was sick and sign up with East Bay Paratransit. SNAP gives me something to do and socialize with other ladies in the building.
I joined SNAP during COVID and the Shelter-In-Place order and have been receiving food/groceries. I am very satisfied with the program. Would look forward to getting more involved.
I am pleased with the program. Joined SNAP about a year ago and am involved. I am active and doesn't need it, but it is very helpful to other folks who have history of stroke and can't get out of the house.
I'd like to see SNAP continue at Harbour View. I can't wait for our classes to resume after COVID. SNAP makes me and my neighbors a part of something. It changes my mood, makes me feel less isolated, and helps socialize with my neighbors. I am looking forward to the classes, outings, movies and dinner.
When COVID-19 is over, I would love to see the ladies again. They bring so much joy to me and other ladies in the building.
SNAP is a lifesaver for us. It keeps us going and gives us something to do like bingo, exercise, and Spanish classes. I love that they are a help to us especially at this time they still come out and distribute food and meals and update us with news. They are always so kind.

I like that SNAP program has no requirements to join and is open to everyone. It is useful and free, and we can use it anytime and whenever we want to.
SNAP helps me a lot. I've been very involved since SNAP is here at Nevin Plaza, helping set up a brown bag program once a month. I was friend with the previous arts and craft teacher; I am not an art person, but she encouraged us to do what we can. Through SNAP, we went to different organizations, home care and senior centers.
It's a good program
I am very involved with SNAP. I tried to join every meeting they have. The staff there Rosilyne, La Juana and Luz are very nice.
SNAP is a good program. I like the ladies there.
The staff are doing a good job. SNAP is a program to keep especially for seniors who are isolated and lonely. I would go and sit in the meetings sometimes.
SNAP gives us something to do and something to occupy our mind. It is an outlet for us those who stay at home. I got to mingle with other residents. It helps me a lot. The staff are very nice!
Joined SNAP since shelter in place. Staff are very helpful and informative.
The food is a big help. Because I can't stand too long, the meals come in handy.
It helps me with a lot of things - we have games, exercise, and treat other people nicely. Communication is good between the staff and participants. I like SNAP.
I joined SNAP right around Shelter-In-Place started, and I got the food boxes. It's important for us especially when everyone is staying at home now, the food box helps us make a meal and stuff. I don't usually eat the meals because of my asthma but I give them out to other people.
I didn't join the meetings often and mainly have received food. But I think SNAP has helped other people in the building a lot. I wouldn't say it helps me connect with others, but it definitely improves my mood.
The staff are very understanding and thoughtful. They listen to you and understand your emotions; La Juana and Rosilyne especially are very kind to me.

PEI ANNUAL REPORTING FORM

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS REPORTING FORMFISCAL YEAR: 2019-2020

Agency/Program Name: Native American Health Center- Native Wellness Center Richmond

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.

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 2019 to June 2020, 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 number of potential responders. NAHC reached a total of 68 unduplicated members by the end of June 2020. In comparison to contract year 18- 19, we seen a significant decrease in services due to the start of the

pandemic. Many of the events we attend and programs we offer take place in the spring and summer months and due to the pandemic, we were unable to provide these services.

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. Prior to the pandemic, NAHC was in the process of converting our data from paper to electronic records via the Smartsheets application. This process was unable to be completed as we were unable to work on-site, and the focus had to be shifted to responding to the pandemic and other crisis that had developed. There was a total of 16 behavioral health related referrals processed during this contract year. At this time, we are unable to provide complete data on the quantity of non-behavioral health related referrals processed during this time.

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 regarding 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 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 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 can 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 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 can learn about the culture and the reason why certain practices are gender exclusive. This is part of the cultural education component of our work.

In response to the pandemic, NAHC has moved our groups to a virtual platform. We now offer weekly classes and workshop through the Ringcentral platform. New members are required to pre-register and adhere to our virtual group guidelines. Our data has shown this transition has had both negative and positive impacts on our program. In terms of deliverables, the program has seen a significant decrease in numbers because we are unable to open our doors and provide our normal services. Many of our members lack access to electronic devices, cell phones, and even adequate housing. This has created a communication barrier and a huge challenge for the staff to address their needs and provide crucial services. We also serve a large elder population in Richmond and many of our members have since declined services until they can return in person. Some positives outcomes since the transition include reaching a larger target population, members who experience transportation barriers and/or have mobility issues do not find our program to be more accessible, and we are not able to record lessons and workshops to send out to those who have missed a class or are unable to attend due to scheduling conflicts.

Son Jarocho:

This was a workshop that focused on Son Jarocho folk music from Vera Cruz, Mexico. This class was added to our program to reflect the traditions and practice of indigenous communities in Mexico and allowed us the opportunity to show more inclusiveness for indigenous peoples from Latin American countries. Songs, dance, and the use of instruments were taught throughout the workshop and a community celebration was held at the end of the class.

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.

EVENTS

Traditional Medicine Workshop:

This workshop was provided to youth and their families in collaboration with Building Blocks for Kids. It was offered at Garcia Belding Park for during their summer program. We had a total of 14 participants engage in a traditional medicine workshop and medicine bundling activity. The goal was to educate participants in traditional Native medicines and holistic approaches to wellness. Our workshop included Sage, Cedar, Sweet grass, and tobacco as well as information on the uses of lavender and other herbs. We also used this as an opportunity to recruit new members and assess for needs in the community.

Dream Catcher Making workshop:

This workshop was also a collaboration with BBK. The purpose was to teach the community how to make Dreamcatchers as well as educate them on their meaning and traditional use. We created a workshop curriculum and provided materials for each member to complete on dreamcatcher for them to take home. A total number of 16 people participated in the workshop.

Indigenous Walk for Sobriety:

Every year NAHC collaborates with California's chapter of the United Urban Warrior Movement to organize the Annual Indigenous Peoples Walk for Sobriety. This year was our 5th Annual. Participants walk to bring awareness to the impact of the use of alcohol and other drugs have on our community and the need for support. We walk from Grocery Outlet on Macdonald Ave. to our host location. This year we gathered at St. Luke's Methodist Church where City leaders, local politicians, community activists, and community members were honored and spoke on the impact alcohol and other drugs have on our communities and what we can do to support. Community members gave testimonials on their personal experiences and we held ceremony. During this event lunch and a health fair were also organized where local organizations met with and provided resources to the community. A total of 14 community members personal met with NAHC staff to discuss our programming and how we can support. Overall, there were over 50 people in attendance. Due to the inability to get information on every attendee we did not reflect the total number in our service summary for the event.

Indigenous Peoples day Pow Wow

Health and Wellness Fair- Lifelong Medical SNAP Program Collaboration:

Over 21 community members in attendance. This health and wellness fair was organized by both NAHC and Lifelong Medical in response to needs expressed by members for resources and necessities. We provided members the opportunity to receive basic needs items like canned foods, fruits, and vegetables, hygiene products, clothes, and household items. All the items distributed were either donations collected or purchased by both programs. Resource tables and information booths from various organization were present including Contra Costa Crisis

Center, Lifelong Medical, NAHC, Homehealth and Hospice, and Medical representatives. NAHC also provided a musical workshop by our Son Jarocho class instructor and Traditional Drum piece. One highlight from this event is that we were able to serve a large part of our homeless clients and provide them with clothing, hygiene products, and a free lunch.

Annual Halloween Celebration and Wellness fair:

The purpose of our Annual Halloween event is to engage with more youth and families and provide a safe place for youth to have fun as opposed to traditional “trick or treating”. We offer a range of activities like pumpkin carving, art workshops, distribute candy bags, provide a meal, and a traditional drum session. A total of 17 members were in attendance.

Richmond Powwow- Sponsorship and Outreach

Mental Health First-Aid Training:

A total of 19 participants attended this training. Jennifer Bruggeman from Contra Costa Behavioral Health Services facilitated this training in November of 2020. Direct service staff from NAHC, staff and interns from Lifelong Medical, and community members attended the training and received their certification.

NAHC’s Richmond site has had a vision in moving towards providing mental health specific trainings to the community. This was our first training that would pioneer this component of our programming.

QPR Training- Community

Talking Circle with Theda Newbreast:

Traditional Female Consultant, Theda Newbreast facilitated our quarterly talking circle in November. A total of 5 members attended this event. The topics of focus were substance use prevention, healing, resiliency, and use of traditional medicines.

Annual Harvest Celebration:

A total of 9 members attended our annual Harvest Dinner.

AICRC Pow wow:

A total of 42 contacts were made with potential responders. Staff met with members of the community over a duration of 14 hours. This event is part of our yearly outreach calendar and is used as an opportunity to recruit new members and assess and identify needs within our target population.

Richmond's Annual Pow wow:

This year NAHC had the honor of being a sponsor in our Annual Pow wow. Funds were used to sponsor the Drum competition and support with other associated costs. The Richmond Pow wow is an extremely valuable event to the Native American population in Contra Costa because they are very little programs and services in the area. It allows local Native a space to celebrate and embrace our culture and traditions as well as strengthen our community. Staff also conducted outreach at this event and had a total of 12 contacts with potential responders.

Indigenous Peoples Day Powwow:

This event was an outdoor Outreach opportunity to recruit new members and give information on the programming that NAHC offers. It was held in Berkeley at Peoples' Park and this is an Annual event that we attend. We connected with a total of 58 potential responders.

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:

- Engage 150 community members through prevention service programming.
- 65% of our members utilizing referral services will be successful in accessing (connecting with) services over a 12-month period.
- Program staff will participate in 20 outreach events or activities throughout the course of the year.
- 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:
- Members will have increased access to prevention activities and mental health support.
- Members will increase their engagement in NAHC mental health prevention and treatment services.
- NAHC will engage a diverse population of first responders throughout Contra Costa County.
- Members, Peers, and Staff will be trained in behavioral health related topics including but not limited to Mental Health First Aid.

Due to the pandemic, we were not able to capture this data. Traditionally, we would administer surveys to our members at the beginning and near the end of our fiscal year but due to the

pandemic we were not able to develop workflows to accurately capture this information safely and regarding HIPPAA compliance.

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.

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. Regarding behavioral health referrals specifically, NAHC Richmond partners with several 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 several 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 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. Therefore, 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 city, 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 often express their gratitude for the program and staff. The center plays a vital role in the community for support and a safe space. We created a drop-in space where members can come in and have a safe space to relax and remove themselves from environments that may cause stress or be triggering them. Many of our members are experiencing homelessness and/or in recovery and have expressed to staff their gratitude for creating a space that supports them. Our site provides light meals and coffee, clothing, hygiene products, blankets, and anything else they may need to get through the day. Unfortunately, we have not been able to figure out a safe way to continue to provide this service to those who are in need due to the pandemic.

Peer and Family Centered Programs

Contra Costa Behavioral Health Services

Office for Consumer Empowerment

As submitted for EQRO 2020-21

CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Peer and Family Centered Programs

The Office for Consumer Empowerment (OCE; see Appendix A for brochure and program overviews) holds several peer wellness and recovery skills trainings and social inclusion trainings focusing upon persons receiving services and family members, including peer provider monthly trainings. The Family Services Coordinators, in collaboration with OCE, also hold monthly and periodic trainings for Family Partners in the children's system of care and Family Support Workers in the adult system of care. The following describes OCE programs.

Social Inclusion

Contra Costa Behavioral Health Services' Committee for Social Inclusion is a community alliance of peers with lived experience of behavioral health challenges, including co-occurring challenges such as substance use and homelessness. Family members of persons receiving behavioral health services and behavioral health providers are also part of this alliance. Committee members collaborate to educate the public on the facts about behavioral health and co-occurring challenges, emphasizing the ability of people to recover and achieve wellness. Social Inclusion promotes acceptance of persons with lived behavioral health experience within the community. In 2020, there were 11 Social Inclusion presentations. The April Social Inclusion meeting was cancelled due to COVID-19. All subsequent meetings through the end of the year were facilitated virtually via the online video conferencing platform Zoom. The Mental Health Services Act (MHSA) Virtual Community Forum on the Evolution of the Peer Movement took the place of the September Social Inclusion meeting. Please refer to the Social Inclusion committee flyers and meeting packets (Appendix B).

PhotoVoice

PhotoVoice is a social advocacy tool that people overcoming discrimination and lack of opportunities can use to share their experiences through a combination of photography and narrative. It is a technique that enables community residents of all ages and languages to share information about their communities through pictures. PhotoVoice accomplishes the following objectives:

- Engages peers in documenting strengths and problems
- Promotes dialogue about important issues
- Educates the broader community about behavioral health challenges

PhotoVoice draws upon the principles of documentary photography as a means of using visual representation for advocacy and social change. Images serve as signifiers of culture, highlighting values and expectations of individuals, communities, and society. What participants choose to photograph, when and how, is shaped by community values as well as how participants would like to reflect their lives. Images prompt emotions, thoughts and experiences in ways that

narrative alone cannot. Narrative and image are united in PhotoVoice as the expression of artists as participants in ten-week classes using curriculum developed by Boston University Center for Psychiatric Rehabilitation.

In 2020, the following goals were achieved:

- Developing and leading a four-hour PhotoVoice facilitator training for staff from Contra Costa Health, Housing and Homeless Services division (H3). Five H3 staff members participated in the training.
- Successful PhotoVoice class and artwork from H3 facilitators
- Samples of H3 PhotoVoice exhibition pieces displayed in a PowerPoint presentation at the November Committee for Social Inclusion meeting in acknowledgement of Homelessness Awareness Month in Contra Costa County
- January and February PhotoVoice Subcommittee meetings facilitated to promote PhotoVoice classes, offering participation in activities taken from PhotoVoice curriculum and encouraging critical thinking around prejudice, discrimination and stigma. There were 8-10 participants per meeting.
- Planning for possible transition of PhotoVoice Subcommittee meetings from in-person to virtual format on Zoom in 2021.

(See Appendix C for PhotoVoice brochure, subcommittee agendas and sign-in sheets, facilitator training agenda, and H3 PhotoVoice PowerPoint.)

Wellness and Recovery Education for Acceptance, Choice, and Hope (WREACH)

WREACH, a subcommittee of the Committee for Social Inclusion, is a speakers' bureau dedicated to reducing stigma and encouraging awareness of lived behavioral health experience to transform how the community within Contra Costa County views behavioral health and recovery. It is made up of persons with lived behavioral health experience, including peers, family members, and providers, in Contra Costa County. What binds the members of this group together is that they share in their monthly meetings the common bond of experience living with mental health or substance use challenges and/or homelessness. Speakers utilize their wealth of knowledge, drawing from their personal experiences, to educate the community and promote wellness.

WREACH held 2 subcommittee meetings in 2020 with meetings thereafter suspended due to COVID-19. Resumption of subcommittee meetings via Zoom is currently under consideration. Shelter-in-place guidelines have necessitated the scaling back of WREACH presentations. Before COVID-19 restrictions took effect, there were 2 in-person WREACH presentations to local venues that included introduction to the speaker's bureau and/or presenters sharing their stories. There was also a virtual WREACH presentation facilitated over Zoom on November 3rd. Additionally, the WREACH Lead Facilitator created and facilitated 4 live presentations featuring

a rap song and PowerPoint that they developed incorporating their personal recovery story. This presentation was also recorded and disseminated to county employees and representatives from community-based organizations for the purposes of further exhibition to help reduce stigma, educate the public, or to foster hope in individuals who are living with behavioral health challenges. There was 1 Tell Your Story Workshop in 2020. Facilitation of the Tell Your Story Workshop over Zoom is also under consideration. (See Appendix D for WREACH brochure and subcommittee meeting agendas.)

Wellness Recovery Action Plan (WRAP) Program

The WRAP program involves groups once a week over the course of 8 to 10 weeks, 2 to 2 ½ hours per group. During the process of developing a WRAP Plan, group members create a wellness toolbox in which they place "tools" which help them stay well. WRAP includes a Daily Maintenance Plan. WRAP helps group participant to identify triggers and create a triggers action plan. Participants identify early warning signs and create an early warning signs action plan. The next part of WRAP involves making a list of what it is like when things are breaking down and creating an action plan. WRAP allows group participants to develop a crisis plan. The crisis plan in WRAP can sometimes be used as an alternative to an advanced directive. After that, they create a post- crisis plan which is used to begin the transition into wellness.

In 2020, the following goals were achieved:

- WRAP I certifications for personal WRAP for SPIRIT 2020 graduates
- Martinez Detention MH Services prior to COVID-19 restrictions: 2 eight-week groups with 3-4 participants and 7 one-on-one WRAP I certifications
- Behavioral Health Court prior to COVID-19 restrictions: 1 ten-week group with 3-4 participants
- Development of Work for WRAP Zoom groups to assist peer service providers
- OCE facilitation of 2 ten-week Work for WRAP Zoom groups with peer provider co-facilitator from Forensic MH Services: 6-8 participants per group
- OCE continues to maintain supply of WRAP materials to assist any certified WRAP facilitators working in County-operated programs for use in WRAP groups and/or one-on- one facilitation.

(See Appendix E for WRAP for Work flyer and attendance sheet.)

Service Provider Individualized Recovery Intensive Training (SPIRIT) Program

The Service Provider Individualized Recovery Intensive Training (SPIRIT) program is a series of three college courses totaling 9 credit units in a unique collaboration including Contra Costa Behavioral Health Services, Contra Costa College and over 30 county behavioral health provider and/or behavioral health peer and family-run organizations. The six-month class and internship

are instructed by OCE peer instructors and guest speakers to provide students with the skills they need to become peer providers. Due to the COVID-19 Shelter-in-Place order in Contra Costa County issued on March 16th, the SPIRIT 2020 class transitioned from an in-person program to virtual format using the Zoom online video conferencing and Canvas learning management system platforms. The SPIRIT staff provided technical support to the students when technical challenges arose. Fortunately, all the students were able to access the course online as some had personal devices that they were able to use, while others were loaned a Chromebook laptop for the semester issued by Contra Costa College. The second module of the program, SPIRIT II, commenced virtually on the Zoom and Canvas platforms from March 23rd through May 20th totaling 16 class sessions.

Under normal circumstances, the last module of SPIRIT (SPIRIT-III) is completed during the college's Summer Semester. However, under direction from Contra Costa College administration, a recess period took place in 2020 between the end of SPIRIT-II on May 20th and the beginning of SPIRIT-III on August 24th at the start of the Fall Semester. This extended transition allowed the program staff to tailor the SPIRIT III internship phase to an online/hybrid format.

When SPIRIT III began, the students attended their internships with various human services agencies using online platforms with supplemental activities. COVID-19 safety and health measures were observed during this period. SPIRIT III convened from August 24th through September 28th totaling 6 class sessions as well as a minimum of 60 hours of virtual work study/internship completion. Upon completion of all three modules, SPIRIT 2020 students attended a drive-thru graduation certificate ceremony on September 29th that fully complied with COVID-19 health and safety guidelines. A virtual graduation ceremony took place on October 5th using the Zoom platform. All SPIRIT graduates receive a Certificate of Achievement, which is a requirement to work for Contra Costa County as a peer provider. A total of 38 students graduated in 2020. (See Appendix F for SPIRIT syllabi and graduation flyer and program.)

SPIRIT Vocational Program

SPIRIT Peer Vocational Specialists coordinate and place SPIRIT students into internship positions in County-operated programs and Community-based Organizations (CBOs) by outreaching to and recruiting representatives to participate in the Virtual SPIRIT Work-Study Fair, providing ongoing support to the students before and during internships to ensure a positive outcome and experience, conducting site visits to support and meet the needs of both the students and the agency, and providing additional training on internship ethics and professionalism. During 2020, Peer Vocational Specialists managed to maintain partnership and support with collaborating agencies and transitioned what had historically been an in-person Work Study Fair

and it to the first ever “Virtual Work Study Fair.” This Virtual Work Study Fair required support and commitment to flexibility from partnering agencies.

Prior to conducting the Virtual Work Study Fair, Peer Vocational Specialists coordinated 32 meetings with representatives from collaborating CBOs and County-operated programs to obtain commitment to participate in this temporary transition to virtual/in-person/hybrid internship. To support this effort, the SPIRIT Peer Vocational Specialists identified virtual-internship and direct- internship tasks and duties, as well as local community advocacy and educational meetings pertaining to the behavioral health system of care to support agencies and students in utilizing their skills learned. This information was shared with the agencies. After commitment calls, Peer Vocational Specialists confirmed 25 collaborating agencies to participate in the Virtual Work Study Fair, leading to internships. This commitment allowed placement of all 39 interning students. Nine agencies engaged in virtual internships with the remaining 16 agencies engaging in remote-hybrid internships.

The COVID-19 pandemic affected some of the partnering agencies, as they had to temporarily forfeit the internship portion of the program due to agencies needing to reevaluate how the pandemic would affect their funding, staff tasks, and workload. Nonetheless, the graduating cohort was able to apply their learned skills amid a pandemic. During the 2020 class and after graduation, Peer Vocational Specialists continued to motivate and mentor students, provide job resources and monthly vocational trainings, and assist with resumes, cover letters, and mock interviews, while also working with hiring agencies to send the appropriate resumes that fit their job requirements.

Monthly vocational trainings are conducted and designed to provide ongoing educational support for current SPIRIT students and past graduates. Trainings include presenters covering various topics pertaining to the behavioral health system of care. Topics are intended to strengthen skills of individuals looking for work or currently working within County-operated programs and CBOs.

During 2020, 10 monthly trainings were convened to educate current SPIRIT students, past graduates and peer providers currently working in the behavioral health field. SPIRIT vocational training attendance totaled approximately 280 individuals (some of which were duplicated) that attended the trainings.

<u>Monthly trainings held in 2020 facilitated by:</u>

SPIRIT Vocational Program and collaborating Behavioral Health Partners

- January – Motivational Interviewing
- February – Cultural Sensitivity Workshop

- March – Motivational Interviewing II – Cancelled due to COVID-19 April – Ways to Cope with Feelings Related To COVID-19
- June – Weekly Summer Series, Peer Support Core Competencies from Senate Bill 803
    - Week One (June 22nd) and Week Two (June 29th)
- July – Weekly Summer Series, Peer Support Core Competencies from Senate Bill 803
    - Week Three (July 6th) and Week Four (July 13th) August – SPIRIT III Internship Prep & Forms
- September – No training held due to MHSA Community Forum on Evolution of the Peer Movement and due to SPIRIT Graduation
- October – Multicultural Layers of Identity
- November – Navigating COVID-19 & Holiday Community Resources

Employment Placements:

Peer Vocational Specialists serve as a liaison for SPIRIT graduates and employers, and track employment/volunteer status as it pertains to vocational placement into the behavioral health field. 19 placements were made in 2020, 18 graduates were placed into paid positions and 1 graduate into a volunteer position. 13 of the graduates placed were of the 2020 cohort.

Outreach and tabling in all regions of the county:

- Feb 18th – Putnam Clubhouse Birthday Celebration
- Sept 23rd – Evolution of the Peer Movement MHSA Forum

(See Appendix G for training flyers and attendance records.)

Overcoming Transportation Barriers

The Overcoming Transportation Barriers program is a systematic approach to develop an effective client/family/caregiver-driven transportation infrastructure that supports the entire mental health system of care. The goals of the Overcoming Transportation Barriers program are to:

- Improve access to mental health services.
- Improve transit system navigation.
- Improve independent living and self-management skills among clients.

The target population is clients of all ages, families, and caregivers served by the County-operated mental health clinics. Staff for the program consist of 2 Commute Navigation Specialists (CNSs), who are also Community Support Workers (i.e., peers).

This year's goals were to focus on three areas:

- Flex Fund
- One-on-One Peer Support
- Pilot a Ride Share Program

First, Phase One, known as Overcoming Transportations Barriers Flex Fund: 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. Some examples of flex funding will be to cover the cost of a new tire or a loaded Clipper card to provide fare to and from appointments or groups.

The OTB Flex Fund piloted at the Central County Adult Mental Health Clinic started in January with a handful of flex fund requests and was halted in March due to the Shelter-in-Place restrictions.

However, in that short period of time each request submitted was completed at about an average of a week's time. The project started again once restrictions were eased, and presentations to clinics and programs are in progress.

Second, Phase Two will be for a CNS to provide one-on-one peer support travel training to clients by riding public transportation together. Referrals for this program will come from providers within the adult and children's system of care. Phase Two has been put on hold due to the shutdown and Shelter- in-Place.

Third, Phase Three will be to pilot a rideshare program with a small, targeted group. This is still in the conceptual and discussion phase. The OTB workgroup and the CCBHS Quality Improvement & Quality Assurance team will continue to research methods, costs and consult with the project administrator. The rideshare program is currently being piloted in Contra Costa Public Health for clients of the Whole Person Care initiative. Phase Three was put on hold due to the Shelter-in-Place.

Due to staffing changes where one of the two CNS's was promoted to work in the Children's Mental Health System of Care, and the pandemic which led to the Shelter-in-Place restrictions, the project suspended its 1:1 peer travel training program and the Flex Fund project that had just started in January. During the pandemic, the Commute Navigation Specialist acted as a liaison between county Behavioral Health staff and transit authorities to analyze existing County transportation and public transit resources by keeping participants up to date on the changes in transit systems during the pandemic via email to the distribution list for the Transportation Subcommittee, which OTB staff facilitates bi-monthly under the umbrella of the Committee for Social Inclusion. Staff also presents updates and announcements regularly at Social Inclusion meetings.

As a result of feedback by clients in the Transportation Subcommittee, physical wallet/pocket cards were created for clients who experience high stress situations or need a quick coping

strategy. Referenced coping strategies on the cards included: meditation, deep breathing, riding with friends, prayer, listening to music, journaling, reading, and practicing a hobby. Cards were distributed at all CCBHS outpatient clinics and included with bus vouchers upon request. The OTB workgroup revised the wallet cards with recommendations and input from the subcommittee into trifold wallet cards and are now provided in both English and Spanish. The OTB brochure that outlines the available services and resources continues to be distributed throughout the clinics and in the welcoming packets for new clients.

Additionally, a request was made to pilot Transportation Packets for new clients to be provided in the East County Adult Mental Health Clinic. The packets are prepared in English and Spanish contains a welcoming letter from the Commute Navigation Specialists and an ADA Paratransit application, introduction to BART, transit schedules, Regional Transit Connection (RTC) Discount ID Card application, OTB brochure and OTB trifold cards.

During Shelter-in-Place, OTB staff transitioned the Transportation Subcommittee meetings to virtual format via Zoom. The program continued bi-weekly planning meetings and planned and facilitated 4 of 6 community subcommittee meetings. At the community subcommittee meetings, it was noted that we gained new participants and lost our participants who live in congregate care that are required to stay in at home to minimize transmission risk. After asking the subcommittee their thoughts on keeping the meetings via Zoom after the Shelter-in-Place, participants agreed and requested to have an option to attend either physically or virtually. This way if a participant isn't feeling well, they can still receive the support from their peers and stay informed.

In the early summer, one of the two Commute Navigation Specialist's had been promoted to work in the Children's System of Care. Currently the program is operating with 1 FTE and has requested freeze approval to backfill the other position. The OTB workgroup will continue to monitor concerns shared by clients while accessing public transit and other transportation resources and staff a transportation hotline for clients and families/caregivers to seek out support.

(See Appendix H for subcommittee meeting agendas and flyers and resource brochures.)

In addition, OCE produces and disseminates the Peer Perspectives newsletter. (See Appendix I for the Winter and Summer 2020 editions.)

PEI ANNUAL REPORTING FORM

PREVENTION REPORTING FORM

FISCAL YEAR: 2019-2020

Agency/Program Name: People Who Care Children Association

Project: PWC Clinical Success After-School Program

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 summarize the Scope of Services as outlined in the Service Work Plan. Please also address any other relevant activities or events that took place during the reporting period.

For the first 3 quarters of the 2019-20 school year, our program flourished, building new momentum amongst the student population at Pittsburg's alternative high school site, Black Diamond. Having hired a new instructor and Black Diamond teacher, the word spread quickly about our program offerings and we welcomed many new faces. Our teacher, mental health specialist, and clinician worked in concert to provide a program that engaged clients intellectually, creatively, and most important to our work, emotionally. Each week, students engaged in learning experiences that built transferable, 21st century skills that will undoubtedly serve them in future professional contexts. They learned about entrepreneurship, collaborating effectively, professional communication, and assessing needs in a community. In racially and sexually heterogenous groups, they created original business ideas and learned how to write full-length professional business plans and pitch presentations. They practiced public speaking and ultimately presented their work for a panel of professionals from the business community. We offered trainings for our clients and community members to receive training and employment as census workers. We invited guest teachers from Wells Fargo who came and led weekly workshops for clients around financial literacy and planning. We are incredibly proud of the breadth and quality of our program offerings that all work to build key competencies and spark interests that are crucial for later success in life. However, the fundamental difference that sets PWC apart from any other after-school program in the area is our focus, commitment, and ability to provide mental and emotional health services to young people who need it. The

lack of sufficient counseling in schools and/or affordable options outside of school, is no secret. This is especially significant in our adolescent population who often do not and/or cannot receive services outside of school due to lack of familial or financial support. This is compounded by the negative associations many have with mental health care and therapy and associated stigma/shame. At PWC, we believe counseling and emotional health is the foundation upon which human being build the infrastructure necessary to live healthy, fulfilling lives and the strength, resilience, and skills to handle the hardest parts of life. Therefore, at PWC, mental health support, access to counseling, and emotional skill-building is at the very center of the work we do: it is an essential piece of our program that to varying degrees is embedded into every decision, lesson, and process. We provide access and normalize receiving care because it is for everyone.

Due to the pandemic, school closures, and the consequent disconnection students are experiencing from school and communities of support, at-risk youth are in a vulnerable position. PWC provided necessary access to mental health support for students most at-risk in Pittsburg at the time. School failure, disengagement, and adverse childhood events (ACEs) are common in our community. Thus, school closure poses a very real threat to more than their physical health: it threatens their emotional well- being, their likelihood of graduation, and their futures. The likelihood of recidivism into or development of failure and disengagement due to separation from school/community becomes more and more likely the longer the closures persists. Our clients are predominantly seniors and juniors, in one of the most pivotal transitions of their lives so far: the months before adult life. Because of COVID19, it is more important to provide the support that we hope will assist in sustaining belief in themselves.

In the first half off the fiscal year, we provided on-site mental health counseling to 6-12th grade students in Pittsburg. Mental health practitioners have saturated caseloads in PUSD and have medical stipulations that disqualify many students and preclude school-site counselors from being able to see them more than for 1-time crisis-specific mental health check-ins. This positions us as a vital service for young people in Pittsburg. In our after-school program, we integrate social-emotional supports, trauma- informed curriculum and intervention, and exciting enrichment opportunities with free individual and group therapy.

After the shutdown, in addition to the wrap-around support and programming at PWC, an essential priority has been ensuring that our clients never experience an interruption in mental health services and that our clinician remain in contact with students, delivering content that is useful and engaging.

As the shelter-in-place continues, a lot of what was planned for our Green Jobs Training Program needed to be delayed for safety reasons. We have found innovative ways to keep students on board and connected to services, for instance, offering remote courses in personal health and life skill-building, finance, and holding weekly zoom meetings for emotional health.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services. Numbers served during the fiscal year (See the attached). Describe any adaptation of services due to COVID-19 that may be relevant

From April to mid-May we organized online tournaments to ensure that we were keeping the students supported and ensuring that they continued to feel a part of a community during this unprecedented time. Around 40 students participated in each week-long and 2 week-long competition. These involved countless challenges and games that accessed most learning styles and student interests. The challenges were organized as an online scavenger hunt and students competed to complete each step thoroughly and thoughtfully. For example, students had to write a poem, make a mask out of household items, cook a meal for 50 cents or less, download and score as many points as possible in a free game app etc. It was so much fun, and we ended up having around 10 winners!

Simultaneously, the Green Jobs Bridge program (virtual adaptation of our existing/pre-covid program) began on May 15th, ending June 19th. A total of 12 unduplicated, and 78 duplicated students participated in the program. From there, students had 3 weekly sessions via zoom. Mondays were reserved for community building and life skill-building. Our credentialed instructor, and mental health specialist, met with the kids and had restorative conversations around topics like change, self-love, managing stress and anxiety, trauma, police brutality, and institutional racism.

Wednesdays and Fridays were the days our instructor taught personal finance concepts to our students. The topics covered were organized in modules that corresponded with assigned industry level online virtual simulation for each concept. Modules involved Wednesday and Friday direct instruction and group activities. The instructional plan general included an assigned reading, a virtual zoom lesson and discussion, a quiz, and a simulation that put new understandings to the test in a real-life scenario.

The modules were: Budgeting and Saving, finding an apartment, choosing, and balancing a bank account, getting a credit card, fixing your credit, online banking, time management and health, paying and filing taxes, intro to investing for retirement, risk vs. return, and diversification.

Finally, students participated in a weeklong simulation from (6/22- 6/26) in which they had to put all the skills and learning to the test and make all the financial and life decisions in an open simulation that combined all the other modules. Their goal was to have the highest net worth by the end of a week's- time. Our winner went from 0 and homeless to home-owning, college-educated with 250k in the bank.

For PEI – Prevention programs, please describe: ***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.

Our client's mental and emotional health is assessed weekly through a variety of measurements. The students engage in weekly self-report check-ins around their emotional state and perceived well-being. Additionally, they meet in group and individually for counseling. They are welcomed to myriad programs through-out the week to foster a sense of belonging, build resilience and emotional stability. Metrics such as improved school attendance and decreased incident of behavioral problems at school support the efficacy of our program and services as well. In addition, the clinician conducts on-going and frequent behavioral observations to assess all clients and provide services as needed. For example, the therapist may ask the client to rate their level of depression on a scale of 1-10. Clients are also asked by PWC staff about their school experience, attendance, participation, which is tracked and utilized to indicate outcomes.

As our current clinician, Betty Brown collects information from individual and group sessions on a weekly basis. In addition to utilizing rating scales with clients, other surveys are given which provide clients opportunities to answer questions and self-report experiences, personal growth, and challenges. Such information is summarized in progress notes which are secured in files off-site, in compliance with HIPPA standards.

PWC's triage and assessment approach ensures that client receive the most appropriate level of care: offering on-site preventative services, providing counseling in therapy groups/individual/family sessions, making referrals to outside mental health services as needed.

PWC's use of a triage model allows us to maintain clear pathways for client receipt of mental health services. As previously reported, participants first complete an intake packet, identifying their unique reasons for working with PWC. Our mental health resource specialist, Miss Pope, 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 clients' needs are and what their family needs may be as well. As she discovers such needs, she provides resources and initial recommendations. This allows for initial assessment. Ms. Connie, PWC's executive director, greets new clients and builds rapport, making an introduction of the client to the on-site clinician. As Ms. Connie introduces the client to the mental health clinician, it is made clear that receiving counseling services is part of the program. This normalizes the practice and makes students feel comfortable receiving help. The clinician continues this warm welcome and explores the circumstances. Youth have become familiar with supportive staff, who are also looking out for additional support needed or signs of distress of the individual. This internal referral system, frequent open-communication, and clear protocols all play a vital part in

making our triage model work effectively to eliminate as many barriers as possible from mental health services.

This referral system recently successfully served a high school senior who had arrived to complete community service hours. On a registration page, she indicated a strong emotion tied to an interaction with a friend of the family. Recognizing a potential red flag, staff invited the participant to meet the clinician, in a supportive and friendly manner. The clinician was able to begin building rapport with the client, who disclosed feelings of depression and withdrawal from relationships after a traumatic experience with an older boy. With a safe environment, access to therapy, and a supportive network of adults, she was able to process her emotions and begin healing from this event. This resulted in her ability to re-build confidence, to engage more fully in activities, to strengthen relationships in her life, and end her patterns of disengagement and absenteeism from school.

On another occasion, another youth was participating in a green-jobs program offered at PWC. A staff member was getting to know her and recognized that she seemed to be working through some intense feelings and possible depression. This staff member referred her for 1-1 counseling that helped the student address feelings of severe depression and hopelessness in a safe space and to feel engaged and capable of taking steps to improve their emotional health. The clinician was able to work to mitigate self- harm ideation and to create a safety plan with the client throughout the year.

In addition to individual and group sessions, PWC conducts home visits as needed which aim to not only support the client, but also their families. Being mindful of cultural differences and perceived shame or stigma around mental health services, staff members offer support to families in an understanding, compassionate, and accepting way.

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

Please refer to Aggregate Data Reporting Form

CULTURAL RESPONSIVENESS:

How have services been informed and structured to meet the diverse cultural needs of your clients/members/participants? What is being done by your organization to support cultural responsiveness both within the workforce and for those served by your organization?

At PWC, cultural responsiveness begins in our own awareness and understanding of the ways in which our own culture may affect clients' families from racial backgrounds different from our own. Our staff is a diverse group of professionals from African American, Latinx, and Caucasian backgrounds. PWC's staff receives weekly consultation from Porta Bella Hume Counseling Center in its work setting. Through this service we better understand the organization and the culture of the clients we serve. We anticipate how clients will interact in conflict situations and

how they may support one another in conflict prevention. Because PWC 's clients consist of a large population of the young people of color, understandings around race, implicit biases, privilege, and lived experience is essential to our efficacy. Additionally, in a more logistical sense, both our primary instructor and curriculum lead and our office assistant speak fluent Spanish so that we can communicate and support the large number of clients/families who come from Spanish speaking homes. Due to the demography in Pittsburg and in effort to further expand our ability to provide inclusive and culturally responsive programming to our clients, PWC is currently seeking a bilingual Spanish and English-speaking individual to join our staff as Site Coordinator. Latinx clients upon entering PWC's office/program site often seek Spanish speaking individuals. Our values around diversity, center on the core belief that mental and emotional health supports vital and that they are effective when cultural awareness is one of many large considerations involved in effective treatment.

Our mental health specialist along with countless other routines, behaviors, and interventions, educates the kids with loving sincerity and very real concern for their safety by requiring kids to break habits like wearing hoodies that might make them more likely to invite contact with law enforcement. She explains the hoodie rule as a vital protective measure for their safety. This is an example of risk reduction measures specifically related issues of race and bias in our society as they affect youth of color. One example of programmatic supports that promote cultural literacy in our clients is our emotional/life-skills groups; these offer a safe space to have the critical conversations necessary to build better understanding between students from different cultures. Clients explore their own lived experience and confront their own biases in a way that creates an environment of mutual respect and strengthens their ability to empathize with people different from themselves. All therapeutic groups on-site or on-line follow agreed upon norms around listening and speaking respectfully etc. PWC's emotional and life-skills groups, which are a vital component of every program we offer, help young people see that what appear to be characteristics in each other that they assume are irreconcilable or that clash with their own personalities are, in fact, better understood through a culturally responsive lens. This way students unpack biases and build relationships that change their perspectives. PWC continues to commit to the constant need for educating our clients on how to deal with challenges caused by racially conflict and misunderstanding of cultural differences. Thus, we create opportunities for clients to learn from and about one another and to engage in ways that honor who they are, while challenging clients to be mindful and respectful of others. PWC works to influence the culture of its organization so that its policies and practices are informed by utilizing guiding principles of cultural proficiency and its responsiveness.

COLLABORATIVE PRACTICES:

Describe how you are working with any other agencies or organizations to better serve clients/members/participants? If this is currently not being done, please describe any effort to build relationships with other community service providers?

Since 2016, People Who Care (PWC) Children Association has been in collaboration with several East Contra Costa County nonprofits, including Opportunity Junction, Loaves & Fishes, Brighter Beginnings, Monument Impact, Village Community Resource Center, Contra Costa County CASA, Winter Nights, Cope Family Support Center, Rainbow Community Center, and Dream Catchers Empowerment Networks. Through this partnership, in August 2019, the East Contra Costa Alliance (ECCCA) was established, with the long-term goal of strengthening the ecosystem of organizations addressing poverty in East Contra Costa through direct services, community organizing, and advocacy for systems change.

The purpose of the Alliance is to: 1) Address issues affecting East Contra Costa residents, particularly those impacted by racial inequities, poverty, social isolation, or other obstacles that greatly affect their communities, 2) Share and leverage resources among participating nonprofits and private funders, to create a more sustainable ecosystem to better support services to disadvantaged populations, and 3) Work towards building nonprofit capacity and sustainability understanding the important role nonprofits play in addressing the needs of the diverse members of the community.

One successful example of the results of the work of the Alliance happened in June of this year. PWC had a client family desperately in need of resources due to having lost their home in a fire. By reaching out to other service providers within the Alliance, PWC was able to offer immediate temporary solutions for this client family through their own access to vital information and resources for support. Today, this client family has relocated and is living safely with extended family members within East Contra Costa County.

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 mental health program is continuing with the theme of self-discovery while beginning to intertwine concepts of teamwork and community building. This year we were fortunate to welcome Betty Brown, an associate Marriage and Family Therapist from the Hume Center.

By providing a safe space where clients can process their unique life situations and begin building healthier relationships, they build confidence, problem-solving skills and resilience that serves them in many contexts both at home, at school, and in life. The linkage to community is particularly important at PWC, as clients have ample time and space to practice serving others by participating and engaging in community events, such as crab feeds or setting up and supporting local parades. These opportunities not only provide practice in building social skills but generate positive feed-back for client who find themselves serving others, being

recognized, and thanked, and feeling an inner satisfaction of being part of something bigger than themselves.

Oftentimes, a client may begin participating in PWC programs and, with the support of friendly staff, reveal specific needs that could be addressed by being linked to other services in the community. Clients and families may experience lack of food, anxiety around housing stability, or health concerns. PWC staff can then provide referrals and linkage to resources that support these individuals and families. When basic needs of housing and food are met, individuals can then experience relief and begin to focus on inner growth.

Believing in a person's ability to learn, grow, overcome, and eventually thrive is a foundational belief of PWC's program. All staff engage with youth in an accepting, compassionate manner that meets them where they are at, yet also sees the potential for what they can become. At-risk youth need the support that PWC provides, in having and offering clinicians to support client with mental health needs and giving these individuals and their families linkage to resources in the community. By normalizing mental health services and restorative conversations, we de-stigmatize and dismantle preconceptions about therapy and mental health care; it is a vital part of our program that we believe is helpful and transformative to any human let alone the young people in our community who often have experienced adverse childhood events and painful disruptions in their lives without having had access or the ability to seek/receive therapy before our program. It is no secret that mental health disparities are rampant in underserved communities and our program provides a much-needed support to our youth and a vital service in Pittsburg. More-over, an essential qualification of being a staff member at PWC is a commitment to racial/social justice. Additionally, staff must share the belief that mental and emotional health supports are a basic human right (not a privilege), while demonstrating awareness of the disparities that need to be addressed in terms of access in our community. PWC is also committed to on-going professional development to ensure we remain culturally responsive and non-discriminatory in every sense and situation.

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.

Clinician Vignettes:

One afternoon a participant in PWC's Green Jobs program had been speaking with a staff member. She shared information that indicated a high level of distress and signs of depression. The staff member appropriately asked if she would be willing to meet and talk with the on-site clinician. That was the afternoon that I met a client I will call "Heather."

Heather was introduced to me and kept her eyes averted. I invited her into my office, and she came in and took a seat. We had a typical “first time meeting” exchange, where I asked some basic questions about family and where she lives and attends school. She was easy to engage with, yet her body language showed resistance to open up on deeper issues. She disclosed having a recent break-up with a boyfriend and spoke of having a best friend. She appeared uncomfortable, her knee bouncing up and down, and she was ready to go out of the room. After letting her know that she is welcome to come and talk with me anytime during my available hours, she went out to a main room, engaging with peers. Shortly later, she came in asking two things: could her best friend lay on the couch in my room, and could she write on my dry-erase board/easel. I warmly invited her and her friend in. Heather turned the writing board facing away from me and proceeded to fill it, top to bottom, with writing. Line after line she wrote how something had happened to her and she hadn’t been able to tell anyone and how nobody knew all of what she struggled with. She also wrote that life felt overwhelming and how there were times she did not want to live. After she completed writing, she left the room to hang out with others. Her friend also left. I read the message and observed her, knowing that it would be important to follow up before she departed that day. In less than twenty minutes she made her way back to my room, indicating that she had left her phone behind. I asked if we could talk privately for a few more minutes and she agreed. We used that time together to explore the message she left behind, in a supportive and non-intrusive way. She was able to speak about personal safety, the risk of self-harm, and suicidal ideation. She had a safety plan that was currently working. I shared with her that I looked forward to meeting with her again.

Shortly after that day, our county went into shelter-in-place restrictions. The PWC office was closed. We completed outreach to clients, leaving messages that we missed them, hoping they were well, and giving them a phone line to call and access support. While I cannot address this case in a manner of it unfolding over time, I offer it here to demonstrate how all of us work together to demonstrate care of the youth who come to participate in programs at PWC. The important part is that kids come and stay in the afternoons and have access to loving and supportive adults and therapeutic services that are delivered in ways that work for the kids, their reservations fall away and their ability to trust and thus heal, grows.

Another client, who I will call James, came in one day, early in 2020. He had been referred to PWC to complete community service hours due to school attendance truancy. He was friendly, smiling, and engaging, although he rarely gave direct eye contact. We did, however, build great rapport. He came to talk with me at least twice weekly. James presented as a transgender (girl to boy) youth. I heard from staff that his mom was not supportive of this change, while his dad was supportive. Because James presented as male in his appearance, I began using male pronouns from the beginning. A couple of months later, I did ask what his pronoun preference was, and he confirmed that he preferred male pronouns.

James was experiencing the ups and downs of self-identity. Staff observed him enacting gender roles with peers. James was inquisitive and seemed hungry for attention and approval. In sessions, he demonstrated artistic talent, and a keen interest in pets and music. Our exploration of family and relationships was cut short, due to COVID-19 and the shelter-in –place requirements. This case demonstrates how PWC is diverse, able to accept and support marginalized youth, and encourage their healthy development for the future.

People Who Care (PWC) ChildrenAssociation PEI Annual Report

FY 2019-2020

Appendix

Introduction

The 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 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

PWC Student Survey –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.

As shown in Table 1, the participants were divided into cohorts based on when they started the PWC After-School Program.

Table 1. Participant Survey Administration (July 1st, 2019 – June 30th, 2020)

		PWC Survey			
	Participants N	Cohort	Period	Pre-	Post
Quarter 0	59	0	July - September	49	32
Quarter 1	57	1	October - December	45	26
Quarter 2	54	2	January - March	46	11
Quarter 3	0	3	April - June	0	0

School Day Attendance Data from Pittsburg Unified School District (PUSD)

Through networking efforts with PWC, and the PUSD Director of Student Services, Pittsburg Unified School District (PUSD) staff did provide attendance records for most 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 35 participants of the 37 students referred to the program through the Student Attendance Review Board (SARB), due to attendance and behavior issues, and students that attended Black Diamond Continuation School.

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 **15** students.

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.

Through our dedicated staff, and technology-advances, our success is well documented. The 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, 2019 – June 30th, 2020)

	July-Sept	Oct-Dec	Jan-March	Apr-June	Total Served
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
# Students (Duplicated) Served Each Quarter	111	173	148	54	486
# New Students Served Each Quarter	123	43	32	9	207

As in past years, prior the start of the 2019-2020 school year, PWC recruitment plan involves 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.

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 officemanager 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).

Our data collecting methods help regarding 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.

The types of schools that PWC participants attend, the majority (52%) of participants come from the alternative school system. (See Table 4.)

Table 4. Distribution of School Types Represented in the PWC Program Year: (July 1st, 2019 – June 30th, 2020)

School Type	Frequency	Percent
Alternative School placement (e.g., continuation, independent study)	107	52%
Traditional High School	73	35%
Traditional Middle School	12	6%
Adult School/Graduated	15	7%
Totals	207	100%

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.

As indicated above, a lot of what was planned for our Green Jobs Training Program needed to be delayed due to COVID-19. Also, as indicated, we worked hard to make changes to ensure that the services we provide weren't delayed for our clients offering remote courses in personal finance and holding weekly zoom meetings for emotional health and life skills. Although, the objective that 65% of the green jobs participants will increase their knowledge and skills related to Entrepreneurship, and the "green economy" was not met in this instance; 100% of the participants enrolled in the remote courses did gain knowledge in aspects of business such as marketing/advertising, accounting and banking skills, which was very successful.

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 53 students enrolled in the after-school program who answered the resiliency questions on pre-and-post Student Surveys, 79% demonstrated improved resiliency. This exceeds the target objective that 65% of participants would demonstrate improved resiliency.

It is important to note of the 53 students that answered the resiliency questions, 32 participated in multiple Cohorts. 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 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 15 probation students enrolled in the after-school program, (80%) 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 on the number of students from

the lists who committed an offense and the number of students who "re-offended" or went to juvenile hall.

Of the 15 student names submitted there was 3 new offense, and 0 new admission to Juvenile Hall. Overall (80 %) 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 42 students enrolled in the after-school program who answered the survey questions about caring adults on their post Student Surveys (66%) indicated that they had caring

relationships with adults in their lives; however, this does not meet 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, which could be attributed to COVID-19, and challenges in families during this troubling time.

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 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).

To see if students reported that there was a caring adult in their lives, we examined their responses to these 4 questions on their Post Student Surveys. The 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 positive. Results are presented in Table 6.

Table 6. Demonstration of Participant Relationships with Caring Adults

There is an adult (other than my parent/guardian) who…	% of positive responses Overall (n=62)
tells me when I do a good job	68%
I trust and could talk to	61%
believes that I will be a success	71%
notices when I am upset about something	63%
Average of all 4 questions	66%

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 35 students referred to the program by the PUSD Student Attendance Review Board (SARB) and attend Black Diamond High Continuation School enrolled in the after-school program with attendance data available for their respective cohort periods, 77% 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 each cohort in session. Student level data was compared between the first week of participation and the last week of participation in each cohort. Attendance was "perfect" if there was no indication of absence, truancy, tardiness, etc. To be considered "perfect" a student had to attend every full period of class for the entire week.

Attendance data was available for 35 of the 37 students referred to the program through the Student Attendance Review Board (SARB), for attendance and behavior issues, and attend Black Diamond Continuation School, (not including those who participated in the program for less than 10 days, and/or outreach students), Of the 37 students with attendance data available for their respective cohort periods, 77% 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 35 students referred to the program by the PUSD Student Attendance Review Board (SARB) and/or attend Black Diamond High Continuation School enrolled in the after-school program with attendance data available for their respective cohort periods, 66% decreased or maintained a rate of 0 tardiness. This exceeds the target objective that 60% of participants would decrease tardiness.

Summary of Findings

Of the five program objectives, *four* were fully achieved (increased knowledge, improved resiliency factors, low rates of re-offense, increased school day attendance and decrease tardiness), and one was close (caring relationships with adults). (See Table 9)

Table 9. Actual Outcomes as Compared to Target: Fiscal Year 2019-2020

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.	N/A	N/A	N/A
65% of the youth program participants will show improved youth resiliency factors (i.e., self-esteem, relationship, and engagement.)	65	79	122%
75% of the youth program participants will not re-offend for the duration of their program participation.	75	80	107%
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	66	94%

There will be a 60% increase in school day attendance among youth participants for the duration of their program participation.	60	77	128%
There will be a 60% decrease in the number of school tardiness among the youth participants for their program participation.	60%	66%	110%

Overall, PWC has fully met their targets regarding 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.

This year PWC Clinical Success After-School Program has been a huge success. Currently, we believe we have created a formula for success alongside with learning that will serve our community and our cohorts well. Our clients 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.

PEI ANNUAL REPORTING FORM

PREVENTION FORM

FISCAL YEAR: 2019-2020

Agency/Program Name- 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 / STRATEGIES:

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 (2019/2020), 456 unduplicated members (target: 300) spent 57,290 hours engaged in Clubhouse programming activities (target: 40,000 hours). 55 newly enrolled Clubhouse members (target: 70) participated in at least one Clubhouse activity; 11 of these new members were young adults aged 18 to 25 years (target: 12 young adults). In addition, at least 60 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	456	152%
Number of Hours spent in Clubhouse programming	40,000	57,290	143%
Number of new members participating in at least one Clubhouse activity	70	55	79%
Number of young adults (age 18-25 yrs.) participating in at least one Clubhouse Activity	12	11	92%
Number of activities specifically for young adults (age 18-25 yrs.)	40	60	150%

Other services:

Members helped prepare and eat 30,938 meals at the Clubhouse (target: 9,000). This is significantly higher than in past years due in large part to the implementation of a food pantry in response to COVID-19. Although a target had not been set for rides, 1,543 rides were provided to members to and from Clubhouse activities, job interviews, medical appointments, and more. During the contract year 1,403 in-home outreach visits (no target set) were provided. Again, the significant increase is directly attributable to shifts made in response to COVID-19 which resulted in more outreach visits, walks, mobile wellness calls, and visits to members receiving food delivery.

Additionally, under Project B, 131 postings (target 124) were made on the Career Corner Blog and 4 career workshops were held (target 4). The workshops included 1) Interagency Meet N Greet Workshop-learn about the resources in the community, September 19, 2019 (67 Attendees); 2) Friendship: Making Friends, Developing Best Friends, Becoming Ready for Romance, January 16, 2020 (49 Attendees); 3) Ways to Cope with Strong Feelings related to COVID-19, April 9, 2020 (56 Attendees); and 4) Sweep Away Barriers, Community Mental Health Awareness, May 8, 2020 (92 Attendees).

Table 2: Other services provided to Clubhouse Members

	Target Goal	Actual	% Target
Number of Meals prepared and eaten at Clubhouse	9,000	30,938	344%
Number of Rides to and from Clubhouse Activities	No target set	1,543	N/A
In-home outreach visits	No target set	1,403	N/A
Number of Blog Postings	124	131	106%
Number of Career Workshops	4	4	100%

For Project C, the SPIRIT graduation was successfully coordinated by the Clubhouse and attended by 378 people on 7/29/19. The holiday party on 12/18/19 had 389 people in attendance with the collaboration of multiple agencies along with the OCE. The annual Community Picnic was held virtually on 6/26/20 and was well attended with 397 participants. Catered BBQ meals were delivered via volunteers to each home. The volunteers came to the Clubhouse and stayed in their cars while the meals were loaded into their cars for no-contact delivery to their assigned homes. Attendees Zoomed in for virtual picnic activities like trivia,

bingo, Paint Night, and musical performances. By all accounts, all three events were highly successful, but the picnic was a special achievement considering the adaptations that had to be made during the pandemic, and the extra importance of gathering during such a difficult time.

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 three Contra Costa County mental health clinics twice a year. The first Survey Week took place in November 2019 in three clinics: East/West/Central Adult Mental Health. However, due to COVID, the second Survey Week was cancelled in May 2020.

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 PROGRAM EVALUATION:

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, sign-on logs, and phone calls. None of the program-level outcome data is confidential and it is recorded in the program database. Any confidential information provided on individual 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, an online survey site, and analyzed by Hatchuel Tabernik and Associates, an external evaluation firm.

In June 2020, members, and their family members (called caregivers in this report) were encouraged to complete the annual Clubhouse survey via Survey Monkey. The number of members and caregivers completing the survey was 124 (the target was 120), of whom 34 were caregivers and 90 members. Among members in the survey, 2.2% were aged 18-21, 3.3% were 22-25, 24.4% were 26-35, 20.0% were 36-45, 28.9% were 46-59, and 21.1% 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.

<u>Caregiver Respite</u>

The data in this report represents only those caregivers completing the survey who reside in Contra Costa County (N=34). Of the 34 Contra Costa County caregivers who responded to the survey, 72.7% were parents or guardians of a Clubhouse member, 15.2% were siblings, 6.1% were Aunts/Uncles or Cousins, 3.0% were the child of the Clubhouse member, and 3.0% were a husband/wife.

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 (96.9% satisfied), as well as with the Clubhouse activities/programs that they themselves participated in (90.9% satisfied). In both areas the target of 75% was exceeded. A large proportion of caregivers (90.6%) also reported that Clubhouse activities and programs provided them with respite care. Such respite is intended to reduce their stress and lead to more independence for the Clubhouse members. Seventy percent of the members agreed or strongly agreed that in the last year, their independence had increased. This is lower than the goal of 75% but may reflect the shift to virtual programming due to the impact of COVID-19 and the shelter in place order. Although exceeding the target of 75%, a slightly lower proportion of the caregivers (79.4%) also perceived that their family member had become more independent in the last year.

Table 3: Caregiver Respite

		GOAL	ACTUAL
Measures of Success	N	%	%
% caregivers reporting Clubhouse activities provided them with respite care	34	75	90.6%
% caregivers reporting high level of satisfaction with Clubhouse activities and programs in which their family member participated	34	75	96.9%
% caregivers reporting high level of satisfaction with Clubhouse activities and programs in which they participated	34	75	90.9%
% caregivers reporting an increase in member's independence	34	75	79.4%
% members reporting an increase in independence	90	75	70.0%

Below are some responses from the caregiver survey to the question of what was liked best about the Clubhouse:

"I love Putnam. X has always a safe place with the Putnam family. It provides a good guidance for his well-being" (caregiver)

"Follow up calls, having her take accountability ... acknowledging her birthday. Career finding and motivating her" (caregiver)

"It's a safe and calming environment and it kept my wife purposeful during the shelter in place order. Being able to do outreach and food deliveries to members kept my wife mentally healthy." (caregiver)

"Supportive, caring staff & interest in well-being of its members, creating a social environment and positive outlook on life. Outreach to members in community." (caregiver)

And from the members survey:

"Being involved with the community and all that Putnam has done for this community during shelter in place" (member)

"Everything. Loves staff and members. Keeps me out of the hospital. best program to have for people with mental illness. Makes me feel connected to the community without stigma." (member)

"everyone there is welcoming with a friendly smile People are glad to see me" (member)

"Friendship and meeting new people." (member)

"camaraderie, people care for each other, staff is so nice, showing respect and concern" (member)

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, 84.4% 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, 87.5% also agreed or strongly agreed that their family members overall health had improved.

The member ratings for their own improvements in these categories averaged 86.7%, 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 85.6%. Additionally, 85.4% 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)	34	75	84.4
% members reporting increase in their own health (mental, physical, emotional well-being)	90	75	81.1
% members & caregivers combined reporting increase in their health (mental, physical, emotional well-being)	124	75	82.6
% members reporting an increase in peer interactions	89	75	85.4

Other comments made on the surveys by members and caregivers include the following:

"There's a lot of independence for members. The members help create the program. The clubhouse tends to see what the members want. I appreciate and benefit from the scholarship program. I like the structure of the clubhouse it has a good balance between social and nonsocial activities." (member)

"we work as a cooperative partnership; I can work at the gym it's important to my mental well-being" (member)

"It is a community within itself. You learn how to broaden your horizons. A place that is safe. Everyone there for each other." (member)

"interactions with people teach you to be more independent. People are so friendly" (member)

"It gives me somewhere to go so I'm not home depressed." (member)

"The staff are always inclusive and supportive of the members. Always reaching out and always providing a listening ear. They are like a second family to me. (:" (member)

"The independent the members have as well as the input they are able to provide into decisions. Plus, very supportive." (caregiver)

"Variety of activities; the Clubhouse always looks after my brother’s well-being and is there for him when he needs it." (caregiver)

"The staff is very professional, friendly, objective and helpful." (caregiver)

"Its non-judgmental caring attitude with families of and their loved one(s) living with mental health challenges." (caregiver)

"It provides a structured, supportive and compassionate environment to its members. Most importantly, it provides hope." (caregiver)

Hospitalizations

For the tenth 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 54 active members in June 2020. If data had already been collected for the member in the previous year (June 2019) then this data was entered, and information was garnered for the previous reporting year only (since July 1, 2019). 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 54 members, one member was dropped from the analysis 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). The final number of members included in the analysis was 53.

The number of hospital days prior to Clubhouse membership for those 53 members included in the analysis ranged from 0-228 days, with a mean of 19.6 days. Post Clubhouse membership, the number of days hospitalized ranged from 0-82 days with a mean of 2.3 days of hospitalization. In terms of episodes of hospitalization prior to Clubhouse membership, the Clubhouse members experienced 0-5 episodes of hospitalization (a mean of 1.11 episodes). After Clubhouse membership, members experienced on average 0.17 episodes of hospitalization (range 0 - 5 episodes). In terms of change of episodes, 53% of those providing data showed a decrease in hospitalizations or maintained zero hospitalizations (43%), 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 Episodes	53	53%
Maintained 0 episodes prior and after	53	43%
Increase Episodes	53	4%

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 19.6 days (range 0-228 days) before Clubhouse membership to 2.3 days (range 0-82 days) after Clubhouse membership ($t=2.73$, $df=52$, $p<.01$).

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=12), 1 to less than 2 years (n=11), and 2 to 3 years, but less than 4 years (n=30) (see Table 6). Although there is a slight 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 less than 2 years (100%) to those who have been Club members from 2-3 years but less than 4 (93%), the proportion of those who show a decrease or no change in episodes remains high 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	6	50%	9	82%	13	43%
Maintained 0 prior and after	6	50%	2	18%	15	50%

Increase	0	0	0	0	2	6%
TOTAL	12		11		30	

When looking at actual number of Hospitalization episodes Before and After Clubhouse membership (Table 7a) using paired t-tests, there is a statistically significant decline in number of episodes from Before to After Clubhouse membership independent of how many years of clubhouse membership.

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	12	1.08	11	2.0	30	.80
Episodes Hospitalization After Membership		.08*		.09***		.23*

*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 1-2 years 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	12	28.75	11	21.18	30	15.40

Days Hospitalization After Membership		0.50		2.73**		2.90

*p<.05; **p<.01; ***p<.001

Overall, using the self-report data of Clubhouse members, it seems evident that members of Putnam Clubhouse consistently show a decrease in hospitalization in terms of episodes and total days from before to after Clubhouse membership.

Career Development Unit

During the 2019-2020 contract year the Clubhouse made career support services available to all members including the 195 members working in paid employment and the 92 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 49 who began jobs during the year and the 28 who returned to school. Of the members completing the member survey who used career services (n=58) 86.2% 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 (28 had employment goals and 30 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)	58	75	86.2
% members referred to appropriate education resources within 14 days (of those indicating education as goal)	30	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)	28	80	100

"(likes) Follow up calls, having her take accountability ... Career finding and motivating her." (caregiver)

"(likes) Work programs helping member have duties at the club and the assistance to help find job" (caregiver)

"(suggests) Have more transitional employment opportunities or allow members rotating paid employment at the clubhouse itself." (caregiver)

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 2019-20 contract year.

Table 9 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 most programs and activities. Members were most satisfied with the Friday Night Socials/TGIF Fridays, Meals and Rides and least satisfied with the Career program. Caregivers were most satisfied also with Friday Night Socials/TGIF Fridays and Meals and least satisfied with the Career program.

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
	% Very Satisfied/Somewhat satisfied (N)	% Very Satisfied/Somewhat satisfied (N)
Friday Night Socials/TGIF Fridays	98.4% (63)	96.3% (27)
Meals	97.6% (83)	96.3% (27)
Rides Program (transportation to/from Clubhouse)	97.4% (38)	94.4% (18)
Healthy Living Program	96.4% (55)	90.9% (22)
Wednesday Nights Expressive Arts Program (music and/or art)	94.0% (50)	96% (25)
Work-Ordered Day (Monday – Friday daytime activities	93.8% (81)	96% (25)

Holiday programs	91.8% (61)	95.8% (24)
Young Adult Activities	88% (25)	94.7% (19)
Weekend Activities	88.5% (52)	96.0% (25)
Career Development Unit (assistance with education and/or employment)	86.2% (58)	88.5% (26)

Finally, both members and caregivers were separately asked to rank 10 Clubhouse programs/activities in order of importance to them. Programs/activities were ranked from 1-5 in terms of importance. Using a point system where #1 Rank carried 5 points and #5 Rank carried 4, points were added for each activity and the highest mean indicated the most important activity. For the members the top three ranked programs/activities were Work Ordered Day, Meals and TGIF Fridays. For caregivers, the top 3 ranked activities/programs were Career Development Unit, Work-Ordered Days, followed by Young Adult Activities.

Table 10: Ranking of Program Activities in terms of Importance by Caregiver and Member

Clubhouse Programs/Activities	Member	Caregiver
Work-Ordered Day (Monday – Friday daytime activities)	1	2
Meals	2	6
TGIF Fridays	3	7
Career Development Unit (assistance with education and/or employment	4	1
Healthy Living program	5	5
Rides Program (transportation to/from Clubhouse)	6	4
Young Adult Activities	7	3
Holiday programs	8	9
Weekend Activities	9	8
Wednesday Nights Expressive Arts Program (music and/or art)	10	10

*program/activities ranked for Members

Overall, the caregivers and members alike had many positive things to say about the Clubhouse programs and activities:

"nowhere else is like the clubhouse it's an oasis which prevents negativity around mental illness" (member)

"It is a community within itself. You learn how to broaden your horizons. A place that is safe. Everyone there for each other." (member)

"I like interacting with fellow members at TGIF and the meals." (member)

"I like the people interaction during the WOD and lunch time." (member)

"It gives us a new focus and looking at things you could be doing in your life. You can learn by doing the WOD using computers, etc. It helps me knowing those things in the future." (member)

"What I like best about the clubhouse is how everyone works together to get all the important activities done in the day. The work order day tasks and hospitality work as well, are all accomplished in a very well-organized way." (member)

"I like the friendly atmosphere and the incredible variety of programming." (member)

"It gives me a place to go better than staying at home. It provides resources." (member)

"Love the social activity and getting to meet everyone on holiday events." (caregiver)

"Large variety of activities available for members." (caregiver)

"Past 10 years it has been a place of support and healing and great sense of community. Invaluable resources to growth and development" (caregiver)

"I love the way staff came up with Zoom virtual Clubhouse so quickly and also reached out to members by the phone and organized social distance walks." (caregiver)

"I have been a supporter for many years, and I have been recommending Putnam to other families with mental health issues children." (caregiver)

The Clubhouse was successful in achieving most of its contract goals and objectives for the year 2019-20 contract, although the shift to a virtual clubhouse format due to COVID-19 may have had a negative impact on recruitment. However, the Clubhouse pivoted admirably in response to COVID, shifting to a virtual format and substantially increasing their at-home support in terms of food service (344% of the target!) and home-visits (an increase from 103 in 2018-19 to 1,403 in 2019-20). A supplemental review of the new Virtual Clubhouse can be found as an attached Appendix. Overall, the Clubhouse has demonstrated highly positive outcomes this year, with high satisfaction ratings of services and programs, as well as high ratings for member and caregiver wellness. This year's outcomes again bode well for a promising and sustainable future.

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

Please refer to Aggregate Data Reporting Form Not Applicable

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:

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?

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.

PEI ANNUAL REPORTING FORM

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR: 19-20

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 / ACTIVITIES:

Please summarize the Scope of Services as outlined in the Service Work Plan. Please also address any other relevant activities or events that took place during the reporting period.

During fiscal year 2020, The Rainbow Community Center provided services to members of Contra Costa County's Lesbian, Gay, Bisexual, Transgender, Questioning and Intersex (LGBTQI+) 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 LGBTQI+ community. Special emphasis is placed on reaching LGBTQI+ 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, 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 LGBTQI+ community (e.g., community members' increased rates of depression, anxiety, suicide, substance abuse, and victimization), delivers health promotion messages, and increases LGBTQI+ community members' knowledge of local and national behavioral health resources.

Tier 1: Outreach and engagement, isolation reduction and awareness building – Rainbow Community Center organized outreach programming through multiple in-person events/groups up until California's "shelter in place" order March 16 including weekly HIV+ group for self-

identified men and monthly HIV+ group for self-identified women, bi-monthly Senior Luncheon and Gender Voice support group, 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: Support groups and services promoting resilience and self-efficacy for individuals with identified mild to moderate mental health needs – 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: In depth and individualized support for those with high levels of need due to crisis issues or mental health disorders – Rainbow provided one-on-one brief-intervention services (Tier 3/Indicated) to the target community in FY20. Tier 3 services are designed to assist at-risk community members in accessing needed care and treatment.

Senior Programming: Rainbow has identified LGBTQI+ seniors as a particularly vulnerable population. As such, programming for LGBTQI+ Seniors includes Tier 1, Tier 2, and Tier 3 components. Services include organizing two congregate meals (Outreach/Tier 1) per month, up until mid-March 2020. Zoom Senior Lunches restarted in June 2020. Beforesheltering in place Rainbow was delivering regular in-person and telephonic Social and Support Groups 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). Additionally, Rainbow transitioned to crossing over our Kind Hearts Food Pantry program and transitioned into a Supply Train Program. This program continues to provide essential services to our community members living with HIV/AIDS and to LGBTQI+ people over the age of 55. Our weekly Supply Train staff and community volunteers deliver food boxes to the homes of people living with HIV/AIDS and qualifying seniors, and weekly we conduct extensive check in calls with all our seniors, especially those who are sick and cannot leave their homes before sheltering in place. Rainbow is a distribution program for the Senior Food Program, Gleanings Program through the Food Bank of Contra Costa, and Solano Counties. Additionally, our community members work with registered dietitians that prescribe nutritional supplements to our HIV positive clients that are enrolled in the Extra Helpings Program.

Project #2: LGBTQI+ Youth Support Programming – Rainbow has identified LGBTQI+ 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. During the second half of the FY, the Rainbow Community Center Youth Program served a total of 285 youth; 69 unduplicated youth; 85 school-based youth served through one-on-one counseling. Our youth services with LGBTQI+ and ally youth ages 11 to 25 includes: youth groups, workshops, special events, community collaborative events and field trips. These activities are typically centered on social-emotional learning (SEL), professional, and life skills development. Additional youth services included our QscOUTs program (psycho-social educational group) and/or one-on- one clinical services took place offsite at schools within the Acalanes Union High School District and Diablo Valley College, Pleasant Hill. During the months of "shelter-in-place" due to the state's order, we adapted our services, facilitating virtual activities. For example, youth groups and clinical one-on-one services were moved to online platforms through video conferencing (Zoom).

Youth services consisted of ongoing youth groups, such as: Artistic Expressions, Youth Gender Voice, and Queer Open Mic, TAY HIV+ Support, movie screenings and support groups for parents/guardians and transgender/gender nonconforming children ages 11 and under. In many cases, groups centered around LGBTQ+ awareness and/or celebratory months/days. These groups were developed through an educational and empowerment lens to promote self and group development. 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 consistently. 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. During shelter-in-place, we highly promoted our virtual activities via the platforms mentioned above. In response, we were able to provide a safer, brave, and confidential space for our LGBTQI+ local youth and additionally had participation of youth from out-of-state, i.e., Gender and Sexuality Alliance (GSA) from Seattle, WA.

Due to COVID-19 and "shelter-in-place", The Rainbow Community Center's Youth Program has had to shift how we provide services and outreach to our LGBTQI+ youth. We continued, more intentionally, our cross-department collaborations within our programming, training, and clinical services, to meet the various needs of our clients. We partnered with another social services agency, who also serves LGBTQI+ youth, hosting co-facilitated virtual youth groups, to provide enrichment and education *and* processing and emotional support during these challenging times. Additionally, we heavily promoted our mental health services for any youth who may be in need, while continuing to provide relevant resources on how to navigate the "shelter-in-place" and pandemic.

Project #3: Inclusive Schools – The Inclusive Schools Coalition continued the work of the MHSA Innovations Project to promote acceptance for LGBTQI+ 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 local school districts, such as: 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 LGBTQI+ youth in Contra Costa County. Target populations included: a) LGBTQI+ students, their peers, and groups of students who were bullied and marginalized due to racial, ethnic, class, sex, gender identity, gender expression, 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 Contra Costa County 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 outreach and promote inclusive services, while advocating for LGBTQI+ students/youth. To better meet the needs of the youth/students, the Coalition shifted its efforts to more collaborative work through partners, agencies, and individuals who work with LGBTQI+ youth/students. The Coalition planned collaborative educational events and the "Welcoming Schools and Communities Summit" in the fall 2019. Due to COVID-19 and "shelter-in-place" orders, meetings were paused, to meet the immediate needs of our community members, however, Coalition members were still able to connect with Rainbow regarding consultations, best practices, and solutions on how to support LGBTQI+ youth/students.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services. Please include: Numbers served during the fiscal year. Describe any adaptation of services due to COVID-19 that may be relevant. How are participants identified as needing mental health assessment or treatment? List of indicators measured, including how often data was collected and analyzed.

Rainbow's mental health counseling program aims to increase the resiliency of our community, help stabilize high-risk people with acute mental illness, and help our community thrive. Rainbow provides culturally competent virtual services, such as Individual Therapy, Partners' Counseling, and Family Counseling. We also offer coaching sessions for Mental Health professionals on how to work with LGBTQI+ folks.

LGTBQI+ 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 compelled to hide their HIV status or LGBTQI+identities. These fears mean that LGBTQI+ 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 LGBTQI+. 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 continued with its adjusted intake procedures established in the previous fiscal year to ensure that all who seek services at Rainbow are assessed in a manner that is *trauma-informed and culturally responsive*.

In conjunction with Rainbow's intake process, staff 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 our Youth Coordinators, they 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 Rainbow's dedication to a safe, LGBTQI+-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 in the first three quarters of the school year 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 LGBTQI+ 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, when bravely disclosed. 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 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.

During fiscal year 2020 Rainbow served a total of 941 (1174 last fiscal year) contacts. For

Tier 1 and *Tier 2* we served total of 583 (904 last fiscal year) unduplicated contacts. Within the contacts, 217 (596 last fiscal year) are part of the Pride and Joy groups, 140 (266 last fiscal year) belong to youth programs. Some contacts are part of both groups, reflecting the gap when summing the two programs. Counseling and case management *Tier 3* met 216 (181 last fiscal year) contacts unduplicated. Within School based counseling Rainbow met with 142 contacts. (184 last fiscal year).

The chart on the next page accurately reflects Rainbow's **Pride and Joy program** attendance.

(please note some of the services also apply to youth)

Contact ID	Full Name	Event Date	Number of Attendance	Number of Contacts
Program Tier: Tier 1 **(569 records)**			569	217
Program: Amigos **(20 records)**			20	16
Program: Community Events **(41 records)**			41	40
Program: Men's Social Group **(26 records)**			26	13
Program: Rainbow Game Night **(49 records)**			49	15
Program: Senior Program **(302 records)**			302	73
Program: Social Guy-zing **(91 records)**			91	67
Program: Walk Ins **(9 records)**			9	7
Program: Womxn's Social Group **(31 records)**			31	20
Program Tier: Tier 2 **(2,048 records)**			2,048	266
Report Group: Kind Hearts **(1,467 records)**			1,467	161
Program: Food Pantry Brown Bag **(268 records)**			268	61
Program: Food Pantry Brown Bag Home Delivery **(35 records)**			35	16
Program: Food Pantry Extra Helpings **(202 records)**			202	46
Program: Food Pantry Extra Helpings Home Delivery **(19 records)**			19	6
Program: Food Pantry Gleanings **(929 records)**			929	160
Grand Totals (2,617 records)			2,617	433

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.

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.

Additionally, to support LGBTQI+ youth, collaborative events helped boost our outreach and advocacy.

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. 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, 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 LGBTQI+ 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 their immediate and long-term needs.

As stated previously, Rainbow has intake procedures which track the amount of time between initial contact and initial assessment.

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

Please refer to Aggregate Data Reporting Form

CULTURAL RESPONSIVENESS:

How have services been informed and structured to meet the diverse cultural needs of your clients/members/participants? What is being done by your organization to support cultural responsiveness both within the workforce and for those served by your organization?

Rainbow has secured an Associate Clinician who is fluent and bilingual in Spanish to serve and center a marginalized part of our community who are Spanish speaking and Latinx more intentionally moving forward more expansively.

A new strategy of diversifying Rainbow's cultural growth and reach and management with implementing a Training and Curriculum Manager position with a seasoned SOGIE (Sexual Orientation, Gender Identity and Expression) national trainer and published educational curriculum writer that joined in March 2020. This has enabled Rainbow to launch within the two months of the state's "shelter in place" orders, a meaningful update to culturally informed work through virtual SOGIE workshops and trainings. This position has the goal of building out and providing a more "expansive" and accessible educational LGBTQI+ experience through serving more professional sectors within our communities that directly serve and impact the livelihood and well-being of our most marginalized LGBTQI+ community members in additions to populations that Rainbow has served previously. This position's goal works in concert with our community partners, targeting and building cultural responsiveness through the launch of virtual models of Educator Subscriptions, Adult Affinity Groups, Consultation and Coaching, Workshops, Trainings, Keynote Addresses, and the launch of Digital Curriculum for sale online later in the fall of 2020.

COLLABORATIVE PRACTICES:

Describe how you are working with any other agencies or organizations to better serve clients/members/participants? If this is currently not being done, please describe any effort to build relationships with other community service providers?

Rainbow has continued partnership, through this past fiscal year with Planned Parenthood around safer sex education and barrier access and started partnering with the local Good Vibrations' Training and Education Department within our HIV Prevention Program and Senior Older Adults Program to help destigmatize intimacy with holding an HIV positive status and generational aging.

Additionally, due to the pivot of several of our in-person senior and food security programs we have partnered with Putnam Clubhouse, Monument Crisis Center, and Shepard Lutheran Church with safer and lessened stigmatized food access.

Rainbow has been building greater alliance with youth and family LGBTQI+ education opportunities with all three of the county's PFLAG chapters: Claycord, Lamorinda (new chapter this year!) and Danville – San Ramon Valley through a Gender and Sexuality Alliance (GSA) Forum, advocating for the first Pride flag raising in Clayton, and a Summer Bridge Youth Zoom Support Group that is carrying on into the fall with two Rainbow Youth Coordinators stepping in as facilitators after a community-based clinician was unable to continue to guide the group.

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?

In our mental health and case management programs we utilize strengths-based and trauma-informed approaches in all our interactions with clients. 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 the programming that 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 safer environment where our clients receive non-judgmental, supportive services that help them feel welcome and accepted.

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.

Freddie: Rainbow Is a Light at the End of the Tunnel

Freddie, 23, shares his Rainbow experience:

Being at Rainbow feels very calming. You don't have to stress. I'm staying in a shelter right now, and my case manager there connected me to Rainbow. It's really helped me out a lot.

When you're at Rainbow, your stress levels go down, and it's cool to have that support. It's a community of people just like myself. Everybody is not the same as who I am but it's like we all have a basic general understanding that it's ok to be yourself here. And that's cool.

I'm currently attending community college, studying psychology. I go to the library every chance I get. I got interested in psychology in high school when I took psychology and sociology classes, and they were cool and fun to go to. After I get my degree, I'd like to go into social work because I want to give back to the community. Being a homeless LGBTQ youth, I'd like to help people out the way people have helped me out.

Rainbow has really helped me regain my confidence and feel comfortable in the work environment so I could get a job. They help LGBTQ youth get clothes and transportation they need for job interviews and on the job, which is cool. I couldn't have gotten my job without Rainbow and having this job has given me an opportunity to grow as a person, to learn how to take care of myself and be responsible with my own life. It's a lot of fun, honestly. My coworkers are sweet, and the customers are cool, hardworking people.

My job has given me a window of opportunity because I can see that I can go to school, I can go to work, and I can work toward something cooler than just minimum wage forever. My coworkers and I get along great. We look forward to seeing each other which is cool.

You can get support at Rainbow that you might never have had but always needed. If you need transportation or a place to live, Rainbow has your back. You could call them really late, and they'll always answer your call. They won't leave you hanging. They'll always be there and make sure you're not out in the street. Rainbow's services are important for your mental health and your general safety.

Everybody needs support and foundation, and you can't get that foundation without having support. If you're lost and don't know where to go, Rainbow is a light at the end of the tunnel. They've helped me out in so many ways I wouldn't even think to get help.

PEI ANNUAL REPORTING FORM

PREVENTION REPORTING FORM

FISCAL YEAR: 19-20

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

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 racial & gender justice, 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's integrative program model works to improve the social and material conditions for young people in Richmond and West Contra Costa County. RYSE recognizes that a community mental health model must incorporate multiple modalities and points of entry for a youth to seek out the services they need to thrive. 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. Beginning in March 2020, virtual programming and teletherapy were developed and activated. Over the grant period, 283 new members enrolled, for a total of 613 unduplicated members attending. Since March 2020, we experienced an additional 322 youth participants (not unduplicated) who are not formally enrolled as members

via our virtual program offerings. Health and wellness content promoted via social media (Instagram Live videos and TikTok) also engaged youth in our community, with over 2,000 views.

Health and Wellness

- COVID-19 Response: On March 13, 2020 RYSE closed our physical center and posted resources for the community, and a few days later a shelter-in-place order was implemented across the Bay Area. Within a week, RYSE had quickly pivoted to setting up new virtual systems and safety protocols to continue to provide creative youth development programming, teletherapy, and leadership outlets for young people across the city. In the last months of the funding period, RYSE successfully shifted our services, supports, and systems change efforts to online and telehealth platforms to the fullest extent possible. Knowing that in crisis response, it is rare that youth of color are prioritized; public safety policies can put Black and brown youth at risk of surveillance and criminalization; school-based and distance-learning decisions are made without student input and don't address the realities of those with highest needs; and disinvestment threats to youth programming loom on the horizon, RYSE has:
    - Developed online resources and youth-specific materials about COVID-19 and school requirements/policies/supports.
    - Held space during all programming to answer questions and provide information about SIP and COVID-19, including hosting "Ask a Doc" on Instagram.
    - Supported students across WCCUSD to respond to distance learning policies, survey over 282 fellow youth about needs and ideas, organize a Youth Town Hall for over 100 participants on distance learning, and participate in local, statewide, and national forums to share their experiences and expertise.
    - Cultivated space for youth to express themselves, decompress, and engage in wellness activities and skill-building during this time.
    - Provided individualized outreach to each youth member to check in about emotional, physical and economic needs and maintain relationships, including triage of urgent needs for their families and providing teletherapy and case management.
    - Engaged systems such as the West Contra Costa Unified School District, Contra Costa District Attorney's Office and Department of Probation regarding young people whose circumstances are not prioritized by system policies such as undocumented youth, youth with special needs, youth looking to reenroll/ transition back into school after incarceration, youth who are homeless or housing unstable, and youth who are in foster care.
    - Prepared a robust safety and reopening plan that has begun to be implemented this Summer season and allows RYSE to monitor public health regulations and

make adjustments that center the safety, needs, and well-being of young people and of RYSE staff, as well as provide support to community and systems partners serving young people in West Contra Costa.
    - Created a Youth COVID-19 Care Fund, providing direct cash disbursements to nearly 200 youth and their families, as well as assisted the City of Richmond with establishing a community-guided Richmond Rapid Response Fund.
    - Convened biweekly COVID Collective Care calls where up to 100 WCCC public system and CBO partners cultivate resilience and interdependence strategies, with RYSE youth artists and cultural workers sharing wellness and arts practices with adult partners.
- Uprising Against State Violence and Racial Trauma Response:

Statement of Solidarity with Black Youth Organizers 6/3/2020 and Black Healing Resources**:**

RYSE stands in love and solidarity with Black young people and young people of color across the Bay as they stand in their power and speak out against white supremacy and state-sanctioned violence. We stand in love and solidarity with young people who are taking to the streets or organizing virtually. We stand in love and solidarity with young people however they are holding, coping, struggling, surviving, and sustaining.

To our young people— RYSE loves you, we see you, we are sorry that our systems have not cared for you, and we know we have work to do to show up rightfully with you and for you. We commit to centering your emotional, physical and political safety. We commit to holding adults and the systems accountable to your safety, your humanity.

This commitment is ever present in this time of the COVID-19 pandemic and the ongoing pandemic of white supremacy and state-sanctioned terror against Black communities.

To our adult and system partners— We are aware of actions across the Bay, including in Pinole, that have been organized by Black youth leaders. There have been numerous attempts to violently threaten and dismantle their efforts towards peaceful demonstration. We STRONGLY condemn those who choose to mischaracterize and co-opt their efforts. We STRONGLY encourage and insist you use your places of power, influence, and responsibility to support our young people, to let them know they are loved, to apologize and commit to do better, and to hold each other in mutual support and accountability.

Ways we can show up for Black young people and young people of color to support their physical and political safety:

- Listen and show up ready to take their lead—support their leadership and ask them what they need.
- Offer support, guidance, and resources.

- Ensure their safety—be a buffer between young people and law enforcement or white supremacists, support as peacekeepers, and legal observers.
- Show them love & compassion, not shame or judgment—we are all learning and mistakes may be made.
- Affirm their showing up and taking leadership as acts of courage.
- Provide emotional support—do not censor their righteous rage, anger, and grief.

To our white and non-Black community members— here is a list of anti-racism resources and funds to support.

We must all continue to hold each other accountable in dismantling and ending white supremacy so that we can all dream, build, and flourish in the loving, just systems we deserve.

- Education and economic justice: 107 young people completed Education, Career, Let's Get Free or Case Management Plans and received tailored education and career support and linkages supporting mental health. This included individualized education advocacy provided in partnership with 22 young people in areas such as IEP support, support navigating a suspension, or with school transfer/ credit completion challenges. Individualized homework support, tutoring and SAT prep was provided in partnership with UC Berkeley's Upward Bound and AJ Tutoring.
    - Youth participants in Education for Liberation programming planned and facilitated community discussions about how schools should develop safety plans to protect undocumented youth and their families in school. They also planned and facilitated a Know Your Rights workshop for their peers about different types of police interactions and how to positively and safely respond in each situation, and held a bilingual Know Your Rights workshop in Spanish that built capacity for sharing information with their parents.
    - 22 young people completed Community Service requirements with support from RYSE. While completing service learning, most were able to participate in Youth Leadership Institutes and gender justice or racial justice workshops held in the center, as well as receive tailored case management support to work toward their health and wellbeing goals.
    - College navigation support included individualized and group higher education workshops (financial aid, scholarship information, higher education exposure activities, and a college resource fare), a field trip to the Black College Expo, and resources for undocumented students.
    - Youth participants in Hire Up, Rysing Professionals, and Side Hustle programming cultivated their creative, professional, interpersonal and healing/wellness skills as essential to career development. Participants received resume and job application support, participated in career panels, community projects and job

shadowing. Programming engaged at least 33 young people who came to RYSE through reentry/transition from juvenile confinement.

- RYSE continued our ongoing partnership with the Hidden Genius Project (HGP), a Tech Literacy and Skill-Building program for Black-identified males in the areas of computer science and entrepreneurship. The 3rd HGP cohort, RICH3, completed a 15-month intensive training program to a total of 23 young men ages 15-18, which included skill-based training in the areas of computer science and software development; critical thinking and problem solving; business law and entrepreneurship; leadership development; and identity development. In addition to the intensive, HGP alumni supported the Side Hustle program, offering peer-to-peer business mentorship; co-facilitated workshops; and HGP staff offered feedback for the Side Hustle small business pitch event. Amidst the transition to virtual programming, HGP and RYSE have stayed in consistent communication around best practices, coordination of services for youth, and monthly updates.

- Food justice: Tasty Tuesday programming continued to be held weekly, providing healthy cooking and community-building workshops addressing food scarcity. Our center maintains a full refrigerator for young people to access after-school-snack as needed. Other highlights included Smoothie Pop-Ups and food as a centerpiece for cultural community events held at RYSE (e.g., Night Out for Safety and Liberation; La Feria de Septiembre; Black Futures When Culture Speaks). Our garden has been closed for the past year due to RYSE Commons construction and will reopen with our expanded campus. We continue to receive donations from the food bank, however, navigate the challenge of receiving few nutritious options, and will be seeking new partnerships.
- Culturally affirming identity groups and peer support: RYSE peer support groups are designed for establishing emotional, physical, political safety to acquire tools and skills that combat and actively dismantle harmful norms. These affiliation groups - Young Men's Group, Sister Circle, Alphabet Group (LGBTQ youth and allies), Tribe Asé and Breaking the Frame: Anger Management Group - are spaces to gather to build connections to young people's own and one another's experiences through art, storytelling, somatic experiences and movement, and activities that highlight topics that impact young people's lives and healthy relationships. Over 89 young people participated in these groups.
- Leadership cohorts: 19 youth leadership cohorts were activated, with 3-10 members in each. Cohorts included HERE Action Researchers, Hidden Genius Project Rich 1, Hidden Genius Project Rich 2, RYSing Professionals, Side Hustle, Youth Justice Fellowship, CCA + RYSE Create Cohort, Climate Justice Posters Cohort, Video Advanced Media Producers, Music & Audio Advanced Media Producers, Visual Arts Advanced Media Producers, Spoken Tides, We So Bay Collaboration, Public Health Interns, Census Outreach Cohort,

District Local Control Accountability Plan Fellows, Phone Banking Interns, and Richmond Youth Organizing Team, and 116. Interns engaged in political education and organizing and leadership skill-based trainings including non-violent communication, feminism, gentrification, education justice, school to prison pipeline, immigration industrial complex, voter registration, healing practices, self/community care, and culture building/keeping. In July and August 2019, interns planned and hosted "This is How We RYSE: Remember, Reclaim, Resist, Reimagine," a 7-week program of training, workshops, and field trips to local youth organizations in WCCC. Interns built curriculum and facilitated the academy, centering identity, shared leadership, and new definitions of health and success.

- Arts-based healing: Young people have identified Creative Youth Development (CYD) as fundamental for healing from violence and distress (interpersonal and institutional), and for building power to dream and enliven beloved community. CYD is embedded in RYSE's model for atmospheric healing in WCCC, and heals and humanizes through reflection, connection, meaning-making, and narrative building. RYSE engaged over 326 young people through arts-based healing programming from July 2019-June 2020. Our arts-leadership pathway, Advanced Media Producer interns (AMP), engaged 27 young people in Visual Arts/ Multimedia Production, Music/ Performing Arts, and Video with weekly artistic mentorship, project-based learning, and opportunities to facilitate workshops, produce work, and apply their skills at RYSE and in the community. All AMP interns participated in the Summer Youth Leadership Institute. Visual Arts AMP interns developed a 2-month summer visual arts exhibition for Kaleidoscope Coffee in Point Richmond, which ended with a closing reception of young spoken word poets, dancers and open mic. Music/ Performing Arts AMP interns collaborated on a national We Are the World remix music video with the Music and Youth Development Alliance (MYDA), featuring two RYSE poets' original poetry and one RYSE singer's performance.
    - Daily arts workshops, pop-ups, and creativity-fueled youth events occurred each month and were integrated with health, education, and leadership programming, actively addressing trauma, stigma, healing and healthy relationship-building for young people using a variety of modalities.
    - AMP interns and core youth from RYSE's Youthtopia production collaborated with Neutral Zone in Ann Arbor, MI to explore gentrification in Ypsilanti, MI and Richmond, CA. Throughout the summer and fall, youth met through weekly video calls to develop a script, and RYSE youth visited Neutral Zone and performed in their culminating production in December 2019. Artwork from RYSE youth was included in the production, entitled *Staying Power: Concrete, Not Wood*.
    - The RYSE x George Miller Center collaboration builds bridges between RYSE members and the members of George Miller Center with the goal of building artistic confidence, community, and capability for all involved. The George Miller

Center works with young people in Richmond with developmental and intellectual disabilities to increase their confidence and connection to their peers. This ongoing partnership with Visual Arts AMP builds upon RYSE's Theory of Liberation and equity framework, where community building and resistance to narratives of disabled individuals are essential in pushing for our unified liberation. Sessions to date have included a step dance workshop, screen printing on fabric and murals, where Visual Arts AMP Interns co-facilitate the Visual Arts sessions.

- For the entire month of February 2020, RYSE youth celebrated African, Black, Caribbean History and Futures. The month kicked off with a "Woke Diaspora" Spirit Week to celebrate Black youth power, pride, resilience, and joy, and included professional photo shoots, youth-led open mics, and viewing parties of films that centered Black communities. The month culminated with a large-scale community event, When Culture Speaks, with over 120 community members in attendance and included a fashion show, visual arts exhibition, and musical performances.
- RYSE completed our collaboration with the Green Patriot Poster Project in March, where members developed posters addressing climate injustices and its effects on the future of our environment. During a series of workshops, youth learned about the climate crisis and mobilization actions. The workshops included presentations from young leaders of the Sunrise Movement and Richmond Groundworks, as well as a visit from the National Park Service's Principal Climate Change Scientist, Patrick Gonzales, and guest teaching artist and activist, Nancy Pili Hernandez. The program concluded with an interactive tour of the Rosie the Riveter/WWII Home Front National Historical Park to learn more about the rich history of the shipyards and World War II "Total Mobilization."
- In the spring of 2020, RYSE partnered with Youth Speaks on a collaborative 10-week performance process and production with three RYSE youth who wrote and performed original poems about identity, community, belonging, displacement, gentrification, and their love for the Bay Area. They, along with other local arts organizations and Youth Speaks, performed in Richmond and on the BART line, as well as in San Francisco in early March. Performances included poets, dancers, and storytellers, and allowed for transformational community building.
- RYSE began a pilot program which trains youth to present and facilitate trauma informed and healing arts professional development workshops. Youth facilitated trainings were held at the Alameda County Office of Education's Inventing Our Futures Institute in Oakland summer 2019, Creative Arts Charter

School in San Francisco fall 2019, and the National Guild for Community Arts Education National Conference in Austin, TX fall 2019. RYSE Video Fellow, Isaiah Grant, participated on two filmmakers' panels- Ecology of Place at IMPACT Film Forum (SF Green Film Festival 2019) as well as Richmond Rainbow Pride Film & Culture Event. RYSE transitioned this program to a virtual space in March 2020, where 15 RYSE artists joined and led webinars and virtual workshops with partners including, the National Guild for Community Arts Education, Arts Education Alliance for the Bay Area, the Alliance for Media Arts + Culture, and WCCUSD.

- RYSE continued our partnership with California College of the Arts on a design program, RYSE with Design. RYSE members and CCA Design and Architecture students are developing a design element centered on the theme of belonging that will be installed and on permanent display in RYSE Commons when it opens in 2021. Workshops began in December 2019 and continued onsite through March 2020. Students and members continue to attend virtual workshops and studio design sessions. The program will culminate at the end of July through a community presentation of the design renderings.
- Projects completed by AMP Interns and youth artists include:
  - RYSE Pride Video by Isaiah Grant
  - Police Brutality Music Video by Anii (Jashawna Chaney):
  - Youth poet, Adriana Avalos, reads her collaborative poem written with fellow youth poet, Geovanni Jahiem Jones, in response to the We Are the World song:
  - RYSE youth artists and activists, Isaiah Grant, and Geovanni Jahiem Jones, joined the Alliance for Media Arts + Culture's Summer Youth Summit Video Roundtable on Rebuilding Systems for Equity

- Youth-led community events: Community events such as Youth Justice Month, Health is a Humxn Right, the Black History/Black Futures Lit Diaspora Fashion Show, Not-So-Silent Night, La Feria de Septiembre, Night Out for Safety and Liberation, and RYSE Pride included healing circles, workshops, trauma-informed reflection, skill-building, and arts based activities like screen printing, photography, fashion, spoken word, beadmaking, dance, poetry, performance, design and event production activities. Events were designed to connect to the broader community and families of young people, and to position young people as leaders in telling their stories and healing themselves and their communities. Our last physical events in the building were during African, Black, Caribbean History and Futures Month with a "Woke Diaspora" Spirit Week to celebrate Black youth power, pride, resilience, and joy. Each day of the week was themed so Black youth members, and allies, could dress up and engage in fun activities. Members enjoyed professional photo shoots, performed in youth-led open mics, watched and

discussed movies that centered Black communities. To close out the week, staff and members organized a Block Party outside of RYSE, coming together for food, music, games, and dancing. This month culminated with a community fashion show centering young Black designers and models, where youth members walked the runway, performed, danced, and felt powerful in their own bodies.

As the intersecting crises of a global pandemic and state sanctioned racial trauma/violence permeated our community beginning in March 2020, youth participants have increasingly stepped into leadership roles in virtual forums, school board/city council/statewide advocacy calls, and in organizing their peers and community members in centering the experiences of undocumented youth, youth with disabilities, Black families, and youth who are reentering from incarceration in public health, public safety, and education system responses.

Trauma Response and Resiliency

RYSE directly supports victims of critical injury through our hospital-based violence prevention program and community referrals. Our clinical team works to ensure that all participants in our program have

access to both immediate and primary care options as well as a range of other resources to ensure safety, recovery, and wellbeing.

RYSE works with youth to provide transitional support and reentry services for youth leaving juvenile hall and the Boy's Ranch to establish a youth-led process for successful transition back into the community. Many of these engagements require assessments of needs including coordination of care for legal, medical, and resource navigation. RYSE has successfully deepened our relationship with the Contra Costa Probation Department.

RYSE launched a collaborative agreement with the District Attorney's Office to bring restorative justice diversion to Contra Costa County. 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. RYSE staff began training and preparation in August 2019 to launch in early 2020. To date, 11 young people have participated.

RYSE's continuum of direct services to systems change approach is critical to our partnership with WCCUSD. Over the past year there have been numerous incidences of violence profoundly impacting young people, including the loss of student's lives. RYSE has worked to support the school system as best we can during persistent and heightened moments of crisis occurring at the schools and District levels and build from there.

Individual students, parents, teachers and administrators continue to turn to RYSE for support and coordination. RYSE Center opened early for students who did not feel safe attending school

providing sanctuary amidst distress; and facilitated conversations and meetings amongst District staff to develop a protocol and communication tree that is responsive, trauma-informed and ensures comprehensive supports for all school community members impacted. RYSE served as a space for students to process and work to address the saturation of trauma they experience in schools from holding altars to facilitating arts-healing activities to developing plans for how the RYSE Commons space can better meet their needs in and out of school.

During this reporting period, RYSE's clinical staff engaged 120 young people in therapeutic counseling and staff supported 41 young people in re-entry, diversion, and school-linked intensive case management and support.

- Case management was provided for all participants, building integration and access to RYSE's full model. Services provided include but are not limited to: welcome home care packages; support with transportation to and from court; providing information to incarcerated client's family; clothing support; DMV appointments; transportation; grocery shopping; housing assistance; character letters; community service hours support; anger management programming.
- Individual clinical therapy ranged from 3-6 stabilizing counseling sessions, to continuous relationship and monitoring between the therapist and young person over the entire year. During this reporting period, 17 young people who require Spanish for themselves or in communication with their parent/guardian received therapy.
- RYSE continued an arts-based healing program at the Orin Allen Youth Rehabilitation Facility entitled Freedom Beatz. This program uses hip hop history and healing-centered listening and writing exercises that include developing and recording of a Cypher, a collaborative hip-hop medium grounded in respect, community, and authenticity. A central component of the workshop series is for youth and corrections officers to be learning equally alongside one another and collaborating creatively - facilitating mutual respect and promoting healthier relationships. Workshops are designed to shift harmful power dynamics toward young people by adult officers and improve relationships among young people.
- In Spring 2020, RYSE clinical staff resumed attending the Richmond Office of Neighborhood Safety Operation Peacekeeper Fellows meetings twice weekly to provide emotional and psychosocial support to participants, as well as facilitate warm-handoff referrals to mental health services at RYSE and in the community. Breaking the Frame: Anger Management (BFAM) is a group where anger is framed within the socio-political context of trauma and violence in our communities. Participants engaged in conversations around the source(s) of their anger/trauma, developed healthy coping skills, and found ways to channel the energy into creating restorative change by utilizing music, art and media; psychoeducation; Theater of the Oppressed techniques; and Non-Violent Communication. In response to the Shelter-In-Place Order, uprisings and

environmental distress, BFAM was transformed into the podcast, No Supervision, to increase young people's access to coping tools while also providing youth with messaging that uplifts their righteous anger. Episodes created can be found here: https://anchor.fm/nosupervision

Inclusive Schools

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.

- DLCAP Interns conducted an analysis of WCC District funding and mental health supports available for youth and other measures ensuring safe environments for LGBTQQ youth.
- Richmond Youth Organizing Team planned and led a Summer 2019 Academy titled, 'This is How We Ryse: Remember, Reclaim, Resist, Reimagine,' providing foundational organizing and social justice training for their peers such as Organizing 101, Mental Health, Know Your Rights, Civic Engagement, Census 101 and Gender Justice and Allyship. In February was our week-long Spring Youth Leadership Institute, where youth organizers deeply engage in workshops including ones about decolonization, interrogating systems of oppression, understanding gender identity, creating life and vision boards, and solidarity across differences.
- COVID-19 Safety & Wellness: During the COVID-19 pandemic and shelter-in-place, Alphabet Group members have been meeting virtually. In addition to their workshops and activities, youth members have been researching and running a social media awareness campaign, sharing health and wellness resources specifically for queer youth. On June 23rd, they held a virtual panel discussion on their findings and reflections, where they also interviewed LGBTQ+ community leaders Carolyn Wysinger, Kiki Tapiero, and Cielo Flores on how adult allies can show up in support for queer youth.
- RYSE Pryde Month Events: Alphabet Group organized three virtual events celebrating the power and joy in their communities that persists despite the ongoing pandemics of COVID-19, racism, and hate. One event included collaborating with Drag Queen Die Anna who provided a glam tutorial to share about make-up, performance, and daily care practices. The group also organized a social media campaign highlighting historical and present-day pioneers in the equality movement for the LGBTQ+ community. The final event as mentioned above was the Ryse Pryde Panel that explored the experiences of Alphabet Group members during COVID19 and a community leader panel discussion. Select quotes from member who participated in the events:

    - *This is the generation that can make a change for a better future. Youth voices are powerful and will always be powerful because we know what we want, and we know what we need.*
    - *We are the future of this world, this beautiful planet we call home. It's up to us to make our voices be heard. RYSE's Alphabet Group stands in solidarity with our LGBTQ+ community, peers and allies of all backgrounds. Our arms are wide open, welcoming, and full of love.*
- Action Research Projects: The Intersections Cohort at RYSE was founded by youth fellow Dulce Garcia. Youth interns are conducting action research focusing on the impacts of gender discrimination and sexual prejudice in schools and how these factors contribute to unsafe learning spaces and negative school climate. Most recently, they have been surveying their peers and will be working on a video storytelling project.
- Youth-Directed Films: Isaiah Grant is a youth filmmaker, long-time Alphabet Group member, and now current RYSE Youth Staff. Most recently, he created a video in celebration of LGBTQ+ self and community love at RYSE.

Systems Change

- **Rapid Response for Systems Transformation:**
  Since the Shelter-In-Place began in March, we have convened an ongoing community care call with almost 100 city and public systems, health and social services providers, and the school district to elevate a range of critical supports for Contra Costa County. This West Contra Costa COVID Community Care Coalition recently launched the Richmond Rapid Response Fund (R3F) to support our community.

- **Youth Leadership Representation:**
  Every RYSE leadership cohort involved in policy roundtables or committees at the District or local level have pushed for accountability to young people in the information-sharing and decision-making processes that impact their lives. They have helped frame policy decisions, ensured that parents and youth have a say, and made recommendations for reconciliatory practices that undo the exclusions and harms they witness during the meetings they attend.
    - R.O.N.A - Resilient Youth Organizing Now & Always *(Youth leaders coordinated a West Contra Costa Youth-Led Town Hall on April 30th, high school panelists presented on students navigating stress, COVID-19, the healthcare system, government actions, and distance learning. Two youth poets performed. Youth Organizers facilitated three breakout groups: Letter to you representative advocating for legislation; Our community our choice; and Centering health and wellness, distressing, self and community care in times of a pandemic.*

- Black Youth Forum *(space for black identified youth to share our needs and demands for WCCUSD*)
- DLCAPs youth fellows Stephanie and Dawit participated in *Student Support Circle, Institutional Racism and Implicit Bias* with Tony Thurmond: https://www.facebook.com/watch/live/?ref=watch_permalink&v=897173690800182

- **Kids First Richmond:**
  RYSE continues to be 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 are enlivened within the implementation and launching of the Department. We have provided guidance on the development and implementation of the oversight board as well as the community needs assessment which launched this summer. RYSE will host focus groups as well as participate in community forums. Simultaneously, we have also organized against the Mayor's effort to circumvent the will of voters, youth, and community by attempting to cap the Kids First measure; without using accurate data or partnering with the community. This occurred during the uprisings for Black lives and the defund movement. RYSE has joined a diverse collaborative working to reimagine public safety and protect and increase investments for essential services and programs.

- **Training and Sharing Praxis (CCHS and Health Partners):**
  In September, RYSE was awarded the Robert Wood Johnson Foundation Disrupting Systems of Dehumanization for Boys and Young Men of Color award, providing support for our deepening partnership with the Contra Costa County Health Services Department, Trauma Transformed, John Muir Hospital and LifeLong in designing a Health Home for youth of color. As part of this work, three Public Health Interns from WCCUSD have conducted a needs assessment into youth health needs to inform planning for the health clinic. RYSE is part of the Contra Costa Health Department Envision Health workgroup developing the next Strategic Plan and desired community impacts for the county health department. This includes serving on the Countywide Social Needs Taskforce.

- **Speaking/training engagements included, but were not limited to the following:**
  - Baltimore City Department of Health Site Visit, July 16
  - Contra Costa Victim Assistance Center - informational training on CalVCB, July 31
  - Center for Human Development Site Visit, August 7
  - Restorative Justice Diversion Training, August 27-30
  - Healing Justice Alliance Conference, September 11-13

- WCCUSD Counseling New Hire/Interns Training, October 2
- Center for Human Development Site Visit, October 17, *RYSE staff shared best practices for hospital-based intervention programs for victims of violence*.
- Building Blocks for Kids, CELI, November 2, *Shared RYSE approach and practices to healing-centered leadership and systems change*
- Beyond Violence All Partners Meeting, November 5, *RYSE staff presented on the RYSE clinical model that centers the lived experience of young people of color.*
- Public Health Advocates Statewide Conference, Long Beach, November 21, *Presented RYSE's articulation, approach and practices in violence prevention and intervention*
- California Wellness Foundation Conference, San Diego, November 22, *Presented RYSE's articulation, approach and practices in violence prevention and intervention*
- Asian & Pacific Islander Mental Health Empowerment Conference - Clover, CA, November 21-22, *RYSE presented on the RYSE clinical model that centers the lived experience of young people of color*
- Contra Costa Community Restorative Justice Training, December 3 John Muir Residents presentation, January 2, *RYSE presented to residents at John Muir Health about RYSE approach in preparation to residents providing on-site information about health to RYSE youth.*
- CoCo RJ Training: Interpersonal Violence & Restorative Justice, January 17
- Youth Listening Session-Mental Health CA, January 23
- CPR/AED/First Aid Training, January 29,
- CoCo RJ Training: Creative Interventions- Accountability, Safety and Emergency Responses, February 13
- Supporting Male Survivors of Violence National Site Visit to RYSE, March 6, *RYSE presented our articulation, approach, and practices in violence prevention and intervention to violence interrupter programs from Philadelphia, Santa Cruz County, and Richmond*
- CoCo RJ Training: Privilege, Power, & Equity, March 11
- Webinar, Manager and Supervisors "Combating Sexual Harassment in Social Justice Organizations", March 11
- WCCAA's 60 Min in the Faculty Lounge, May 22, Clínical Director *Marissa Snoddy speaks at on the importance of mental health supports for young students during the shelter-in-place:* https://www.facebook.com/watch/live/?v=957584634670730&ref=watch_permalink

- SEL, Beyond the Checklist, June 3, *Education and Justice team members Deysi Chacon and Andrew Yeung present on Communities for Just Schools Fund panel:* https://www.youtube.com/watch?v=czjjuUZlfgk

- **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. DLCAP Fellows hosted, attended or co-facilitated 18 community events or workshops to build transparency and community engagement in LCAP funding process, including meeting with SNAT, WCCUSD School Board and District focus groups. Meetings held since December 2019 include 5 SNAT meetings, 8 WCCUSD school board meetings, 1 School site council meeting, 3 DLCAPS Committee Meetings, and 1 District Breakout meeting with youth. After attending the school to prison pipeline training by Tia Martinez, DLCAP Fellows decided to focus on creating a cohort of organizers to focus on transforming students' experiences with policing in school. The immediate focus was to continue getting accurate data from the district about school suspension, expulsions, tardies, and referrals. It was also named the need to understand how race, gender and ability are part of the frame for these policies. Currently DLCAPS youth and SNAT members are drafting the LCAP to include funding and support systems impacted youth and youth with disabilities.

- **Census:**
  Our Census 2020 outreach and education efforts were led-by and centered young people of color from West Contra Costa (WCC), utilizing many of the outreach activities and education strategies utilized in our annual civic and voter engagement programming. Activities included phone banking, door-to-door canvassing, community events, virtual youth workshops planned post-shelter-in-place and social media, which extended our reach beyond WCC. Additionally, staff and youth assumed the role of informal ambassadors for the Census 2020; posting about the census on social media after they completed the census for their household, talking to family and friends about the census and youth leaders developed content for social media. Census outreach and education was also interwoven in our general program and organizational activities; announcements were made during virtual youth programs, census education was integrated into our member check-in and case management calls after the shelter-in-place order was announced, virtual youth-led town halls, the weekly WCC Community Cares Calls and on our monthly blog post.

- **RYSE Commons:**

On September 6th, 2019 over 200 community members attended both in person and virtually for the RYSE Commons Groundbreaking Ceremony, held on the land where construction has been ongoing since July 2019. Youth-led design of space continues, as youth cohorts have and will continue to engage in design sessions for how spaces can include programs and projects they envision. Partnership conversations and collaboration with health system partners, Probation, the District Attorney, and the West Contra Costa Unified School District have been vital to developing and re-imagining ways that RYSE Commons can create and sustain healing conditions for young people. We have successfully raised $4,526,153 of the $10M campaign (received and committed). All funds are being used to meet our NMTC and bridge loan commitments that allowed us to receive financing for the project up front.

This current crisis is and will continue to take an inevitable, unjust toll on the community, but it can also create an opportunity to galvanize multiple efforts, generate a response which limits the negative impact of COVID-19, and bring additional partners to the table to take community health and power-building in Richmond to the next level, embedded into activation plans for RYSE Commons. RYSE Commons is the physical manifestation of the collective care work we have been leading during this crisis. It exemplifies the infrastructure needed to weather uncertain times with a community led /youth led approach. The RYSE Commons vision runs resolutely through everything that we do. The pandemic required us to call and build upon an already strong network of partners, leaders, and advocates. Our collective work, our love, rage, and hope, our radical community care—this is what RYSE Commons is all about. RYSE Commons is more than just a building. RYSE Commons is a movement led by our past, present, and next generation of youth leaders. RYSE Commons is a container for the transformative work our youth and adult leaders are presently doing and will only continue to grow. RYSE Commons is the physical home that will finally provide the space, state-of-the-art equipment, and resources to match the power of the young visionaries working within it. This property will allow RYSE to develop a Health Home for young people of color as a key component of RYSE Commons.

RYSE was also featured on and contributed to the following sites during this reporting period:

- ACES Connection: Recommendation Roadmap for Prop 64 Expenditures
- Prevention Institute : California's Proposition 64 Youth Education, Prevention, Early Intervention & Treatment Fund Briefing Paper
- RYSE co-authored an abstract about the collaborative work on Prop 64, which was accepted and presented at the American Public Health Association November 2019 meeting
- East Bay Express: Rising to the Challenge in Richmond

- Fast Company: This Center is a Space for At-Risk Youth to Learn How to Create Change
- San Francisco Business Times: Richmond Youth are Turning Dreams into Reality Through Innovative Economic Pathways
- Insights, Volume XVII, Winter 2019: *Trauma and Child Welfare: Strategies for Preventing and Intervening to Promote Healing*
- Center for Healthy Schools and Communities: Restorative Justice in Action
- Afterschool Matters, *Trends in Creative Youth Development*
- The Aspen Institute: Forum for Community Solutions, *Scan of the field of healing centered organizing: Lessons learned.*
- Partnership for the Future of Learning, CA COVID Response
- Forward Promise, Impact of COVID 19 in Communities of Color
- Dhaliwal, Kanwarpal & Casey, Jill & Aceves-Iñiguez, Kimberly & Dean-Coffey, Jara. (2020). Radical Inquiry—Liberatory Praxis for Research and Evaluation. New Directions for Evaluation. 2020. 49-64. 10.1002/ev.20415.
- School Mental Health Crisis Leadership Lessons: Voices of Experience from Leaders in the Pacific Southwest Region
- Restorative Justice in Action: Lesson Learned for Successful Implementation of Restorative Justice

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.

RYSE works in persistent proximity with young people to listen to, validate, and hold their lived experiences and articulations of distress, as well as those of resistance and resilience. We also work in proximity to the organizations and agencies responsible for young people. Amidst the profound changes and impacts of the pandemic and the uprisings on our communities, we stay steadfast in all our relationships and connection. We have had to make pivots within pivots, reacting, responding, and still stewarding our vision and values for a long-term vision of liberation. The Shelter-In-Place and pandemic required us to adjust and adapt all our operations and efforts, including our evaluation and inquiry. While we were not able to conduct our annual member survey, below are findings from our various program impact surveys conducted during Fall 2019 and Spring 2020 that reflect key measures in our service workplan. We are working with our internal team and evaluation partners to recalibrate our member impact tools to continue to stay attuned to and center member experiences, needs, and priorities.

Key measures:

- *70% of RYSE members report benefits of RYSE programs and services that support mental health and wellness.*
- *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.*

Findings:

- *RYSE's Spring 2020 surveys of counseling, case management, and trauma response support participants found the following (N=38):*
- ➔ *100% of participants felt understood and respected by case management and clinical staff.*
- ➔ *100% of participants felt that case management and counseling spaces were safe spaces for them to express their needs, concerns, fears, goals and aspirations.*
- ➔ *92% of participants agreed or strongly agreed that being part of counseling/ case management helped them know more about rights and choices when navigating public systems (such as health, education, juvenile justice, foster care immigration, and law enforcement).*
- ➔ *100% of participants agreed or strongly agreed that counseling/ case management has helped them feel that it is okay and positive to be in programs or services that support their mental health.*
- ➔ *100% of participants agreed or strongly agreed that counseling/ case management has helped them to be able to be more vulnerable and confront pain head on.*
- ➔ *100% of participants believe they will be able to use what they learned in counseling/case management.*

Select quotes from Spring 2020 participants:

"[Something new I will try is] ... mood charting to help me understand how I am feeling and what I need to get better."

"[Something new I will try is] ... communication with people who are important to me or have hurt me."

"[RYSE case managers are] … very understanding and willing to put in the work to help one out, going the extra mile to make sure I am being taken care of during hard times."

"I feel loved and supported - it's a great healing space - I feel cared for."

Key Measure:

- 70% of members demonstrate progress toward desired skills/goals related to their participation at RYSE (subset of members with a defined plan) Select results from Fall 2019 and Spring 2020 Program LITs:

Findings:

- ➔ 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: 75% 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: 99% agree or strongly agree that their GPA improved and 99% agree or strongly agree that they reached one or more of their education or career related goals.
- ➔ Hire Up: 50%-75% agree or strongly agree that they feel more prepared and confident as job applicants along seven key measures.
- ➔ Young Men's Group: 100% agree or strongly agree that they have a better understanding of how social conditions of violence affect individual and community health.
- ➔ Transition & Reentry: 67% agree or strongly agree that RYSE supports have helped them know more about their rights and choices when navigating public systems.

Key Measures:

- *80% of the total number of stakeholders involved in TRRS series will report increased understanding and capacity to practice trauma-informed youth development.*
- *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*

Findings:

- Convene biweekly West Contra Costa COVID Community Care calls where up to 100 WCCC public system and CBO partners cultivate resilience and interdependent strategies, with RYSE youth artists and cultural workers sharing wellness and arts practices with adult partners.
- RYSE partnered with Trauma Transformed to launch the Racial Reckoning Series, known in previous years as the Trauma and Healing Learning Series.
    - At least 609 adult stakeholders have attended the Series to date,
    - which has included 4 sessions. See information below on each session.
    - Part 1: Revealing White Privilege and Healing Racial Trauma
    - Part 2: Revealing White Privilege and Healing Racial Trauma

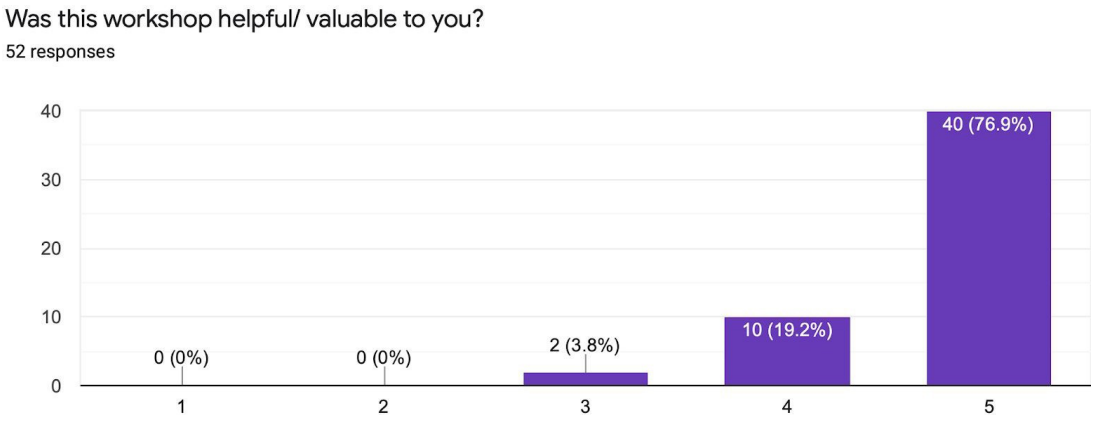
- Part 1: Revealing the Racial Harms of Public Education and the School to Prison Pipeline
- Part 2: Revealing the Racial Harms of Public Education and the School to Prison Pipeline
- 100% of session evaluation respondents form Session 1 (N=92) answered that they would recommend the series to colleagues and co-workers.
- Parts 1 and 2 of our Revealing White Privilege and Healing Racial Trauma have been required viewings of staff at Contra Costa First Five and for staff in Supervisor John Gioia's Office.
- Select quotes from Series participants:
  - *I really appreciate the series because it calls out the compliance of non-black groups in perpetuating racist thinking and policy. I was not prepared to reckon with that part of myself but am glad to start to reckon with it.*
  - *My current understanding of this is that I can't only consider how "systems" are acting upon people's lives and how I can act on them, but that I myself am a part of them. Talking about systemic oppression can make it easy, especially for white folks, to feel separate from the systemic problem. Even though I know that I am a part of white supremacy and have to be an active part of dismantling it, this statement helps me get deeper into this idea and get closer to the truth of it. It also means that I have more to do as a part of the system to be active, aware, and productive in dismantling oppression and working towards liberation.*
  - *I appreciate the deepened conversation on what it looks like for organizations to disrupt their systems for the purposes of healing racial trauma.*
  - *You (Tia Martinez) and this training and Ryse is an embodiment of change.*

- The moments of supremacy and uprising we are in have pushed some of our County leadership to put forth the call for the County Office of Racial Equity and Social Justice. Next month, Supervisors John Gioia and Federal Glover, who represent the district RYSE is in, will introduce a board order to establish such office based on the directions and recommendations from a community engaged planning process. RYSE and Contra Costa Health Services, along with partners at Family Justice Center, Trauma Transformed, and Public Health Advocates are part of the core team. This Executive Summary provides details of the planning process, which is grounded and held in radical inquiry.

RYSE Program Data since COVID-19 Shelter-In-Place- March 2020-July 2020

Virtual Program Survey:

- When asked if the program/ workshop was helpful or of value, approximately 50 young people responded that they felt that it was helpful and valuable to them. Not one young person selected 1 or 2 as an answer for this question. What we can learn from this data is that young people felt that:
    - It was a welcoming space It gives space to interact with others – connection
    - It felt like a safe space
    - It is a space that allows young people to express themselves
    - Understanding and open to young people's needs



- Out of 52 responses in the Virtual Program Survey, 40 young people said that they would recommend the program/ workshop they attended to a friend.

- Although most youth who have filled out the Virtual Program Survey feel very positive about the programs and Workshops they are attending, the two main areas they have felt that RYSE Staff can improve are o.
    - Adding more online Polls and/ or Games
    - Making more time in the workshop/ Program to complete everything that is planned out to do

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.

- While the total number of youths served during this reporting period is 613, 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 member's 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 works closely with partners to reflect youth agency and power and shift harmful practices. Examples include:

- As part of countywide and multi-system care teams, RYSE often brought a perspective about a young person that speaks to their assets and successes and counters stigmas or challenges that they face elsewhere.
- Arranging caregiver and guardian meetings to help align understanding of local resources for violently injured and criminal legal system impacted youth.
- Establishing a referral pathway to housing services and working with housing partners to better accommodate and respond to young people navigating trauma.
- Working with schools to avoid credit loss and smooth transitions for transferring, reentry and secondary school completion.
- Building coalitions and youth leadership teams focused on services for higher-need students that prioritize young people in systems.
- Naming how language within systems impacts young people, e.g., working to change practice of calling youth "wards" in response to conversations with young people.
- Outreach and coaching for local employers to design job pathways and supports that are tailored for systems-impacted young people.
- Engaging in and sharing RYSE youth participatory action research about young people's experiences with mental health and coping, navigating gender-based violence, and

seeking/ accessing health care to inform providers about needs, gaps and desires from young people most impacted by trauma.

- Hosting site visits with La Clínica de la Raza, Trauma Transformed, and LifeLong Medical - discussing sustainability, co-location, and partnership for a youth-centered health home.

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.

Youth Leader Check In: 4/7/20

As we move into our second month of physical distancing during the COVID-19 pandemic, youth leaders are convening virtually to base build, organize, and advocate for their peers and families. RYSE is actively working with members to identify and respond to needs.

We checked in with Camila, one of our youth organizing interns, to share about her experience so far, and to identify the needs she is witnessing in her communities.

How are you feeling during this time of physical distancing and shelter-in-place?

I'm feeling like I'm on a rollercoaster, it's a mix of emotions. I get anxious and overwhelmed but at the same time I'm happy and I feel secure. I get to spend time with my family and have more time to do stuff I'm not able to do on a daily during class time and while being safe at home. And I'm also anxious because I know I can't get out of my house and, well, the virus keeps on getting worse.

What are some concerns and needs you are hearing from youth and from the community?

Info from food banks, on what to do if you have coronavirus if you do not have medical or a health service, and what to do if you get in a position where you can't handle the stress and anxiety. Also, how to get help if you are not a U.S. since citizens are getting help from the government. I guess the most important thing is to keep calm and wash your hands as much as you can and to not touch your face.

Which virtual programs have you been a part of at RYSE, and what has that been like?

I'm currently involved in the virtual art meetings every Wednesday. I find it fun to be in and safe. I love that place, TBH, I feel like I can open my mind and not be judged even though I haven't done much. I feel like it is the safe place I'll always wanted to be in.

Is there anything that you've found inspiring or grounding lately that you'd like to share?

Yes, it's an idea that Camila Cabello (my favorite singer/idol) gave me in one of her latest live videos: the way I'm handling this quarantine is putting my emotions down on paper by drawing, or trying to get better at making poems, or even writing songs (haven't worked yet but trying). And, well, something I'd want to practice is dancing—I'm looking for salsa videos on YouTube.

We checked in with Ann, one of our youth organizing interns, to share about her experience so far, and to identify the needs she is witnessing in her communities.

How are you feeling during this time of physical distancing and shelter-in-place?

At first, I was calm about it because I enjoy staying at home, but I became anxious and overwhelmed when we were told it can last for weeks, all I thought was, what will I do in the next few weeks, what will happen with school, work, and everything else. It's been weird since I got used to having a schedule every day and not being able to go or do usual things is an adjustment.

What are some concerns and needs you are hearing from youth and from the community?

There are a lot of folks in the community who do not have any resources and many people who have been off work who lost their source of income. Which brings us to not having access to food and essentials. With online education happening, some households do not have Wi-Fi or students do not own technology. Also, there are youth that do not feel safe in the household which can make the Shelter-In-Place difficult for them overall.

Which virtual programs have you been a part of at RYSE, and what has that been like?

So far, I've been to the SPEAK POET virtual workshop/program. It was a new but great experience. I had a chance to connect with RYSE folks who I missed seeing and hearing from. It felt great to still be able to do workshops that involve writing poetry which has been my ways of coping during thesetimes.

Is there anything that you've found inspiring or grounding lately that you'd like to share?

My initial reaction was to make sure I'll be able to get things done. What I have noticed is that many have been using these times to try to be productive and making sure they are constantly doing work. This pandemic should not be a sudden competition on productivity. There have been times I've lost track of days, but I've learned to go with how my mentality, emotions, and body wants to be during that day. I took some of the days to get back on activities I couldn't do during busy times. Also, I feel like this has been the moment when the world is telling everyone to slow down. To let ourselves realize what we have in life. To be able to stay home, be with loved ones or even alone. Just knowing that it is okay to let ourselves be with time, let ourselves feel any emotions about all this. Let ourselves finally be us.

Do you have a personal wellness practice that you'd like to share?

In the chances I get in the mornings before I have virtual classes, I would light a scented candle and journal to write my hopes for the coming days and what I've been grateful for or just how I'm feeling now. I've been writing poems and listening to music more than usual. I've been doing exercises to keep my body moving. Cooking has been more than usual too. I've been painting and taking naps a lot also. Lastly, I've been watching a lot of shows and movies.

Trauma Response and Recovery

P. is a 16 yr. old young woman who came to RYSE in crisis and experiencing a high-level of distress. She had fled her home where she had been repeatedly physically and sexually abused by someone who lived with her. P. had told this to many service providers who made child abuse reports, but without "substantial evidence" the reports had been dismissed over the last two years. P. was continuously placed back in her home. Disappointed in systems that were supposed to protect her, P. felt it was safer for her to be on the streets where she was engaging in survival sex to get her needs met, than to be at home. As opposed to assuming what P. needed, RYSE staff worked with her to identify what her goals were and what safety looked like for her. We were able to get P. into a youth shelter in San Francisco, where she could stay while her case was being investigated by child welfare. Although the process had been hard on P. because she repeatedly had to "prove her abuse in court," she eventually was believed and became a foster youth. This opened more housing possibilities for her and the Trauma Response Specialist working with P. was able to connect her with two organizations, The Sparks Initiative and Voices Youth Programs, that supported finding P. a safe place to live. In addition to this work, RYSE has been able to consistently provide P. with financial supports to purchase clothes and essential items she had lost. With all that was happening in P's life, it was important to her to not fall behind in her education and to finish school. RYSE was able to support this by providing her with transportation support to be able to continue attending her school, no matter where her foster care placement was located. P. self-reported that she felt that supports she received from many RYSE staff prepared her for her future and that RYSE "feels like a family...everyone is so helpful, so loving."

PEI ANNUAL REPORTING FORM

PREVENTION REPORTING FORM

FISCAL YEAR: 19-20

Agency/Program Name: Stand! For families Free of Violence

Project (if applicable): Youth Education and Supportive Services (YESS)

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

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

SERVICES PROVIDED / ACTIVITIES:

Please summarize the Scope of Services as outlined in the Service Work Plan. Please also address any other relevant activities or events that took place during the reporting period.

Contractor will assist the department to implement the Mental Health Services Act ("MHSA") Prevention and early Intervention ("PEI") Program. Specifically, Contractor's services hereunder will include, but not limited to, the following:

- The contractor will assist the department with implementing the "You Never Win with Violence" and "Expect Respect" program.
    - Contractor will provide primary prevention activities to educate seven-hundred fifty (750) middle and high school youth about teen dating violence.
    - Contractor will provide up to sixty (60) school personnel, service providers, and parents, subject to their capacity to participate with Contractor's outreach efforts, with knowledge and awareness of the scope and causes of dating violence, including bullying and sexual harassment, to increase knowledge and awareness of the tenets of a healthy dating relationship.
- Assist the department with implementing the "Expect Respect" programs.
    - Contractor will provide secondary prevention activities for up to Two hundred (200) youth experiencing or at risk for teen dating violence.
    - Contractor will conduct up to sixteen (16) gender-based support groups that are each ten (10) weeks long as feasible within school's semester schedule.
- CCC residents receiving services under this contract are referred to as "clients".

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services. Numbers served during the fiscal year. Describe any adaptation of services due to COVID-19 that may be relevant For PEI – Prevention programs, please describe: 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.

- During this reporting period we served 1445 participants in 55 presentations of *You Never Win with Violence* curriculum. Goal exceeded.
- *Expect Respect* and *Promoting Gender Respect* curricula-based Groups: 146 participants and seventeen 17 groups were served. Goal achieved.
- Provided 17 gender-based support groups that were 10-sessions each. Goal exceeded.
- Adult Allies: Provided teachers and other school personnel training. Goal achieved. (Please see attached evaluation report.)

All data collected from pre and post evaluation surveys are initially reviewed after each presentation and/or support group to determine if clients completed the questionnaire and if the surveys contained information requiring staff immediate follow up and/or intervention.

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

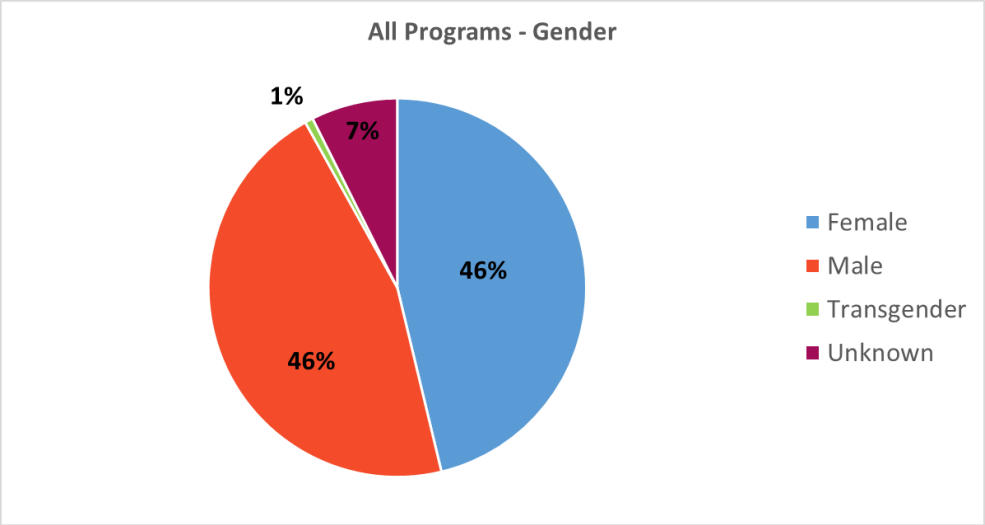
Please refer to Aggregate Data Reporting Form and tables provided in this report.

Total Clients Served:

We have served a total of 1778 clients through all our Prevention programs throughout the Fiscal Year.

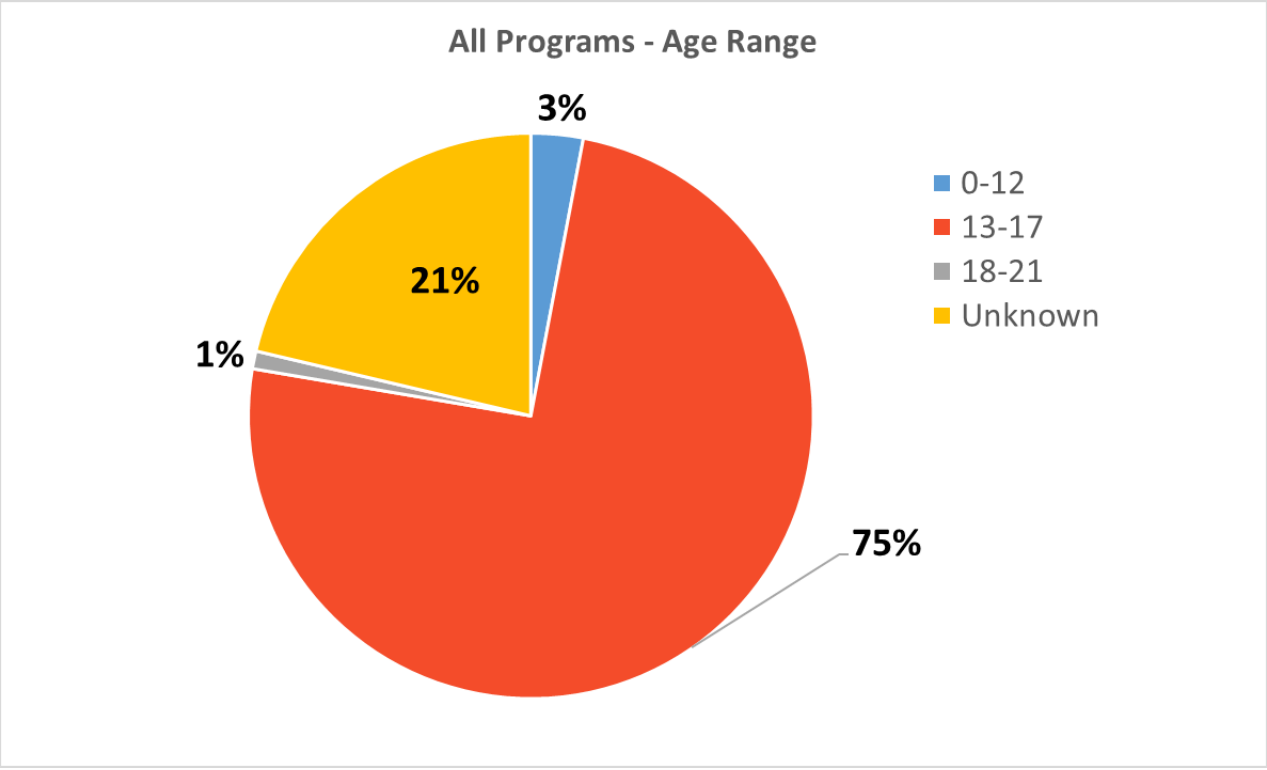
Gender:

Male Identified: 851 clients; Female Identified: 862 clients; Transgender: 13 clients; Unknown/Unreported: 52 clients.



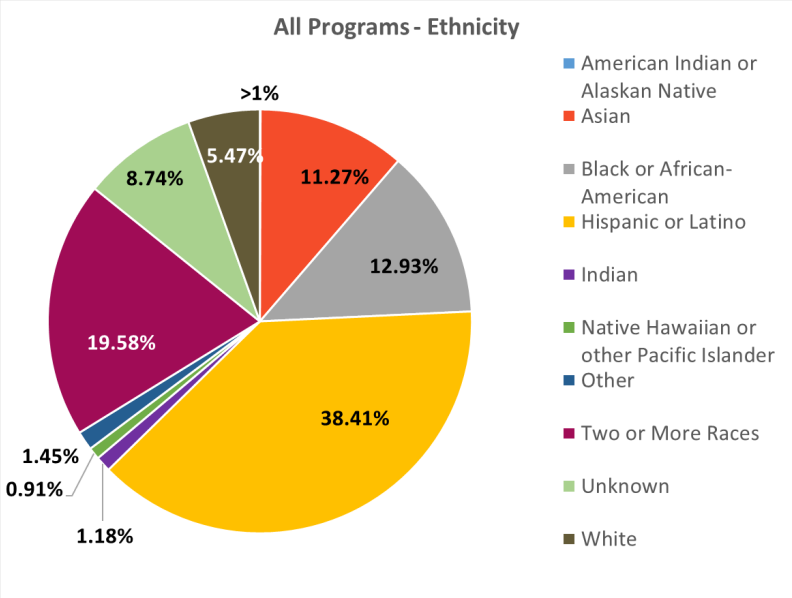
Age:

0-12: 53 participants; 13 – 17: 1328 participants; 18-21: 18 participants; Unknown/Unreported: 379 participants.



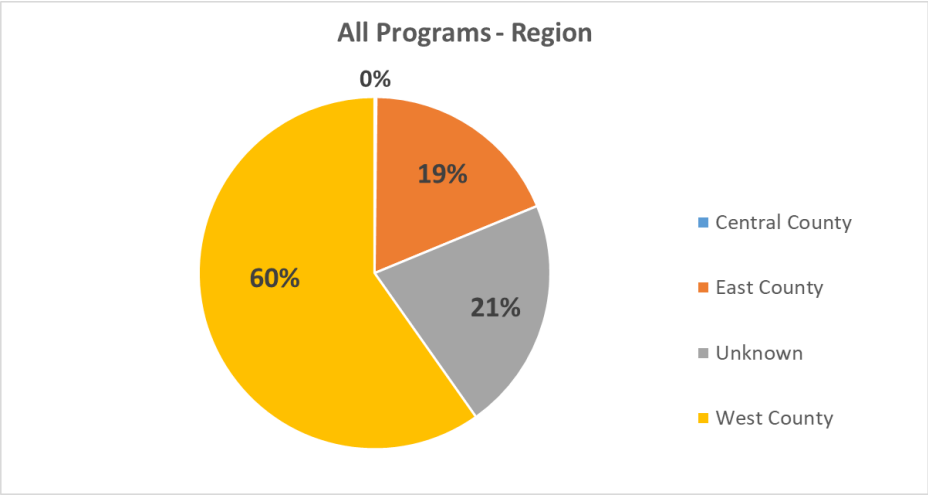
Ethnicity:

African American/Black: 241 participants; American Indian/Alaska Native: 1 participant; Asian: 210 participants; Native Hawaiian/Pacific Islander: 17 participants; Caucasian/White: 102 participants; Hispanic/Latino: 716 participants; Indian: 22 participants; Other: 27 participants; Multi-racial: 365 participants; Unknown/Unreported: 77 participants



Region:

Central County: 3 participants; East County: 331 participants; Unknown: 381 participants; West County: 1063 participants.



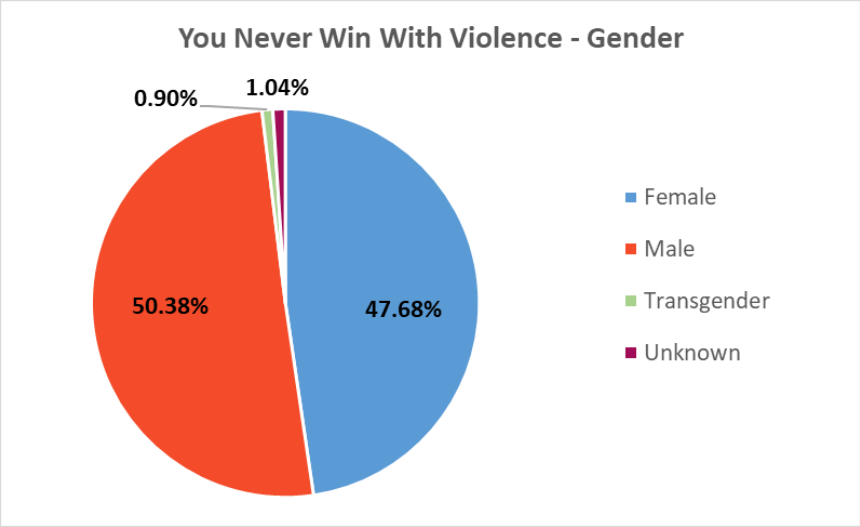
You Never Win with Violence

Total Youth Served

We served a total of 1,445 youth through our YNWWV presentations this Fiscal Year.

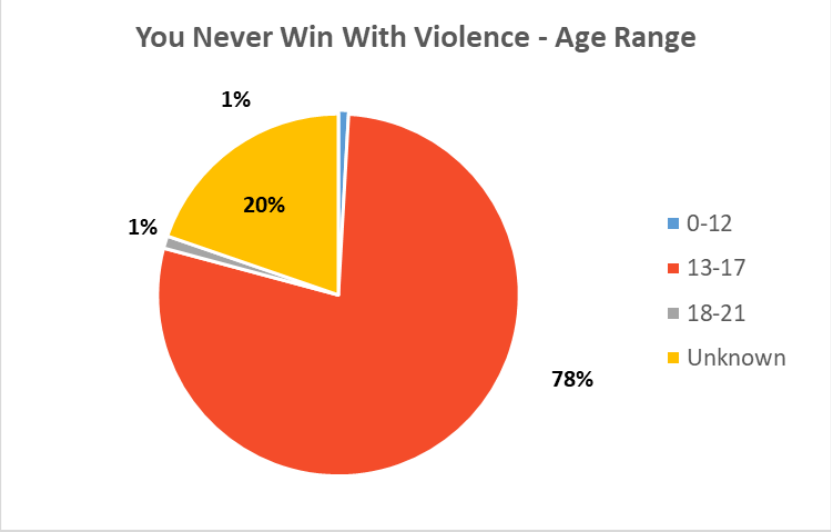
Gender

Male Identified: 728 participants; Female Identified: 689 participants; Transgender: 13 participants; Unknown/Unreported: 15 participants



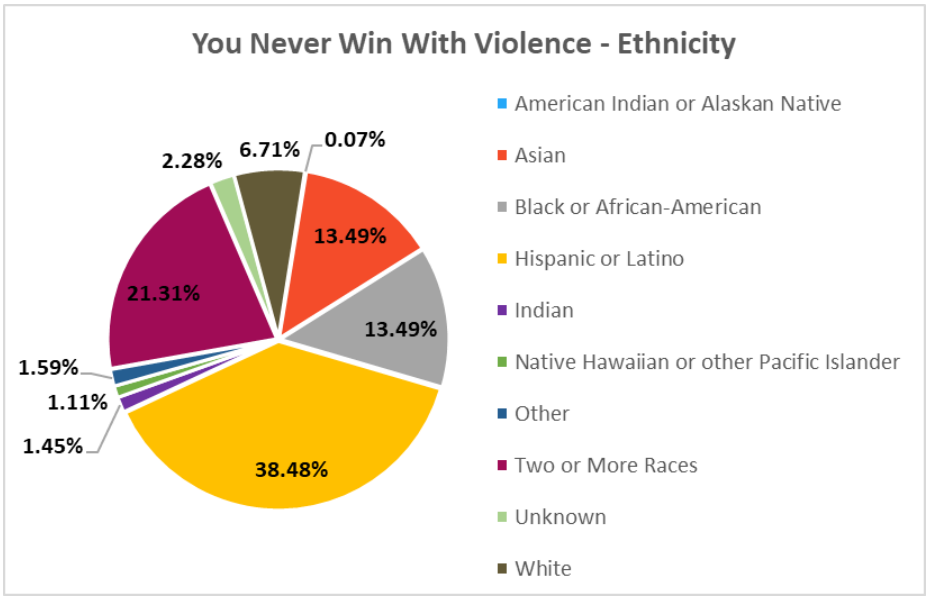
Ages

0-12: 13 participants; 13-17: 1131 participants; 18-21: 16 participants; Unknown/Unreported: 285 participants



Race/Ethnicity

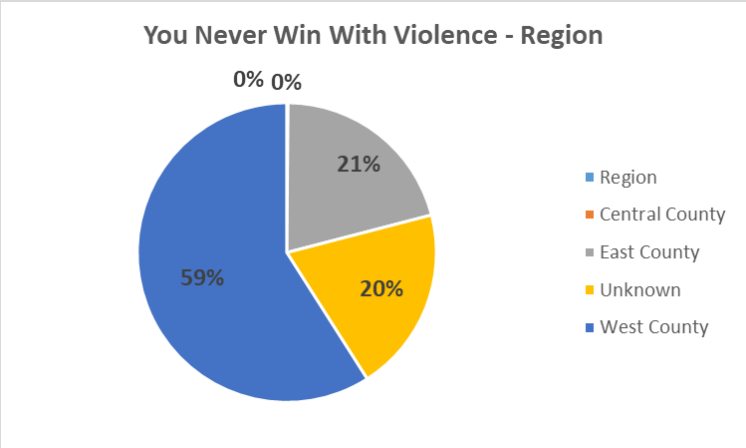
African American/Black: 195 participants; American Indian/Alaska Native: 1 participant; Asian: 195 participants; Native Hawaiian/Pacific Islander: 16 participants; Caucasian/White: 97 participants; Hispanic/Latino: 556 participants; Indian: 21 participants; Other: 23 participants;



Multi-racial: 308 participants; Unknown/Unreported: 33 participants.

Region

Central County: 2 participants; East County: 301 participants; Unknown: 289 participants; West County: 853 participants



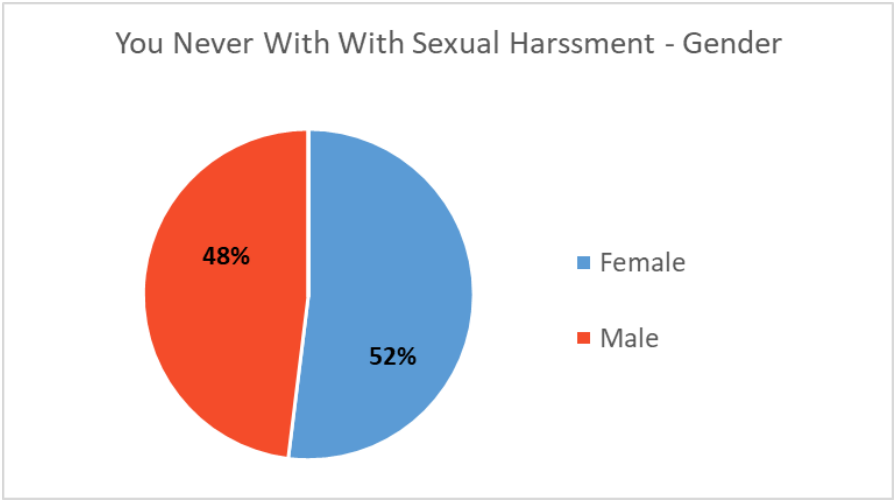
You Never Win with Sexual Harassment

Total Youth Served

We served a total of 152 youth through our YNWSH presentations this Fiscal Year.

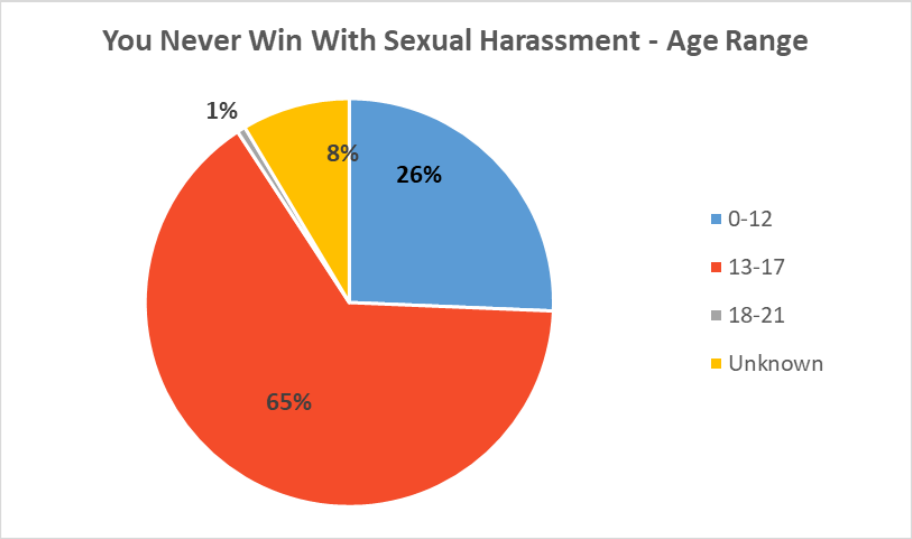
Gender

Male Identified: 73 participants; Female Identified: 79 participants.



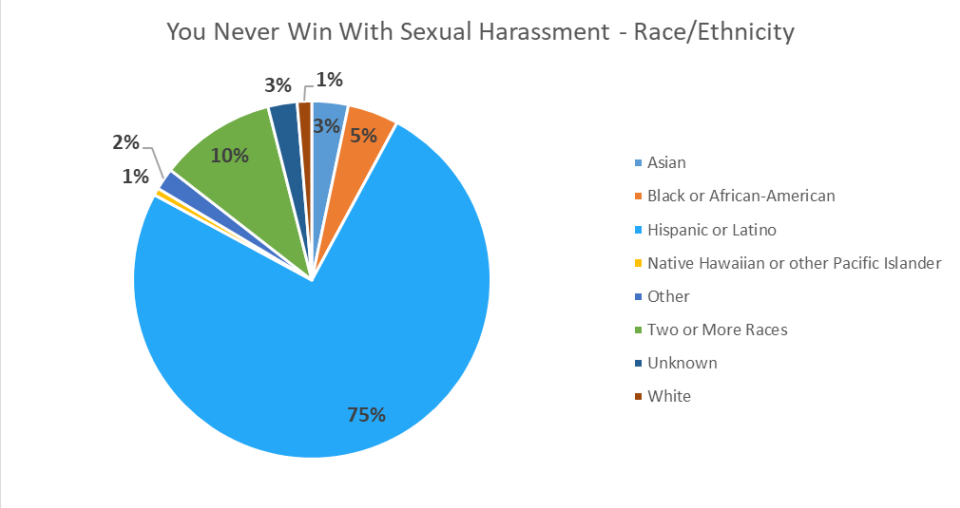
Ages:

0-12: 39 participants; 13-17: 99 participants; 18-21: 1 participant; Unknown: 13 participants



Race/Ethnicity:

African American/Black: 7 participants; Asian: 5 participants; Native Hawaiian/Pacific Islander: 1 participant; Caucasian/White: 2 participants; Hispanic/Latino: 114 participants; Other: 3



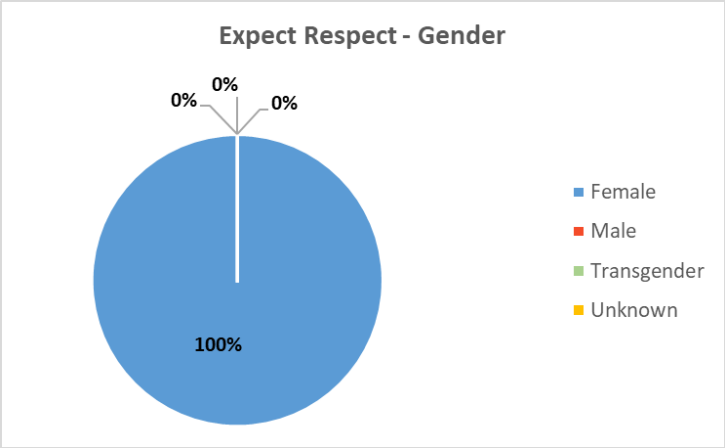
participants; Multi-racial: 16 participants; Unknown/Unreported: 4 participants.

Expect Respect:

Total Youth Served: We have served a total of 87 participants through our Expect Respect support groups this Fiscal Year.

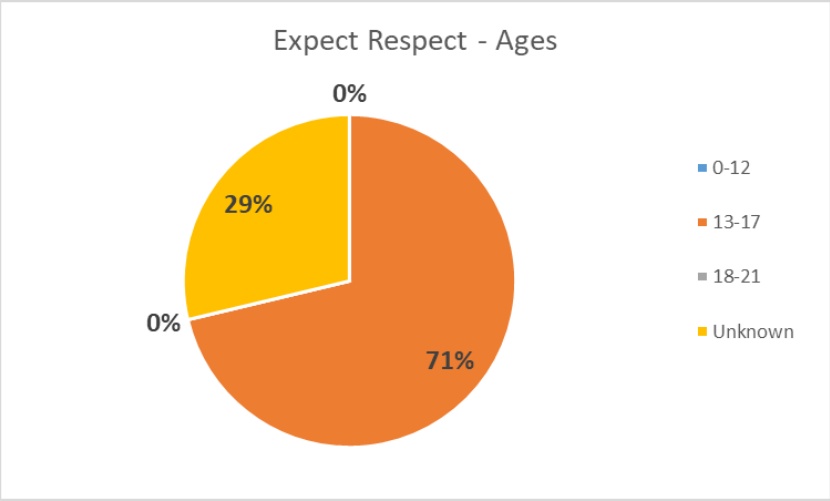
Gender:

Female identified: 87 participants.



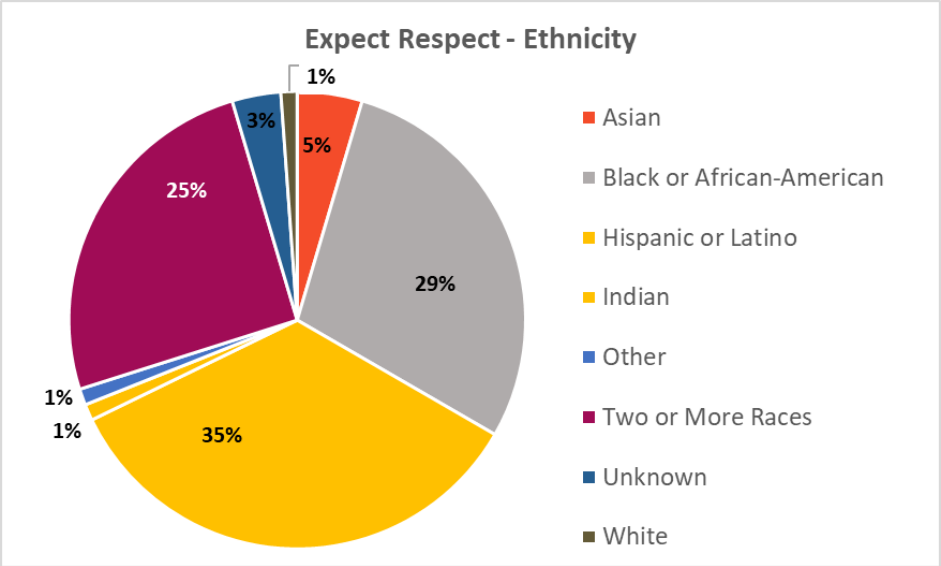
Ages:

13-17: 62 participants; Unknown/Unreported: 25 participants.



Race/Ethnicity:

African American/Black: 25 participants; Asian: 4 participants; Caucasian/White: 1 participant; Hispanic/Latino: 30 participants; Indian: 1 participant; Other: 1 participant; Multi-racial: 22 participants; Unknown/Unreported: 3 participants.

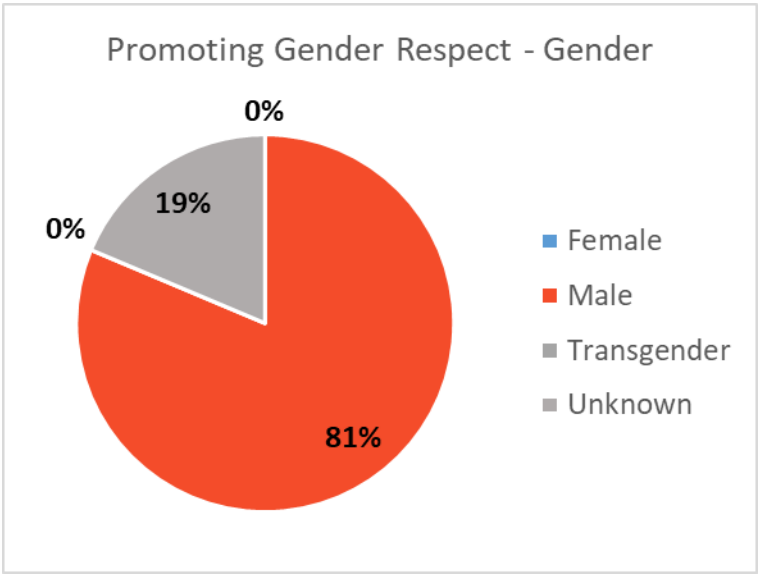


Promoting Gender Respect:

Total Youth Served: We served a total of **59** participants in our Promoting Gender Respect support groups this fiscal year.

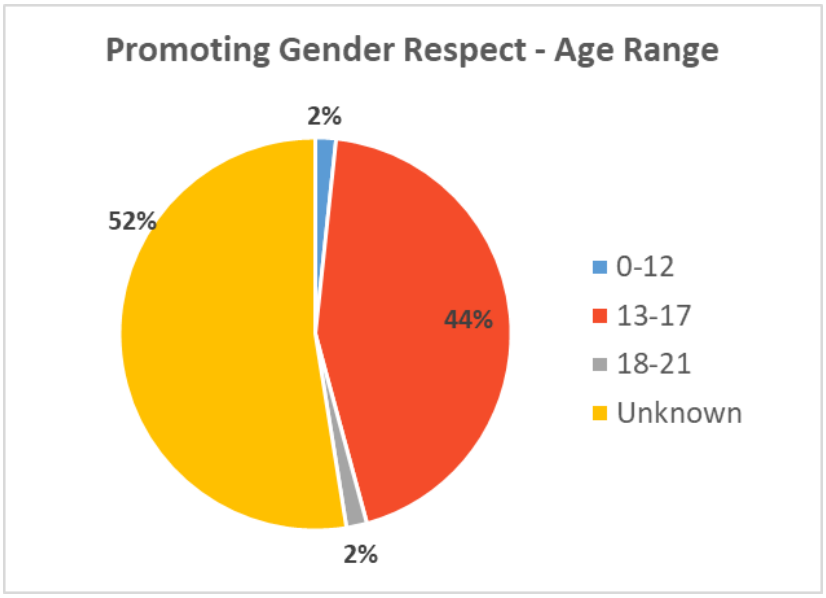
Gender:

Male identified: 48 participants; Unknown/Unreported: 11 participants.



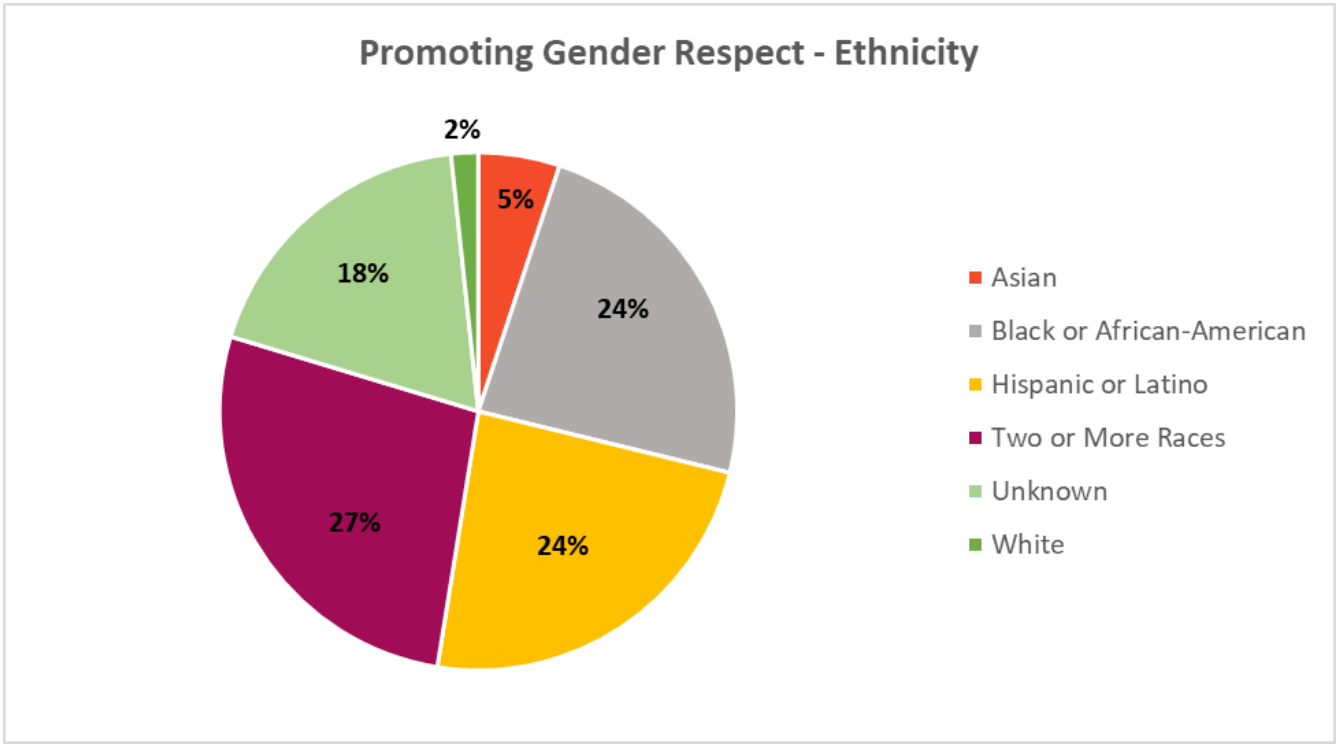
Ages:

0-12: 1 participant; 13-17: 26 participants; 18-21: 1 participant; Unknown/Unreported: 31 participants.



Race/Ethnicity:

African American/Black: 14 participants; Asian: 3 participants; Caucasian/White: 1 participant; Hispanic/Latino: 14 participants; Multi-racial: 16 participants; Unknown/Unreported: 11 participants



CULTURAL RESPONSIVENESS:

How have services been informed and structured to meet the diverse cultural needs of your clients/members/participants? What is being done by your organization to support cultural responsiveness both within the workforce and for those served by your organization?

STAND! provides services to populations living on the margins. Agency policies instruct staff to be inclusive in their provision of services as reflected in the policies and procedures. STAND! services are client centered, with the use of inclusive tools including: a language line, bi-lingual staff, availability of ethnic/cultural foods and celebration of cultural holidays and special events.

STAND!'s staff are regularly trained on numerous culturally responsive approaches to family dynamics, values etc.

STAND! partners with other culturally specific agencies and organizations to provide culturally responsive services to our clients. Coordination among the culturally specific organizations includes trainings, meetings, shared resources, as well as referrals and resources**.**

STAND! provides a warm and welcoming environment in all work and service sites including: Pictures, posters and a website of diverse cultural images, informing the public of STAND!'s policy on cultural diversity and website with infographics regarding: Current trends and activities and positions on diversity and social justice activities. A statement of all-inclusive cultures and racial/ethnic groups.

COLLABORATIVE PRACTICES:

Describe how you are working with any other agencies or organizations to better serve clients/members/participants? If this is currently not being done, please describe any effort to build relationships with other community service providers?

The YESS Program provides services in West and East Contra Costa County School Districts. The school health centers, and administrative staff are the primary contacts for student referrals and access to students at each of the schools receiving our services. We also collaborate with the following agencies in the provision of services of our student clients:

- Community Violence Solutions (CVS) provides services to victims of sexual assault and sexual harassment. Clients are provided services and support based on the presenting issues.
- California Partnership to End Domestic Violence invites our YESS program to participate in the annual state-wide Teen Dating Violence Campaign on panel discussions and community presentations.
- Waymakers Statewide Family Violence Campaign coordinates with our YESS program YAV volunteers in focus groups and evaluation surveys and outreach activities.

- STAND! also partners with the following organizations in our effort to provide services and supportive resources to our clients: CAL CASA, East Bay YMCA, Bay Area Community resources (BACA), Ryes Youth Center and the CCC Family Justice Centers.

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 YESS program operates within the policies and procedures of our parent organization STAND! for Families Free of Violence.

STAND! is a catalyst for breaking the multi-generational cycle of violence, promoting safe and strong families, and rebuilding lives. This requires that all staff adhere to state laws governing client confidentiality and professionalism.

STAND!'s policies and procedures require staff employ a client centered, trauma informed approach to service provision. STAND!'s policy requires staff to respond to client's inquiry within 24 hours of contact with follow up services and support.

STAND! services include: A twenty-four (24)-hour Crisis Line, twenty-four (24) Bed Emergency Shelter, seven (7) Transitional housing units, Community Services program located in east, central and west Contra Costa County; a clinical Services Program, and a Non-Violence Program for individuals who've caused harm and many other programs and services.

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.

<u>Stand's YESS Team program most proud of events in this reporting period:</u>

- STAND's YESS Team conducted presentations on: Sexual Harassment and Victim Blaming, per special request by Richmond High School. This event included approximately eleven to twelve hundred (1100-1200) students and fifty-six (56) presentations in every classroom, over a three (3) day period.
- We were able to successfully transition our operation to virtual programming of services to student volunteers during Covid-19, practicing Contra Costa County guidelines for "Shelter in Place" and health safety precautions.
- STAND! staff and Youth Against Violence (YAV) volunteer's participation in this year's statewide Teen Dating Violence Campaign in Sacramento on Orange day. Two (2) of our

YAV volunteers, Cate, and Sarah, were selected as hosts at the Orange Day Rally at the California State Capital. This event was sponsored by the California partnership to End Domestic Violence.

- The Youth Against Violence Program was awarded at the Annual Rebuilding Lives Luncheon with the Rollie Mullin Leadership Award. Fourteen (14) of our YAV volunteers received award.
- Two of our YAV youth volunteers received awards from the Contra Costa County Youth Hall of Fame.
- YAV volunteers participated, along with staff in a Teen Dating Violence Campaign at five (5) High schools, during the Teen Dating Violence Awareness Month.

Special Events/Activity/Outreach focus:

February 2020 was an action-packed month with activities and events. We conducted our 5th annual Teen Dating Violence (TDV) and Awareness month campaign. This year's theme was "Love is Not a Game," meaning that no one wins in abusive relationships, a relationship should not feel competitive, nor should anyone suffer. We are teammates and partners not two opposing teams. YAV did a phenomenal job coming up with the theme and activities, as well as the designs behind the campaign and imagery. We did 4 lunch time outreach sessions at Pinole Valley High, Hercules, De Anza, and El Cerrito high schools. YAV led TDV related games to get their peers and other students involved as well as teaching them random trivia about facts behind abuse. Also, goodie bags filled with customized lanyards, shirts, informational cards, pens as well as customized sweatshirts bearing "Love is not a game" to all YAV members and staff. On each campus, our staff and youth leaders reached out to health center staff, teachers, youth peers, on campus support officers, via PA announcements, school clubs and more to spread awareness of the campaign and the message. A video was also created to continue sharing the message regarding "Love is not a game". (Please see link to view.)

In another Teen Dating Violence awareness month activity, YAV volunteers coordinated with athletes at their schools to wear orange during a sporting event. YAV attended the games and photographed the athletes wearing the symbolic orange color during TDV month. This portion of the campaign was to highlight that often athletes get a bad rap for being hyper aggressive or even abusive. The display of the orange color brought awareness and understanding that it is supported by many of these perceived school role models and popular students.

PEI ANNUAL REPORTING FORM

PREVENTION REPORTING FORM

FISCAL YEAR: 19-20

Agency/Program Name: Vicente Martinez High School

Project: C.O.R.E. of Vicente - Community Optimizing Resources for Empowerment

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 summarize the Scope of Services as outlined in the Service Work Plan. Please also address any other relevant activities or events that took place during the reporting period.

The Prevention and Early Intervention (PEI) program at Vicente Martinez High School and Briones School is called C.O.R.E. which stands for Community Optimizing Resources for Empowerment. C.O.R.E. is an integrated mental health focused learning experience for 10th-12th grade at-risk students of all cultural backgrounds. The program is facilitated by Martinez Unified School District (MUSD). We provide 9th-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.

Key services include student activities that support:

- Individualized learning plans
- Mindfulness and stress management interventions
- Timely access and linkage to direct mental health counseling
- Team and community building
- Character, leadership and asset development
- Career-focused preparation and internships
- Parent involvement

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 therapist, a Pupil Personal Services credentialed academic counselor. 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
- Teacher Professional Development
- Outreach

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. Our

academic counselor 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 to help them prepare for a successful transition into independent adulthood.

Teacher Professional Development: Teachers continue to attend professional development opportunities to increase knowledge about supporting at-risk students.

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.

Of the 155 students who were enrolled at Vicente and Briones over the course of the school year, 97% of the Vicente student body and 54% of Briones students participated in PEI activities.

Overall, students participated in an average of six different services per individual over the course of the year.

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. Note: This year, due to the school closure because of COVID-19 some students did not complete all hours and were given a waiver for these hours.

- ***Alameda Food Bank:*** Over the Thanksgiving holiday break, students worked with the Alameda Food Bank to prepare food packages for those in need.
- ***Dia de Los Muertos:*** Students enjoyed volunteering at the Día 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. Internships for the year included:

- ***Culinary Academy:*** Sixteen 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 food on their own. The sixteen students who participated and completed the program are now certified food handlers. All students have been hired in the hospitality industry and have been offered enrollment in Diablo Valley College's culinary certificate program, which is an impacted program.
- ***Martinez Early Intervention Preschool Program:*** Five 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. Our Vicente - Briones principal is now the principal of MEIPP as well, so this has helped the availability of internships for our students.
- ***Martinez Teen Police Academy:*** Three 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 offered the opportunity to work with the National Park Service 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 and Briones 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 one full time mental health counselor on campus daily. When once students were resistant to participating in mental health counseling, now it is the norm among our students.

- ***COPE Family Support Services:*** PEI funds were utilized to contract with COPE Family Support Services. A social work intern 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.
- ***Girls' Groups:*** Our mental health counselor continued her 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 a 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.
- ***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 during the school day 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 regarding their past or present experiences. Psychology Club students also took field trips to 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 continued their weekly podcast 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:*** Vicente and Briones continued the work they did over the last two years 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 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.
- ***Suicide Prevention:*** A representative from the Contra Costa Crisis Center provided a forty-five-minute workshop to all 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:*** Our Vicente mental health counselor and academic counselor took sixteen 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.

- ***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. Note: These hours were adjusted when the school closure took place due to COVID-19.
- ***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.
- ***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 on their challenges and struggles. The principal developed a shared Google Doc where data was recorded 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.

- ***College Visits:*** Students had the opportunity to visit and tour Diablo Valley College. Diablo Valley College staff visited our campus as well to facilitate a FAFSA application

workshop. Note: Some of our other college visits were cancelled due to the school closure due to COVID-19.

- ***Concurrent College Enrollment:*** Ten Vicente and Briones 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 academic counselor and English teacher 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. Note: Due to the school closure due to COVID-19 some students were not able to complete their senior portfolio. Emphasis was placed on completing high school credits in a distance learning environment over completing the portfolio.

Teacher Professional Development: Teachers continued to participate and lead professional development opportunities to increase their knowledge about how to better support at-risk students.

- ***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:*** Vicente and Briones continued to hone the skills they gleaned from their work 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 to remedy challenges on campus instead of turning students away through suspension.

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. 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.
- ***Mental Wellness Conference:*** Two staff members attended the 2020 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 was again a recipient of the Model Continuation High School Recognition through the California Department of Education and the California Continuation Education Association. 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:*** 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. We continued our work with the Contra Costa Crisis Center, Loaves and Fishes, Feet First, Sandy Hook Promise, Contra Costa Food Bank, Roary, Kiwanis, COPE Family Services and the California Department of Education as well as local private families who provide funding for scholarships for our graduating seniors.
- ***Western Association of Schools and Colleges:*** We remain fully accredited by the Western Association of Schools and Colleges (WASC). This means that all graduates receive a fully accredited high school diploma. In the Spring of 2021, we will have a mid-term visit as a part of our six-year accreditation cycle.

School Closure: A relevant event that took place during this reporting period was the school closure due to the COVID-19 pandemic. Our last day of in-person instruction was Friday, March

13. On Monday, March 16 we instituted distance learning. This was a significant change for students, staff, families and our community in general. This shift caused our staff great concern for students since so many of our students rely upon our school as a safe place with caring adults that they depend on. We increased outreach to students during this time. Knowing our students well, we did frequent checks with students who let us know previously that home life was extremely difficult or chaotic. We also increased our support for parents who now had children at home and were responsible for making sure they were completing their work. We continued our regular services for students, including individual and group mental health and academic counseling using virtual means. Our social work intern from COPE Family Services also continued her individual and group work with students and families virtually.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services. Numbers served during the fiscal year. Describe any adaptation of services due to COVID-19 that may be relevant. For PEI – Prevention programs, please describe: 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.

<u>The following are our outcome measures of success from the 2019-20 PEI work plan.</u>

Engagement Focus:

- Increase identification of students that have 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 services.

Short Term Focus:

- Increase timely access and linkage to supportive and mental health services.
- Increase mental health resilience among Vicente/Briones students.

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 life goals.

<u>Outcome Measures of Success</u>

Engagement Focus:

- At least 85% of enrolled students will receive a) an orientation on program offerings, b) a self-identified needs assessment targeting risk factors that may include, but are not limited to, poverty, ongoing stress, trauma, racism, social inequity, substance abuse, domestic violence, previous mental illness, prolonged isolation.
    - Met. This goal was met at a rate of 97%. 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 90% of identified students will participate in four services per quarter that supports their individual learning plan.
    - Met. The average number of PEI activities of those who participated was seven.

Short Term Focus:

- At least 90% of students identified as facing risk factors will be referred to supportive services and/or referred to mental health treatment and will participate at least once in referred support service or mental health treatment during the school year.
    - Met.
- At least 70% of students participating in four 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. We will revise this goal and use the California Healthy Kids Survey (CHKS) which is completed annually. The goal will need to be an overall percentage since the CHKS does not disaggregate the individual student data, only schoolwide data is available.

Intermediate Focus:

- 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.
- At least 70% of students who participated in four or more services and who regularly participate in mental health counseling will earn 100% of the expected grade level credits as measured at the end of the school year.
    - Met.

Our schools closed and transitioned to a distance learning model on March 16, 2020. We continued providing PEI services and even increased services during this time. All services were provided via virtual means. Our outreach increased to families and students seeing that we

understood the impact this model was having on our students. We offered times for families and students to meet so that we could provide support.

Indicators that measure reduction of risk factors and/or increase in protective factors that may lead to improved mental, emotional and relational functioning:

- ACE (Adverse Childhood Experiences) Questionnaire
    - Measured: When all students begin at Vicente
- Individual Success and Achievement Plan
    - Measured: Quarterly for all students
- School Attendance
    - Measured: Quarterly, individual, and schoolwide percentages
- Credit Accrual
    - Measured: Quarterly, individual, and schoolwide data
- Disciplinary Data
    - Measured: Semi-annually, schoolwide data
- Multi-Tier System of Support
    - Measured: Weekly by staff on an individual student basis
- Student Work Samples
    - Measured: Quarterly
- California Healthy Kids Survey
    - Measured: Annually
- Brief Mood Survey
    - Measured: At every mental health counseling session

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

Please refer to Aggregate Data Reporting Form

CULTURAL RESPONSIVENESS:

How have services been informed and structured to meet the diverse cultural needs of your clients/members/participants? What is being done by your organization to support cultural responsiveness both within the workforce and for those served by your organization?

Services have been informed and structured to meet the diverse cultural needs of our students and families by listening to the needs of our community members. Also, when there is a common thread of concern or need happening in our community, we take it upon ourselves to find a solution in the way of counseling, education, or support. When a need is identified, we respond by adjusting programming to meet that need.

Vicente Martinez High School staff supports cultural responsiveness by having a willingness to embrace the complexities of diversity and we are open to new ideas, contradictory information

and advice. We also strive to acknowledge gaps in each of our cultural knowledge and understanding. We embrace the practice of equal access for all our students and uphold non-discriminatory practices in service delivery. We are constantly collaborating with our students and families to identify and understand their needs, strengths and culturally based behaviors. We design and implement our program to meet the diverse needs of our families and students. Our staff participates in the Martinez Unified School District's Equity Committee and parents and students are invited to participate as well.

COLLABORATIVE PRACTICES:

Describe how you are working with any other agencies or organizations to better serve clients/members/participants? If this is currently not being done, please describe any effort to build relationships with other community service providers?

We contracted with COPE Family Services. COPE provided a social work intern to help support our work with our at-risk students and their families. Services provided included: workshops for students focusing on organization, mindfulness, mindset, bettering school attendance, planning and support with addiction (cell phone use, vaping, marijuana). We also started extensive parent support with the help of COPE Family Services. They provided weekly parent workshops as well as individual parent coaching. In March, when our schools closed due to COVID-19 these services continued through a virtual model.

Loaves and Fishes provided three sessions of a ten-week culinary academy for Vicente and Briones students. This was provided free of charge to our students and Loaves and Fishes raised funds so that our students could participate. Students worked in the Loaves and Fishes professional kitchen, learning a variety of culinary techniques and skills useful for the job market. Students earned high school elective credit for their participation and most students were placed in jobs at the end of the internship. During the experience, students prepared and served food to members of the Martinez community in need. After attending the internship, several students became assistants at the next culinary academy. Due to COVID-19, the final culinary academy was cut short by a few weeks. Once we are available to resume the academy the students will be able to finish out their experience. Loaves and Fishes is committed to continuing to offer our students this opportunity for years to come.

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 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. Sixty-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 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 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 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 can 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 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 are much better. I will also get to graduate early if I stay on track. The staff at Vicente has also help me to get a job by helping with writing 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.

Thank you, Lori and staff, for all you do. He is so much happier at your school. His grades are so much better. I always knew it was all the homework at AHS that made him receive low grades.

A ton of stress has been lifted off his shoulders. When he does good, he is happy and so are we. Our home life is less stressful. ~ Parents of J.D.

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 19/20

Contra Costa Behavioral Health Services

Mental Health Services Act

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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 (CPAW) 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: a) increase access to underserved groups, b) increase the quality of services, to include better outcomes, c) promote interagency collaboration, or d) increase access to services. While Innovation projects have always been time-limited, the Innovation Regulations have placed a five-year time limit on all 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 2019-20:

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 substance dependence. This is a priority because CCBHS does not have a coordinated system of care to provide treatment services to youths with substance use and co-occurring mental health disorders. The CORE Project is an intensive outpatient treatment program offering three levels of care: intensive, transitional, and continuing care to adolescents with co-occurring substance use and mental health disorders. Services are provided by a multi-disciplinary team, and include individual, group, and family therapy, as well as linkage to community services. The Center for Recovery and Empowerment project began implementation in FY 2018-19.

2) Cognitive Behavioral Social Skills Training (CBSST). Many consumers spend years residing at County augmented Board and Care (B&C) 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 applies this therapeutic practice to the population of individuals that have been placed in augmented Board and Care facilities. The CBSST Project includes 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 learn and practice skills that enable them to achieve and consolidate recovery-based skills. The Cognitive Behavioral Social Skills Training project began implementation in FY 2018-19.

3) 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 flexibleresources 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. Two 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.

4) 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 Projectbegan 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 19-20
Partners in Aging	County Operated	Countywide	45	176,222
Overcoming Transportation Barriers	County Operated	Countywide	200	191,842
Center for Recovery and Empowerment	County Operated	West	80	614,467
Cognitive Behavioral Social Skills Training	County Operated	Countywide	240	168,334
Administrative Support	County	Countywide	Innovation Support	430,184
		Total	*565*	*$1,581,049*

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 were 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 (MHSA) states that five percent of MHSA funds will be used 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 19-20

Projects Implemented			1,581,049
		Total	*$1,581,049*

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 19/20 = 128

Out of 128 total clients served 6 Demographics Forms were submitted for current fiscal year.

Table 1. Age Group

	# Served	
Child (0-15)	0	
Transition Age Youth (16-25)	0	
Adult (26-59)	3	
Older Adult (60+)	3	
Decline to State	0	

Table 2. Primary Language

	# Served	
English	6	
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	1	
White or Caucasian	3	
Hispanic or Latino/A	1	
Native Hawaiian or Other Pacific Islander	0	
Other	0	
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	2	
Filipino	0	
Japanese	0	
Korean	0	
Middle Eastern	0	
Vietnamese	0	
More than one Ethnicity	2	
Decline to State	0	
Other	0	

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

	# Served	
Caribbean	0	
Central American	1	
Mexican/Mexican American /Chicano	1	
Puerto Rican	0	
South American	0	
Other	0	

Table 6. Sexual Orientation

	# Served	
Heterosexual or Strait	4	
Gay or Lesbian	1	
Bisexual	0	
Queer	0	
Questioning or Unsure of Sexual Orientation	0	
Another Sexual Orientation	0	
Decline to State	1	

Table 7. Gender Assigned Sex at Birth

	# Served	
Male	2	
Female	4	
Decline to State	0	

Table 8. Current Gender Identity

	# Served	
Man	2	
Woman	4	
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	6	
Decline to State	0	

Table 10. Veteran Status

	# Served	
Yes	0	
No	6	
Decline to State	0	

Table 11. Disability Status

	# Served	
Yes	4	
No	2	
Decline to State	0	

Table 12. Description of Disability Status

	# Served	
Difficulty Seeing	0	
Difficulty Hearing or Having Speech Understood	0	
Physical/Mobility	1	
Chronic Health Condition	1	
Other	2	

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 are able to move between these levels of care depending on their need. These levels of care begin with an Intensive Care phase of treatment, where 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, and they are drug tested weekly to encourage honesty and accountability. The 12-Step principles of recovery are introduced through educational presentations and weekly individual and group sessions facilitated by therapists and counselors. Teens are then 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 14-17 with substance use disorders and co-occurring mental health disorders will be the targeted group.
b. **Total MHSA Funding for FY 2019/20:** $619,579
c. **MHSA-funded Staff:** 5.0 Full-time 1.0 Part-time equivalents
d. **Total Number served**: For FY 19/20: 11 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 Services admissions and/or acute psychiatric admissions.
    - Child and Adolescent Level of Care Utilization System (CALOCUS).

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 Board and Care's (B&C's) that house Contra Costa County (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.

f. **Target Population:** Adults aged 18 years and older who are currently living in Board and Care Homes, receiving services at a County-operated Adult clinic, and are diagnosed with a serious mental illness.
g. **Total MHSA Funding for FY 2019/20:** $168,334
h. **MHSA-funded Staff:** 2.0 Full-time equivalents
i. **Total Number served**: For FY 19/20: 30
j. **Outcomes**:
    - Patient Health Questionnaire (PHQ-9) and 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 are asked to fill out the Level of Care Utilization System (LOCUS).
    - 5150's will be tracked for pre/post data and length of hospital stay.

Program: Overcoming Transportation Barriers

The Overcoming Transportation Barriers (OTB) program is a systemic approach to develop an effective consumer-driven transportation infrastructure that supports the entire behavioral 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 consumers. The program targets consumers throughout the behavioral health system of care.

a. **Target Population:** Consumers of public mental health services and their families; the general public.
b. **Total MHSA Funding for FY 2019/20:** $191,842
c. **MHSA-funded Staff:** 2.0 full-time equivalents
d. **Total Number served**: For FY 19/20: 55 encounters
e. **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 1, 2016. Partners in Aging consists of up to two Community Support Workers (CSWs), up to three 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.

Community Support Workers and Student Interns provide linkage, in-home and community-based peer support, and health/mental health coaching to consumers open to or referred to the IMPACT program. In addition, the CSWs and Student Interns provided outreach to staff at Psychiatric Emergency Services (PES) and Miller Wellness Center (MWC). 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 Interns also provide brief AOD screening and referrals, as well as conducting intakes, assessments, and providing individual psychotherapy. Additionally, a Gero-psychiatrist is available 8 hours/week to provide consultation, and in-person evaluations of IMPACT clients.

a. **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.
b. **Total MHSA Funding for FY 2019/20:** $176,222
c. **MHSA-funded Staff:** 2.0 full-time equivalents
d. **Total Number served**: For FY 19/20: 32
e. **Outcomes**:
    - Reductions in Level of Care Utilization System (LOCUS) scores.
    - Reductions in Psychiatric Emergency Service visits and hospitalizations.
    - Decreased Patient Health Questionnaire (PHQ-9) scores.

Innovation Project Annual and Final Reports

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INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: 2019/20

Agency/Project Name: **Center for Recovery and Empowerment (CORE)**

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 program located in West Contra Costa County for adolescents with co-occurring substance use (SUD) 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 full-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.

Referrals to the CORE program are made by psychiatrists, social workers, school counselors and nurses, probation, Kaiser, John Muir Behavioral Health Center, community-based organizations or self-referrals. Referrals are initially screened over the phone by the Program Supervisor or other dedicated staff and then the client and/or family member are asked to come to the center for an assessment. To be accepted into the project, clients need to meet an appropriate mental health diagnosis, SUD level of need and willingness/ability of client and family (if appropriate) to participate in program. Once admitted, program enrollment and on-site treatment begin.

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

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6) Individual therapy – clients are pulled from milieu twice a week, or as needed throughout the day.
7) Group therapy: Moral Reconation Therapy – 1x/week, Recovery Assignments are done in group 5x/week
8) Toxicology screening and individual consultation with nurse to discuss results 1x/week
9) Adventure Therapy – ecotherapy, mindfulness, and recreational activities for youth after lunch
10) Family therapy – Family therapy is conducted 1x/week per client in the late afternoon or evening
11) Community recovery meetings – Clients are transported to and from Young People in Alcoholics Anonymous (YPAA) meetings 2x/week. They attend with Recovery Coach and work with an individual sponsor from 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.

Service Impact from Shelter-in-Place Restrictions (COVID-19)

Services offered through the CORE program were significantly impacted by COVID-19. In-person programming was suspended when the Shelter-In-Place went into effect on March 16, 2020. Clients were provided with telephonic support and resources while the center was temporarily closed. In June 2020, half-day in-person services commenced, as permitted by safety protocols, and the program was able to resume a modified curriculum. In-person services primarily included the adventure therapy component, including bike rides and other outdoor activities. Education support through Golden Gate Schools and YPAA meetings were offered daily via Zoom. Individual therapy was provided via telehealth. Some key services such as sober social events were difficult to provide during COVID, due to public safety precautions. In addition, the program experienced high staff turn-over.

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?

Many obstacles were faced for this project during the 19-20 fiscal year, particularly around staffing. A new Mental Health Clinical Specialist started on July 5, 2019 which brought the program to a nearly full staffing pattern as outlined in the concept. Unfortunately, in January and February of 2020 both the original Mental Health Clinical Specialist and the Psychiatric Nurse Practitioner left the program, making it very challenging to continue providing the full scope of services. Problems with staffing continued to develop and it became difficult to fill positions, particularly during COVID. At the time this report was written, all of the original staff left the program. A workgroup has been established which includes leadership from Behavioral Health Services and Substance Use Disorder departments, to create a strategy and plan around filling positions and restructuring the project. Future goals for CORE include providing more direct clinical and administrative support and oversight, as the program is in a stand-alone location. Workflows and policies are being reviewed to allow for greater enrollment and program completion/success. In addition, feedback has been solicited from former

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families and participants, in an effort to improve parent & family support and engagement.

Another obstacle that developed due to COVID was the inability to deliver core elements of the program that were not conducive to telehealth or virtual platforms. Many work-arounds had to be implemented to keep clients present and engaged. For example, there was low attendance when YPAA meetings initially went to a virtual platform and students were asked to participate from home. The Community Support Worker began picking kids up and offering YPAA Meetings on the large screen television in main room at the CORE site. Another work around involved the food program, which occurred on Wednesdays prior to COVID. An agency called White Pony delivered food to the CORE site for youth and their families. When the center closed due to COVID, staff began delivering food to families at home. This helped keep families engaged in the program and provided some support to those struggling financially due to the pandemic.

PROJECT CHANGES: ☐ No changes
Please explain whether any changes were made to the Innovative Project during the reporting periodand the reasons for the changes, if applicable.

Many staffing changes have occurred over the project's term, particularly during the reported fiscal year. High staff turnover created challenges in providing services to fidelity of the model. This was particularly true for substance use related programming, and such services sometimes had to be referred out to other agencies.

Regarding groups, staff learned that certain formats worked better than others. Mindfulness was introduced into groups, following the guidelines of the UCLA Mindfulness Project. The group therapist was trained in the project and began providing many new techniques including meditation and different creative measures to use as coping tools. Groups also resumed outside on the patio with families and caregivers. Moving forward, staff want to incorporate further parent-to-parent support groups that include a psycho-education feature.

Originally, the project outline consisted of three levels, in which the clients would be in each level for 12-weeks. As the project progressed, it was determined that this duration should be shortened to eight weeks. This would allow for quicker movement into the next phase and also allow for the mentorship portion of the project to be rolled out sooner to increase flow between levels.

At the time this report was written, further minor modifications to the program were being considered. A workgroup was established to review existing policies and procedures. Changes will be reflected in the next (FY20-21) annual report. Stakeholder involvement and feedback related to the project is additionally garnered through the Consolidated Planning and Advisory Workgroup (CPAW) meeting and Innovation CPAW Sub-Committee meeting.

OUTCOMES AND PROGRAM EVALUATION:
Please provide quantitative and qualitative data regarding your services.

- *What are the learning goals of the project?*

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- *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 see 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.

Assessment Tool. This project used the Teen Addiction Severity Index (T-ASI) to measure many of its outcome goals upon enrollment and at 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 to assessment and is 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.[1]

Demographics. During the 19-20 FY, the program served a total of 11 youth (four males and seven females). They ranged in age from 14 – 17 years old, with an average age of 15.4 years. Nine of the youth enrolled (82%) identified as being of LatinX/Hispanic decent and 2 (18%) identified as African American. Approximately 90% were from the West County (Richmond) region of the county and 10% from Central County (Martinez). Duration of time enrolled in the program ranged from approximately one week to one year, with an average enrollment of 3.5 months.

Learning Goal Outcomes:

Learning Goal #1: Abstinence or reduced substance use
All clients enrolled in the program during the reporting period who completed both a pre- and post- T-ASI assessment (n=7) reported a reduction in substance use. All were able to attain stretches of sobriety that were longer than reported in the year prior to enrollment in the program. Program leadership is considering moving to a harm reduction model, to allow clients to stay enrolled in the program (if they are motivated to so), even if they have a relapse or if a family member is using substances.

Learning Goal #2: Reduce symptoms of mental illness
Of clients enrolled in the program during the reporting period who completed both a pre- and post- T-ASI assessment (n=7), 57% reported a reduction in number of days during the month that they experienced symptoms of a mental illness. The remaining 42% reported no change in mental health symptoms. None reported an increase in symptoms.

Learning Goal #3: Reduce the need for in-patient mental health/substance abuse treatment
Of the clients enrolled in the program during the reporting period (n=11), three (or 27%) had contact with the Mobile Crisis Response Team or were evaluated at Psychiatric Emergency Services (PES)

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during enrollment or within one year post enrollment. One was connected to Juvenile Probation within the year following discharge from CORE.

Learning Goal #4: Increase academic success
Of clients enrolled in the program during the reporting period who completed both a pre- and post- T-ASI assessment (n=7), six (86%) reported an improvement in school attendance and/or grades. One reported no change.

Other observations regarding data. Peer & Family Relationships are another key data point measured in the T-ASI. The majority of students reported an improvement in peer and family relationships, marked by less conflict with parents and friends. Youth who were enrolled for longer periods of time also reported choosing friends who engage in less substance use.

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 upon enrollment. If the program cannot meet the needs of the client, they may be referred out to various other services. Besides residential SUD, CORE refers youth and parents/providers on behalf of youth to the following:

- 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 Narcotics Anonymous
- REACH
- Hanna Boys Center (residential but not primarily SUD)
- Rebekah House (residential but not primarily SUD)
- RYSE Center
- MISSEY (for CSEC youth)
- Golden Gate Schools/County Office of Education - Alternative Education
- Contra Costa County Child & Family Services (CFS)
- First Hope
- James Morehouse Project
- Behavioral Health Access Line
- West County Health Center
- Richmond Works Program
- West County High Schools Health Centers

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- Monument Crisis Center
- Familias Unidas
- Latina Center

If a client is enrolled in the program and needs additional services specifically in phase two, they may be referred 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.

Case Vignette 1:

Al (pseudonym) is a 17-year-old Latinx male. His preferred pronouns are he/him/his.
Al lives with his mother and a younger sibling. He has minimal contact with his biological father. Al had been expelled for using substances at school. He had several physical altercations with peers at school. He was failing all of his classes. Per parent's report, client was leaving home without permission. Al and his mother would argue frequently about his grades and cannabis use. His mother found cannabis vape pens in his room. Parent contacted the program in the fall. Al agreed to participate and attend the intensive outpatient program at CORE. Al's attendance was inconsistent in the beginning. CORE staff met with Al and his mother to problem-solve regarding his attendance. Al and his mother agreed they would make a commitment to participate. Al would attend the program daily. Parent would wait with Al for the CORE van to arrive at his home. Al took an interest in his classes with the help of a tutor from the Golden Gate Day school. He started earning his high school credits and improved his grades. He participated in daily bike rides, walks and hikes with the adventure therapist. Al shared he enjoys riding bikes with the group. He participated in a weekly mindfulness group. He participated in a bi-weekly peer recovery group. He participated in individual therapy as well as family sessions with his parent. He met with the peer recovery coach daily. He reduced his use of cannabis and eventually stopped using cannabis daily. Per parent report, the client no longer leaves home without permission, and they argue less. Al has a goal to participate in a youth employment program this summer. Al wants to apply for Job Corps next fall.

Case Vignette 2:

Andrea (pseudonym) is a 17-year-old Latinx female. Her preferred pronouns are her/she/hers.
Andrea lives with her parents. She is an only child. Andrea was skipping school, stealing money from her parents, and failing her classes. She was rude and disrespectful to teachers and school staff. She would leave her house when her family was sleeping. Andrea would go out with peers to parties. She would use alcohol, methamphetamine and cannabis. Andrea's parents were extremely worried about her safety and substance use. Andrea had conflicts with her parents daily. She would yell, curse, and leave home. Her parents called CORE and scheduled an intake. Andrea denied having issues with substances. She blamed her parents for making such a big deal. Andrea had challenges when she

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started the CORE program. She would refuse to participate in the groups. She would yell at staff. It took her a month to adjust to the routine and schedule of CORE. She met with the substance use counselor and the peer recovery coach daily. She participated in socialization groups, mindfulness groups and recovery groups daily. She slowly started to share in the recovery groups and learned about the 12 steps of recovery. Andrea became interested in school. Andrea would turn in her assignments and took pride in her work. The teacher shared that Andrea was a quick learner and a good student. Andrea responded well to praise from the teacher and staff at CORE. Andrea participated in individual and family sessions weekly. Andrea and her parent's relationship improved over time. She set a goal for herself of getting in good physical shape. She participated in daily hikes and bike rides with the adventure therapist. She enjoyed the once-a-week visits to the gym. Andrea became a leader among her peers. She started talking about her recovery and not wanting to use substances. She showed off the 30-day chip she earned at a recovery meeting. Andrea has a year and six months of being sober. Andrea's grades are A's, and she is on track to graduate from high school. She is interested in going to college. Andrea participated in the summer Youth Works program. She received positive feedback from the work site. Andrea was invited to return next summer.

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1. 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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INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: 19/20

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* X 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&C's). The project involves a team designed of one Mental Health Clinical Specialist (MHCS) and one Community Support Worker (CSW) whose primary responsibility is to lead CBSST groups at B&C's that house Contra Costa County (CCC) consumers.

At the beginning of this fiscal year, the project was underway and serving six B&C's located throughout the county. This included both group and individual rehabilitation services. The individual services were provided by either the MHCS or the CSW. The team completed the first module during February and were beginning to start the second module in March when the risk of COVID-19 impacted further care. Through June there was still a mix of supportive contact with individual rehabilitation. Additionally, the team continued to work with clients for crisis informed care.

The CBSST project is designed to enhance the quality of life for those residing in B&C's 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) ARF's (adult residential facilities)
- Served 1 large (70-bed) RCFE (residential center for the elderly)
- Provided CBSST individual and group rehabilitation services to 30 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

From April - June the team received training around how to talk with the B&C operators about best practices for infection control due to the risk of COVID-19. This included site visits and working with

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B&C's to ensure survey completion. The surveys included information about Personal Protective Equipment (PPE) needs. The team delivered PPE to the sites to ensure safety and helped manage fears around new Shelter-in-Place guidelines by providing psycho-education and support.

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 process of working with working with B&C operators (from engagement to completion of all three modules) expanded from ten months to one year. This was due to the engagement period taking longer than initially anticipated, as well as the length of time it took to work through each module. The goal setting process took approximately three weeks and then module content was repeated to consolidate learning, due to a significant number of clients presenting with cognitive impairment and/or symptoms interfering with learning. Going at a slower pace improved clients' ability to absorb and retain information, as well as strengthening the therapeutic relationship.

During the Shelter-in-Place restrictions, there was more opportunity to work with individuals one on one. Staff discovered some people did better with this type of engagement. It signified to the team that this service should be investigated further because it provided more time for individual processing of the modules. It also allowed those who were reluctant or less able to participate in group due to symptoms of their mental illness such as paranoia, thought blocking, or active auditory hallucinations, to engage more successfully with providers and better learn content. Individual rehabilitation with people through telehealth (virtual) platform also worked very well. In some cases, it was a preference for clients. Some challenges did arise around using Zoom, such as access to electronic devices or wi-fi, a learning curve around how to navigate the platform, and low-quality audio or video connection.

The team held some in-person sessions in backyards or other outdoor settings. Some clients had challenges with social distancing and mask requirements, and for some, in-person meetings increased their anxiety. Excessive heat also led to cancelling outdoor sessions. The team decided that overall Zoom seem to work better for most encounters.

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 a decrease in the number of B&C's served, due to only one client being involved in the project at a particular site. When that client transitioned out of the project to work directly with his case manager, there was no longer a need to include that B&C.

When Shelter-in-Place restrictions began, the team figured out how to successfully work with clients to use technology and operate Zoom. They shared these resources with the mental health clinics which helped to continue additional services within the system.

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The closing of one B&C required the team to transition clients to other living situations. These clients were stepped down and the team used the Problem-Solving Skills module to help with this transition. Clients were transitioned to alternative housing such as MHSA Housing, Room and Board, other B&C's and one client moved in with her family.

When clients got to module three, the team started to incorporate outings into the curriculum. Two trips included picnics that were located at local regional parks. As a group, they would plan the event including, menu, transportation, and any activities they wanted to do while there. This involved coordinating with staff and using skills they learned in the modules. Two outings were planned to visit different museums right before COVID, but plans had to be postponed due to the Shelter-in-Place.

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?

4) Will a client change level of service within placement?

5) Will client maintain placement?

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) – Pre and post each module
- **GAD-7 (Generalized Anxiety Disorder)** assessment monitoring presence/severity of anxiety symptoms (self-report, self-administer) pre and post each module
- **RAS (Recovery Assessment Scale)** assessment measuring aspects of recovery with focus on hope and self-determination (self-report) Pre and post each module
- **ILSS (Independent Living Skills Survey)** assessment obtaining individual's view of his/her own community adjustment (self-report structured interview) Pre and post for all three modules. Only administered once all three modules were completed.

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We adopted the PHQ-9 and GAD-7 to align with tools utilized in the regional specialty mental health clinics to track symptoms for all clients. Use of the ILSS aligns with the 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 met with an Evidence Based Practice Workgroup and CBSST lead staff in the clinics and discussed adding an addendum to the ILSS. We came up with additional questions for specific components such as leisure and community, that seemed more relevant to consumers' actual experiences.

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 completion of the first and second modules.

Strengths of the tools used: 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 they can tap into. And 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 and build independent skills. These discussions can relate directly to the goal setting work of CBSST.

Lessons learned: 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 one on one 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).

Table 1: Percent Change in Average PHQ 9 Scores, July 1, 2019 through June 30, 2020

Fiscal Year	Average Score of First Survey of this Fiscal Year	Range	Average Score of Second Survey of this Fiscal Year	Range	Average Score of Third Survey of this Fiscal Year	Range	Percentage of Change
2019/2020 (n=19)	6	(0 to 15)	2.8	(0 to 8)	2.5	(0 to 4)	-58.3%

Board and Care Homes that were not calculated in the totals were missing surveys due to modules not completed.

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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

Data samples included in this reporting period were minimal due to Shelter-in-Place restrictions from March to end of the fiscal year. All Board and Care homes were included in the sample, but Menona only had one client during the reporting period. Client was only able to complete one round of surveys. Additionally, Family Courtyard did not complete the PHQ-9 during reporting period.

Table 2: Percent Change in Average GAD-7 Scores, July 1, 2019 through June 30, 2020

Fiscal Year	Average Score of First Survey of this Fiscal Year	Range	Average Score of Last Survey of this Fiscal Year	Range	Percentage of Change
2019/2020 (n=26)	5.7	(0 to 17)	4.5	(0 to 17)	-21.0%
Board and Care Homes that were not calculated in the totals were missing surveys due to modules not completed.					
GAD-& Score Key: 0-4 Minimal Anxiety, 5-9 Mild Anxiety, 10-14 Moderate Anxiety, 15-21 Severe Anxiety					

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 County behavioral health clinics. 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 linking 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. The CBSST team also advocates with clinics for providing the appropriate level of service (i.e. case management services instead of money management services), as well as the optimal level of housing.

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.

Perspectives: Board and Care Operator
Feedback on working with program, provided by an owner/operator (Evangeline C.)

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I just want to tell you that Johnson Care Home is so fortunate to have you continue to provide us with your program. Working with the CBSST team has made an impact on the residents. It helps them to stay motivated with their future goals. They feel supported. My experience of working with Contra Costa Behavioral Health has been different since working with the CBSST team because we are receiving additional support for our residents. I observed that having CBSST group has helped residents to be connected and get a chance to engage and be able to express themselves in ways because of the group. The residents are comfortable with the CBSST team and if they need to speak to anyone about an issue or need someone to talk to, the CBSST team is the first one they want to call. CBSST team is doing a wonderful job!! We really appreciate having the CBSST team to continue to provide us help for our Board and Care. The team is always responsive.

Perspectives: Janet, CBSST group participant

Janet began participating in a CBSST group at her 6-bed Board and Care in May 2019. As we got started, Janet let us know that she "hadn't enjoyed" CBSST when doing group prior at a different location. She demonstrated some suspiciousness/paranoia regarding engagement with people she didn't know including providers. It's likely that group being held at her home made it easier to give CBSST a second chance.

In December 2019, the operator determined to close the home and retire. Residents had six weeks to find alternative housing. We utilized the "Problem Solving Skills" module of CBSST to help group participants through this transition. Janet initially discussed going back to her previous placement, an enhanced Board and Care, due to fear that she would not have a place to live. Through exploring options in group, however, she became open to the idea of applying for a spot in MHSA-funded shared housing. Historically it has been difficult for consumers living in licensed Board and Cares to access these limited spots, in part because it can be hard to assess whether an applicant is ready when they have not been living independently and demonstrating the necessary skills. We knew Janet well enough due to the intensive nature of our work with her, to advocate with the clinic to consider this level of care. Additionally, we could support her referral directly, rather than wait for a case manager to be assigned in order to refer and possibly lose the bed. Ultimately Janet was approved for the shared housing, avoiding a return to a level of care that she no longer needs.

Janet moved to her new residence, a house she shares with three other women in February 2020, right before the COVID-19 pandemic and Shelter-in-Place began. She has done amazingly well adjusting to her new home, especially given the context of the pandemic. The CBSST team shifted to providing Janet support as an "alumna" of CBSST, through a combination of individual check-ins and joint calls with another alumna/former housemate, who moved to a room and board. We thus could help Janet consolidate what she learned in our program and apply this to her new situation.

As restrictions have recently eased and everyone is vaccinated, Janet was able to invite the CBSST team to her home in April 2021 for an in-person visit. Her pride in a well-maintained living space, the lovely garden she cares for, the meals she shops for and cooks, was wonderful to see.

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Q&A with Janet regarding our program:

What was helpful about group on site at Concord Hill Home? "Catch up on my goals and my wishes, a place to open up and get to know each other, safely."

How was it different from going to a group at the clinic or RI? "More personable and more enjoyable, and I like the subjects. They're good for my health."

What has been helpful about working with our team, including through the move to a new place? "Keeping up the support I needed, and I was able to re-locate safely. I was made sure to be comfortable."

What did or do you like about the curriculum for group? What did you not like? "Every day that we (providers) came and the goals and the three C's." (*There's nothing she didn't like about group)*

What changes would you recommend? "The only changes I would recommend is for you to come more often to have more visits"

Case vignette: Richard

Richard is a 74-year-old male living in Family Courtyard, Residential Center for the Elderly, a 70-bed facility. He participated in CBSST group from the outset in January 2019 through March 2020 when this group ceased due to Covid-19 restrictions. Richard initially had a difficult time identifying personal meaningful goals. He focused instead of his physical health issues that he wanted to manage but did not feel would ever go away. Richard had symptoms of anxiety and depression and a demonstrated sense of hopelessness about his life holding possibility of positive change.

Richard did share, upon assessment and later during group, that he loved music, and had been a performing singer. He talked about his experiences as a young adult doing auditions in Hollywood, as well as performing more recently as a street performer near the UC Berkeley campus. These were fond memories for Richard and clearly a core part of his identity. However, he was pessimistic about having any way to perform again, and dismissive of setting this as a goal.

Richard began to demonstrate confidence in the group as a leader, in terms of understanding the concepts and practicing the skills taught. This shift was particularly noticeable as group focused on the Social Skills module. He also became a leader and a voice amongst the residents who had multiple complaints about feeling unheard by staff in the facility. Richard practiced voicing these concerns in group, in preparation for resident council meetings where he shared complaints with staff.

This confidence developed during the Social Skills module served as a foundation for Richard to turn toward his music as a goal. The (third and final) Problem Solving module saw Richard working on ways to perform again. His girlfriend, another group member, became his "manager" and together they tackled questions of what venues he could approach to perform, how to advertise, even developing a stage name. Richard had always frequented the local library for reading, but often complained about

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the noise level there and wondering if it was worth going. His goal of being a performer rejuvenated his relationship with the library—he printed fliers there, and successfully set up a performance to be held onsite there.

"Rick Starr" was scheduled to perform at the library on March 17th, 2020. This unfortunately was the day before Shelter-in-Place went into effect, and the libraries had already shut down all services. Still, Richard remained hopeful in the weeks to follow that he may have another chance in the future.

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INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: 2019/20

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 Barriers (OTB) innovation project began implementation in September 2016 and started 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. As of June 30, 2020, 40 clients accessed help from the OTB team for this fiscal year. A total of 15 inquiries were also made by staff in various programs.

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 typically access these services by calling the dedicated phone line for transportation assistance. A Commute Navigation Specialist (CNS) assesses their needs and provides one-on-one support on how to access services and get to appointments.

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 Shelter-in-Place, OTB moved the Community Sub-Committee meetings to a virtual platform via Zoom. The program continued bi-weekly planning meetings and facilitated four of six Community Sub-Committee meetings. At these meetings, it was noted that new participants were gained, while some ongoing participants were lost for various reasons. Sub-Committee members were asked their preferences about continuing meetings via Zoom after Shelter-in-Place. Members requested to have the option of attending either in person or virtually, to accommodate instances in which a participant felt unwell yet wanted to still receive support and stay informed while not having to leave their home.

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In the early summer, one of the two Commute Navigation Specialists left her position due to a promotion. Currently the program is operating with 1 FTE and has requested freeze approval to backfill the other position. The OTB workgroup continues to monitor concerns shared by clients while accessing public transit and other transportation resources, as well as staffing a transportation hotline for clients and families/caregivers to seek support.

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.

In January 2020, OTB rolled out a Flex Fund initiative at the Central County Adult Mental Health Clinic to helps support clients in attending their mental health appointments. Through a collaboration with a community-based organization, clients receive financial support to cover transportation costs when there is no alternative funding source. Flex funds are for time-limited transportation services or supports and are not intended to pay for ongoing expenditures. Flex funding requests are tracked in a database and reviewed by the OTB team before funding is approved and distributed. It is required that clients have an upcoming appointment and attendance is confirmed. Flex fund distribution is detailed below in the outcomes section.

In March 2020, the Flex Fund effort was suspended due to COVID-19. However, in that short period requests were processed in approximately one week. This is significant because previous flex fund efforts took an excessive amount of time and often did not meet expectations for clients in need.

During the pandemic, and as the project was adjusting to changes, the Commute Navigation Specialists acted as liaisons between County Behavioral Health staff and transit authorities. They analyzed existing County transportation and public transit resources and kept participants up-to-date on the changes in transit systems. This happened via email, as well as announcements at Social Inclusion meetings and Overcoming Transportation Barriers Community Sub-Committee meetings.

Per feedback by clients in the Transportation Sub-Committee, physical wallet/pocket cards were created for clients who experience high-stress situations or need a quick coping strategy. Referenced coping strategies on the cards included: meditation, deep breathing, riding with friends, prayer, listening to music, journaling, reading, and practicing a hobby. Cards were distributed at all CCBHS outpatient clinics and included bus vouchers upon request. Per recommendations from the Sub-Committee, the OTB workgroup revised the wallet cards into trifold wallet cards in both English and Spanish. The OTB brochure that outlines the available services and resources continues to be distributed throughout the clinics and in the welcoming packets for new clients.

Additionally, a request was made to pilot transportation packets for new clients to be provided in the East County Adult Mental Health Clinic. The packets were prepared in English and Spanish and contained a welcoming letter from the Commute Navigation Specialists and an ADA Paratransit application, introduction to BART, transit schedules, Reduced Transit Card application, OTB brochure

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and OTB trifold cards.

Posters were also created that depicted transportation services available within the County. These posters were distributed in East County Adult and Children's Clinics. Posters were printed in both English and Spanish and reflected important information around support for filling out transportation paperwork, available peer support, and mapping bus routes. Contact information was also included.

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) To improve service access through client education on transportation usage and encouragement of independent living skills in getting to and from services.

2) To promote efficient use of transportation resources through navigation support: how to use public transit, read transit schedules, plan travel routes, and apply for discount passes.

3) To foster clients' life skills for social engagement, increase productive and meaningful activity, and reduce isolation through the application of learned transportation skills.

4) To increase attendance rates at County-operated clinics by addressing both physical and emotional barriers with the development of solution-focused transportation skills.

5) To reduce stigma through ongoing peer support from Commute Navigation Specialists.

The OTB project started collecting data on April 25, 2017. The data collected for the project provided outcomes showing the type of support provided by the OTB team and where referrals originated. The support included providing resources, referrals and other types of educational training around different modes of transportation.

Exploring a new transportation intervention in the adult system.

Analysis of service improvement survey data and data from our non-clinical PIP has shown that transportation is one of the most frequently identified barriers to appointment adherence. To help address clients' transportation needs, the MHP is planning to pilot a new transportation intervention, providing clients rides to clinic appointments using Round-trip Lyft. In 2019, Contra Costa Health Plan (CCHP)

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piloted this intervention with clients enrolled in Whole Person Care (WPC) and found that among clients who were open to Behavioral Health clinics, those who had round-trip Lyft rides scheduled no-showed to appointments at lower rates than those who did not have rides scheduled. CCMHP is working on implementing this intervention with clients scheduled for a co-visit appointment at East County Adult Clinic, the clinic with one of highest no-show rates and most limited transportation options. The pilot is scheduled to begin in early 2020.

Table 1., 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.

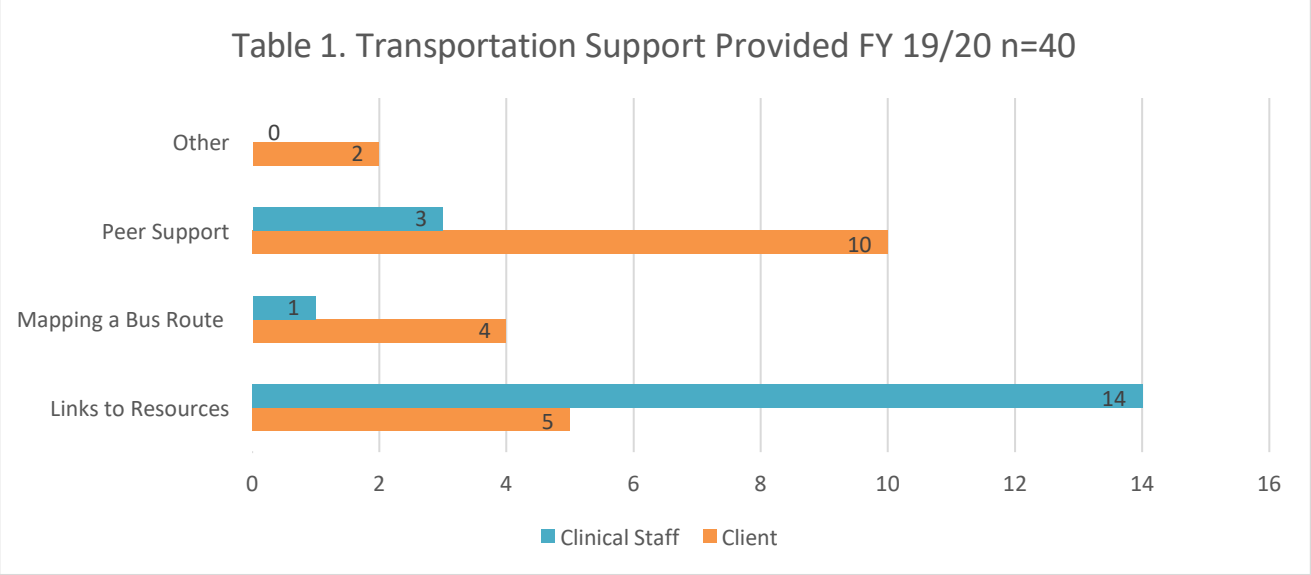

Table 2., below shows total number of calls received by clients and where the referral source originated. Referral source known as "other" describes sources such as family members, friends, word of mouth, presentations or outside therapists.

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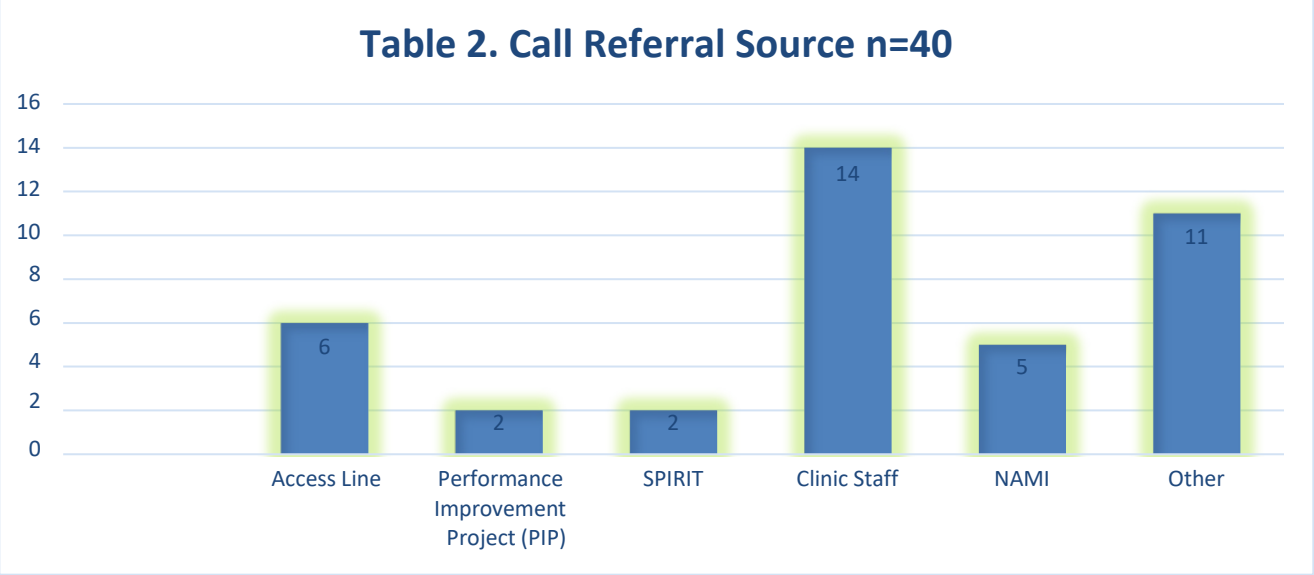
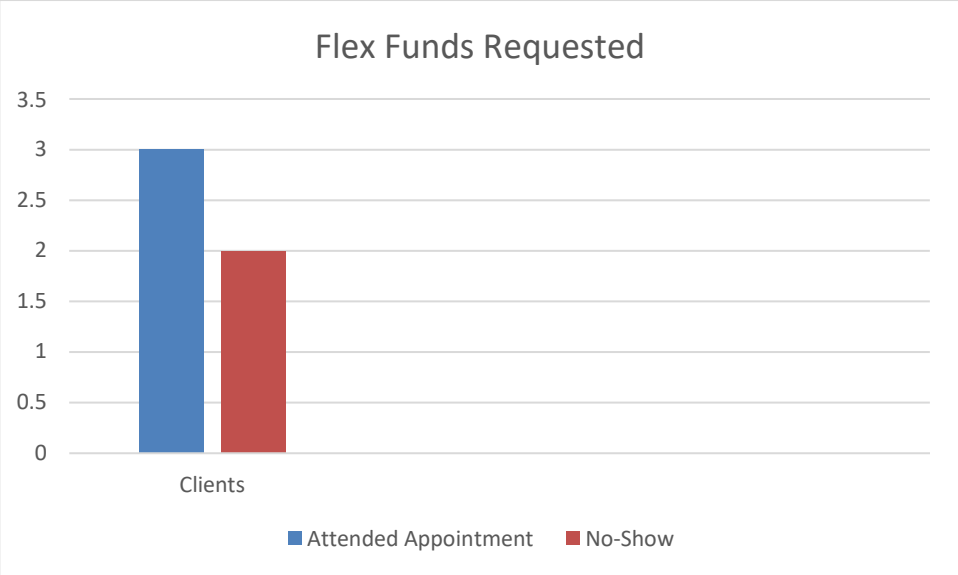


Table 3., below shows the total number of Flex Fund Forms submitted and funds requested in order for clients to access services. Requests submitted included funding for gas cards, transit fares, and DMV fees.



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.

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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 the County. This action established a process to help provide a connection between these entities and the project's team. During this process, improved access to resources and materials became available to clients and the team was better able to support 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 staff during the current fiscal year. Collection was difficult due to the restrictions in place, so alternative methods of collection were utilized. Staff working the OTB project sent out questionnaires with the following questions:

1) To what extent did your client find the services received from OTB helpful?
2) Would you recommend our services to other clients in the future?
3) How did the services provided by OTB benefit your client's ability to make it to their future appointments?
4) Was the turnaround time fast enough for your client to get the most benefit from the services from OTB?
5) Is there anything you would like to have seen done differently in your experience with OTB?

Responses were received from staff at various locations. Included below are two examples:

1)**To what extent did your client find the services received from OTB helpful?**
Due to OTB's help, my client was able to attend in-person appointments without the fear and anxiety of breaking down on the side of the road or being in an accident. Overall, it has helped the client attend to other basic needs as well, such as getting groceries and going to medical appointments. The client has expressed deep gratitude for OTB's assistance.

2) Would you recommend our services to other clients in the future?
I would absolutely recommend the services of OTB. OTB immensely helped my client manage and reduce their environmental stressors while ensuring my client can use their funds for other necessities.

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3) How did the services provided by OTB benefit your client's ability to make it to their future appointments?
Without this financial support, my client would likely have had to continually choose between driving an unsafe vehicle and obtaining necessary in-person care.

4) Was the turnaround time fast enough for your client to get the most benefit from the services from OTB?
OTB was incredibly responsive to questions, followed up, and was quick to act.

5) **Is there anything you would like to have seen done differently in your experience with OTB?**
Understandably, there were some questions the car mechanic had that I could not answer as a case manager/the person not in charge of billing. Since there were four parties involved (client, case manager, OTB, auto shop) it took some additional coordination. Perhaps in the future, if schedules allow, there could be a conference call between some of the parties. However, the auto shop may become more familiar with the process in the future as well.

Questionnaire 2:

1) To what extent did your client find the services received from OTB helpful?
Client found the service extremely helpful to be able to get around to not only appointments but other activities to improve his independent living skills.

2) **Would you recommend our services to other clients in the future?** Absolutely!

3) How did the services provided by OTB benefit your client's ability to make it to their future appointments?
Client lives a good distance from Bart and bus stops, so it helps cut the travel time drastically.

4) Was the turnaround time fast enough for your client to get the most benefit from the services from OTB?
Yes, turnaround was about 2 weeks which I thought was fast.

5) **Is there anything you would like to have seen done differently in your experience with OTB?**
Yes, once an order is submitted and approved it should not be changed. My client has a disability that requires a key lock and that was changed to a much cheaper combo lock, I had to purchase out of pocket a new key lock for my client because I wanted him to have a lock he could use.

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FINAL INNOVATIVE PROJECT REPORTING FORM

FISCAL YEAR: 2019/20

Agency/Project Name: Contra Costa Behavioral Health/Partners in Aging

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.

The Partners in Aging Innovation Project was based on the innovative idea to add Community Support Workers (CSWs) and Interns to the IMPACT Program. The goals were to find out if clients of the IMPACT Program would benefit from these new additions to the treatment team. Community Support Workers are able to provide linkage to community resources, advocacy and in-home and in-community rehab support and coaching. This addition expands the reach of the IMPACT Program beyond the therapy session. The addition of an Intern expanded the ability to serve additional clients and develop a workforce that has skills and passion for working with older adults.

Our IMPACT Program provides psychotherapy services to older adults, who are 55 and above. During FY 19/20 we were serving older adults with mild to moderate depression, anxiety and Post-Traumatic Stress Disorder (PTSD), who were eligible to receive services at a Federally Qualified Health Center. We had a clinician located at Concord Health Center 2, Pittsburg Health Center and West County Health Center.

Due to the COVID-19 Pandemic in March 2020 our IMPACT clinicians began to provide telehealth services by phone or Zoom to their clients. In January 2021 the eligibility for the IMPACT Program changed. Currently, we are serving older adults 55 and above, who have moderate to severe depression, anxiety and PTSD, who have Medi-Cal or Medicare/Medi-Cal benefits. Services are provided through telehealth, and in-person at the West County WIC Building adjacent to West County Health Center, Pittsburg Adult Mental Health and Older Adult Mental Health in Concord.

PROJECT OVERVIEW:
Please provide an overview of the innovative project.

The Partners in Aging Innovation Project began on September 1, 2016 with the hiring of one Community Support Worker (CSW), and one Intern. Every Fall we welcome a new Intern into our

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program. Most of our Interns have chosen a dual track for the Internship with Older Adult Mental Health. They have split their time between our Intensive Care Management Program and IMPACT. This has given our Interns a breadth of experience by providing services to clients ranging from mild to severe and persistent mental illness. They have also been able to provide services that are clinic based and home or community based. They have provided a wide range of services, including individual therapy, case management, collateral contacts and crisis intervention. Our Interns have also frequently engaged in outreach or research projects, including outreach to West County, and the development of a binder of resources for clients experiencing cognitive decline. Interns always bring a spark of curiosity and passion to our clinic and we are happy to be able to increase the mental health workforce that can specialize in providing services to older adults. We were able to hire one of our Interns as a Permanent Full-Time Mental Health Clinical Specialist in January 2021.

Our first Community Support Worker joined the Partners in Aging Program on 9/1/2016. She left our program on 1/31/19 due to her extensive commute and finding a job closer to her home. We filled her position in June 2019 and expanded the program to hire a second CSW in July 2019. These two CSWs have continued with our program. One of the CSWs transitioned to a Permanent CSW II position in February 2021 on our East County Intensive Care Management Team. We have not filled her position due to not knowing whether or not this position would be funded past August 31, 2021.

Our CSWs and Interns served 27 clients during the 2019-2020 fiscal year. Most of these clients received multiple services. Our CSWs are able to build rapport and provide peer support, coaching, multiple linkage and mental health rehabilitation 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 aided in linking clients to important resources such as In-Home Support Services, 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. They can also check in with the clients in between their sessions with their IMPACT clinician. 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. During the COVID-19 pandemic our CSWs have been providing weekly food deliveries to several of our vulnerable older adult clients.

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.

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 did not receive referrals from PES during this reporting period. The lack of referrals from PES was also impacted by the switch in the IMPACT program to seeing clients with mild to moderate symptoms in

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November 2017.

Our Intern served a caseload of approximately 5 IMPACT clients during FY 19/20. He completed intakes and provided psychotherapy. He was able to develop rapport with a range of clients and make progress towards therapeutic goals. Prior to terminating with his clients he provided them with community referrals, and made recommendations for the next Intern regarding next steps for treatment, or discharge from IMPACT.

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 Partners in Aging Project was impacted during FY 19/20 by the COVID-19 Pandemic. In March 2020 therapy and intake assessment services rapidly shifted from in-person to telehealth. Many IMPACT clients chose to continue receiving services through telehealth (primarily by phone). The majority of our clients preferred to use the phone rather than Zoom, which seems to reflect some older adults having difficulty with technology. This digital divide has impacted our ability to connect with clients. We continue to provide services primarily through telehealth. We began increasing our In-Person services in the Spring of 2021.

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.*

We have evaluated the success of this project using several different methods. We began utilizing the PEARLS (Program to Encourage Active and Rewarding LiveS) Questionnaire in approximately August 2017 with Partners in Aging clients. The PEARLS is administered when the client begins receiving a service from our Partners in Aging Intern or CSW, every 6 months, and at closing. 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 worked collaboratively with the Business Intelligence Team to develop a report that

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would show differences in PEARLS scores over time. Additional indicators that we have used include PHQ-9 scores, chart review, Monthly Service Summaries, and qualitative interviews with our staff. The PHQ-9 are administered frequently by the IMPACT clinicians. We are waiting for the Business Intelligence team to complete the report that tracks the PHQ-9 scores over time.

We have not formally requested stakeholder evaluation of this project. Our clients are invited to participate in the MHSIP Consumer Perception Surveys and Focus Groups, but we are not able to determine which results may be coming from IMPACT or Partners in Aging clients. In general, these results have shown that our clients are happy with the services that they are receiving.

Cultural competency is an essential element of all our programs at Older Adult Mental Health. In addition to required yearly trainings our staff frequently engages in additional trainings and discussions related to cultural competency. We serve a diverse group of older adults and provide services in the client's native language through the use of the Language Line. We also have clinicians who speak languages other than English, including Korean, Spanish and Arabic. We are open to feedback from our clients and staff related to cultural competency and committed to continuous growth in this area.

Preliminary results of the PEARLS data indicates that all participants showed a decrease in depressive symptoms as measured by the PHQ-9. These decreases ranged an average of 1 point for clients with mild and moderate depression to 5 points for clients with severe depression, which was about 25% of the clients. Clients with severe depression were shown to improve in their overall evaluation of their physical health. Clients with mild to moderate depression were shown to improve their social connections and activities. Unfortunately, we do not have demographic data linked to this report. Demographic data was collected but was not used to create the report. This would be an area to improve in future reports and projects.

These results indicate that the Partners in Aging Program had a positive impact on these clients with different trends depending on the level of severity of the client. It is notable that clients with the most severe depression benefited the most in terms of the reduction in depressive symptoms. This indicates that the current focus of the IMPACT and Partners in Aging Programs on serving clients with moderate to severe depression is likely to lead to significant benefits for the clients served as we go forward with this project.

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. Since clients are able to obtain a sense of safety and security through the resources offered by the CSWs they are able to focus on their mental health treatment and work towards obtaining their goals. Adding this level of support to the IMPACT model was an innovative way to improve service delivery, meet the needs of clients in the community, and integrate the peer perspective into treatment planning. Our CSWs have become critical to the functioning of all our Older Adult Mental Health Programs!

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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 plan for continued funding for the Partners in Aging Project is still being developed. Our Intern will be able to be funded through MHSA WET Funds. Our goal is to secure funding to continue to have two Community Support Workers in the Partners in Aging Program. These CSWs have become vital to the functioning of all of our Older Adult Mental Health programs and can continue to support IMPACT as well as our Intensive Care Management Program. We are working with the MHSA Team to determine how these positions will be funded beginning 9/1/21. The MHSA funding would be supplemented by the Medi-Cal billing that our CSWs and Intern complete for all billable services. We are planning to attend the Innovations Committee Stakeholder Meeting on 5/24/21 to advocate for the continuation of the Partners in Aging Program. We are also meeting with the MHSA Team on 6/1/21. We have also been discussing these plans during annual meetings with the MHSA Team.

LEARNING GOALS:
Please explain whether the project achieved its intended outcomes or learning goals and a summary of what was learned.

The goals of the project were to learn the following:

1) Do older adults access IMPACT services with the assistance of peer support workers?

   Yes. Our CSWs successfully provided services to approximately 22 IMPACT clients to improve their access to IMPACT services during FY 19/20.

2) Do older adults engage in SBIRT?

   All patients seen at the health centers engage in SBIRT evaluation.

3) 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?

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Yes, they are using these skills regularly, and our CSW can continue to encourage clients, and provide reminders and support.

4) 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.

5) 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.

6) 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.

7) Does social isolation decrease?

   Yes, we have observed that social isolation decreases through the support of Partners in Aging. Our CSWs connect clients to community resources, including Senior Centers and Adult Day Health Care Programs. In addition, we have connected clients to support groups, including grief support groups. Our CSWs have formed positive rapport with many of our clients and have become important sources of support, which has also reduced social isolation.

8) Does quality of life increase?

   Yes, we have observed increases in quality of life, including clients feeling more able to

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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.

9) 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 have requested 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 hoping that this report can separate the clients who received Partners in Aging services from the other IMPACT clients to see if there is a difference in the change in the scores over time between these two groups.

The initial results that we have received from the PEARLS report show that depression was reduced in all the cases with a range from approximately one point on the PHQ-9 to five points showing a small to significant decrease in depressive symptoms.

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.

The Partners in Aging Project has been shared with stakeholders throughout Contra Costa County. We have presented on our programs to several groups, including presenting twice to the Adult Protective Services Multi-Disciplinary Team Meeting. This MDT brings together providers from several disciplines who serve older adults together to discuss complex cases. We also present our programs to newly hired Adult Protective Services Social Workers. We have also presented to the SPIRIT Program on a yearly basis. We have presented our programs to the Behavioral Health Access Line approximately once a year. In addition, we have presented our programs to the West County Senior Coalition and have presented twice to the Advisory Council on Aging.

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.

One of our Partners in Aging clients was a 61 year old Afghan-American female who was primarily Dari speaking. She reported a history of severe trauma, which resulted in a traumatic brain injury for herself and the death of her husband. When she began therapy, she expressed feeling inadequate and depressed. Our CSW supported this client with taking the necessary steps towards receiving Disability benefits from Social Security. She assisted the client with making medical and psychiatric appointments to obtain needed documentation and assisted and accompanied her to Social Security

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appointments. This client now has a steady income and has expressed significant relief of her symptoms. She described herself as "doing much better." The CSW also assisted her with the intake process for joining groups at Choices in Aging. This is an example of the ways that our CSW was invaluable in assisting this client in obtaining the services that she needed to be able to focus on her mental health treatment, and significantly improve her quality of life.

Another client was a 66-year-old Caucasian woman who was referred for depressive symptoms. She scored an 18 on PHQ-9 at intake. She had just lost one of her dogs and was wheelchair dependent due to pain. She was very isolated despite living with family friends who often relied on her for childcare. She was estranged from her biological family, felt like a burden, had low self-esteem and would often cancel appointments due to transportation issues. Both of our CSWs helped her get set up with transportation through Contra Costa Health Plan to get free taxi vouchers to her medical appointments and Paratransit services. They also eventually helped her navigate public transportation systems (before COVID) to give her a better sense of independence. They connected her with food resources, such as Meals on Wheels, Monument Crisis Center, and food banks, so she was no longer dependent on her family friends for groceries. They also helped her get other supplies such as adult diapers through her PCP. She was also linked to Friendly Visitors which helped with her sense of isolation. During COVID they helped her apply for her stimulus check and encouraged her to engage in social activities with her housemates such as going for walks and working in her garden. At the end of treatment client was able to express needs and healthy boundaries to her housemates, engage in more independent activities which decreased her depressive symptoms and was also able to independently socialize more.

Screenshot of MHSA Website Indicating Date INN & PEI Plans Posted for 30 day Public Comment: 5/28/21