



— 3-YEAR PEI — EVALUATION REPORT

Contra Costa Behavioral Health Services
Mental Health Services Act
As submitted for MHOAC

FY 2018–2021

cchealth.org/mentalhealth/



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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 FYs 18-21, over 29,000 consumers of all ages were served per year by PEI programs in Contra Costa County. This report includes updates from each program and is organized by PEI program category.

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

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

EVALUATION COMPONENT

Contra Costa Behavioral Health Services is committed to evaluating the effective use of funds provided by the Mental Health Services Act. Toward this end, a comprehensive program and fiscal review process has been implemented to: a) improve the services and supports provided; b) more efficiently support the County's MHSa Three Year Program and Expenditure Plan; c) ensure compliance with statute, 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

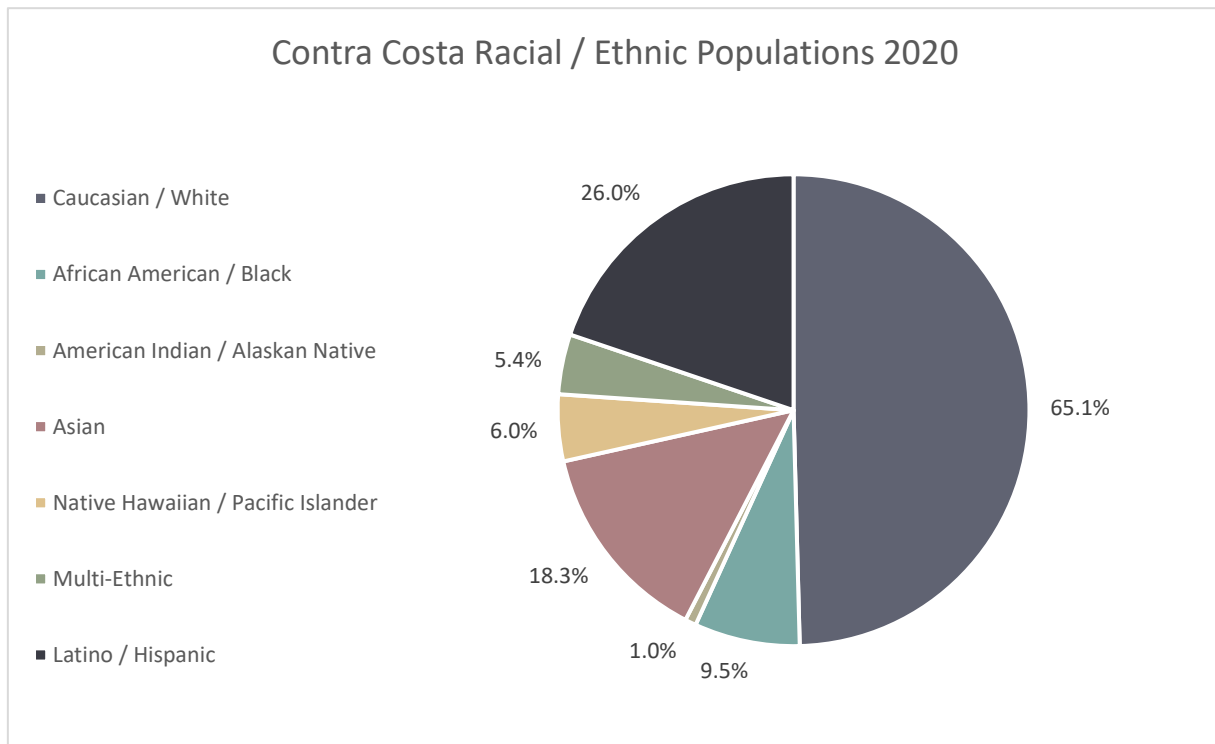
Each program receives a written report that addresses the above areas. Promising practices, opportunities for improvement, and/or areas of concern are noted for sharing or follow-up activity, as appropriate. The emphasis is to establish a culture of continuous improvement of service delivery, and quality 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](#). During FYs 18-20,

completed PEI Program and Fiscal Review reports were distributed at the following monthly CPAW meetings: September 2018, February 2019, March 2019, April 2019, August 1, 2019, January 9, 2020, February 6, 2020. Reviews for FY 20-21 were not completed due to the COVID-19 pandemic.

PEI AGGREGATE DATA FYs 18-21

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](#) and the 2020 Decennial Census results, it's estimated that 7.2% of people in Contra Costa County are living in poverty, down from an estimated 9% in 2018. Children, adolescents & young adults (ages 0-25) continue to make up approximately 30% of the population and 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 29,000 individuals per year during the previous three-year period, FYs 18-21. 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 during the during the previous three-year period, FYs 18-21. Please note that the below figures are not a full reflection of the demographics served, particularly for the latter half of FY 19-20 and FY 20-21. Data collection was greatly impacted by the COVID-19 pandemic. A notable amount of data was not captured for most participants for two primary reasons: a significant number of participants declined to respond to demographic information, and, due to COVID-19, conducting surveys and self-reporting on behalf of clients served by PEI programs decreased. Additionally, different interpretations of the requested information by the respondents created challenges.

Total Served: FY 18-19: **32,949**; FY 19-20: **32,442**; FY 20-21: **29,105**

| Table 1. Age Group | FY 18-19 # Served | FY 19-20 # Served | FY 20-21 # Served |
|--------------------------------------|------------------------------|------------------------------|------------------------------|
| Child (0-15) | 2,530 | 1,395 | 831 |
| Transition Age Youth (16-25) | 5,207 | 4,514 | 2,944 |
| Adult (26-59) | 10,831 | 9,096 | 7,204 |
| Older Adult (60+) | 2,684 | 2,623 | 3,185 |
| Decline to State / Data Not Captured | 11,700 | 14,814 | 14,941 |

| Table 2. Primary Language | FY 18-19 # Served | FY 19-20 # Served | FY 20-21 # Served |
|--------------------------------------|------------------------------|------------------------------|------------------------------|
| English | 20,471 | 24,071 | 22,766 |
| Spanish | 6,181 | 1,959 | 1,522 |
| Other | 642 | 1,033 | 891 |
| Decline to State / Data Not Captured | 5,655 | 5,393 | 3,926 |

| Table 3. Race | FY 18-19 # Served | FY 19-20 # Served | FY 20-21 # Served |
|---|------------------------------|------------------------------|------------------------------|
| More than one Race | 1,014 | 646 | 318 |
| American Indian/Alaska Native | 94 | 348 | 136 |
| Asian | 1,866 | 1,932 | 1,512 |
| Black or African American | 3,697 | 3,262 | 2,251 |
| White or Caucasian | 11,393 | 7,537 | 8,270 |
| Hispanic or Latino/a | 8,377 | 3,849 | 2,812 |
| Native Hawaiian or Other Pacific Islander | 103 | 618 | 55 |
| Other | 409 | 248 | 142 |
| Decline to State / Data Not Captured | 5,996 | 14,104 | 13,842 |

| Table 4. Ethnicity (If Non-Hispanic or Latino/a) | FY 18-19 # Served | FY 19-20 # Served | FY 20-21 # Served |
|---|------------------------------|------------------------------|------------------------------|
| African | 190 | 443 | 309 |
| Asian Indian/South Asian | 150 | 1,036 | 754 |
| Cambodian | 7 | 3 | 2 |
| Chinese | 50 | 195 | 37 |
| Eastern European | 29 | 135 | 27 |
| European | 273 | 304 | 128 |
| Filipino | 143 | 33 | 30 |
| Japanese | 8 | 3 | 5 |
| Korean | 13 | 2 | 6 |
| Middle Eastern | 238 | 12 | 14 |
| Vietnamese | 23 | 152 | 185 |
| More than one Ethnicity | 173 | 463 | 109 |
| Decline to State / Data Not Captured | 3,002 | 28,453 | 26,650 |
| Other | 940 | 153 | 110 |

| Table 5. Ethnicity (If Hispanic or Latino/a) | FY 18-19 # Served | FY 19-20 # Served | FY 20-21 # Served |
|---|------------------------------|------------------------------|------------------------------|
| Caribbean | 11 | 4 | 3 |
| Central American | 590 | 101 | 100 |
| Mexican/Mexican American /Chicano | 3,784 | 1,251 | 713 |
| Puerto Rican | 15 | 9 | 14 |
| South American | 162 | 8 | 23 |
| Other | 23 | 23 | 95 |

| Table 6. Sexual Orientation | FY 18-19 # Served | FY 19-20 # Served | FY 20-21 # Served |
|---|------------------------------|------------------------------|------------------------------|
| Heterosexual or Straight | 14,997 | 11,553 | 16,400 |
| Gay or Lesbian | 220 | 99 | 198 |
| Bisexual | 133 | 156 | 132 |
| Queer | 24 | 18 | 21 |
| Questioning or Unsure of Sexual Orientation | 40 | 25 | 52 |
| Another Sexual Orientation | 168 | 82 | 111 |
| Decline to State / Data Not Captured | 17,367 | 20,509 | 12,193 |

| Table 7. Gender Assigned at Birth | FY 18-19 # Served | FY 19-20 # Served | FY 20-21 # Served |
|--|------------------------------|------------------------------|------------------------------|
| Male | 10,289 | 10,113 | 7,031 |
| Female | 11,925 | 11,311 | 10,822 |
| Decline to State / Data Not Captured | 18,339 | 9,495 | 11,252 |

| Table 8. Current Gender Identity | FY 18-19 # Served | FY 19-20 # Served | FY 20-21 # Served |
|--|------------------------------|------------------------------|------------------------------|
| Man | 8,699 | 10,263 | 6,846 |
| Woman | 8,801 | 11,281 | 10,696 |
| Transgender | 149 | 146 | 91 |
| Genderqueer | 13 | 11 | 14 |
| Questioning or Unsure of Gender Identity | 14 | 8 | 15 |
| Another Gender Identity | 68 | 15 | 68 |
| Decline to State / Data Not Captured | 15,205 | 10,718 | 11,377 |

| Table 9. Active Military Status | FY 18-19 # Served | FY 19-20 # Served | FY 20-21 # Served |
|--|------------------------------|------------------------------|------------------------------|
| Yes | 52 | 31 | 81 |
| No | 3,049 | 2,873 | 2,894 |
| Decline to State / Data Not Captured | 29,848 | 29,073 | 26,132 |

| Table 10. Veteran Status | FY 18-19 # Served | FY 19-20 # Served | FY 20-21 # Served |
|--------------------------------------|------------------------------|------------------------------|------------------------------|
| Yes | 75 | 103 | 178 |
| No | 8,045 | 3,427 | 3,173 |
| Decline to State / Data Not Captured | 24,829 | 28,912 | 25,756 |

| Table 11. Disability Status | FY 18-19 # Served | FY 19-20 # Served | FY 20-21 # Served |
|--------------------------------------|------------------------------|------------------------------|------------------------------|
| Yes | 360 | 558 | 965 |
| No | 2,660 | 1,768 | 1,410 |
| Decline to State / Data Not Captured | 29,929 | 30,094 | 26,730 |

| Table 12. Description of Disability Status | FY 18-19 # Served | FY 19-20 # Served | FY 20-21 # Served |
|---|------------------------------|------------------------------|------------------------------|
| Difficulty Seeing | 33 | 88 | 101 |
| Difficulty Hearing or Have Speech Understood | 38 | 77 | 66 |
| Physical/Mobility | 91 | 219 | 252 |
| Chronic Health Condition | 126 | 163 | 225 |
| Other | 406 | 36 | 62 |
| Decline to State / Data Not Captured | - | 25,320 | 28,399 |

| Table 13. Cognitive Disability | FY 18-19 # Served | FY 19-20 # Served | FY 20-21 # Served |
|---------------------------------------|------------------------------|------------------------------|------------------------------|
| Yes | 116 | 144 | 115 |
| No | 987 | 1,327 | 1,983 |
| Decline to State / Data Not Captured | - | 25,387 | 27,007 |

| Table 14. Referrals to Services | FY 18-19 # Served | FY 19-20 # Served | FY 20-21 # Served |
|---|------------------------------|------------------------------|------------------------------|
| Clients Referred to Mental Health Services | 1,850 | 1,120 | 964 |
| Clients who Participated/ Engaged at Least Once in Referred Service | 1,681 | 883 | 794 |

| Table 15. External Mental Health Referral | FY 18-19 # Served | FY 19-20 # Served | FY 20-21 # Served |
|---|------------------------------|------------------------------|------------------------------|
| Clients Referred to Mental Health Services | 18,464 | 22,025 | 20,397 |
| Clients who Participated/ Engaged at Least Once in Referred Service | 191 | 21,849 | 214 |

| Table 16. Average Duration Without Mental Health Services | FY 18-19 # Served | FY 19-20 # Served | FY 20-21 # Served |
|---|------------------------------|------------------------------|------------------------------|
| Average Duration for all Clients of Untreated Mental Health Issues (In weeks) | 17.6 | 55.9 | 67.5 |

| Table 17. Average Length of Time Until Mental Health Services | FY 18-19 # Served | FY 19-20 # Served | FY 20-21 # Served |
|---|------------------------------|------------------------------|------------------------------|
| Average Length for all Clients between Mental Health Referral and Services (In weeks) | 4.4 | 4.5 | 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, the Needs Assessment and Community Program Planning Process identified children ages 0-5 with serious emotional disturbances as underserved. The FY 17-20 MHSA Three-Year Plan substantially increased funding, and subsequently treatment capacity, in the Children's System of Care in order to provide prevention and early intervention services to families with young children experiencing serious emotional disturbances.

In FY 20-21, We Care Services for Children (in collaboration with The Early Childhood Prevention and Intervention Coalition - ECPIIC) was awarded the Early Childhood Mental Health 0-5 Outreach RFP (with services beginning FY 21-22). We Care Services for Children supports families and children from birth to six years old with a wide range of early childhood education and mental health programs. Through targeted, compassionate, and effective early intervention services, We Care helps young children and their families reach their full potential, regardless of their abilities or circumstances. The collaborative program awarded the RFP, called The Everyday Moments/Los Momentos Cotidianos, provides programming for families with children ages 0-5 and includes three components: 1) Family Engagement and Outreach; 2) Early Childhood Mental Health Home-Based Support; and 3) Parent Education and Empowerment.

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 22-23 |
|---|-------------------------|-----------------------------------|--|
| Asian Family Resource Center | Countywide | 50 | \$159,567 |
| COPE | Countywide | 210 | \$268,660 |
| First Five | Countywide | (Numbers included in COPE) | \$89,343 |
| Hope Solutions | Central and East County | 200 | \$408,952 |
| Jewish Family Community Services | Central and East County | 350 | \$185,112 |
| Native America Health Center | Countywide | 150 | \$265,486 |
| The Latina Center | West County | 300 | \$133,184 |
| We Care Services for Children (0-5 Children Outreach RFP) | Countywide | 99 families | \$128,750 |

TOTAL1,359+ \$1,639,054

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 22-23 |
|--------------------------|----------------------|-----------------------------------|--|
| Building Blocks for Kids | West County | 400 | \$238,280 |
| Vicente | Central County | 80 | \$197,076 |
| People Who Care | East County | 200 | \$243,789 |
| Putnam Clubhouse | Countywide | 300 | \$718,777 |
| RYSE | West County | 2,000 | \$533,653 |

TOTAL2,980 \$1,931,575

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 22-23 |
|----------------|----------------------|-----------------------------------|--|
| First Hope | Countywide | 200 | \$2,719,036 |
| TOTAL | | 200 | \$2,719,036 |

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/acclimation.
- 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 22-23 |
|----------------------------------|---------------|----------------------------|-----------------------------------|
| James Morehouse Project | West County | 300 | \$112,442 |
| STAND! Against Domestic Violence | Countywide | 750 | \$146,548 |
| Experiencing Juvenile Justice | Countywide | 300 | \$404,992 |
| TOTAL | | 1,350 | \$663,982 |

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 22-23 |
|----------------------------------|-------------------------|-----------------------------------|--|
| Child Abuse Prevention Council | Central and East County | 120 | \$136,709 |
| Center for Human Development | East County | 230 | \$171,488 |
| La Clínica de la Raza | Central and East County | 3,750 | \$306,573 |
| Lao Family Community Development | West County | 120 | \$208,073 |
| Lifelong Medical Care | West County | 115 | \$142,914 |
| Rainbow Community Center | Countywide | 1,125 | \$828,312 |

TOTAL..... 5,460 \$1,794,069

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 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 22-23 |
|----------------|------------------------|----------------------|--|
| OCE | County Operated | Countywide | \$232,189 |
| CaIMHSA | MOU | Countywide | \$78,000 |

TOTAL..... \$310,189

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) In FY 20-21 The Contra Costa Crisis Center was awarded the Suicide Prevention focused RFP for their proposed PES Follow Up Program. This new Follow Up Program is designed for patients with suicidal ideation/attempt being released from PES. The program aims to increase linkages and reduce service gaps by offering immediate 24/7 support from counselors who are specially trained in providing crisis and suicide intervention and assessment. The Crisis Center is accredited by the American Associate of Suicidology (AAS) and provides local response for the National Suicide Prevention Lifeline (NSPL) as well as the 211 Information and Referral
- 3) A multi-disciplinary, multi-agency Suicide Prevention Committee has been established, and has published a countywide Suicide Prevention Strategic Plan. This ongoing committee oversees the implementation of the Plan by addressing the strategies outlined in the Plan. These strategies include i) creating a countywide system of suicide prevention, ii) increasing interagency coordination and collaboration, iii) implementing education and training opportunities to prevent suicide, iv) implementing evidence-based practices to prevent suicide, and v) evaluating the effectiveness of the County's suicide prevention efforts. 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 22-23 |
|---|----------------------|-----------------------------------|--|
| Contra Costa Crisis Center | Countywide | 25,000 | \$401,603 |
| Contra Costa Crisis Center Suicide Prevention RFP (PES Follow Up Program) | Countywide | TBD | TBD* |
| County Supported | Countywide | N/A | Included in PEI administrative cost |

TOTAL 25,050 \$401,603

*These funds are already rolled into Contra Costa Crisis Center’s funds allocation for FY 22-23

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 | \$389,491 |

TOTAL \$389,491

PREVENTION AND EARLY INTERVENTION (PEI) SUMMARY FOR FY 2022-23

| | |
|---|-------------|
| Outreach for Increasing Recognition of Early Signs of Mental Illness | \$1,639,054 |
| Prevention | \$1,931,575 |
| Early Intervention | \$2,719,036 |
| Access and Linkage to Treatment | \$663,982 |
| Improving Timely Access to Mental Health Services for Underserved Populations | \$1,794,069 |
| Stigma and Discrimination Reduction | \$310,189 |
| Suicide Prevention | \$401,603 |
| Administrative, Evaluation Support | \$389,491 |

Total \$9,849,000

APPENDIX A - PROGRAM PROFILES

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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:
- b. 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.
- c. 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.
- d. 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.
- e. Target Population: Asian and Pacific Islander immigrant and refugee communities (especially Chinese and Southeast Asian population) in Contra Costa County
- f. Payment Limit: FY 22-23: \$159,567
- g. Number served: FY 18-19: 238; FY 19-20: 583; FY 20-21: 584
- h. Outcomes:

- FY 18-19:
 - All program participants received system navigation support for mental health treatment, Medi-Cal benefits, and other essential benefits.
 - Services are offered in the language of the consumer.
 - Program hosted two community wellness events and psycho-education workshops for the community.
- FY 19-20:
 - 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.
- FY 20-21:
 - Continued 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.
 - Primarily reached 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).
 - Emphasized on offering support to vulnerable populations like the elderly and the homeless.
 - Primary method of outreach and engagement with potential responders were program brochures. These brochures were printed in several languages, such as Chinese, Vietnamese, Laos, and Mien to reach a wider range of potential responders. These brochures consisted of AFRC's mission, the types of services offered, language availability, and contact information.
 - Held virtual psychoeducation workshops for community members on mental health (warning signs, risk factors, stigma reduction, etc.), self-care, human wellness, cultural and family/parenting issues, and where and how to get help if needed, particularly for those who may feel limited due to language barriers.
 - All program participants received system navigation support for mental health treatment, Medi-Cal benefits, and other essential benefits.
 - Program collaborated with other service providers via zoom during the pandemic to share resources, information, and support.

www.bbk-richmond.org

Point of Contact: Sheryl Lane

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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 22-23: \$238,280
- d. Number served: FY 18-19: 438; FY 19-20: 336; FY 20-21: 466

e. Outcomes

- FY 18-19:
 - Over the course of the 17-18 year, BBK Health and Wellness Team met with 33 community organizations, government agencies and individuals around partnering and collaboration.
 - BBK held Sanctuary groups and parents who attend have consistently reported that they learned something new about holistic health, and that they intended to follow up with a partner organization that they learned about through BBK sponsored events.
 - Summer Program at Belding Garcia Park and expanded programming to Monterey Pines Apartments in South Richmond. Children participating received at least one healthy meal per day and family members had access to wellness activities and developmental playgroups.
 - BBK partnered with COPE and Child Abuse Prevention Council to offer weekly evidence-based parenting classes. Care providers developed a strong knowledge base on child development and positive parenting skills.
- FY 19-20:
 - 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-care, 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, YouthService 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.
- FY 20-21:
 - Due to the COVID-19 pandemic, BBK continue to engage the community via a virtual model.
 - Connected families to accessible mental health professionals that provide no and low-cost individual, family, and group mental health support and prevention services.
 - Continued to conduct check-in phone calls with program participants, conducted needs assessments, and connected 24 families to food resources, financial assistance, and free/reduced internet service options, and tenants’ rights resources.
 - 68 people participated in seven Family Engagement Virtual Events. BBK staff hosted these activities, sometimes in collaboration with community partners including the East Bay Regional Park District. Based on participant feedback, BBK staff focused on family game nights, family bonding arts & crafts, dancing, and storytelling.
 - Offered Zumba, cooking classes, and playgroups through Facebook live. In the month of July 2020, 313 people

joined the live streams. In June 2021, staff launched the 2021 summer program via Zoom in collaboration with the Mindful Life Project, the Native American Health Center, a local Zumba instructor, and Redemption Fitness & Wellness LLC to host live for one hour, 5-days a week, arts and crafts activities, mindfulness activities, story times, boxing classes, and Zumba classes. A total of 88 people participated in these daily activities.

- In response to feedback from men surveyed in the community, BBK launched its first men and father's peer group in 2021. Since March 2021 staff, in collaboration with a male facilitator from Richmond, BBK has hosted a total of four meetings and has served 30 men. Through these meetings, men have built relationships with other men in their community and had conversations about Healthy Communication with Partners, How to Manage Strong Emotions, Goal Setting and Celebrating Accomplishments, and Getting to Know Ourselves. Additionally, before the end of the meetings participants are led through a drumming circle. Since the launch of the Men's Sanctuary called "Holding Space" BBK has seen increased participation and participants share their excitement about having a healthy space to build relationships and learn from other men.
- In February 2021 BBK launched their Life Coaching program. Eight women received six free one-hour sessions with a certified life coach. Participants set short-term goals, midterm, and long-term goals, and used a strength-based approach to create a plan to achieve their goals. The sessions focused on identifying strengths, support systems, and worked on shifting mindset.

<http://chd-prevention.org/>

Point of Contact: David Carrillo

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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 22-23: \$171,488
- d. Number served: FY 18-19: 342; FY 19-20: 733; FY 20-21: 198
- e. Outcomes:
- FY 18-19 African American Wellness Program:
 - Mind-Body-Soul support groups in Pittsburg and Bay Point throughout the year with topics such as "Depression and Stress," "Maintaining Emotional Well Being," "Guide to Vitamins and Minerals in Fresh Foods," "Self-Care

(Physical, Emotional, Mental and Spiritual).”

- Several community health / mental health workshops throughout the year.
- 100% of the participants in the Mind-Body-Soul peer health education support groups reported and increased wellness (wellbeing) within fiscal year.
- Participants in AA Wellness Program received navigational support for their service referral needs.
- FY 18-19 Youth Empowerment Program:
 - LGBTQ youth empowerment support groups in Pittsburg and Antioch throughout the year with topics such as: “Family and Peer Conflict,”
 - “Challenges to Relationships,” “Community Violence and Loss,” “Queer History and Activism,” “Stress, Anxiety and Depression,” “Identity Development and Coming Out.”
 - 85% of the participants in the Empowerment Psycho-Educational Leadership support groups reported an increased sense of emotional health and well-being within fiscal year.
 - 100% of participants in Empowerment in need of counseling services were informed and referred to LGBTQ-sensitive resources available to youth.
 - 36 LGBTQ Youth Support Groups facilitated at Pittsburg High, 26 at Deer Valley High, and 42 at Rivertown Resource Center.
- FY 19-20 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
- FY 19-20 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.
- FY 20-21 African American Wellness Program:
 - The African American Wellness Program Roster for support groups from July 2020- June 2021 contained a total of 141 unduplicated attendees.
 - There were 389 newsletters distributed to people (outreach) and 67 people attended outreach events.

- Participants who attended the Mind, Body & Soul support groups received tools & techniques to identify barriers. Participants were individually provided services to help them address their current issues. Participants were referred to Contra Costa Crisis 211 and the Mental Health Access Line.
- Staff assisted participants by helping them to navigate through the system by assisting with calls to the Mental Health Access line for appointments, attending doctor appointments, and following up with participants to check on progress.
- FY20-21 Youth Empowerment Program:
 - 57 individuals were served. This number is much less than previous years due to the extreme difficulty in connecting with LGBTQ+ youth in their home environments during COVID-19. Youth cited lack of privacy in their home environments and overall stress due to the pandemic as a reason for lack of participation.
 - Telephone communications, email and secure video conferencing, via Zoom, were the main forms of delivering telehealth support to participants, since COVID-19.
 - Staff facilitated 43 educational group sessions, one leadership session, and 833 individual check-ins, assessments and support sessions. This is double the number of individual check-ins and one-on-one meetings from the previous year. The sharp increase in this number is due primarily to the shelter in place order, which 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.
 - Staff worked closely with local schools in East County to coordinate care and referrals.
 - Staff 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 provided 10 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.

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 22-23: \$136,709
- d. Number served: FY 18-19: 164; FY 19-20: 169; FY 20-21: 159
- e. Outcomes:
 - FY 18-19:
 - Four 22-week classes in Central and East County serving parents and their children.
 - All parent participants completed pre- and post-tests. All parents improved their scores on at least four out of five 'parenting constructs' (appropriate expectations, empathy, discipline, self-awareness, and empowerment).
 - FY 19-20:
 - 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).
- FY 20-21:
 - Two 20-week classes in Central and East County serving parents and their children. Modifications were made as needed to accommodate challenges that arose due to the COVID-19 pandemic.
 - The Nurturing Parenting Program enrolled a total of 83 Latino parents and 76 children during the fiscal year.
 - The first semester Central County served 22 parents, successfully graduating 17 parents, East County served 20 and graduated 12 parents. The second semester Central County served 21 parents and graduated 13, East County served 20 parents and graduated 15.
 - Parents who dropped out of the program were contacted to gather feedback and offer additional support. Parents dropping out reported having the opportunity to return to the work force, others shared feeling overwhelmed with school demands and not having time to attend sessions.
 - All parent participants completed pre- and post-tests. Overwhelmingly, parents improved their scores on at least four out of five 'parenting constructs' (appropriate expectations, empathy, discipline, appropriate family roles, and values power independence)

www.crisis-center.org

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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, LGBTQ, 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 22-23: \$401,603
- d. Number served: FY 18-19: 18,128; FY19-20: 21,577; FY 20-21: 20,082
- e. Outcomes:
- FY 18-19:
 - Spanish language coverage was provided 80 hours/week
 - Call abandonment rate was 1.5%
 - Lethality assessments were provided for 100% of callers rated mid to high level risk.
 - Responded to 1,345 calls from people in crisis, suicidal or experiencing mental health issues.
 - A pool of 25 volunteers was maintained, and 2 volunteer trainings were offered during the year
 - FY 19-20:
 - 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
 - FY 20-21:
 - Services provided in English and Spanish, and callers have access to the Language Line interpreter services in 240+ languages.
 - 20,082 Mental Health / Crisis Calls received. Provided callers linkage to mental health services through community resources as appropriate for each call. 100% of callers were assessed for suicide risk level, and all callers with a risk level of medium or high were offered a follow-up call.
 - Maintained a pool of 58 active call center volunteers during this reporting period.
 - Provided 54 hours of training curriculum over 10 weeks virtually (30 hours) and in-person (24+ hours) for each new volunteer training cohort in June-July 2020 and January-February 2021.
 - Continued to provide virtual outreach and education presentations regarding Crisis Center Agency Services, Suicide Prevention, Grief & Loss, and participated in virtual resource fairs due to COVID-19 concerns during this reporting period

- Continued to co-chair the Suicide Prevention Coalition monthly meetings virtually with County Mental Health
- Exceeded target goals for Suicide Assessment and Intervention Trainings by providing free virtual trainings offered to all partner agency providers countywide with optional CE credits available:
 - Three- 6-hour Trainings
 - Three- 1-hour Trainings (one conducted in Spanish)
 - Two- 4-hour Trainings

<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 on strengthening the positive attachment between parents and children by building a parent's capacity for the following five aspects:

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

All classes are available in Spanish, Arabic, Farsi and/or English. 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 with identified special needs. Our targeted population includes caregivers residing in underserved communities throughout Contra Costa County.

- c. Payment Limit: FY 22-23: \$268,660
- d. Number served: FY 18-19: 226; FY 19-20: 235; FY 20-21: 200
- e. Outcomes:
- FY 18-19:
 - Offered Triple P evidenced based parenting classes at 27 site locations across the county
 - Pre and Post Test Survey results indicate program participants showed a 41% decrease in depression, 34% decrease in anxiety, and 33% decrease in overall stress
 - Access and linkage to on-going treatment supported through warm hand off referrals for housing, vocational, legal and mental health services
 - Program served 246 individuals in parenting classes, and 91 individuals for case management services
 - FY 19-20:
 - 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 handoff referrals for housing, vocational, legal, and mental health services.
 - FY 20-21:
 - Provided twenty-one (21) Triple P Positive Parenting Group classes and seminars to groups in West, Central and East Contra Costa County. Enrolled 257 individuals in these classes and seminars.
 - Provided a Family Transitions Triple P training program and accredited 22 practitioners.
 - Continued Triple P classes online using the Zoom video conferencing platform due to the COVID-19 pandemic.
 - 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.
 - Access and linkage to on-going treatment supported through warm hand off referrals for housing, vocational, legal, and mental health services.

<http://www.first5coco.org/>

Point of Contact: Wanda Davis

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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 22-23: \$89,343

d. Number Served: FY 18-19: 182; FY 19-20: 189; FY 20-21: 189

e. Outcomes:

- FY 18-19:
 - Completed 17 parenting classes for East and West County parents of children ages 0–5 (C.O.P.E.)
 - Parents self-report on symptoms such as hopelessness and dysphoria, decreased by 41% overall
 - Parents self-report on symptoms such as anxiousness and situational anxiety, decreased by 34% overall
 - Parents self-report on symptoms such as nervousness, muscle tension and inability to relax, decreased by 33% overall
 - Intensity of Behavior Problems which measures the frequency of each problem behavior, decreased by 19% as indicated by the chart above
 - Behavior Problems which reflect parent tolerance of the behaviors and the distress, decreased by 43%
- FY 19-20:
 - 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
- FY 20-21:
 - Delivered 15 classes throughout the county at various times and convenient locations to accommodate transportation barriers. (Through partnership with C.O.P.E.)
 - Held 14 presentations and briefings to early childhood organizations as an engagement and recruitment tool
 - Offered case management support to 45 families who asked for additional resources.
 - Trained and accredited 7 practitioners who supported classes for parents with children ages 0-5.

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, yatmingiude.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 22-23: \$2,719,036
- d. Staff: 27 FTE full time equivalent multi-disciplinary staff
- e. Number served: FY 18-19: 900; FY 19-20: 960; FY 20-21: 987
- f. Outcomes:
 - FY 18-19:
 - Help clients manage Clinical High-Risk symptoms
 - Help clients maintain progress in school, work, relationships
 - Reduce the stigma associated with symptoms
 - Prevent development of psychotic illnesses

- Reduce necessity to access psychiatric emergency services/ inpatient care
- FY 19-20:
 - Helped clients manage Clinical High-Risk symptoms and maintain progress inschool, 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.
- FY 20-21:
 - Helped clients manage Clinical High-Risk symptoms and maintain progress in school, work, and relationships.
 - Two conversions out of 63 from clinical high risk to psychosis (conversion rate of 3%).
 - 108 First Hope clients had zero PES visits or hospitalizations.
 - Zero completed suicides in FY 20-21.
 - Conducted fewer outreach presentations than usual due to the COVID pandemic; however, First Hope still trained 66 clinicians that included staff from hospitals and community-based mental health agencies such as Seneca and Putnam Clubhouse, as well as psychology interns.
 - 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.

<https://www.hopesolutions.org/> Point of Contact: Sara Marsh

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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 22-23: \$408,952

d. Number served: FY18-19: 445; FY 19-20: 433; FY 20-21: 367

e. Outcomes:

- FY 18-19:
 - Improved school functioning and regular attendance of school-aged youth in afterschool programs.
 - Improved family functioning and confidence as measured by the self-sufficiency matrix (SSM) and individual family goals and eviction prevention. (SSM evaluates 20 life skill areas including mental health, physical health,

child custody, employment, housing stability).

- FY 19-20:
 - 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.
- FY 20-21:
 - Altered services as needed to accommodate family needs during the COVID-19 pandemic.
 - 89% (16/18) of youth that participated in the afterschool academic and tutoring program achieved at least 4 benchmarks.
 - 94% (74/79) of the families receiving intensive case management, showed improvement in at least one area of self-sufficiency as measured annually on the 20 area, self-sufficiency matrix (and had an average score of stable (3) or better on this assessment).
 - 100% (193/193) of families maintained their housing and 100% (103/103) of families at risk for eviction remained housed. One of the families living for many years at Garden Park Apartments was able to purchase their own home

- 98% (126/128) of families requesting assistance with concrete resources had their request fulfilled. This was a heavy year for concrete service needs as families coped with the stay home orders, home schooling, unemployment and access to the financial resources being offered under the pandemic. Examples of their requests included access to food, employment support/unemployment applications, technological resources (computers, internet) transportation, healthcare and mental health resources and benefits offered under the Rescue Bill.
- 80% (8/10) of families taking the Parental Stress Index assessment showed lowered levels of stress after group participation.
- 100% (10/10) of the residents who attended the wellness/harm-reduction group sessions reported using the coping strategies they learned in the groups.
- 100% (74/74) of parents who received educational advocacy/coaching reported having an improved/positive experience working with school personnel.
- Provided 914 hours of advocacy for families working with remote learning.
- Many parents attended the remote support groups at the 4 sites. Anecdotal feedback from the parents was uniformly positive, as reported above. Hope Solutions had challenges with getting the Parental Stress Index data due to the paper/in-person nature of the assessment. With the realization that the pandemic would be continuing for a while, Hope Solutions applied for and received a grant to purchase digital versions of the PSI assessment tool and will be using that in the coming year to be able to obtain more feedback.

JAMES MOREHOUSE PROJECT (JMP) AT EL CERRITO HIGH (FISCAL SPONSOR OF BAY AREA COMMUNITY RESOURCES)

<http://www.jamesmorehouseproject.org/> Point of Contact: Jenn Rader

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(510) 231-1437, jenn@jmhops.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 22-23: \$112,442
- d. Numbers Served: FY 18-19: 416; FY 19-20: 405; FY 20-21: 328
- e. Outcomes:
- FY 18-19:
 - Stronger connection to caring adults/peers (build relationships with caring adult(s), peers) for participating youth.
 - Increased well-being (diminished perceptions of stress/anxiety, improvement in family/loved-one relationships, increased self-confidence, etc.) for participating youth.

- Strengthened connection to school (more positive assessment of teacher/staff relationships, positive peer connections, ties with caring adults) for participating youth.
- Reduced likelihood of ECHS youth being excluded from school.
- Strengthened culture of safety, connectedness and inclusion schoolwide.
- Measures of Success
 - 90% of participating students will show an improvement across a range of resiliency indicators, using a resiliency assessment tool that measures change in assets within the academic year, 2017 to 2018.
 - 90% of participating students will report an increase in well-being through self-report on a qualitative evaluation tool within the academic year, 2017 to 2018.
 - ECHS School Climate Index (SCI) score will increase by 15 or more points from 2017 to 2018.
- FY 19-20:
 - 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.
- FY 20-21:
 - Continued to provide services virtually due to the COVID-19 pandemic. The JMP stayed connected with school staff, young people and families, through a range of outreach strategies: setting up a JMP space on Google Classroom, staffing an ongoing drop-in space through Google Meet and collaborating closely with teachers, guidance counselors, the attendance clerk and JMP's administrative team to ensure that JMP was able to contact students/families in need.
 - 328 young people participated in 12 different groups and/or individual counseling.
 - Partnered with community-based organizations like the Seneca MRT in crisis situations.
 - Fifteen-Twenty people attended JMP led monthly evening English Language Advisory Committee (ELAC) meetings on Zoom. Families learned to access resources in the community and how to advocate for the rights of their children with school staff. Immigrant families also received case management support connecting them to legal, housing and other family supports in addition to counseling services for youth on-site.
 - 92% of participating youth reported feeling like "there is an adult at school I could turn to if I need help."

- 93% of participating youth “I deal with stress and anxiety better” after program participation.
- 72% of participating students reported they “skip less school/cut fewer classes after program participation.

<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 22-23: \$185,112
- d. Number served: FY 18-19: 224; FY 19-20: 311; FY 20-21: 225
- e. Outcomes:
 - FY 18-19:
 - Provided assessment and short-term intervention to 141 bilingual clients.
 - Provided individual health and mental health navigation services to 141 clients.
 - Provided 4 trainings on cross-cultural mental health concepts for 35 to 40 frontline staff from JFCS East Bay and other community agencies.
 - Provided 2 (2-hr) mental health education classes to 20-24 Arabic-speaking clients; 4 (2-hr) mental health education classes to 10-12 Dari/Farsi-speaking seniors; 4 (2-hr) Dari/Farsi-bilingual parenting classes to 10-12

Afghan & Iranian parents; 4 (2-hour) mental health education classes to 10-12 Russian-speaking seniors.

- Referred 27 high-risk individuals to bilingual therapy services with JFCS East Bay's bilingual therapist.
- FY 19-20:
 - 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.
- FY 20-21:
 - Served 225 people, including 120 frontline staff and 105 clients.
 - Facilitated two virtual trainings (via Zoom) during the pandemic. Trained 120 service providers from the community, exceeding the target of training 75 frontline staff
 - Provided 10.5 hours of individualized mental health education sessions to 14 Russian-speaking seniors.
 - Provided three 7- week series online psychosocial support groups serving 20 Afghan mothers.
 - Provided 77 clients with bilingual/bicultural case management.
 - Provided over 100 hours of culturally attuned therapy services to 3 refugee clients with in-house and referred 5 refugee clients to external providers.
 - 94% of the adult case management clients reported upon exit that they were able to independently seek help for mental health services.
 - 92% of the adult case management clients reported knowing how to link to the appropriate persons for resolution of health or mental health issues.
 - 100% of the adult case management clients reported upon exit that they had an increased understanding of

health and mental health care systems in Contra Costa County.

- 94% 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.
- 78% of participants of the Russian Mental Health Classes reported to have a better understanding of when and how to seek help.
- 100% of participants of the Russian Mental Health Classes reported that they have an increased ability to recognize stress and risk factors in themselves and/or family members, reported feeling more supported after coming to the group, and reported having a better understanding of the concepts discussed in individual sessions.
- 100% of participants of the Afghan Mothers' Support Groups reported having an increased ability to recognize stress and risk factors, a better understanding of trauma and how it affects the mind and body, a better understanding of the concepts discussed in group, having learned helpful techniques to deal with their own stress and emotions, a better understanding of when and how to seek help if I need it, feeling more supported after attending the group, having learned helpful parenting skills that they will use with their own children, and being able apply what they learned from the group in their own life.
- Provided culturally and linguistically appropriate care to all consumers served.

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 casemanagement 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 22-23: \$404,992
- e. Staff: 5 Mental Health Clinical Specialists: 3 probation liaisons, 2 clinicians at the Ranch
- f. Number Served: FYs 18-19, 19-20, and 20-21: 300+
- g. Outcomes:
 - FYs 18-19, 19-20, and 20-21:
 - 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 for at risk youth.
 - Provide referrals, short-term therapy, and short-term case management to help 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 placements and rates of recidivism.
- Help youth and families increase problem-solving skills

<https://www.laclinica.org/>

Point of Contact: Laura Zepeda Torres

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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 22-23: \$306,573
- d. Number served: FY: 18-19: 6960; FY 19-20: 922; FY 20-21: 845
- e. Outcomes:
 - FY 18-19 Vías de Salud:
 - Participants of support groups reported reduction in isolation and depression
 - Offered 7,153 depression screenings, 633 assessments and early intervention services, 1,554 follow-up services
 - FY 19-20 Vías de Salud:

- Offered 3623 depression screenings (120% of yearly target), 296 assessments 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
- FY 20-21 Vías de Salud:
 - Offered 8,521 depression and anxiety screenings (284% of yearly target), 1,180 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 (472% of yearly target), and 2,786 follow up support/brief treatment services to adults covering a variety of topics such as depression, anxiety, isolation, stress, communication and cultural adjustment (222% of yearly target).
 - Continued to provide telehealth services as needed due to COVID-19.
- FY 18-19 Familias Fuertes:
 - 100% of parents reported increased knowledge about positive family communication
 - 100% of parents reported improved skills, behavior, and family relationships
 - Offered 955 screenings for youth, 185 assessments for youth, 262 follow-up visits with families
- FY 19-20 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
- FY 20-21 Familias Fuertes:
 - Offered 766 screens for risk factors in youth ages 0-17 (102% of yearly target), 233 Assessments (includes child functioning and parent education/support) with the a Behavioral Health Specialist were provided to parents/caretakers of children ages 0-17 (310% of yearly target), and 597 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 (199% of yearly target).
 - Continued to provide telehealth services as needed due to COVID-19.

<https://lfcd.org/>

Point of Contact: Kathy Chao Rothberg, Brad Meyer

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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 Southeast 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 Southeast Asian Families at risk for developing serious mental illness.
- c. Payment Limit: FY 22-23: \$208,073
- d. Number served: FY 18-19: 125; FY 19-20: 128; FY 20-21: 126
- e. Outcomes:
 - FY 18-19:
 - 100% of program participants completed the Lubben Social Networking Scale (LSNS) assessments. Results indicate program participation leads to a decrease in social isolation.
 - Held 5 Strengthening Families Program (SFP) Educational Workshops
 - Held 4 Thematic Peer Support Group Events – in various locations including outdoor parks and spaces
 - 92% of program participants were satisfied with services

- FY 19-20:
 - 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
- FY 20-21:
 - A total of 126 clients completed the Pre LSNS assessment and 126 clients completed the Post LSNS assessments. The average progression was 5 with a high correlation between the participant's progression and level of participation in monthly social peer support groups activities and workshops.
 - 95% (120 of 126 respondents) of the participants were satisfied with the program services, and 5% (6 of 126 respondents) were somewhat satisfied with the program services.
 - 12 participants that were referred to mental health services because of monitoring clients' mental health status.
 - Held 10 SFP workshops during the program year (1 workshop per month from August 2020 to May 2021).
 - Facilitated 24 different thematic peer support groups/events during the FY.

<https://thelatinacenter.org/>

Point of Contact: Miriam Wong, 3701 Barrett Ave #12, Richmond, CA 94805

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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 for developing serious mental illness.
- c. Payment Limit: FY 22-23 \$133,184
- d. Number served: FY 18-19: 327; FY 19-20: 314; FY 20-21: 309
- e. Outcomes:
 - FY 18-19:
 - Workshops reached an additional 67 participants
 - Latina Center offered a free summer camp which served 91 children
 - A total of 240 parents participated in evidenced based parenting curriculum
 - FY 19-20:
 - 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 their programs.
 - 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 28 referrals.
 - 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.
- FY 20-21:
 - Served 309 individuals
 - 198 parents completed a pre-survey in Spanish.
 - Parenting classes were held via Zoom due to the COVID-19 Pandemic.
 - During the fiscal year, 3 mental health workshops were offered and conducted for 72 participants. The Latina Center's social networks garnered more than a thousand views and shares on these workshops/health topics.
 - 80% participants stated the course helped them improve their relationships.

LIFELONG MEDICAL CARE

Lifelong Medical Care

<https://www.lifelongmedical.org/> Point of Contact: Kathryn Stambaugh

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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 22-23: \$142,914
- d. Number served: FY 18-19: 138; FY 19-20: 150; FY 20-21: 106
- e. Outcomes:
- FY 18-19:
 - More than 50% of participants demonstrated self-efficacy and purpose by successfully completing at least one long-term project.
 - 93% of respondents self-reported improvement in mood as a result of participating in SNAP.
 - 98% of respondents reported satisfaction with the SNAP program.
 - FY 19-20:

- 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.
- FY 20-21:
 - Provided services in observance of COVID-19 safety protocols and local mandates and ordinances with services provided primarily in a virtual format. Virtual services took place via telephone and zoom and include telephonic wellness checks and social calls, case management and referrals to mental health and community resources, screening for depression and isolation, as well as meal and grocery distribution in person, thanks to donations from Sojourner Truth Church, Help Berkeley, and Bridge Storage and Artspace.
 - Provided two enrichment events in accordance with COVID-19 safety protocols.
 - Presented two live Brazilian music and dance performances in collaboration with Brasarte, a Brazilian Cultural Center in Berkeley. The event also included raffles and audience participation in the dancing. Participants identified “A Taste of Brazil” performances as one of the most enjoyable experiences of the year.
 - COVID-19 challenges prevented LifeLong from conducting the annual survey this year. LifeLong is developing plans to conduct the annual survey in FY 21-22.
 - LifeLong staff completed regular wellness checks and social calls to participants throughout the year and administered the PHQ-2 assessment when appropriate.

NATIVE AMERICAN HEALTH CENTER (NAHC)

Native American Health Center (NAHC)

<http://www.nativehealth.org/>

Point of Contact: Anthony Guzman, Veronica Shawnego

Contact Information: 2566 MacDonald Ave, Richmond, CA 94804

(510) 434-5483, anthonyg@nativehealth.org or veronicash@nativehealth.org

1. GENERAL DESCRIPTION OF THE ORGANIZATION

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

2. PROGRAM: NATIVE AMERICAN WELLNESS CENTER – PEI

- a. Scope of Services: Native American Health Center provides outreach for the increasing recognition of early signs of mental illness. To this end, they provide mental health prevention groups and quarterly events for Contra Costa County Community Members. These activities help develop partnerships that bring consumers and mental health professionals together to build a community that reflects the history and values of Native American people in Contra Costa County. Community-building activities done by NAHC staff, community members, and consultants, include: an elder's support group, youth wellness group (including suicide prevention and violence prevention activities). Quarterly cultural events and traditional arts groups including: 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 west region), who are at risk for developing a serious mental illness.
- c. Payment Limit: FY 22-23: \$265,486
- d. Number served: FY 18-19: 101; 19-20: 68; FY 20-21: 143
- e. Outcomes:
 - FY 18-19:
 - Program participants will increase social connectedness within a twelve-month period.
 - Program participants will increase family communications.
 - Participants that engaged in referrals and leadership training will increase their ability to navigate the mental health/health/education systems.

- FY 19-20:
 - 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
- FY 20-21:
 - Engaged 143 community members through prevention programming.
 - 100% of the 13 members who accessed individual referrals services were successfully linked to the requested aid, such as food, behavioral health
 - NAHC trained 2 interns and 1 staff in prevention and intervention modalities. This staff participated in Question Persuade and Refer, an emergency response training to self-harm and suicide. She participated in a virtual 8-week San Francisco MHSA certification training that focused on behavioral modalities such as Wellness Recovering Action Plan, Motivational Interviewing, Mental Health First Aid, and Safety Planning
 - During this reporting period, 6 of 6 members report they are having an increased ability in accessing resources.
 - Attendance and engagement in NAHC mental health prevention and treatment services doubled from the previous fiscal year, with 1004 points of contact in FY 20-21.
 - Staff trained 2 interns in partnership with the SPIRIT program, and one staff member also received training on Question, Persuade, Refer, and participated in an 8-week virtual training that focused on behavioral modalities such as Wellness Recovering Action Plan, Motivational Interviewing, Mental Health First Aid, and Safety Planning.

Point of Contact: Jennifer Tuipulotu

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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 22-23: \$232,189

- d. Staff: Three
- e. Number Served: FYs 18-19 and 19-20: 400+; FY 2021: 1336
- f. Outcomes:
- FY 18-19:
 - Increased access to wellness and empowerment knowledge and skills by participants of mental health services.
 - Decrease stigma and discrimination associated with mental illness.
 - Increased acceptance and inclusion of mental health peers in all domains of the community.
 - FY 19-20:
 - 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
 - FY 20-21:
 - Facilitated 12 monthly Committee for Social Inclusion meetings with an unduplicated count of 63 participants in attendance.
 - PhotoVoice served an estimated 800 people through subcommittee meetings open to the community, one Recovery Month exhibition, and trainings.
 - WRAP served 108 people, held 10 in-person WRAP groups (Forensics division). WRAP II County-wide facilitator completed 14 one-on-one WRAP plans for client. And the team held 1 WRAP quarterly subcommittee meeting.
 - WREACH reached 365 people through 62 presentations.

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 22-23: \$243,789
- d. Number served: FY 18-19: 207; FY 19-20: 207; FY 20-21: 140
- e. Outcomes:
 - FY 18-19:
 - Participants in Youth Green Jobs Training Program increased their knowledge and skills related to entrepreneurship, alternative energy resources and technologies, and Green Economy.
 - Participants of the PWC After-School Program showed improved youth resiliency factors (i.e., self-esteem, relationship, and engagement).
 - More than 50% of participants did not re-offend during the participation in the program
 - Participants in PWC After School Program reported having a caring relationship with an adult in the community or at school.
 - Majority of participants showed an increase in school day attendance and decrease in school tardiness.
 - FY 19-20:
 - 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 competitions.
 - 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.

- FY 20-21:
 - 100% of the participants enrolled in PWC's remote courses gained knowledge in aspects of business such as marketing/advertising, accounting, and banking skills.
 - Of the 117 students enrolled in PWC After-School Program that answered the resiliency questions on pre-and-post Student Surveys, 81% demonstrated improved resiliency.
 - Of the 23 probation students enrolled in PWC After-School Program, 99% did not re-offend during their participation in the PWC After-School Program.
 - Of the 117 students enrolled in PWC After-School Program that answered the survey questions about caring adults on their post Student Surveys 72% indicated that they had caring relationships with adults in their lives.
 - PWC was very successful with assisting schools in approving student's school attendance by having students on community service log on to school and participate in school activities during school hours while also performing their community service hours.

PUTNAM 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 22-23: \$718,777

d. Number served: FY 18-19: 322; FY 19-20: 456; FY 20-21: 505

e. Outcomes:

- FY 18-19:
 - 70 new members enrolled and participated in at least one activity
 - Held 4 career workshops
 - Prepared 9,000 meals for members
 - Provided 54,437 hours of Clubhouse programming to members
 - Clubhouse membership made a positive impact by decreasing hospitalizations

- FY 19-20:
 - 456 unduplicated members spent 57,290 hours engaged in Clubhouse programming activities. 55 newly enrolled Clubhouse members participated in at least one Clubhouse activity
 - Members helped prepare and eat 30,938 meals at the Clubhouse. 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 provided to members to and from Clubhouse activities, job interviews, medical appointments, etc..
 - 1,403 in-home outreach visits were provided.
 - 131 postings 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.
- FY 20-21:
 - Members spent 58,642 hours engaged in Clubhouse programming).
 - 54 newly enrolled Clubhouse members participated in at least one Clubhouse activity, 16 of whom were young adults ages 18-25 years.
 - 62 activities were held for young adult members ages 18-25 years.
 - 89 members and caregivers completed the annual survey.
 - 90% of caregivers who completed the annual survey reported that Clubhouse activities and programs provided them with respite care.
 - 100% of caregivers who completed the annual survey reported a high level of satisfaction with Clubhouse activities and programs.
 - 100% of caregivers and 92% of members completing the annual survey reported that the member's independence had increased.
 - 94% of Clubhouse members who used the Career Unit indicated that they were "very satisfied" or "satisfied" with the services related to employment and education.
 - 100% of Clubhouse members who indicated education in their career plan (return to school/finish degree/enroll in a certificate program) as a goal were referred to education resources within 14 days.
 - 100% of members who indicated employment as a goal in their career plan were referred to employers, applied for jobs, and/or had a job interview within 3 months of indicating goal.
 - 26,432 meals were served to members.
 - 94% of members completing the annual survey reported an increase in peer contacts.
 - 93% of members & 84% of caregivers (88% combined average) completing the annual survey reported an increase in their health and well-being (mental, physical, emotional).
 - The program achieved its goal of reducing hospitalizations and out-of-home placements of active members.

<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 LGBTQ 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 22-23: \$828,312
- d. Number served: FY 18-19: 1174; FY 19-20: 941; FY 20-21: 677
- e. Outcomes:
- FY 18-19:
 - Rainbow held 28 trainings during the year
 - Rainbow's Inclusive School Coalition served the following four districts: Mt. Diablo, Pittsburg, Acalanes, West Contra Costa Unified
 - Youth Support Programming served: 144 youth via outreach; 176 youth in groups; 43 through one-on-one work; 387 through school-based outreach; 118 through mental health services, and 65 through psycho-social groups

- Pride & Joy program reached 1,054 members of the community through events/groups; 387 through brief intervention; and 204 through individual services
- FY 19-20:
 - 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.
- FY 20-21:
 - Served a total of 677 unduplicated clients. Offered services to LGBTQ seniors, adults, and youth through their various tiered services
 - Tier 1 and Tier 2 reached 396 unduplicated clients. Tier 1 provides community-based programming through events and outreach. Tier 2 is group-based programming such as support groups and food pantry deliveries.
 - Tier 3 served a total of 281 clients. Tier 3 provides one-on-one clinical services such as school-based counseling, clinical counseling, and case management. 2009.68 hours of services were provided to clients with Tier 3 alone.
 - Provided virtual services due to the COVID-19 pandemic and adopted an electronic health records platform called, Simple Practice. Virtual offerings have allowed Rainbow to extend service offerings to a wider base, for example, offered district-wide rather than being limited to individual sites as was the case prior to the pandemic with our in-person service model.
 - For several older adults who lacked technology skills and adequate technology, Rainbow started a Tablet Program which provided loaner tablets for seniors in order for them to gain experience with handheld devices and enable them to attend social zoom events, furthering the impact of decreasing feelings of isolation and depression for all who participated.
 - Rainbow Community Center's Kind Hearts Food Pantry (RCCKHFP) delivered 148 meals and food resources to 24 unduplicated and 49 duplicated LGBTQI+ Seniors (55+), and HIV positive community members throughout Contra Costa County

<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 LGBTQ 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 22-23: \$533,653

Number served: FY 18-19: 720; FY 19-20: 865; FY 20-21: 255

d. Outcomes:

- FY 18-19:
 - 254 RYSE members participated in at least two programs within the integrative model
 - 7 youth-generated videos were created to address health, social inequity and stigma reduction.
 - RYSE served 34 youth through the Hospital-Linked Violence Intervention Program (R2P2)
 - RYSE reached at least 1105 adults through community-wise and sector specific trauma-informed care trainings, presentations and gatherings.
 - RYSE reached at least 500 young people through their Queer Trans Summit
 - 75 young people received services through RYSE's school-linked services
- FY 19-20:
 - 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 part 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.
- FY 20-21:
 - Served 255 young people virtually, plus hundreds of youths and adults engaged through online/events. RYSE primarily engaged young people and community members through virtual programs and events and through trainings and workshops in high schools, continuation schools, partner agency sites and within juvenile hall. While unduplicated numbers of enrolled youth members reached were lower than in years with in-person operations, RYSE reached hundreds of additional young people who were not formally enrolled through social media engagement, virtual events, and in providing emergency financial support to young people and their families.
 - At least 97 members engaged in direct academic and career supports including 1:1 case management,

education & career workshops, and mentorship/coaching. 21 young people engaged in identity groups (LGBTQQ group, Young Men's Group, Sister Circle). At least 42 youth participated in leadership cohorts, projects, led campaigns, and training in RYSE's Youth Leadership Institute. 28 young people participated in RYSE's Youth Leadership Institute in April 2021.

- RYSE has established a partnership with Brighter Beginnings and hosted their staff to begin a cross-referral process between agencies.
- Through RYSE's Youth COVID-19 Direct Supports Fund, RYSE provided over 300 \$500 disbursements, including participants impacted and hospitalized by gun violence. COVID care funds were used to fund 25 RYSE Scholars, students who were provided with a \$500 disbursement to help with meeting immediate school-related expenses in Fall 2020.
- As a result of participating in RYSE programming RYSE members:
 - 70% reported benefiting from RYSE programs and services that support mental health and wellness, and reported positive or increased sense of self-efficacy, positive peer relation, youth-adult relations, and agency in impacting change in the community.
 - 95% felt a sense of safety, respect, and community with RYSE staff and young people
 - 97% felt RYSE staff created clear, engaging, accessible workshops.
 - 94% felt they are paying more attention to their and others' emotions and feelings and that mental health supports are okay and positive.
 - 90% felt they are interacting more with people of different cultures than their own, speaking up more, and believe they can make a positive difference in their school or community.
 - 97% felt counseling or case management is space of safety, mutual trust, and helping with emotional and navigation goals.

<http://www.standffov.org/>

Point of Contact: Reina Sandoval Beverly

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(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 22-23: \$146,548
- d. Number served: FY 18-19: 1903; FY 19-20: 1778; FY 20-21: 743
- e. Outcomes:
 - FY 18-19:
 - 77 You Never Win with Violence presentations reached 1987 participants
 - 18 Expect Respect groups reached 192 participants
 - Youth Against Violence: 10 youth leaders trained in summer 2017
 - Adult Allies: 31 adults trained in two presentations

- FY 19-20:
 - *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)
- FY 20-21:
 - Served 743 participants in 30 presentations of “You Never Win with Violence”.
 - Adult Allies: 30 teachers and 40 other school/community personnel trained.
 - STAND! was unable to conduct Expect Respect and Promoting Gender Respect Support Groups due to the Covid-19 Pandemic.

<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 22-23: \$197,076
- d. Number served: FY 18-19: 121; FY 19-20: 245; FY 20-21: 125
- e. Outcomes:
- FY 18-19:
 - 95% of Vicente students enrolled participated in PEI related activities.
 - PEI services were extended to Briones independent study students; 37% participated in services.
 - All seniors participated in a minimum of 15 hours of service learning.
 - Staff organized and hosted 70 different types of activities and events to enrich the curricula.

- All students were offered mental health counseling.
- Developmental Assets Profile (DAP) assessment was administered to all students.
- FY 19-20:
 - 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%.
- FY 20-21:
 - 97% of enrolled students received a) an orientation on program offerings, b) a self-identified needs assessment targeting risk factors. 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 participated in four services per quarter that supported their individual learning plan. The average number of PEI activities of those who participated was seven.
 - At least 90% of students identified as facing risk factors were referred to supportive services and/or referred to mental health treatment and participated at least once in referred support service or mental health treatment during the school year.
 - At least 70% of students who participated in four or more services and who have had chronic absenteeism increased their attendance rate by 5% as measured at the end of the school year.
 - At least 70% of students who participated in four or more services and who regularly participated in mental health counseling earned 100% of the expected grade level credits as measured at the end of the school year.
 - The schools closed and transitioned to a distance learning model on March 16, 2020. PEI services continued and even increased services during this time. All services were provided via virtual means. Outreach increased to families and students given the impact this model was having on students. Times for families and students to meet so that we could provide support were offered.

APPENDIX B – PROGRAM ANNUAL REPORTS FY 20-21

| | |
|--|-------|
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PEI ANNUAL REPORTING FORM

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

FISCAL YEAR – 2020-2021

Agency/Program Name: VistAbility/Asian Family Resource Center (PEI)

PEI STRATEGIES:

Please check all strategies that your program employs:

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

SERVICES PROVIDED / STRATEGIES:

Please describe the services you provided in the past reporting period. Please include qualitative and quantitative data depicting: 1) the types and settings of potential responders you reached during the past reporting period; 2) methods used to reach out and engage potential responders; 3) any strategies utilized to provide access and linkage to treatment, and 4) strategies utilized to improve timely access to services for underserved populations.

Within the past reporting period, during the pandemic 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). In addition, due to the ongoing COVID-19 pandemic, we emphasized on offering support to vulnerable populations like the elderly and the homeless. These groups and individuals are frequently underserved as a result of language barriers and cultural differences.

Our primary method of outreach and engagement with potential responders were program brochures. These brochures were printed in several languages, such as Chinese, Vietnamese, Laos, 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. Due to the ongoing COVID-19 pandemic, we have had to scale back on community events and have reduced the number of sites we distribute our brochures to. We still offer brochures at supermarkets and housing complexes, but we have decided to focus on more interpersonal community, sharing our resources from family –to- family and via word of mouth.

Furthermore, we hold psychoeducation workshops for community members in regard to the importance of prevention and early intervention relative to mental health, as well as self-care and human wellness. Because of the pandemic, all workshops are held virtually. These workshops also touch on cultural 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, Medic-Cal recipients. For individuals who are not qualified for this treatment program, they would then immediately risk, 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.)

We were unable to host meetings and workshops due to the pandemic, however we were able to help individuals access services by connecting with local community leaders such as pastors and community associations. We received training for new updated 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.

OUTCOMES AND PROGRAM EVALUATION

Please provide quantitative and qualitative data regarding your services.

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

We utilize the Demographics Form to conduct evaluation and measure outcomes. Some questions in the form have been modified to better reflect cultural competency. Some of the qualitative data we collect include primary language spoken, race, ethnicity, gender, sexual orientation. Our quantitative data includes the number of individuals that attend group, 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: Not Applicable (Using County form)

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

Not Applicable

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 Cost 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 assistances, regardless of race, color, ethnicity, religion, sexual orientation and with the assistance of our bilingual staff; we are able to 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 English as a Second Language and need of 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.

During the COVID-19 pandemic, many underserved populations in Contra Costa County struggled greatly. More specifically, the Southeast Asian refugee community was especially hit hard, due to language barriers, cultural differences, and lack of resources. One example in this community was a 76-year-old Laotian woman, who come to the United States in 1991 with her three sons, after losing her husband during the Vietnam war. She had a lot of troubles during the COVID-19 pandemic. She is dependent on government assistance and struggles with supporting herself and her children. One son lost his job, while another son struggles with mental health issues and homelessness, and her other son moved out of state and is out of contact. The 76 years old mother is severely depressed, and not knowing what else to do, she attempted suicide. After this AFRC staff were able to reach out to the family and began engaging in assisting the family with their medical and psychiatric needs.

The AFRC staff were able to help the son with mental health issues find a psychiatrist, as well as opening a case to further support his needs and treatment. Staff were also able to help find employment and referred him to an agency to help him find housing. Because our staff were able to support her children, the mother's condition also improved greatly without the additional stress. Our staff were also able support her providing case management and counseling.

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

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

FISCAL YEAR – 2020-2021

Agency/Program Name: Building Blocks for Kids, Project of Tides Center

Program Name: Not About Me Without Me

PEI STRATEGIES:

Please check all strategies that your program employs:

- | | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Provide access and linkage to mental health care |
| <input checked="" type="checkbox"/> | Improve timely access to mental health services for underserved populations |
| <input checked="" type="checkbox"/> | Use strategies that are non-stigmatizing and non-discriminatory |

SERVICES PROVIDED / ACTIVITIES:

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

The goals of the 2020-2021 scope of work are three-fold: (1) Community and Family Engagement: working with Richmond and West Contra Costa County 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.

BBK set out this year to create new and strengthen activities and programs that elevate parental resilience, healing, and personal and collective empowerment. Our community research project completed in 2020 explored what adults residing in the Bay Area want and need for their emotional well-being. Most of those who responded are Black and Latinx parents with 61% who have children between 0-17.

These findings and the insightful voices of residents are included in BBK's [Navigating Towards Emotional Wellbeing](#) report.

The COVID-19 pandemic caused and continues to create an immense mental, physical, emotional, and financial strain for individuals and families. Over the last year families living throughout West Contra Costa County continued to face challenges in accessing support services for themselves and their families. In the 2020-2021 fiscal year, despite the challenge of having to shut down all in-person activities BBK quickly pivoted our programs to an online virtual environment to meet families in the comfort of their homes. BBK's incorporation of healing centered care strategies moved our work one step beyond trauma-informed care to recognize that well-being is a function of the environments where people live, work and play and in partnership with parents/caregivers, we seek to influence public policies and practices that directly and indirectly affect mental health and emotional wellbeing.

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.

- 1) **Community and Family Engagement: Ensure Richmond/West County 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 2020-2021, 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. Over the last year, BBK staff continued to conduct check-in phone calls with our program participants and conducted a Needs Assessment. Based on the results, our staff successfully connected 24 families to food resources, financial assistance, and free/reduced internet service options, and tenants' rights resources.
 - **Family Engagement:** In the 2020-2021 fiscal year a total of 68 people participated in seven Family Engagement Virtual Events. BBK staff hosted these activities, sometimes in collaboration with our community partners including the East Bay Regional Park District. Participants shared the need for fun, hands-on activities that would help families spend time together and have a distraction from the pandemic and other stressors in their lives. With this information, BBK staff decided to pivot and focus on family game nights, family bonding arts & crafts, dancing, and storytelling.
 - **Health & Wellness at the Park (Virtual Summer Program):** As a result of the COVID-19 pandemic, our 2020 and 2021 were entirely virtual. Over the summer of 2020, BBK offered Zumba, cooking classes, and playgroups through Facebook live. In the month of July 2020, 313 people joined our live streams. In June 2021, our staff launched our 2021 summer program via Zoom. We collaborated with the Mindful Life Project, the Native American Health Center, a local Zumba instructor, and Redemption Fitness & Wellness LLC to host live for one hour, 5-days a week, arts and crafts activities, mindfulness activities, story times, boxing classes, and Zumba classes. A total of 88 people participated in these daily activities.

- 2) **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:** In the 2020-2021 fiscal, BBK hosted a total of 32 peer support meetings. A total of 131 women participated in the meetings and learned about self-care, self-love, financial health, forgiveness, and managing difficult relationships with family members. In response to what men shared with us during community research conducted in 2019-2020, we launched our first men and father’s peer group in 2021. Creating spaces for men-centered wellness is exciting and is a continuum of overall family wellness. Since March our staff, in collaboration with a male facilitator from Richmond, BBK, has hosted a total of four meetings and has served 30 men. Through these meetings, men have built relationships with other men in their community and had conversations about Healthy Communication with Partners, How to Manage Strong Emotions, Goal Setting and Celebrating Accomplishments, and Getting to Know Ourselves. Additionally, before the end of the meetings participants are led through a drumming circle. Since the launch of the Men’s Sanctuary called “Holding Space” we have seen increased participation and participants share their excitement about having a healthy space to build relationships and learn from other men.
 - **Life-Coaching:** In February 2021 we launched our Life Coaching program. Eight women received six free one-hour sessions with a certified life coach. Participants set short-term goals, midterm, and long-term goals, and used a strength-based approach to create a plan to achieve their goals. The sessions focused on identifying strengths, support systems, and worked on shifting mindset.
- 3) **Self-and-Collective Advocacy: Train and support families to self-advocate, build collective advocacy and directly engage the services they need.**
- **Parent Education:** Two of BBK’s staff members were trained on the COFI’s (Community Organizing and Family Issues) Family Focused Organizing Model curriculum which is evidenced based and focused on healing centered care that supports parents and caregivers in recognizing and addressing the systemic and environmental causes of personal and community trauma. Our staff will be launching this workshop in late 2021.

MEASURES OF SUCCESS:

- **Linkages with Mental Health and Social Service Providers**
 - 100% of families identified as needing mental health and support services were successfully linked to providers.
- **Organizational Support and Family Engagement**
 - 75% of participants reported greater feelings of community
 - 75% of participants reported having a stronger family bond
 - 100% of participants reported having a better understanding of ways to support positive emotional and wellbeing
 - 100% of participants were connected to a resource that supports family wellness
- **Reduce risk for negative outcomes related to untreated mental illness**
- **Sanctuary**
 - 90% of respondents report improved access to mental health education and mental health support services
 - 90% of respondents that consistently participate in a Sanctuary Group report feeling connected to others and confident in their strengths.
 - 90% of respondents feel fortified to make positive changes within themselves and their families
 - 90% of respondents can identify at least two other group participants that they can connect with outside of the Sanctuary Meetings

- 100% of respondents report progress on achieving at least one wellness goal
- **Train and support families to self-advocate and directly engage the services they need Sanctuary Facilitator and Wellness Coach**
 - 90% of parents that work with a Sanctuary Facilitator and Wellness Coach will report that they feel safe to advocate for mental health services for themselves, their child or other family members.
 - 100% of participants will feel fortified to make positive changes in their families
 - 100% of participants will report a plan for supporting mental wellness for themselves
 - 100% of participants will report progress on achieving at least one wellness goal

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.

BBK routinely collects essential demographic fields (adult/child, race, gender, preferred language). BBK's self-administered sign-ins /forms are simple and easy to understand/complete within a room full of activities occurring. However, with the onset of COVID-19 and the shelter in place restrictions we were challenged with how we can continue to provide virtual programming for the families we serve and collect the data in virtual settings. Collecting data in a virtual setting proved to be a challenge for BBK and our families. At the point of registration for programming, we only asked if youth or adults were attending the activity instead of asking birthdate/age. We took this route because we know that our families prefer to have quick and easy registrations/ sign-ins. For this fiscal year (61) youth attended virtual programming (396) adults attended virtual programming.

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?

BBK ensures that participants' voices are at the core of our programming. For example, participants help us determine topics they want to discuss, learn and facilitate. They share who they want as guest speakers and decide what day and time programs take place. Lastly, we incorporate artistic expression in our programs, this includes dancing, drumming, and art projects.

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?

BBK continues to be a community of social innovators working to support Black and Latinx families in West Contra Costa County. We support families to use their voices and experiences to directly inform the systems they interact with, and which impact them. We envision 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 quality education and all families to achieve emotional and physical well-being. Our staff continues to keep families' health & wellbeing at the forefront of our work in all of 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 develop the leadership capacity of parents/primary caregivers. Our ultimate aim is that Richmond and West County parents/primary caregivers affect positive changes in homes, 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.

Blanca has participated in BBK programs since 2014. She has been a regular participant in our Latina Sanctuary, Family Engagement events, and our advocacy workshops. Through the years she has shared her interests in learning new things and the importance of having a healthy family, both physically and emotionally. This last year, Blanca has faced a lot of challenges ranging from health to financial challenges. Although she and her family have struggled she has continued to show an eagerness to learn and improve her life. After participating in a leadership development program, Blanca facilitated a workshop on Financial Health in our Latina Sanctuary group. The workshop focused on Achieving Financial Freedom, Saving and Budgeting, and Addressing Cultural Ideas about Money Management. Blanca continues to be a great resource to other women in the program and encourages them to continue their personal development.

PEI ANNUAL REPORTING FORM

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

FISCAL YEAR – 2020-2021

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

PEI STRATEGIES:

Please check all strategies that your program employs:

- | | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Provide access and linkage to mental health care |
| <input checked="" type="checkbox"/> | Improve timely access to mental health services for underserved populations |
| <input checked="" type="checkbox"/> | Use strategies that are non-stigmatizing and non-discriminatory |

SERVICES PROVIDED / STRATEGIES:

Please describe the services you provided in the past reporting period. Please include qualitative and quantitative data depicting: 1) the types and settings of potential responders you reached during the past reporting period; 2) methods used to reach out and engage potential responders; 3) any strategies utilized to provide access and linkage to treatment, and 4) strategies utilized to improve timely access to services for underserved populations.

The Nurturing Parenting Program enrolled a total of 83 Latino parents and 76 children during the fiscal year. The first semester Central County served 22 parents, successfully graduating 17 parents, East County served 20 and graduated 12 parents. The second semester Central County served 21 parents and graduated 13, East County served 20 parents and graduated 15. Parents who dropped out of the program were contacted to gather feedback and offer additional support. Parents dropping out reported having the opportunity to return to the work force, others shared feeling overwhelmed with school demands and not having time to attend sessions. CAPC staff-maintained communication in between classes to motivate parents to stay connect and offer support, parents shared having the support during the uncertainty of the Pandemic has meant a lot to their families. The Child Abuse Prevention Council (CAPC) reached out to the Latino community in Central and East County offering The Nurturing Parenting Program (NPP) starting the first 20-week session in July 2020 ending December 2020 and the second session starting January 2021 ending in June 2021. Parents and their children enrolled to participate in the 20-week parenting education program offered in the evening. The Nurturing Parenting Program (NPP) collaborated with community-based agencies and school districts such as First 5 Center, Head Start, WIC, Contra Costa County Behavioral Health, Mt. Diablo Unified, 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 in a culturally sensitive manner.

As we continue the battle against COVID-19 CAPC, and The Nurturing Parenting Program continue adjusting our classes to best served our community. The NPP team continued working remotely 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 challenges for our population. Staff continues engaging parents linking them to workshops, 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.

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 bond and build a stronger relationship with their children whenever possible.

CAPC made modification to the structure of the program to provide support, offering 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). The children meet with their facilitators in a separate space to continue the program and materials are delivered monthly to have parents and children working together to promote family time.

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.

CAPC continues to support our community by offering services weekly and NPP staff continues our program as planned. In addition to the curriculum information and psychoeducation is presented to help identify mental health/behavioral challenges that may need professional support. NPP kept one of the three sessions 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 “normal” parenting practices. Presentations enhance the program 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 also offers direct services to help parents feel more comfortable and confident when accessing resources. NPP engages with each family to offer linkages to the appropriate resources and staff follows up to gather information about how outcome of services.

OUTCOMES AND PROGRAM EVALUATION

Please provide quantitative and qualitative data regarding your services.

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

Parents enrolled in The Nurturing Parenting Program were administered the evaluation tool Inventory AAPI “A” at the beginning of the program and Inventory 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. After administering Inventory AAPI, A outcomes are reviewed to develop strategies and identify parents whose parenting practices or emotional state may interfere with parenting putting them at higher risk of child abuse. The Nurturing Parenting Program complements the evidence-based curriculum with a Mental Health consultant who attends parent groups to discuss mental health, during these sessions mental health awareness is offered, and staff supports with linkage for parents interested in accessing early intervention programs for their children or higher level of care. Staff meets regularly to discuss group dynamics and review plan, participants' response and staff's observations. Upon completion of the program, staff reviews the results of both inventories to help reflect areas of improvement and measures the "risk" of child abuse and neglect after parents' participation. Staff discusses results of parents who may 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 are allowed to exhibit normal developmental behaviors. Self-concept as a caregiver and provider is positive. Tends to be supportive of children.
- B High Level of Empathy. Understands and values children's needs. Children are allowed to display normal developmental behaviors. Nurture children and encourage positive growth. Communicates with children. Recognizes feelings of children.
- C Discipline/ VALUES ALTERNATIVES TO CORPORAL PUNISHMENT Understands alternatives to physical force. Utilizes alternatives to corporal punishment. Tends to be democratic in rule making. Rules for family, not just for children. Tends to have respect for children and their needs. Values mutual parent-child relationship.
- D APPROPRIATE FAMILY ROLES tends to have needs met appropriately. Finds comfort, support, companionship from peers. Children are allowed to express developmental needs. Takes ownership of behavior. Tends to feel worthwhile as a person, good awareness of self.
- E VALUES POWER-INDEPENDENCE Places high-value on children's ability to problem solve. Encourages children to express views but expects cooperation. Empowers children to make good choices.

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.

AAPI Results Session 1 & 2 East County

| Construct | A | B | C | D | E |
|-----------|------|------|------|------|------|
| Form A | 8.36 | 7.91 | 8.00 | 9.45 | 6.91 |
| Form B | 8.55 | 8.18 | 8.82 | 9.45 | 5.91 |

| Construct | A | B | C | D | E |
|-----------|------|------|------|------|------|
| Form A | 6.57 | 6.43 | 7.00 | 7.71 | 6.86 |
| Form B | 7.74 | 7.32 | 7.11 | 8.63 | 6.68 |

AAPI Results Session 1 & 2 Central County

| Construct | A | B | C | D | E |
|-----------|------|------|------|------|------|
| Form A | 7.94 | 7.88 | 7.69 | 8.81 | 7.62 |
| Form B | 7.75 | 8.88 | 8.94 | 8.62 | 7.06 |

| Construct | A | B | C | D | E |
|-----------|------|------|------|------|------|
| Form A | 6.55 | 6.36 | 6.45 | 8.64 | 5.64 |
| Form B | 7.33 | 7.78 | 8.00 | 8.00 | 5.33 |

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.

County forms will be mail.

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?

After over 18 months dealing with the Pandemic, Staff shares professional challenges affecting our daily lives. Parents have shared not only worries about COVID but social justice. During last session, parents shared feeling vulnerable when out in the community and many times not feeling safe. CAPC executive director has offered staff the opportunity to participate in trainings to better prepare ourselves when supporting families.

CAPC continues to motivate all staff to help others and most importantly to practice self-care and safety. Staff meets regularly to modify our approach and ensure we are taking care of our own Mental Health as we support others.

As families face confusion and frustration our team continues committed to build bridges between families and community supports and resources. Our team discussed benefits of providing psychoeducation to increase awareness and teach parents to monitor themselves as well as their children. Our NPP team agrees that is highly important to dedicate time to know families utilizing a cultural approach to help them feel comfortable opening up and share areas of need. This program offers a safe place for families.

CAPC encourages conversation to help identify our own challenges, countertransference to support parents in the most effective manner possible and ensure they have access to the support they need in a timely manner. NPP staff shares areas in which more support may be needed to help manage our mental health decreasing the risk of emotional fatigue and projecting to the community we serve. 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 continues 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 offered in their language of preference. To support this need staff has worked with parents by linking to access line and coaching them to advocate for their family. 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.

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.

Parents' feedback is important to us to improve our program and professional practices.; Please see below.

"Participating in this program helped me understand that my own emotional state made things worse at home"

"Listening to other families in similar situations helps me not to be so critical of my own family and to keep trying to improve"

"I really enjoy participating with my children in the class, we get along and have fun"

"During this zoom session I have learn how to use my computer and I don't feel alone"

"I would like to learn more about how to support my teen"

"My son has a mental health diagnosis and during the time he participated in the NPP children class, I was surprised to hear him talk to other children and the teachers"

A Family's Story

Mr. & Mrs. Perez came to the United States as young adults and started a family, today they are proud parents to two boys and a girl. They are loving parents who have faced many challenges being far from their natural supports and raising a child with Mental Health needs. Mom shared his oldest son has been diagnosed with Selective Mutism and has an IEP to support his needs as well as Mental Health support. Mom & Dad participated in the Nurturing Parenting Program about 4 years ago and asked to be enroll again as they felt the need to connect and decrease isolation triggered during the pandemic. Mom shared their oldest son has struggled many years in developing relationships outside the family circle due to his Mental Health. Mom remembered when the family first participated in the program, she noticed a change in her two boys and as time went by and specially during the first few months of the pandemic she observed her oldest son regressed in his treatment and his mental health needs became "stuck."

Mom shared during the time they participated in the zoom sessions for the Nurturing Parenting Program she was happily surprised to hear how her oldest son participating with teachers and with the other children, Mom had not heard his son use his voice to communicate with other people outside the home. Mom explained that every week when mom and dad participated in the parents' component group they made sure to motivate their three children not to miss their session the next day. Mom mentioned she had not seen her children play and participate in a virtual class until the NPP children group started.

Mom expressed gratitude for having this program during the pandemic and for motivating parents as well as children to participate in activities that help not only with parenting skills but helped the whole family built a stronger connection and to have fun together.

Mom & Dad explained how challenging it was to keep the boys engaged in their academic virtual sessions and when it was time for the Nurturing Parenting Program the boys would be happy and excited to join. "I would be in the kitchen and could hear my son using his voice during class, I have no words to express how happy I was. My son to this date doesn't talk at school and he did during this class". "I would continue to attend to this class any time I am given the opportunity, I learned something new every time and I see how much it has helped my son with Mental Health needs and all of us in our relationship as a family" Mom shared.

PEI ANNUAL REPORTING FORM

SUICIDE PREVENTION REPORTING FORM

FISCAL YEAR – 2020-2021

Agency/Program Name: Contra Costa Crisis Center

PEI STRATEGIES:

Please check all strategies that your program employs:

- | | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Provide access and linkage to mental health care |
| <input checked="" type="checkbox"/> | Improve timely access to mental health services for underserved populations |
| <input checked="" type="checkbox"/> | Use strategies that are non-stigmatizing and non-discriminatory |

SERVICES PROVIDED/ACTIVITIES

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

July 1, 2020-June 30, 2022

Due to the continuation of the county’s COVID-19 Shelter-In-Place orders, March 2020- June 2021, 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 in the office and a select few of our most experienced staff and volunteers remotely from home.

Scope of Services:

24-hour Crisis & Suicide Hotline

- 1) Provided immediate counseling, active listening, emotional support, and referrals to community resources on our 24-hour Crisis & Suicide hotline via phone and text for all Contra Costa County residents. Calls and texts are answered by live Call Specialists in English and Spanish, and we continued to have access to the 24/7 Language Line interpreter services for over 240 languages.
- 2) Provided callers linkage to mental health services through community resources as appropriate for each call. 100% of callers were assessed for suicide risk level, and all callers with a risk level of medium or high were offered a follow-up call.
- 3) Provided debriefing, supervision, silent monitoring, and consultation for all staff and volunteers in a manner that meets national industry standards and American Association of Suicidology accreditation standards. Our staff and volunteers reflect Contra Costa County demographics in our diversity of country of origin, languages spoken, culture, gender, religion, sexual orientation and socio-economic class.

- 4 Exceeded target goals for total call volume, call response time, and call abandonment rate during this reporting period.

Recruit and Train Volunteer Pool

- 1) Continued to recruit and train a diverse group of volunteers representing communities countywide with bi-lingual fluency in Spanish, Russian, Swedish, Punjabi, Hindi, Urdu, Korean, Mandarin, Croatian, and French.
- 2) Maintained a pool of 58 active call center volunteers during this reporting period.
- 3) Provided 54-hours of training curriculum over 10 weeks virtually (30 hours) and in-person (24+ hours) for each new volunteer training cohort in June-July 2020 and January-February 2021.

Outreach & Education

- 1) Exceeded target goals for Suicide Assessment and Intervention Trainings by providing free virtual trainings offered to all partner agency providers countywide with optional CE credits available:
 - a. Three- 6-hour Trainings
 - b. Three- 1-hour Trainings (one conducted in Spanish)
 - c. Two- 4-hour Trainings
- 2) Continued to provide virtual outreach and education presentations regarding Crisis Center Agency Services, Suicide Prevention, Grief & Loss, and participated in virtual resource fairs due to COVID-19 concerns during this reporting period.

Co-chair Suicide Prevention Committee

- 1) Continued to co-chair the Suicide Prevention Coalition monthly meetings virtually with County Mental Health.

County Coroner Referrals and Suicide Data

- 1) Continued to receive monthly Coroner data and maintain collaboration for referrals from the Coroner's Office to our Grief Counseling Support Group services for grieving survivors.

OUTCOMES AND PROGRAM EVALUATION

Please provide quantitative and qualitative data regarding your services.

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

We provided In-Service trainings in the afternoons every month and in the evenings every week during this reporting period as an opportunity to all staff and volunteers to promote knowledge of community resources and continuous cultural humility in working with and supporting a diverse population over the crisis hotlines such as youth, seniors, people who are homeless, people who have mental illness, and people who experienced trauma.

We are active participants in meetings that strive to improve cultural sensitivity, awareness, and education to better serve our clients such as Asian Pacific Islander Task Force, System of Care, CPAW, Historically Marginalized Communities, Special Needs Committee, and the Reducing Health 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.

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.

Our core values of compassion, integrity, inclusion, accessibility, and collaboration along with continuous cultural humility development is written, spoken and practiced. Our policies, protocols, and office environment support these values.

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 refer to the Aggregate Data Reporting Form)

VALUES:

Reflections on your work: How does your program reflect MHS 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 on the belief that emotional support can make a significant difference in a caller's ability to self-manage and minimize psychiatric hospitalization 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:

- 1) **Compassion:** We are driven by a desire to alleviate the emotional pain, distress, and needs of our clients.
- 2) **Integrity:** We respect and honor our colleagues and clients through trustworthy actions.
- 3) **Inclusion:** We affirm the value of differing perspectives and are committed to representation from, and service to, all members of our diverse community.
- 4) **Accessibility:** We believe that people in need should be able to get help 24/7/365.
- 5) **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 #: 445566, 445580, 445581

The caller was a 15-year-old trans identified female who texted on the Crisis Text line. She stated that she was feeling suicidal, had plans to run away, and was feeling hopeless. The call specialists quickly assessed for suicide lethality and determined that the caller was currently home alone, and her plan was to jump off the City Center in San Ramon which was a five-minute bike ride from her house. She was feeling overwhelmed by her anxiety, depression, and bullying from school peers because of her gender identity. She has reported the bullying to her school but feels as though her school does not care about her. She could not agree to stay safe that night but agreed to continue the conversation on the phone.

Over the phone, the Call Specialist continued to develop rapport and provide active listening and emotional support. The caller stated that she is also bullied by people in public whenever she goes to the grocery store, mall, etc. Her parents and siblings know that she identifies as a woman, but she does not really have any friends. Her girlfriend is currently in the hospital after attempting suicide by taking a whole bottle of pills and was not afraid to do it too. She stated that she is very tempted to continue to go through with her plan for a suicide attempt and stated she has issues with impulsivity control. She takes medication for anxiety, depression, and ADHD but has not been currently seeing a therapist, counselor, or psychiatrist due to COVID-19 concerns. The caller would not provide the number for her parents or siblings for help.

The call specialist remained on the line while a shift team member called police for a wellness check while providing active listening and emotional support until the police arrived at her home. The caller declined a follow-up call but was reminded that she can continue to call or text the crisis lines 24/7 for emotional support.

Following this call, the Shift Team Lead and volunteers provided debriefing and consultation to the Call Specialist for support.

PEI ANNUAL REPORTING FORM

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR – 2020-2021

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

PEI STRATEGIES:

Please check all strategies that your program employs:

- | | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Provide access and linkage to mental health care |
| <input checked="" type="checkbox"/> | Improve timely access to mental health services for underserved populations |
| <input checked="" type="checkbox"/> | Use strategies that are non-stigmatizing and non-discriminatory |

SERVICES PROVIDED/PROGRAM SETTINGS:

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

Center for Human Development's African American Wellness Program provides prevention and early intervention services that empower participants to; first, increase emotional well-being, second, decrease personal stress and isolation and thirdly, increase their ability to access appropriate mental health services. During the fiscal year of July 1, 2020-June 30, 2021, African American Wellness Program provided services to African Americans living in Bay Point, Pittsburg, and the surrounding East County communities. Key activities included culturally appropriate education on mental health topics through six Mind, Body, and Soul support groups. Key activities also include a monthly newsletter and outreach at health orientated community events, and navigation assistance for culturally appropriate mental health referrals. Community Health Advocate Michelle Moorehead and Resident Leader co-facilitated services for the African American Wellness Program. Our East County office location is at the Spark Point center in Bay Point. Through collaboration with Spark Point, the African American Wellness Program was able to provide services to participants and local community members.

The program activities during the 12-month period included the following:

Six facilitated Mind, Body, and Soul support groups' one location:

- Pittsburg Health Center, Pittsburg 1st & 3rd Tuesday and 1st & 3rd Thursday afternoon.
- Pittsburg Senior Center, Pittsburg 2nd & 4th Wednesday afternoon.

Due to Covid-19 Pittsburg Senior Center support groups were held via free conference call.com

Due to the Pandemic, the African American Wellness Program support groups adjusted to meet the needs of our participants. Our support groups were held at the Pittsburg Health Center with a 6-participant limitation. Each participant would sign up weekly for an appointment to attend following all CDC guidelines while in attendance. Our Pittsburg Senior Center support group was conducted through free conference call.com. This free service allowed our program to have conference call meetings with our senior participants. Since our senior population were the most vulnerable to the Covid-19 virus, their meetings were conducted this way for their safety.

A newsletter was sent to participants' residence, and/ or sent via email. It contained our support group topic, community resources and updated information regarding Covid-19. The Covid-19 virus brought on more depression, anxiety, stress, and isolation to many of our participants. C.H.A., Michelle Moorehead, and R.L., Lisa Gordon, provided "one-on-one" appointments with participants. These were conducted via telephone. In addition to the support groups this was extra support assistance to participants. Having one-on-one appointments helped ease feelings of stress, depression, and isolation. We encouraged our participants to journal their thoughts and feelings to work through them. We took these measures to ensure that all participants' needs were met, and no participant was left behind. The Recreation Coordinator, Joy, at the Pittsburg Senior Center collaborated with the African American Wellness Program and held a Senior Day at Small World Park in Pittsburg. Due to Covid-19 restrictions, our activities were conducted with social distancing, hand sanitizer, and mask requirements at all times. There were classes for participants, a welcome, a brief group discussion, questions & answer sessions, games, and a bag lunch provided. C.H.A. Michelle Moorehead & R.L. Lisa Gordon conducted follow up calls to participants to get their input and thoughts on how they felt about the event. African American Wellness Program also attended a Juneteenth celebration on June 19, 2021, in collaboration with Grace Bible Fellowship Church of Antioch. Our program tabled at this event in celebration. Juneteenth is a day to celebrate & commemorate the ending of slavery in the United States. During this event, our program provided information about mental health (emotional wellness), invitation to attend our monthly support groups, gift bags, and a copy of our monthly newsletter. We outreached to 32 participants at this event.

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.**

The African American Wellness Program Roster for support groups from July 2020- June 2021 contained a total of 141 unduplicated attendees. There were 389 newsletters distributed to people (outreach) and 67 people attended outreach events. Participants who attended the Mind, Body & Soul support groups received tools & techniques to identify barriers. Participants were individually provided services to help them address their current issues. Participants were referred to Contra Costa Crisis 211 and the Mental Health Access Line. C.H.A Michelle Moorehead & R.L Lisa Gordon assisted participants by helping them to navigate through the system so that they can receive the care they need. The Community Health Advocate would call the Mental Health Access line with the participant to ensure the participant received an appointment. The Community Health Advocate also supported participants by attending doctor appointments to assist with advocating for the

participants' care. The appointment was scheduled from the initial phone call and the time between scheduling an appointment and seeing a therapist or other provider was up to 4 weeks. The Community Health Advocate and Resident Leader would follow up with participants to check on progress. The African American Wellness Program serves adults 18 and older living in East Contra Costa County. This program supports participants by empowering them to recognize and achieve inner strength and develop coping strategies to maintain emotional wellness.

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

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

LINKAGE AND FOLLOW-UP:

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

Participants are provided resources and referrals to help increase emotional wellness and reduce stress, depression, anxiety, and isolation in their lives. The program creates a welcoming safe environment to all participants. The Mind, Body, and Soul support group helps give participants hope while facing life challenges and helps them address and overcome barriers such as homelessness, lack of medical coverage, lack of transportation, or lack of food. The African American Wellness Program supports participants' needs by linking participants who are low income and disadvantaged due to lack of resource, with other community resources to meet their needs. Participants enter the program through word of mouth, referrals by 211, or referrals from the Mental Health Department at Pittsburg Health Center. The Mind, Body, and Soul support groups are a support system that aims to begin the healing process and ease the hardship of transition participants may have encountered in life due to sudden, unexpected trauma. We strive to teach the tools & techniques that will help defuse a hectic situation by using some of our self-care practices such as breathing, mindfulness, taking a brief walk, etc. Participants were linked to Mental Health Services through the Mental Health Access Line and were followed up with by their Primary Care Doctor

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?

African American Wellness Program reflects the mental health and wellness for our participants. We provide services to assist participants with overall intervention services and prevention. We are active in the community and our program conducted outreach in collaboration with other agencies. C.H.A. Michelle Moorehead and R.L. Lisa Gordon attended a weekly outreach program in Bay Point along with East County Response Coalition at the West Pittsburg Church. This collaboration with The Bay Church of Pittsburg provided: portable showers to the homeless, medical care for the uninsured through the John Muir Mobile Care Van, and a food give away provided by Bay Point All in One. African American Wellness Program also attended to support the community with our program services for mental health (emotional wellness), inviting community members to attend our support groups, and providing mental health services. Our program collaborated with Hope Solution to assist with housing for participants experiencing homelessness or at risk of homelessness by providing mental health support.

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?

E.H. is one of our male participants who is aged over 60 years. He has attended the Mind, Body, and Soul support group for the last 1.5 years. E.H. came to the support group for depression, but he is also a cancer survivor. He was referred by another long-time participant and during his time attending, he was able to work through his depression by talking with other participants. He was also given a referral to the cancer support community located in Antioch where E.H. resides. He has been cancer free for 2 years now. His health has improved from attending our support groups and utilizing the tools and techniques learned during our class time.

S.M. is one of female participants who is also over 60 years old. She has attended the Mind, Body and Soul support group for 3 years. S.M. came to the support group from a referral from another participant. She needed emotional support for her feelings of anxiety. S.M. was referred to the Mental Health Access Line. The C.H.A., Michelle Moorehead, assisted her with making an appointment. S.M. began seeing a therapist and her anxiety levels improved. S.M.'s health has improved, and she is now walking and eating healthier which is helping her emotionally. She continues to attend the support group because of the warm, familial atmosphere.

T.P. is one of our female participant's aged 26-59 years old. She has attended Mind, Body and Soul support group for 1.5 years. T.P. came to the support group with some serious health challenges. She had a stroke, heart attack, and had suffered a fall which resulted in a broken collar bone. T.P. is disabled and is wheelchair dependent. She was referred by another participant. Due to her existing health challenges T.P. was experiencing depression and isolation. She began attending M.B.S support group and made new friends which uplifted her spirits. She also learned how to use the tools and techniques taught in class in her daily life. T.P. was provided with a 211 referral and Mental Health Access Line for therapy. She is seeing a therapist and feeling better emotionally. She continues to attend Mind, Body, and Soul support group.

PEI ANNUAL REPORTING FORM

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR – 2020-2021

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

PEI STRATEGIES:

Please check all strategies that your program employs:

- | | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Provide access and linkage to mental health care |
| <input checked="" type="checkbox"/> | Improve timely access to mental health services for underserved populations |
| <input checked="" type="checkbox"/> | Use strategies that are non-stigmatizing and non-discriminatory |

SERVICES PROVIDED/PROGRAM SETTINGS:

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

Center for Human Development's Empowerment Program provides weekly support groups, youth leadership groups, and mental health resources for lesbian, gay, bisexual, transgender, queer, questioning (LGBTQ+) youth and their heterosexual allies, ages 12 - 20, in East Contra Costa.

The annual goal is to reach 80 unduplicated youth from July 1, 2020, through June 30, 2021.

During the course of the contract, staff will provide the following services:

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

Component 2: Facilitate one (1) weekly educational support group session at Deer Valley High School in 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 on 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 session at Hillview Junior High School in 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 in 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 twice (2) per year.

Kevin Martin, Empowerment Program Coordinator, facilitated the following services from July 1, 2020, through June 30, 2021. Mr. Martin is a full-time employee working 40 hours per week on the project. During this reporting period, Empowerment has worked with 57 unduplicated youth, which is less than our goal of 80 unduplicated youth. This number is much less than previous years due to the extreme difficulty in connecting with LGBTQ+ youth in their home environments during COVID-19. Staff utilized a variety of methods to establish and maintain connection with participants including phone calls, texting, email, Facebook, Zoom, collaborations and referrals from other providers, referrals from peers, and referrals from school teachers, counselors and administrators.

Component 1: Facilitate 40 to 50 weekly meetings at Pittsburg High School in 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. First, it eliminates the need for additional transportation as students are already at school. Second, 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. Third, 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.

Staff facilitated:

| | |
|---|-----|
| Individual check-ins, assessments, support sessions | 178 |
| Group sessions | 0 |
| Unduplicated participants | 7 |

From July 1, 2020, through June 30, 2021, Kevin Martin was not successful in facilitating group sessions specifically for youth from Pittsburg High School. This is due to the difficulties for students to be able to feel safe or comfortable participating in a group over Zoom in their home environments, as well as the increased stress and anxiety from having to keep up with the demands of school from home. Due to these challenges, staff focused on conducting frequent individual check-ins and one-on-one assessment and support sessions. Staff conducted 178 individual check-ins and one-on-one assessment and support sessions with students from Pittsburg High School during this year. Throughout the year, CHD staff continued to receive new referrals from school staff and service providers on campus during weekly Care Team meetings and from peer participants. The number of unduplicated participants is low (7 compared to 31 the previous year) because not all students returned CHD staffs repeated efforts to make contact, likely due to the previously mentioned challenges for students at home during COVID-19. Staff has also continued to work closely with school staff and other service providers on campus to secure space for groups for the upcoming school year, as providing in-person 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), which has been exacerbated by the COVID-19 pandemic.

Topics for the Pittsburg participants included: initial assessment, establishing norms, surviving trauma at home, LGBT terminology, healthy boundaries, processing jealousy, discrimination by authority figures, coping with stress, writing as a coping method, conflict with friends, Trans awareness, challenges in family dynamics, symptoms of depression, self-image,

affirmations, assumptions, identifying emotions, holiday & family stresses, concerns for Winter break, intentions for 2021, experiences over Winter break, setting and upholding personal boundaries, "4 Pillars of Healthy Relationships", speaking authentically about emotions, questioning gender identity, the process of coming out, LGBTQ+ Black History Icons, racial stress, political stress, personal stories of identity realization, having difficult conversations, prolonged stress related realities of COVID-19 shelter in place order (missed opportunities, stress and mental health), self-care, time management, ending romantic relationships, tools for changing perspectives (opportunity from victimization), end of school year stresses and excitement, openly LGBTQ+ celebrity representation and activism, coping with anxiety, and reopening from COVID-19.

Component 2: Facilitate 20 to 26 weekly meetings at Deer Valley High School in 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 recently, CHD's Empowerment Program was one of the only social-emotional support program available to Deer Valley High students. This year Deer Valley High School (DVHS) partnered with additional community based social-emotional, academic and mental health providers, creating a Care Team: a network of supportive school staff and service providers working at Deer Valley High School allowing for expedient linkage to additional support services as needed.

Staff facilitated:

| | |
|---|-----|
| Individual check-ins, assessments, support sessions | 158 |
| Group sessions | 0 |
| Unduplicated participants | 10 |

From July 1, 2020, through June 30, 2021, Kevin Martin was not successful in facilitating group sessions specifically for youth from Deer Valley High School. As mentioned in Component 1, this is due to the difficulties for students to be able to feel safe or comfortable participating in a group over Zoom in their home environments, as well as the increased stress and anxiety from having to keep up with the demands of school from home. Due to these challenges, staff focused on conducting frequent individual check-ins and one-on-one assessment and support sessions. Staff conducted 158 individual check-ins and one-on-one assessment and support sessions with students from Deer Valley High School during this year. Throughout the year, CHD staff continued to receive new referrals from school staff and service providers on campus during weekly Care Team meetings and from peer participants. Staff also received 2 referrals through DVHS's Care Team for students attending other schools in the district. The number of unduplicated participants is low (10 as compared to 40 the previous year) because not all students returned CHD staffs repeated efforts to make contact, likely due to the previously mentioned challenges for students at home during COVID-19. Staff consistently heard from youth referred through the DVHS Care Team that they had not and could not disclose their LGBTQ+ identity to their families, due to their religious or cultural beliefs, directly impacting their mental wellbeing.

Topics for the Deer Valley youth included: establishing norms, initial assessments, bisexual awareness and myths, LGBTQ+ terminology, the process of coming out, Trans awareness, gender terminology, "safe spaces" to be LGBTQ+, emotion identification, speaking authentically about emotions, questioning identity, self-image, body dysphoria, affirmations, assumptions, what is therapy?, transition support, holiday & family stresses, concerns for Winter break, intentions for 2021, experiences over Winter break, coming out support, "4 Pillars of Healthy Relationships", healthy boundaries, LGBTQ+ Black History Icons, conflict with friends, coping with stress, anxiety, depression, writing as a coping method, ending romantic

relationships, domestic violence, divorce, racial stress, political stress, personal stories of identity realization, having difficult conversations, prolonged stress related to realities of COVID-19 shelter in place order (missed opportunities, stress and mental health), self-care, time management, end of school year stresses and excitement, LGBTQ+ activism, anxiety related to reopening from COVID-19.

Component 3: Facilitate 30 to 36 weekly meetings at Rivertown Resource Center in 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.

Staff facilitated:

| | |
|---|-----|
| Individual check-ins, assessments, support sessions | 356 |
| Group sessions | 34 |
| Unduplicated participants | 30 |

Due to all the previously noted challenges associated with COVID-19, staff facilitated one weekly support group for all high school age youth throughout East Contra Costa County to continue to engage LGBTQ+ youth in safe, supportive, social interaction with peers to promote emotional health, positive identity, and reduce isolation through life skill development. Staff also held frequent individual check-ins, assessments, and support sessions for LGBTQ+ youth throughout East Contra Costa County whether they attended group sessions or not.

From July 1, 2020, through June 30, 2021, Kevin Martin facilitated 34 virtual sessions of youth support group for high school aged youth throughout East Contra Costa County. The group met using the Zoom platform. The number of meetings met our goal of 30 to 36 sessions for the year and group attendance numbers were down significantly, due to all the previously noted challenges related to COVID-19. This group had an average attendance of 3 youth per session for this reporting period. Low attendance was 1 and high attendance was 7. The number of unduplicated participants is low (30 as compared to 83 the previous year), undoubtedly due to previously mentioned issues related to COVID-19. Staff also noted that attendance dropped precipitously toward the end of the year, and students expressed feeling overwhelmed by all the demands for their time and spiked at random times. This year, staff also collaborated with Rainbow Community Center's Youth Program on one session per month to help expand youth's social support networks and connection to community support providers. CHD staff conducted 356 individual check-ins, assessments, and support sessions during this year with youth not associated with one of our school sites.

Topics for the Rivertown group included: group development, establishing group agreements, visibility through Pride flags, Schizophrenia, addressing peers who overstep boundaries, tools for managing anxiety, confronting friends who repeatedly harm us with their words, the challenges and positives of remote learning, continuing to have to "shelter in place", creative complaining (the benefits of venting), communicating effectively with your therapist, managing an overcrowded home environment (when extended family move in), the required process of transitioning prior to gender alignment surgery, disappointments and challenges to returning to distance learning, the use of "they" pronouns, bisexuality awareness, bi celebrities and icons, Hispanic Heritage Month and LGBTQ+ Hispanic icons, suicide prevention, effects of being mis-gendered, coping with gender and body dysphoria, virtual Halloween celebration, LGBTQ+ History, anxiety and more tools for coping, Transgender Day of Remembrance, virtual winter holiday celebration, identifying and communicating needs to family, spectrums of identity, identifying values important for relationships, Inauguration of President Biden and Vice President Harris,

negatives and positives of 2020 as well as hopes and intentions for 2021, Confirmation of Pete Buttigieg as Secretary of Transportation (first openly gay person to be confirmed as Presidential Cabinet Secretary), shifting perspectives (victimization to opportunity), Black History Month and Black LGBTQ+ icons, mental health perspectives in the Black community, moving out of your childhood home, screen in of "Women of Impact: Changing the World," queer womxn of history, screening of clip from "Disclosure", Why celebrate womxn's (not women's) history month?, screening of Ted Talk "A Short History of Tran People's Long Fight for Equality", Day of Silence Campaign, the verdict in Derek Chauvin trial, stress management, Alcohol and Drug abuse in LGBTQ+ community, gender identity and gender resources, mental health awareness, LGBTQ+ Pride history, screening of "Screaming Queens."

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.

Staff facilitated:

| | |
|---|-----|
| Individual check-ins, assessments, support sessions | 141 |
| Group sessions | 9 |
| Unduplicated participants | 9 |

From July 1, 2020, through June 30, 2021, Kevin Martin facilitated 9 sessions of virtual youth support groups for middle school age youth attending Hillview Junior High School. The number of meetings is short of our goal of 20 to 25 sessions for the year. As in other components, this is due to the difficulties for students to be able to feel safe or comfortable participating in a group over Zoom in their home environments, as well as the increased stress and anxiety from having to keep up with the demands of school from home. As this is our only middle school age group, staff continued to plan for weekly group sessions, however generally they quickly became monthly group sessions. Due to these challenges, staff focused more on conducting frequent individual check-ins and one-on-one assessment and support sessions. Average group attendance for this period was 2. Low attendance was 2 and high attendance was 3. The number of unduplicated participants is low (9 as compared to 20 the previous year) because not all students returned CHD staff's repeated efforts to make contact, likely due to the previously mentioned challenges for students at home during COVID-19. Staff also conducted more than 141 individual check-ins, assessments, and support sessions with students during this year.

Participants came to this group primarily as former participants and through referrals from student surveys, as well as the school's COST team, comprised of the school's counseling staff, administrators and teachers, as well as other service providers working with students at the school including CHD's Project Success program, CHD's Beyond Violence program, Lincoln Children's Services clinicians, and JFK University clinicians. Staff continued to receive referrals from the COST team right up to the end of the school year.

Topics covered in this group include group development, establishing group norms, expectations for group, the Thanksgiving break, identifying and communicating needs to family, negatives and positives of 2020 as well as hopes and intentions for 2021, coping with health issues, safety planning, self-care, values important to you, identifying feelings, check-ins.

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.

Staff facilitated:

| | |
|---------------------------|--------------------------------|
| Group sessions | 1 |
| Unduplicated participants | 3 participants, 0 unduplicated |

As noted in all prior components, the challenges associated with COVID-19 significantly impacted the ability of staff to complete this component. Youth participated in one Leadership group session before all expressed being too overwhelmed with school and other responsibilities to engage in Leadership activities. The one session was an interview with 3 Leadership participants by a member of the Contra Costa County Meds Coalition regarding youth perspectives on abuse of prescription medications in the city of Antioch. Staff continued to look for opportunities to engage participants in leadership activities to little avail. Staff is optimistic that next year, whether back to meeting in person or continuing to meet virtually, participants will be better adjusted to be able to engage in Leadership.

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 LGBT History Museum and Historical Castro District in San Francisco. Staff is exploring alternative 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 10 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 encouraged 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, Fred Finch, CHD Beyond Violence Program, Contra Costa County Mental Health Access Line, STAND for Families Against Violence, and Antioch Police Department for suicide risk assessment. As noted earlier, all Empowerment participants also received a Safety Phone List with contact information for the Contra Costa Crisis Center, Trevor Project, LGBT Youth Talk-line, Rainbow Community Center (RCC), Planned Parenthood, Homeless Hotline, Run Away Hotline, Community Violence Solutions, and STAND for Families 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, 2020, through June 30, 2021, staff did not facilitate specific formal trainings. However, throughout the year Kevin Martin was an active member of Care Teams and COST team at Deer Valley High School, Pittsburg High School and Hillview Junior High, respectively. Kevin provided faculty, staff and administration ongoing, real-time support and information for supporting the LGBTQ+ youth in their classes and schools.

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.**

From July 1 through June 30, 2021, staff facilitated 43 educational group sessions, one leadership session, and 833 individual check-ins, assessments and support 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 one-on-one meetings and assessments were provided allowing staff to identify possible "red flags", such as symptoms of anxiety, depression, and suicidal ideation, or youth in distress. Check-ins and one-on-one meetings are held regularly due to COVID-19. During check-ins and one-on-one meetings, staff always inquires as to youth's experiences with school, family and peers, interest, wellness, 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 had 833 individual one-on-one meetings with youth during this year. This is double the number of individual check-ins and one-on-one meetings from last year. The sharp increase in this number is due 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, email and secure video conferencing, via Zoom, are the main forms of delivering telehealth support to participants, since COVID-19. As indicators warrant, staff makes referrals to appropriate, culturally responsive services. As noted previously, staff has ongoing relationships with Care and Cost Teams at the above listed schools which include mental health providers allowing expeditious entry into treatment, as youth become willing to do so (except in emergency circumstances). Staff also has a functioning know ledge of the processes for referral to access services through Contra Costa Health Services and private providers, and actively support participants and their guardians navigate these systems. The average length of time between referral and access to treatment for this year is just over 2 weeks. The average duration of symptoms related to mental illness prior to referral is just under 4 months. Follow-ups regarding effectiveness of treatment is ongoing after access to treatment.

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.

DEMOGRAPHIC DATA:

Not Applicable (Using County form)

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

LINKAGE AND FOLLOW-UP:

Please explain how participants are linked to mental health services, including how the PEI program: 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 a previous section, specific referrals for new mental health support were made for ten (10) youth during the year. The average length of time between report of symptoms onset and referral for treatment during this reporting period is 3.9 months and the average length before entering treatment after referral is 2.3 weeks. 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 for Families Against Violence, Runaway Hotline, Homeless Hotline, and are encouraged 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.

- 1) General encouragement of all participants to seek services that could be of support to them is continual during all sessions. Specific and direct encouragement and referrals are offered to participants during one-on-one check-ins and assessments by Empowerment staff. Staff administers the Adolescent Mental Health Continuum Short Form (MHC-SF) periodically during one-on-one meetings to help assess need for referral to mental health services.
- 2) Empowerment staff follows up verbally with participants regarding referrals to external services on a weekly basis until participant successfully engages in services, or no longer wishes to engage services. The current average length of time between referral and entry into treatment is 2.3 weeks. Staff also continues to follow-up on effectiveness of treatment during individual sessions after entering treatment and works to provide supplemental support as appropriate.

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 12 to 20, in East Contra Costa County, which is a highly diverse community in regard to ethnic makeup and socio-economic status, with large percentages of 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 individual check-ins, assessments and support 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 participating in Empowerment are treated with respect as individuals, and staff makes a concerted effort to do so without bias or judgment. As noted in monthly program notes, 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 12-20, 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, as noted in our demographic form, 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, drug and alcohol use and abuse, community development and engagement, leadership and activism, physical, mental and sexual health and safety. And as noted in previous sections, when staff identifies potential concerns for any participant, they respond immediately to offer information and referrals for additional support services.

VALUABLE PERSPECTIVES:

Reflections on your work: How does your program reflect MHS 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?

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 some of their responses:

"Hello! My name is Joseph. I have been going to Empowerment youth group meetings for almost two years now. I was pretty hesitant on going to my first meeting because I didn't know any of the people there and because I was unsure of myself. Now I can confidently say that I have made the right choice. Empowerment offered me much needed support in starting and continuing my gender journey. Back when I was still questioning my gender, I was able to share my own experiences and hear others' experiences as well. I have not met one mean or uninviting person during my time at Empowerment and everyone I have talked to have been so supportive and are always offering advice. Having a supportive group of people that I could talk to who are like me, really helped me come out of my shell and realize that I am not alone in this world. I was able to gain the confidence I needed to talk further steps towards becoming my true self. Empowerment has provided me with so many resources regarding mental health, gender identity, and how to get help. I've laughed and cried with Empowerment, and through Empowerment I feel that I have been able to grow as a person and really find myself." ~JP 6/21

"My experience with empowerment has been really amazing because it is a safe place to be able to talk to people and just have a place to rant. They don't judge you and make you feel comfortable to talk about anything. I have learned a lot in Empowerment, things that I never knew before and I'm glad that I am a part of it." ~IG 6/21

"When I was in my sophomore year, I was approached with the QSCOUTs program (facilitated by CHD Empowerment staff and clinical intern from RCC for eight weeks, then transitioned into an Empowerment group) in my school's GSA club. The idea of learning more about the community I was still just walking into, and receiving support was extremely inviting. My biggest takeaway from the 'Empowerment' program is just the trust and support it can create. My group over the two years I was a more active member, were people I looked forward to seeing every week, even if we didn't talk outside of the group; we all became friends in ways that just isn't really possible without a program like this. It was an environment you could almost immediately feel comfortable with. Most new members would start sharing and joking with the rest of us within a few visits, which in my opinion conveys just how inviting the group can be. That kind of supportive vibe was what guided me and kept me going majority of the time within those two years. I am also still in contact with most of the group members, even if we do not talk a lot, I am there for them as I trust they are for me too. This program is incredible in terms of the discussions you will have, the memories you can create with people who will be more than just supportive, and I highly recommend it for any LGBTQ+ youth who needs and/or wants that kind of experience." ~ RE 6/21

It is notable that all three of these are long-term (more than one year) participants of Empowerment Program. They came to the Empowerment Program differently; one by referral from their private clinician, one by direct staff outreach to a school-based club, and one was referred by a peer. Each either was already referred or received referrals linking them to additional support services (both school and community based) in conjunction with Empowerment support groups. This year two (one is a junior in high school) successfully graduated from high school with healthy goals and feelings of optimism 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
PREVENTION REPORTING FORM**

FISCAL YEAR – 2020-2021

Agency/Program Name: C.O.P.E. Family Support Center

PEI STRATEGIES:

Please check all strategies that your program employs:

- | | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Provide access and linkage to mental health care |
| <input checked="" type="checkbox"/> | Improve timely access to mental health services for underserved populations |
| <input checked="" type="checkbox"/> | Use strategies that are non-stigmatizing and non-discriminatory |

SERVICES PROVIDED/PROGRAM SETTINGS:

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

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, of children ages 6-17.
- 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 257 individuals in these classes and seminars.

Trainers: A total of 22 practitioners were accredited, in the following levels:

- Level 2 Seminar Stepping Stones
- Level 3 Triple P Discussion Groups
- Level 4 Group Triple P
- Level 5 Enhanced Triple P
- Level 5 Family Transitions A total of 22 practitioners were accredited.

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.

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.

- 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.

Confidentially: To ensure our participants' confidentiality and integrity is upheld, COPE uses a confidential and secure reporting system using a non-identifying code.

Cultural Competency:

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, practitioners 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 video conferencing classroom where parents and staff recognize, appreciate, and capitalize on diversity to enrich the overall learning experience.

All participants are provided services regardless of race, gender, sexual orientation, or religion.

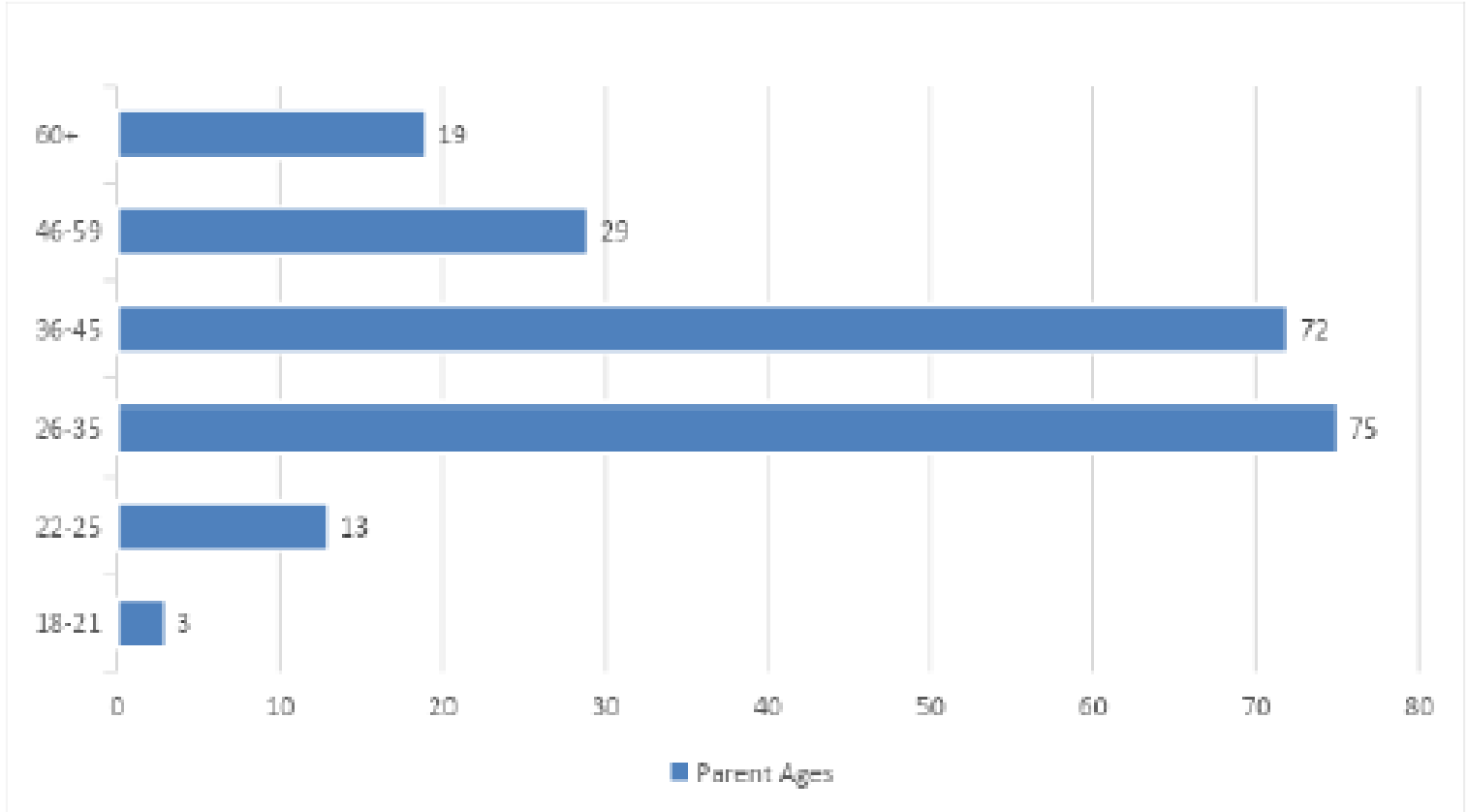
Current practices include:

- Designated language. i.e., Spanish speaker
- Practitioners are trained to understand cultural differences in parenting practices, and we strive to develop effective and consistent parenting skills that nurture the uniqueness of each family.
- Immigration Status was never asked
- Income and level of education was respected
- All information is confidential and reported using a non-identifying code
- Parents and practitioners sign a confidentiality agreement

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.

Age Group



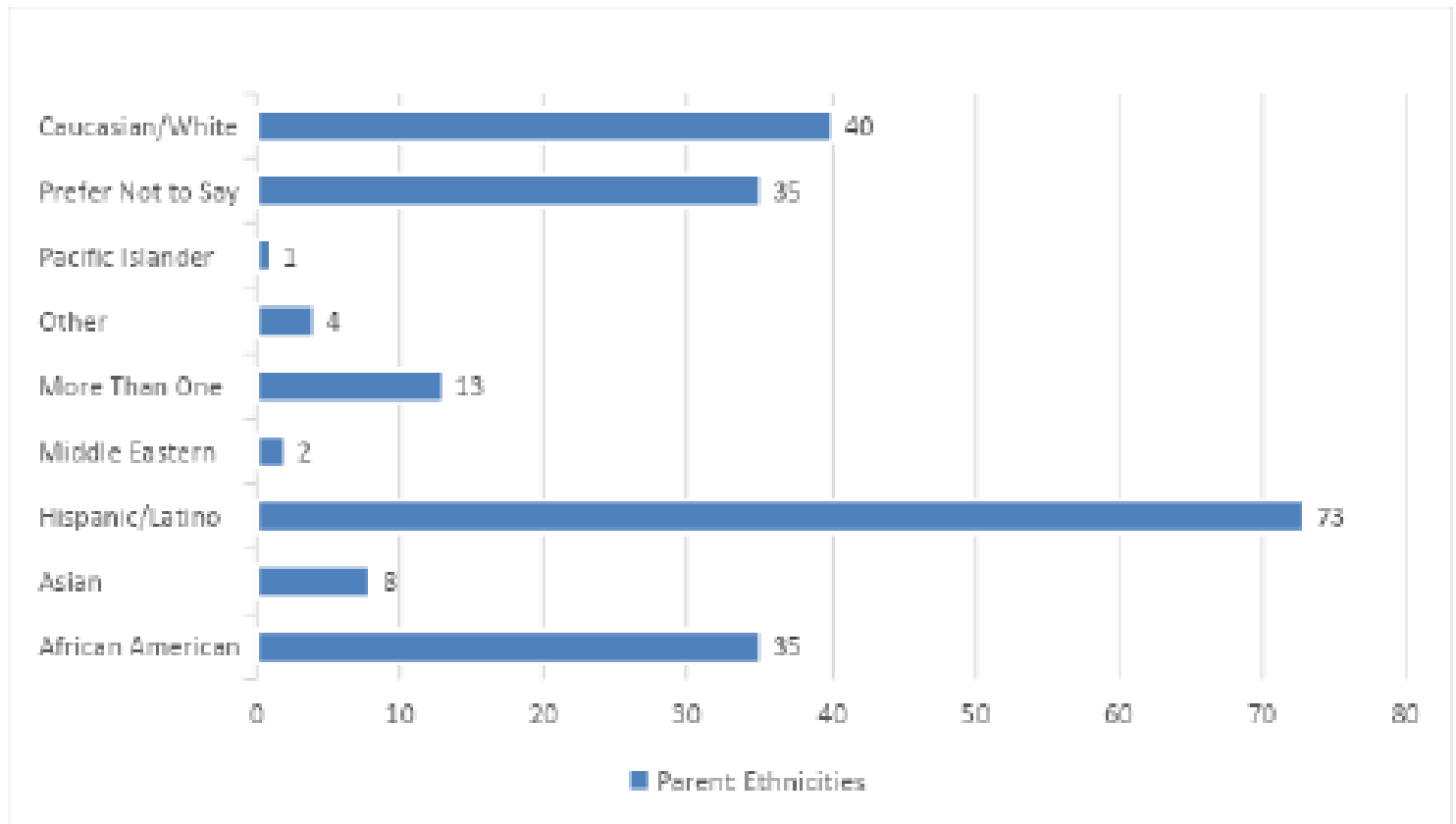
Veteran Status:

7 participants reported being a veteran.

Race of responding participants:

| | |
|------------------------|----|
| More than 1 | 27 |
| Asian | 9 |
| Black/African-American | 30 |
| Hispanic/Latino | 20 |
| White | 27 |
| Decline to Respond | 98 |

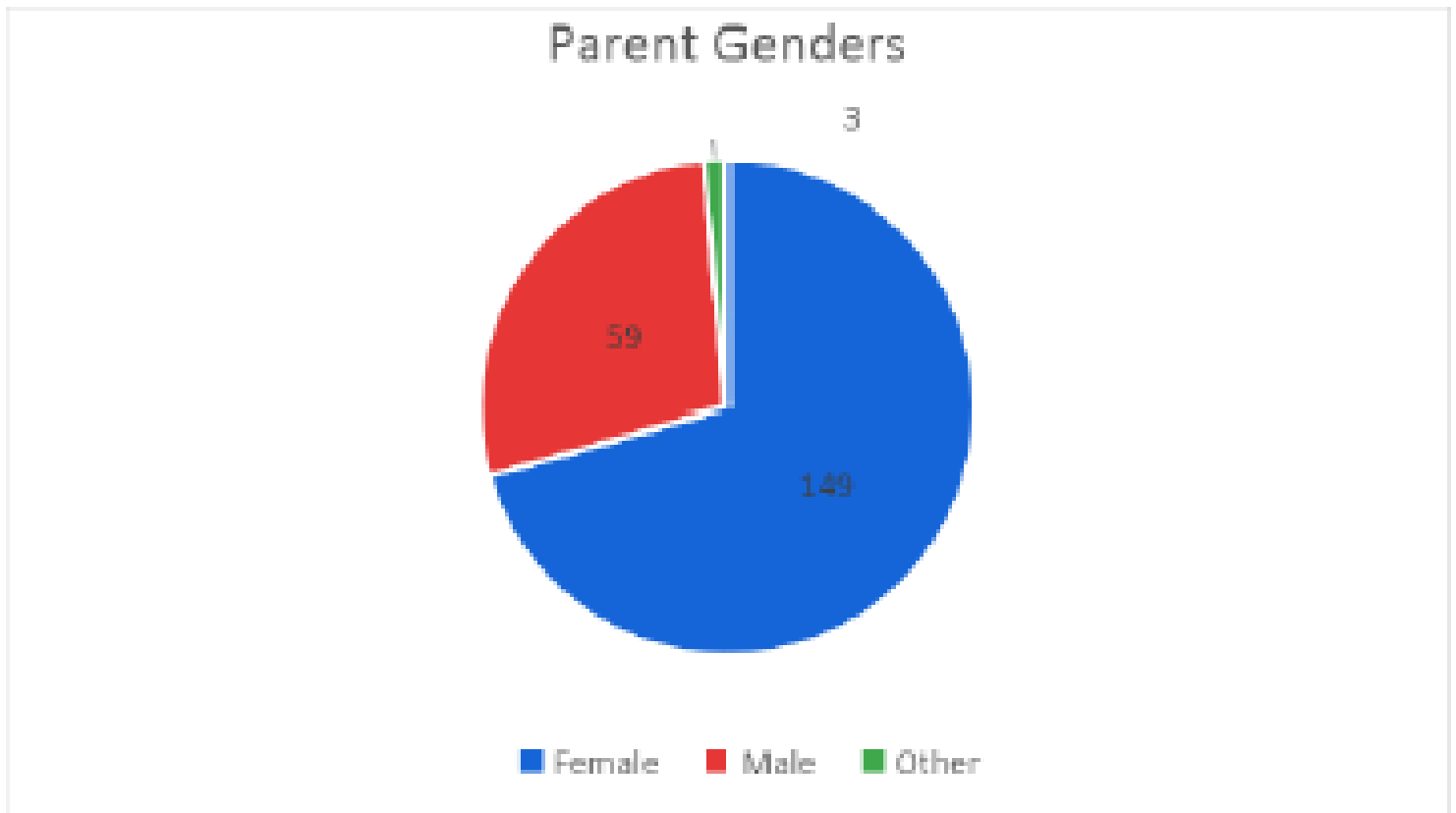
Ethnicity



Sexual Orientation:

| | |
|--------------------|-----|
| Heterosexual | 94 |
| Bisexual | 5 |
| Decline to Respond | 112 |

Gender:



Disability Status:

| | |
|------------------------------|---|
| Mental Health | 8 |
| Chronic Physical or Mobility | 5 |
| Communication | 3 |

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?

COPE uses The Triple P Positive Parenting Program rated by the California Evidence-Based Clearinghouse for Child Welfare as "Well-Supported by Research Evidence".

Fidelity to the program is ensured through the engagement of accredited practitioners:

- Utilization of session checklists that provide documentation that all components of the curriculum are presented as required by Triple P America.
- Monthly Peer Assisted Support Services (PASS) practitioner support meetings.
- Periodic audits of classes by program coordinators/managers to ensure fidelity to the 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?

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 receive timely access 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.

Strategies Utilized to Provide Access and Linkage to Treatment include:

- Provide pre and post assessments that identify those parents who are in the clinical range and case management to community members in need of services
- Collaboration between staff and a 'point person' at each agency to ensure timely access to resources

We focused on strength-based strategies that encourage parents to choose a goal and work on a strategy that reflects their family dynamics.

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?

Statements:

"I feel more like I'm parenting now than fighting with my child."

"I didn't realize how poorly I was talking to my child and how my language affected her willingness to cooperate."

"I found out that I get better results when I talk to my children rather than yell at them."

"When I wait 5 seconds after giving directions to my son, it's like a light switch turns on and then he does it."

"It's a different era now. It won't be like how I grew up. I cannot expect my son to be like me and I need to be mindful of his feelings and support his own interests. My expression can show it all."

Vignettes:

At the beginning of a Group Triple P class a father reported difficulty with his young daughter to cooperate with the morning tasks geared towards getting her dressed and ready for school on time. I challenged the parent to consider his tone and temperament when giving his daughter instructions and to implement the strategy of Giving Clear, Calm Instructions in the hopes of nurturing a better morning outcome. By the end of the class the parent reported significant improvement but

acknowledged it remained a work in progress in his own regulation. This facilitator praised him for the reported outcome and encouraged him to remain consistent as it will take more than a few weeks to totally correct years of misbehavior on both their parts. Parent reported being encouraged to continue and even relayed interest in either taking another Triple P class or doing some private parent coaching sessions with his parenting partner.

In a Teen Triple P class, one parent, who has a son with a developmental disorder, explained she was concerned her son was always quick to react emotionally if something did not turn out well for him. She was hopeful he would exhibit some self-control and cease being verbally aggressive. She indicated the group discussions reminded her to be patient by using the self-regulatory model in dealing with his emotions due to his disability. She was motivated to use the strategies she learned in class.

A court mandated father having daytime visits with his son, was granted overnight visits after completing a Group Triple P class. He was eager to be able to start using more of the strategies that he had been learning in class.

In a Spanish Group Triple P Class, a mother shared how difficult it was for her to help her son complete his homework after school, because her son only wanted to play video games. She began working on Ground Rules with her son and became more consistent in helping him with his homework and working on communication strategies. She reported that the Ground Rules were helping her feel more empowered as a parent and that communication with her son was improved.

A parent in a Spanish Teen Triple P Class said "I had many communication problems with my 13-year-old daughter. After I had my second daughter, her behavior became very complicated. One day I found my daughter in the bathroom, where she had cut her arm intentionally. Before enrolling in Teen Triple P, I did not have any help or support from any agency."

The practitioner referred this mom to our COPE Clinical Department for more support. The case manager contacted the mom to provide help and support. Now the family is receiving family therapy. Mom told us that she feels very supported, and the class helped her a lot to better understand her daughter's emotions and to provide her with a safe and learning environment. Mom understands better the importance of giving lots of affection and quality time to her teen children.

Another couple taking a Spanish Teen Triple P class were very concerned about their son's behavior, drug use, and staying out very late with friends. Their son was using marijuana and possibly other drugs. He was staying up very late, sometimes going to bed at 3 am. He also refused to connect to his virtual classes. These parents shared that Teen Triple P has helped them to support each other and work on Ground Rules. They have seen small changes in their son's behavior, as he now participates more in family activities. They gave an example of when their son was somewhere he wasn't supposed to go, the parents called the local police, who looked for him and returned to his house. They applied that logical consequence and created and signed a Behavior Contract to help them. They also looked for opportunities to talk, show affection, hugs etc. Their son is attending an Addiction Support Group now. The father has started working on his own temperament and anger after realizing self-regulation on his part is very important in building a good relationship with his son.

PEI ANNUAL REPORTING FORM

EARLY INTERVENTION REPORTING FORM

FISCAL YEAR – 2020-2021

Agency/Program Name: First 5 Contra Costa

PEI STRATEGIES:

Please check all strategies that your program employs:

- | | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Provide access and linkage to mental health care |
| <input checked="" type="checkbox"/> | Improve timely access to mental health services for underserved populations |
| <input checked="" type="checkbox"/> | Use strategies that are non-stigmatizing and non-discriminatory |

SERVICES PROVIDED / STRATEGIES:

Please describe the services you provided in the past reporting period. Please include qualitative and quantitative data depicting: 1) the types and settings of potential responders you reached during the past reporting period; 2) methods used to reach out and engage potential responders; 3) any strategies utilized to provide access and linkage to treatment, and 4) strategies utilized to improve timely access to services for underserved populations.

Services Provided:

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 that 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. First 5 works closely with its subcontractor COPE to prevent and attend to mental health needs through delivering this evidence-based parenting program which is effective with a diverse parent.

- Fifteen (15) Group Triple P classes for parents with children ages 0-5 within Contra Costa County. Classes were provided in English and Spanish in East, West, and Central County. All classes were free to all participants.
- Forty-five (45) families court-mandated over-the-phone with children ages 0-5 received additional case management services.

The Types and Settings:

Fourteen presentations and briefings as outreach activities to early childhood organizations to inform them about Triple P class offerings and program participation requirements.

Performed briefing presentations to staff at the following organizations: First 5 Centers, Family Justice Centers, Brighter Beginners Centers, Building Blocks for Kids, The Latina Center, Welcome Home Baby Program, Tandem Partners in Early Learning, and school districts throughout Contra Costa County.

- Antioch/Pittsburg/Martinez/West Contra Costa/San Ramon/ Oakley Unified

Methods used to reach out and engage potential responders:

- Online Flyers
- Outreach emails to social workers/community organization
- Social media: Instagram and Facebook
- Referrals from other CBOs
- Past participants were contacted to inform them of new services.
- Attending School Academic Review Boards and presentations at Preschools

Strategies utilized to provide access and linkage to treatment:

Several strategies are utilized to provide access and to promote linkages to treatment:

1. C.O.P.E. maintains a 24-hour response time to parents seeking services. To ensure parents who are court-mandated are enrolled in the correct class, COPE completes an over-the-phone intake form and requires them to provide a copy of the court order.
2. A waiting list for parents with children ages 0-5 was utilized to enroll parents in the next available class. Make-up sessions are available for parents who missed one class, this allowed them to stay enrolled in the program and increased completion rates.
3. All Triple P classes and Seminars were conducted using the Zoom video conferencing platform.

Parents were supported on online access and management of zoom video conferencing. Classes were adapted to ensure engagement of all participants and conform to an online platform, utilizing polls, break-out rooms, and chats to share experiences and do book exercises.

4. Class and seminar materials books, tip sheets, and incentive at First Five Centers and Family Justice Centers throughout Contra Costa County, as well as COPE's office or by mail to accommodate the needs of the participants.

Strategies utilized to improve timely access to services for underserved populations.

- Classes are offered in West, Central, and West Contra Costa County.
- Classes are offered in both English and Spanish Languages
- 9-week classes were offered every quarter
- Classes were provided at different times throughout the day over zoom video conferencing.
- All classes were free to all participants.
- COPE Staff supported participants when logging in to zoom and completing pre and post-assessments over the phone when needed.

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.

First 5 completed all provisions of the 2020-21 contract.

Program activities were provided by accredited Triple P qualified staff and 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. First 5 has developed a secure database containing assessment data for all classes. Data is entered quarterly into the database. Assessment data is collected from each participant and data quality is maintained through monitoring, regular check-ins with the practitioners, weekly review of the class checklist, and periodic auditing of classes.

Parenting Classes:

195 Participants in Triple P Parenting classes during the fiscal year. Eighty percent (80%) of families completed the Triple P program. Data was collected after the first and last session through a pre- and post-assessment. Data was analyzed with use of the following assessments:

List of indicators and data that measured reduction of negative outcomes in Group classes:

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

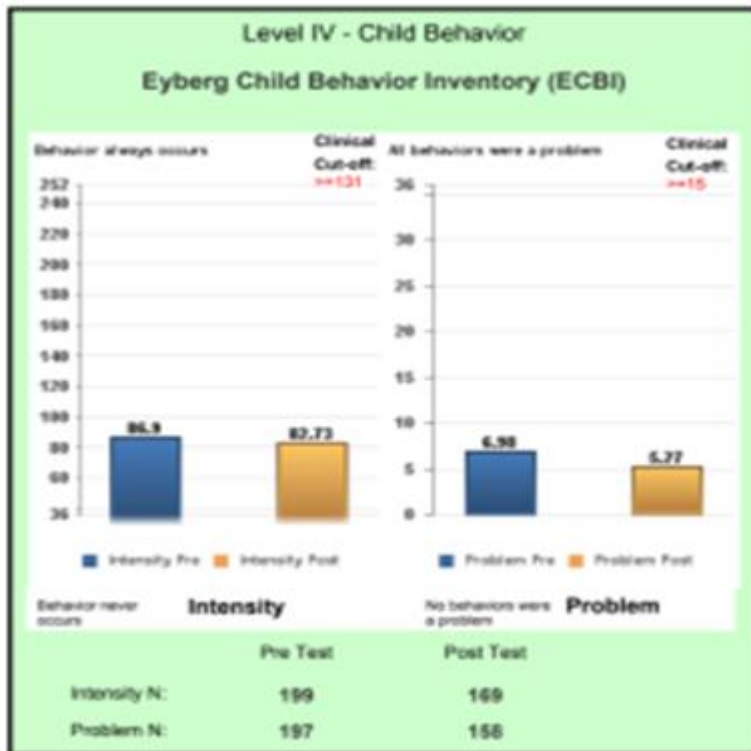
- The Parenting Scale measures dysfunctional discipline practices in parents.
- The Eyberg Child Behavior Inventory measures parental perceptions of disruptive child behavior using both an intensity scale and a problem scale.
- The Intensity scale measures the frequency of each problem behavior.
- The 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.

The Parenting Scale measures dysfunctional discipline practices in parents



The Eyberg Child Behavior Inventory measures parental perceptions of disruptive child behavior



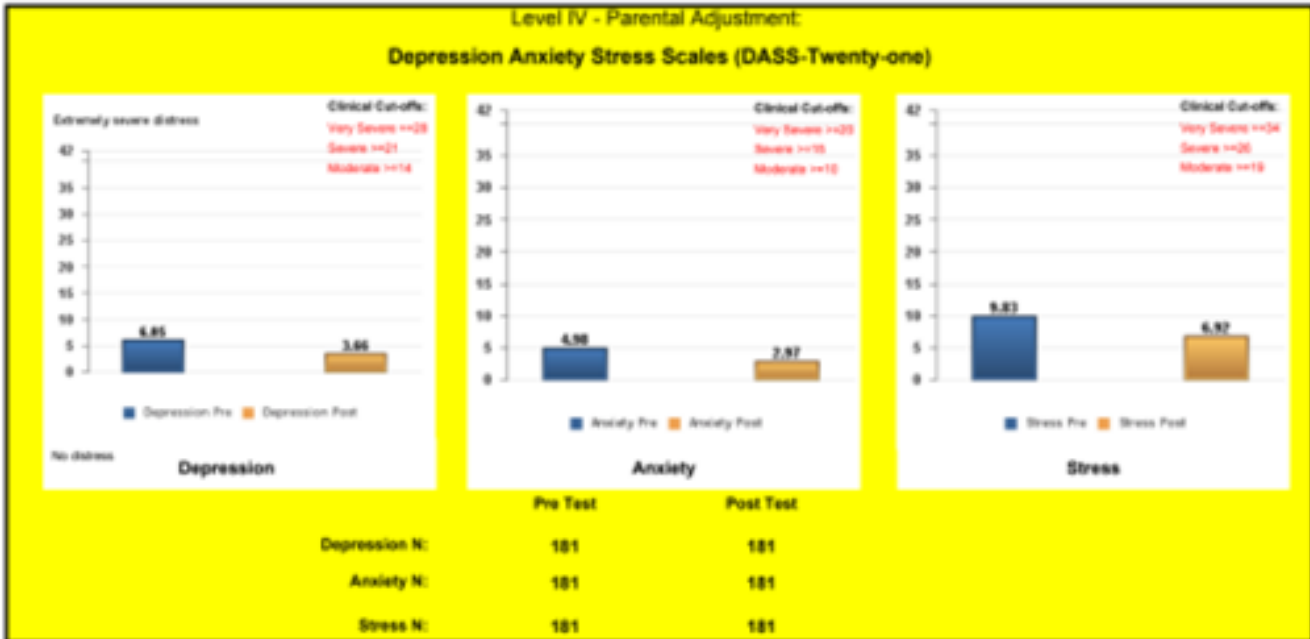
Participants were provided the Depression Anxiety Stress Scale as part of the pre and post-assessments. Participants who scored above the clinic cutoff on the DASS pre or post-assessment for depression, anxiety, or stress were contacted individually and referred as necessary to community resources for additional support and services. Those parents who expressed a mental health concern were also contacted and referred to a mental health service.

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

OVERALL RESULTS

Average of all Pre-Post Parent/Caregiver Scores

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



Case Management:

Case management services to 45 families who asked for additional resources. Additionally, if a parent's assessment(s) indicated a concern, the participant was contacted to determine if additional community support was needed. We utilized the services of our clinical interns to address the needs of parents and families with more intensive challenges.

Services included:

- Pre- and post-class assessment support.
- Resource referrals such as Early Childhood Mental Health (Therapy).
- Recruitment into appropriate programs offered by C.O.P.E. and other CBO's.
- Family and/or individual counseling sessions.
- Employment and Development department (Job training and placement, Unemployment and Medical registration benefits).
- Family Justice Center (legal and domestic violence services).

Cultural Competency:

The program has a culturally diverse staff, both personally and professionally with sensitivity and training in the needs and characteristics of diverse populations of participants. The 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.

All participants are provided services regardless of race, gender, sexual orientation, or religion.

Current practices include:

- Designated language. i.e., Spanish speaker
- Practitioners are trained to understand cultural differences in parenting practices, and we strive to develop effective and consistent parenting skills that nurture the uniqueness of each family.
- Immigration Status was never asked
- Income and level of education was respected
- All information is confidential and reported using a non-identifying code
- Parents and practitioners sign a confidentiality agreement

Triple P Train the Trainers:

Each year we identify gaps in program support this allows us to determine what training will be offered to maintain or increase trainers in the Triple P training programs to ensure timely access to service. This year were train and accredited 7 practitioners who supported classes for parents with children ages 0-5.

Trainings offered:

- Level 2 Seminar, Stepping Stones (1 person),
- Group Triple P (3 people),
- Level 3 Triple P Discussion Groups (3 people).

Additionally, staff are trained on the ASQ3 /SE developmental screeners to determine if additional developmental support is needed to determine the root cause of the concern. The ASQ data is also collected within the database.

Data Collection and Tracking:

The ETO database portal is used to track the following:

- Participant demographics.
- Pre- and post-assessments in all classes.
- Seminar attendance and evaluations.

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.

- 215 individuals attended Triple P provided programs in Contra Costa County for the 2020-2021 Fiscal Year.
- 74% of the participants were female.
- 49% of the participants were Latino/a.

- 11% of the participants identified as African American.
- 42% of the participants were either Spanish-speakers or bilingual Spanish/English

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?

Triple P Program provides a self-regulatory model to choose strategies that support their family's dynamics. We focused on strength-based strategies that encourage parents to choose a goal and work on a strategy that reflects their family dynamics. Participants define their own goals, work on strategies, and receive support from practitioners. Overall, positive parenting has a powerful impact on a child's emotional wellbeing and strengthens the parent-child relationship.

Services supported parents in increasing parenting skills in meeting their children's social and developmental needs. Parents learned that the quality of the parent-child relationship is the major factor associated with the well-being of young children. The parent-child relationship nurtures emotional and social development, builds resiliency skills, and teaches the child how to self-regulate their emotions. Having a strong parent-child relationship supports Kindergarten readiness.

The program staff collaborations with other organizations to provide needed resources to address basic needs and link them to cultural relevant supplemental services ranging from parent-child activities to therapy, support groups, and leadership opportunities for parents allow us to connect families directly with a wide range of 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.

One father of 4 children, 2 daughters and 2 sons 10, 5, 3, and a 14-month-old who recently lost his wife due to COVID-19 enrolled in a Triple P class looking for help managing his children. During these classes, he has been implementing all the tools that the program has to offer, those for planned activities/high-risk situations. His children are under 10 and these activities have helped him significantly, as he has been and will continue implementing all the strategies provided by the Triple P program. He also enrolled and completed the Supporting Father Involvement program that COPE offers and is receiving therapy. The Father stated: "I had no idea how assertive communication worked, all I used to do was yelling to my children, but now I am calmer when I am communicating with them." "Thanks to the planned activity exercise I am now able to have my children in bed by 8:30 pm and have some time to myself."

A mother and a father took a group Triple P class together, they discovered a treasure, they said. Every exercise, homework, and conversation during the class they asked questions, gave examples about how implementing the program into their lives was helping them. They have a 1-year-old son and an 11-year-old daughter, and they worked together to change their ways of parenting. They were open to suggestions, and they came up with their own ideas that apply to their situation. The parents stated:

"I've never thought that planning an activity beforehand would have such positive results. I am going to continue using the guide from the book. Thank you so much."

"Triple P program allows parents to take care of themselves." "Preparing in advance and talking about the rules was very helpful, even if we think children are not listening." "With this class, I learned about not raising my voice when I believe my child is disrespectful, I'm modeling for my child."

A probation officer at Juvenile Hall contacted COPE seeking a parenting class for teen parents, the child was a newborn, and the teen parent needed to take a class online, due to restrictions of his confinement. The teen parent only has limited access to a device and internet connection. The staff found a class at a convenient time for both the probation officer and the teen parent. The teen parent was not participating at first only when asked, but by the 3rd class, the facilitator reported that the teen parent was very engaged, sharing his own experience as a son and the type of parent he wanted to be for his own child. The teen parent expressed feeling empowered by hearing the other parents' success stories.

Two African American mothers at a recovery home were recommended to take parenting classes in preparation for reunification. At the moment only a Seminar for black families in East County was available which they both attended with their counselor. It created such an impact that they both enrolled in a Triple P class, one of the mothers continued attending the seminars, filling out evaluations with great reviews about the program, facilitators as well as suggestions for future topics. At the March seminar she shared having lost a close friend and feeling very sad, a couple more parents have suffered a recent loss and the facilitator adjusted the topic to: "Coping with loss and the impact on parenting." The mother was very thankful as she was a week away from reunification with her almost 2-year-old daughter and wanted to be emotionally ready for her. At one of the April seminars, the mother logged in to zoom with her child, which made the facilitator, COPE staff, and other participants very happy.

PEI ANNUAL REPORTING FORM

EARLY INTERVENTION REPORTING FORM

FISCAL YEAR – 2020-2021

Agency/Program Name: CCCBH/First Hope

PEI STRATEGIES:

Please check all strategies that your program employs:

- | | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Provide access and linkage to mental health care |
| <input checked="" type="checkbox"/> | Improve timely access to mental health services for underserved populations |
| <input checked="" type="checkbox"/> | 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.

First Hope provides early identification, assessment, and intensive treatment services to youth aged 12-30 years, who show signs indicating they are at Clinical High Risk (CHR) for psychosis or who have experienced their First Episode of Psychosis (FEP) within the past 18 months. Target diagnoses include Other Specified Schizophrenia Spectrum and Other Psychotic Disorder, Schizophreniform Disorder, Schizophrenia, Schizoaffective Disorder, and Affective Psychoses.

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

- 1) **Community outreach and psychoeducation** – First Hope conducts outreach presentations/trainings in early intervention in psychosis to organizations throughout our community who can assist us in identifying youth who are experiencing early warning signs of an emerging psychosis. These organizations include schools, county regional child and adult county mental health clinics, community-based mental health agencies, other community organizations such as our local LGBTQI+ community center, hospitals, psychiatric emergency services, primary care clinics, as well as community members at NAMI meetings and at our local clubhouse. 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 2020/2021 we conducted fewer outreach presentations than usual due to the COVID pandemic; however, we still trained 66 clinicians that included staff from hospitals and community-based mental health agencies such as Seneca and Putnam Clubhouse, as well as psychology interns.

- 2) **Screening and assessment** – In order to provide a high level of responsiveness and access to immediate help, First Hope has an Intake Clinician of the Day who takes screening calls as well as a Clinician of the Day (COD) who takes 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 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) also has some capacity to provide an urgent response to those in crisis in inpatient psychiatry or crisis residential treatment, to facilitate discharge and the start of outpatient services. With COVID-19, our ability to conduct meetings on the inpatient units was adversely impacted. However, video or phone visits were still possible throughout, and in-person visits have increased again over the past year.

- 3) **Intensive, family-centered treatment services** – First Hope uses the evidence-based Portland Identification and Early Referral (PIER) and Coordinated Specialty Care (CSC) treatment models, which have been shown to be effective in both preventing conversion to psychosis and ameliorating disability associated with psychotic disorders. Please see section **EVIDENCE-BASED OR PROMISING PRACTICES** for additional information on these models as well other evidence-based practices used in First Hope. Our multidisciplinary treatment team includes mental health clinicians, occupational therapists, educational and employment specialists, a partner, a peer specialist, a rehab counselor, an RN, and psychiatrists. Services include immediate access for evaluation, family psychoeducation and multifamily groups, crisis intervention, individual and family psychotherapy, care coordination, supported education and employment, occupational therapy, psychiatric evaluation and medication management, peer support and mentoring, substance use counseling, nursing medication support, and health promotion services. In addition, over the past three months, we began piloting a cognitive rehabilitation program to further our ability to address persistent cognitive impairments and to promote improved functional outcomes.

Treatment services are offered in any language using the language line. Treatment services in Spanish are provided by our Spanish-speaking clinicians. 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 three) Spanish-language groups.

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 PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

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

All our clients who are offered First Hope treatment services beyond our initial assessment are identified as being early in their onset/course of a serious mental illness. As of June 30, 2021, 143 clients were enrolled in our treatment services, along with their family members. Please refer to our Aggregate Data Reporting Form for quantitative data on total number of clients and family members served throughout the fiscal year.

Participants' early onset of a potentially serious mental illness is determined by either a

1. Structured Interview for Psychosis-Risk Syndromes (SIPS), a semi-structured interview that is the gold standard assessment for determining if an individual is at Clinical High Risk for psychosis (CHRp) or
2. First Episode Psychosis (FEP) assessment which includes a medical records review, client's self-report, and collateral information from family members and current and former providers

The following two methodologies are used to determine the effectiveness of services:

We maintain a database to track functioning, positive and negative symptoms, and critical events. Data had been collected every six months, but we are looking to revamp our data collection and analysis procedures over this upcoming year. We have applied for federal grant funding to build a new data feature in our county's electronic health record, ccLink, and we will be reviewing our current assessment measures and protocols and considering revisions and additions.

The County Behavioral Health Division's Utilization Review/Quality Improvement Committee process provides ongoing analysis of the qualitative aspects of the program each month. When issues are identified, the First Hope Program Manager identifies and implements a corrective plan of action.

Evaluation forms provided to clients and families are available in English and Spanish. Any program outcome analyses that are shared with funders or other entities outside of Contra Costa County Behavioral Health is de-identified and aggregated.

One major challenge we experienced over this past fiscal year was a dramatic increase in the number of referrals to our program. Shortly after the pandemic began in the spring of 2020, our referrals initially decreased slightly compared to the same period the previous year (2019). However, starting in July 2020, our referrals began to increase significantly, between a quarter to a third higher than the previous year. By the beginning of 2021, we were experiencing a 50% increase in our referrals compared to the previous year. Despite starting a waitlist and implementing other strategies, it became clear by March 2021 that First Hope no longer had the capacity to continue adding individuals to our waitlist, and we made the difficult decision to suspend new referrals so that we could maintain our capacity to provide the highest level of care possible to the clients and families already enrolled in our program. This suspension of new referrals is what accounts for the lower number of "clients referred to mental health services" in item #9 of our Aggregate Data Reporting Form.

Since that time, we have made steady progress in moving individuals off our waitlist into active services. We hope to re-open to new referrals sometime this fall.

We are pleased to report that despite the unprecedented demand for our treatment services and the multitude of challenges faced by our treatment team, we were able to maintain our capacity to provide excellent clinical care for our clients, as evidenced by the following:

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 2 conversions from CHR to psychosis from July 2020 through June 2021, out of 63 CHR clients served, which is a conversion rate of 3%.

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

From July 2020 through June 2021, 108 First Hope clients had 0 psychiatric emergency room visits or inpatient psychiatric hospitalizations, while 35 First Hope clients had a combined total of 64 visits to the psychiatric emergency room, 36 of which resulted in an inpatient hospital stay. Six First Hope clients represented 41% of the PES visits (26/64). As noted earlier, we are in the middle of revamping our data analysis procedures to better assess whether rates of PES visits and hospitalization improve over baseline rates for our clients.

Three of our clients were arrested, one of whom was charged, during the period of July 2020 through June 2021. None were convicted of a crime nor sentenced.

Suicide risk is a major concern with psychosis, with a lifetime risk of about 5% for suicide completion. Furthermore, this risk is elevated during the FEP period and particularly within the first year of treatment when the risk is 60% higher than in later years. From July 2020 through June 2021, we had 8 suicide attempts and 0 completed suicides.

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

Our First Hope program has remained open for services for the entire duration of the pandemic, with a successful transition to telehealth for those who desire it and a continuation of in-person individual sessions as clinically indicated or as preferred by the client or family. Despite transitioning fully to telehealth, our group programming continues to be vibrant and well-attended, with 11 Multi-Family Groups and 2 peer groups running.

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 our Aggregate Data Reporting Form

EVIDENCE-BASED OR PROMISING PRACTICES

What evidence-based, promising practice, or community practice-based standard is used in your program and how is fidelity to the practice ensured?

As noted in section 1 (Services Provided/Activities), First Hope uses the evidence-based Portland Identification and Early Referral (PIER) and Coordinated Specialty Care (CSC) models. PIER and CSC 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 mental health clinicians, occupational therapists, educational and employment specialists, a community support worker family partner, a community support worker peer specialist, a rehab counselor with a specialization in substance use disorders, an RN, and psychiatrists.

Our clinicians are trained and certified to provide Structured Interview for Psychosis risk Syndrome (SIPS) assessments, Cognitive-Behavioral Therapy for psychosis (CBTp), and Multifamily Group Treatment (MFGT), evidence-based practices for assessing and treating CHR and FEP. They participate in ongoing consultation and supervision meetings in order to maintain fidelity to these treatment models. Clinicians meet biweekly with Dr. Barbara Walsh of Yale University, one of the co-authors

of the SIPS, with Dr. Kate Hardy of Stanford University, an eminent trainer of CBTp, and with Dr. Jude Leung, First Hope Program Manager and a faculty member of the PIER Training Institute.

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 of them returned on 11/5/20, 11/12/20, 12/3/20, and 12/8/20 as volunteers to speak with our newer clients and families about their experiences with First Hope.

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

“When I first found this program (First Hope) that was my only hope to get help for my daughter. Now that she’s in, I am so happy that our lives have changed for good. Thank you.”

“Es un buen programa, es bueno que haya personas que se procupen por la salud de los jovenes. Gracias por toda su ayuda, estamos muy contentos con el personal todos y todas son muy carioñosos y respetivos.”

“Staff and counselors are great. It is helpful having someone to talk to.”

“I love First Hope! They do an excellent job caring for their clients!”

“It’s been helpful to learn techniques to support my child, support with speaking to the school. Support with my child getting organized.”

“Very understandable staff, friendly and approachable.”

“Anna has been a great therapist for us. We are both more comfortable about dealing with my daughter’s issues.”

“Anna has been very understanding and listens to what I need.”

“Great services that First Hope provides, and I love all of the different options that the different therapists provide.”

“Staff here is great! Psychiatrist and therapist helped me achieve treatment and listened to what I had to say and trusted me as much as I trust them.”

“Would love to see more offices that accommodate all areas of the county so that it is more accessible to all clients.”

“First Hope has helped me and my family greatly. The most helpful thing has been being able to receive help when and if I need it more than the months prior.”

“Everyone is very approachable and respectable. We are very appreciative of the services offered.”

“I have a safe place now to express my problems, or personal issues.”

“Have First Hope open on weekends!”

“The most helpful thing about the services I’ve received were when they had my back and were comforting me knowing I was going through stuff. Wonderful service. Amazing, kind, honest people here. Would recommend to others who would need stuff like this.”

“Everything is great. So great.”

“I have been very pleased with the staff and how easy it is to get appointments.”

PEI ANNUAL REPORTING FORM

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

FISCAL YEAR – 2020-2021

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

PEI STRATEGIES:

Please check all strategies that your program employs:

- | | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Provide access and linkage to mental health care |
| <input checked="" type="checkbox"/> | Improve timely access to mental health services for underserved populations |
| <input checked="" type="checkbox"/> | Use strategies that are non-stigmatizing and non-discriminatory |

SERVICES PROVIDED / STRATEGIES:

Please describe the services you provided in the past reporting period. Please include qualitative and quantitative data depicting: 1) the types and settings of potential responders you reached during the past reporting period; 2) methods used to reach out and engage potential responders; 3) any strategies utilized to provide access and linkage to treatment, and 4) strategies utilized to improve timely access to services for underserved populations.

Types and settings of services provided:

Hope Solutions provides on-site case managers and youth enrichment coordinators at 7 housing sites. One of these sites houses 27 formerly homeless families (Garden Park Apartments/GPA). The parents in these families have a disability as an eligibility criterion for this permanent housing, and most of the disabilities are in the area of mental health and substance abuse challenges. Three of these housing sites are affordable housing for 247 households that have incomes at 50% or lower than the Average Median Income of the community. (Los Medanos Village/LMV and Bella Monte Apartments/BMA) These households are challenged due to limited income and frequently have other challenges due to lack of resources, surviving systemic racism, experience with family and community violence, and challenges with immigration status. The last 3 housing sites house 4 individuals at each of 3 houses (MHSA housing). These 12 residents are referred by CCC behavioral health, with serious mental health histories, and are funded as MHSA housing residents under this grant. All of the residents in these sites are offered support services on-site.

Methods used to reach out and engage potential responders/Strategies utilized to provide access and linkage to treatment:

Hope Solutions staff work on-site at housing for vulnerable residents. During the pandemic and stay-home-orders case managers reached out to residents who self-referred or were referred by the property management, using remote systems

including phone calls, facetime, zoom and when needed in-person appointments. Youth Enrichment staff worked with school systems and community volunteers to provide remote tutoring and social skill building activities via zoom for the youth. Residents were introduced to service staff when they first move into the housing and services available to residents are described. After moving in residents at affordable housing sites are contacted using fliers, robot-calls and newsletters as outreach methods letting residents know of community events and resources. Support staff working with GPA and MHSA housing have frequent (daily – weekly) contact with residents to assist with needs as they arise.

Because staff are on-site and available to provide various types of support (food/transportation/health referrals/emotional support) residents learn to trust and utilize these services and reach out for them when needed. When families or individuals have problems with mental health challenges, they already have a trusting relationship with the case managers and can reach out for mental health resources. Staff are trained in trauma-informed care and several of the staff are licensed mental health professionals. All programs are supervised by licensed mental health professionals and concerns about emerging mental health problems are addressed in a timely manner. Monthly team meetings and weekly staff supervision discussions allow for the provision of mental health support quickly and sensitively as concerns come up.

Youth enrichment staff work directly with the youth in afterschool and summer programs. Youth can form trusting relationships with those staff, also, as they receive a nourishing snack and help with homework. The staff also work directly with parents and school personnel and can collaborate with families when mental health issues arise. Referrals to mental health resources are made as needed in the context of these ongoing relationships.

Strategies utilized to improve timely access to services for underserved populations.

Case managers and youth enrichment coordinators collaborate to provide support groups at all sites in addition to the services described above. The residents of the housing sites where services are provided often have limited familiarity with mental health resources. Some residents also have concerns about the stigma that could be attached to using this type of service. By forming ongoing relationships with residents, and offering education about how mental health support works, staff are well situated to address questions and fears about mental health problems and mental health resources.

By providing a variety of programs and supports in the setting of people's housing we are also able to receive referrals from property managers when behavioral issues arise that threaten someone's housing. Neighbor conflicts, problems with substance use, and family conflicts are some of the types of referrals the on-site case managers receive from property managers. Eighty-five percent of the residents in these programs are people of color and due to systemic racism have mistrust of many resources including mental health support. Staff in these programs have training in cultural humility, and most live in the same communities. Their life experiences and training help them to address this mistrust with personal experience.

If a resident requests a mental health referral, registered interns can provide home-based counseling to the youth in the programs. Case managers also assist adult residents to find appropriate counselors through the county ACCESS line, assisting people to ask for what they want in a counselor, including specifics of race, gender and experience. By offering basic education about how mental health counseling works (time, costs, modality options) people who have little knowledge of mental health resources can engage with these services.

During the pandemic staff used remote methods of contact including phones, texting and zoom. Youth had a hard time engaging with zoom after being on it all day for school. Youth enrichment coordinators and volunteers continued to help with homework afterschool. Additionally, youth enrichment coordinators spent time supporting and advocating for youth and families as they interacted with the school systems remote systems. Digital equipment and emotional support were offered to both youth and their families. Case managers assisted with PPE for families as requested and supported families that needed

to quarantine with food and other resources. During the pandemic we have found that the work has continued, and we have needed to be flexible and responsive with new ways to connect and provide assistance.

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 following outcome measures were included in our 2021 contract.

Measures of Success

- At least 75% of the youth regularly attending homework club will achieve six or more academic benchmark skills during the school year ending in June 2021.
- At least 75% of the families with children, in the program, will show improvement in at least one area of self-sufficiency as measured annually on the 20 area, self-sufficiency matrix within the fiscal year, 2020 to 2021.
- Two (2) family vignettes, showing the improvements and positive outcomes of the work of this project (including GPA, Lakeside, LMV, and BMA communities) will be provided with the end of fiscal year final report.

We gathered much more outcome data related to our work, and those outcomes are reported here. These outcomes are based on the ongoing case management and youth enrichment work which is provided daily and documented in notes, assessments and attendance records kept in a digital database, or in HIPAA compliant, locked files. The digital data base is protected with HIPAA level protections including passwords on the database and on the computers used for this work. We also require HIPAA training annually for all staff to be sure that everyone understands how to protect client information. Data is collected collaboratively with residents and outcomes are shared with residents as part of our client-centered, trauma informed, culturally competent approach. Staff are trained and hired with cultural awareness as a critical component of skills for the work. Most of our staff live in and are committed, personally, to the communities they serve.

For some of the outcomes we use client centered/reported information (as on the self-sufficiency matrix and on the annual goal achievement). We also use some standardized evaluation tools like the Piers-Harris Self-Esteem assessment and the Parental Stress Index to help us evaluate effectiveness of our work. These are given once a year at the end of the fiscal year.

Specific Goals and Outcomes for the 20-21 fiscal year:

Goal: 75% of youth that participate in the afterschool academic and tutoring program will achieve at least four (6) new CA Academic benchmarks.

Outcome: 89% (16/18) youth achieved at least 4 benchmarks.

This outcome is based on students who were able to attend the program on a regular basis. As described above, this program was challenging for youth who had already been on zoom all day for school. Traditional report cards were not provided by the schools again this year and the numbers cited for this outcome are based on our internal assessments and observations by our Academic Supervisor, a credentialed, bi-lingual teacher.

Goal: At least 75% of the families receiving intensive case management, will show improvement in at least one area of self-sufficiency as measured annually on the 20 area, self-sufficiency matrix.

Outcome: 94% (74/79) of households were able to achieve this goal and had an average score of stable (3) or better on this assessment.

The self-sufficiency matrix is reviewed annually for residents that are receiving intensive support from case managers.

In addition to those two goals listed in our contract, we also attach two vignettes regarding work with two residents. We also include the following additional outcomes for the past year:

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

Outcome: 100% (193/193) of families maintained their housing.

All families in our programs were able to maintain stable housing. Impressively, one of the families living for many years at Garden Park Apartments was able to purchase their own home. The mother in this family had gotten a BA and MSW degree while living in supportive housing and is now working as a medical social worker. Her husband is a truck driver. They have two growing sons who look forward to having their own room and backyard. We share this success as an example of the very positive impact housing can have on previously homeless families.

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

Outcome: 100% (103/103) of families at risk for eviction remained housed.

During the eviction moratorium case managers helped families who lost income access financial support so that they would not face a large debt when the eviction moratorium is lifted. Support was also given to help families struggling with depression and behavioral problems due to the stresses of the stay-home orders. Case managers regularly met with property managers and accessed community resources to assist families to live as peacefully and safely as possible during this time.

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

Outcome: 98% (126/128) of families requesting assistance with concrete resources had their request fulfilled.

This was a heavy year for concrete service needs as families coped with the stay home orders, home schooling, unemployment and access to the financial resources being offered under the pandemic. Examples of their requests included access to food, employment support/unemployment applications, technological resources (computers, internet) transportation, healthcare and mental health resources and benefits offered under the Rescue Bill. Thanks to the Rescue Bill and other resources these needs were able to be met. A couple of families requested help with benefits that the case manager was not able to provide, but she assisted them to find the right resource for these requests.

Goal: 85% of families will show improvement on Parental Stress Index after attending support groups.

Outcome: 80% (8/10) of families taking the Parental Stress Index assessment showed lowered levels of stress after group participation.

During the stay home orders we worked to provide group support online. This was difficult for parents, however, while they were managing children who were home schooling. We ended up crafting multiple small groups for 2 or 3 parents at a time and fit to their schedules. They reported that this was helpful and that they were able to get to know some of their neighbors more deeply when having these smaller discussion groups.

Many parents attended the remote support groups at the 4 sites. Anecdotal feedback from the parents was uniformly positive, as reported above. We had challenges with getting the Parental Stress Index data due to the paper/in-person nature of the assessment. With the realization that the pandemic would be continuing for a while, we applied for and received a grant to purchase digital versions of the PSI assessment tool and we will be using that in the coming year to be able to obtain more feedback.

Of the ten parents taking the PSI, only 2 scored as having an increase in stress compared to last year's scores. Considering the challenges of the year, this seems like a positive outcome!

The parenting group in east county designed a satisfaction survey for their housing community that was made available in a digital format. Twenty-nine residents living at both properties (BMA and LMV) responded, giving feedback to property management and services about their appreciations and concerns. Hope Solutions staff facilitated discussions between residents and property management about addressing improvements at the properties that were identified in the survey. Issues addressed included safety, property cleanliness and management scheduling and availability. All parties involved reported feeling like this was a successful start to improved ongoing communication with property management. One of the residents was supported in his role as a leader and spokesperson for resident issues. This process started in a Community Café group and grew into a very successful process lead by residents.

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

Outcome: 100% (10/10) of the residents who attended the wellness/harm-reduction group sessions reported using the coping strategies they learned in the groups.

Wellness and self-care were frequently requested topics in the groups during the pandemic. Managing feelings of anxiety and depression while home was an ongoing need. During and after the groups, parents expressed appreciation for all the support they received. They especially liked the art projects and the mindfulness approaches to surviving this difficult time.

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

Outcome: 100% (74/74) of parents who received educational advocacy/coaching reported having an improved/positive experience working with school personnel.

This was a year of youth enrichment coordinators shifting gears and providing many hours of advocacy for families working with remote learning – 914 hours in total. Examples of educational advocacy included outreach to facilitate parent/teacher connections, IEP meetings and meetings related to accessing educational supports, and managing the digital platforms used by the teachers. Several of the Lakeside families served were mono-lingual and worked with Hope Solutions staff who provided translation support. Families reported gratitude and relief to have the advocacy support during this difficult time.

As our report reveals, and as everyone knows, it has been a challenging year. Youth, and their families, have been particularly stressed with the stay-at-home orders and the need to do home-schooling. Hope Solutions staff have worked to assist these families with practical resources and emotional support. We have adjusted our program to meet the needs of the communities and we are proud and grateful to have been successful in helping people cope and survive during the pandemic. We all sincerely hope that next year will be better.

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 Attached demographic form.

VALUES:

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

MHSA values parallel well with Hope Solutions values:

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

Providing housing and support services with these values allows Hope Solutions staff to support wellness, recovery and resilience in residents and clients in our programs. The Strengthening Vulnerable Families program reflects MHSA and HS values 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 are able to 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 is able to make this request in the context of other resources and thus is not singled out or identified with this particular need. By having a trusted, long-term relationship with an on-site case manager, residents are able to move past fears of stigma or discrimination as they seek mental health assistance.

During the COVID pandemic residents have been supported remotely and in-person to be able to access resources and to receive emotional support while coping with the stay-home orders, home-based school, anxiety and depression over concerns about the virus.

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.

Kleo and Kandy find safety

Kleo moved to a permanent supportive housing program 5 years ago. Before moving in she was living with friends and family for short times and moving often. She was leaving a violent relationship with her ex and came to her new housing with her 5-year-old daughter, Kandy. Mother struggled with her feelings about her separation and struggled with depression and anxiety.

When she first moved in, she was shy and mistrustful of her neighbors. Support staff reached out to her to welcome and orient her to the housing and community resources. They helped her make the transition to her new home with furnishings and food resources. They encouraged her to participate in parent support groups and social activities at the housing site.

Kleo and Kandy had been living in a nearby bay area town and mother was able to continue to work in that town while attending classes at a community college where she studied sign language. Managing the commute and childcare was hard for this family, but staff worked to support mother to pursue her plans and dreams with resources and encouragement.

Kandy participated in youth enrichment programming at the property as much as she could. Tutors helped her with her homework, and she began to make friends with other children at the property. When Kleo told staff that Kandy was having a hard time sleeping and was missing her father, they referred Kandy to receive mental health counseling on-site at the housing program. (Mother was also receiving mental health therapy from a community counseling center). Moving and having her parents separate was difficult for Kandy and services staff were active in supporting both mother and daughter during this sad and difficult time.

During the pandemic several family members in mother's extended family died, some of COVID, some of other causes. Mother's grief and depression hit a new low and at one point she became suicidal. Staff and extended family supported mother to go to the hospital and support staff helped her when she returned to housing after a 3 day stay. Kandy was able to stay with her aunt when mother was hospitalized and staff helped to coordinate communications with mother, daughter, family, property management and the hospital. They also supported Kleo to continue with her therapy after she returned to her home.

Today Kleo continues to have a job and has completed a 2-year associate degree in sign language. She hopes to attend a 4-year college to continue her studies in this field. Kandy is in 4th grade and doing well with her studies and her peers. Despite many challenges, this family has been able to find their balance with permanent housing and support when needed.

Jim in MHSA housing

Jim, now in his early sixties, grew up in an affluent neighborhood, attended good schools and landed a job as a stockbroker after college. He married, had a child, and moved on to a position as a regional sales manager with a telecommunications company. It was during this period that he was diagnosed with a serious mental illness and moved from a shared apartment into a board & care. He also developed a drug addiction that quickly began depleting his family's resources, affecting his relationships and his work. Eventually, he lost his job, his marriage, and his home. After a couple of years at the board & care, he moved into an independent living situation and into the house he has now shared for several years with three other men as part of a permanent supportive housing program.

When Greg began supporting Jim as his PSH case manager, the pandemic was in full swing, and he observed that Jim spent much of his day isolated, drinking beer and smoking cigarettes on the patio or watching television in his bedroom. With no vehicle, Jim typically would ride his bike to go cash his weekly check, do other errands—or do some light exercise. One day he mentioned to Greg that he was having a problem with his bike. Greg offered to check the problem given his own experience working on bikes. Greg was able to fix the issue, and as the two got talking more about biking, Greg suggested that they go for a ride together. That first casual ride turned into a weekly 20-mile ride that usually included a stop for coffee and the opportunity for Jim to talk about both his concerns and his hopes for his own life. With Jim’s increasing sense of trust and comfort, Greg was able to connect with Jim’s mental health specialist and money manager, creating a wider team to support Jim’s interests.

It was on one of those bike and coffee rides that Jim mentioned he missed being able to participate in classes and events at RI and Putnam Clubhouse as he had done intermittently before the pandemic. He also mentioned that while there, he had been called on to share his own story about addiction and mental health challenges, saying he had appreciated the opportunity to do so. Greg suggested Jim apply for the SPIRIT program, and Jim eventually did so. Greg helped him put his resume and application together and coordinated with the program leads, and while Jim was not accepted to the program this past year, the process did get him thinking about seeking part time work and “getting back out into the world.” Jim is now on a path to attend the Clubhouse several times a week and work with the staff and other Clubhouse members on job placement.

After some challenging times, with support and encouragement, Jim is finding his way.

PEI ANNUAL REPORTING FORM
PREVENTION REPORTING FORM

FISCAL YEAR – 2020-2021

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

Project (if applicable): Community Bridges

PEI STRATEGIES:

Please check all strategies that your program employs:

- | | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Provide access and linkage to mental health care |
| <input checked="" type="checkbox"/> | Improve timely access to mental health services for underserved populations |
| <input checked="" type="checkbox"/> | Use strategies that are non-stigmatizing and non-discriminatory |

SERVICES PROVIDED / ACTIVITIES:

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

1. We facilitated two virtual trainings (via Zoom) during the pandemic. In total, we trained 120 service providers from the community, exceeding our target of training 75 frontline staff.
 - December 17th, 2020: Domestic Violence—Serving South Asian Survivors and Pandemic-Related DV Trends. 43 attendees. Presenter: Bindu Fernandez, Executive Director of Nierika
Participants learned about:
 - The types of abuse faced by immigrants and survivors of South Asian communities.
 - Trends in the South Asian landscape in regard to domestic violence.
 - Pandemic-related Domestic Violence Trends.
 - June 2nd, 2021: Culturally and Religiously Attuned Care: Clinical Considerations for Working with Muslim Clients. 77 attendees. Presenter: Dr. Rania Awaad, Director of the Muslim Mental Health Lab at Stanford, University School of Medicine
Participants learned about:
 - Identifying ways to frame counseling for Muslim clients.

- Understanding assessment considerations for working with Muslim clients.
 - Identifying successful counseling methods for Muslim clients that implement culturally and religiously sensitive techniques in a clinical setting.
- JFCS East Bay held groups throughout the year for Dari- and Russian-speaking communities of Contra Costa County.

Russian-Speaking Seniors Telehealth Mental Health Education Sessions: The purpose of the mental health education sessions is to help combat isolation, anxiety, grief, and promote wellness through learning relaxation techniques. Due to the pandemic, the decision was made to provide individual (45-minute) mental health classes via phone with 14 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 14 individualized sessions: “Decreasing Anxiety Level during Covid-19 Pandemic.” The one-on-one format also allowed each Russian senior to get more individualized attention and personalized support from our Russian-Speaking Case Manager. The original hour-long format was also changed to 45 minutes as most Russian seniors preferred a shorter format expressing that they could not stay alert for 1hr virtual sessions.

Afghan Refugee Mothers’ Support Group (20 Afghan Mothers Served, 3 (7 week) support groups completed.): Due to the pandemic, our support groups were done over Zoom. Given the nature of remote work and lack of confidential spaces at home for many of our clients, these clinical support groups were done instead as psychosocial(non-clinical) support groups. Our three 7-week support group series aimed to decrease social isolation, encourage positive parenting, and provide refugee mothers with stress management techniques. Our reasoning for focusing on providing psychosocial support to Afghan mothers is rooted in evidence-based research that the entire family unit benefits when a mother is more relaxed and knows how to cope with stress (i.e., if a mother has coping skills to deal with stress, it is more likely her children will have better developmental outcomes.) In addition, our support groups are also a place where we facilitate sharing of information regarding available resources.

The Afghan Mothers’ support groups were reduced to 1.5-hour sessions, from 2 hours (due to mothers needing to share the computer with other family members in the household). Staff adapted and allocated some of unused support group hours to create two (1.5 hour) public health workshops for existing support group participants. These workshops were led by Dr. Zarin Noor (Director of the International Clinic at the Primary Care Clinic at UCSF Benioff) and by medical residents at UCSF Benioff Children’s Hospital. These workshops proved incredibly useful as they lessened many mothers’ fears around getting the Covid-19 vaccine and gave them a safe space to have basic vaccine questions answered by medical professionals.

- March 23rd, 2021: Covid-19 Prevention and Vaccine Information, Presenter: UCSF Benioff Children’s Hospital, Director of International Clinic within the Primary Care clinic, Zarin Noor, M.D.:
 - How Covid-19 is transmitted.
 - How to prevent Covid-19 transmission.
 - How the Covid-19 vaccine works and common side effects of the vaccine.
- May 26th, 2021: Children’s Nutrition and Picky Eating
Presenter: UCSF Benioff Oakland Children’s Hospital (Community Advocacy Primary Care) Expert Medical Residents)

Participants learned about:

- Crucial Children's Nutrition information
- Techniques for how to deal with children who are picky eaters

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.

1. Served 225 people. Clients include 36 children (ages 0-15); 11 transition-aged youth (ages 16-25); 40 adults (ages 26-59); and 18 older adults (ages 60+). Please note that we only have demographic information for 105, the remaining 120 did not complete intake information since participation was exclusive to only staff trainings.
2. Completed 40 pre-post assessments with adult case management clients (ages 18+).
3. Facilitated 2 cross-cultural mental health trainings to 120 frontline staff.
4. Provided 10.5 hours of individualized mental health education sessions to 14 Russian-speaking seniors.
5. Provided three 7- week series online psychosocial support groups serving 20 Afghan mothers.
6. Provided 77 clients with bilingual/bicultural case management. Case management clients include 37 children (ages 18 and under) and 40 adults (ages 18 and older).
7. Provided over 100 hours of culturally attuned therapy services to 3 refugee clients with in-house and referred 5 refugee clients to external providers.
8. Facilitated two virtual trainings during the pandemic.

Health and Mental Health System Navigation (Case Management)

- 94 % of the adult case management clients reported upon exit that they were able to independently seek help for mental health services. At entry, 67 % of clients reported that they did not know how to do this.
- 92 % of the 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, 73% of clients reported that they did not know how to do this.
- 100 % of the adult 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, 91 % 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:

- 94% 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. Out of 120 training attendees, 69 completed the anonymous Zoom survey.

Russian Mental Health Classes:

- 78% of participants reported to have a better understanding of when and how to seek help. The other 22% responded “neutral” to the question.
- 100% of participants reported that they have an increased ability to recognize stress and risk factors in themselves and/or family members.
- 100% of participants reported to feel more supported after coming to the group.
- 100% of participants reported to have a better understanding of the concepts discussed in individual sessions.
*Data was collected by instructor after each individual session as a verbal self-report.

Afghan Mothers’ Support Groups:

- 100% of participants reported to have an increased ability to recognize stress and risk factors in myself or family.
- 100% of participants reported to have a better understanding of trauma and how it affects the mind and body.
- 100% of participants reported to have a better understanding of the concepts discussed in group.
- 100% of participants reported to have learned helpful techniques to deal with their own stress and emotions.
- 93% of participants reported to have better understanding of when and how to seek help if I need it.
- 100% of participants reported to feeling more supported after attending the group.
- 100% of participants reported to have learned helpful parenting skills that they will use with their own children.
- 100% of participants reported to apply what they learned from the group in their own life.
* Of 20 clients who participated in support groups, 16 clients completed post-support group surveys. Pre-support group surveys were cut from data collection given it was most clients first time using Zoom. Post-group surveys were kept as staff believed clients would be familiarized enough with Zoom to complete a Zoom survey after the final session anonymously.

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):

1. Is able to independently seek help for mental health services.
2. Is able to 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.
3. Has an understanding of consumer rights in relation to medical care, including the right to seek a second opinion?
4. Is able to apply for health benefits when eligible.
5. Has the ability to communicate with doctors and providers about medical and mental health issues.
6. Has an understanding of health and mental health care systems in Contra Costa County?
7. Has a healthy/expanding support network; household is stable, and communication is open.
8. Has adapted to American culture.
9. For parents: has well-developed parenting skills.
10. For parents: can name at least one parenting skill they can apply at home.

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

1. I have an increased ability to recognize stress and risk factors in myself or my family.
2. I have a better understanding of when and how to seek help if I need it.
3. I feel more supported after attending the group.
4. I have a better understanding of the concepts discussed today.

Afghan Mothers' Support Group Indicators (Yes/Neutral/No):

1. I have an increased ability to recognize stress and risk factors in myself or my family.
2. I have a better understanding of when and how to seek help if I need it.
3. I feel more supported after attending the group.
4. I have a better understanding of the concepts discussed today.
5. I have a better understanding of trauma and how it affects the mind and body.
6. I have learned helpful techniques to deal with my own stress and emotions.

7. I have learned helpful parenting skills that I will use with my own children.
8. I plan to apply what I learned from the group in my own life.

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

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

DEMOGRAPHIC DATA:

Not Applicable (Using County form)

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

EVIDENCE-BASED OR PROMISING PRACTICES

What evidence-based, promising practice, or community practice-based standard is used in your program and how is fidelity to the practice ensured?

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, staff attended a two-part “Diversity, Equity, Inclusion, and Justice” (DEIJ) training presented by our affiliate HIAS. The training aimed to help develop staff’s understanding of U.S. DEIJ concepts, and history, and how those concepts intersect with resettlement work. The training also addressed DEIJ concepts from other countries and the tension between US perspectives and other worldviews of DEIJ. Through this training, staff were encouraged and trained to be DEIJ advocates for their clients with respect to their identities and countries of origin.

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.

Afghan Mothers Support Groups: Given that stress during resettlement can potentially become overwhelming and create strain on family dynamics, our agency’s Afghan Mothers’ Support Groups aims to mitigate the potential negative effects of such stress through the teaching of positive parenting skills as well as relaxation techniques. 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: A Racial Justice Advisory Team has been created at our agency, made up of non-leadership and leadership staff. In addition, JFCS East Bay has hired a DEI consultant to train all staff.

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.

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

Sarah is a 35-year-old Eritrean refugee who was mandated to be in therapy as part of her welfare-to-work Domestic Violence Exemption. She was the only client mandated to be in therapy as a condition of her domestic violence exemption from Welfare-to-Work. When Sarah entered therapy, she was already receiving case management services from our agency and was given the option of whether or not she would also like to receive her therapy from JFCS East Bay or receive therapy from another agency. Sarah chose JFCS East Bay.

During her first therapy session, Sarah did not want to be in therapy. She was guarded, hesitant and answered any intake questions with “yes” or “no.” After thirty minutes of this, the therapist informed the client she wants her to know: 1. she is safe in therapy and 2. The therapy is here to support her. Immediately, Sarah burst into tears expressing her fears of opening up to anyone and sharing that sometimes days are so stressful she does not know how to put it into words. Over the next months, Sarah opened up. She shared her escape from her abusive husband which she had never talked about before, in detail, and the terrible beatings she had endured. She shared her fears of raising a daughter alone in a new country where she doesn’t speak the language and the struggle of trying to be a role model for her. She shared her feelings of isolation, having been ostracized from the local Eritrean community for having chosen to leave her husband. Throughout Sarah’s sessions she worked to process her trauma and learned how her anxiety stemmed from her traumatic life with her ex-husband and being rejected by her own community. Sarah rated her confidence a zero when she first entered therapy and said it was the main goal she would like to work on in therapy. Sarah believed if she could regain her confidence, she could start achieving her goal to create the life she wanted for her and her daughter.

Sarah practiced deep-breathing and progressive muscle relaxation outside of sessions while doing trauma processing in session. As Sarah’s confidence began to improve, she started to set goals: learn English, find work, and make new friends. Sarah made such a dramatic improvement in a few months that she was informed she was no longer mandated to be in therapy. However, Sarah requested to continue because she stated she wanted to keep working on herself and felt she was benefiting from it.

In Sarah’s last therapy session as she was reflecting on her experience in therapy, she stated "I learned how to love myself. I learned about self-care." Sarah reported that that before therapy she "didn't know" how to love herself but with the provider’s help she learned to do so. Sarah expressed that this has helped make her a better mother and that she’s proud of the work she has done to heal. Sarah also expressed she learned how to “set goals” in therapy. (By the end of therapy, Sarah was working and taking English classes regularly as well as making new friends though socially distancing). Sarah rated her confidence as 70% in her final session. Her provider asked her how come she rated her confidence 70% and Sarah responded that to her 70% is a good number because the other 30% of her confidence is up to her to continue to always work towards her goals and dreams. Sarah explained that the 30% will always be there because that’s the part she is responsible for in her everyday actions. She expressed that her emotions are more “stable” now and she has a greater sense of calm even when life gets challenging. Sarah shared that she often takes some of the techniques she learned from therapy, like deep-breathing, and uses them with her daughter.

PEI ANNUAL REPORTING FORM

ACCESS & LINKAGE TO TREATMENT REPORTING FORM

FISCAL YEAR – 2020-2021

Agency/Program Name: James Morehouse Project/BACR fiscal sponsor

PEI STRATEGIES:

Please check all strategies that your program employs:

- | | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Provide access and linkage to mental health care |
| <input checked="" type="checkbox"/> | Improve timely access to mental health services for underserved populations |
| <input checked="" type="checkbox"/> | 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. In 2020-2021, the JMP had a team of eight clinical interns. Over this full year of school closure, interns and staff worked remotely through telehealth platforms across JMP mental/behavioral health programs—this included individual/group counseling, crisis intervention and support and youth development. JMP groups engaged a wide range of young people facing mental health and equity challenges. In 2020-2021, 328 young people participated in 12 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.

Since we began building out our telehealth capacity in the spring of 2020, we were able to hit the ground running in the fall of 2020 and continued to offer individual, group and crisis intervention/support remotely throughout the school year. This included partnering with community-based organizations 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 continued at the high level we took on over the spring of 2020. The JMP stayed connected with school staff, young people, and families, through a range of outreach strategies: setting up a JMP space on Google Classroom, staffing an ongoing drop-in space through Google Meet and collaborating closely with teachers, guidance counselors, the attendance clerk, and our administrative team to ensure that we were able to contact students/families in need. 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.

Fifteen-Twenty people attended JMP led monthly evening English Language Advisory Committee (ELAC) meetings on Zoom. Families learned to access resources in the community and how to advocate for the rights of their children with school staff. Immigrant families also received case management support connecting them to legal, housing, and other family supports in addition to counseling services for youth on-site.

The JMP Director continued her work in Contra Costa County as a trainer for T2, the Bay Area wide collaboration working to shift public systems toward trauma informed practices.

At ECHS, the JMP director worked closely with two new assistant principals to lead the entire faculty in an intensive year-long professional development series around race and equity. Panels of African American recent graduates and African American current parents shared their experiences with school staff, staff met in affinity groups, participated in a BLM in Schools training, examined research and continued to deepen their self-reflection around the ways that white privilege, white supremacy and implicit bias impact instructional practices and school culture and drive inequitable outcomes on campus. Insights learned influence ongoing policy discussions at the school level (e.g., eliminating tracked courses in the English department for 9th-10th grades, deepening equitable grading practices and broadening participation in AP courses schoolwide). This work will continue in the 2021-2022 school year when we return to in-person instruction.

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 2020-2021) 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.
 - From student evaluation: 92% of participating youth reported feeling like “there is an adult at school I could turn to if I need help.”
- Increase in well-being (diminished perceptions of stress/anxiety, improvement in family/loved-one relationships, increased self-confidence, etc.) for participating youth.
 - From student evaluation: 93% of participating youth “I deal with stress and anxiety better” after program participation.
- Strengthened connection to school (more positive assessment of teacher/staff relationships, positive peer connections, ties with caring adults) for participating youth.

- From student evaluation: 72% of participating students reported they “skip less school/cut fewer classes after program participation.
- Strengthened culture of safety, connectedness and inclusion schoolwide.
 - The WCCUSD was not successful in implementing a schoolwide climate survey in 2020-2021. From student evaluation: 72% of participating students reported they “skip less school/cut fewer classes after program participation.

DEMOGRAPHIC DATA:

Not Applicable (Using County form)

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

The JMP completed the County Demographic Form with the exception of the following:

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

Part 3: We capture only 6A, as reported by PS. It is not consonant with our respect for personal sovereignty to ask young people to identify their own sexual orientation, gender identity or disability status based on our need to know. Young people’s identity language belongs to them; they can choose to disclose aspects of their identity in ways that feel useful and owned by them. We do not 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 services are delivered 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. Over the 2020-2021 school year, the JMP moved the referral process online, creating fillable forms that are linked with our customized Salesforce database through our fiscal sponsor, BACR. This was a much-needed upgrade in efficiency and allowed us to track referrals more effectively than the previous system of paper referrals and binders. In addition to this formal process, the JMP also received referrals through texts, emails and calls to JMP staff to connect young people with services. When services are on-site, JMP staff/interns were able to easily follow up with students to ensure that they successfully engaged with (or formally declined) services. This process was more difficult in a remote environment. In the event of a crisis or urgent referral, every effort was made to connect students with services immediately. If there was a need to discern if a student needed to be hospitalized, the JMP partnered with the Seneca MRT in that determination. During school closure over the 2020-2021 school year, MRT staff were

also virtual, and the JMP enlisted the participation of local police departments to solicit a wellness check in-person in students' homes if there was uncertainty around a student in crisis' status. The length of time between referral and entry into services was 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 of these efforts foster resilience and wellness as they engage young people and caring adults in active and robust relationships.

The range of supports and opportunities at the JMP 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.

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.

From a parent letter, June 2021:

“You (JMP) very quickly connected D. with B, a counseling intern, and it was a wonderful connection for D. He had been so isolated, staying alone all day in his bedroom and would not connect with any of his distance learning classes. His connection with D allowed him to feel connected to school again. I'm so grateful for that!”

From a parent letter, July 2021:

I am S' mom and want to let you know how completely awesome the Bridge week was for S.

On Monday morning, he was refusing to even get out of the car. He did not want to go. I finally told him if he doesn't like the first day, I won't make him go to the rest of the week. He got out of the car and went. When I picked him up a few hours later, he had a huge smile on his face and told me he loved it and said he made two new friends! He readily went to the remaining days, each day reporting with enthusiasm how he really likes "his" school and can't wait for the school year to start. Needless to say, I was so relieved and happy for him. Thank you so much for this program!!!

From a graduating senior, May 2021:

Dear JMP family,

The past four years in ECHS were a struggle for me, and the only people that were getting me through this were you guys at the JMP. I wish you all knew how much of an impact you made in my life. When I was a sophomore, I was suicidal, if it wasn't for you guys, I wouldn't be here today. All your love, hugs and care saved me, which is why I'm standing here today, and I just can't thank you enough for all that you have done. Thank you for being my safe space, my home, my family.

JMP Clinical Intern reflection, June 2021:

I was working with a young Asian American woman who was physically/ sexually assaulted at 9 and horribly bullied in middle school. She struggled with feeling silent on zoom and in on-line classes. She joined the Water group (for young BIPOC women) and then worked with me individually for 5 months.

In this time, dealing with lack of motivation towards school, depression, and anxiety. She was able to give a presentation in class without panic; use her voice and articulate her anger and frustration with the existing societal misogyny, somewhere in our work together, she determined that her goal was to return to a state where she was "unapologetically herself" as she was when she was 5-6-7 years old. During our last session, she reported that she felt much more confident and able to recognize and accept her feelings and that she would never have thought she could "have a great life" before therapy.

JMP Clinical Intern reflection, June 2021:

I was working with an African American 9th grader. His grandfather, who was a primary caregiver, died in his presence early in the fall of the year.

- He said "I don't want to go to therapy. I'm fine" to his grandmother. At the end of first session, counselor asked, "How was that? How'd it go?" He responded, "Oh, it was ok. I thought you were going to make me talk about feelings. This is fine." After a couple of months, organically, he began to talk about that loss much more openly, crying. He shared about how he loved his grandpa, talking about memories. Sharing what he had learned at the end of the year, he said, "I'm intuitive & I look at life differently now...Life is so short. You have to live every day to its fullest!" to the counselor, he shared, "you are caring and irritating...just like my grandmother." The counselor shared, "BEST compliment EVER since I know he adores his grandmother..."

PEI ANNUAL REPORTING FORM

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR – 2020-2021

Agency/Program Name: La Clinica de La Raza, Inc./ Vias de Salud and Familias Fuertes

PEI STRATEGIES:

Please check all strategies that your program employs:

- | | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Provide access and linkage to mental health care |
| <input checked="" type="checkbox"/> | Improve timely access to mental health services for underserved populations |
| <input checked="" type="checkbox"/> | 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 who the program has targeted and how your services have helped in improving access to services. Where are services provided and why does your program setting enhance access to services?

Vías de Salud (Pathways to Health) targets Latinos residing in Central and East Contra Costa County and has provided: a) 8,521 depression and anxiety screenings (284% of yearly target); b) 1,180 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 (472% of yearly target); and c) 2,786 follow up support/brief treatment services to adults covering a variety of topics such as depression, anxiety, isolation, stress, communication and cultural adjustment (222% 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) 766 screens for risk factors in youth ages 0-17 (102% of yearly target) ; 2) 233 Assessments (includes child functioning and parent education/support) with the a Behavioral Health Specialist were provided to parents/caretakers of children ages 0-17 (310% of yearly target); 597 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 (199% 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.

La Clinica'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 Clinica's behavioral health clinicians were primarily providing services via telehealth to continue offering essential services to clients. During Shelter in Place orders, La Clinica conducted telephone-based and video conference appointments via a secure platform, although we also did provide some in-person visits to patients who came to the clinic for medical appointments. Starting in April 2021, we increased the presence of our IBH staff on site and provided more in-person visits. However, we have continued a hybrid model continuing to utilize phone and video conference appointments. Given that many visits were conducted via telehealth there was a reduction of the number of BH screening during this time. Since April 2021, we have been expanding the number of BH screening since a larger percentage of our patients are coming in person for their visits. We also developed a workflow and provided training to our Medical Assistants on conducting BH screening during telehealth visits.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

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

Participants are referred to the Integrated Behavioral Health (IBH) team through either their primary medical provider or self-referral. Clients are given an annual behavioral health screen which includes screening for substance use, anxiety, 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 Clinica tracked the following data on an ongoing basis:

- 8,521 out of 3,000 Depression & Anxiety Screenings at La Clinica's primary care sites.
- 1,180 out of 250 assessments and early intervention services were provided by a Behavioral Health Specialists within the FY 19-20
-) 2,786 out of 1,250 support/brief treatment services were provided by a Behavioral Health Specialists within FY 19-20

La Clinica tracked the following data on an ongoing basis: A. 766 out of 750 Behavioral Screenings of clients aged 0 –17 was completed during the 12-month period by parents (of children 0-12) and adolescents (age 12-17) B. A total of 233 out of 75 assessments or visits (including child functioning and parent education/support were provided for FY 19-20C. 597 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 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. In June 2021, the Integrated Behavioral Health Department at La Clinica, began a monthly anti-racism work group to further address the issues of structural racism and how to improve cultural responsiveness to the communities we serve.

The average length of time between report of symptom onset and entry into treatment is 22.5 months. To obtain this data, we did a chart review of 10 randomly selected patients that received treatment this fiscal year.

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

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

Data for gender identity, ethnicity and disability will only be collected by clients seen by a behavioral health provider. Other demographic data is already collected and a standard part of the data collection process for all clients during registration for medical care. It would be burdensome and could harm the client relationship to try to collect this data as part of the screening process during a medical appointment. The Familias Fuertes program serves children and data on veteran status and military status will not be tracked.

For clients under the age of 18, La Clínica collects sexual orientation if it is directly connected to the reason for referral or treatment plan. Given that La Clínica is providing brief treatment, La Clínica wants assessments to be as targeted as possible. La Clínica also wants to be sensitive to the reality that our adolescent population is in the process of forming their identity and sexual preferences and do not think would be appropriate to ask sexual orientation in our entire adolescent client population.

For the Familias Fuertes program, data for gender identity, ethnicity and disability is only collected by clients seen by a behavioral health provider. Other demographic data is already collected and a standard part of the data collection process for all clients during registration for medical care. It would be burdensome and could harm the client relationship to try to collect this data as part of the screening process during a medical appointment.

LINKAGE AND FOLLOW-UP:

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

Participants are referred to behavioral health services through their primary care provider or self-referral. Participants are scheduled into our Integrated Behavioral Health Clinicians' (IBHC) schedules directly from their medical appointment. For more urgent need, clients are scheduled for a same-day or 'warm hand-off' appointment with the IBHC. La Clínica encourages all medical providers to discuss the behavioral health referral before it is scheduled to ensure that participant is both interested and motivated to attend the appointment. If the client does not show to the IBHC appointment, the IBHC will call the client to attempt to reschedule the appointment, which may include clarification of purpose of appointment. If the behavioral health clinician assesses participant to need a higher level of care than our program model, La Clínica will work to link the participant to the appropriate services. La Clínica continues to meet with and support the participant until they are linked and follow up with the recommended service.

For clients in the Vias de Salud and Familias Fuertes program, the average length of time between referral and treatment is 20days. This is measured utilizing the third next available appointment for new patients.

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.

A 51-year-old Caucasian male was referred by their Primary Case Provider (PCP) for depression. The patient has been married to current wife for three years and the living situation is very difficult--living with spouse's ex who has dementia and one of

ex's daughters. There is no bed to sleep in; the patient and wife sleep in recliners next to each other. Additionally, the wife has significant health issues. The patient and wife have been trying to get housing for over a year. IBH connected pt. to La Clinica Case Manager who is helping with housing resources. Both the patient and wife come from previous abusive marriages in which they were physically attacked and hurt; both easily triggered. The patient and wife have considered themselves mutually supportive. One night recently, the patient hit wife hard in his sleep. The patient was given an urgent appt with Integrated Behavioral Health Services. The patient was extremely upset, denied any intent to hurt wife, but wife was triggered, not sure she believed him, and ready for him to leave. After difficult discussion and psycho-ed with the Integrated Behavioral Health Clinician, the patient and wife realized that his hitting her was part of a sleep disorder. The patient was urged to take melatonin at night and call their Primary Care Provider for urgent appointment and referral. Although the patient's PCP was not in the office, another provider was able to provide an appointment and immediate referral to a neurologist. The patient continues to take melatonin which he finds helpful and is keeping all medical appointments. The patient continues receiving IBH support during this difficult time.

A 52-year-old Asian female who has lived most of her life in the US. The patient was married to an abusive and controlling man for 15 years, has been divorced for five. The couple have two teenage children, neither of which want anything to do with their father. The patient's ex has kept patient in court for the last five years with demands for spousal support. The patient has been so angry, traumatized, and depressed that she has been unable to work for some time. The patient is also disappointed with court system. The patient states she has no one to talk to about her situation except at La Clinica IBH. Her parents are supportive, but she doesn't want to upset them. Her children have their own needs. The patient states she doesn't feel she has the emotional strength to join any type of support group at this time but can share her worries and problems one on one. The patient is learning to set boundaries with ex and to take back some control of her own life. The patient states that being able to talk about her situation helps her maintain a stronger and more positive perspective. The patient's PCP has also worked closely with patient., and, after several trials, has found a combination of meds that is helping to control the patient's depression. The patient plans to continue with therapy and treatment through La Clinica.

PEI ANNUAL REPORTING FORM

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

FISCAL YEAR – 2020-2021

Agency/Program Name: The Latina 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 / STRATEGIES:

Please describe the services you provided in the past reporting period. Please include qualitative and quantitative data depicting: 1) the types and settings of potential responders you reached during the past reporting period; 2) methods used to reach out and engage potential responders; 3) any strategies utilized to provide access and linkage to treatment, and 4) strategies utilized to improve timely access to services for underserved populations.

The Latina center offered culturally and linguistically relevant 10 to 12 weeks parenting classes and mental health workshop in community- based settings (School, Churches, The Latina Center office through our platform of Zoom) in West Contra Costa we made referrals to mental health services as well as providing educational and therapeutic, online services.

During FY August 2020–Jun 2021 we serve a total of 309 participants between our parenting classes, mental health workshops, Psycho-educational therapy, support group.

Our community outreach staff conducted calls to recruit and engage parents to participate in our programs, using Flyers, phones calls, Facebook, referrals from the San Francisco supreme court, West Contra Costa County Schools, health clinics, Child, and Family Services (CFS) During this annual reporting period

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

Parenting Class Pre-Survey Results.

- 65% of parents wanted to acquire new skills
- 75% of parents wanted to improve their communication with their children.
- 82% of parents wanted to improve their relationship with their family.
- 55% of parents wanted to learn more about child development.
- 48% of parents wanted to learn more about Mental Health.

54% of participants identified as a survivor of some form of violence (physically, emotional, verbal, sexual, economic abuse) including current or experience with domestic violence (in their childhood, as a teenager or as a adults)

- 25% of children suffered physical abuse.
- 43% of children suffered verbal abuse.
- 32% of children suffered emotional abuse

We continue with our service and parenting classes with referrals from other agencies such as Courts, CFS, Outreach calls, Schools, “word of mouth”

Referrals for Service from other agencies

During the fiscal year Primero Nuestros Niños (Our Children First) have the referrals from other agencies to receive services of parenting classes.

- 9 participants from (CFS) Child Family Service agency.
- 24 participants from Court of San Francisco and Richmond.
- 76 participants from other programs inside The Latina Center to our program.
- 48 participants from other schools.

Referral to other agencies

- 3 participants were referred to Mental Health Child Services
- 15 participants were referred services for a support group.
- 40 participants have benefited from our Community Circles.
- 15 of them have received services from our therapist in Mental Health Javier Nunton which inform is attached.
- 25 participants in community circles from our program of Celebrating Recovery with Community Facilitator.

Mental Health workshops

72 parents received information about some of the most common health problems in our Latino community.

During the fiscal year, 3 mental health workshops were offered and conducted by our expert on the subject, Javier Nunton in which 72 participants registered by filling out a pre and post evaluation, were they mention 75% of the participants recognizes mental health problems as a health condition.

- 25 participants recognize they suffer from slight depression.
- 34 participants recognize they suffer from anxiety.
- 13 participants recognize they suffered from stress.
- 64% participants recognized they suffered from stress and anxiety due to the pandemic and since they stop working.

With more than a thousand views and shares on our social networks the education of this stimulating topic that is Mental Health continues.

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

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

VALUES:

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

- **integrity and confidentiality of the individuals served?**

The Latina Center serves the Latino Community with culturally and linguistically relevant parenting classes structured to support our clients by giving them tools to thrive in their lives, providing a warm hand off one on one coaching, assistance with the help of our experts a well train staff, we also provide a post evaluation at the end of every session to make sure our goal as a program and educator is well received.

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 health services and programs. Our culturally and linguistically relevant program reaches people where they are with strategies that are neither non-stigmatizing nor discriminatory assistance with the process of contacting a crisis line or other program. We refer clients to our partners such as Familias Unidas, Early Childhood Mental Health.

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.

Anonymous: I learned how to express myself with my children, knowing how to listen to them, before I yelled at them all the time, now I put into practice what I have learn, such as the message in YO, I apologize to them when is necessary, they reflect when I speak to them and communication with my children has improve a lot. Thank you.

Anonymous: I learned to have more patience, to practice how to listen reflectively instead of just listening.

Anonymous: I learned to improve my behavior as a parent with my children, also learned that children have their own language.

Anonymous: I learned to use the consequences, now I set healthy limits and I learned to be more persistent with myself.

Anonymous: I learned how to talk to my children and listen to them, I learned how to do family meetings, and that they learned from my example.

Miguel: He has recognized that he needs to change for his children to achieve that change.

Leticia: She started working with her son, setting limits her son's video games and has had good results with his behavior now that he does not have to punish but to guide.

Martin: He is putting into practice understanding and understanding his children better since he grew up during violence between his parents, and has been able to control his emotions, it has felt much better.

Juana: She says that the classes have helped her a lot, now she pays more attention to her children.

Lizette: She says that now she has felt calmer now that she has more communication with her son, and the father of her son.

Ana: I did not know the difference between encouraging and praising, now I realize that I have been praising him all the time and now I understand his selfish reactions to others.

Lina: I have family meetings on Sundays with my children and there we talk about problems and agreements.

Patty: I am working to regain trust with my children by increasing communication with them. She also shared that reflective listening has helped her improve her relationship with her son, since they were not speaking to each other, and it has helped me to know how to talk to him.

Diana: She shared that she used punishment and this program has helped her not to punish because it lowers her self-esteem.

Gabriela: She says she was authoritative now that she learned to use the message in me, she no longer yells at them and now she gives her children options.

Sergio: He shared that before he was angry with his children when they made a lot of noise and it was because he wanted to attract attention, but he admits that he spends a lot of time working and has little time left to live with his children, now he tries not to get angry and listen to what the two of them want to say to you, and now they are doing healthier activities.

Karina: She shared that her daughter feels that she does not do things well and always ask her opinion on how she does things to make herself feel better. Karina says that she behaves insecure and that she is working, applying the options for each question she asks and that worked for me so that she can start to have confidence in herself.

Marlon: He shared that he has improved communication with his ex-wife Karina who is also in the class, now she is working with her daughter, giving her options regarding the things she asks of him.

Veronica: She used to give her daughter punishments and time out, and what she notices is that she got angry a lot later, she felt sad and with a behavior to attract attention, now what she does is apply consequences instead of punishments.

Bebahi: She learned to unite her family with family reunions, and because of the situation of separation and divorce that they are going through.

Maribel: She shared that her children are not expressive at all, and it is because they are the same as their parents from Maribel, and what she learned in class is how to express her love to her children, she sends texts to their phones saying, "I love you" and they respond now the same way.

Zoila: She has put cooperation into practice and that has helped her children to cooperate at home, since Zoila used to do everything around their house.

Carlos: He shared that he has been taking the messages in Yo into practice and they have served him to communicate with his eldest son and to avoid the aggressive discussions that they used to have and disrespect each other. Carlos has learned to control his temper and aggressiveness.

Mario: He commented that he has been learning a lot from the classes and that his communication with his daughter and his wife has improved because every time he wants to communicate with her, he talks with a message in "I" and he has learned

to control his temper, already He doesn't get that angry and one thing he is proud of is that now he is in AA, he has learned to control himself.

Pedro: He was grateful that the police detained him because they sent him to these classes and thanks to the parenting classes, he has learned new ways to improved himself as a better father and person for his family.

Jaqueline: Commented that from what she has learned she feels more confident when disciplining her children and will help her with the court process.

Hipolita: She learned to involve her children for the different responsibilities of the home without making a difference by their ages, they will all do it the same.

Blanca: I have been working with my son applying the consequences and it has worked for her and her son is learning to be more responsible with his belongings. Blanca has had a hard time doing it all this time for her son but now she is learning how to apply the tools from the classes.

Lizette: She learned the difference between punishment and discipline and separating actions from her son's decisions and applying a consequence according to his actions.

Maggie: She learn the difference in listening and hearing that is not the same thing and giving positive attention to her children.

Maria: As a mother, I feel happy with having these tools because I have made many mistakes in the past, and now I feel like my life is stable and clearer on how to guide my children.

Jazmin: She was able to identify the misbehavior of her youngest daughter and what she learns from the classes is how to encourage her.

Herbert: He shared thar these classes are helping him personally to process some of his problems as a person and give a better version of himself to his daughters.

Douglas: He learned to communicate with his son without yelling at him and he gives the importance and the time he needs and is seeing the difference in the response he is having from the child.

Basilio: He understood that communication with his son, knowing how to talk to them and spending quality time with then will improve the relationship and become stronger family. Now I understand that is very important for my child spend time with me.

Betty: She learned that the way she talks to her children is the reason why they misbehave and do not obey, they are afraid of her and that is why they do not talk to her because of her voice and body language

Andrea: I have recognized the difference between motivation and praise, and I have identified in my daughter that I have been praising her all this time and did not understand her behavior, now I will change my strategy to obtain better results.

Doralis: She comments that she uses always a Your messages and that in her ignorance she wanted others to realize how bad they were scamming her, now she recognizes how bad she's been, and she wants to stop doing that.

Hipolita: I hold my family meeting every month and I involved everyone in the responsibilities of the house

PEI ANNUAL REPORTING FORM

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR – 2020-2021

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:

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> | Provide access and linkage to mental health care |
| <input checked="" type="checkbox"/> | Improve timely access to mental health services for underserved populations |
| <input type="checkbox"/> | 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 who the program has targeted and how your services have helped in improving access to services. Where are services provided and why does your program setting enhance access to services?

Lao Family Community Development’s (LFCD) Health and Well-Being Program for CCC Asian Families (HWB) continued to focus on delivering PEI services to 120 unique clients targeting South Asian and Southeast Asian immigrant/refugee/asylee residents living in Contra Costa County. This report covers services provided between July 2020 to June 2021. We served 126 participants from both communities representing a diverse group (Nepali, Tibetan, Lao, and Mien): Nepali (55/63= 87%), Bhutan (5/63=8%, Tibetan 2/63=3 %, other 2%) Laos 52% Mien 33% and Other 10% Majority (54%) were aged 26-59; seniors over 60+ years was approximately 44%; and young adults ages 16 to 25 were (2%). For FY 2020 – 2021, a total of 126 participants were enrolled (105% of enrollment goal for this fiscal year).

We provided navigation and timely access to internal and external services including linkages to mental health and other service providers such as: a) Partnerships for Trauma Recovery in Berkeley, a community based organization offering linguistically accessible mental health care and clinical services; b) Contra Costa Regional Hospital in Martinez, West County Health Center in San Pablo, Contra Costa County Mental Health Services in San Pablo, California’s Employment Development Department, and Highland Hospital in Oakland, all public health facilities for physical health services and severe mental health access; c) La Clinica Fruitvale Free Clinic in Oakland for free physical medical and mental health service, d) Bay Area Legal Aid in Oakland and Richmond, for related services in family violence, restraining orders, and other civil legal assistance, e) linkages to access the American Bar 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 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, Highland Hospital in Oakland, and La Clinica Fruitvale Free Clinic in Oakland; 2) the USCIS office in San Francisco for immigration assistance; 3) Jewish Family and Community Services – East Bay for onsite legal assistance with naturalization and immigration services 4) Federal SSA offices in Richmond or Oakland for SSI benefits or Temporary Protected Status. These access and linkage services were provided for clients by providers located in both inside and outside CCC county in line with participants’ individual service plans.

Enhanced services included: 1) assisting individuals to build connections and links in their cultural communities; 2) strengthening family relationships and communication within their families; 3) reducing stigmas associated with seeking mental health support through education and awareness; and 4) helping individuals learn how to navigate the public and community mental health and well-being systems and in some cases private providers.

The following were activities that were carried out in the first half of the program year:

Strengthening Families Program (SFP) Educational Workshops 1:

LFCD held a total of 10 SFP workshops during the program year. (1 workshop per month from August 2020 to May 2021).

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 2-5 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 conducted via phone, zoom and occasionally in person. Locations included participants’ homes, community parks and community buildings, days and weekends as needed.

From South Asian community, total of 8 SFP workshops from August to March 2021. We did via zoom or in person depending on the client’s time and availability. We focused on graduation and closing out of cases in June 2021.

For our South Asian population, a 2-5 hours 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) Safety Protocol related to COVID 19 2) Parent Relationship Conflicts 3) Mental and Health Insurance Access, 4) Behavioral health in areas of alcohol and drug abuse and its relationship to well-being, 5) Healthy Communication Conflict Resolution skills within the family, 6) Wellbeing and Resilience in the areas of Immigration status such as Temporary Protected Status (TPS), green cards and citizenship, 7) 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.

From Southeast Asian community, total of 10 SFP workshops from August to May 2021. The Southeast Asian population preferred monthly 2–5-hour workshops in addition to weekly sessions as needed to allow clients to make up missed workshops. 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 conducted via phone, zoom and occasionally in person. Locations included participants’ homes, community parks and community buildings, days and weekends as needed.

The top 5 most significant challenges identified by the SEA population were: 1) Stressor outlet and Safety Protocol related to COVID 19 2) Mental Health/SSI related assistance, 3) Affordable Housing Assistance, 4) Health insurance/Mental Health Access, 5) Citizenship and Employment, 6) 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 (Note: LFCD opened continued the Health and Well-Being Community Garden at the San Pablo office and has facilitated individual and peer group support activities at this location.)
- 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

Enrollment and Participants Individual and Family Goals

For the reporting year from July 2020 to June 2021, 126 program participants were enrolled. 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, and free service.
- 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.

Alumni are important for outreach and referrals through their networks to build awareness of the services available. 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. 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 12 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 and private services including mental health assistance, 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.

During the program year, COVID-19 had made a significant impact on our usual in-person Peer Support Groups. Case managers had to get creative to find ways in which our clients could still be supported. The case managers began hosting Facebook Live events bi-monthly focusing on different topics surrounding difficulties living in the pandemic. For example, the topics ranged from isolation, coping with grief after a death related to Covid-19, and financial health during the pandemic.

Additionally, we organized HWB graduation event on 6/27/2021 at 1865 Rumrill Blvd., San Pablo California. Total 126 participants have graduated in 2020/2021 HWB program year. Despite of pandemic situation, we tried our best to provide services and support to our clients. During that event, our program supervisor Ms. Brittany Ferguson, SEA community case manager Mouang Saeyang and SA community case manager Ishwar Sitaula held the event. There were couple of volunteers who helped us a lot during the event time. We had total 72 clients among those 10 were new and prospective clients for the South Asian community. Due to cold weather clients could not stay at the program very long and there was a verity of foods, such as Pizza for the children and fresh chicken and vegetable sandwiches for the adults. There were many gifts to go. Both case managers had distributed gifts and incentives to the participants. Also, both case managers have received 6 gifts cards worth \$25.00 each to give away to our current and active clients. In this way, both case manager has distributed our elderly and needy clients accordingly. In the upcoming social gathering we will have more activities if COVID-19 issues go away

permanently. In this time, our participants have still had a fear of COVID-19, therefore, many of them could not attend the event. Many of them were working during the night shift and could not make at the event. Both case managers, and our program supervisor have thanked the participants for their active involvement in the event and make the program successful. We also thanked all the volunteers for their best efforts.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

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

Participants were given a Pre and Post Lubben Social Networking Scale (LSNS-6) mental health assessment to help identify mental health needs. The LSNS-6 assessment was administered to each individual program participant at the beginning and end of their time in the program. According to program protocol, clients with initial or final scores that indicate a high level of social isolation and/or a lack of social connectivity are recommended and referred for mental health assistance.

The LSNS-6 assessment is a tool that measures social connectivity and gauges social isolation in adults by analyzing the perceived support that the participant receives from family, friends and neighbors. According to Boston College’s School of Social Work, the LSNS-6 “consists of an equally weighted sum of 10 items used to measure size, closeness and frequency of contacts of a respondent’s social network.” This provided quantitative data that measured the effectiveness of our HWB program within the framework of establishing mental health/well-being through social interaction/community building.

NOTE: Based on discussions with clinicians at the Mental Health Services of Contra Costa County, an improved assessment tool will be used to identify mental health needs. The Refugee Health Screener (RHS-15) is a screening tool developed in a community public health setting to detect a range of emotional distress among refugee groups that better aligns with the populations that are served by this program.

A total of 126 clients completed the Pre LSNS assessment and 126 clients completed the Post LSNS assessments. The average progression was 5 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 | 126 | 126 | |
| Average Range | 12 | 24 | 12 |
| (Min) Range | 12 | 19 | 7 |
| (Max) Range | 16 | 27 | 11 |

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 consider 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 purposes. The evaluation forms are reviewed by the program staff and changes were implemented according to the participants' evaluations. Comments in the evaluations included recommendations for cultural activities, outdoor events including using the recently opened Community Garden at the San Pablo office.

The last evaluation tool used was a general program evaluation form that was created by the program staff to measure the participants' comfort level, participants' engagement, and the cultural competency of the program services. The tool was also used to measure the participants' knowledge of accessing services that were related to their mental health and well-being and the impact of stigma on their will to seek services after receive program services. The evaluation was completed via phone by non-program staff that spoke the same languages as the participants.

The results stated that the 95% (120 of 126 respondents) of the participants were satisfied with the program services, and 5% (6 of 126 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, Center for Human Development, Contra Costa Regional Medical Center in Martinez, Highland Hospital in Oakland, La Clinica Fruitvale Free Clinic in Oakland, and East Bay Area Legal Aid in Oakland and Richmond, Law office of Laura A. Craig, Jewish Family Services – East Bay in Walnut Creek, etc.

From July 2020 to June 2021, there were 12 participants that were referred to mental health services because of monitoring clients' mental health status. Most of 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 4 weeks depending on availability of services with an average time of about 3 weeks.

One of our continuing challenges is utilizing the county mental health services as it can take up to 16 weeks to get an appointment. By comparison, access to private low-cost and CBO mental health services takes an average of 3 weeks.

DEMOGRAPHIC DATA:

Not Applicable (Using County form)

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

Please refer to Aggregate Data Reporting Form.

LINKAGE AND FOLLOW-UP:

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

Participants were linked to mental health services and other providers depending on their need and goals identified in the individual service plan. From July 2020 to June 2021, this PEI program referred 12 participants to different agencies inside and outside Contra Costa County using the following step-by-step procedure:

1. We carefully, patiently and attentively listen to the participants in a safe confidential setting as they explained their needs. Through our culturally competent counselors, we begin to establish understanding and trust with the participants.
2. We gave support to participants while helping them develop their individual service plan with step-by-step goals and tasks including identifying linkage providers.
3. Then, we encouraged individual participants to access and seek service provided by others. This process can take from 1 to 8 weeks in duration.
4. Once the participant feels strongly that they can trust us with their confidential information, then we escort them (most of the time) to the provider for the warm handoff.
5. If we are not able to do this, we set up a phone conference call to provide an introduction and assure that there is a translator available when they go to their appointments. We also provide the participants with name and address to assist them. If the provider is not available, we send an email and call while the participant is there to witness this.
6. Next, we followed up with the participant and referral partner within the week. Then we stay in contact either weekly, every two weeks, 3 weeks, or monthly depending on the length of time in their treatment and in the program with more attention upfront until the treatment is complete. Average time from the referral to consultation first appointment, evaluations and then entering the treatment at the referral partners' office is 1 to 8 weeks (depending on availability of interpreters and appointment slots at the outside partners; we have found public providers take longer than CBOs or private).

This is the list of the external services including linkages to mental health and other service providers such as:

1. West County Health Center in San Pablo, Contra Costa County Mental Health Services in San Pablo, Community Health for Asian Americans in Richmond, California EDD in Richmond, Department of Rehabilitation in Richmond, Center for Human Development, Contra Costa Regional Medical Center in Martinez, Highland Hospital in Oakland, La Clinica

- Fruitvale Free Clinic in Oakland, Trauma Recovery in Berkeley, and Regional Center of the East Bay in Concord for physical health services, severe mental health access and/or developmental disability services.
2. Dr. Lee Hee, MD, a private practice medical doctor in Oakland for affordable medical care.
 3. Soledad Miranda, a medical enrollment navigator from Center for Human Development, Mrs. Miranda assist our client with faster and more accessible connection to Medical and Cal Fresh needs.
 4. 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.
 5. Jewish Family Services—East Bay with naturalization and immigration services.

VALUES:

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

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 competency) to the mental health PEI services and providers helps participants to begin their recovery path sooner.

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. They 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 period, we have had several clients with mental health stress as a result of issues concerning immigration, housing, finances and physical health. Here are a few stories:

A 61-year-old Mien client passed her naturalization interview and received her Naturalization Certificate the same day. The client came to seek my support and services almost a year ago. The client has no family in the country and the client has limited English ability and was very stressed about being able to pass her interview. When she enrolled in the HWB program, she was stressed and full of anxiety because she was worried if she was going to pass. The HWB

Case Manager assisted her and assured that she will pass because she is eligible for interpreting assistance from Case Manager. With the support, and multiple study sessions, the client was ready to take her naturalization exam. One year later, the client successfully passed her Naturalization interview. The client expressed how happy she was because now she does not have to worry about her status, and she travel back to her county to visit her family. The completion, and successful passing of her naturalization exam allowed the client to gain a newfound sense of confidence in her English and her ability to advocate for herself in this country.

Another HWB participant G. Acharya, recently purchased a large single-family home in Richmond Annex despite the difficulties during the COVID-19 pandemic. The client was suffering from extreme mental distress and anxiety due to family violence occurring back home. An additional stressor on the client was that they were unable to return home to Nepal to assist with aiding for their ill father. In addition to the family stressors, the client lost his job driving for Uber due to the pandemic. With the assistance of Ishwar, the client was able to develop a savings plan and goal to purchase their new home. The accomplishment has made a significant positive impact on the mental health of the client. And has allowed the client to gain a sense of stability during these unprecedented times.

Lastly, we had a client who was a 62-year-old Male Mien, client was on disability benefits and was discontinued due to lack of health benefits for check up on his illnesses. The client needed his medical coverage so he can refill his medications. The client also experienced a great deal of various illnesses, which includes mental health-depression, high blood pressure, muscles, and bones weakness. Client found out from friends in the community that HWB case manager can assist him with applying for medical benefits. Client came to meet with the Case Manager and was assisted in applying for benefits so the client could regain his financial benefits. However, the client's application was mistakenly downloaded into his son's medical account with the county's end of work. Together, client and case manager connect with a community medical navigator to resolve the issues. Finally, the client's file was found and downloaded in his correct file and now the client's application is approved for his medical health coverage. The client now can go see a doctor and get his medication refill.

PEI ANNUAL REPORTING FORM

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR – 2020-2021

Agency/Program Name: LifeLong Medical Care

PEI STRATEGIES:

Please check all strategies that your program employs:

- | | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Provide access and linkage to mental health care |
| <input checked="" type="checkbox"/> | Improve timely access to mental health services for underserved populations |
| <input checked="" type="checkbox"/> | Use strategies that are non-stigmatizing and non-discriminatory |

SERVICES PROVIDED / ACTIVITIES:

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

LifeLong Medical Care’s SNAP program 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 openness to reveal unmet needs and accept 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.

LifeLong provided services on-site at three housing developments: Nevin Plaza, Friendship Manor, and Harbour View Senior Apartments, as well as at the Native American Health Center. Throughout the reporting period LifeLong provided services in observance of COVID-19 safety protocols and local mandates and ordinances with services provided primarily in a virtual format. Virtual services took place via telephone and zoom and include telephonic wellness checks and social calls, case management and referrals to mental health and community resources, screening for depression and isolation, as well as meal and grocery distribution in person, thanks to donations from Sojourner Truth Church, Help Berkeley, and Bridge Storage and Artspace. While it was deemed unsafe to resume activity groups on-site in person during the reporting period, LifeLong did provide two enrichment events in accordance with COVID-19 safety protocols.

Throughout the reporting period seniors facing isolation, depression, and other stressors benefited from creative activities and supportive interactions with LifeLong staff. A health fair organized in collaboration with the Native American Health Center,

postponed due to shelter-in-place restrictions in 2020, is still on hold. In May 2021, we were able to present 2 live Brazilian music and dance performances in collaboration with Brasarte, a Brazilian Cultural Center in Berkeley. The event also included raffles and audience participation in the dancing. The outdoor performances were safely spaced and masked, following Covid guidelines. Participants identified “A Taste of Brazil” performances as one of the most enjoyable experiences of the year; after such a long stretch of isolation because of the pandemic it provided both entertainment and the opportunity to safely reconnect with the community.

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 clothing.

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.**

LifeLong assesses mental health at the initial enrollment and during regular interactions with case management staff. The SNAP enrollment form includes questions about mental health symptoms and whether participants would like support to access services. The enrollment form also screens for depression using the PHQ-2 and PHQ-9 as appropriate. If the participant is unable to complete a form, staff are trained to ask these questions verbally. In addition to this formal process, we also check in with participants throughout the year to identify emerging issues.

In addition to the use of the PHQ-2, LifeLong historically measures mood, isolation, and program satisfaction through a confidential annual survey developed with consumer input. COVID-19 challenges prevented LifeLong from conducting the annual survey this year. LifeLong is developing plans to conduct the annual survey in FY 21-22. LifeLong staff completed regular wellness checks and social calls to participants throughout the year and administered the PHQ-2 assessment when appropriate. Data on all services provided was collected and submitted through the SNAP program as part of our monthly reporting.

SNAP staff are not mental health clinicians and therefore do not conduct clinical histories/assessments or provide therapy. This information is therefore not available to report. Referrals to mental health providers are provided as follow up to a positive PHQ-2 screen or upon client request.

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.

This year, with the limitations of Covid-19, outreach to new SNAP members primarily happened through our weekly food distribution, which draws SNAP members as well as residents who were not previously involved with SNAP. The food distribution program allows staff to meet new people and build relationships of trust. We offer support to potential and current participants at these events.

Once a resident not previously involved with SNAP, 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 participant is unable to complete a form, then staff asks these questions verbally. For residents who are already involved with SNAP, staff regularly check in on their well-being and offer mental health referrals as appropriate.

For participants who are open to mental health or community support referrals, the SNAP case manager does regular check-ins 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)

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 refer to Aggregate Data Reporting Form

VALUES:

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

SNAP promotes MHSA values to the fullest, as described below:

1. **Wellness, recovery, resilience:** SNAP staff create inclusive, welcoming, and accepting environments where participants support and encourage each other. During COVID-19, in-person activities are limited, but SNAP staff check in regularly via telephone and during on-site food distribution.
2. **Access and linkage:** SNAP offer highly accessible services in the buildings where our target population live, with extensive telephone contact added during COVID-19. 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 and facilitates referrals to mental health resources as needed. If the participant already sees a mental health provider, staff checks in regularly to encourage them to participate with external care providers.
3. **Timely access for underserved populations:** Services are provided directly in the building or local neighborhood (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: SNAP staff use a strength-based approach in resident outreach, engagement and services. When operating in-person, SNAP facilitators create group environments that support diverse social thought processes, energy levels, and abilities, allowing each participant's strengths to surface and shine. Participants can come and go

from groups as they need, and it is each person's choice to participate or not. Participants have become comfortable and trusting enough in these groups to talk freely about their mental health issues, without fear of being judged. While we are mainly "remote" now, we continue to support consumers in a manner that is non-stigmatizing and non-discriminatory (and have normalized food distribution to reduce stigma around food insecurity). In addition, LifeLong staff are offered and regularly participate in training to support non-stigmatizing, non-discriminatory approaches including trauma informed care, motivational interviewing, and cultural humility.

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.

One of our participants who contracted COVID-19 has struggled to recover. The effects have been long-lasting and prevented her from preparing her own meals. The meal distribution coordinated by LifeLong's case manager through Help Berkeley has been the major source of this participant's meals as she continues to build back strength. LifeLong delivers meals to the door, then knocks to let her know they're there. Each week when she gets her meals, she calls to let us know she got them and thanks us.

When offering "A Taste of Brazil" at 2 Richmond locations for participants in collaboration with Brasarte, some residents were hesitant to come outside to join the performance after so many months isolating indoors. Others were uncertain about trying something new like experiencing a foreign language, different music and culture. In the end with encouragement and support to address hesitations both performances were attended at maximum capacity allowable for the current COVID-19 restrictions. The participants reported being extremely moved and grateful for this offering and requested similar events in the future for continue to bring music and dance back to senior residences.

PEI ANNUAL REPORTING FORM

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

FISCAL YEAR – 2020-2021

Agency/Program Name: Native American Health Center- Native Wellness Center Richmond

PEI STRATEGIES:

Please check all strategies that your program employs:

- | | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Provide access and linkage to mental health care |
| <input checked="" type="checkbox"/> | Improve timely access to mental health services for underserved populations |
| <input checked="" type="checkbox"/> | Use strategies that are non-stigmatizing and non-discriminatory |

SERVICES PROVIDED / STRATEGIES:

Please describe the services you provided in the past reporting period. Please include qualitative and quantitative data depicting: 1) the types and settings of potential responders you reached during the past reporting period; 2) methods used to reach out and engage potential responders; 3) any strategies utilized to provide access and linkage to treatment, and 4) strategies utilized to improve timely access to services for underserved populations.

Types and settings of potential responders

Despite the impact of COVID-19 shelter in place, the Native American Health Center continued to use the strategy of outreach by providing prevention and early intervention services to increase the awareness of early signs of mental illness, assist community members to access culturally appropriate mental health services. We accomplished this through virtual Native American cultural groups, community events, mental health and wellness workshops. These services increase social connectedness, cultural connection, and general awareness of community and county resources to improve member's overall well-being while providing an opportunity for linkages to other required services.

Strategies to provide access and linkage to treatment

From July 2020 to June 2021, Native American Health Center (NAHC) served the Contra Costa County Native community as well as underserved and underrepresented populations. NAHC strongly believes that culture is prevention and integrates Native American cultural practices and traditions throughout our programming.

Throughout Contra Costa County, we provide advocacy for the needs of the community and build partnerships with local organizations within our PEI network and throughout Contra Costa County. These partnerships have grown the network of

potential responders for our service population. We can increase access and linkages to treatment that are unique to individual needs and medical preferences. For example, most of the time we are using the 211-phone number to connect members to services. Typically, we call together with the member to ensure timely access to care.

Strategies to improve timely access to services for underserved populations

We conduct an intake to enroll members into our prevention services. During intake interviews (either by phone or virtually through RingCentral) staff assess members for potential 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. 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.

During this reporting period we have pivoted our tracking on Smartsheets, a web-based project management program. This fiscal year, we made 33 referrals to behavioral and related services, for 13 individuals through our early intervention one-on-one services.

Methods to engage potential responders

We engage potential responders through our culturally based services that include peer support, cultural groups and workshops, wellness checks, virtual community events, and one on one resource support. We effectively use collaboration with community partners to support and network while sharing vital resources with each other. This reporting period we served 349 participants, 139 unduplicated through our group, peer support, cultural workshops, wellness checks, virtual events and one on one resource support. All services were provided virtually except for one in-person event.

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. Therefore, 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 virtually and over the phone 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. 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-which 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 Arts Circle

This group has become well established in our Center and in the community and has transformed from in person to virtually. As the group gathers more, the beading skills improve, and they are getting to do more advanced projects. It has 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 are unable to

learn at home. Beadwork is a common practice in the American Indian/Alaskan Native community and the skill is typically passed down through familial interaction. For many urban Natives, this tradition is not as common and by providing this class we have the opportunity to allow members to relearn lost traditions and promote cultural connectedness.

Traditional Drum Circle and Pow Wow Dance Practice

This group is offered virtually for Men of all ages, and often combines youth, adults, and their families. The facilitator teaches various types of Pow Wow 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. Each song is broken down into the English phonetics spelling of the words for members to learn in a visual and auditory way. 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.

Urban Rez Book Club and Story Time

This group has just emerged during the COVID-19 Shelter in Place. During the Drum Group, there had been many questions and stories shared to further enhance the learning of the songs and understanding of the history and traditions of our Native people. We quickly realized there were so many stories to be told there was not enough time and space to tell and share stories. This group is important because it give Native Americans the opportunity to tell our own stories of our people, from our people instead of the misunderstandings and misrepresentations many of us experience in public schools and in the media at large. This group also allow us to teach members about cultural traditions and practices, promotes healing through traditions and spirituality, and provides a sense of identity and cultural connection to our Urban Native community.

Virtual Events

Community events are a fundamental approach to reaching first responders. Traditionally, we host many in person events, such as: Traditional Medicine Workshop, Dream Catcher Making Workshop, Health and Wellness Fair in collaboration with Lifelong Medical SNAP Program, as well as many others. Community events allow us the opportunity to outreach to potential responders and link critical resources to prevent a mental health crisis. The pandemic negatively impacted our ability to host in person events, however also provided an opportunity for virtual collaboration with other programs, expanding our reach and capacity to serve new individuals.

This fiscal year, we were able to hold 4 virtual community events and 2 in-person socially distanced events.

Virtual Running Is My High

This event has been a long-standing event in the community since the 1970s and is normally a friendly competition run/walk. Due to COVID-19 Shelter in Place, we moved the event to virtual platform, planning week-long of wellness activities and events to promote health and wellbeing and social connectedness during a time of isolation. The weeklong wellness activities reached 300 attendees and included the following:

Virtual Cooking Demonstration: This wellness activity was partnered with an indigenous chief from the community, Crystal Wahpepah and Wahpepah's Kitchen. This was a virtual cooking demonstration of traditional indigenous foods. The chief talked about the importance of healthy eating and how to provide self-healing through cooking and eating, of what we put into our foods and into our bodies. The teachings were promoting foods as our medicines.

Virtual Mindful Movement: This wellness activity promoted mindfulness and how to use mindfulness and meditation as a form of healing and promoting a healthy mind to combat some of the stress and anxiety experienced during isolation and the COVID-19 pandemic. During the activity participants learned about what mindfulness is and different breathing techniques. We had a mini discussion and lead a meditation to practice formal and informal mindfulness.

Virtual Zumba: This wellness activity was a fun and energizing fitness dance class to promote movement, and exercise in a fun and safe way.

Virtual Round Dance: This wellness activity promotes fitness in a traditional way. The Round Dance is a traditional social dance in Native American culture. We thought this would be the best way to close out the wellness activities because this dance brings the people together. Traditionally this dance is done at a pow wow or other social gatherings. The dance is done in a circle while holding hands and moving in a clockwise direction taking one step at a time. This is a dance everyone with legs can do, elders, babies, adults and teens. The songs are also a very important part in where the beat signifies the heartbeat of Native American people. We have to keep the drum as a center of all of our traditions.

Virtual Gathering of Native Americans

Prevention staff attended (2) family virtual GONAs and facilitated mindfulness activities. This collaboration was an opportunity to outreach and recruit individuals into early intervention services. This event reached an estimated 60 people.

Virtual Suicide Prevention Media Campaign Event

In collaboration with the suicide prevention programs, the Program Coordinator attended, and facilitated mindfulness activities at the campaign event. This event included a youth-led photo voice project that fostered resiliency and hope. This collaboration was an opportunity to outreach and recruit individuals into early intervention services. This event reached an estimated 27 people.

Virtual Teachings of the Water

In partnership with San Francisco-based Prevention programming, the Teachings of the Water allows community to learn about the traditional and spiritual connectedness water gives to the people. The outcomes of Dr. Masaru Emoto's water experiment was taught to the group, which concludes that the energy you put into water reflects the shape and energy the water holds. We used this fact to encourage participants to give that same logic to how they treat themselves and foster positive thinking and positive self-talk to prevent a mental health crisis. During this event, we had the opportunity to link members to one another during a time of isolation to foster social wellbeing during a vulnerable time. Participants reported

back that they felt more connected to community, and that it is important to share the knowledge of water with generations to come.

39 people attended this virtual event.

In-Person Events

This fiscal year we were unable to host our normal events such as Traditional Medicine workshop, Dream Catcher Making Workshop, and Health and Wellness Fair with Lifelong Medical SNAP Program. However, in June we were able to host our first in-person basket weaving workshop since shelter-in-place, as well as a Mental Health Awareness Month at the Indigenous Red Market with Socially Distanced Beading Circle.

Social Distance 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 workshop 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 in person workshop of the year took place in June and had a total of 13 participants. We were able to meet outside in our parking lot, all socially distanced. Lifelong medical center came over to promote the COVID-19 vaccine and testing site available close by. This event was a huge success as we are able to connect community to valuable resources and connect with our members who are not able to join in our virtual services.

This event is a valuable tool to connect our community with traditional cultural teachings. The weaving technique that is taught is often referred to as a form of meditation because it requires deep focus. This technique is a healing traditional to combat a mental health crisis as it allows individuals to connect their mind and body while making beautiful art.

Mental Health Awareness Month at the Indigenous Red Market with Socially Distanced Beading Circle

This event is a staple in the Native American community at large across all bay area counties. We gather to sing, dance, socialize and practice our culture. Indigenous Artists come to sell and promote their artwork. This is a socially healing event to connect and nourish our social wellbeing and connectedness. The Richmond site of Native American Health Center held a socially distanced beading circle during this event. We gave out beading kits and promoted our weekly virtual group. During this event we were able to connect our community to our services in Richmond. We reached 61 individuals.

Mental Health Awareness Month at the Indigenous Red Market with Socially Distanced Beading Circle

This event is a staple in the Native American community at large across all bay area counties. We gather to sing, dance, socialize and practice our culture. Indigenous Artists come to sell and promote their artwork. This is a socially healing event as a way to connect and nourish our social wellbeing and connectedness. The Richmond site of Native American Health Center held a socially distanced beading circle during this event. We gave out beading kits and promoted our weekly virtual group. During this event we were able to connect our community to our services in Richmond. We reached 61 individuals.

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 Center's program evaluation uses an electronic health record system and a web-based project management system to manage and track data such as member demographics, participation and satisfaction surveys. We discuss the data along with regular debriefs on services at the weekly program status meeting. Additionally, we use a Plan, Do Study, Act approach to improve programming informed by qualitative and quantitative data.

A key piece of community feedback is collected through our annual satisfaction survey normally administered twice a fiscal year. This reporting period, due to COVID-19, we used a web-based platform and distributed the survey in June 2022. We received 6 responses from members engaged in the Center services. Given this was our first year of on-line surveys, we will work to increase the number of surveys and improve survey recruitment.

Outcome 1: Engage 150 community members through prevention service programming.

Result: This fiscal year we engaged 143 community members through prevention programming, 95% of our goal.

Outcome 2: 65% of our members utilizing referral services will be successful in accessing (connecting with) services over a 12-month period.

Result: 100% of the 13 members who accessed individual referrals services were successfully linked to the requested aid, such as food, behavioral health.

Outcome 3: Program staff will participate in 20 outreach events or activities throughout the course of the year.

Result: Program staff participated in 6 events or activities throughout the course of the year.

Outcome 4: 10 participants, including NAHC staff, community members, volunteers and interns, and partner agencies will be trained in Mental Health First Aid.

This fiscal year, we NAHC trained 2 interns and 1 staff in prevention and intervention modalities. This staff participated in Question Persuade and Refer, an emergency response training to self-harm and suicide. She participated in a virtual 8-week San Francisco MHSA certification training that focused on behavioral modalities such as Wellness Recovering Action Plan, Motivational Interviewing, Mental Health First Aid, and Safety Planning.

Outcomes, FY 20-21

Members will have increased access to prevention activities and mental health support.

During this reporting period, 6 of 6 members report they are having an increased ability in accessing resources.

Members will increase their engagement in NAHC mental health prevention and treatment services.

When asked what areas improved due to NAHC prevention services, the 6 participants, reported mental health, emotional stress, substance abuse prevention. In examining the annual data comparing FY 19-20 and FY 20-21, attendance has doubled. In FY 19-20 we offered 506 points of contact in prevention services. In FY 20-21, we offered 1004. This data tells us that members has been an increased engagement in NAHC mental health prevention services since the onset of the pandemic.

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.

During this last year Center staff trained 2 interns in partnership with the SPIRIT (Service Provider Individualized Recovery Intensive Training) Program of Contra County Behavioral Health, Office of Consumer Empowerment and Contra Costa College. This 8-week intensive program trained peer interns the valuable tools necessary to become a Peer Support Specialist. Throughout the program participants were educated on how to use and apply 211 resources to community members, QPR (Question, Persuade, Refer) Suicide training, data entry, Microsoft Office skills, and effective goal coaching techniques.

One Center staff also received training on Question, Persuade, Refer, and participated in an 8-week virtual training that focused on behavioral modalities such as Wellness Recovering Action Plan, Motivational Interviewing, Mental Health First Aid, and Safety Planning.

DEMOGRAPHIC DATA:

Not Applicable (Using County form)

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

VALUES:

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

Historical traumas and mistreatment have resulted in the Native community disproportionately experiencing generational poverty, substance abuse, and mental illness. NAHC aims to address these social determinants of health using a cultural framework. We focus on overall wellness, recovery, and resilience. These principles are embedded in traditions and culture and are aligned with MHSA values.

Our philosophy, culture is prevention, is the driving force behind our service strategies and goals. Traditions and culture are embedded in all our programming. 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 bridging both western and traditional modalities. We integrate health related topics such as 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 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.

Native Wellness Center 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. Our Community Health Workers, serve as system navigators bridging relationships with local agencies, and ensuring members are linked with reliable providers internally and externally.

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.

Our program participants are the heart and soul of our community at the Native American Health Center. Before the pandemic, the Native American Health Center played a vital role in the community for support and a safe space from the busy city life. 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 to bad habits. Throughout this difficult year of shelter-in-place, many of our members expressed their gratitude for the program and staff despite not being able to meet in person.

For example, one member told us that our virtual groups were the only form of human connection they had while isolating at home. This person knew how important it was to stay in tune with their community who grew into family, as we all shared time and space with each other every day through a tiny screen.

Another program participant was able to remain sober through our cultural groups and workshops. This person was taught the value of cultural traditions and practiced spirituality through our Traditional Arts Circle. To make art and sit in the circle, they were required to remain true in their sobriety. They stated to myself and the group as a whole, "beading saved my life." Never in a million years would I have thought that a Native American elder would be willing to teach through a virtual platform because of historical traditions and values always had been in person with hands on teaching. There were many ups and downs with learning new technology, but when this member told us how the Traditional Arts Circle transformed their life, they were even more committed to keep teaching. This sacred Traditional Arts Circle is more than putting beads on a string, it brings in a sense of focus and perseverance to be one's higher self.

Multiple members conveyed their dire need for crucial resources, such as weekly COVID-19 testing and linkage to the COVID-19 vaccine. Serving a community of some of the most vulnerable population in the Bay Area, this connection to resources is our pledge to ensure a healthy community. One of the members who received these resources told us that we saved their life and potentially the lives of those around her. The Native American Health center is committed to linking services as prevention and early interventions of a mental health crisis, a public health crisis and beyond.

PEI ANNUAL REPORTING FORM
PREVENTION REPORTING FORM

FISCAL YEAR – 2020-2021

Agency/Program Name: The Contra Costa Clubhouses, Inc.

DBA Putnam Clubhouse

PEI STRATEGIES:

Please check all strategies that your program employs:

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

SERVICES PROVIDED / STRATEGIES:

Please describe the services you provided in the past reporting period. Please include 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 (2020/2021), 500 unduplicated members (target: 300) spent 58,642 hours engaged in Clubhouse programming activities (target: 40,000 hours). 54 newly enrolled Clubhouse members (target: 70) participated in at least one Clubhouse activity; 16 of these new members were young adults aged 18 to 25 years (target: 12 young adults). In addition, at least 62 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 | 500 | 167% |
| Number of Hours spent in Clubhouse programming | 40,000 | 58,642 | 147% |
| Number of new members participating in at least one Clubhouse activity | 70 | 54 | 77% |
| Number of young adults (age 18-25 yrs.) participating in at least one Clubhouse Activity | 12 | 16 | 133% |
| Number of activities specifically for young adults (age 18-25 yrs.) | 40 | 62 | 155% |

Other services:

Members helped prepare and eat 26,432 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, 376 rides were provided to members to and from Clubhouse activities, job interviews, medical appointments, and more. During the contract year 523 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, 126 postings (target 124) were made on the Career Corner Blog and 6 career workshops were held (target 4). The workshops included 1) Making Friends, September 23, 2020 (49 attendees); 2) Developing Best Friends, September 30, 2020 (36 attendees); 3) Becoming Ready for Romance, October 13, 2020 (39 attendees); 4) Interagency Resource Fair, May 18, 2021 (89 attendees), and 5) Sweep Away Stigma, Mental Health Awareness Month, May 1 - 14, 2021 (147 attendees).

Table 2: Other services provided to Clubhouse Members

| | Target Goal | Actual | % Of Target |
|--|---------------|--------|-------------|
| Number of Meals prepared and eaten at Clubhouse | 9,000 | 26,432 | 294% |
| Number of Rides to and from Clubhouse Activities | No target set | 376 | |
| In-home outreach visits | No target set | 523 | |
| Number of Blog Postings | 124 | 126 | 102% |
| Number of Career Workshops | 4 | 6 | 150% |

For Project C, the SPIRIT graduation was successfully coordinated by the Clubhouse, although it was held in two different events due to COVID restrictions. The first event was a drive through graduation on September 29, 2020 (65 attendees), and the second event was virtual with a video of the drive through graduation and speakers held on October 5, 2020 (179 attendees). The virtual holiday party on 12/11/20 had 376 people in attendance. Multiple agencies delivered meals to guests at their homes throughout the County, and hosted activities to celebrate together virtually. The annual Community Picnic was held virtually on 6/25/21 and was well attended with 361 participants. Multiple agencies participated in the event which included catered meal delivery and lots of engaging activities including Jeopardy, bingo, a music concert, and other fun games.

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 (November 2020) was canceled due to COVID restrictions, but the second Survey was administered in 6 county adult and children's clinics in June 2021.

Under Project D, the Clubhouse assisted County Mental Health in implementing the Portland Identification and Early Referral (PIER) program for individuals at risk of psychosis, First Hope, by providing logistical and operational support as per contract

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services.

- **List of indicators that measured reduction of risk factors and/or increase in protective factors that may lead to improved mental, emotional and relational functioning. Please include how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.**

Project A data is collected upon initial membership in the Clubhouse and then daily through a combination of self-completed forms, surveys, 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 2021, 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 89 (the target was 120), of whom 24 were caregivers and 65 members. Among members in the survey, 3.1% were aged 18-21, 4.6% were 22-25, 30.8% were 26-35, 13.8% were 36-45, 21.5% were 46-59, and 26.2% were 60 years or older. The age distribution is representative of the age range of Clubhouse members overall.

Because not all respondents answered each item, all survey data reported below reflects the responses of those completing each individual survey item. The survey percentages referenced in this report consist of those who 'Agree' or 'Strongly Agree' with the given statement. Those who responded 'Don't know' or 'No opinion' were not included in the analysis.

Caregiver Respite

The data in this report represents only those caregivers completing the survey who reside in Contra Costa County (N=24). Of the 24 Contra Costa County caregivers who responded to the survey, 75% were parents or guardians of a Clubhouse member, 12.5% were the child of the Clubhouse member, 4.2% were siblings, 4.2% were a husband/wife and 4.2% were grandparents.

Caregivers who participated in this year's survey reported the highest level of satisfaction with 100% of respondents Agreeing/Strongly Agreeing that they were satisfied with the Clubhouse activities and programs that their family member attended and 100% reporting satisfaction with the Clubhouse activities/programs that they themselves participated. In both areas the target of 75% was exceeded. Most caregivers (90%) 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. Ninety-two percent of the members agreed or strongly agreed that in the last year, their independence had increased and 100% of caregivers who responded also perceived that their family member had become more independent in the last year. Both these measures finding far exceed the goals of 75% and indicate how important Contra Costa Clubhouse is always to both members and caregivers, but especially during these trying times of COVID

Table 3: Caregiver Respite

| | | Goal | Actual |
|--|----|------|--------|
| Measures of Success | N | % | % |
| % Caregivers reporting Clubhouse activities provided them with respite care | 10 | 75 | 90.0% |
| % Caregivers reporting high level of satisfaction with Clubhouse activities and programs in which their family member participated | 24 | 75 | 100% |
| % Caregivers reporting high level of satisfaction with Clubhouse activities and programs in which they participated | 16 | 75 | 100% |
| % Caregivers reporting an increase in member's independence | 20 | 75 | 100% |
| % Members reporting an increase in independence | 63 | 75 | 92.1% |

Below are some responses from the caregiver survey to the question of what was liked best about the Clubhouse

"I like that the clubhouse members have a safe place to stay active. I love the job search support, job placement, and activities. The members also put on a great show during events, plays, fundraisers, etc. " (Caregiver)

"Based on my son's feedback. The Putnam Clubhouse provides him with an environment where he interacts with people and contributes to others." (Caregiver)

"It provided support and companionship for my son during some difficult times this past year." (Caregiver)

"They create a community for young adults with mental health to have a safe environment." (Caregiver)

"It is a nurturing community" (Caregiver)

Member and Caregiver Well-Being

Several survey items addressed improvements to the well-being of the caregivers and the members in terms of emotional, physical, and mental health. When averaging responses to self-perceived improvement of their own mental, physical, and emotional well-being, 83.6% 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, 98.2% also agreed or strongly agreed that their family members overall health had improved.

The member ratings for their own improvements in these categories averaged 92.7%, far greater than the goal of 75%. The combined family members rated improvement and the member's self-ratings for improvement in these areas averaged 88.2%. Additionally, 93.8% 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) | 17 | 75 | 83.6% |
| % Members reporting increase in their own health (mental, physical, emotional well-being) | 64 | 75 | 92.7% |
| % members & caregivers combined reporting increase in their health (mental, physical, emotional well-being) | 80 | 75 | 88.2% |
| % Members reporting an increase in peer interactions | 64 | 75 | 93.8% |

Other comments made on the surveys by members and caregivers include the following:

"It gives my daughter purpose and meaning when she feels lost" (Caregiver)

"I love that there is such a place where one can go and feel that they are no different from anyone else. My daughter was treated with respect, and it gave her confidence knowing that she can be supported in anything she needs. " (Caregiver)

"Everybody is caring and cordial. Make you feel like you are part of it" (member)

"Supportive and no judgement, could talk about issues in safe place" (member)

"Being in a warm, supportive community of my peers." (member)

Hospitalizations

For the 11th 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 52 active members in June 2021. If data had already been collected for the member in the previous year (June 2020) then this data was entered, and information was garnered for the previous reporting year only (since July 1, 2020). 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 do not 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 52 members, one member was dropped from the analysis because they showed that they had been hospitalized for an extended time (454 days) prior to Clubhouse and represented an outlier to the data of other members. The final number of members included in the analysis was 51. The number of hospital days prior to Clubhouse membership for those 51 members

included in the analysis ranged from 0-68 days, with a mean of 9.12days. Post Clubhouse membership, the number of days hospitalized ranged from 0-82 days with a mean of 2.26 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 .82episodes). After Clubhouse membership, members experienced a range of 0-3 episodes (a mean of 0.12 episodes). In terms of change of episodes, 46% of those providing data showed a decrease in hospitalizations or maintained zero hospitalizations (48%) from before to after clubhouse membership, and 4% showed an increase in hospitalization episodes from before to after Clubhouse membership. One person maintained with one hospitalization episode before and one after Clubhouse membership.

Table 5: Percentage of # of episode changes before and after Clubhouse Membership

| Episode Change (prior &after Clubhouse membership) | N | % |
|--|----|-----|
| Decrease Episodes | 23 | 46% |
| Maintained 0 episodes prior and after | 24 | 48% |
| Maintained 1 episode prior and 1 after | 1 | 2% |
| Increase Episodes | 2 | 4% |
| TOTAL | 50 | |

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 statistically significant decrease in average number of hospitalization days from 9.3days (range 0-68 days) before Clubhouse membership to 2.3 days (range 0-82 days) after Clubhouse membership (t=2.94, df=49, 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.

To investigate the effect of longevity of clubhouse membership on hospitalizations, Members were split into three groups according to their number of years as a Clubhouse member (less than 1 year(n=10), 1 to less than 2 years(n=20), and 2 to 3 years, but less than 4 years(n=20)(see Table 6).Looking at episode change from prior membership to post membership, it would seem that those members who have been with clubhouse for more than a year show a higher percentage of those who had decreased or maintained zero hospitalization episodes prior to post member (95% for both 1-2 years and 2-3 years) compared to those who had been a member less than a year (90%). The findings indicate that longevity of Clubhouse membership is beneficial in helping prevent hospitalizations.

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) | | | | | | |
| Decrease | 2 | 20% | 15 | 75% | 6 | 30% |
| Maintained 0 prior and 0 after | 7 | 70% | 4 | 20% | 13 | 65% |
| Maintained: 1 prior and 1 after | 1 | 10% | 0 | 0 | 0 | 0 |
| Increase | 0 | 0 | 1 | 5% | 1 | 5% |
| TOTAL | 10 | | 20 | | 20 | |

When looking at actual number of Hospitalization episodes Before and After Clubhouse membership (Table 7a) using paired t-tests, the results show a statistically significant decline in number of episodes from Before to After Clubhouse membership for those who have been members for a year or more but no significant change for those who had been a member for less than a year.

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 | 10 | 0.40 | 20*** | 1.50 | 20* | 0.40 |
| Episodes Hospitalization After Membership | | 0.10 | | 0.15 | | 0.10 |

*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 members of less than a year, the decrease for those member 1-2 years was statistically significant (t=3.50, df 19, p<.01). However, for those respondents who had been members for more than 2 years, there was a very slight increase in number of days hospitalized but this was not significant.

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 | 10 | 4.10 | 20*** | 16.60 | 20* | 4.60 |
| Days Hospitalization After Membership | | 0.40 | | 0.65 | | 4.80 |

*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 for those who have been members 2 years or less, a decrease in total days from before to after Clubhouse membership.

Career Development Unit

During the 2020-21 contract year the Clubhouse made career support services available to all members including the 237 members working in paid employment and the 124 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 18 who began jobs during the year and the 14 who returned to school. Of the members completing the member survey who used career services (n=36) 94% 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 (21 had employment goals and 15 had education goals). 100% of members who indicated employment as a goal in their career plan successfully completed their goal and were referred to employers, applied for jobs, and/or has a job interview within three months of indicating goal (target 80%). 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) successfully completed their goal and 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) | 36 | 75 | 94.4 |
| % Members referred to appropriate education resources within 14 days (of those indicating education as goal) | 15 | 80 | 100% |
| % Members referred to appropriate employment resources, applied for a job, or had a job | 21 | 80 | 100 |

| | | | |
|--|--|--|--|
| interview within three months (of those indicating employment as goal) | | | |
|--|--|--|--|

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 all programs and activities, except Rides (members 86%) and Career service (Caregivers 87%). Members were most satisfied with the Healthy Living Program (100%) and least satisfied with the Rides program (86%). Caregivers were 100% satisfied with almost all the programs offered bar WOD (94%) and Careers Development Unit (87%).

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) |
| Healthy Living Program | 100% (45) | 100% (8) |
| Meals | 98% (54) | 100% (18) |
| Work-Ordered Day (Monday–Friday daytime activities) | 98% (51) | 94% (18) |
| Virtual Shelter in Place Programming | 98% (51) | 100% (15) |
| Holiday programs | 98% (49) | 100% (17) |
| Young Adult Activities | 96% (28) | 100% (12) |
| Evening Programming (e.g., Putnam Gamers, Music Appreciation, Time to Unwind, Writing/Reflecting) | 96% (47) | 100% (15) |
| Career Development Unit (assistance with education and/or employment) | 94% (36) | 87% (15) |
| Weekend Activities | 91% (43) | 100% (19) |
| Rides Program (transportation to/from Clubhouse) | 86% (29) | 100% (11) |

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 1, points were averaged 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, Healthy Living, and Meals. For caregivers, the top ranked activity/program was also Work Ordered Day, followed by Career Development Unit, and Weekend Activities.

Table 10: Ranking of Program Activities in terms of Importance by Caregiver and Member

| Clubhouse Programs/Activities | Member Mean (N) | Caregiver Mean (N) |
|---|--------------------|-----------------------|
| Work-Ordered Day (Monday –Friday daytime activities) | 3.72 (32) | 4.00 (10) |
| Healthy Living Program | 3.46 (28) | 2.20 (5) |
| Meals | 3.40 (35)) | 3.00 (12) |
| Virtual Shelter in Place Programming | 3.36 (36) | 2.71 (14) |
| Career Development Unit (assistance with education and/or employment) | 3.11 (18) | 3.83 (12) |
| Weekend Activities | 3.03 (30) | 3.31 (13) |
| Evening Programming (e.g., Putnam Gamers, Music Appreciation, Time to Unwind, Writing/Reflecting) | 3.00 (27) | 2.58 (12) |
| Rides Program (transportation to/from Clubhouse) | 2.55 (20) | 3.00 (10) |
| Holiday programs | 2.32 (22) | 2.89 (9) |
| Young Adult Activities | 2.07 (15) | 2.14 (7) |

*program/activities ranked for Members

Overall, the caregivers and members alike had many positive things to say about the Clubhouse programs and activities:

"I enjoy the work ordered day. There is a lot of work to do. I do enjoy the outings and programs like healthy silvers." (member)

"I liked the incredible variety of programs that the program has to offer, including the virtual programming." (member)

"The clubhouse gives me the opportunity to learn and grow and positively contributes to my learning and growth. the clubhouse is amazing" (member)

"I want to explain above--the virtual programming was so very important during covid --I don't want to look like i gave it a 5 .. but once covid lifts -I think the in-person work ordered day is just so essential and great and is very very important" (caregiver)

"Having my loved one meet new people. Engaging in outings/social activities together. Having my loved on learn & develop new life skills" (caregiver)

Caregivers and Virtual Programming

| Clubhouse Programs/Activities | | Caregiver Response |
|---|----|--------------------|
| Virtual Programming | N | |
| Loved one participated in virtual programming during shelter in place | 23 | 87% |
| Loved one used the Putnam Pantry grocery delivery | 24 | 45% |

Comments from Caregivers about how Virtual Programming Supported their loved one:

Caregivers described how Clubhouse virtual programming supported their loved one in terms of helping with the isolation experienced during Shelter in Place and making them feel connected to others:

"He felt connected. He also led some programming"

"...it provided a huge source of comfort and community and helped with the isolation."

"Kept her from feeling alone and depressed. She had more enthusiasm, joy and blossomed with peace and became more outgoing and happier."

"She was in lots of meetings and had great interaction."

"Through outings, zoom calls, meal delivery, family group support, wrap around, COVID information."

Comments from Caregivers about what they liked about Virtual Programming for their loved one:

"I liked that the clubhouse would keep in contact with their members. It would give them contact with other people during the shelter in place."

"Kept my wife's spirits up, kept her engaged. Kept her from slipping away during Covid. She especially liked the tours of famous places. Never stop doing that!"

"My daughter is able to participate, even from home. Seeing her friends and feeling like she is still apart."

"She loved the Zoom groups as she could choose different things every day and still safe from having to go out. She liked the beginning of the Putnam Peas-in-a-Pod, and the check-ins with Sandy."

"That It was very easy to use, and she didn't have to drive anywhere it was easily accessible and had many options for interactions."

Comments from Caregivers about what they would change about Virtual Programming for their loved one:

Half of the caregivers were completely happy with the virtual programming. A few had some comments on issues they had or of ways they thought the virtual programming could improve.

"Better in person meetings when this pandemic is over."

"Keep it somewhat intact instead of letting it go!!"

"Less cross talk"

"...more physical activities, sports maybe"

"My son really benefits most from in person but virtual helped him to build community"

"Sometime the links for zoom are down"

Comments from Caregivers about continuing Virtual Clubhouse (hybrid programming) beyond Shelter in Place

The majority of caregivers wanted the hybrid model to continue beyond shelter in place.

"Definitely needs to continue"

"I believe it will help so much more individuals who cannot be physically in the clubhouse."

"I think it is a good option for those who still don't what to go into the bldg. and for those who have do half day at the space and half at home. It's also good for members because attendance is limited in the bldg. itself until COVID is more of a thing of the past "

"I think the Virtual Clubhouse is a valuable option for those unable to physically or emotionally attend an in-person event/activity."

"It may have to for some especially those who are immunocompromised"

"It is great to have something for the clients to do even from home. Yes, it's great to get out and be there, however it's good to be seeing people that your familiar with and used to doing things with."

"Please continue the hybrid!! My daughter also has social anxiety, and they are a good way for her to connect wi5 others, which is what she needs."

A couple of Caregivers voiced their preference to stay in-person

"It might be nice; however, I feel in person activities are so much more rewarding"

"I think in person is great for vaccinated members for those who are not vaccinated virtually makes sense"

The Clubhouse was successful in achieving all of its contract goals and objectives for the year 2019-20 contract.

Members and Virtual Programming

Members were asked which Virtual programs they participated in. The responses were open-ended, but a large proportion of members claimed to participate in the Work Order Day. Other programs mentioned included meditation, Spanish with Lily, Book club, ASL, Healthy Slivers, Making Do and Morning Meditation. Over half (54%) of the members reported utilizing the Putnam Pantry.

How did Clubhouse (programming and reach out) support Members?

Members indicated that clubhouse helped support them by helping them with the isolation by staying connected and informed, by keeping them occupied and helping in practical ways such as rides and resume help.

"Amazing, got me out of my shell and to interact with others-led to cohosting groups"

"Gave me less isolation, people to talk to and meet new people"

"Helped me with housing situation. Also, structure"

"It gave me purpose during the day."

"Helped me with resume's, good to check in and see what everyone is doing"

"It made it really convenient for me to connect with the Clubhouse and other members and the programs that the Clubhouse has to offer. It was so helpful when I felt isolated because of social distancing and other circumstances due to COVID -19.

Being able to access the Putnam community provided me the type of support that I really needed at the time. I was also very impressed with how the Putnam Clubhouse switched to virtual programming and made the experience so seamless."

"Mentally and emotionally supportive"

What did you like about Virtual Clubhouse and what would you change?

When asked what they liked about Virtual Clubhouse, members frequently referred to the accessibility and convenience of the program as well as the connectedness it provided to the members.

Being able to access the Putnam community provided me the type of support that I really needed at the time. I was also very impressed with how the Putnam Clubhouse switched to virtual programming and made the experience so seamless. My virtual experience with the Putnam Clubhouse has been very user friendly.

"Access from home, more activities online."

"Accessibility-couldn't participate without it"

"Allows access since transportation is barrier and mobility"

"Being able to connect and participate"

"Being able to see friends"

"Being connected and included"

"Convenient, could leave if wanted to, didn't have to leave house"

"During the shelter in place I was lonely, so I looked forward to speaking to someone"

When asked what they would change about Virtual Clubhouse, many members responded with "nothing" they liked it as it was.

"It is very welcoming I wouldn't change anything"

Some members mentioned the timing of different programs and how they would prefer that to change:

"I preferred Virtual Clubhouse when it was held from 8:30a.m.-5p.m. as opposed to 9a.m.-12p.m. Being as I appreciated Virtual Clubhouse quite a lot, aside from longer hours, I am currently at a loss as to how I might improve Virtual Clubhouse."

"Timing would like later in evening"

"Probably make gamer night longer or make additional nights of gamer night"

"I would bring back work ordered day following lunch until the end of day."

Others mention technical issues or problems with zoom:

"Inconsistency with links"

"ZOOM gets awkward when there are too many participants in one room. Maybe break things up into smaller groups??"

When asked about their feelings about keeping a hybrid programming model for future Clubhouse membership, all but two of the members who responded enthusiastically supported the idea:

"I think it's a great idea. It will keep people connected wherever they are."

"I think it's good because I can be in my own space and communicate comfortably because I have social anxiety"

"I would love to continue virtual along with in-house!"

The two members who were not supportive, were not against the idea, just ambivalent:

"Ambivalent. I am much more in favor of physical attendance!"

"Mixed feelings"

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

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

EVIDENCE-BASED OR PROMISING PRACTICES:

What evidence-based, 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. Arduous 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 is why Clubhouse participants are intentionally called members rather than patients, clients, or consumers. These members work together as colleagues with peers and a small, trained staff to build on personal strengths, rather than focusing on illness. The term “member” reflects the voluntary, community-based nature of the Clubhouse, making clear that members are significant contributors to both the program and to their own well-being. Thus, the term “member” is empowering rather than stigmatizing. Clubhouse membership is voluntary and without time limits. It is offered free of charge to participants. Being a member means that an individual is a valued part of the community and has both shared ownership and shared responsibility for the success of the Clubhouse.

All activities of the Clubhouse are strengths-based, emphasizing teamwork and encouraging peer leadership while providing opportunities for members to contribute to the day-to-day operation of their own program through what’s called the work-ordered day. The work-ordered day involves members and staff working side-by-side as colleagues and parallels the typical business hours of the wider community. Work and work-mediated relationships have been proven to be restorative. Clubhouse participation reduces risk factors while increasing protective factors by enhancing social and vocational skill building as well as confidence. The program supports members in gaining access to mainstream employment, education, community-based housing, wellness and health promotion activities, and opportunities for building social relationships.

Putnam Clubhouse operates under the belief that every member has individual strengths they can activate to recover from the effects of mental illness sufficiently to lead a personally satisfying life. Fundamental elements of the Clubhouse Model include the right to membership and meaningful relationships, the need to be needed, choice of when and how much to participate, choice in type of work activities at the Clubhouse, choice in staff selection, and a lifetime right of reentry and access to all Clubhouse programming including employment.

Additional components include evening, weekend, and holiday activities as well as active participation in program decision-making and governance. Peer support and leadership development are an integral part of the Clubhouse. The programming also incorporates a variety of other supports include helping with entitlements, housing and advocacy, promoting healthy lifestyles, as well as assistance in finding quality medical, psychological, pharmacological and substance abuse services in the wider community.

VALUABLE PERSPECTIVES:

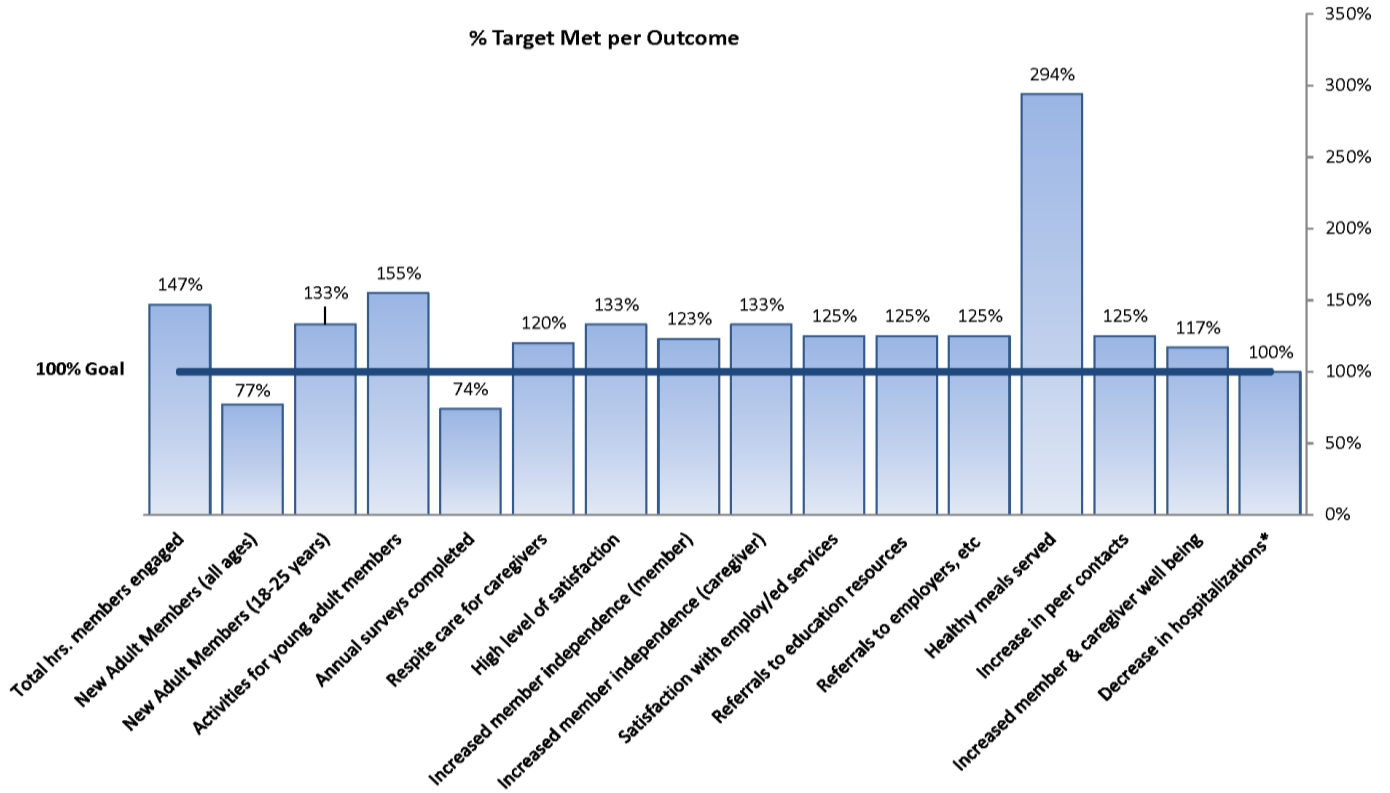
Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

Throughout this report we have included quotes from program participants and family members describing personal experiences and perspectives about the Clubhouse’s impact on their lives.

| | Measure | Outcome |
|---|--|--|
| A | Members will spend at least 40,000 hours annually engaged in Clubhouse programming. | Members spent 58,642 hours engaged in Clubhouse programming. |
| B | At least 70 newly enrolled Clubhouse members will participate in at least one Clubhouse activity, including 12 young adults ages 18-25 years. | 54 newly enrolled Clubhouse members participated in at least one Clubhouse activity, 16 of whom were young adults ages 18-25 years. |
| C | At least 40 activities held for young adult members ages 18-25 years. | 62 activities were held for young adult members ages 18-25 years. |
| D | At least 120 members & caregivers will complete the annual survey. | 89 members and caregivers completed the survey. |
| E | At least 75% of caregivers completing the annual survey will report that Clubhouse activities and programs provided them with respite care. | 90% of caregivers who completed the annual survey reported that Clubhouse activities and programs provided them with respite care. |
| F | At least 75% of caregivers completing the annual survey will report a high level of satisfaction with Clubhouse activities and programs. | 100% of caregivers who completed the annual survey reported a high level of satisfaction with Clubhouse activities and programs. |
| G | At least 75% of caregivers and members completing the annual survey will report that the member’s independence increased. | 100% of caregivers and 92% of members completing the annual survey reported that the member’s independence had increased. |
| H | At least 75% of Clubhouse members who use the Career Unit will indicate that they are “very satisfied” or “satisfied” with the services related to employment and education. | 94% of Clubhouse members who used the Career Unit indicated that they were “very satisfied” or “satisfied” with the services related to employment and education. |
| I | At least 80% of Clubhouse members who indicate education in their career plan (return to school/finish degree/enroll in a certificate program) as a goal will be referred to education resources within 14 days. | 100% of Clubhouse members who indicated education in their career plan (return to school/finish degree/enroll in a certificate program) as a goal were referred to education resources within 14 days. |

| | | |
|---|---|--|
| J | At least 80% of members indicating employment as a goal in their career plan will be referred to employers, apply for jobs, and/or have a job interview within 3 months of indicating goal. | 100% of members who indicated employment as a goal in their career plan were referred to employers, applied for jobs, and/or had a job interview within 3 months of indicating goal. |
| K | At least 9,000 meals will be served to members. | 26,432 meals were served to members. |
| L | At least 75% of members completing the annual survey will report an increase in peer contacts. | 94% of members completing the annual survey reported an increase in peer contacts. |
| M | At least 75% of members & caregivers completing the annual survey will report an increase in mental, physical, and emotional well-being. | 93% of members & 84% of caregivers (88% combined average) completing the annual survey reported an increase in their health and well-being (mental, physical, emotional). |
| N | Decrease in hospitalizations and out-of-home placements of active Clubhouse members. | The program achieved its goal of reducing hospitalizations and out-of-home placements of active Clubhouse members. |

Measures of Success Chart: Progress to Target Annual Report: July 1, 2020–June 30, 2021



*Hospitalizations: Goal met by statistically significant decrease in number of episodes/days of hospitalization/out-of-home placement post-Clubhouse membership.

Prepared by Hatchuel, Tabernik and Associates.

PEI ANNUAL REPORTING FORM

PREVENTION REPORTING FORM

FISCAL YEAR – 2020-2021

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:

- | | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Provide access and linkage to mental health care |
| <input checked="" type="checkbox"/> | Improve timely access to mental health services for underserved populations |
| <input checked="" type="checkbox"/> | Use strategies that are non-stigmatizing and non-discriminatory |

SERVICES PROVIDED / STRATEGIES:

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 fiscal year began amidst the continued COVID-19 Pandemic, school closures, the consequent disconnection students experienced from school, and the lack of community support. However, during this past year, PWC successfully provided our clients services needed to reduce the likelihood of school failure, disengagement, and recidivism that threatened their emotional health due to separation from school and community as the closures persisted

Even though the Pandemic continued to provide challenges to providing services in a safe and secure setting, PWC successfully implemented safety guidelines to secure and provide Mental Health services at its Community Service program. We offered twice weekly zoom mental health counseling to 8th to 12th grade students in Pittsburg in the first half of the year. In addition, PWC simultaneously conducted community service social distancing activities working with Pittsburg City and Cal Works Employees and at the Pittsburg Senior Center by performing landscaping, clean-up, and other activities weekly on Tuesdays, Thursdays, and Fridays. Nicolasa Munoz, a Post-Doctoral Fellow, began to work with PWC in September 2020 from Portia Bell Hume Behavioral Health Center Pittsburg and Paramjit S. Virk Student of Post MSN in Psychiatric Mental Health Nurse Practitioner both from the Portia Bell Hume Behavioral Health Center, Concord. In addition, PWC simultaneously conducted community service social distancing activities working Downtown Pittsburg with Cal Works Employees and at the Pittsburg Senior Center by performing landscaping, clean-up, and other activities weekly on Tuesdays, Thursdays, and Fridays.

The PWC's program/office site was closed to the public this year; however, the clinician, Paramjit, Post MSN, provided brief mental health interventions offsite in the community. He also developed behavioral plans with the youth, worked on social skills building, and offered supportive mental health services as needed. Also, through the community service component of its program, PWC successfully provided support to the schools. Schools were having challenges with students signing on to school via Zoom during school hours; thus, the Students Attendance Review Board (SARB) assigned students to the PWC Community Service Program to perform community service hours due to attendance issues. PWC was creative in providing students the opportunity to earn community service hours during school by signing onto Zoom during school hours and making additional hours for performing physical community service hours after that. While working with Downtown Pittsburg employees and Cal Workers, Lumpy's Diner provided PWC clients with internet and a safe space outside the patio to log on to Zoom and school. At the Senior Center, Park and Recreation Departments Official did the same. Thus, students were successful with completing their required community service hours on time.

While Paramjit, Post MSN, provided community support, Ms. Pope followed the triage model to identify clients with mental health needs, provide resources, and refer accordingly and help link with the clinicians. As the primary clinician for the PWC Clinical Success Program, Ms. Nicolasa reviewed surveys with clients and parents, provided short-term therapy and case management, and coordinated and provided anger management groups via Zoom weekly or as needed. She also assisted PWC with its financial assistance program funded by the East Bay Community Foundation to provide direct financial assistance funding to PWC's clients and families. She provided counseling services to the families as well. PWC provided 82 client families Visa Gift Cards in the amounts of \$200, \$350, and \$500 totaling \$30,000.

PWC reserved Wednesdays for online Community Awareness Workshops to middle-school clients conducted by Ms. Raquel Curran of the Pittsburg Police Department. Discussions included, for example, therapeutic conversations around topics like police brutality and institutional racism. Unfortunately, as the shelter-in-place continues, we delayed much of what we planned for our Green Jobs Training Program for safety reasons. However, we have found innovative ways to keep students on board and connected to the Green Jobs "Eco" Friendly Car Wash Program services, such as offering remote courses in personal financial health and life skill-building, finance, and holding Zoom workshops conducted on Thursdays by Wells Fargo Bank.

Moreover, as the Pandemic continues to impact our clients and families, an essential qualification of PWC's staff is its continued commitment to racial/social justice. Additionally, the team shares the belief that mental and emotional health supports are a fundamental human right (not a privilege) while demonstrating awareness of the disparities that our clients need in terms of access in our community. PWC is committed to on-going professional development to ensure it remains culturally responsive and non-discriminatory in every sense and situation.

OUTCOMES AND PROGRAM EVALUATION:

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 (Please See Attached Appendix)**
- **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.**

Due to limitations established due to Covid-19, our client's mental and emotional health assessment continued weekly through self-report online or telephone check-ins around their emotional state and sense of well-being. Additionally, they meet through online groups and individually for counseling via phone or Telehealth. We offer clients the opportunity to meet

on-site, via phone, through the web while providing additional access to staff members such as central office personnel has been vital in maintaining clients engaged and connected. They are welcomed to myriad online and on-site programs throughout the week to foster a sense of belonging, build resilience and emotional stability. Metrics such as improved school attendance decreased incidents of behavioral problems and completed community hours support the efficacy of our program.

PWC's triage and assessment approach ensures that clients receive the most appropriate level of care. This approach offers clients on-site preventative services in the Community service program and telehealth services for clients interested in individual or group therapy and making referrals to outside mental health services needed. PWC's use of a triage model allows us to maintain clear pathways for client receipt of mental health services. 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 intervention allows her to build the necessary relationships needed to discover each client's needs and provide resources and initial recommendations.

This system allows for initial assessment information to be gathered, facilitating the identification of clients that would benefit from further mental health support services. Ms. Pope then places a referral for the clinician, consults with the client, and provides all pertinent information. The clinician then contacts the client and the client's parent to welcome the family to the program and explains the clinician's role, confidentiality, limits to confidentiality, and informed consent. Once the warm welcome is established, and roles are defined, the clinician reviews the client's initial survey. During this initial contact, the clinician works on rapport building, assessing the client's needs, and building on the client's motivation to engage in treatment through motivational interviewing. Once the client is involved in treatment, ongoing scheduled sessions are established either via telephone or Telehealth.

Additionally, youth become familiar with supportive staff, looking out for additional support needed or signs of distress. The supporting team, in this case, Ms. Adriana, has also played a key role in identifying and linking clients and families to PWC's mental health services. Her cultural competence and bi-lingual skills have helped facilitate the linkage between families with mental health services provided at PWC. This internal referral system, frequent open communication, and clear protocols all play a vital part in making the triage model work, which effectively eliminates barriers to mental health access. 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)**

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.

CULTURAL RESPONSIVENESS:

Please provide quantitative and qualitative data regarding your services.

- 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?**

Here at PWC, its staff and clinical team are aware that the agency's cultural responsiveness begins in each of our awareness and understanding of how our own culture may affect clients' families from racial backgrounds different from our own. Our staff is a diverse group of professionals, including African American and Latinx 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 support one another in conflict prevention. Because PWC's clients consist of many young people of color, understanding 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 manager speak fluent Spanish to communicate and support many clients/families who come from Spanish-speaking homes. Due to the demography in Pittsburg and 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 Program Facilitator. 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 effective when cultural awareness is one of many extensive considerations that involved ineffective treatment.

Our mental health specialist and countless other routines, behaviors, and interventions educate clients with loving sincerity and genuine concern for their safety. We require all clients to break habits like cutting class and other delinquent behaviors that might make them more likely to invite contact with law enforcement. These protective measures are examples of risk reduction measures specifically related to issues of race and bias in our society as they affect the youth of color.

One example of programmatic supports that promotes 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 experiences 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 online 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 characteristics in each other that appear to be irreconcilable. Creating clashes with their personalities is 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 dealing with challenges caused by racial 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 inform guiding principles of cultural proficiency and 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?**

The People Who Care (PWC) Children Association has collaborated with several East Contra Costa County nonprofits throughout the years. Today, PWC and its Executive Director have established relationships with several collaborating agencies/organizations as follows:

The Pittsburg Afterschool Community Collaborative (PACC). Established in 2010, PACC consisting of the Pittsburg Unified School District, City of Pittsburg, Success Through Self (STS) Academy, People Who Care, and many other local programs, was created to support collaboration between critical partners afterschool activities for youth in Pittsburg.

Since 2012, PWC has had an ongoing relationship with Future Build, a nonprofit organization located in Pittsburg, CA. In partnership with the Pittsburg Power Company, Contra Costa Workforce Development Board, Pittsburg Adult Education

Center, Contra Costa Building and Construction Trades Council, Future Build provides a Pre-Apprenticeship Certificate Training to low-income individuals over 18 Pittsburg/Antioch areas of East Contra Costa County. PWC has referred several of its Green Jobs Training Program participants to the Future Build program throughout the years.

In addition, since 2014, PWC's Executive Directors has been a member of the East County ED Support Group, consisting of ED's from Opportunity Junction, Loaves and Fishes, St Vincent DePaul, Village Community Resource Center, White Pony Express, and People Who Care. This group meets twice monthly to provide emotional support, address common issues, and shared knowledge and information. Collaboration through this relationship has benefited PWC and its clients in many ways. For example, PWC and Opportunity Junction, which provides employment training and job placement for low-income adults over 18, has created an employee partnership arrangement. Where OJ has referred, and PWC has hired its former Officer Manager and its current Officer Manager. In addition, in collaboration with Loaves and Fishes, Loaves and Fishes, PWC will provide free lunches for its program participants once PWC open their offices when students return to school in the fall.

Furthermore, since 2016, the People Who Care (PWC) Children Association has collaborated with several East Contra Costa County nonprofits. These agencies include 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. Established in August 2019, the East Contra Costa Alliance (ECCCA) through this partnership, 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. Finally, and most recently, on May 5, 2021, PWC, Monument Impact, and La Clinica in Pittsburg collaborated to provide COVID-19 Vaccine Registration to residents of the El Pueblo Apartments, Contra Costa County housing in Pittsburg. These units contain low-income residents, many of whom are seniors, African Americans, and Latino/a families, including PWC's clients and 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?

Timely access to mental health services is an important ongoing goal. Outreach and community participation are paramount in maintaining visibility among the community while providing multiple forms of access, such as, on-site, internet, or telephone help maintain PWC accessible to the community we serve. Additionally, PWC multidisciplinary relationships have built relationships among the community professionals and paraprofessionals that facilitates our community accessing mental health service through PWC.

Our mental health program is continuing with the theme of self-discovery while beginning to intertwine concepts of teamwork and community building. 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.

Building relationships in the community is particularly important in the process of wellness, recovery, and resilience. Clients have ample time and space to practice serving others by participating and engaging in community events, such as crab feeds, supporting local parades, or participating in City events that celebrate diversity. These opportunities not only provide practice in building social skills, but also improves the client's sense of belonging and sense of self.

Due to the high levels of stigma related to mental health, PWC offers mental health supportive services that take a traditional and nontraditional stance to mental health services. This year one clinician provided onsite services in the Community Service

program. This was a unique approach, which allowed clients to develop a relationship with the clinician while completing community service hours required by SARB or the Court. This also gave the clinician the opportunity to address behavioral difficulties in vivo. Moreover, often 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. By normalizing mental health services and restorative conversations, we de-stigmatize and dismantle preconceptions about therapy and mental health care. It is no secret that mental health disparities are rampant in underserved communities and our program provides much-needed support to our community.

VALUABLE PERSPECTIVES:

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

Clinician Vignettes:

The following stories show the diverse perspective and background of PWC's participants, as well as the traditional and non-traditional mental health strategies utilized by the program to support and help clients and families succeed. Please note that to respect confidentiality and HIPAA regulations pseudo names will be used and identifying information will not be included. Federico was referred to the organization by his probation officer. Initially Federico was not interested in therapy, or anything related to mental health support. Federico was not required to receive mental health treatment, and so the clinician simply introduced himself and made himself accessible and visible to the client. The clinicians' visibility and accessibility created a sense of safety leading to the client responding to and seeking mental health support. Once the therapeutic relationship was established, the client began to open up to the clinician and discuss experiences of loss and abandonment. The client slowly after began to increase his group participation which is evident of his increased self-esteem. Not only did Federico complete his court mandates, but eventually took on a leadership role among his peers and was referred to a youth training program after he completed his required court mandates.

A second client, Margaret, also came into PWC for community work needs as part of legal mandates; however, Margaret was familiar to PWC staff as she had participated in the Greens Job program in the past. The client had a significant history of angry outburst and disruptive behavior in group settings. Margaret had experienced difficulties maintaining positive relationships with peers and reported significant conflict with her mother. The trusting relationship PWC staff had developed with Margaret facilitated and helped get through the mental health stigma this particular client had. Throughout consistent efforts and encouragement from PWC staff the client agreed to speak with a clinician at least once. Once the clinician spoke with the client, the client agreed to meet for a few more sessions which ultimately led to her active participation in therapy. The client eventually opened up and began to process past experiences of sexual trauma, intimate partner violence, and grief and loss. She not only completed her required legal mandates, but she successfully interviewed and obtained employment. She continued to work with the clinician in therapy even after completing PWC's program and her relationship with her mother began to improve.

Another client who I will call, Mario, was referred to PWC by the school system due to truancy. Mario had recently immigrated to the USA, and unfortunately, he was not aware of how the school system worked and failed to inform the school that he was ill when absent. Mario presented as a polite and kind young man; however, PWC's office manager began to develop a relationship with his legal guardian who disclosed to the office manager that Mario had been abducted in his country of origin and held for ransom. This incident led to him coming to the USA. The client was then referred to the clinician. Mario was not interested in individual therapy, but he agreed to check in with the clinician in addition to participating in group therapy. In

group therapy, Mario was engaged and actively participated despite his limited English knowledge. The clinician utilized the weekly calls to educate the client on how to navigate the school system and helped him identify main contacts in the school setting. Additionally, although Mario's aunt was not a client herself, the clinician also provided the space for her to express her concerns and share her story.

Lastly, Marquese was a young man who was referred to PWC by his probation officer. Marquese was referred to the clinician by PWC staff due to high levels of stress per client's report. Marquese was another client that was not interested in traditional therapy; however, he agreed to weekly check in calls. Initially the check-in calls were brief, yet as the client began to feel safe and a relationship was established, the client openly shared about his mother's financial hardship that resulted in him and his mother being homeless. Marquese and his mother luckily moved in with family relatives. The clinician used brief motivational interviewing interventions during the check in calls, often pointing out Marquese progress and encouraging his good work.



The purpose of this evaluation is to help discern if program elements and activities are resulting in significant outcomes for targeted youth. Thus, the focus is to track the progress of the objectives set for the program at the beginning of the year according to funder expectations as aligned with actual program activities as follows:

1. PWC Knowledge Test-A participant pre-/post-test designed to measure Financial Education and Entrepreneurial knowledge was not created for this fiscal year due primarily to challenges encountered due to the pandemic.
2. PWC Student Survey–Replicated as previously approved by Mental Health Administration staff, this year's participant pre-/post- PWC designed the survey to measure the following: resiliency, community support; recidivism; and program satisfaction.

Students take the pre-survey at program intake and the post-survey at the end of the usually 12-week program. As shown in Table 1, we divided the participants into cohorts based on when they started the PWC After-School Program. It is important to note that many students chose to re-enroll in multiple courses upon completion. To that end, we recorded these students' surveys and stated the methodology used for the analysis.

Table 1. Participant Survey Administration (July 1, 2019 – June 30, 2020)

| PWC Survey | | | | | |
|------------|----------------|--------|------------------|------|------|
| | Participants N | Cohort | Period | Pre- | Post |
| Quarter 0 | 30 | 0 | July-September | 30 | 27 |
| Quarter 1 | 33 | 1 | October-December | 30 | 26 |
| Quarter 2 | 67 | 2 | January-March | 62 | 58 |
| Quarter30 | 29 | 3 | April-June | 29 | 23 |

School Day Attendance Data from Pittsburg Unified School District (PUSD)

Due to the pandemic and school closure this fiscal year, student attendance data was not available. However, as previously mentioned, PWC was very successful with assisting schools in approving student's school attendance by having students on community service log on to school and participate in school activities during school hours while also performing their community service hours.

Probation Data from the Contra Costa County Juvenile Services Department

PWC provided the Contra Costa County Juvenile Services Division, Director of Field Services, a list of the program participants and duration in the PWC After-school program. PWC asked the Director to report on the number of students who committed an offense or who re-offended or went to the juvenile hall during their participation in the PWC After-School Program.

EVALUATION FINDINGS:

In this year of implementation, PWC continues to make notable progress in assisting at-risk youth in striving for a higher quality of life by providing them with a safe and supportive environment to get vocational training, mentoring, counseling, and peer group support. Clients are encouraged to stay in school, develop goals for their future and lead a purposeful, healthy life. The following pages summarize the program's progress this year as related to its tangible goals and targets.

Outreach and Participation

PWC planned to serve a targeted number of 175 unduplicated participants in this reporting year. (See Table 2.) the actual number of unduplicated participants was **140**.

Table 2. Program Participation by Quarter (July 1, 2019 – June 30, 2020)

| | #Students (duplicated) served each Quarter | #New students served each Quarter |
|--------------------------------------|--|-----------------------------------|
| Quarter 1 July-September | 30 | 30 |
| Quarter 2 October-December | 33 | 19 |
| Quarter 3 January-March | 67 | 56 |
| Quarter 4 April-June | 29 | 35 |
| Total Served | 159 | 140 |

Our data collecting methods help to maintain clients' confidentiality. The client's confidential personal data are assured by following strict guidelines for collecting and managing the 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.

Goal 1: Enhance the Quality of and Access to Resources

Objective 1.1: 65% of the total number of green jobs program participants will increase their knowledge and skills related to entrepreneurship, alternative energy resources and technologies, and "green economy" according to program curricula for the duration of their program participation. Result. As indicated above, unfortunately, as the shelter-in-place continued, we delayed much of what we planned for our Green Jobs Training Program for safety reasons. However, we have found innovative ways to keep students on board and connected to the Green Jobs 'Eco' Friendly Car Wash Program services, such as offering remote courses in personal financial health and life skill-building, finance, and holding Zoom workshops conducted on Thursdays by Wells Fargo Bank. Although this objective did not meet the 65% target 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 175 youth program participants will show improved youth resiliency factors (i.e., self-esteem, relationship, and engagement.) **Result:** Of the 117 students enrolled in the after-school program which answered the resiliency questions on pre-and-post Student Surveys, 81% demonstrated improved resiliency. This percentage exceeds the target objective that 65% of participants would demonstrate resiliency.



Objective 2.2: 75% of the 175 youth program participants will not re-offend for the duration of their program participation. **Result:** PWC provided the Contra Costa County Juvenile Services Division, Director of Field Services, a list of the program participants and duration in the PWC After-school program. PWC asked the Director to report on the number of students who committed an offense or who re-offended or went to juvenile hall. Of the 23 probation students enrolled in PWC After-School Program, (99%) did not re-offend during their participation in the PWC After-School Program. This percentage exceeds the target objective of 75% of participants will not re-offend during their program participation.

Objective 2.3: 70% of 175 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 117 students enrolled in the after school the program which answered the survey questions about caring adults on their post Student Surveys (72%) indicated that they had caring relationships with adults in their lives. This percentage exceeds the target objective that 70% of participants would have a loving relationship with an adult in the community or at school during their program participation.

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 and a 60% decrease in school tardiness among the 175 youth participants for the duration of their program participation. **Result:** As previously mentioned, due to the pandemic and school closure last year, student attendance data was not available; however, as also previously mentioned, PWC was very successful with assisting schools in approving student's school attendance by having students on community service log on to school and participate in school activities during school hours while also performing their community service hours. Thus, PWC was very successful in meeting this goal of improving school day attendance.

Summary of Findings

| Outcome Measure | Target | Actual | Percent |
|---|--------|--------|---------|
| 65% of the total number of green jobs program participants will increase their knowledge and skills related to entrepreneurship, alternative energy resources and technologies, and “green economy” according to program curricula for the duration of their program participation. | 65% | N/A | N/A |
| 65% of the youth program participants will show improved youth resiliency factors (i.e., self-esteem, relationship, and engagement.) | 65% | 81% | 124% |

| | | | |
|--|-----|-----|------|
| 75% of the youth program participants will not re-offend for the duration of their program participation. | 75% | 99% | 132% |
| 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% | 72% | 103% |
| There will be a 60% increase in school day attendance among youth participants for the duration of their program participation. | 60% | N/A | N/A |
| There will be a 60% decrease in the number of school tardiness among the youth participants for their program participation. | 60% | N/A | N/A |

Overall, PWC has fully met its targets in regard to the resiliency items in the surveys. One of the most significant tributes to the program is that the youth continue to choose PWC to complete their community services hours, despite the ability to achieve their hours with other programs, churches, or in another city.

The above data indicates that the PWC Program serves the high-risk youth population that it has always intended to do. In addition, this fiscal year, we planned to provide services for 175 multicultural youth residing in the Pittsburg communities; however, despite the pandemic and school closure, a total of 140 unduplicated students participated in the program as of June 30, 2021. This year PWC Clinical Success After-School Program has been an enormous success.



PEI ANNUAL REPORTING FORM

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR – 2020-2021

Agency/Program Name: Rainbow Community Center of Contra Costa County

PEI STRATEGIES:

Please check all strategies that your program employs:

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

SERVICES PROVIDED / PROGRAM SETTING:

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

Rainbow Community Center implemented community outreach and early intervention services targeting members of Contra Costa County’s Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, plus (LGBTQI+) community with a special emphasis on reaching LGBTQI+ seniors, people living with HIV, transgender community members, and community members with unrecognized health and mental health disorders.

Pride and Joy (Tiers 1 and 2) activities raised awareness about existing mental health/health disparities within the LGBTQI+ community such as community members’ increased rates of depression, anxiety, suicide, substance abuse and victimization (e.g., bullying, family rejection, Intimate Partner Violence ‘IPV’, sexual assault, and hate violence). The programs described in further detail in this reporting section assisted our historically underserved community members in finding culturally affirming/welcoming health and mental health support services and increased their ability to cope with oppression when they accessed health and mental health services delivered by Rainbow Community Center of Contra Costa County.

Increases in isolation, depression, anxiety, and vulnerability to multiple intersections of trauma remained acute particularly for those community members who are marginalized due to race, socioeconomic status, and other risk factors. Rainbow thoughtfully and rapidly adjusted its outreach and service model to move most of its services into the virtual platform. In addition to responding to the ongoing public health emergency, the projects outlined here continued to deliver health promotion messages and increase LGBTQI+ community members’ knowledge of local and national resources available to

provide mental health support – including Contra Costa County’s Access Line, 211 services, CC County HIV/STI testing services, local domestic violence and sexual assault services, national suicide helplines and East Bay health and mental health services.

Clinical Services Provided:

In our Clinical Department we switched our mental health services to virtual while continuing to improve access to services. The availability of virtual clinical services has increased and enhanced access, particularly with our adoption of Simple Practice as an electronic health records platform. Furthermore, the addition of a Medi-Cal Billing Specialist to our staff enabled our agency to authorize clinicians to provide services for Medi-Cal recipients and streamlined the ability of clients to receive those services. In the past year, we have seen a significant increase in the demand for our services from various parts of the state along with an increased demand in more remote parts of the county. As our virtual outreach has increased to meet the demand, we have been able to offer LGBTQI+ clinical support groups in schools, for example, that have been offered district-wide rather than being limited to individual sites as was the case prior to the pandemic with our in-person service model.

Senior Services Provided:

Prior to the pandemic, Rainbow Community Center’s Senior Program (RCCSP) offered a senior luncheon the first and third Friday of every month, where regular and newcomer senior attendees socialized, ate healthy meals, and gained information from other community resources. Due to COVID-19, we had to adapt our services. During this last fiscal year, while in shelter-in-place, we launched virtual services for all our “lunch programs.” In the fall of 2020, we added a virtual support group for Older Adult Women entitled “Women of the Rainbow” which has enabled us to serve women identified community members who have suffered isolation and lack of community exacerbated by the pandemic. For several older adults who lacked technology skills and adequate technology, we started our Tablet Program which provided loaner tablets for seniors in order for them to gain experience with handheld devices and enable them to attend social zoom events, furthering the impact of decreasing feelings of isolation and depression for all who participated.

In addition, we were able to offer a handful of limited in-person interactions after the restrictions on outdoor in-person gatherings were lifted in the spring of 2021. RCCSP coordinated free congregate meals to LGBTQI+ seniors at various local restaurants in Concord and surrounding areas. We continued with virtual luncheons via video conferencing every two weeks. The Older Adults Program Manager organized volunteers to outreach to 200+ senior clients to encourage luncheon participation, which increased to weekly check-ins during this past year of shelter-in-place. In the fourth quarter of the fiscal year alone, we provided case management/wellness calls to 60 seniors, totaling 110 phone calls.

Our adapted Friendly Visitor Program (FVP) was facilitated to help members with various needs, providing resources and referrals, such as: reducing isolation in the community, assessing their supply needs, physical, mental, emotional, and overall wellness. Additionally, our Older Adults Program Manager continued to cross collaborate with RCC’s HIV Prevention Manager. This collaboration helped with health promotion for older adults through outreach, free testing services and referrals to PrEP and PEP education and navigation, which primarily occurred via virtual promotion and mobile in-home testing services, along with limited testing at RCC’s Concord location.

In collaboration with our Housing and Youth Care Manager, seniors received meal deliveries as part of our Kind Hearts Food Pantry Service described in detail in the next section. As part of that collaboration between the two managers, we restructured the distribution of the Senior Nutrition Program to enable client choice while receiving their nutritional package. During shelter-in-place with cross collaboration with our FVP and SOAP programs we were able to assess seniors’ needs and facilitate a delivery service, providing basic materials, health/medical supplies, and all other necessary items.

Our Senior Outreach and Advocacy Program (SOAP) addressed the needs of seniors living or transitioning into higher care. The goal of the program is to ensure that our senior members are respected as they transition into these facilities, i.e., appropriate pronouns, access to gender appropriate clothing, visitation rights for partners, etc. We utilized the time while in shelter-in-place to strategize on how to outreach and promote SOAP and other senior program services.

In addition to SOAP and Friendly Visitor, senior programming provided individual case management on an as needed or long-term basis. Clients benefitted from a myriad of services as well as internal and external resources and referrals to other agencies through our many regional partnerships.

Kind Hearts Food Pantry Services Provided:

Rainbow Community Center's Kind Hearts Food Pantry (RCCKHFP) delivered 148 meals and food resources to 24 unduplicated and 49 duplicated LGBTQI+ Seniors (55+), and HIV positive community members throughout Contra Costa County this past fiscal year. Additionally, due to COVID-19 restrictions and safety concerns for our staff and volunteers, we successfully partnered with Monument Crisis Center, and the Food Bank of Contra Costa County which provided an off-site pick-up location (1990 Market St. Concord, CA 94520), food, and Ensure food supplements for community members with a positive HIV diagnosis. Additionally, RCC partnered with the county's Extra Helpings Food Program which specifically supplements community members with nutritional support with immunocompromised statuses and diagnoses.

Our program implemented separate COVID-19 safety protocols consistent with wearing masks, maintaining safe recommended distances, providing gloves, and serving aprons to all our staff and volunteers. As the virus, along with the Delta Variant, continued to spread throughout Contra Costa County we promoted safety for our community members, offering "social distance" drop off services, leaving food and resources in a pre-designated area or at the client's front door when requested. As a result, we received more requests for food service deliveries amongst our Seniors, community members with a positive HIV status, and marginalized populations, including LGBTQI+ people of color, and Black Trans identified community members in the county we serve.

Youth Programs Services Provided:

The Rainbow Community Center Youth Program (RCCYP) pivoted from in person to virtual programming for this past fiscal year. This program supported 200+ unduplicated LGBTQI+ Youth and Allies utilizing virtual platforms and a handful of in person sessions after the state reopened in June. Additionally, we collaborated with Acalanes Unified School District and offered a virtual six-week QscOUTs LGBTQI+ Allyship training for students. All training was led by our Youth Program Outreach Coordinators. Other virtual programs included weekly Gender and Sexualities Alliances (GSA) support groups, hybrid support for the Parents/Guardians of Transgender & Gender-Nonconforming Children group, Action Changes Things High/Middle School Workshops, and Artistic Expression for LGBTQI+ Youth.

We will continue to expand our programs with safety first as the Delta Variant continues to spread and increase LGBTQI+ Youth rates of isolation and mental health risks according to the Trevor Project's two research studies conducted three months into the pandemic and in May 2021, a year into the pandemic: <https://www.thetrevorproject.org/survey-2021/> Additionally, we are outreaching to more at risk youth that are marginalized, Black Trans identified, and people of color throughout Contra Costa County offering Sexual Orientation, Gender Identity and Expression (SOGIE) training, QscOUTs training, and more partnerships with school districts in West Contra Costa County.

HIV Services Provided:

Our HIV Prevention outreach has been strongly present during this fiscal year. We have been focusing on targeting many of our underserved communities as well as covering multiple areas in Contra Costa County. Virtual outreach increased and was directed in many of our social media platforms such as Facebook and Instagram with targeted email blasts as well as dating apps like Grindr. When COVID-19 restrictions were lifted in June, we managed to create multiple events in different cities, where we spoke about all the services we offer through our agency. We have been learning continually that many of our community members have been experiencing increased depression and isolation. Because of this awareness, we were able to be responsive and offer multiple programs where our clients felt welcomed, cared for and seen.

The HIV Prevention Manager continued to organize “Men Who Have Sex with Men” (MSM) targeted groups and events that helped promote all our services. Those services include Contactless HIV, Gonorrhea and Chlamydia Testing along with Contra Costa County’s “Home Is Where the Swab Is” mobile in-home testing alternative. We also stayed in touch with many clients who called to receive information about PrEP, Testing, Social and Support Groups and our Safer Sex Packages Drop Off Program. We continued to offer a range of monthly social groups which all pivoted to virtual including “Amigos” for our MSM Spanish-speaking clients, “Mocha” for our MSM of color that are living with HIV, and our “Social GuyZing” group that is open and welcoming to all male identified folx including transgender and non-binary men.

During periods of allowable outdoor gatherings, we were able to offer a small number of in-person socially distanced events including a successful Day of the Dead event in November in Brentwood that targeted LGBTQ Latinx community members who were all new to our services. In the spring we continued to pilot pandemic relief in-person gatherings which brought in new clients eager for social connection, some of whom were less interested in on-line/virtual support. Returning and new clients welcomed in-person gatherings and celebrated the opportunity to reconnect and socialize face-to-face.

HIV Services for Seniors Provided (Weekly HIV+ Support Group):

The Rainbow Community Center’s HIV Prevention Program has continued to offer various groups for MSM individuals each month. These groups include a weekly HIV Support Group where attendees have a safe space to share health and personal concerns. The group’s attendance has been remarkably consistent during COVID-19 restrictions and during the shifting landscape of occasional lifting of some of those restrictions. Many long-time group members have gradually joined the virtual meetings, continuing to focus on one another’s health in a supportive communal environment. As some shelter-in-place restrictions were lifted, we were able to offer the option of an outdoor dinner once a month while continuing to hold online support groups after the dinner gathering, ensuring that all members enjoyed the social aspect of the group whether or not they could participate in-person.

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.**

Quantitative and Qualitative Data Summary:

During FY 2021, RCC served a total of 677 unduplicated clients. Tier 1 and Tier 2 reached 396 unduplicated clients. Tier 1 provides community-based programming through events and outreach. Tier 2 is group-based programming such as support groups and food pantry deliveries. Community event and outreach numbers dramatically decreased during the pandemic due to the inability to hold in-person gatherings for most of the fiscal year; however, we had a significant increase in our return rates of clients for support groups conducted via telehealth.

Tier 3 served a total of 281 clients. Tier 3 is our one-on-one clinical services such as school-based counseling, clinical counseling, and case management. 2009.68 hours of services were provided to clients with Tier 3 alone. Our school-based counseling dramatically dropped because schools were closed during the pandemic. Limits on partnerships and constraints of “virtual school” presented few options to offer 1:1 clinical services or support group options in partnership with public school districts and other educational agencies.

Even with those restrictions we were able to offer some services to schools through contract agreements for virtual services and through our receipt of a Kaiser Grant for Trauma Informed Support Group Services at two secondary school sites (one in Mount Diablo Unified and the other in West CC Unified). Overall, we saw a dramatic increase in the community’s need for individual mental health counseling with challenges of waiting lists echoing the demand.

(Note: The data presented above does not include reporting of our virtual events, post pandemic events/outreach, training and housing data.)

Participant Identification (Assessment and Treatment), Length of Time between Onset and Treatment, Indicators, Data Collection and Evaluation including cultural competency:

Clinical participants are identified through assessing functional impairment. We also assess people for Domestic Violence and Substance Abuse for referrals outside of our agency. While we do treat acute diagnoses, we are not a Crisis Center. The average length of time between symptom onset and entry into treatment is dependent on our waitlist rather than symptom severity. Data is collected through various assessments at the beginning of each treatment plan along with as needed and annually. If something needs to be changed in the treatment plan, clinicians pivot accordingly because of those regular assessments. Each clinician is required to participate in an annual cultural competency training offered by the county through Relias. We also offer psychoeducation sessions for our Mental Health professionals on how to work with LGBTQI+ folx.

For Tier 3, clinicians and case managers submit service logs once a week. The RCC Data Specialist creates a report based on the service log once a month. Our Billing Specialist collects Medi-Cal data by utilizing the Electronic Health Record System provided by RCC and The County (Simple Practice and ShareCare respectively).

In the past fiscal year, we transformed our Medi-Cal Billing systems. From July 2020-December 2020 we had authorizations for 3 Medi-Cal clients. Once our newly hired Medi-Cal Billing Specialist did an internal audit some systemic issues came to light. She realized that the agency had less clarity on what data needed to be collected and clinicians had to manage various impacts of the pandemic. After supporting clinicians to improve our data collection, in the beginning of 2021 we were able to capture more clients for Medi-Cal Billing. From January 2021 to June 2021, we were able to bill for 14 additional clients who were all authorized through the Utilization Review in Contra Costa County.

For Tier 2, Program Managers and Coordinators submit data after each support group and/or program session. The Data Specialist creates monthly reports reflecting attendance and demographic information. We also collect demographic information for new attendees and also encourage returning clients to complete demographic forms on an annual basis.

Most of our community events and outreach, which encompass Tier 1, happened virtually this year which made it more difficult to collect data. For example, we had numerous virtual events to celebrate LGBTQI+ Pride in October along with celebrating our 25th anniversary. Events that are streamed live on FB and other media make it more difficult to track participants as only some participants choose the “event registration” option. With limited return to small in-person gatherings at the end of the spring and early summer, we also were challenged by adhering to social distancing requirements in our ability to approach community members at special events. In the virtual, we did have incredible return rates for many clients - coming to programs. This was especially true for our older adult population who relied on pivoting to virtual programs to decrease isolation and depression.

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

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

LINKAGE AND FOLLOW-UP:

Please explain how participants are linked to mental health services, including how the PEI program: 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.

We provided encouragement for individuals to access services by advertising various support groups that we offer on our website along with promoting our services on multiple social media platforms including our Facebook and Instagram pages. We continued to provide case management and wrap-around support services for many clients who regularly access our support groups. Also, our Clinical Intake Coordinator provided referrals to clients for faster access to services when we were not able to meet their needs immediately. In terms of methodology, we switched to an on-line intake form as part of our move to virtual. While some time was needed to adjust to a new intake system, we were able to continue with serving clinical clients on a first come/first served basis. As part of our intake process, we were also able to prioritize special needs including pairing clients with a Spanish speaking clinician, EMDR, alternative relationship styles, and enabling BIPOC clients to be seen by BIPOC clinicians.

Our Training and Curriculum Manager and our Director of Adult Programs and Training reached out to public school districts and private schools, highlighting our youth programs, along with offering our teacher training programs for educators, administrators, and other school-based services professionals. Additionally, we trained public health employees, community-based organizations, and other private sector professionals on how to work with LGBTQI+ youth and adults. A revamp of our Sexual Orientation, Gender Identity and Expression (SOGIE) curriculum and training modules for a virtual audience enabled us to surpass previous training records creating a regional and global demand for our offerings that continues to grow our audiences of allies and LGBTQI+ community members who are culturally competent and can address bias and discrimination.

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?

There is no better reflection on an agency's work than its Mission, Vision and Values. Amazingly, during the pandemic year of much upheaval and tenuousness for many local CBOs, Rainbow Community Center came together as an agency combining input from staff and Board members to revisit all these nonprofit cornerstones. The MHSA values of wellness, recovery and resilience coupled with our foundational strategies that are non-stigmatizing and non-discriminatory are reflected in our revised statements on our website, <https://www.rainbowcc.org/aboutus> and also included below:

Mission: Rainbow builds community, equity, and well-being among Lesbian, Gay, Bisexual, Transgender, Queer, Questioning and Intersex (LGBTQI+) people & our allies.

Vision: Rainbow envisions a society that advocates for and celebrates gender and sexual diversity, racial justice, safety, and liberation for all through healing centered engagement.

Rainbow transcends its vision from inclusive to expansive*, as we will be able to represent by centering and reaching a wider scope of Marginalized LGBTQI+ and Intersectional Identities more effectively.

Historically Marginalized and Intersectional LGBTQI+ Identities encompass:

- Transgender and Gender Non-conforming
- Black, Indigenous and People of Color
- Women
- Neurodiversity & Mental Health Abilities
- Physical Abilities
- Body Diversity
- HIV Status
- Elders
- Youth
- Immigrants
- Interfaith
- Familial Composition
- Class/Socioeconomic Status

*'inclusive' with its implied power differential, whereas 'expansive' refers to centering power with marginalized people

Values:

Authenticity: We are legitimate and true, able to express hope, pride, joy, love, compassion, and support with one another and ourselves.

Bravery: We cultivate emotional strength building spaces for ourselves and one another that inform and redefine safety.

Education: We teach in welcoming, dynamic, fluid, open-hearted, and impactful ways demonstrating we are always learning.

Healing: We believe in holistic, restorative, and transformational approaches and processes.

Liberation: We are committed to racial and economic justice through the work of solidarity, positive representation, equity, and advocacy, to achieve freedom of limits.

In addition to the above core Rainbow Values, each of our department/program areas reflect focused MHSA values of wellness, recovery, and resilience that shape how each department operates to best serve the subgroups in our care.

Clinical /Training Values:

We improve timely access by giving referrals. Our whole organization is based in serving the underserved and centering the most marginalized and vulnerable. We focus more on members of the LGBTQI+ community for 1:1 counseling while allies are referred to broader group-based services or referrals out to partner agencies like PFLAG. Allies remain central to our service base in our training department, where we value underserved and intersectional communities as a deep part of our education and professional development work. We target specific instances of discrimination-based trauma in our treatment plans using wellness, resiliency and recovery reframed as measurable outcomes. We strategize as thought partners to ensure that all our training and curriculum work is non-discriminatory and non-stigmatizing. All of our training work is embedded with an intersectional lens towards our understanding of gender identity and sexual orientation-based discrimination and bias.

Senior Services Values:

Rainbow's Kind Hearts Food Pantry especially reflects our value of serving the client's individual needs in a non-stigmatizing manner. Because of the Food Pantry's market-like experience, and its stigma and shame-free environment, clients can supplement their nutrition while also reducing feelings of isolation and increasing their sense of acceptance. Throughout our older adult program model, we infuse the value of supporting LGBTQI+ seniors viewed from a wellness arc on the life continuum. Deeply embedded in our approach to working with the older adult population is the notion of honoring elders, with the awareness that many of our clients did not receive that respect when they were younger and may not have opportunities to experience that respect from families of origin now or in their earlier lives. We honor the history/herstory of the LGBTQI+ community while valuing membership in vital, expansive, and expressive communities.

HIV Services Values:

We maintain regular contact with many of our community members that are interested in the services we provide. Our underserved populations include people who are living with HIV, are undocumented, uninsured, and unemployed along with people who are monolingual Spanish speakers. We recognize that all these people often require more than one of the services we offer, including our support groups, Sexually Transmitted Infection (STI) testing, Food Pantry and access to PrEP. Continuing to reflect MHSA values of wellness, recovery, and resilience, we employ a multi-pronged approach to HIV Prevention enabling clients to access a range of support and care options.

The HIV Prevention Program plans each event and outreach opportunity aimed at various community members who are underserved. We create bilingual content, reach out to businesses throughout Contra Costa County, Alameda County and beyond. We make our events accessible, safe, and friendly for folk to attend. We provide access and linkage to mental health care by promoting our services during events and through one-to-one interactions with community members. Our HIV

Prevention Manager is also a regionally and internationally recognized drag queen who can link clients to services in engaging and creative ways whether it is from the stage or walking through the crowd, speaking directly to community members in need of connection and services.

HIV Services Values for Seniors (HIV+ Support Group):

Amazingly, our Monday HIV Support Group has not stopped its weekly meetings during the past fiscal year. We learned how to navigate throughout COVID-19 restrictions while also having the ability to bounce back and forth between virtual and in-person meetings. Some of the conversation topics that came up during the group were loneliness, isolation, depression, mental health, and addiction. Many of our attendees are over the age of 55 and require a safe space to meet and process many of the struggles that come with living long term with HIV.

Youth Programs Values:

At the heart of our youth program is the valuing of relationships and sustained contact over time. Rainbow Community Centers Youth Outreach Coordinators check in with LGBTQI+ Youth weekly during our Wednesday drop-in support groups. Without this support most of our Youth would not have the support of a Peer Leader who is able to mirror our 12-25-year-old clients. They provide and offer the perspective of a parallel life experience as a LGBTQI+ youth themselves. During the pandemic we also offered in person events that allowed our program participants to experience fellowship and socialize with other LGBTQI+ Youth. At the foundation of all our Youth Programs is the goal of decreasing isolation and suicide rates amongst LGBTQI+ Youth.

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.

Enveloping our vignettes is our adoption of the recently created LGBTQI+ “Progress Flag.” In addition, our updated Rainbow logo has an added Progress Pride bar of colors underscoring the words “Community Center” with our Transgender flag colors alongside of Black and Brown sections acknowledging our People of Color in community and folx we have lost to the AIDS Epidemic ongoing and our Trans Women of Color who are being murdered at an increased rate year after year.



In the month of June 2021, we raised the Progress Pride flag, designed by Daniel Quasar, at our current center building, Concord City Center, Clayton City Hall, and several cities in the county!

Senior Services Valuable Perspectives:

Winter Break Story: Right before most of our staff went on winter break, our Older Adults Program Manager and one of our clinicians worked together closely to support a senior client who was in the hospital in serious condition after a house fire. Staff coordinated contacting the client, helping to coordinate care for him upon his release along with referring him to housing services. They also reached out to his brother to coordinate care for the client and his dog who was also displaced by the fire. The same client had only recently been assessed for suicide risk by the Program Manager. Coordinated care is at the heart of RCC’s valuable perspectives.

Paul-Program Participant and Fabulous Rainbow Volunteer: <https://www.rainbowcc.org/paul>

When Paul and his husband Ben moved to Concord from San Francisco shortly after retiring, the first thing they wanted to do was “sink some roots and meet some people.”

“So, I went online to look for places to connect with other gays,” Paul says, “and the first thing I ran across was Rainbow. I’m a joiner—I like to pitch in. And I consider myself very lucky to be a vigorous 73-year-old. I hope to be of service as long as possible.”

Paul has dedicated his time and talents to many organizations over the years, including over 25 years to the National AIDS Memorial in Golden Gate Park. When he found Rainbow online, he was eager to support our programs any way he could and began attending Rainbow senior lunches a couple of Fridays each month before the lockdown.

“Paul has been a great member and contributor to Rainbow,” says Christopher Holden, Rainbow’s Older Adults Program Manager. “He and his husband Ben have always stepped up to the plate to help in any way possible. They both bring enrichment to the senior zoom lunch and other activities they join.”

“It’s been very rewarding,” Paul says, “because we moved away from our San Francisco communities so to find contemporaries who were interested in keeping things going, that was a real reward. And, of course, when COVID came along, those connections became even more important.”

Once safety precautions required pausing the in-person senior lunches, Paul was among those who stepped in to help contact our participants by phone to ensure they felt cared for and connected. He also delivered biweekly meals, and he and Ben made Christmas deliveries for Rainbow as well.

A former journalist, Paul’s memoir, “Never Felt Better, Looked Worse, Nor Had Less: Growing Up Off Center in the Middle West” is filled with his vivid and poignant descriptions of growing up in the Kansas City area. “My parents were very social, always playing cards,” says Paul, “and I was an impressionable kid always taking notes.”

Paul has entertained the seniors at Rainbow lunches by reading chapters from his book, including the one about coming out to his father, powerfully describing the tension in the air as he waited for his father to speak:

“All else was silent, except for the murmur of the radio and the nearby electric ice cream maker whirring and gushing salt water into the gravel. I cleared my throat, then took another drag on my cigarette.”

“My father was a pretty hard-shelled old-school dyed in the wool Republican,” Paul says now, “and I had thought it would be easy to come out to my mother and very difficult with my father.” But as Paul describes in the book, his father responded by tossing him a cold beer and saying, “The way I see it, if the others can’t accept that, well then, screw ‘em. It’s none of their dadburned bidness.”

Today, Paul sees his volunteer work with Rainbow as an essential part of his week. “I honestly believe that we are called on to show up for each other, even strangers—especially strangers.”

We deeply appreciate Paul and our other wonderful volunteers who show up for our community! “I am grateful every day,” Paul says. “I’m the luckiest guy.”

HIV Services Valuable Perspectives: (Social Groups):

JP is one of our community members who has been suffering from depression over the last few months. He has learned to socialize with other people within our community, especially in groups and events that are geared towards LGBTQI+ Spanish-speaking communities. He has also learned about services and linkages such as testing and PrEP Education.

HIV Services Valuable Perspectives (HIV+ Support Group):

RR is a community member that has been attending our HIV Support group for over 12 years. He has made many strong friendships during the group, and it has helped him throughout many struggles, especially during this past year. These include isolation, depression, living with HIV and living with an alcoholic partner who suffers from Vertigo.

Another HIV+ Support group member recounted, “I joined the group in 2003 because I found I had become disconnected from the gay community after moving out of SF. It is primarily an opportunity to socialize with gay men. One aspect of the group I enjoy is the opportunity to share my experience with newly infected people to help ease their anxiety. Having been infected for over twenty years when I joined the group, I was a good example of a survivor.”

Food Pantry Valuable Perspective:

MS, 90-year-old Kind Hearts Food Pantry Participant:

MS is a 90-year-old participant in the Kind Hearts Food Pantry who receives delivered food and food resources every 2 weeks. MS stated that not only does he appreciate the nutritional vegetables and fresh fruits from our program, but also looks forward to having a visitor come to his home to socialize with, even if it's only for no more than 5 minutes. MS continued that without this interaction from our Volunteers he would remain isolated with very little socialization, and that our Volunteers always leave him feeling more connected and appreciative of the food he receives.

Youth Services Valuable Perspectives:

DM, 43-year-old School Administrator, attended Action Changes Things High/Middle School Conference, Rainbow Community Centers Youth Programs:

DM acknowledged that the students who attended our LGBTQI+ Allyship training were engaged in the training and wanted to receive more information related to supporting LGBTQI+ Youth on campus. DM said due to the training they would hang the PRIDE flag in their on-campus office, so that it signaled LGBTQI+ Allyship for their students and provide a safe space for LGBTQI+ students in support and discussions.

Marie, participant in Housing and Youth Programs:

“The difference that Rainbow has made in my life is that I’m alive. I’m not dead. I’m not homeless. If it wasn’t for getting in touch with Rainbow, I would have killed myself, to be honest. I wouldn’t be alive today so to them I’m truly grateful. I’m grateful for my life—to be able to eat, to be able to speak, to have a job, to be able to give back to the community that I love and that I’m so passionate about. That’s how Rainbow has changed my life: that I’m still living.

Bringing people of all ages together is amazing. When you’re young you don’t necessarily see a representation of who you are. For instance, if you’re a trans man, you don’t necessarily see peers who are trans as well so you might think you’re the only one. We have our separate groups by ages but we’re all here together, and it’s very important for youth to see there are elders just like them that they can look up to. It’s important to see the elders who are here, and they’re just like you. They are LGBTQ, living their lives to the fullest. If you have a question, or a concern, or you’re feeling awkward— don’t worry, we’ve all felt that way. We’ve come out or we haven’t come out, and we know how you feel. We come together as a unity and as a whole, and that’s what the rainbow flag is, bringing the community together and uniting us all.”

**PEI ANNUAL REPORTING FORM
PREVENTION REPORTING FORM**

FISCAL YEAR – 2020-2021

Agency/Program Name: RYSE

PEI STRATEGIES:

Please check all strategies that your program employs:

- | | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Provide access and linkage to mental health care |
| <input checked="" type="checkbox"/> | Improve timely access to mental health services for underserved populations |
| <input checked="" type="checkbox"/> | Use strategies that are non-stigmatizing and non-discriminatory |

SERVICES PROVIDED / PROGRAM SETTING:

Please describe the services you provided in the past reporting period. Please include 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, on-discriminatory, and which actively address stigma and discrimination that creates physical, mental, and emotional harm and burden for young people in West County. Direct Service Amidst the profound changes and impacts of the pandemic and the uprisings on our communities, we stay steadfast in all our relationships and connection. 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. Now, over a year into the shifts caused by the pandemic, RYSE's community care has looked like virtual education, career and therapy supports, arts-based healing workshops, direct financial and fundamental needs support, community resource guides and presentations, convening partners across the County, amplifying young people's voices in protest, in policy reimagination, and in participating in decisions affecting their lives, and holding grief for and with each other through countless losses. The RYSE community experienced a devastating loss on January 3rd, 2021, when Marissa Snoddy, RYSE Clinical Director, passed away suddenly at the age of 35. The RYSE community has been stunned, shocked, and saddened beyond measure. Throughout January, we created spaces for members and staff to remember Marissa and grieve her passing -and RYSE's leadership continues to plan ways to honor her legacy and ground our work moving forward. As a queer, Black practitioner, RYSE benefited profoundly from her deep and intentional partnership with young people in crisis; her dedication to believing young people and believing in their power and ability to heal; and her commitment to creativity, culture and collective care at the root ending violence in all its forms. As a practitioner and supervisor,

Marissa's powerful life and beautiful spirit have profoundly influenced the wellbeing of program participants and RYSE's approach to healing and gender justice. Over the past 6 months, RYSE's community health team, with the support of the greater RYSE staffing system, has reconfigured roles and responsibilities while holding this loss for one another, for young people, and for the community. RYSE's Associate Director is directly supervising the team RYSE's contracted clinical supervisor Erica Woodland has taken on an expanded role, and in July a new part-time therapist and clinical case manager were hired. Hiring is still underway for the Clinical Director role.

Health and Wellness

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. Beginning in March 2020, virtual programming and teletherapy were developed and activated and have continued throughout the FY20-21 year. Clinical and case management staff were deemed essential workers to provide in-person supports where needed. In-person supports have included hospital bedside support, emergency triage meetings, clinical therapy, case management when a safe virtual meeting space cannot be determined, juvenile custody transition/reentry meetings, and emergency transportation support. Health and wellness content promoted via social media (Instagram Live videos and TikTok) also engaged youth in our community. This year has called us to illuminate a path towards liberation and healing for the larger community rooted in young people's priorities.

In FY20-21, we served 255 young people virtually, plus hundreds of youth and adults engaged through online/events. RYSE primarily engaged young people and community members through virtual programs and events and through trainings and workshops in high schools, continuation schools, partner agency sites and within juvenile hall. While unduplicated numbers of enrolled youth members reached were lower than our annual goals in years when we operate in-person, RYSE reached hundreds of additional young people who were not formally enrolled through social media engagement, virtual events, and in providing emergency financial support to young people and their families.

COVID-19 Response: Through RYSE's Youth COVID-19 Direct Supports Fund, we have provided over 300 \$500 disbursements to-date, including participants impacted and hospitalized by gun violence. RYSE staff and therapists worked directly with young people to identify needs, and provide acute financial support as needed, as well as comprehensive wellbeing care. The circumstances young people are navigating continue to bring to bear the severe lack of economic security they carry, as well as their lack of access to welcoming and helpful financial institutions and systems. In our intake forms, rent housing, food, utilities continue to be main areas where financial crises are felt, and support is needed. In all cases where mental health support was indicated as a need, RYSE staff followed up and coordinated care. Most participants do not have bank accounts; there has never been a month without young people needing support who are marginally housed or without an address. When needed, RYSE has been issuing cash gift cards, and have launched a new partnership with Community Financial Resources (CFR) about providing more tools and resources needed to build a financial portfolio (credit building/ wealth building) to youth members, preparing to launch in Fall 2021. With partner organizations, we are also in conversation about the need and opportunity to guarantee basic income for all residents. RYSE continued to convene bi-weekly West Contra Costa COVID Community Care Calls, as well as to work closely with Contra Costa County Health Services to maintain up-to-date and relevant resources for our community, including testing and vaccination sites, community-level data, and mutual aid/health resources as conditions and access have shifted. •**Education & Economic Justice**—At least 97 members have engaged in direct academic and career supports including 1:1 case management, education & career workshops, and mentorship/coaching.

Education & Economic Justice: At least 97 members have engaged in direct academic and career supports including 1:1 case management, education & career workshops, and mentorship/coaching. COVID care funds were used to fund 25 RYSE Scholars, students who were provided with a \$500 disbursement to help with meeting immediate school-related expenses in Fall 2020. They continued to receive 1:1 support, join in College Access workshops, and attend different programs and events to support

their interests and skill building (i.e., photography, credit management, budgeting and basics, youth justice and workshops on professionalism, budgeting and time management). One of the students shared with us that they utilized the money for tuition and expressed the impact that this disbursement made for them and their higher education journey. Many of these students joined a group of 24 youth attendees for Life After High School, a series of workshops that seeks to expose young people to different post-secondary opportunities and learn about tools like LinkedIn. Members participated RYSE's Photovoice project, a collaboration project with Richmond Promise that seeks to share the experience of youth as they navigate higher education through film photography. Many young people continued to hold the additional economic and caretaking responsibilities throughout this past year, and RYSE worked to create flexible paid leadership opportunities that considered these dynamics. RYSE Education 4 Liberation (E4L), District Local Control & Accountability Plan (DLCAP), Richmond Youth Organizing Team (RYOT), and Freedom is A Verb (FIV) Interns met virtually throughout the year. Each cohort worked together 1) learn about how to challenge our inequitable school system & become peer educators for other youth in our community 2) to advocate with and for their peers in school and hold space for students to share their needs and plan together, and 3) to design community-based solutions to the problems they face, beyond police, prisons, and punishment. E4L, DLCAPS and RYOT interns work closely together in their advocacy and organizing, they have collaborative meetings, trainings, planning sessions, and support each other's organizing efforts throughout the year. They learned about and conducted research, reviewed and shared understanding and recommendations for policies, and served on panels, and held community events. Interns served as part of the Healthy Richmond Coalition of organizations and school district representatives, who advocated for a focus on mental health/social emotional learning in the LCAP.

Identity Groups and Peer Support: RYSE identity groups have met virtually throughout the year. Fewer of these groups have been active this year compared to prior years, yet the groups have been consistent and trusted spaces for tailored programming that engages small groups of young people. Identity group programming includes a mix of youth development and wellness-support workshops, as well as 1:1 support and coaching. 21 young people engaged in identity groups (LGBTQQ group, Young Men's Group, Sister Circle). One of the benefits of virtual programming was the ability to incorporate health and wellness supports into all programming: RYSE's Community Health Manager has collaborated with the College Access, Education 4 Liberation, Young Men's Group, and other programs to hold Health and Wellness workshops tailored to each group.

Leadership Cohorts & Career Pathways: At least 42 youth participated in leadership cohorts, projects, led campaigns, and training in RYSE's Youth Leadership Institute. Youth leadership cohorts have included Video, Visual Arts, Music Production, Performing Arts, Immigrants Justice Fellowship, Education for Liberation, Freedom is a Verb, Richmond Youth Organizing Team, and District Local Control and Accountability Plan Team. Young people have led workshops, spoken on local and statewide forums, and organized and conducted research into issues affecting their families and communities. RYSE established and announced the first-ever Richmond Youth Poet Laureate, provided youth-led trainings for WCCUSD teachers, and engaged young people and architects in skill-sharing to include youth-designed components in our new facility. Youth Organizing members researched, developed, and held workshops in May to engage their peers on community topics such as mental health, food justice, unhoused communities, and the history of ICE. Despite the challenges of the past year, young people continue to be met with intention, love, resources, fortitude, and movement. 28 young people participated in RYSE's Youth Leadership Institute in April 2021. Staff and Youth Leadership Retreats included tours of the new RYSE Commons building, sessions re-grounding in Theory of Liberation values and impact planning; collecting visioning/questions/ideas for RYSE Commons; and creating virtual community-building spaces. All youth participants received wellness kits, lunch gift certificates, and were invited to join in a group virtual yoga/movement session. As part of the retreats, the RYSE Community Portrait Project process was launched with staff and youth members, rooting community building and belonging for Commons in embodied arts. The project is inspired by artist Mickalene Thomas, and includes staff, youth members, partners, and families creating self-portraits that will be installed in a grid in the new RYSE Commons building. This is a process of embodied

arts, of designing belonging in the building before it even opens and ensuring that the visual identities of our community are centered and celebrated.

Sexual and Reproductive Health Promotion: RYSE has established a partnership with Brighter Beginnings and hosted their staff to begin a cross-referral process between agencies. RYSE distributed Health and Wellness kits to members of RYSE's identity groups and cohorts. Monthly sexual and reproductive health social media posts begun that are culturally relevant, healing-centered and promote destigmatization.

Arts-Based Healing: RYSE staff and youth alumni have led dynamic music, visual, and performing arts workshops online supporting skill-building in creative writing (songwriting/ poetry), visual arts, videography, theatre, and event production. We worked with the Probation Dept. on virtual access to arts/ music programs. We increased collaboration with local and national partners, ensuring youth artists' voices are shared with a broader audience. Many RYSE interns need to support households with paid work, so RYSE developed systems for more one-on-one work with interns to build out more flexible projects. We've collaborated with the Richmond Arts & Culture Commission to develop the city's first Youth Poet Laureate, who will help develop a collective poetry anthology by Richmond youth. Paid arts interns are developing a theatrical production, *The Land of Sankofa*, to premier RYSE Commons' new Black Box theater. Education & Justice, Youth Organizing, and Community Health programming have all collaborated closely with artists at RYSE to integrate creative youth development and healing. Examples include: 1) RYSE's Photovoice project, a collaboration project with Richmond Promise that seeks to share the experience of youth as they navigate higher education through film photography. 2) A youth-created podcast by members of RYSE's Breaking the Frame Anger Management peer support group, to increase young people's access to coping tools while also providing youth with messaging that uplifts their righteous anger. 3) Creating poetry and artwork as part of the Education for Liberation youth cohort's role in the Dignity in Schools California Youth Political Education Series, a shared learning space around Police-Free Schools with youth leaders and organizers from across the state.

Youth-Led Community Events: Young RYSE artists and activists co-created events and social media campaigns during RYSE's themed months, such as Black Cultures Month (February 2021) and Pride Month (June 2021). Black Cultures month included events such as Black Poets Stand Up, Family Feud, Music & Movements Workshop, Night Out for Safety and Liberation, and a virtual movie night. RYSE's social media campaign for Pride month highlighted local queer artists and activists, information on pronoun use, and included a Fly Your Flag snack and create event.

- <https://rysecenter.org/blog/2021/2/25/05aoyeffy9yg5zfgb4ibixcikt0lkl>
- <https://rysecenter.org/blog/2021/6/24/june-recap-ryse-pryde-2021>

RYSE's *Ask-A-Doc* Series has continued in partnership with John Muir Hospital –youth co-developed monthly Social Media events with doctor's answer to youth questions about COVID-19, safer sex practices, nutrition and exercise, substance use, and overall general health. In March 2021, RYSE's Board of Directors hosted a community discussion and expert panel: Sick of White Supremacy: Medical Racism, Vaccine Inequity, BIPOC Immunity. A recording is available at <https://vimeo.com/527525905>. Password: RYSE31721.

Throughout the year, RYSE artists were commissioned or planned/led/ co-facilitated events and workshops that included:

- Cooking Demos and Tasty Tuesday
- Create CA's youth led webinar, Student Role & Participation in Advocacy, with youth reps from RYSE, Generation UP, and ACLU's Arts Justice fellowship
- Youth Art Exchange's Youth Arts Summit Virtual Gallery

- Invention Corps Berkeley, Black Liberation Art Gallery
- Land of Sankofa script reading
- The Alliance for Media Arts + Culture Video Roundtable on Access
- Young Black Voices: Trans-Atlantic Live
- Arts Now Community Arts Integration Professional Development Workshop Series for West Contra Costa Unified School District (8 workshops)
- KiND (Kids in Need of Defense) Workshop for asylum seeking youth
- Reimagining Our Schools Poetry workshop for Californians for Social Justice
- Odes to Home *Staying Power* poetry performance with guest writer, Kiese Laymon
- Youth Power Open Mic
- RYSE x Youth Empowerment Project: Rhythm & Poetry Workshop
- Building Blocks for Kids Anniversary Show Poetry Performance
- RYSE's Racial Reckoning Series (5 sessions)
- Music AMP Mixtape party-celebration of beats produced by Music Advanced Media Producer Interns
- East Bay RYSING live performances at UC Theater (four performances)
- RYSE Anthology, The Mic & Our Glory, Release Party
- Out of the Mouths of Beings (Richmond Talent Show with three local arts organizations)
- WCCUSD Black/ African American Graduation poetry performance (commissioned poetry for graduation)

Trauma Response and Resiliency

RYSE staff have also seen how the health burdens of young people have only been exacerbated by conditions of the past year. As too many in our community are engulfed in survival mode to tend to basic needs, we are working to respond to those needs and the compounded distress. As too many in our community are engulfed in survival mode to tend to basic needs, we are working to respond to those needs and the compounded distress. We are responding to an increase in severe mental illness, suicidal ideation, anxiety, and depression. We are fielding increases in domestic violence and intimate partner violence, human trafficking, eviction and displacement, and gun violence -all alongside the ongoing harms and disregard by the systems responsible for young people. Some of specific ways we are responding:

- Prioritized staff health and status as information bearers, with ongoing COVID-19 presentations, social media and online resources, care supports, and wellness activities. Held space during all programming to answer questions and provide information about SIP and COVID-19, including hosting "Ask a Doc" on Instagram; and posting public health and vaccine information on RYSE social media.
- Clinical and case management staff were deemed essential workers to provide in-person supports where needed.
- Telehealth services and teletherapy services were increased and expanded, and all programming went online.
- Our approach remains direct services for systems change, with integrative strategies grounded in racial and gender justice, economic justice, harm reduction, healing-informed and trauma-informed care, and youth leadership.
- Many young people have lost loved ones over the past year. We are conscious of how the transitions coming up must make space within RYSE to hold and heal for our community.

Community Triage and Care: RYSE has engaged in continued need for support and coordination around community crises and critical incidents. We have coordinated with leadership teams and clinical staff at both Kennedy and Richmond High and the Office of Neighborhood Safety in response to community violence and loss, including multiple deaths among young people in Richmond and West Contra Costa. This coordination has supported sharing of critical updates, identified needed supports, and created response plans. Support RYSE has offered included connecting to language interpretation, financial support to families, and hospital-based intervention. These experiences underline the interconnectedness of youth, family, and school communities, especially concerning community loss and acute and atmospheric trauma.

Case Management & Clinical Therapy: At least 80 members engaged in 1:1 case management and/or clinical therapy with RYSE staff. Young people led the process of identifying goals, completing community service and other system-oriented projects, enrolling in school, creating plans for employment, securing documentation, health insurance, transportation, legal support, relationship and safety support, and housing. RYSE staff provided relationship-based, trauma and healing-informed support, coaching and care as well as built relationships with CBOs and County services to increase responsiveness and relevance for young people.

- 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. RYSE's bilingual therapist was able to provide Spanish services when needed. New hires in July 2021 include a part-time bilingual therapist and a bilingual clinical case manager.

Probation, District Attorney's Office: This year, RYSE has continued to deepen our partnership with the Department of Probation and the District Attorney's Office. Continued to provide restorative justice diversion and transition & reentry supports with young people in custody via virtual telehealth and in-person when needed. RYSE has also been working with juvenile justice systems partners to plan for relocation of young people from DJJ and coordinate throughout the pandemic. We adapted our partnership with the CCC Juvenile Hall to offer a virtual version of our Freedom Beatz program.

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 LGBTQ youth. Worked with partners at Healthy Richmond to advocate for inclusion of youth recommendations in the Local Control and Accountability Plan for the 21-22 school year.
- For RYSE Pride Month, youth and staff co-organized Vibrant & Visible Celebrations across RYSE including a Pose-Themed Social Media Contest highlighting Queer Community Members; An LGBTQ+ Terminology Workshop hosted by Young Men's Group; social media content about pronouns developed by youth

members; Community Health resources in partnership with East Bay Getting to Zero/LGBTQ+ Connection and Children's Hospital Oakland.

- RYSE engaged in a contract through the school district to provide professional development services in arts integration to WCCUSD teachers with a focus on outreach to the Kennedy family of schools. These services were developed and coordinated by the Arts NOW Community organizations, including RYSE, East Bay Center for the Performing Arts and The Junior Center of Art and Science. This work advanced positive school climate goals by helping teachers build capacity for arts-based healing in their classrooms and cultivating trauma-informed and racially just spaces. As part of this work, RYSE partnered with local CBOs to ensure questions about arts access are part of school board candidate forums and future conversations.
- RYSE partnered with parents and staff from Healthy Richmond and Building Blocks for Kids to host a WCCUSD School Board Candidate Meet & Greet open to youth, parents, teachers, and community. The Meet & Greet provided space for students and parents to connect with candidates directly, to ask questions, learn about the values that centered their campaigns and build relationships. The Meet & Greet was attended by 51 students, parents, candidates, and community members.
- E4L interns developed and shared a survey about mental health experiences of youth in WCCUSD, including impacts from COVID-19, shelter-in-place, and distance learning. They developed questions and facilitated 1:1 interviews for youth to share their experiences on mental Health and wellness. The inquiry included 208 survey responses, and 4 interviews, including 50 Kennedy High students and 21 Richmond High students.
- Throughout the year, RYSE Commons construction continued, and RYSE began to hold tours with our systems and community partners. The new Superintendent, Dr. Hurst, as well as the prior Superintendent, Matt Duffy, attended the RYSE Commons tour on one Dr. Chris Hurst's first days on the job. Partners from the County Office of Education, DA's Office, Public Defender, Probation, and Richmond Office of Neighborhood Safety were also in attendance, and it was an opportunity to convene, dream and plan for a community-based hub that center's young people and can further support linkages and community care across systems.
- RYSE's gender justice model was featured in the Obama Foundation: MBK Leadership Forum: Breaking Barriers, Building Dreams, as well as in the MBK Equity Framework Guide. RYSE youth and staff presented at the 2021 Gender Spectrum Professionals' Symposium.

Systems Change

As 2021 advances and we consider a post-pandemic reality, RYSE's work continues to be showing up for Black, Indigenous and POC young people and their families. Our Theory of Liberation and service-for-systems change frame requires proximity, loving support and response, and collective power-building. It has allowed RYSE to center communities that experience disproportionate harm by systems and pandemics. RYSE continued to coordinate mutual aid and rapid response through the WCC Care Coalition, The R3F, and RYSE's COVID-19 Youth Fund.

Rapid Response for Systems Transformation: Since March 2020, RYSE has convened monthly WCC COVID Community Care calls with up to 100 WCCC city and public systems, health and social services providers. Community-wide coordination through these meetings has included sharing of resources for the community and youth-specific materials about COVID-19 and school requirements/policies/supports, including updates/presentation/ social media posts about COVID-19 public health research, guidelines, and local ordinances. Many partners on the calls shared with their families. RYSE leadership communicated directly with CCC Health Services Dept., the CCC Board of Supervisors, City of Richmond staff, and WCCUSD leadership to share needs, understand, and coordinate resources and response.

Racial Reckoning Series: 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. Youth members helped open and ground each space, as well as provided graphic recordings.

- 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

Reimagining Public Safety: RYSE is engaged in Reimagining Public Safety efforts and is cited as a model for what a non-police response to addressing mental health issues looks like.

Department of Children Youth and Families: RYSE continued to monitor and engage in implementation of the Department of Children Youth and Families in Richmond. In July, the City of Richmond approved the first round of grants to 20 youth-serving organizations. When organizing for Kids First over the past decade, RYSE did so to enliven the vision of young people and establish the infrastructure (& resources) needed to best serve the health of Richmond/North Richmond youth.

Office of Racial Equity and Social Justice: In response to the uprisings for racial justice in 2020, many of which were organized by young people, and acknowledging the work young people have led for years in naming racialized inequities and harms in Contra Costa County, County leadership called for an Office of Racial Equity and Social Justice. The strategies will be enacted through a community planning process grounded in active listening, witness-bearing, truth and healing. Core partners include: Supervisor John Gioia, Supervisor Federal Glover, Contra Costa Health Services, Family Justice Center -Central/East Care Call Convener, RYSE -West Contra Costa Care Call Convener, Trauma Transformed, Public Health Advocates, with Contra Costa Regional Healthcare Foundation. The following tenets of community engagement will ground and guide the work in all phases and eventually into the Office itself. These tenets will withstand and inform any and all changes to timeline and phases: Acknowledge ~ Affirm/Apologize ~ Amend ~ Align ~ Activate ~ Assess and Adapt.

The first ORESJ Community Update on December 16, 2020, had 300 attendees. Below is a snapshot of key sentiments shared.

How do we move at a righteous, reparative pace? Some of us are ahead, some of us have just arrived, and some of us are still figuring out if we want to show up. How do we move at the pace of trust? And whose trust?

How do we hold and switch between the internal and external work?

How do we engage in the being and the doing, in ways that we are not moving too fast but also not becoming stagnant?

How will we stay updated on and engaged in the planning process for the Office?

Who will run and staff the Office?

How do we build loving power in which the Office is an outcome, but not the outcome?

How do we ensure radical inclusivity and meaningful engagement of all BIPOC communities across intersections of gender, class, ability, sexual orientation, faith, status, language, age/generation, region?

How do we ensure we are naming and addressing white supremacy and anti-Blackness at every step, and across and within our communities?

How will we ensure prioritizing BIPOC resident and BIPOC-led partner engagement and decision-making?

How do we ensure we are not caretaking our white kin at the burden of our BIPOC kin?

How do we prepare for when our white kin and systems leaders get scared or threatened by our power and demands?
How do we prepare for backlash while we build power?

How do we ensure healthy struggle does no harm? And where this is harm, how do we engage in restorative/transformational accountability?

Preparing for and Practicing Racial Justice with Dr. Ken Hardy -January 21, 2021. This gathering was open to residents and organizations in Contra Costa County to build collective understanding, commitment, and practice for racial justice and healing. This session followed and responded to recommendations and suggestions from the December 16th Info Session about the Office and Process. 100 attendees. Dr. Hardy discussed the tasks of the privileged and the tasks of the subjugated, as well as the necessity of internal soul work for meaningful systems transformation. Learnings from the gathering will contribute to the County Office of Racial Equity and Social Justice Community Engagement Process.

ORESJ Listening Session -RYSE hosted -April 27, 2021. This session was open to residents and community workers in Contra Costa County and was one of a number of Listening Sessions held by the ORESJ core partners. 26 attendees, majority of whom identified as BIPOC in registration. The slides for the Listening Session are included [HERE](#). Witnessing and deep listening, transcription and notes were taken to document the experiences of racism endured by BIPOC community members in Contra Costa.

Finally, on June 22, 2021, a presentation of preliminary learnings and recommendations from the 1st phase was brought to the Board of Supervisors.

- The presentation and public comments brought beauty, pain, fortitude, tenacity, and tenderness, and can be seen here: https://contra-costa.granicus.com/MediaPlayer.php?view_id=1&clip_id=2334 (starts at 3:34)
- The slide deck can be viewed at <https://drive.google.com/file/d/1dIXyD9GJUN98cdhr1ph9mO5ZbrvdXM7f/view?usp=sharing>

Training and Sharing Praxis (CCHS, Health Partners): Through this unprecedented year, RYSE continued to work in close relationship with CCHS and health partners to respond, pivot and avoid tendencies toward a normal that dehumanizes and minimizes the lives and wellbeing of Black, brown, and indigenous young people. RYSE remains in partnership and advocacy along with public health practitioners across the state. RYSE staff and youth leaders participated in and led in 2-5 conferences, trainings or webinars per month. A list is available if requested.

RYSE Commons & Health Home: RYSE still has a construction project for the RYSE Commons 45,000 square foot campus moving ahead, to be completed Fall 2021. 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 container for the transformative work our youth and adult leaders are presently doing and will only continue to grow. Youth and staff have begun reopening and impact planning. Systems partners have been

invited and begun to tour the space, and a table of health partners have convened to begin working to activate a co-located health clinic on site.

Investment in Youth Wellbeing: We continue to be engaged in local efforts to track and allocate resources from the American Recovery and Reinvestment Act and ensure reinvestment in West Contra Costa County through a number of community working groups and committees. We are proud to be listed among 286 groups who received a significant investment from individual donors MacKenzie Scott & Dan Jewett. RYSE's statement shares our intentions and the possibility connected with these funds: <https://rysecenter.org/blog/investing-in-bipoc-youth-power>

Earlier today, MacKenzie Scott and Dan Jewett announced a \$2.7 billion contribution to 286 organizations. RYSE is incredibly honored to be announced alongside these groups. We are grateful to Ms. Scott, Mr. Jewett, and their team for this profound financial investment in our work. RYSE exists because twenty years ago, queer, BIPOC young people had the courage to organize and demand a space in their city that centers their collective healing, bold visions, and immense creativity.

This investment allows us to take huge steps forward in 1) completing RYSE Commons-a 45,000 sq. foot campus and youth-led hub in Richmond, CA for organizing, power-building, educational advocacy and support, creative expression, joy and play, healing and restorative justice, youth-led businesses and community projects, media and technology; 2) launching Phase 2 of the Commons campaign, a co-located health clinic designed for and by BIPOC youth; 3) dreaming Phase 3, housing security for our most structurally vulnerable youth and their families; and 4) building a strong infrastructure to grow and sustain BIPOC youth power throughout the Bay Area. RYSE appreciates this transformational approach to sharing and reallocating wealth, investing deeply and with deep trust for BIPOC-led organizations. For understanding what it means and what it takes to redistribute justly. For valuing and affirming RYSE as a BIPOC, queer, women-led organization that cultivates community, creativity, and power for all BIPOC young people to dream and build what is best and just for them and their communities.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services.

- **How are participants identified as needing mental health assessment or treatment?**
- **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 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 2020 and Spring 2021 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 as we return to hybrid and in-person programming. All surveys also asked young people to share basic needs and ways that RYSE could support them during the pandemic, with staff assigned to follow up roles.

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 (n=85); As a result of participating in RYSE programming:

- 95% of members who responded agreed or strongly agreed that they felt a sense of safety, respect, and community with RYSE staff and young people
 - 97% of members who responded agreed or strongly agreed RYSE staff created clear, engaging, accessible workshop.
 - 45% of members responding said they would try something new and 35% that they would maybe try something new.

"K is probably the best instructor I've ever had; I'm learning so much from him. He makes sure I understand the topics while doing it myself - that's probably one of the qualities I admire most about him."

"I always thought that I wasn't capable of staying engaged in long zoom meetings, but I realized it's not me, RYSE is doing it right! I was engaged the whole time because of everyone's energy!"

"I liked that even though I didn't know anyone, we were able to go into random breakout groups and build a house together"
"The warm and fuzzies made me feel so seen"

- 94% of members who responded agreed or strongly agreed that they are paying more attention to their and others' emotions and feelings and that mental health supports are okay and positive.
- 90% of members who responded agreed or strongly agreed that they are interacting more with people of different cultures than their own, speaking up more, and believe they can make a positive difference in their school or community.
- 97% of members who responded agreed or strongly agreed that counseling or case management is space of safety, mutual trust, and helping with emotional and navigation goals.

"I learned about the Restorative Justice approach, when it is necessary to use, and how to use this in needed situations."

"I learned I am not alone :) "

"They are very inclusive; all mama bees have a very positive vibe, and they do a great job connecting you with resources you needs."

"Throughout counseling I've learned more deeply how my actions affect me, and now every day I move differently."

Key measures: 70% of members demonstrate progress toward desired skills/goals related to their participation at RYSE (subset of members with a defined plan)

Findings: 97% of members with a case plan made progress in their goals. 95% of members responded that they learned something new during the RYSE programs and that they will be able to use what they learned.

“I learned a lot about why local elections are so important & also gained communication skills.”

“I think this internship was helpful because i learned the business aspect of the music industry.”

“I personally have a huge passion of learning about the LGBTQ+ community and I am also queer, so I like learning about my community.”

Key Measures: 70% of RYSE members report an understanding and capacity to build community with races, cultures and sexual orientations and genders different from their own.

Findings: 90% of members responded that they have a better understanding of people of different cultures than their own. 87% responded that they have a better understanding of LGBTQ identity. 93% responded that they have a better understanding of how different groups in their schools share common challenges.

“I have learned that there are so many issues that the immigrant community faces, such as access to health care, their basic human rights are being denied to them.”

“I was able to learn about the many important terms that apply to discrimination.”

“The lesson we learned on cat calling women “

“I am thinking about our conversations about body image and mindfulness.”

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.

100% of session evaluation respondents from the Racial Reckoning Series, Session 1 (N=92) answered that they would recommend the series to colleagues and co-workers. Select participant quotes:

“It 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.”

Inquiry into the WCC Care Coalition has included the following: 75% reported being able to provide more resources and supports to partners and communities because of the Coalition, and 63% reported deepening their understanding of white supremacy, structural racism, and/or racial trauma and healing through the Coalition.

“Knowing that there energized young folks in our community who are leading and teaching a better way to ‘Be’ ”

“Healing from trauma through the trainings and connections with other partners, as well as the amazing performances from RYSE youth and staff!”

“It’s been very important to me emotionally and it’s given me examples of language and ways of doing things that have helped my organization figure out “who” to be during this time.”

“The tone and opportunity to be human together. I get a lot of clarity out of the meetings, and it helps me keep my resolve around the work we are doing.”

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

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

While the total number of youths served during this year is 255, 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 Part 7. We do refer youth to outside services (clinical and non-clinical); however, they often report negative or uncomfortable experiences with outside referrals. In most cases, RYSE staff continue to provide case management to support engagement in external nonclinical services. 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.

RYSE’s Leadership Pathways (RLP) provides opportunities for personal and professional growth within the organization. The purpose of the RLP is to engage and empower youth in becoming informed community leaders, develop skills that will allow them to effectively advocate for themselves and their community, and prepare youth for college and career. This includes predictable, loving, and empathetic relationships with adults and opportunities to build creative and leadership confidence

within their community. The pathways include an organizing and leadership program that elevates youth from a RYSE member to an active participant in RYSE's internship program. Young people who may have previously engaged in any number of drop-in workshops, community projects or events, and individualized health, academic or career supports may apply to join one of 10+ internship cohorts in an area of their interest such as Digital Storytelling, Public Health Youth Participatory Action Research (YPAR) or Richmond Youth Organizing Team. The paid internship begins with the Youth Leadership Institute, a week-long intensive focused on political education, healing practices, cultural tools and narrative-building, and organizing. Throughout internships, youth complete individual and community projects, as well as engage in Education and Career and/or Wellness Plans to holistically support individual goals. Internships prepare youth who wish to apply for RYSE's Fellowship Program. The model structure includes introductory, intermediate, and advanced levels of leadership training, skill building, youth leadership retreats, and workshops on social justice and communication. YPAR interns have developed mixed-method projects and reports into critical experiences affecting BYMOC such as trauma, coping and peer/adult relationships both in and out of school. Interns have led workshops for adult practitioners in the community, created resources for their peers, and are currently engaged in planning for the re-opening of RYSE Commons. In the coming year, RYSE is planning for greater economic skill-building and support for interns, policy and advocacy/leadership coaching, and a pathway to health-related careers through RYSE's public health model and health clinic.

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 has developed robust public health and safety protocols that inform our meetings, programming and use of physical space. These have been adjusted as conditions change, are informed by CDC and county health guidelines, and have been shared with partners in our community. We remain closely connected and cognizant of Contra Costa County surges, hotspots, and inequities in vaccination rates and health burden in our communities. Along with the young people we serve, of our 38-person team, many staff are also navigating significant system barriers related to documentation status, aging out of the foster care system, family incarceration, and supporting childcare or family members with chronic illness, unstable employment, etc. One third of our staff are youth pathway leaders: still young people themselves who were formally members. This deep relationship within our community impacts how we reopen our physical center. Some of the questions we are considering, and sharing in conversation with partners:

- Who and what are we opening for?
- Who is most burdened? Most protected?
- What are the implications for our ecosystem/safety net?
- Where are we seeing the forces of disaster capitalism playing out in our systems and ecosystem?
- How do we engage in healthy struggle against these forces and towards belovedness?

Along with this response to current and exacerbated conditions, over the last 5 years, we have heard more frequently from members the desire for RYSE to have a health clinic - a physical space at RYSE to tend to primary, behavioral, and tertiary health that feels loving, non-judgmental, responsive, and affirming. Conversations with young people and providers about the idea and concept for a health home by and for young people have been met with resounding agreement and enthusiasm for the need of such space. Through these conversations, the following needs have surfaced: culturally appropriate and culturally rooted services; youth development competency of providers; gender and sexuality affirming services and care; sexual health

services; family planning; wound care; mental and behavioral health; health services for young people who are most vulnerable to systems harm, neglect, and/or policing “hard to reach” youth (e.g. undocumented, commercially and sexually exploited, engaged in trafficking, homeless, queer and transgender youth); dental services; health insurance and health care navigation; and accessibility/transportation.

An exciting development is the advancement of plans to create an onsite health clinic at RYSE, which will be able to open not too long after the RYSE Commons campus is complete. This will be a health home rooted in young people’s healing and safety (physical, emotional, political), expanded onsite primary care, sexual health, clinical case management, and mental health care linkages and resource navigation for youth and families. Current building renovation into a fully accessible health home includes a wheelchair ramp that connects the clinic with the RYSE Commons healing garden, HVAC, outdoor spaces, equipment. Health partners have begun to tour the space and provide insight for center activation.

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 Richmond Youth Organizing Team (RYOT) Interns and DLCAPS Fellows closed out this year’s program by hosting youth-led workshops. RYOT Interns are grounded in social justice principles and values and participate in leadership training, exploring issues in their communities, developing community organizing skills, and coordinate events to educate their peers.

DLCAPS Fellows are the youth representatives on the District Local Control Accountability Plan for Parents and Students Committee. The role of the DLCAPS Fellows is to ensure youth voice and opinions are implemented in the Local Control Accountability Plan at the end of the year. They work together with and advocate for their peers in school, holding space for students to share their needs and plan together.

That said, youth-led workshops are part of our Youth Organizing internship model. All youth interns in our department prepare + train throughout the year to develop and facilitate a workshop at the end of their internship on a topic of their choice and they do it in partnership with another youth leaders or a community organization. They create their own flyers, curriculum, outreach plan, and facilitate their workshops at the end of the year. All workshop sessions are open to all youth ages 13-21.

MENTAL HEALTH & SELF CARE WORKSHOP

May 5th 2021
By Jaquelin



AGENDA

01

Check In & 5 Minute
Meditation

02

Mental Health
Awareness Month &
Stigma

03

Depression &
Anxiety

04

Where to Reach Out
for Help

05

Coping Cards

06

Check Out

RYOT Intern Jaky facilitated a beautiful and needed workshop. She opened the space with a meditation, talked about Mental health Awareness Month, discussed depression & anxiety for students during distance learning & guided youth into an art activity. As a note, feelings of depression and anxiety can present itself in many forms that do not simply look or feel like sadness, especially for BIPOC communities. RYSE recognizes many diagnoses individuals in historically oppressed

communities receive are normal responses to injustice, oppression, and trauma, responses to very real, very valid factors outside of the person.



Yolanda opened the space with a check in, shared a video on the history of ICE and its harmful impacts on community pre-and during COVID. She led a Kahoot game with information and facts on ICE & immigration, closed us out with a session on how to defend & protect yourself from ICE and offered resources. Yolanda’s dream is to become an Immigration Defense Lawyer to support undocumented immigrants.



RYOT Intern Malaika & DLCAPS Fellows Michelle and Stephanie hosted an amazing youth-led workshop on Food Justice with 10 youth participants & 4 adults allies.

Homelessness in California

Luis Hernandez



DLCAPS Fellow Luis facilitated his first youth-led workshop! He showed us a video elevating experiences of unhoused folks, created a kahoot game with statistics and data on housing inequities, guided us into a padlet activity for youth to share how they/RYSE can support and closed us out with a call to action through a petition.

PEI ANNUAL REPORTING FORM

ACCESS & LINKAGE TO TREATMENT REPORTING FORM

FISCAL YEAR – 2020-2021

Agency/Program Name: STAND! For Families Free of Violence

DBA Putnam Clubhouse

PEI STRATEGIES:

Please check all strategies that your program employs:

- | | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Provide access and linkage to mental health care |
| <input type="checkbox"/> | Improve timely access to mental health services for underserved populations |
| <input checked="" type="checkbox"/> | 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.

Our Youth Education and Support Services (YESS) program offers education, prevention and early intervention services that support middle and high school students with navigating healthy relationships. Our You Never Win with Violence workshops (one focuses on teen dating violence and healthy relationships and the other on teen sexual harassment) are offered in individual classrooms. Through these workshops we educate youth on warning signs for teen dating violence, inform them of the reporting process, and link them to supportive services (i.e., student health center, therapy, crisis lines, our support groups, and our STAND! counseling services). Our support groups (Expect Respect and Promoting Gender Respect) work with 10-15 youth for an entire semester utilizing evidence-based curriculum and promising practices to support youth in exploring relationship trauma, healing, and tools for healthy relationship behavior.

Our expected outcomes were to provide primary prevention activities to educate seven-hundred fifty (750) middle and high school youth about teen dating violence, 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.

We served **seven hundred and forty-three (743)** participants and provided **thirty (30)** presentations of “You Never Win with Violence”. We were unable to conduct Expect Respect and Promoting Gender Respect Support Groups due to the Covid-19 Pandemic.

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**

Please Note: In March 2020 Contra Costa County was forced to “Shelter in Place”, close all schools, and non-essential services due to the covid-19 pandemic. The closure of schools caused the immediate shut down of YESS program services within the schools. Although STAND! For Families Free of Violence is considered an essential service the agency in effort to keep staff safe and comply with state and county guidelines for combating the Covid-19 pandemic, all staff were reassigned to “Shelter in Place” work mode, using virtual platforms to provide services from March 2020 through June 30, 2020. During this time the YESS team redesigned the entire in-person school base program to a virtual program.

Although we were able to adapt all our services to a virtual format to meet the needs of students our engagement with students strongly relies on our partnership with the schools to provide services. The covid-19 pandemic has had a huge impact on schools’ accessibility, student services, and student learning. Schools were not equipped to accept many supportive services for students from outside providers due to the remote learning structure and student resources at home.

In July 2020 we strived for some normality and was able to provide the following virtual services to students:

1. During this reporting period we served **seven hundred and forty-three (743)** participants in **thirty (30)** presentations of “You Never Win with Violence”. Goal shy of seven (7).
2. **Zero (0)** Expect Respect and Promoting Gender Respect gender-based support groups conducted.
3. Adult Allies: **Thirty (30)** teachers and **forty (40)** other school/community personnel trained. Goal exceeded.

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 services.

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.

The COVID-19 pandemic presented the YESS team with some challenges collecting student demographics. All demographic data is collected from pre, and post evaluation surveys given to students when services are provided. As mentioned above the

YESS team was able to modify all services to a virtual format including the pre, and post evaluation surveys. However, student's completion of the surveys strongly relied on teachers support with distribution and collection due to the decrease in YNWWV presentation time.

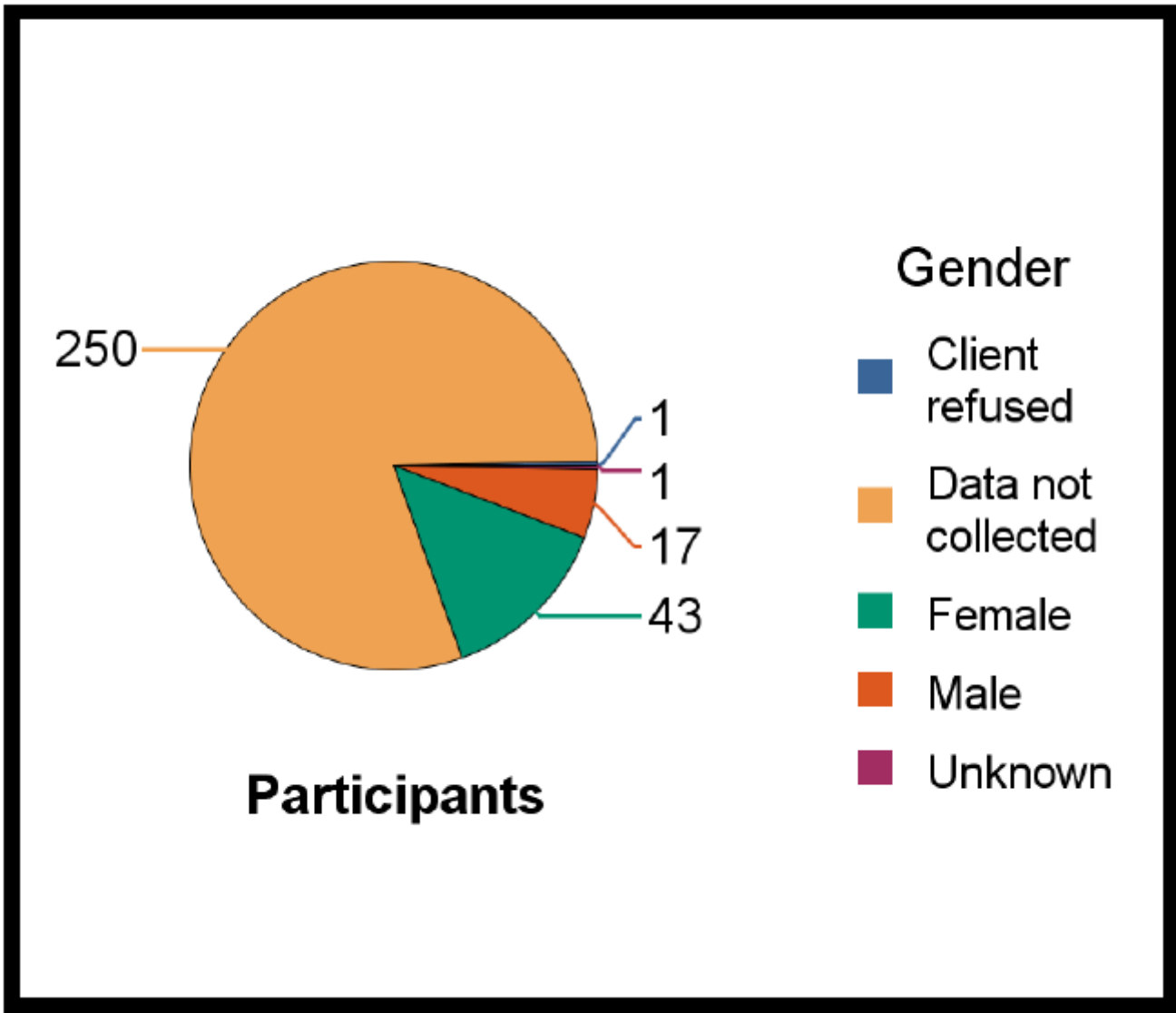
The YESS team provided services to **seven hundred and forty-three (743)** students and **thirty (30)** presentations of YNWWV. The demographics listed below only show **three hundred and twelve (312)** students from the completed and collected pre and post evaluation surveys received back from teachers. 431 students did not complete surveys.

Total Clients Served: (You Never Win with Violence)

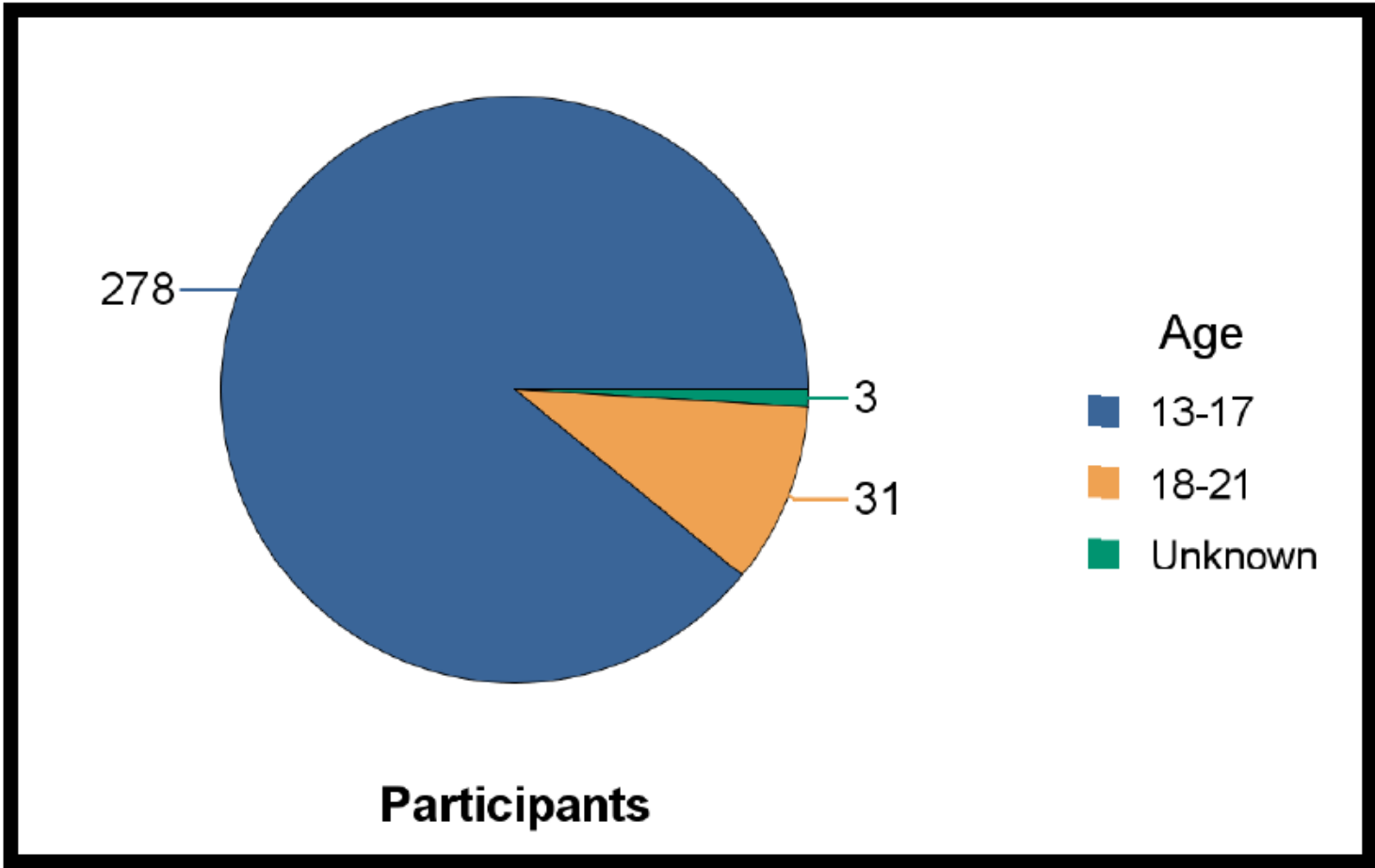
We have served a total of 743 clients through all our Prevention Programs throughout the Fiscal Year.

Gender:

Male Identified: 17 clients; Female Identified: 43 clients; Unknown/Unreported: 252 clients.

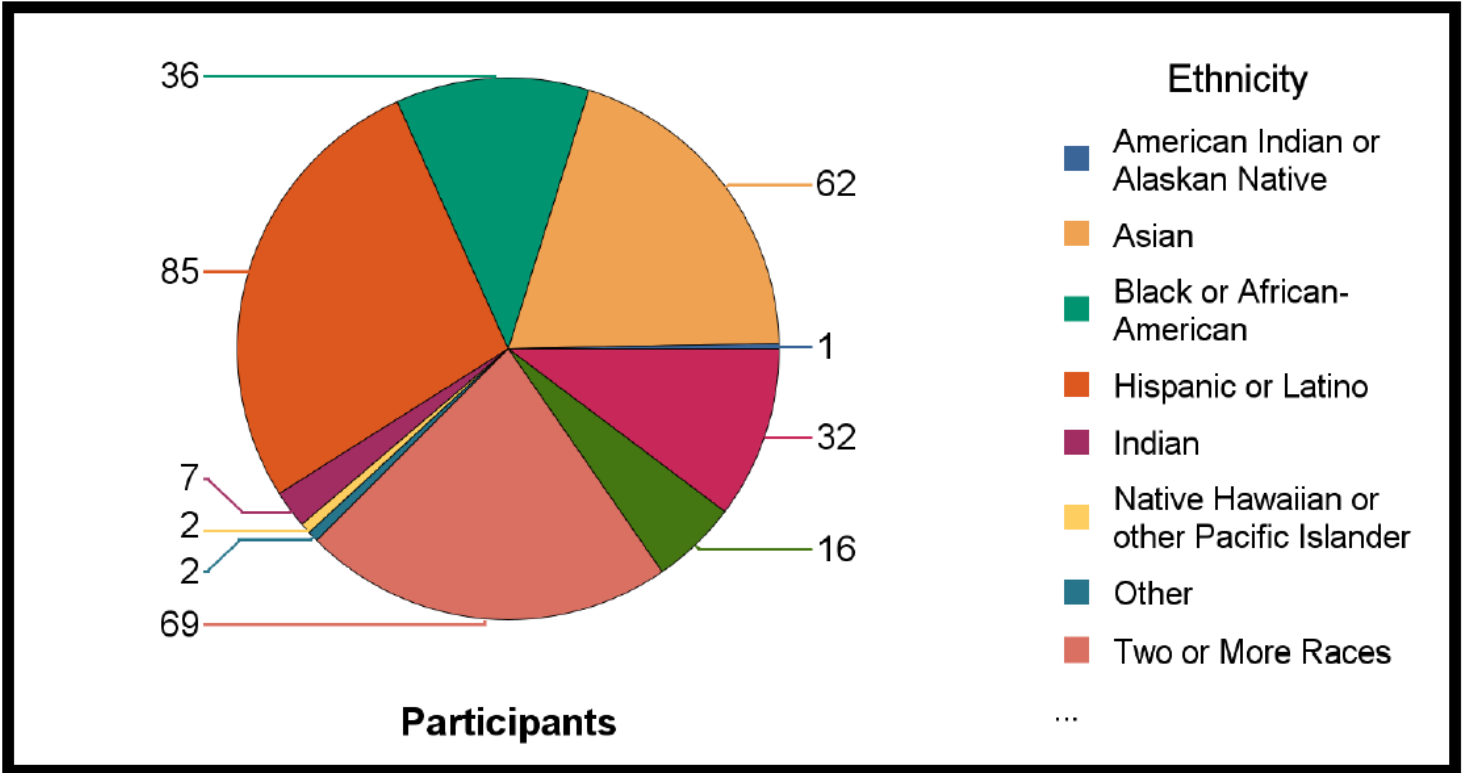


Age: 0-12: 0 participants; 13 – 17: 278 participants; 18-21: 31 participants; Unknown/Unreported: 3 participants.

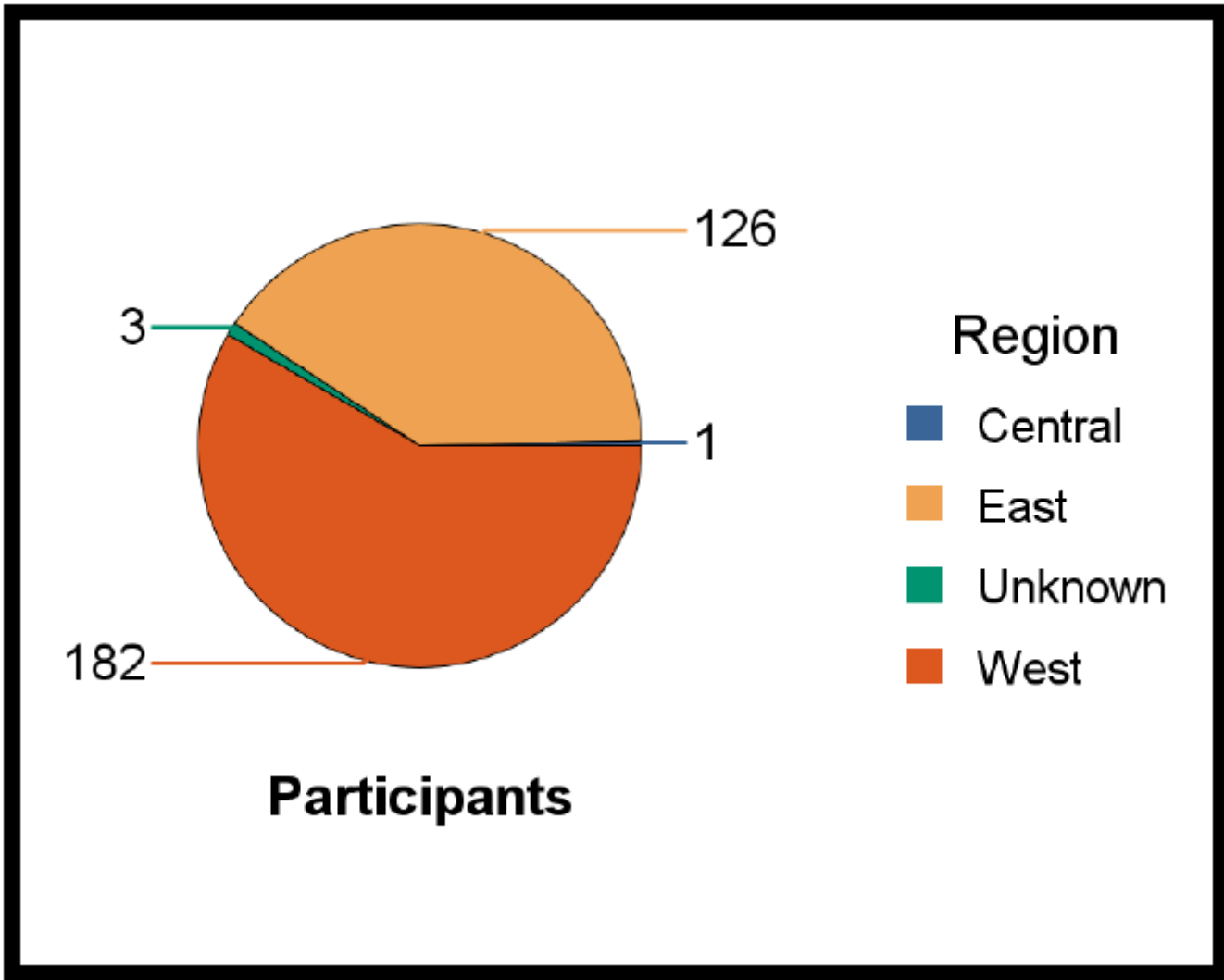


Race/Ethnicity:

African American/Black: 36 participants; American Indian/Alaska Native: 1 participant; Asian: 62 participants; Native Hawaiian/Pacific Islander: 2 participants; Caucasian/White: 32 participants; Hispanic/Latino: 85 participants; Indian: 7 participants; Other: 2 participants; multi-racial: 69 participants; Unknown/Unreported: 16 participants



Region:
 Central County: 1 participant; East County: 126 participants; Unknown: 3 participants; West County: 182 participants.



The following prevention services not provided, and no demographics were collected due to the Covid-19 pandemic:

- You Never Win with Sexual Harassment (YNWWSH)
- Expect Respect (ER)
- Promoting Gender Respect (PGR)

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.

Students who are identified as needing intervention services which can include therapeutic services will be linked to an appropriate service. Referrals are immediately responded to as it is a warm hand-off to another 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 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 Domestic Violence Emergency Shelter, Seven (7) Transitional Housing Units, Community Services Intervention program located in east, central and west Contra Costa County; a clinical/mental health services program, and a Non-Violence Program for formerly incarcerated clients.

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.

STAND!'s YESS Team program is most proud of the following events in this reporting period:

1. We were able to successfully transition our operation to virtual programming of services to student during Covid-19, practicing Contra Costa County guidelines for "Shelter in Place" and safety precautions.
2. Youth Against Violence (YAV) was represented at the statewide Domestic Violence awareness month panel hosted by California Partnership to End Domestic Violence (CPEDV) on zoom. A YAV member of three years spoke about the challenges Covid-19 and the impact it has had on providing prevention services to students.
3. STAND! staff and YAV started a YAV/YESS Instagram account. The account has brought awareness and engagement to the issues of Teen Dating Violence in a way that is accessible and appealing to teenagers.
4. YAV volunteers and STAND! staff used the Instagram account to launch their first virtual Teen Dating Violence Campaign, during the Teen Dating Violence Awareness Month (TDVAM). The campaign was called "They Love Me, They Love Me Not", it highlighted some of the internal struggles that someone might have in an unhealthy or abusive relationship. Also, just the overall signs of what love should look like and how it should not. In addition, the campaign highlighted the red flags and helped to spread a positive message of acceptance and loving oneself.
5. The Family Justice Center, Youth Services Network, and the Vice Mayor of Antioch, CA invited STAND! staff to present their You Never Win with Violence workshop and facilitate four (4) discussion groups focused on teen dating violence and healthy and unhealthy relationships for a TDVAM event. Approximately one-hundred eighty (180) students and forty (40) adults about two-hundred twenty (220) people in total.
6. Introduced YNWWV workshops at a new school, Heritage High School in Brentwood, CA. We presented in six (6) classes in a two-day span.

7. Through the months of April 2021 June 2021, the YESS team put in a lot of work and time planning and preparing for the summer 2021 YAV program. The staff and current YAV (summer 2020) developed a new YAV recruitment plan because there were no school based support groups to draw interest and attention to the summer 2021 YAV program. The recruitment plan was successful, we will be kicking off the summer 2021 summer YAV program in July 2021 with eight (8) YAV!

The YESS team has modified the summer curriculum to include some learnings from the Expect Respect (ER) and Promoting Gender Respect (PGR) curriculum for incoming YAV who did not get an opportunity to participate in our school-based support groups due to the Covid-19 pandemic to best support their success as a STAND! YAV

PEI ANNUAL REPORTING FORM

EARLY INTERVENTION REPORTING FORM

FISCAL YEAR – 2020-2021

Agency/Program Name: Vicente Martinez High School & Martinez Unified School District

C.O.R.E. - Community Optimizing Resources for Empowerment

PEI STRATEGIES:

Please check all strategies that your program employs:

- | | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Provide access and linkage to mental health care |
| <input checked="" type="checkbox"/> | Improve timely access to mental health services for underserved populations |
| <input checked="" type="checkbox"/> | 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.

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 9th-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:

1. Individualized learning plans
2. Mindfulness and stress management interventions
3. Timely access and linkage to direct mental health counseling
4. Team and community building
5. Character, leadership and asset development
6. Career-focused preparation and internships
7. Parent involvement
8. Outreach

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 Personnel 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

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 typically work with the Alameda Food Bank to prepare food packages for those in need. We were unable to participate this year due to COVID-19.
- **Dia de Los Muertos:** Students typically volunteer at the Dia de Los Muertos event in downtown Martinez. This event was canceled this year due to COVID-19.
- **Downtown Martinez Clean-up:** Students typically volunteer 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 report an increased sense of connection to and pride in their community. This event was canceled this year due to COVID-19.
- **MEF Run:** Students and staff volunteered at the Martinez Education Foundation Run for Education, which is a fundraiser for Martinez Unified School District schools. This year the run was virtual
- **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. These experiences were virtual this year.

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:** This program was not offered this year due to COVID-19 but will resume next school year. This ten-week program is sponsored by Loaves and Fishes and is located at their headquarters in Martinez where students 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 have gained skills to make food on their own. Students who participate and complete the program become certified food handlers. All students who have participated 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:** This program was not offered this year due to COVID-19 but will resume next school year. Twice per week there are 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:** This program was not offered this year due to COVID-19 but will resume next school year. Students participate in an eight-week teen police academy sponsored by Martinez Police Department. They learn about the work of a police officer and have 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. Social work and MFT interns provided virtual support for students and parents.
- **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. We were able to provide this program on a limited basis after our reopening in March 2021.
- **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. The group met virtually this year due to COVID-19.
- **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. These presentations were virtual this year.
- **MFT Counseling Opportunities:** Vicente and Briones students have access to individual and group mental health counseling.
- **Psychology Club:** Psychology Club met virtually 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 that we 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 of our students about suicide prevention. This presentation was virtual.
- **Welcoming Schools Summit:** Several students attended this summit virtually 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 coordinated the virtual participation of sixteen senior girls for 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.

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 support 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 virtually visit and tour Diablo Valley College. Note: 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.
- **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 multimedia presentation that then was 7 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. Most of our activities were adjusted to a virtual format.

- **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.
- **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. During the 2019-2020 school year, the last day of in-person instruction was Friday, March 13, 2020. On Monday, March 16 we instituted distance learning. Distance learning continued through March 26, 2021. We reopened schools on March 29, 2021. Students were given the choice of returning school on a modified schedule or remaining in distance learning at home. 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 PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

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

The following are our outcome measures of success from the 2020-21 PEI work plan.

Engagement Focus:

1. Increase identification of students that have greater risk of developing a potentially severe mental illness and those who need additional supportive/protective factors.
2. Increase engagement of identified Vicente/Briones students in services.

Short Term Focus:

1. Increase timely access and linkage to supportive and mental health services.
2. Increase mental health resilience among Vicente/Briones students.

Intermediate Focus:

1. 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.

Outcome Measures of Success

Engagement Focus:

1. 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.
2. 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:

1. 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.
2. 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:

1. 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.
2. 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: **Not Applicable (Using County form)**

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

EVIDENCE-BASED OR PROMISING PRACTICES:

What evidence-based or promising practices are used in your program and how is fidelity to the practice ensured?

Evidence-Based Teaching Strategies

- Clear lesson goals
- Questioning to check for understanding
- Summarizing new learning in a graphical way
- Time for practice
- Provide students with feedback
- Flexibility for how long learning takes
- Teach strategies not just content
- Collaboration
- Project based learning
- Nurture meta-cognition
- Connections to real life

- Individualized supports to address each student’s needs
- Professional Learning Community
 - Data analysis, results drive programs and instructional practices

School-Based Mental Health Strategies

- Safe and Support School Model
 - Engagement
 - Safety
 - Environment
- Restorative Practices in lieu of punitive measures
- School Climate Assessment Tool
- Positive Behavioral Interventions and Supports (PBIS)
Mental Health First Aid
- Trauma Informed Practices
- Collaborative for Academic, Social and Emotional Learning (CASEL)
 - Self-Management
 - Self-Awareness
 - Social Awareness
 - Relationship Skills

Fidelity of these practices is upheld through teacher and staff training, surveys, classroom observations, staff meeting discussions, academic assessments and consistent monitoring of all practices.

VALUES:

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

Our program reflects MHSA values of wellness, recovery and resilience. Our whole staff embraces these values for our students, and we strive to ensure our students are held accountable and are supported in these ways in order for them to thrive. We provide access and linkage to mental health care by providing individual and group services during the school day and referrals to outside mental health services for students needing longer term support and services. The students at Vicente and Briones are some of our most underserved and at-risk students in our school district. 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 support 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 of this pushing me forward, I am more than eager to continue my journey through life.

I feel like there are many things about this school that has helped me personally. With that being said, I think that being able to have one on one conversations with teachers is a great way to ask questions. Being at another school where not many teachers really care is sad because they don't pay attention to students as much. Here the teachers ask if "we are ok"? or "How is your day"? This is something you don't see in schools with so many students. I really like how we are still being taught our academics by lectures. We as students also have independence to work freely and be flexible with our work. We can work on our Math independently but still feel comfortable asking our teachers for help. In conclusion this school has helped my mental health in many, many ways which is very important to me. This is why I like this school.

I like Vicente Martinez High School because the small classes have helped my anxiety. The teachers are very welcoming, as well as very helpful. Credits are easy to make up with the teachers' help. Teachers are available to help whenever students need it. If it wasn't for Vicente my grades would still be bad and that goes with my attendance. I love coming to school and talking to the Counselors when I need it. Whenever I leave school I get very sad and can't wait for the next day to get started.

My proposed graduating date is June 2020. Before I went to Vicente Martinez High School, I never liked school. I stopped going to school and I would just stay at home. When I started Vicente I remember being scared, however, I made friends easily and started to catch up on my credits. When I'm in class I feel like I'm being heard and understood. The support the teachers give makes me feel smart, capable and cared for. The thing I like the most is the flexible schedules. I am able to leave school at noon each day. This allows me more time to focus on myself and my goals outside of school.

This school has helped me in many ways. They offer internships and help us apply for jobs. I struggle with school a lot and suffer from anxiety, depression and ADHD. Sometimes these prevent me from working effectively. I would often get overwhelmed and leave class. The teachers here help me to stay motivated and they are very supportive. Not having any homework to bring home each night has helped me majorly. I know at the end of each class that I'm done for the day and I can go home and work on myself and my happiness.

By attending Vicente I've had a much better experience than I have in the past at other schools. The classes are small, and the teachers and counselors are amazing. I actually get up and go to school now. Whereas before while I was attending Alhambra it seemed to make my life worse. The people and energy here at Vicente 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"