Health, Housing & Community Services
Mental Health Commission

To: Mental Health Commissioners
From: Jamie Works-Wright, Commission Secretary
Date: October 20, 2021

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Berkeley/ Albany Mental Health Commission

Regular Meeting
Thursday, October 28, 2021

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

Public Advisory: Pursuant to Government Code Section 54953(e) and the state declared emergency, this meeting of the City Council will be conducted exclusively through teleconference and Zoom videoconference. The COVID-19 state of emergency continues to directly impact the ability of the members to meet safely in person and presents imminent risks to the health of attendees. Therefore, no physical meeting location will be available.

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

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

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

All agenda items are for discussion and possible action

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

AGENDA

7:00pm

1. **Roll Call**
2. **Preliminary Matters**
    a. Action Item: October 28, 2021 Agenda Approval
    b. Public Comment
    c. Action Item: Approval of the September 23, 2021 minutes

3. **Presentation by Ms. Gigi Crowder, Executive Director, NAMI**

4. **Mental Health Manager's Report and Caseload Statistics - Steve Grolnic-McClurg**
    a. **MH report**
    b. **Berkeley Mental Health Caseload Statistics September**
5. **Narrative report on qualifications for future BMH Staff – boona cheema and Kim Nemirow**

6. **Specialized Care Unit Steering Update & Discussion re: RDA Reports – Dr. Lisa Warhuus**

7. **Re-Imagining Public Safety Task Force Update**

8. **Santa Rita Jail Subcommittee Report**

9. **Whole Person Care - Community Health Records Update**

10. **MHSA INN Homeless Encampment Wellness Project Update**

11. **Prioritize Agenda and Topics for December Meeting**

12. **Adjournment**

Communications to Berkeley boards, commissions or committees are public record and will become part of the City's electronic records, which are accessible through the City's website. **Please note: Email addresses, names, addresses, and other contact information are not required, but if included in any communication to a City board, commission or committee, will become part of the public record.** If you do not want your e-mail address or any other contact information to be made public, you may deliver communications via U.S. Postal Service or in person to the secretary of the relevant board, commission or committee. If you do not want your contact information included in the public record, please do not include that information in your communication. Please contact the secretary to the relevant board, commission or committee for further information. The Health, Housing and Community Services Department does not take a position as to the content.

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

Communication Access Information: This meeting is being held in a wheelchair accessible location. To request a disability-related accommodation(s) to participate in the meeting, including

auxiliary aids or services, please contact the Disability Services specialist at 981-6418 (V) or 981-6347 (TDD) at least three business days before the meeting date. ***Please refrain from wearing scented products to this meeting. Attendees at trainings are reminded that other attendees may be sensitive to various scents, whether natural or manufactured, in products and materials. Please help the City respect these needs.*** *Thank you.*

SB 343 Disclaimer

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

Department of Health,
Housing & Community Services
Mental Health Commission

Berkeley/Albany Mental Health Commission
Draft Minutes

7:00pm
Zoom Webinar

Regular Meeting
September 23, 2021

Members of the Public Present: Carole Marasovic, Andrea Zeppa, Theresa Comstock, Kristen White, John Cervetto, Jonah Markowitz, Tommy Escarcega
Staff Present: Fawn Downs, Michael Bernath, Karen Klatt, Steven Grolnic McClurg Jamie Works-Wright

1) **Call to Order at 7:02pm**
   Commissioners Present: Javonna Blanton, boona cheema, Margaret Fine, Monica Jones, Edward Opton (7:15), Andrea Prichett, Terry Taplin **Absent:** Maria Moore

2) **Preliminary Matters**
   a) **Approval of the September 23, 2021 Agenda**
      M/S/C (Fine, Prichett) Motion to approve the September 23, 2021 agenda
      PASSED
      Ayes: Blanton, cheema, Fine, Jones, Prichett, Taplin **Noes:** None; **Abstentions:** None; **Absent:** Moore, Opton

   b) **Public Comment** – 2 Public Comment

   c) **Approval of the June 24, 2021 Minutes**
      M/S/C (Fine, cheema) Motion to approve the July minutes
      PASSED
      Ayes: Blanton, cheema, Fine, Jones, Prichett, Taplin **Noes:** None; **Abstentions:** None; **Absent:** Moore, Opton

3) **Housing, Homelessness and people with SMI and SUD in Berkeley Presentation – Michael Bernath, BMH, HFSP Kirsten White, RDA, John Cervetto, RDA & Karen Klatt, BMH**
   No Motion Made
   .

4) **Mental Health Manager's Report and Caseload Statistics - Steve Grolnic-McClurg**
   a) **MH report**
   b) **Berkeley Mental Health Caseload Statistics August**
      - **No Motion Made**

5) **Specialized Care unit Update – Dr. Lisa Warhuus – No Motion Made**

6) **Reimagining Public Safety Task Force Update – No Motion Made**

8:58*Motion to extend the meeting for an additional 10 minutes
M/S/C (Opton, Prichett)
PASSED
Ayes: cheema, Fine, Jones, Opton, Prichett, Taplin **Noes:** None; **Abstentions:** None;
Absent: Blanton Moore,

7) **Alternatives to Santa Rita Jail Subcommittee Report – No Motion Made**

8) **Whole Person Care – Access to "Community Health Records" and Public Education Campaign – No Motion Made**

9) **Prioritize Agenda items for October Meeting – No Motion Made**

10) **Adjournment – 9:10pm Meeting ended**

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

NAMI Contra Costa County
National Alliance on Mental Illness

City of Berkeley
Mental Health Commission

October 28, 2021
Gigi R. Crowder, L.E.
NAMI Contra Costa

Mission Statement

The National Alliance on Mental Illness Contra Costa's mission is to provide support, outreach, education and advocacy to individuals living with, and families impacted by, mental illness.

NAMI advocates for access to services, treatments, support and research and is steadfast in its commitment to raising awareness and building a community of hope for all of those in need.

HISTORY

- 1978 – Walnut Creek, CA: Families in Walnut Creek started “Families for Mental and Emotional Recovery.”
- 1979 – Madison, WI: 2 Mothers (Beverly Young and Harriet Shetler) started NAMI as an answer to their frustrations with mental health care.
- 1984 – Walnut Creek, CA: Families further organized

Secured our 501c3 non profit status on July-1990 on 11/23/99 we adopted NAMI Contra Costa as our official name with the State of California.

Mental Illness by the Numbers

1 in 5 U.S. adults experience mental illness each year

1 in 25 U.S. adults experience serious mental illness each year

1 in 6 U.S. youth aged 6-17 experience a mental health disorder each year

50% of all lifetime mental illness begins by age 14, and 75% by age 24

Suicide is the **2nd leading** cause of death among people aged 10-34

Peer 2 Peer

Basics

Family 2 Family (M) (Sp)

Faith Net

Ending the Silence

In Our Own Voice

Warm Line

The NAMI Family Network

Family Support Group

Crash Course

NAMI Contra Costa County
National Alliance on Mental Illness

Cultural Responsiveness

All supports are delivered in a manner consistent with the cultural values and practices of the families we serve.

There is a acknowledgement that there are glaring health disparities in the mental health field. At NAMI CC we thrive to utilize culturally honoring, linguistically inclusive, community defined approaches.

Politics and Advocacy

Advocating for a Non-Police Response

- People with untreated mental illness are 16 times more likely to be killed during a police encounter than other civilians approached or stopped by law enforcement.
- Numbering fewer than 1 in 50 U.S. adults, individuals with untreated severe mental illness are involved in at least 1 in 4 and as many as half of all fatal police shootings.
- Reducing encounters between on-duty law enforcement and individuals with the most severe psychiatric diseases may represent the single most immediate, practical strategy for reducing fatal police shootings in the United States.
- Sponsors of AB 988- aka, Miles Hall Lifeline and Suicide Prevention Act.

NAMI CC Membership

- Membership at a NAMI State Organization, a NAMI Affiliate and the NAMI national organization
- Eligibility to vote in all NAMI elections
- A subscription to The Advocate, NAMI's flagship magazine, as well as access to optional subscriptions to specialty newsletters, and information at the national, state and local levels.
- Member discounts on brochures, videos, promotional items and registration at NAMI's Annual Convention and many state and local conferences.
- Access to exclusive member-only material on www.namicontracosta.org
- Become a NAMI CC member

Thank You for your Time!

MEMORANDUM

To: Mental Health Commission
From: Steven Grolnic-McClurg, Mental Health Division Manager
Date: October 19th, 2021
Subject: Mental Health Manager Report

Mental Health Services Report

Please find the attached report on Mental Health Services for September, 2021.

Mental Health Apps

The Mental Health Division has been participating with a variety of other Counties in a MHSA Innovation project related to utilizing mental health apps. Beginning on November 15th, the Mental Health Division will launch a wellness promotion campaign to encourage everyone who lives, works, gets services, or goes to school in Berkeley to consider utilizing the apps that are being made available: myStrength and Headspace.

myStrength provides personalized and interactive activities that address depression, anxiety, stress, substance use, chronic pain, and sleep challenges. It is an individually tailored program that is designed to empower users and also supports the physical and spiritual aspects of whole-person health.

Headspace is a well-known online meditation and mindfulness resource. The Headspace library incudes exercises to manage anxiety, encourage stress relief, increase focus, enhance sleep, and improve mood. It also includes a variety of exercise videos, from morning workouts, to high intensity workouts, to restorative workouts. Additional features include meditation reminders, tracking your practice statistics, and inviting a buddy to join you.

When we launch our campaign to encourage individuals to utilize these apps, we will send an email to the MHC so that you can both consider utilizing the apps and spread the word.

Information Requested by MHC

The following topics were requested by the MHC Chair.

Evaluating Mental Health Division Staff

The City of Berkeley has a formal mechanism for evaluating staff. Staff are evaluated on a regular basis (this was suspended for the Covid-19 pandemic) through a standardized evaluation tool (see attached Performance Evaluation Form), provided by Human Resources. This frequency of the evaluations is outlined in the Memorandums of Understanding with the various Unions, but in general, evaluations are done on a yearly basis once an employee passes probation. This tool formalizes feedback that is given over the course of the year by the supervisor.

At the heart of the development of clinical skills in mental health is a practice called "supervision." This is a regular meeting (most often weekly) between a clinician and their supervisor, where cases are discussed and clinical issues are reviewed. Supervision is a structured time where clinical staff can explore issues, get feedback, and develop skills. It is meant to be a time where staff get both practical support and where they can explore complex clinical issues.

Supervisors have a number of tools that they utilize in supporting clinical staff in increasing effectiveness. These tools include productivity (the percent of staff time doing medi-cal billable activity with clients), 100% reporting (the % of staff time that is recorded in Clinician's Gateway in line with timeliness of reporting standards), and Clinical Quality Review Team reports (every chart is checked on a regular basis for having required documentation). As part of their role, supervisors utilize staff interest, their knowledge of the staff members strengths and areas of growth, and divisional priorities to develop a training plan for staff. The division utilizes both trainings specifically created for and focused on the division and outside trainings to provide staff the opportunity to develop skills.

In conjunction with weekly supervision, these tools are utilized by supervisors to give regular feedback to staff, in the aims of increasing skill level and effectiveness in a supportive dynamic. Issues are discussed regularly, so that when an individual is provided with formal performance evaluation staff are aware of both strengths and concerns. The goal of this process is to help staff improve their work in a trauma informed way – where issues are predictable and we have a planned pattern of supporting staff in improving performance.

MHSA INN Encampment Wellness Program Timeline and Information

The MHSA Innovation Encampment Wellness Project has had informal input from the MHOAC and a variety of stakeholders. RDA has incorporated this feedback into a final draft, which the division is reviewing. After review and any changes, this proposed project will be posted for 30-day review and the Mental Health Commission would hold a public hearing. The proposed project would then go to City Council for approval and the Mental Health Services Oversite and Accountability Commission for consideration and, hopefully, authorization. After this occurs, the Mental Health Division would issue

an RFP for the services outlined in the project and, following this, a contract signed with chosen bidder.
The main thrust of the project is to support individuals in encampments in their wellness through the use of both a CBO team that has peer providers and the employment of individuals in the encampments themselves in these efforts.

Community Health Record Implementation (CHR)
The CHR is has been approved internally by all stakeholders, and the agreement for participation is currently being routed for signature by the City Manager. Once this agreement is signed, we will be working with Alameda County on next steps for implementation.

Berkeley Mental Health Caseload Statistics
for September 2021

Adult Services	Intended Ratio of staff to clients	Clinical Staff Positions Filled	# of clients open this month	Average Monthly System Cost Previous 12 Months	Fiscal Year 2022 (July '21-June '22) Demographics as of Sept 2021
Adult, Older Adult and TAY Full Service Partnership (AFSP) (Highest level outpatient clinical case management and treatment)	1-10 for clinical staff.	4 Clinicians .5 Team Lead	67	$3,627	65 Clients API: 1 Black or African-American: 20 Hispanic or Latino:2 Other/Unknown: 30 White: 12 Male: 40 Female: 25
Adult FSP Psychiatry	1-100	.75 FTE	61		
AFSP FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			$2,037,600		
Homeless Full Service Partnership (HFSP) (Highest level outpatient clinical case management and treatment)	1-8 for clinical staff	3 Clinicians, 1 Team Lead	14	$5,231	14 Clients API: 1 Black or African-American: 2 Hispanic or Latino:1 Other/Unknown: 9 White: 1 Male: 9 Female: 5
HFPS Psychiatry	1-100	.2 FTE	16		
HFSP FY22 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			TBD		
Comprehensive Community Treatment (CCT) (High level outpatient clinical case management and treatment)	1-20	8 Clinicians 1 Manager	174	$2,181	174 Clients API: 5 Black or African-American: 43 Hispanic or Latino:10 Other/Unknown: 76 White: 40 Male: 89 Female: 85
CCT Psychiatry	1-200	1 FTE	135		

CCT FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			$2,617,010		
Focus on Independence Team (FIT) **(Lower level of care, only for individuals previously on FSP or CCT)**	1-20 Team Lead, 1-50 Post Masters Clinical 1-30 Non-Degreed Clinical	1 Clinical Supervisor, I Licensed Clinician, 1 CHW Sp./ Non-Degreed Clinical	97	$991	99 Clients API: 3 Black or African American: 28 Hispanic or Latino: 2 Other/Unknown: 34 White: 32 Male: 59 Female: 40
FIT Psychiatry	1-200	.5	87		
FIT FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			$900,451		

Family, Youth and Children's Services	Intended Ratio of staff to clients	Clinical Staff Positions Filled	# of clients open this month	Average Monthly System Cost Last 12 months	Fiscal Year 2022 2022 (July '21-June '22) Demographics as of Sept 2021
Children's Full Service Partnership (CFSP)	1-8	1.5 Clinical	6	$4,214	8 Clients American Indian: 1 API: 0 Black or African-American:3 Hispanic or Latino: 1 Other/Unknown: 2 White: 1 Male: 6 Female: 2
CFSP Psychiatry	1-100	0	1		
CFSP FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$489,235		
Early and Periodic Screening, Diagnostic and Treatment Prevention (EPSDT) /Educationally Related Mental Health Services (ERMHS)	1-20	2.5 Clinical	58	$2,036	59 Clients American Indian: 1 API: 2 Black or African-American: 20 Hispanic or Latino: 15 Other/Unknown: 9 White: 12 Male: 29 Female: 30
ERMHS/EPSDT Psychiatry	1-100	0	2		
EPSDT/ERMHS FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$1,062,409		
High School Health Center and Berkeley Technological Academy (HSHC)	1-6 Clinician (majority of time spent on crisis counseling)	2.5 Clinical	Drop-in: 37 Externally referred: 25 Ongoing tx: 24 Groups: 0		N/A
HSHC FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$396,106		

Crisis and ACCESS Services	Staff Ratio	Clinical Staff Positions Filled	Total # of Clients/Incidents	MCT Incidents Detail	Calendar Year 2021 (Jan '21-Dec '21) Demographics – From Mobile Crisis Incident Log (through Sept 2021)
Mobile Crisis (MCT)	N/A	2 Clinician filled at this time	• 93 Incidents • 32 5150 Evals • 8 5150 Evals leading to involuntary transport	• 50 Incidents: Location - Phone • 38 Incidents: Location - Field • 0 Incidents: Location - Home	596 Clients API: 33 Black or African-American: 126 Hispanic or Latino: 24 Other/Unknown: 268 White: 145 Male: 273 Female: 275 Transgender: 7 Unknown: 41
MCT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$771,623		
Transitional Outreach Team (TOT)	N/A	1 Licensed Clinician, 1 Case Manager (both sometimes reassigned due to staffing needs in other units)	30 Incidents	N/A	266 Clients API: 21 Black or African-American: 57 Hispanic or Latino: 13 Other/Unknown: 104 White: 71 Male: 124 Female: 128 Transgender: 4 Unknown: 10
TOT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available))			$272,323		
Community Assessment Team (CAT)	N/A	1 Team Lead, 1 Clinician, 1 Non-Degreed Clinical	118 Incidents	N/A	406 Clients API: 12 Black or African-American: 105 Hispanic or Latino: 24 Other/Unknown: 157 White: 103 Male: 186 Female: 196 Transgender: 2 Unknown: 22
CAT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available))			$735,075		

Not reflected in above chart is Early Childhood Consultation, Wellness and Recovery Programming, or Family Support.
In demographics, other/unknown is used both when a client indicates that they are multi-racial and when demographic info is not knowm.

*Average System Costs come from YellowFin, and per ACBH include all costs to mental health programs, sub-acute residential programs, hospitals, and jail mental health costs.

CITY OF BERKELEY

PERFORMANCE EVALUATION FORM

(PROFESSIONAL & ADMINISTRATIVE)

REV: 2015-Oct

EMPLOYEE NAME: _____ EMPLOYEE NUMBER: _____ CLASSIFICATION TITLE: _____ OTHER TITLE (state whether provisional, acting, working title): _____ DEPARTMENT: _____ DIVISION: _____ STATUS: ☐ Probationary ☐ Permanent PROBATIONARY PERIOD ENDS (DATE): _____ LENGTH OF TIME IN CLASSIFICATION: _____ PERIOD COVERED BY EVALUATION: From: _____ To: _____ Due Date: _____	OCCASION FOR REPORT ☐ Interim probationary report. ☐ Final probationary report (check one below): ☐ ☐ ☐ ☐ ☐ ☐ ☐ ◀ months' probation 2 4 6 8 12 18 24 ☐ Annual evaluation due on: _____ ☐ Change in supervision on: _____ ☐ Terminal evaluation: _____ ☐ Special (give reason): _____

SUMMARY OF DUTIES AND RESPONSIBILITIES DURING REPORT PERIOD. Briefly outline position responsibilities per job specification. Define goals and objectives set and work assigned during report period. (Use additional sheet if necessary.):

_____

RATE EACH CATEGORY AND ITEM* (*see rating key on last page)	◀UNSATISFACTORY*	◀NEEDS IMPROVEMENT*	◀MEETS REQUIREMENTS	◀EXCEEDS REQUIREMENTS	◀NOT APPLICABLE
A. JOB EFFECTIVENESS					
1. Achieves effective results with a minimum of direction and follow-up	☐	☐	☐	☐	☐
2. Produces accurate and thorough work that meets the expected standards	☐	☐	☐	☐	☐
3. Uses time effectively; organizes and distributes time among duties according to their relative importance	☐	☐	☐	☐	☐
4. Prepares and completes complex administrative, statistical, and program studies with comprehensive analysis and sound recommendations	☐	☐	☐	☐	☐
5. Prepares clear, concise, pertinent and complete written communications	☐	☐	☐	☐	☐
6. Demonstrates initiative and resourcefulness in identifying problems, advising and recommending improvements to program administration, and providing logical and workable solutions	☐	☐	☐	☐	☐
B. DEVELOPMENT					
1. Demonstrates growth and development in job skills and development	☐	☐	☐	☐	☐
2. Uses supervision positively and effectively	☐	☐	☐	☐	☐
3. Understands and supports overall program and purposes of work unit	☐	☐	☐	☐	☐

RATE EACH CATEGORY AND ITEM* (*see rating key on last page)	◀UNSATISFACTORY*	◀NEEDS IMPROVEMENT*	◀MEETS REQUIREMENTS	◀EXCEEDS REQUIREMENTS	◀NOT APPLICABLE
C. JUDGMENT					
1. Analyzes problems, determines issues, evaluates facts, and makes sound judgments based upon these facts	☐	☐	☐	☐	☐
2. Takes effective action in emergency situations and performs well under pressure	☐	☐	☐	☐	☐
3. Foresees probable consequences of actions or recommendations	☐	☐	☐	☐	☐
4. Sets priorities; distinguishes between the practical and the impractical	☐	☐	☐	☐	☐
D. PERSONAL CHARACTERISTICS					
1. Cooperation – Maintains harmonious relationships and demonstrates sensitivity to views and feelings of others	☐	☐	☐	☐	☐
2. Motivation – Displays enthusiasm, interest, energy, and persistence	☐	☐	☐	☐	☐
3. Adaptability - Adjusts to new situations or to changes in program direction or procedures	☐	☐	☐	☐	☐
4. Decisiveness - Determines a definite course of action and carries out a decision	☐	☐	☐	☐	☐
5. Reliability - Is conscientious and reliable in following through and completing work assignments in a timely fashion	☐	☐	☐	☐	☐
6. Safety - Follows prescribed safety practices	☐	☐	☐	☐	☐
7. Attendance - Observes established work hours and standards of attendance	☐	☐	☐	☐	☐
Number of days absent during report period: Sick leave: ____ Authorized leave (w/o pay): ____ Unauthorized leave: ____ Workers' comp. leave: ____					
E. ADMINISTRATIVE SKILLS (if applicable)					
1. Develops, administers, and implements programs and services	☐	☐	☐	☐	☐
2. Implements administration policies and keeps supervisor accurately informed as to progress and results	☐	☐	☐	☐	☐
3. Plans and schedules major projects with a minimum of guidance	☐	☐	☐	☐	☐
4. Effectively observes and reviews the results of his/her department and the activities of subordinates	☐	☐	☐	☐	☐
5. Communicates program mission, goals and objectives to line staff	☐	☐	☐	☐	☐
F. SUPERVISORY ABILITY (if applicable)					
1. Effectively plans and coordinates the work of others	☐	☐	☐	☐	☐
2. Delegates duties and responsibilities to subordinates, providing thorough and clear instructions, and follows up as appropriate	☐	☐	☐	☐	☐
3. Motivates and supports subordinates to greater efforts and improved work methods while inspiring respect and maintaining morale of department, division, or unit	☐	☐	☐	☐	☐
4. Observes performance of subordinates; keeps subordinates advised of the quality of their performance; prepares timely, well documented performance evaluations; recognizes and develops abilities of subordinates	☐	☐	☐	☐	☐
5. Develops, establishes and applies goals and standards for work unit	☐	☐	☐	☐	☐
6. Is thoroughly familiar with personnel procedures and handles personnel matters expeditiously and according to established procedure	☐	☐	☐	☐	☐
7. Selects and manages employees in a manner demonstrating knowledge and sensitivity to current legislation governing workforce management, with special attention to affirmative action goals	☐	☐	☐	☐	☐

OVERALL EVALUATION (overall rating should reflect ratings in categories A through F)

☐ Unsatisfactory ☐ Needs Improvement ☐ Meets Requirements ☐ Exceeds Requirements

EVALUATOR's COMMENTS (to be filled out at time report is prepared). Include: ▪ facts and specific performance information; ▪ results achieved; ▪ list major strengths and weaknesses of employee; and ▪ recommendations, including supervisor's plans to improve employee's performance and to meet training needs (if applicable):

EVALUATOR's SIGNATURE	PRINTED NAME	CLASSIFICATION	DATE

EMPLOYEE's CERTIFICATION

In signing this report, I acknowledge that I have reviewed this report and discussed the contents with the evaluator. I understand that I have the right to add my comments regarding the performance evaluation should I wish to do so. (Use additional sheets if necessary.)

☐ I agree with the evaluation
☐ I disagree with the evaluation

EMPLOYEE's COMMENTS:

____

_____ _____
EMPLOYEE's SIGNATURE DATE

REVIEWER's CERTIFICATION

I certify that I have reviewed this report.

REVIEWER's COMMENTS:

____

_____ _____ _____ _____
REVIEWER's SIGNATURE PRINTED NAME CLASSIFICATION DATE

RATING KEY

The following definitions are to be used as guides in rating "level of performance" of items and categories.

EXCEEDS REQUIREMENTS ▸	The results achieved are measurably better than would be expected of most personnel assigned similar duties and responsibilities.
MEETS REQUIREMENTS ▸	The employee is meeting the position requirements in a manner which is acceptable. The results achieved are those expected of most employees with similar duties and responsibilities.
**NEEDS IMPROVEMENT* ▸	Performance is below the acceptable level for this position. Considerable supervision or learning may be required before performance is satisfactory. An employee whose performance is consistently evaluated at this level should be rated "unsatisfactory."
**UNSATISFACTORY* ▸	The employee has not demonstrated the ability or willingness to meet position requirements.
NOT APPLICABLE ▸	The performance factor does not pertain to the rated employee.

*NOTE: ratings of "needs improvement" and "unsatisfactory" require explanation and comment in section for evaluator's comments.

EMPLOYMENT DEVELOPMENT PLAN (to be filled out by the employee following the discussion of the report). Include: ▪ performance objectives and goals for further improvement during the next report period in order to meet or exceed standards for employee's present position; ▪ plans to develop employee skills; and ▪ self-improvement efforts, i.e., specific methods by which employee can work toward accomplishing performance objectives.

____

_____ _____

EMPLOYEE's SIGNATURE DATE

_____ _____

EVALUATOR's SIGNATURE DATE

See message below

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Monday, October 18, 2021 12:11 AM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Behavioral Health Crisis Response System, Crisis Stabilization & Whole Person Care

Hi Jamie,

Would you please kindly forward this email to the Mental Health Commissioners?

Hello Commissioners,

As many know Research Development Associates (RDA) will soon be releasing 2 reports during October 2021. They include the Community Engagement Report on our current Division of Mental Health's mobile crisis response and the Specialized Care Unit (SCU), as well as the Recommendations for the SCU.

In December we'll consider the overarching behavioral health crisis response system and its service components in light of these reports for the City of Berkeley and Alameda County.

This email is to let you know the Homeless Commission has made a recommendation to the Berkeley City Council to fund a crisis stabilization program for people with mental illness based on a program in Bend, OR. The attached document contains the proposal.

As you know, the Division of Mental Health is adopting the Community Health Records system, which embraces the Whole Person Care Model (see below). The upcoming Medi-Cal reforms (CalAIM) embrace this model too (1/22). As you also know, the purpose of this system is to ensure well-integrated, coordinated care by many care team members across multiple systems and sectors, including for crisis

response and stabilization. This model is specifically designed for people experiencing homelessness with complex needs (see below). The
Community Health Records, as we know from the computer dashboard displays, show the individuals' status across many systems. If you need this email again, let me know.

Whole Person Care Model

Who is Served?

- **People experiencing homelessness**
- **People with complex physical, behavioral and social conditions (SDOH)**
- **People with needs for care across multiple systems, especially to eliminate interactions with police, criminal legal & incarceration systems**
- **People with needs for equitable, tailored culturally safe and responsive services**

As part of the Whole Person Care Model Update for our October meeting, we will consider this recommendation. There may be several aspects to consider including evidence-based best practices for screening, assessing, triaging and treating people during crisis response and stabilization, including using trauma informed, harm reduction, equity-enhancing, integrated service delivery best practices for people who need the services.

Specifically according to the last Point in Time Count in San Francisco from 2019, approximately 8,000 people experience homelessness on any given night. Of these individuals experiencing homelessness, 42% self-report alcohol and drug abuse and 39% report psychiatric and emotion conditions. Two men died of suspected drug overdoses in a Berkeley in June (article below). Homeless Commissioner Paul Keahola-Blake was quoted in the article about the overdoses saying it is not the first time they have happened and that he rushed to alert other encampments about the adulterated drugs.

Nosh Arts Business City Community COVID Crime Housing Neighborhoods Schools Obituaries Opinion Events
Today's news The Oaklandside

COVID-19: Outdoor dining guide • By the numbers | **GET READY:** Wildfire Guide

CRIME & SAFETY

58

By Supriya Yelimeli,
June 14, 2021, 4:59 p.m.

2 men who died of suspected drug overdoses at Berkeley park identified

Police believe the deaths at Civic Center Park resulted from a "bad batch" of drugs laced with fentanyl.

Overall the emergence of the opioid and methamphetamine epidemics (and fentanyl in the drug supply) serves as a stark reminder of the need for integrated health, mental health, substance use, social and other related services, including offering harm reduction and starting medication-assisted treatment (MAT) during crisis response and stabilization as it is a standard of care.

The emergence of research about the effectiveness of MAT (medication-assisted treatment) for substance use disorders and harm reduction practices mean that as a standard of care, all individuals should be offered the opportunity to receive it (if prescribed) including as part of crisis response and stabilization. It is also well known that symptoms of psychosis may manifest as a result of mental illness and/or substance use and it may not be apparent to discern the basis of it.

During our October 2021 update discussion, we will consider substance use services as part of any crisis stabilization program for the City of Berkeley, along with many other ideas. The SCU will be designed for immediate crisis response to people with mental illness and/or substance use issues, including potentially having a separate telephone line to encourage people to call for substance use issues like overdoses. Below are some crisis stabilization center suggestions.

Overall it is also important to realize that structural racism and historic discrimination have negatively impacted people of color and that we must consider how to build equity into every component of our behavioral health system, including ensuring crisis response and stabilization includes people experiencing mental illness and/or substance use issues and disorders. These rates may also impact LGBTQIA+ communities or people with multiple identities.

> In San Francisco, the Black overdose death rate is three times higher than the rate for White populations. Black men die at almost twice the rate of White men from liver cirrhosis, though they have lower rates of alcohol use disorder.
>
> Among the population of people experiencing homelessness in San Francisco who have a behavioral health condition, Black individuals are the sickest and most vulnerable. The evidence suggests that physical health, behavioral health, and housing systems are not meeting the needs of people of color, and they should be considered an urgent priority for the system of care.

Last for our discussion about the Whole Person Care Model and person-centered care, we may want to more closely examine what services should be delivered at a crisis stabilization center (we will have the SCU recommendations as well).

For your consideration, possibly consider these services:

- [→] primary medical, psychiatric, substance use referrals and linkages
- [→] coordination of services, discharge planning,
- [→] transport to next step in care, peer navigation support
- [→] Connection to shelter and housing
- [→] Food, clothing, access to showers, laundry
- [→] peer-led counseling and groups, one-on-one peer support
- [✓] humane, cost-effective alternative to ER rooms, inpatient and jail stays

While there may be robust debate about specific programs, it is potentially useful to discuss the components we would want to consider as essential for a crisis stabilization program in the City of Berkeley.

A Respite and Restoration Center can provide a much needed place for people experiencing homelessness, mental illness and substance use disorders to rest and get connected to care.

I look forward to hearing hearing your thoughts.

Best wishes,
Margaret

Margaret Fine
Pronouns: she/her
Chair, Mental Health Commission
Berkeley, CA
Cell: 510-919-4309
LinkedIn: Margaret Fine

MEETING AGENDA
October 13, 2021 – 7:00 PM

Join Zoom Meeting:
https://zoom.us/j/96645301465
To join by phone: Dial 1-669-900-6833 and enter Meeting ID: 966 4530 1465
Commission Secretary: Josh Jacobs (jjacobs@cityofberkeley.info; 510-225-8035)

All agenda items are for Discussion and Possible Action.

1. Roll Call.
2. Public Comment.
3. Approval of minutes from September 8, 2021. [Attachment 1].

Updates/Action Items:

4. Agenda Approval.
5. Staff to report on current numbers of persons receiving housing through Shelter Plus certificates, Section 8 vouchers for homeless, flex subsidies under Measure P and other subsidies; number of people placed in permanent housing from Project Roomkey motels and hotels; and number of people currently at Horizon.
6. Chair and vice-chair update.
7. Q&A with Peter Radu, or his designee, from City Manager's office, on enforcement of sidewalk ordinance and RV ordinance.
8. Presentation update on COVID vaccine from Healthcare for the Homeless.
9. Recommendation for crisis stabilization program in Berkeley.
10. Discussion, and possible action, regarding the RV lot on Grayson.
11. Discussion of shelter designated expressly for seniors.

Attachments:

1. Minutes from Meeting of September 8, 2021.
2. Development of Crisis Stabilization Program in Berkeley.

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

If you do not wish for your name to appear on the screen, then use the drop-down menu and click on "rename" to rename yourself to be anonymous. To request to speak, use the "raise hand" icon by rolling over the bottom of the screen.

To join by phone: Dial 1-669-900-6833 and enter Meeting ID: 938 4539 3201. If you wish to comment during the public comment portion of the agenda, Press *9 and wait to be recognized by the Chair.

Correspondence and Notice of Decision Requests*:*

Deadlines for Receipt:
A) Supplemental Materials must be received by 5 PM the day before the meeting.
B) Supplemental Communications must be received no later than noon the day of the meeting.

Procedures for Distribution:
A) Staff will compile all Supplemental Materials and Supplemental Communications received by the deadlines above into a Supplemental Packet, and will print 15 copies of this packet for the Commission meeting.
B) For any Supplemental Material or Communication from a Commissioner received after these deadlines, it is the Commissioner's responsibility to ensure that 15 printed copies are available at the meeting. Commissioners will not be reimbursed for any printing or materials expenses.
C) Staff will neither print nor distribute Supplemental Communications or Materials for subcommittee meetings.

Procedures for Consideration:
A) The Commission must make a successful motion to accept and receive all Supplemental Materials and Communications into the record. This includes the Supplemental Packet compiled by staff.

B) Each additional Supplemental Material or Communication received by or before the meeting that is not included in the Supplemental packet (i.e., those items received after the respective deadlines above) must be individually voted upon to be considered by the full Commission.

C) Supplemental Materials subject to a Commission vote that are not accepted by motion of the Commission, or for which there are not at least 15 paper copies (9 for each Commission seat, one for staff records, and 5 for the public) available by the scheduled start of the meeting, may not be considered by the Commission.

****Supplemental Materials** are defined as any items authored by one or more Commissioners, pertaining to an agenda item but available after the agenda and packet for the meeting has been distributed, on which the Commission is asked to take vote at the meeting. This includes any letter to Council, proposed Council report, or other correspondence on behalf of the Commission for which a full vote of the Commission is required.*

*****Supplemental Communications** are defined as written emails or letters from members of the public or from one or more Commissioners, the intended audience of which is the full Commission. Supplemental Communications cannot be acted upon by the Commission, and they may or may not pertain to agenda items.*

Any writings or documents provided to a majority of the Commission regarding any item on this agenda will be made available for public inspection at Health, Housing & Community Services Department located at 2180 Milvia Street, 2nd Floor.

Public Comment Policy*:*
Members of the public may speak on any items on the Agenda and items not on the Agenda during the initial Public Comment period. Members of the public may not speak more than once on any given item. The Chair may limit public comments to 3 minutes or less.

Any writings or documents provided to a majority of the Commission regarding any item on this agenda will be made available for public inspection at Health, Housing & Community Services Department located at 2180 Milvia Street, 2nd Floor.

COMMUNITY ACCESS INFORMATION

This meeting is being held in a wheelchair accessible location. To request a disability-related accommodation(s) to participate in the meeting, including auxiliary aids or services, please contact the Disability Services specialist at 981-6342 (V) or 981-6345 (TDD) at least 3 business days before the meeting date. Please refrain from wearing scented products to this meeting.

Communications to Berkeley boards, commissions or committees are public record and will become part of the City's electronic records, which are accessible through the City's website. Please note: e-mail addresses, names, addresses, and other contact information are not required, but if included in any communication to a City board, commission or committee, will become part of the public record. If you do not want your e-mail address or any other contact information to be made public, you may deliver communications via U.S. Postal Service or in person to the secretary of the relevant board, commission or committee. If you do not want your contact information included in the public record, please do not include that information in your communication. Please contact the secretary to the relevant board, commission or committee for further information. The Health, Housing & Community Services Department does not take a position as to the content. Communications to Berkeley boards, commissions or committees are public record and will become part of the City's electronic records, which are accessible through the City's website. Please note: e-mail addresses, names, addresses, and other contact information are not required, but if included in any communication to a City board, commission or committee, will become part of the public record. If you do not want your e-mail address or any other contact information to be made public, you may deliver communications via U.S. Postal Service or in person to the secretary of the relevant board, commission or committee. If you do not want your contact information included in the public record, please do not include that information in your communication. Please contact the secretary to the relevant board, commission or committee for further information. The Health, Housing & Community Services Department does not take a position as to the content.

ADA Disclaimer "This meeting is being held in a wheelchair accessible location. To request a disability-related accommodation(s) to participate in the meeting, including auxiliary aids or services, please contact the Disability Services Specialist at 981-6418 (V) or 981-6347 (TDD) at least three business days before the meeting date. Please refrain from wearing scented products to this meeting."

MEETING MINUTES

September 8, 2021

1. Roll Call: 7:05 PM
   Present: Kealoha-Blake, Marasovic, Behm-Steinberg.
   Absent: Andrew, Gomez.
   Staff: Jacobs, Carnegie.
   Council: None.
   Public: 6.

2. Public Comment: 1

3. Approval of minutes from July 14, 2021.

   Action: M/S/C Kealoha-Blake/Marasovic move to approve the minutes from July 14, 2021 as written.

   Vote: *Ayes:* Kealoha-Blake, Marasovic, Behm-Steinberg.
   Noes: None. *Abstain:* None. *Absent*: Andrew, Gomez.

Updates/Action Items:

4. Agenda Approval

   Action: M/S/C Marasovic/Behm-Steinberg move to move item 6 above item 5 and to approve the agenda.

   Vote: *Ayes:* Kealoha-Blake, Marasovic, Behm-Steinberg,
   Noes: None. *Abstain:* None. *Absent*: Andrew, Gomez.

5. Presentation from Women's Daytime Drop-In Center on new system of transitioning placement of family homelessness in Albany, Berkeley and Emeryville, from Family Front Door to the Women's Daytime Drop-In Center and challenges in addressing family homelessness.

   Discussion; no action taken.

6. Chair and Vice-Chair Update.

   Discussion; no action taken.

7. Presentation from Neighborhood Services in City Manager's office on sidewalk ordinance, RV ordinance, disposition of persons displaced from the freeway

encampments and other encampments following notice, plans in process for alternative shelter and housing placement.

Discussion; no action taken.

8. Statistics on COVID vaccination and testing of persons experiencing homelessness, sheltered and unsheltered, and outreach being conducted to promote vaccinations among persons experiencing homelessness. Staff to report data and outreach practices on COVID vaccination.

   Discussion; no action taken.

9. Staff to report number of current, and recent, COVID positive cases for persons in Berkeley shelters and encampments/streets and on current protocol followed when COVID-positive cases are identified in shelters.

   Discussion; no action taken.

10. Explanation of how HMIS data is used on a day-to-day basis, how it is used to set priorities and how it can be used to create system-wide reports to track progress on homelessness.

    Discussion; no action taken.

Meeting adjourned at 9:00 PM

Minutes Approved on: _____

Josh Jacobs, Commission Secretary: _____

To: Mayor and Members of the Berkeley City Council
From: Homeless Commission
Submitted by: Paul Kealoha-Blake, Chair, Homeless Commission
Carole Marasovic, Vice-Chair, Homeless Commission
Subject: Development of Crisis Stabilization Program in Berkeley

RECOMMENDATION: That City Council refer to the City Manager to develop a crisis stabilization program based on the Bend, Oregon crisis stabilization model, tailored to Berkeley, consistent with Councilmember Terry Taplin's proposal for same.

FISCAL IMPACTS: The exact fiscal impact will have to be determined by the City Manager's office. However, the costs will be substantially offset by the costs that will be saved by reducing the number of 5150 transports for which the City of Berkeley currently allocates 2.4 million annually from Measure P monies. Grants are also available that will fund the crisis stabilization program.

CURRENT SITUATION and ITS EFFECTS: Currently, Berkeley has no options to transport persons in mental health crisis except to the County John George mental health facility or the Santa Rita Jail. As such, the City absorbs the cost of transporting persons which are not covered by insurance and persons, in mental health crisis, are at best, generally, brought to an inpatient facility that stigmatizes them and warehouses them briefly, only to discharge them back to the same situation from where they came, and at worst, acts punitively in placing them into a correctional setting without needed mental health treatment and linkage to resources in their own community.

The United States Department of Justice recently released a scathing investigative report on the lack of community mental health models in Alameda County.
Justice Department Finds that Alameda County, California, Violates the Americans with Disabilities Act and the U.S. Constitution

Disability Rights California has filed litigation based on the same premise. https://www.disabilityrightsca.org/press-release/disability-rights-california-files-lawsuit-against-alameda-county-for-its-failed

Berkeley is one of two mental health divisions in the state that has its own mental health division, independent from the County, with its own mental health streams of funding. Thus, Berkeley is responsible, in large part, for establishing its own community mental health programs. Yet, Berkeley has provided no alternative for persons in mental health crisis to seek stabilization, on a voluntary basis, nor an alternative for law enforcement to transport persons in mental health crisis, when the Berkeley Police Department is actively engaging with a person in mental health crisis, other than the same County facilities, being John George and the Santa Rita Jail, that the Department of Justice has found to be deficient in providing needed mental health services, and as overly restrictive and punitive.

It has been estimated that 40%-50% of Berkeley's 5150 transports are homeless. Thus, the unhoused are greatly impacted by the inappropriate and punitive transports to John George and Santa Rita because of the lack of community mental health models. The unhoused are also greatly impacted by the lack of models so that they are frequently returned to the streets, in the same situation, instead of facilitating linkage to resources in the Berkeley community. The substantial number of unhoused persons that receive 5150 transport has resulted in 2.4 million of Measure P monies, allocated for homeless services, directed towards this transport.

BACKGROUND: On October 13, 2021, the Homeless Commission passed a motion as follows:

That City Council refer to the City Manager to develop a crisis stabilization program based on the Bend. Oregon crisis stabilization model tailored to Berkeley, consistent with Councilmember Terry Taplin's proposal for same and that this report be incorporated into the Homeless Commission's recommendation.

M/S: Yes: Noes:

Abstentions:

ENVIRONMENTAL SUSTAINABILITY and CLIMATE IMPACT: Following the implementation of a crisis stabilization program, a substantial number of persons in mental health crisis will be diverted away from transport to farther away unnecessary institutionalization and incarceration into a community-based model in their own Berkeley community.

RATIONALE for RECOMMENDATION: As an independent mental health division, Berkeley has a responsibility to step up and establish appropriate treatment community mental health models that are community-based. At this juncture, persons in mental health crisis have no local place to stabilize and voluntarily seek assistance, to take respite and to intensively linked up with other services on a 24/7 model. The Berkeley Police Department has no location to bring persons in mental health crisis other than the inappropriate ones provided by the County.

Bend, Oregon has successfully implemented a 23 hour crisis stabilization program that is an excellent model for Berkeley to tailor to Berkeley needs.

There are multiple reasons that the Bend model would work in Berkeley. First, Bend's population, at 93,917, is similar to Berkeley's in numbers. The Bend program is a 24/7 program with recliners where people rest while they are provided intensive mental health support and linkage to community resources as needed. Unlike some crisis stabilization programs elsewhere, Bend's crisis stabilization program is focused on mental health needs. It is not a program directed exclusively towards sobriety or a homeless shelter as are some programs elsewhere. Albeit that they have behavioral health clinicians on staff, Bend's focus is not a medical model. With Bend's current increasing homelessness. they estimate that 30% of persons in mental health crisis utilizing their crisis stabilization program are of homeless status.

Bend's program takes walk-ins unlike some programs. Any person seeking mental health crisis stabilization can walk in voluntarily on a 24/7 basis. There are no financial eligibility requirements. Thus, whether or not a person is medically insured, they will be easily welcomed and accepted into Bend's mental health crisis stabilization program. Persons can come in from any source as long as they voluntarily choose to do so.

When law enforcement engages with a person in mental health crisis in Bend, they present them with three options: the inpatient mental health facility, the jail or the crisis stabilization program. The choice is that of the person in crisis. They will not otherwise be involuntarily directed into the program but provided the three options where they can be transported. Persons in mental health crisis frequently choose the crisis stabilization program. Doing so not only allows them to receive respite and linkage to resources within their own community, it frees them from the stigma of being involuntarily committed or incarcerated.

A survey of participants in the Bend crisis stabilization program revealed that 3% of persons in mental health crisis who had come to the program (37 persons) had stated that had they not come to the

program, they would have taken their lives. There is no greater cost-effectiveness than the cost of saving human lives.

Bend also found that when there was a transport from law enforcement, law enforcement spent only an average of four minutes transitioning persons into the crisis stabilization program as opposed to far longer time required of law enforcement when a person in mental health crisis was directed towards institutionalization or incarceration.

Berkeley's direction will have one distinction in that the Bend program is operated by their County which has an elaborate crisis system. Berkeley's program would be based in Berkeley and contracted out to a nonprofit provider competent to provide 24/7 crisis stabilization program services.

The issues that will have to be addressed by the City Manager's office, which, in part, will be within Councilmember Terry Taplin's proposal, will be funding issues, staffing (both numbers and qualifications) and location.

ALTERNATIVE ACTIONS CONSIDERED: The only alternative is to do nothing and to be complicit with the County in providing a lack of appropriate community-based mental health services for persons in mental health crisis.

CITY MANAGER:

CONTACT: Josh Jacobs, Homeless Services Coordinator, (510) 981-5435

Attachment: Powerpoint presentation from Bend, Oregon

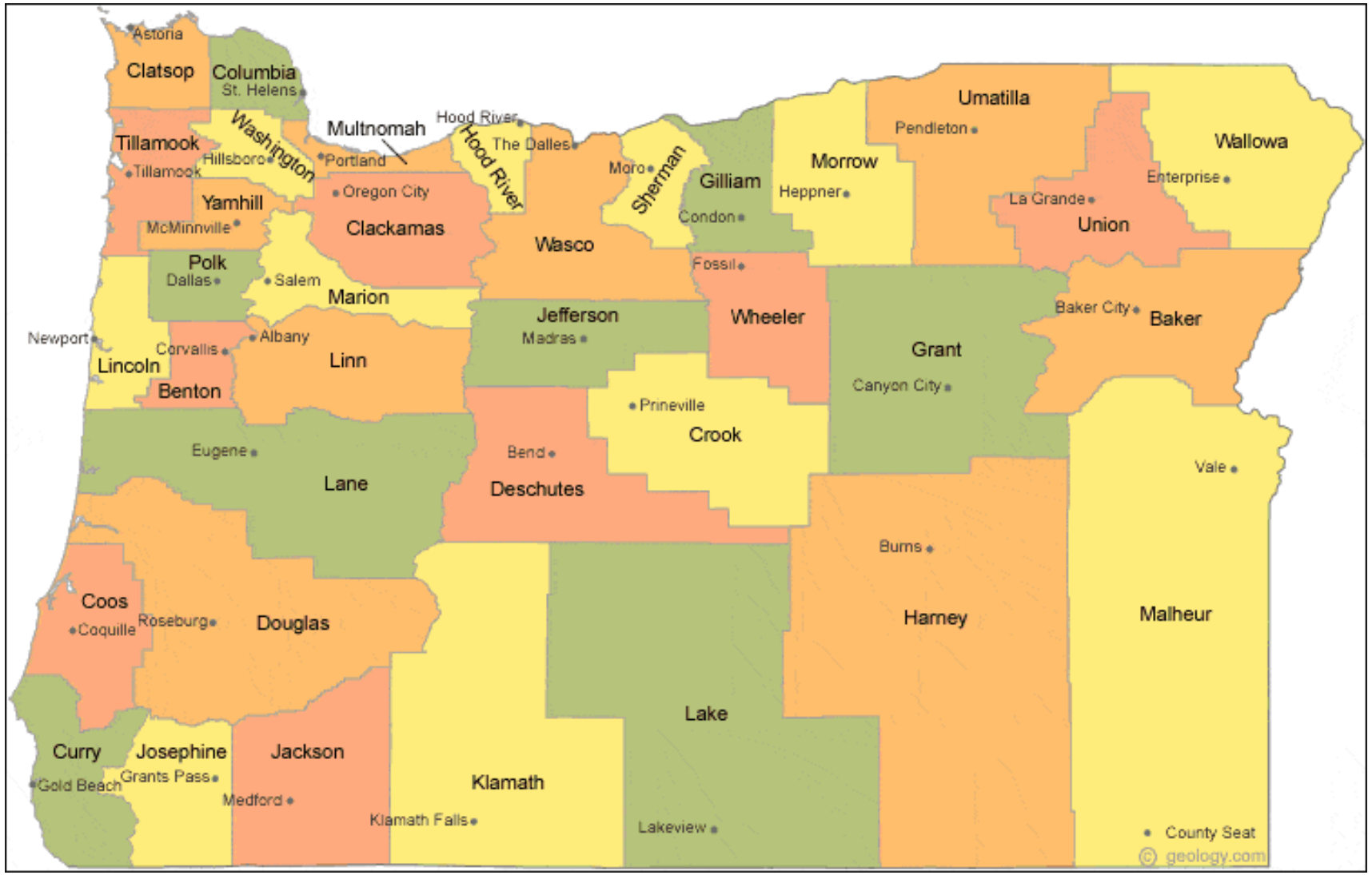
Practical Tips to Open a Crisis Stabilization Unit: A medium-sized county perspective

Holly Harris, M.Ed., LPC – Program Manager, Crisis Services

Adam Goggins, MA, LPC – Crisis Team Supervisor

Deschutes County, Oregon

Population: 200K
County Seat: Bend
Area: 3018 miles²
Person's per Square Mile: 52
Topography: High Desert

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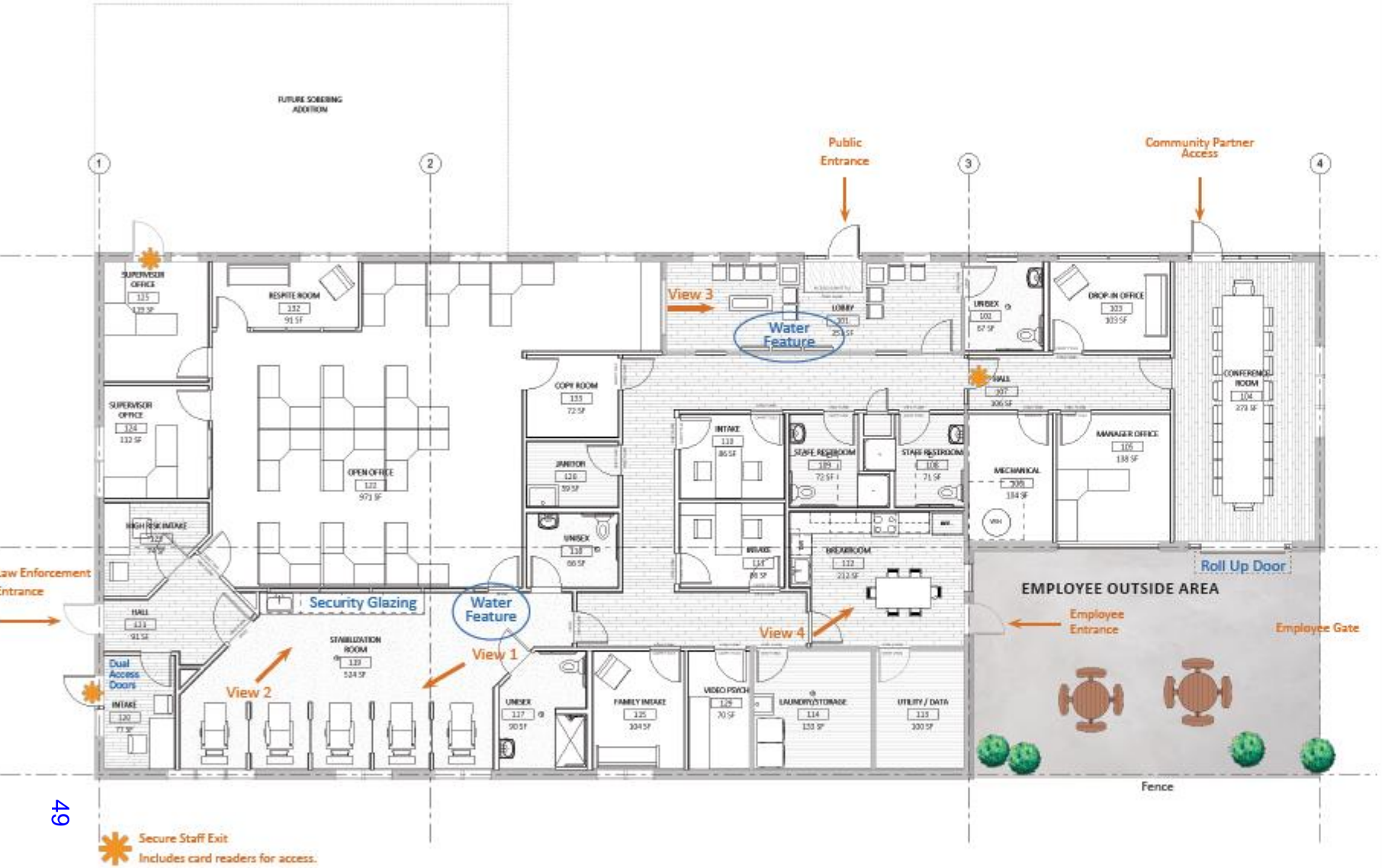
OBLIVION BREWING CO.™

Deschutes County Stabilization Center (DCSC)

Est. June 2020

Quick Facts:
- Voluntary facility
- Treats children and adults
- Accepts walk in's and law enforcement drop off
- 23-hour respite unit

PROPOSED FLOORPLAN



3D VIEWS

View 1 (Stabilization Room 119)

Client seating area for comfort. Partitions for privacy.

View 2 (Stabilization Room 119)

Security glazing allows staff to view the stabilization room through two-way windows (clients cannot see into the office) for monitoring and observation.

View 3 (Lobby)

The lobby includes comfortable seating and an enclosed water feature to create a calm environment for visitors.

View 4 (Break Room)

An equipped employee break room provides a reprieve for staff with access to an outdoor fenced patio.

INSPIRATION

Example of an enclosed water feature.

Goals of the Stabilization Center

- To reduce the number of individuals with Serious Mental Illness who end up in the criminal justice system.

Goals of the Stabilization Center

- To provide a place for law enforcement to quickly bring someone in a crisis so they can get back to their duties

Goals of the Stabilization Center

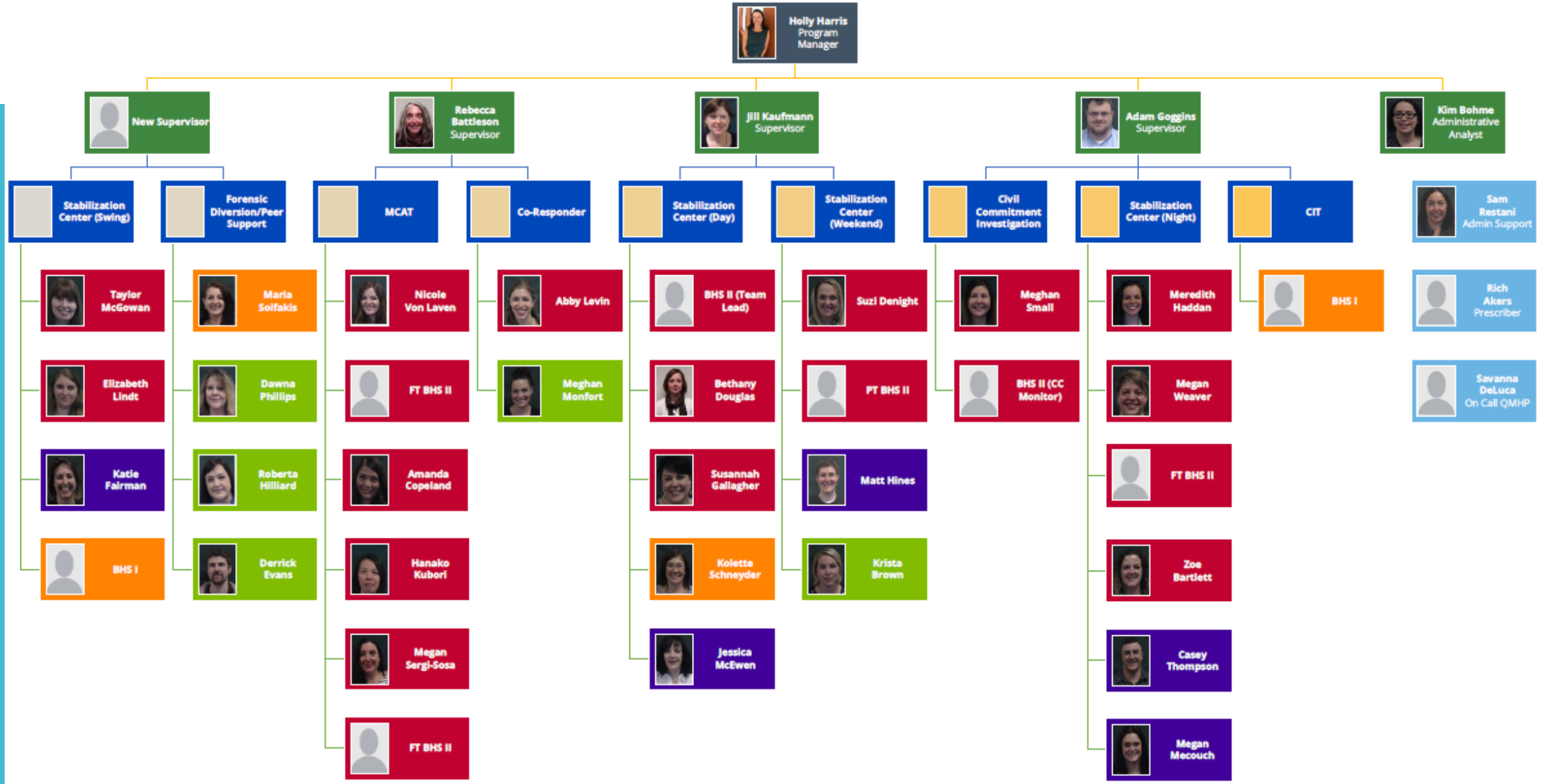
- To reduce the number of individuals going to the Emergency Department for mental health crisis.

Goals of the Stabilization Center

- To help people experiencing a mental health crisis stabilize in their community and become connected to resources so they engage in mental health treatment to regain a better quality of life.

Services Provided at the Stabilization Center

- Crisis Intervention
- Case Management
- Peer Support
- Medication management
- Respite
- Civil Commitment Investigations
- Jail Diversion Program
- Crisis Line


Holly Harris
Program Manager
New Supervisor
Rebecca Battleson
Supervisor
Jill Kaufmann
Supervisor
Adam Goggins
Supervisor
Kim Bohme
Administrative Analyst
Stabilization Center (Swing)
Forensic Diversion/Peer Support
MCAT
Co-Responder
Stabilization Center (Day)
Stabilization Center (Weekend)
Civil Commitment Investigation
Stabilization Center (Night)
CIT
Sam Restani
Admin Support
Taylor McGowan
Elizabeth Lindt
Katie Fairman
BHS I
Maria Soifakis
Dawna Phillips
Roberta Hilliard
Derrick Evans
Nicole Von Laven
FT BHS II
Amanda Copeland
Hanako Kubori
Megan Sergi-Sosa
FT BHS II
Abby Levin
Meghan Monfort
BHS II (Team Lead)
Bethany Douglas
Susannah Gallagher
Kolette Schneyder
Jessica McEwen
Suzi Denight
PT BHS II
Matt Hines
Krista Brown
Meghan Small
BHS II (CC Monitor)
Meredith Haddan
Megan Weaver
FT BHS II
Zoe Bartlett
Casey Thompson
Megan Mecouch
BHS I
Rich Akers
Prescriber
Savanna DeLuca
On Call QMHP
Peer Support Specialist
Individuals with lived life experience who offer support and encouragement to individuals struggling with a mental health condition
Behavioral Health Specialist II (BHS II)
Master's level clinician who assess the needs of client's and make referrals to appropriate resources and to levels of care. All BHS II's have the ability to refer individuals into respite, schedule prescriber appointments, and utilize other services at the DCSC
Behavioral Health Tech (BHT)
A mental health technician runs front desk operations, performs administrative taks, and provides supportive services to individuals recieving services at the crisis center
Case Managers (BHS I)
Bachelor's level clinician who provides direct case management services and with navigating resource systems

Practical Tips to Open a Crisis Stabilization Unit

Practical Tip: Actively Use Sequential Intercept Mapping

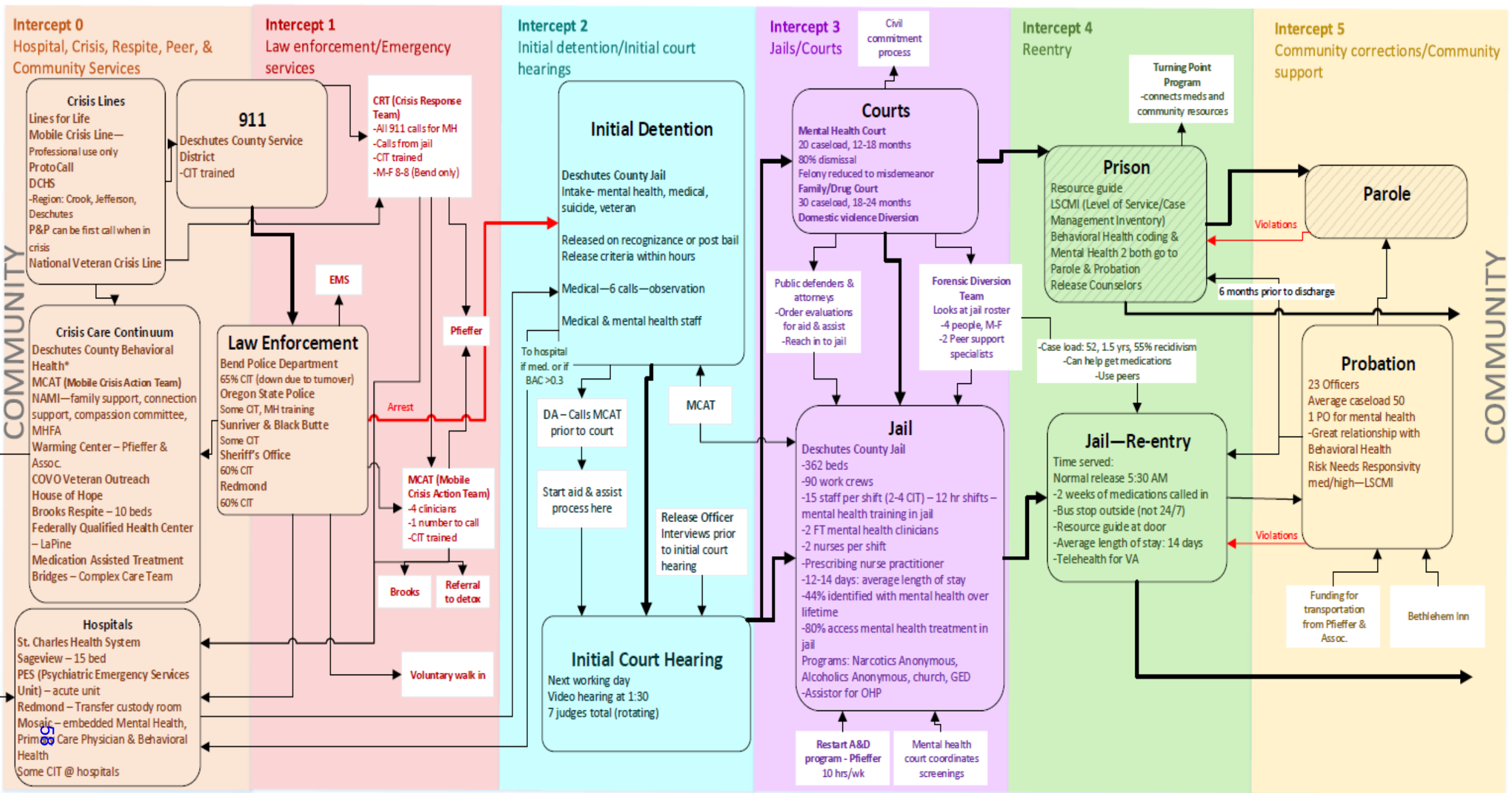
SEQUENTIAL INTERCEPT MAPPING

2012 Top Priorities

- Focus on High Criminal Justice Utilizers
- Expand Detoxification Services
- Hire Court Release Officer
- Enhancement of Jail Mental Health Services

2018 Top Priorities

- 24 hour Stabilization Center/23-hour respite
- Increase the number of Peer Support Specialist
- 100% of officers trained in CIT or MHFA
- Increase the number of LE agencies with a mental health unit



*Walk-in clinic M-F 8-4
-immediate assessment

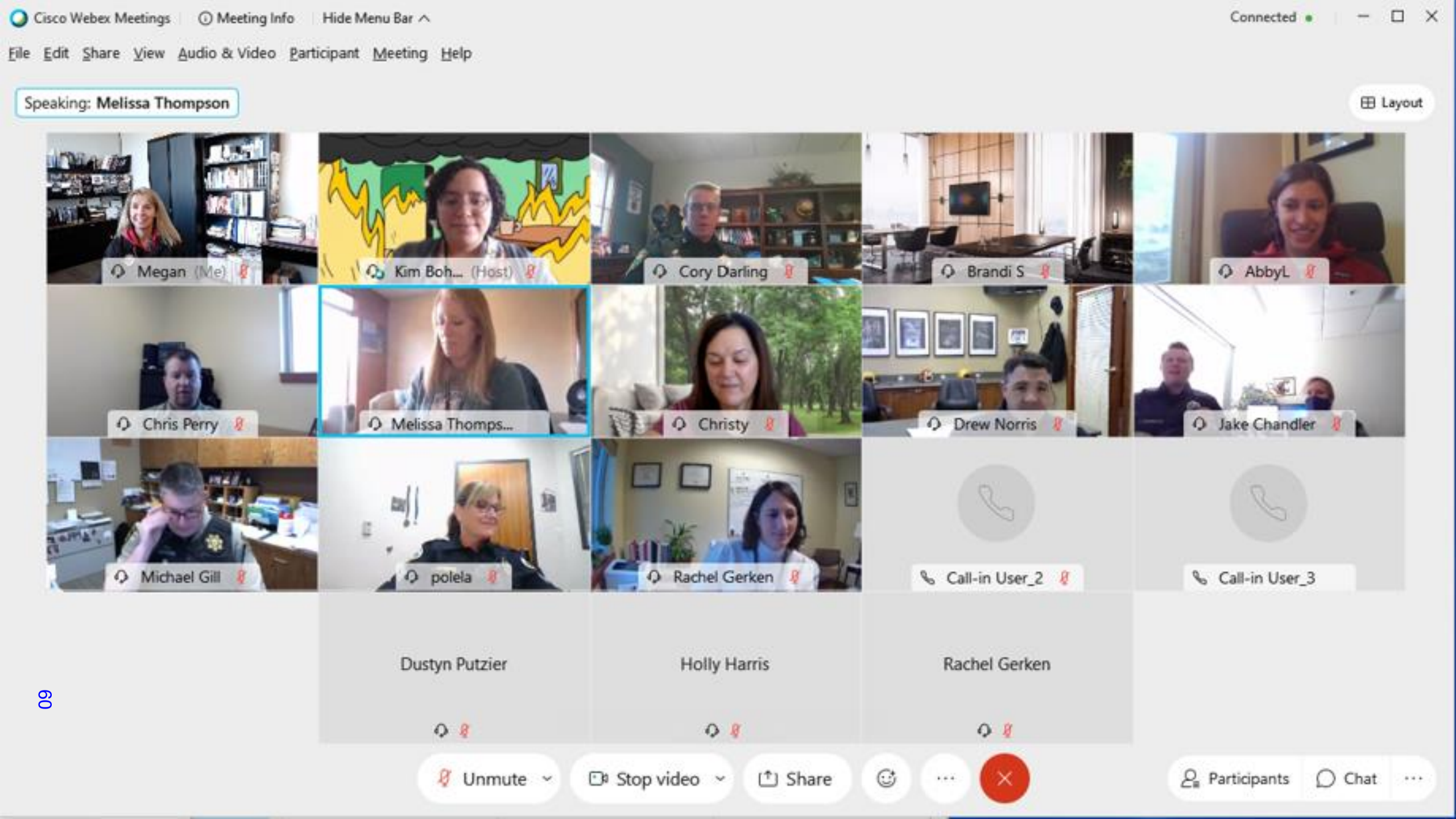
*Law enforcement agency average wait 2.5-3 hrs for police officer hold.

Mosaic Mobile Clinic
-Families can contact for help

*Community Health Workers at hospitals and clinics

Practical Tip: Leverage Relationships Through a Robust CIT Program

Deschutes County has an active CIT Program with dedicated individuals and agencies who show up and contribute. We discuss difficult cases and ongoing systems issues. The meeting is solution focused and is based on mutual respect, trust, and accountability.


Cisco Webex Meetings
Meeting Info
Hide Menu Bar
Connected
File Edit Share View Audio & Video Participant Meeting Help
Speaking: Melissa Thompson
Layout
Megan (Me)
Kim Boh... (Host)
Cory Darling
Brandi S
AbbyL
Chris Perry
Melissa Thomps...
Christy
Drew Norris
Jake Chandler
Michael Gill
polela
Rachel Gerken
Call-in User_2
Call-in User_3
Dustyn Putzier
Holly Harris
Rachel Gerken
Unmute
Stop video
Share
Participants
Chat

60

Practical Tip: Harness Existing Collaborations and Garner Leadership Buy-In

- Advocacy groups (NAMI)
- CIT steering committee
- Acute Care Advisory Board
- Behavioral Health Advisory Board
- Coordinated Care Organizations
- Commissioners
- Local City Councils
- Local Public Safety Coordinating Council (LPSCC)

Present, present, present….to <u>anyone</u> who will listen!

Practical Tip: Have a Good Referral System in Place BEFORE You Open

Mobile Crisis Team and Co-responder

- Operational since approximately 2004
- Currently consists of 2 teams of 3 Masters level clinicians
- They operate in 24 hour shifts where one clinician is the primary on-call clinician for 12 hours with the other two positions serving as back up. They rotate primary
- Recently implemented response without police to certain call types

Jail Diversion

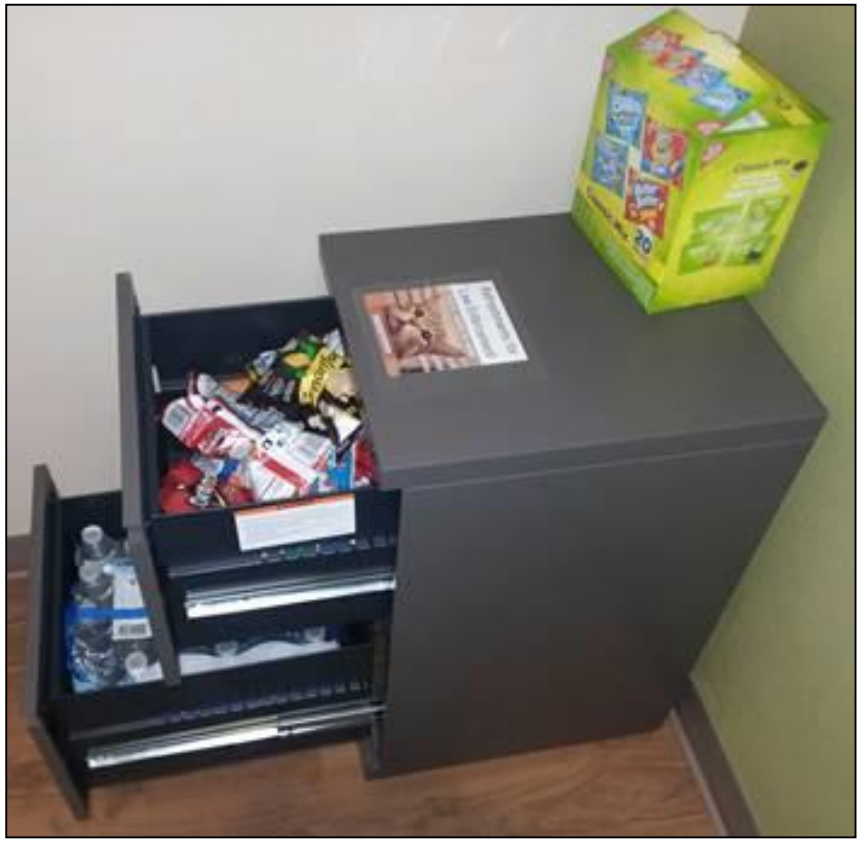
THE STEPPING UP INITIATIVE

National initiative to reduce the number of individuals with mental illness in jails

Deschutes County Forensic Diversion Program

- Established in 2015 through a State grant that later became ongoing funding
- 2 peer support specialist and a case manager
- In reach to the jail, follow up from mobile team contacts
- Consistent reduced the recidivism of the people served
- We Stay involved until the individual achieves four clinical contacts in 60 days

Practical Tip: Maintain a Good Referral System Place AFTER You Open



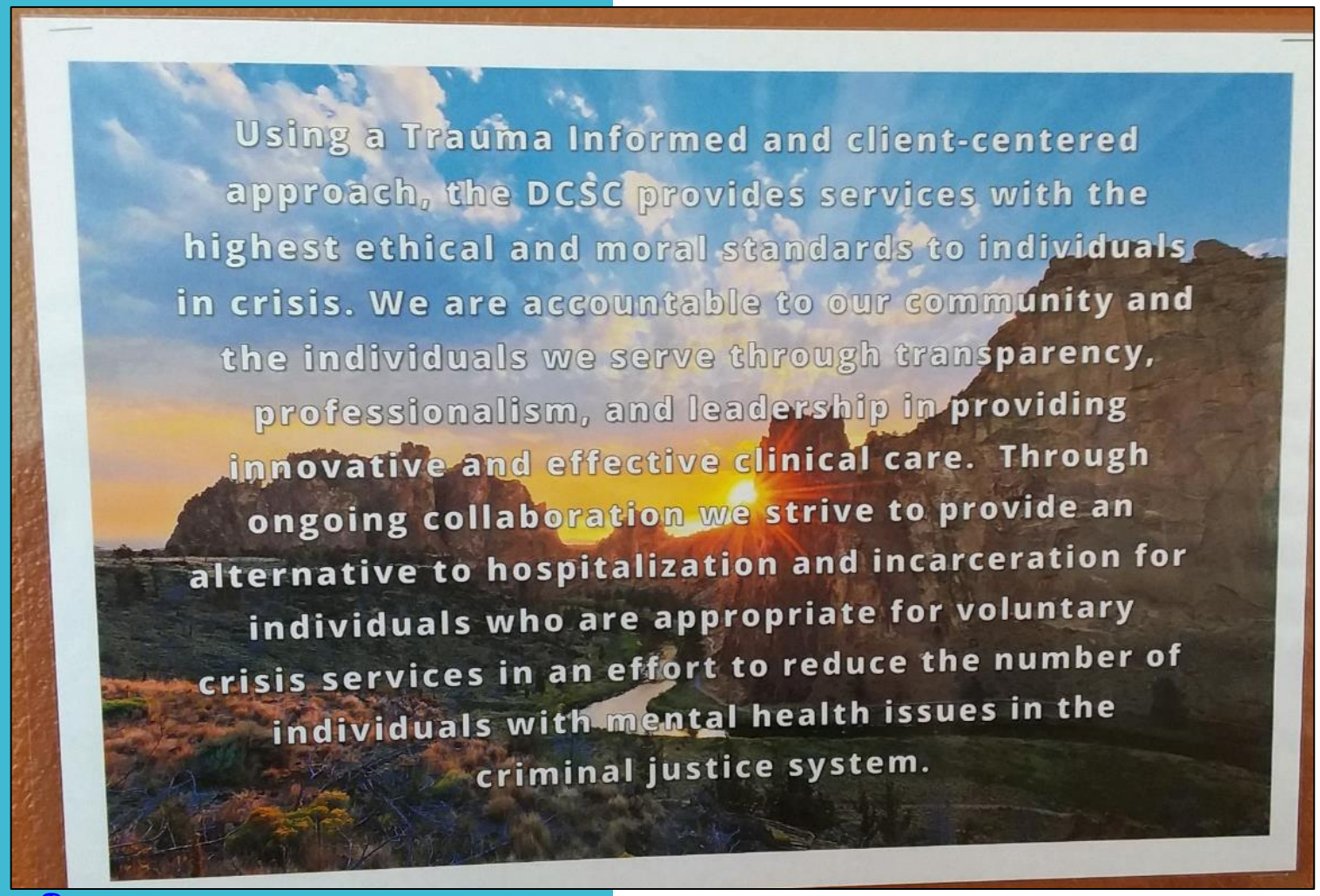
Practical Tip: Do Your Research

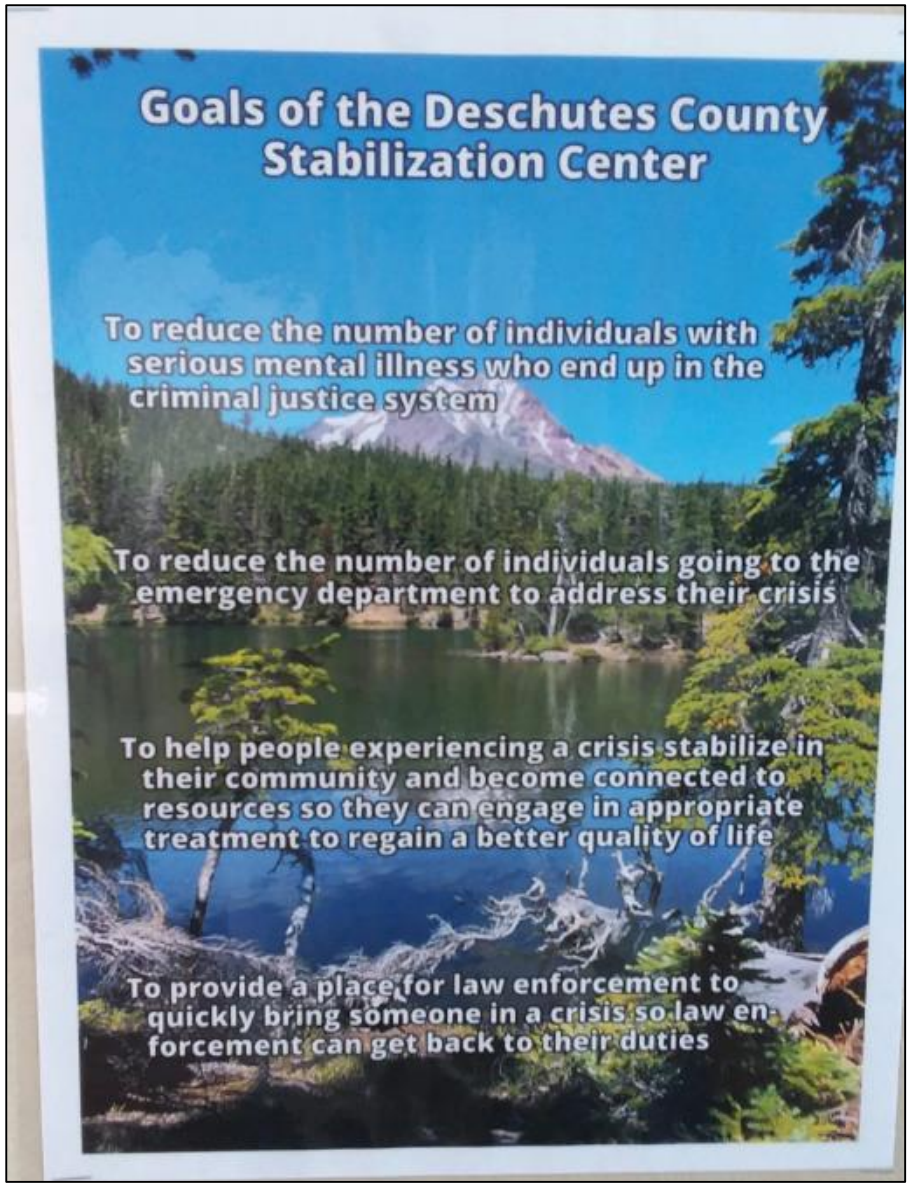
Researching other programs:

- Policies and procedures
- Services provided
  - Respite
  - Sobering
  - Case Management
  - Peer Support
  - Medication Management
- Staffing models
- Forms and paperwork
- Referral Sources
  - Police
  - Walk-Ins
  - Both
- Budgets and funding models
- Site reviews
- Hours and days of operation

Practical Tip: Have Consistent Messaging

- Set Goals Early (in collaboration with key stakeholders) and stick with them
  - Stick to your mission
- Build the program around the goals
- Stay on message
- Garner Media Support when possible


Using a Trauma Informed and client-centered approach, the DCSC provides services with the highest ethical and moral standards to individuals in crisis. We are accountable to our community and the individuals we serve through transparency, professionalism, and leadership in providing innovative and effective clinical care. Through ongoing collaboration we strive to provide an alternative to hospitalization and incarceration for individuals who are appropriate for voluntary crisis services in an effort to reduce the number of individuals with mental health issues in the criminal justice system.


Goals of the Deschutes County Stabilization Center
To reduce the number of individuals with serious mental illness who end up in the criminal justice system
To reduce the number of individuals going to the emergency department to address their crisis
To help people experiencing a crisis stabilize in their community and become connected to resources so they can engage in appropriate treatment to regain a better quality of life
To provide a place for law enforcement to quickly bring someone in a crisis so law enforcement can get back to their duties

The Bulletin

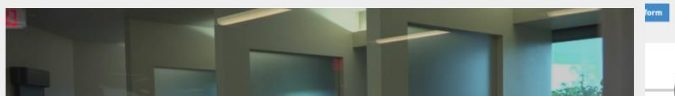
Deschutes County appears to be moving forward with mental health crisis center

$1 million in grant funding no longer in jeopardy

By Brenna Visser
The Bulletin May 23, 2019

Central Oregon daily News

COVID-19 News Weather Live Contests Weekly Features



Stabilization Center a new tool for mental health professionals

6/17/2020

It puts a strain on emergency rooms and law enforcement – people in the middle of a mental health crisis.

Last year, there were 3,000 calls to the crisis line.

The Bulletin

In Bend, mental health worker teams with police

Counselor rides with cops to keep mentally ill people out of jail

By Garrett Andrews • The Bulletin Jun 9, 2019

Abby Levin, a licensed professional counselor with the Deschutes County Health Department, talks with Bend Police officer Jake Chandler while working a shift together. (Ryan Brennecke/Bulletin photo)

RYAN BRENNECKE/The Bulletin

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Long-sought Deschutes County Stabilization Center set to open Monday

a long-sought facility to
day.
ter off Highway 20 in Bend.
utes County Health Services

SOURCE

CULTURE NEWS & FEATURE FOOD & DRINK OUTSIDE CALENDAR SHOP

Decriminalizing Mental Illness

Deschutes County is set to open a stabilization center this spring. With a 17-fold increase in mental health calls over the past decade, it's a welcome addition

BY LAUREL BRAUNS

Calls to the Bend Police Department involving people who were "allegedly mentally ill" increased by 172% from 2010 to 2017. People affected by mental illness end up in prisons and jail at a much higher rate than people without a diagnosis. In response to the increase in calls, Deschutes County has created a number of innovative programs—backed by federal grants—aimed at intervening early to connect people with the resources they need to stay out of jail and the emergency room.

The Deschutes County Sta
2020 and will cost approx
week.

For many people with s
entry into mental healt
commit petty crimes lik
Harris, crisis program
four percent of people
2016, according to a stu
them to get out, as thei

On a national level, Or
America, comparing th
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SOURCE

CULTURE NEWS & FEATURE FOOD & DRINK OUTSIDE

Deschutes County Stabilization Center Opens

People experiencing a mental health crisis finally have a place to go that's not jail or the emergency room

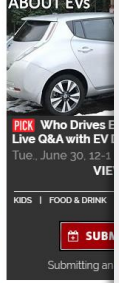
BY LAUREL BRAUNS

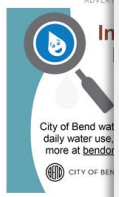
Central Oregon has gained a national reputation for trying out progressive mental health approaches that cost less and help people more. Some of these innovative programs—such as the new Deschutes County Stabilization Center—demonstrate cooperation between local law enforcement, behavioral health agencies and emergency response teams.

The Deschutes County Stabilization Center welcomed its first clients this week. DESCHUTES COUNTY

City and county governments across the U.S. are currently discussing new partnerships and programs to overhaul the criminal justice system and defund the police. This comes in response to worldwide protests against the killing of George Floyd by a police officer in Minneapolis and other incidents of police brutality. Some people in the reform movement believe that it would make more sense for someone in distress to work with a mental health professional rather than an armed police officer who could potentially hurt them or may be perceived as threatening, according to Vox.

In Deschutes County, the new stabilization center adopts this philosophy by providing a place for people to go besides jail when they have mental breakdowns or commit petty crimes.





NEWSLETTER SIG

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CULTURE NEWS & FEATURE FOOD & DRINK OUTSIDE CALENDAR SHOP

NEWS » LOCAL NEWS December 03, 2019

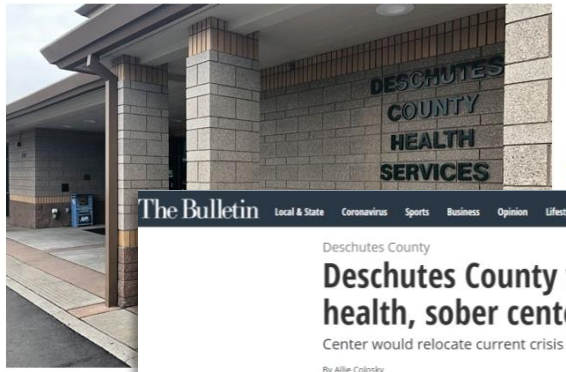
A Progressive Approach To Health

An inside look at Deschutes County Behavioral Health

BY LAUREL BRAUNS

Last week, the *Source Weekly* published a piece about the county's efforts to decriminalize mental illness. Local crisis experts told stories of working within jails and police departments to identify and assist people coping with chronic mental health disorders.

This week, Deputy Director Janice Garceau of Deschutes County Behavioral Health provides an inside look at the organization's progressive approach to mind/body health, its ability to win competitive national grants and its team of peer support specialists who bring hope to those suffering in the community.



The Bulletin

Deschutes County

Deschutes County wants to build mental health, sober center

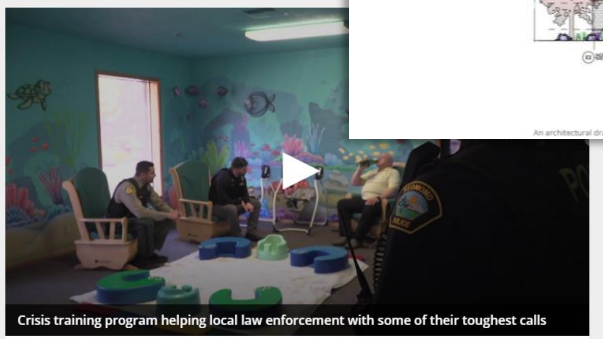
Center would relocate current crisis services, extend hours

By Allie Colosky
The Bulletin Jan 22, 2018

An architectural drawing of the proposed Deschutes County stabilization center. (Submitted photo)

Central Oregon daily News

COVID-19 News



Crisis training program helping local law enforcement with some of their toughest calls

Crisis training program helping local law enforcement with some of their toughest calls

11/12/2019

Living with a mental illness is challenging.

For law enforcement, responding to a call involving someone in crisis is equally tough.

Just this year, in a 9-month period, Deschutes County's Crisis Team fielded an average of 155 calls a month from law enforcement.

OSU-Cascades to host conversation about racial unrest in nation

BPRD to open Juniper kids' pool July 6th

Practical Tip: Develop Creative Approaches to Funding

- Existing Resources
- Grants
- Coordinated Care Organizations
- Phased in approach
- Sustained funding through county general fund & community partner contributions

Initial Funding for the Deschutes County Stabilization Center

- $504,606 – Pacific Source Strategic Investment Dollars (Capital)
- $510,428 – WEBCO Dissolution Payment (Capital)
- $70,000 – Bend Police Department
- $570,000/annually – Deschutes County Sherriff's Office
- $700,000 – Bureau of Justice Assistance Grant
  - Case manager, 20 hours of psychiatric services, contract with OHSU for program evaluation and data collection
- $350,000 – SAMHSA (CCBHC Extension)
- $584,000 – Central Oregon Health Council
- 2.4 million - IMPACTS Grant/Oregon Criminal Justice Commission

Practical Tip: Think outside the 9 to 5

- 2 Master's level clinicians/1 Behavioral Health Technician (front desk)
- Day shift M-F 7 am – 3:30 pm
- Swing Shift M-F 3:00 pm – 11:30 pm
- Night Shift M-W, W-F 8:00pm to 8:30 am
- Saturday/Sunday Day 7am to 7pm
- Saturday/Sunday Night 7pm to 7 am
- 30 min change of shift

Developing a Schedule

- Look at many alternatives as possible
  - Unique scheduling options
    - 12 hour shifts
    - 10 hour shifts
    - Redundancy in scheduling
  - Backup plans
    - On-call
    - Stipend pay
    - Exempt vs non-exempt
  - Full staffing vs. minimum staffing
- Look at other 24-hour scheduled agencies in your area
  - Jails
  - Law enforcement agencies
  - Hospitals

Practical Tip: Work Towards Continuous Growth and Improvement

- Stay Solution Focused
  - Do not avoid difficult topics
  - Do not take things personally or dogmatically
    - Leave your ego at the door and work collaboratively
- Be Flexible
  - Avoid rigidity
  - Get creative with solutions
- Be Responsive (not reactive)
  - Tackling problems as they arise
    - Not tackling problems too "quickly"
  - Solicit feedback
    - Staff, Consumer, and Community Partners
  - Follow through with changes

The Results are In!

Monthly Totals	# of Walk-Ins	# of LEA drop offs	# of ED Diversions-Client	# of ED Diversions-LEA	# of Respite	# of ED referrals	# of Children	# of adults 18+
June 2020	46	6	3	1	9	6	4	42
July 2020	91	15	10	4	21	5	8	83
August 2020	128	22	19	6	22	4	7	121
September 2020	131	21	23	11	25	8	13	118
October 2020	195	36	28	19	28	22	18	177
November 2020	146	26	30	7	33	18	11	135
December 2020	156	41	19	12	37	7	14	142
January 2021	140	32	16	8	16	14	12	128
February 2021	113	27	11	9	28	3	16	97
March 2021	144	32	10	10	35	11	21	123
April 2021	150	20	20	8	34	2	16	134
May 2021	169	31	16	9	37	9	15	154
June 2021	173	34	27	19	44	7	21	152
July 2021	173	39	18	10	45	12	16	157
Yearly Grand Total	1955	382	250	133	414	128	192	1763

Ongoing Grand Totals	1955
Unduplicated Grand Totals	1154

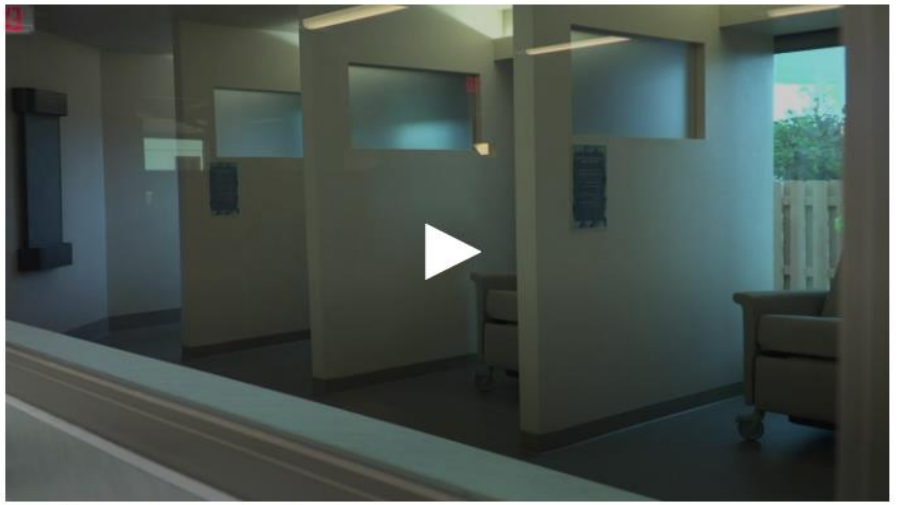
Total Visits	3742

Data

YTD Quick Stats June 2020- July 2021

- Average of 9.5 visits per day
- 20% brought in by LE (average 4.7 min per drop off)
- 21% utilize respite
- 20% diverted from the ED
- 90% adults and 10% children
- 3% said they would have ended their life if the Stabilization Center were not here (37 people)
- 3% were sent to the ED involuntarily

Stabilization Center a new tool for mental health professionals



BY TED TAYLOR | Wednesday, June 17th 2020

It puts a strain on emergency rooms and law enforcement – people in the middle of a mental health crisis.

Last year, there were 3,000 calls to the crisis line.

That's a 42% jump – including a 67% jump in calls from law enforcement.

Central Oregon Daily Photojournalist Steve Kaufmann shows us a new facility in Deschutes County set up to break the cycle.

If you or someone you know is in crisis, you can walk into the crisis stabilization center at 63311 Jamison St. in Bend, Monday through Friday from 8 a.m. to 4 p.m.

You can also call the Deschutes County Crisis Line at 541-322-7500 ext. 9.

TOP LOCAL STORIES

Small health clinics, pharmacies work to combat vaccine waste

Permitting Patience: DNF officials say plan ahead for summer hikes

Works-Wright, Jamie

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Thursday, October 14, 2021 1:44 PM
To: Works-Wright, Jamie
Subject: Division of Mental Health - Approaches to Program and Staff Evaluation for MHC Meeting, 10/28, 7 pm
Attachments: STUDY healthcare among homeless vulnerably housed opportunities for equity oriented health care (1).pdf; STUDY The impact of interventions for youth experiencing homelessness on housing, mental health, substance use, and family cohesion a systematic review.pdf

Hi Jamie,

I hope you're well. Thank you so much for your email and especially, for your work. Would you please kindly forward this email to the Mental Health Commissioners with a copy to the Mental Health Division Manager (Mr. Steven Grolnic-McClurg) and the Director for Health, Housing and Community Services (Dr. Lisa Warhuus)? Thank you so much!

Dear Mental Health Commissioners,

As we know, the Commission has raised questions and discussed evaluating programs and services provided by the Division of Mental Health for people it serves with serious mental illness and co-occurring substance use disorder in Berkeley.

This month we will continue this discussion, particularly to focus on unhoused or precariously housed people living with serious mental illness and co-occurring substance use disorder in the community. At the outset we have taken steps to support the Whole Person Care approach for people experiencing homelessness with complex needs across multiple systems where possible.

Last month we heard from Program Supervisor and Clinician Michael Bernaff from the Homeless FSP (Full Service Partnership) program for unhoused BMH clients at the highest level of care, and RDA about the proposed MHSA INN Homeless Encampment Wellness Project, in order to understand how they are or plan to outreach, engage, and connect to people with SMI and SUD who are unhoused or experiencing housing instability.

This month we will continue our focus on serving unhoused or precariously housed people living with serious mental illness and co-occurring substance use disorder in the community by further addressing initiating and developing ongoing client relationships. The Mental Health Division Manager has also been asked to report on this area so we have a robust discussion.

As we know job descriptions provide for the responsibilities for clinicians, case managers, peer specialists, and other staff (see below for a behavioral health clinician) but there are many additional considerations for initiating and sustaining client relationships:

1. initial client mental health/SUD assessments, treatment plans, and meaningful referrals and follow through;
2. on-going therapeutic support and counseling for individuals, groups, and families;
3. coordination of treatment with other community agencies and services;
4. appropriate crisis intervention as necessary;
5. targeted case management involving multiple systems (e.g. housing, primary and specialist medical care, child welfare/foster care, criminal legal and incarceration) systems;
6. culturally safe and responsive services to Black, Latinx, AAPI, LGBTQIA+, youth, older adults and other people with multiple identities and how services are tailored for effective, empathetic treatment;
7. establish and maintain effective working relationships with clients, clinicians, City staff, community health, or other referral agencies and the public.
8. documentation of client visits and other required reports including charting audits and approval of clients' treatment plans.

Additional Important Considerations: SMI, SUD, SDOH, Inequities, Disparities

There are many factors that impact client relationships including: 1) the nature of serious mental illness and substance use disorder (particularly as to methamphetamine), 2) the nature of clinician, case manager, peer specialist and other staff, 3) social determinants of health, 4) individual and structural inequities and disparities existing in the public health, mental health and other related systems.

Social determinants of health, for example, may include the availability of viable resources to meet needs for safe water, sanitation, housing, and neighborhood environment as well as for food security, healthcare, education, employment, and overall adequate standard of living. Individual and structural inequities and disparities may reflect the quality of tailored culturally safe and responsive services if any for diverse groups of clients: Black, Latina/o/x, Native American, AAPI, LGBTQIA+, people with disabilities, youth, older adults, more.

There is further an attached study about the impact of interventions for youth experiencing homelessness on housing, mental health, substance use, and family cohesion in a systematic review, which may be useful in considering these and additional considerations.

There is also another study attached focused on homeless and vulnerably housed people that discusses their lived experiences and creating a public mental health system that is accessible, trauma-informed, equity-enhancing and designed to use harm reduction. This study, unfortunately, reflects many people who had negative experiences but it raises some critical indicators for considering these client relationships and the barriers to care, when there is a need for an overarching, comprehensive system of care.

Last, there are other viable approaches to evaluating the City of Berkeley's public mental health system, including the Results-Based Accountability evaluation project. There will be an update about the current status of that outcomes-based evaluation project for diverse populations. There will be an update on the Community Health Records, training, and implementation, as well as the status of the proposed MHSA INN Homeless Encampment Wellness program, which can improve the quality of care for people living with serious mental illness and SUD.

Best wishes,
Margaret

Margaret Fine

International Journal for Equity in Health

RESEARCH Open Access

Experience of healthcare among the homeless and vulnerably housed a qualitative study: opportunities for equity-oriented health care

Eva Purkey[1*] and Meredith MacKenzie[1,2]

Abstract

Background: People experiencing homelessness are often marginalized and are known to face barriers to accessing acceptable and respectful healthcare services. This study examines the experience of accessing hospital-based services of persons experiencing homelessness or vulnerable housing in southeastern Ontario and considers the potential of Equity-Oriented Health Care (EOHC) as an approach to improving care.

Methods: Focus groups and in-depth interviews with people with lived experience of homelessness (n=31), as well as in-depth interviews of health and social service provider key informants (n=10) were combined with qualitative data from a survey of health and social service providers (n=136). Interview transcripts and written survey responses were analyzed using directed content analysis to examine experiences of people with lived experience of homelessness within the healthcare system.

Results: Healthcare services were experienced as stigmatizing and shaming particularly for patients with concurrent substance use. These negative experiences could lead to avoidance or abandonment of care. Despite supposed universality, participants felt that the healthcare system was not accountable to them or to other equity-seeking populations. Participants identified a system that was inflexible, designed for a perceived middle-class population, and that failed to take into account the needs and realities of equity-seeking groups. Finally, participants did identify positive healthcare interactions, highlighting the importance of care delivered with dignity, trust, and compassion.

Conclusions: The experiences of healthcare services among the homeless and vulnerably housed do not meet the standards of universally accessible patient-centered care. EOHC could provide a framework for changes to the healthcare system, creating a system that is more trauma-informed, equity-enhancing, and accessible to people experiencing homelessness, thus limiting identified barriers and negative experiences of care.

Keywords: Homelessness, Health equity, Vulnerable populations

* Correspondence: eva.purkey@dfm.queensu.ca
[1]Department of Family Medicine, Queen's University, 220 Bagot street, Kingston, Ontario K7L 3G2, Canada
Full list of author information is available at the end of the article

Background

This study explores the experience of hospital-based healthcare for people who are vulnerably housed or homeless. Literature suggests that the healthcare system is either inaccessible to or fails to meet the needs of certain groups. Data outlines barriers to care for Indigenous Canadians, members of the LGTBQ* community, persons experiencing ongoing or historical trauma, persons using substances, and those experiencing homelessness or who are vulnerably housed [1–10]. Thirty-five thousand Canadians are homeless on any given night and 235,000 Canadians experience homelessness in a year [11]. Average life expectancy for homeless persons is estimated at between 42 and 52 years [12, 13]. Between 44 and 60% of people who experience homelessness will use illicit substances in their lifetime [11, 14, 15].

The primary objective of the Canada Health Act, the foundational legislation of Canada's universal healthcare system, is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" [16]. This would imply that health services must be tailored to eliminate avoidable barriers to access, and should actively seek to protect, promote and restore the health of all Canadians, including the most marginalized.

Data in this study derives from a mixed-methods study funded by the South East Local Health Integration Network (SELHIN) (Ontario, Canada) exploring palliative care services for the homeless and vulnerably housed. In this study, "homelessness" or "vulnerably housed" includes those who are living out-of-doors, in substandard conditions not fit for human habitation, in temporary or unstable accommodations, in shelters, and those who are at risk of losing their existing housing [17].

Methods

Study design

A survey was used to obtain data from health and social services providers (HSSPs) and interviews were conducted with key informants (KIs) from this group. A survey along with focus groups and in-depth interviews collected data from participants with lived experience of homelessness. See Fig. 1 for an outline of all data collection and Additional file 1 for survey tools and interview guides. Ethics approval was obtained through Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board.

Participants and sampling.

Health and social service providers (HSSPs)

A survey was distributed by email widely to organizations throughout the SELHIN who work with people experiencing homelessness (mental health and addiction agencies, housing agencies, legal aid, shelters, food programs, community health centres, primary and palliative care providers among others). The survey included questions about the participant's organization, scope of practice, and thoughts and opinions on the provision of care to people experiencing homelessness with an explicit emphasis on end of life care. All questions were multiple choice, however they all had free text spaces in which participants could include comments and other considerations. 136 HSSPs responded to the survey.

Following survey collection, community agencies identified KIs who had been employed by the organization for at least 1 year and had provided front line services (past or current). KIs were a mix of urban, rural and semi-rural. Research assistants conducted ten in-person or telephone interviews using a semi-structured interview guide

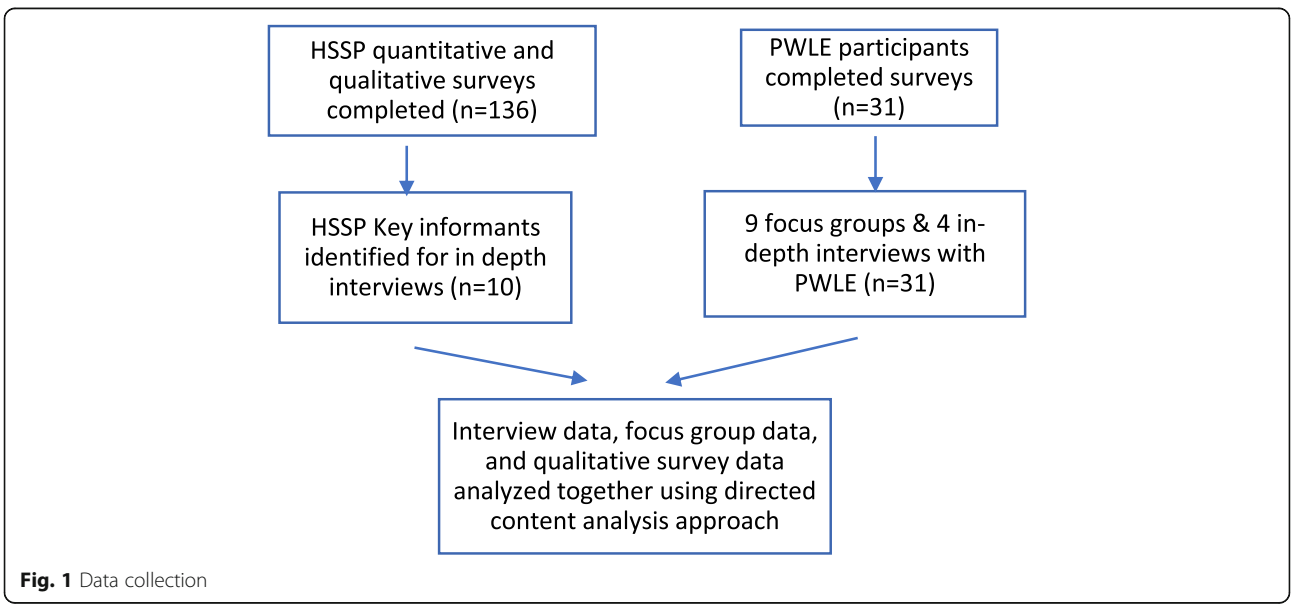


Fig. 1 Data collection

Table 1 Participant Organizational and Socio-demographic data

Variable	Frequency (%)
Health and Social Service Providers:	
Organization provides care to persons experiencing homelessness or unstable housing	74%
Organization provides care to persons experiencing substance use	89%
People with lived experience of homelessness	
Identifying as First Nations, Inuit or Metis	13%
Completed high school of higher education	68%
Minimum of part time employment	33%
Duration of homelessness months or years	39%
Frequency of homelessness	
Once	100%
> 5 times	17%
Service use (last 6 months):	
Emergency department	55%
Healthcare clinic	48%
Hospital	45%
Ambulance services	19%
Self-reported mental health average or poor	58%
Substance use (last 3 months):	
Alcohol	68%
Benzodiazepines	
Cocaine	32%
Opioids	29%
Methadone or Buprenorphine/naloxone	26%
Crystal Methamphetamine	45%

Stigma, or anticipated stigma, had important consequences for health. As reported by others [22], PWLE avoid care due to past negative experiences. They might leave in the middle of a care session, even removing intravenous lines in order to extricate themselves from intolerably stigmatizing situations. PWLE were often isolated from support networks when in care because their support networks, coming from the same social contexts, were equally stigmatized and occasionally overtly excluded by healthcare providers. PWLE lacked trust towards healthcare providers due to past experiences which had significant impacts on their care seeking behavior and likelihood of following through on provider recommendations. Finally, PWLE and HSSPs had many examples in which they felt that complaints were not taken seriously, often due to a history of substance use, which caused them to fear that they would be unable to obtain appropriate care.

Box 2 Participant Quote

It actually got so bad that I actually unhooked my IV and left the hospital and didn't go back. […] I just couldn't. believe it. It was scary actually because when I unhooked that IV, I thought to myself: 'What am I doing here?' That's how scared I was that they actually set it off in me that I started to think 'Oh god, now they are going to do this to me and now they're not gonna take proper care of me.' (FG1A).

The presence of an advocate from outside of their social network (eg. a social services worker or pastoral care worker), had a significant impact on the care patients received. While this was more likely to enable them to receive care in a respectful and appropriate manner, it further highlighted the stigma they experienced when their advocate was not present.

Lack of accountability of the healthcare system towards equity-seeking populations

Participants felt that the healthcare system was not accountable to the people it served. Participants articulated the responsibility of healthcare providers to provide excellent, empathic care to *everyone* who presents, regardless of their socioeconomic status, substance use history, or life circumstances. Healthcare providers were felt to have a lack of understanding of the impact of social determinants of health, ongoing trauma and past adversity on people's health and healthcare presentations. Examples were given of clients asked to leave the hospital because of the way they dressed or smelled. Participants felt that healthcare providers lacked knowledge around harm reduction, around the root causes of substance use and adversity, and that they appeared to lack empathic or compassionate curiosity towards patients and the difficulties they encountered.

Box 3 Participant Quotes

"Being homeless- I mean people look at you as though you're a low life, piece of crap. I mean, you're a drug addict and everything else. You're not worth the shit that you sleep in [..]. You're restricted because of the way you look. You're on the street. You don't have a place. Doors are shut. People just shun you and everything else" (FG9B).

"You know it's all those kids we think about when we hear these horrific news stories of abuse. They went into the foster care system and then we don't think of them again but that little kid ends up being the 30-year-old. with a criminal record and that little kid ends up being a woman who's prostituted for the last 10 years." (KI4).

Respondents wanted to see medical practitioners whose priority were their patients rather than status, job security, or finances. They also felt that having peers with lived experience of substance use, homelessness, or other equity-related challenges operating within the healthcare system would help make care more accountable and acceptable for them and others.

Box 4 Participant Quote
"If you're going to bring new [healthcare providers] in, then you educate them to be this way and if you. don't treat this way. […] I mean - there's a suggestion box [..]! You're going to stand accountable. Let's get the government accountable. Let's get everybody accountable who's looking after us. I AM a human being. If you're not gonna to treat me like a human being - well you're going to hear it right from me." (FG1B).

Inflexibility of the system

HSSPs described a healthcare system that was not tailored to meet the needs of their clients. The system was described as designed by middle class people for middle class clients, expecting conformity to the system rather than tailoring the system to the differing needs, desires and challenges of patients. Examples included the requirement that housing be obtained before treatment could be initiated when housing was not an option; a lack of flexibility for patients who might show up late or miss appointments; and a lack of openness to a harm reduction approach that might allow patients to receive a tailored form of treatment in the context of substance use rather than being dismissed out of hand.

Positive experiences

While the majority of the discussion, both from HSSPs and PWLE, focused on negative experiences of care, there were also some positive encounters related to healthcare experiences where providers upheld dignity, autonomy and choice for patients, where they provided flexible, non-judgemental services in spaces where clients felt welcomed. Participants used terms such as "trust" and "compassionate" to describe these positive experiences of care.

Box 5 Participant Quotes
"She's a nurse here yes. I adore her. I adore her. I respect her and I trust her and she's the sweetest girl that. I've ever had – the sweetest medical care person I've ever had take care of me. She's just amazing […] Yeah. like she's very very thorough and she's very compassionate. I just, oh my heart's with her, I love her. Yeah."
(FG9BRM1)

"They are really like, hey we like the atmosphere of this place. We like that people here treat us really nice and we're people. We feel loved. There are paramedics here who are, you know, assisting us. Um we really feel safe in this space and like there's no judgement and we want to keep coming back here." (KI9).

Discussion

Our findings echo the negative experiences and resulting impacts on health and healthcare access of equity seeking populations described in other studies, including the homeless and vulnerably housed [1–8, 10, 23]. These include care avoidance, stigma, inflexibility of the current system, unmet healthcare needs and a lack of harm reduction philosophies integrated into the delivery of care.

While listening to the voices of our participants is key to understanding the inadequacies of our system, listening to these voices also presents an opportunity for change. There is small and increasing body of literature on Equity-Oriented Health Care (EOHC) and trauma and violence informed care in healthcare settings but these theories are rarely applied to hospital-based medicine and do not address hospital-based medicine for the homeless or vulnerably housed. We believe that the articulation of EOHC [24–26] as an approach may present us with a road map and tools to respond to the concerns of homeless and vulnerably housed clients, particularly with respect to their concerns about discrimination, stigma, and inflexibility of the system as articulated in our study and others [23, 27].

EOHC rests on 3 components. The first is trauma and violence informed care (TVIC) that recognizes the prevalence of past and ongoing trauma in people's lives and acknowledges the way in which trauma affects people's physical and emotional health, interpersonal relationships, and ability to access care. TVIC rests on 5 principles [28]: [1] Trauma awareness and acknowledgement; [2] Safety and trustworthiness; [3] Choice, control and collaboration; [4] Strengths based and skills building; and [5] Cultural, historical, and gender issues. The principles of TVIC are echoed in participants' narratives. Participants shared the great burden of past and ongoing trauma that people facing homelessness and substance use have experienced. The need for safety and trust were explicitly articulated, as well as the challenges in developing that trust. Choice, control and collaboration are the antithesis of the stigmatizing and dismissive care that participants too often received in healthcare encounters, which is neither strengths based nor skills building. Finally, much literature supports the ongoing impact of gender, ethnicity, indigeneity and history on access to care [4, 6, 8].

The second component of EOHC is harm reduction. Most of the literature examining PWLE of homelessness identify substance use and the healthcare system's response to substance use, as significant concerns [2, 14, 15, 23]. Harm reduction encompasses programs, practices, policies and philosophies that aim to reduce the harms of substance use, viewing substance use as a health issue rather than a moral failure [26]. Participants feel that healthcare providers view their substance use as making them less worthy of dignified care and less valuable as human beings. A harm reduction approach requires a fundamental shift in how the healthcare system interacts with people who use substances. In addition to formal policies and programs, such an approach requires us to see the *people* behind the substance use, to recognize their dignity, experiences, trajectories, and challenges.

Cultural safety is the third component of EHOC. Culturally safe care is particularly important in the

Canadian context where Indigenous people continue to experience the negative effects of current and past colonization [6, 29] but would be relevant in any context of human diversity. Culturally safe care explicitly addresses inequitable power relations, racism, discrimination, and effects of historical and current inequities within health care encounters [29]. More than just an attitude, culturally safe care requires knowledge of history and of the root causes and consequences of inequity on the part of healthcare providers.

Finally, EOHC requires that an approach to and delivery of care be developed with input from all stakeholders, including people with lived experience, but also all members of the healthcare team from physicians and nurses to janitors and receptionists. A recent study has found that cross sector collaboration that provides integrated health care improved barriers to access and also enabled self-managed care [30]. These changes require leaders to engage not only with providers who are already advocates for equity-seeking populations, but also with those who are not. EOHC presents a unique opportunity to build partnerships among professional and patient groups that rarely mix outside of clinical care and allows a system to be responsive to the local needs of its population. Communities with higher rates of substance use, higher percentages of Indigenous clients, or recent loss of employment with increase in precarious housing could meet the challenges and opportunities presented by EOHC differently.

Limitations

The HSSPs in our study were almost all involved in providing care to homeless and vulnerably housed individuals and were generally self-described advocates for this group. Our study might have benefitted from integrating the voices of HSSPs who are not specifically committed to working with equity-seeking populations. Additionally, our data was originally collected in the context of work on palliative care. Further questions specifically targeting other healthcare experiences might have yielded additional information. Nevertheless, our findings are amply supported by the extensive verbal and written discussions around healthcare services from all study participants and align with findings in the literature as well [1–3, 10, 23].

Conclusions

There are two key messages in our findings: The first is that the care we are providing to our most vulnerable clients is not adequate and does not meet the professional standards of accessibility, universality, and patient-centeredness. An often-quoted line by Dr. Edward Trudeau from the 1800s proposes that the physician's role is "to cure sometimes, to relieve often, to comfort always". Our findings demonstrate that for certain groups we may be failing on all three counts.

Our second message is that we believe there is a way to raise our healthcare system to this standard, and that EOHC, developed locally and tailored to place, provides a road map from where we can begin. EOHC requires a cultural shift within our profession, away from the standardized one-size-fits-all care we have become used to and back, perhaps, to a more versatile, creative way of delivering care that many of us aspire to. It will require team work in hospitals and clinics, changes to curriculum in medical and nursing schools and continuing professional development. It will require those who hope to be leaders in this field to have compassion and understanding for colleagues for whom this is more difficult. Finally, it will require us to not only listen to, but to *hear* and to *see* the patients before us in all their strength, complexity and occasional despair, to consider the trajectory and meaning of their lives within our broader society, as well as our own privileged place therein.

Additional file

Additional file 1: Appendix A. Health Care and Service Providers Survey. **Appendix B.** Participant with lived experience Survey. **Appendix C.** PWLE focus group and interview guide. **Appendix D.** KI Interview guide. (DOCX 26 kb)

Abbreviations

EOHC: Equity-Oriented Health Care; HSSP: Health and social service provider; KI: Key information; SELHIN: South East Local Health Integration Network; TVIC: Trauma and Violence-Informed Care

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Author's contributions

MM was the principle investigator for this study. She conceptualized the study, developed the research tools, and coordinated the survey, focus groups and interviews. She reviewed and coded the qualitative and survey data, and contributed to the drafting and editing of the manuscript. EP was the co-investigator. She provided consultation during the research process, reviewed and coded the qualitative and survey data, and led the writing of the manuscript. Both authors read and approved the final manuscript.

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Availability of data and materials

All transcripts of interviews and focus groups, survey responses, and quantitative data are available from the authors upon request. Quantitative data is currently under consideration for publication elsewhere.

Ethics approval and consent to participate

Ethics approval was obtained through Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board.

Consent for publication
Not applicable.

Competing interests
The authors declare that they have no competing interests.

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RESEARCH ARTICLE Open Access

The impact of interventions for youth experiencing homelessness on housing, mental health, substance use, and family cohesion: a systematic review

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Abstract

Background: Youth often experience unique pathways into homelessness, such as family conflict, child abuse and neglect. Most research has focused on adult homeless populations, yet youth have specific needs that require adapted interventions. This review aims to synthesize evidence on interventions for youth and assess their impacts on health, social, and equity outcomes.

Methods: We systematically searched Medline, Embase, PsycINFO, and other databases from inception until February 9, 2018 for systematic reviews and randomized controlled trials on youth interventions conducted in high income countries. We screened title and abstract and full text for inclusion, and data extraction were completed in duplicate, following the PRISMA-E (equity) review approach.

Results: Our search identified 11,936 records. Four systematic reviews and 18 articles on randomized controlled trials met the inclusion criteria. Many studies reported on interventions including individual and family therapies, skill-building, case management, and structural interventions. Cognitive behavioural therapy led to improvements in depression and substance use, and studies of three family-based therapies reported decreases in substance use. Housing first, a structural intervention, led to improvements in housing stability. Many interventions showed inconsistent results compared to services as usual or other interventions, but often led to improvements over time in both the intervention and comparison group. The equity analysis showed that equity variables were inconsistently measured, but there was data to suggest differential outcomes based upon gender and ethnicity.

Conclusions: This review identified a variety of interventions for youth experiencing homelessness. Promising interventions include cognitive behavioural therapy for addressing depression, family-based therapy for substance use outcomes, and housing programs for housing stability. Youth pathways are often unique and thus prevention and treatment may benefit from a tailored and flexible approach.

Keywords: Youth, Homelessness, Vulnerably housed, Interventions, Gender, Equity

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Background

Youth homelessness is a major public health challenge worldwide, even in high income countries [1]. Youth experiencing homelessness are defined as, "youth between the ages of 13 to 24 who live independently of their parents or guardians, but do not have the means to acquire stable, safe or consistent residence, or the immediate prospect of it [2]." Youth pathways into homelessness are anomalous and seldom experienced as a single isolated event. Compared to the adult homeless population, youth experiencing homelessness are more likely to report leaving home due to parental conflicts, including: being "kicked out" of the home, abuse (physical, verbal, sexual and other), parental neglect due to mental health problems, or parental substance use [3–11]. The broader context of family dysfunction can lead to youth circumstances that further reinforce situations of homelessness, including desire for separation from unsupportive environments, financial independence, mental health challenges, substance use, and/or run-ins with the justice system [1].

Not only are youth's pathways into homelessness different from the adult homeless population, but their experiences on the street are distinct as well. Once homeless, youth are exposed to many dangers and are at a high risk of further trauma [12]. Youth experiencing homelessness may face a number of daily stressors and have limited coping strategies and resources to deal with these stressors [13]. Youth homelessness is often invisible and includes vulnerable housing situations such as couchsurfing or staying with relatives [14]. Furthermore, youth experiencing homelessness are vulnerable to social and health inequities, which describe the fairness in the distribution of health opportunities and outcomes across populations [15]. Health inequities are differences in health status that are unfair and/or avoidable [16]. Often, the compounding effect of various stratifying characteristics can result in increased disparities between individuals.

Current research has largely focused on adult populations, with a gap in evidence on interventions for youth experiencing homelessness on a broad range of outcomes. Among the current interventions for individuals experiencing homelessness, non-abstinence contingent permanent supportive housing and case management have shown promising results in terms of improving housing stability and mental health outcomes [17]. However, youth are a distinct population and they require specifically tailored, context appropriate, equity-focused interventions and research attention [18]. From systematically searching the literature for youth interventions, this paper will introduce four main categories of interventions applied to youth experiencing homelessness: 1) individual and family therapies (ie. cognitive behavioural therapy, motivational interviewing, etc.) 2) skill building programs, 3) case management, and 4) structural interventions (such as housing support, drop-in centres, and shelters). These interventions are designed to address the complex, multifaceted pathways and contributors to youth homelessness, whether it be addressing substance use issues through motivational interviewing, mental health care through cognitive behavioural therapy, improving unstable family environments through family therapies, increasing access to resources through case management, and enhancing structural support such as income and housing support [19–23]. Given the complexity and interconnectedness of these outcomes, one would hope that these interventions would have an impact on not only the primary outcome, but also extend to other facets of a youth's life. For instance, family therapies have shown promising results on both family functioning as well as substance use, by addressing the toxic family environment and thereby decreasing its contribution to unhealthy substance use patterns [24].

Current research on interventions for the population of youth experiencing homelessness lacks a comprehensive synthesis on a broad range of social and health outcomes. The objective of this review is to synthesize the existing scientific literature on interventions for homeless or vulnerably housed youth in high income countries, and assess the impacts of the interventions on housing, mental health, substance use, and family cohesion, with an equity perspective.

Methods

We established an expert working group consisting of homeless health researchers, academics, clinicians and youth with lived experience of homelessness to conduct this review. We report our results according to PRISMA-E [see Additional file 3] and published an open access protocol on the Campbell and Cochrane Equity Methods website [25, 26].

Data sources and search strategy

Without language restrictions, we systematically searched the following databases from inception until February 9, 2018: Medline, Embase, CINAHL, PsycINFO, Epistemonikos, HTA database, NHSEED, DARE, and Cochrane Central. Combinations of relevant keywords and MeSH terms were searched, including "homeless" and "homeless youth" [see Additional file 1 for search strategy]. We handsearched included studies for primary studies and consulted experts for additional papers. We conducted a grey literature search on homeless health and public health websites.

Inclusion and exclusion criteria

We downloaded citation information into Rayyan online software [27]. All title and abstracts were screened

according to our inclusion criteria (see Table 1) in duplicate by two independent reviewers, and any discrepancies were resolved. Throughout a process of several consultations, our working group, consisting of persons with lived experience and experts in the field, helped develop these inclusion criteria by identifying priority areas in which to focus this review. This study focused on youth between the ages of 13 to 24, however, the age categorizations of youth tend to differ between various definitions, with the medicolegal definition utilizing ages 16 to 21. It is important to note that the broader age range utilized in this paper may lead to risks of over-inclusion, but it was chosen as it is reflective of the currently literature on youth homelessness and includes both high school and university students who are generally still dependents living with family or relying on them for financial or moral support.

Data extraction and analysis

Data extraction proceeded in duplicate using a standardized data extraction form and a third reviewer resolved discrepancies [25]. We extracted data regarding the effectiveness of interventions on a broad range of social and health outcomes. We conducted a scoping exercise to identify key outcome categories in the literature and prioritized reported outcomes with our expert working group members, which included individuals of lived experience. The outcomes rated as being of highest priority (mental health, substance use, housing, and family outcomes) are reported in the body of this paper, and the remaining outcomes (violence, sexual health, personal and social, and health and social service utilization) are reported in the appendix [see Additional file 2]. To reduce overlap between single studies and systematic reviews, we reported the results of systematic reviews and supplemented with data from randomized control trials (RCTs) that were not included in the systematic reviews. Due to heterogeneity of interventions and outcomes studied, we qualitatively synthesized the results. We created a forest plot to summarize RCTs for mental health outcomes, as sufficient data were available and it was a highly ranked outcome.

Health equity analysis

We used the PROGRESS+ framework to apply a health equity lens and enable us to identify characteristics that socially stratify youth experiencing homelessness, and

Table 1 Eligibility criteria

Study Characteristics	Inclusion Criteria	Definitions
Population	Youth between the ages of 13 to 24 who live independently of their parents or guardians, but do not have the means to acquire stable, safe or consistent residence, or the immediate prospect of it [2]. This age range was chosen as it is reflective of the current literature on youth homelessness and includes both high school and university students who are generally still dependents living with family or relying on them for financial or moral support. Furthermore, this definition of homelessness accounts for hidden homeless youth who may not be found in institutional settings but may be couch-surfing with friends or others.	
Interventions	Youth Interventions	Youth interventions are intended to assist youth experiencing homelessness in improving health or social outcomes, which includes both interventions that are created specifically and solely for the benefit of youth as well as interventions for all persons that are applied to the context and needs of youth. Interventions include any program, service, structure, or resource provided with the aim of addressing social and health outcomes. Examples of youth interventions include, but are not limited to, cognitive behavioural therapies and family-based therapies. Cognitive behavioural therapy takes into account emotional, familial and peer influences to build self-control, self-efficacy and reduce negative behaviours [28]. Family-based therapy focuses on intrapersonal factors and re-establishing connections; it seeks to understand individual behaviour and interactions between the individual and their family [20, 29]. Parental monitoring intervention programs providing parenting skills and empowering parents of adolescents [30]. Street outreach and addictions services consist of outreach workers engaging youth living on the street to enhance their wellbeing through programs such as mobile harm reduction programs [31].
Comparison	Any study with a comparison intervention was included, such as standard intervention, alternative intervention, or treatment as usual.	
Outcomes	Studies were not excluded based upon the reported outcomes	
Study Characteristics	Randomized control trials and systematic reviews. All study designs must include interventions with a comparison/control group and have measured outcomes.	
Study Characteristics	Exclusion Criteria	Justifications
	Studies taking place in low- middle-income countries Studies that exclusively report on Indigenous specific interventions	Due to the variability in access to resources and supports in comparison to that in a high-income country, we feel that the settings are different and should be synthesized separately. The analysis of the interventions tailored to this population will be covered by a separate research group.

various drivers of homelessness [15]. In particular, we extracted the following from studies to inform our analysis: 1) study rationale for focusing on youth-centred interventions; 2) the measures used to assess differences in outcomes for women and men; 3) the study's gender-related findings and conclusions; and 4) the study's incorporation of equity considerations (e.g. race/ethnicity and socioeconomic status).

Critical appraisal

We assessed the methodological quality of systematic reviews with AMSTAR II and RCTs using the Cochrane Risk of Bias Tool [28–32]. When assessing the overall risk of bias of RCTs, we defined the risk of bias as "not serious" when there were low risk ratings in all categories or one or two unclear risk, "serious" with one or two high risk categories, and "very serious" with more than two high risk categories.

Results

The search strategy yielded 11,934 potentially relevant citations. After we removed duplicates, we screened 7499 citations and assessed 103 full text articles. Twenty-two citations met the full inclusion criteria (See Fig. 1). Four of the included citations were systematic reviews [33–36] and the remaining 18 citations reported on 15 RCTs (see Table 2 for RCTs and Table 3 for SRs) [19, 21, 37–53].

Methodological quality of the included studies was low or very low, with serious risk of bias across most included studies (see Fig. 2 for RCTs and Table 4 for SRs). The most common domain with a high level of risk was knowledge of the allocated interventions, as blinding was often not possible or difficult with the nature of the interventions.

The main categories of interventions applied to youth homelessness included: 1) individual and family therapy (e.g. cognitive behavioural therapy (CBT), motivational

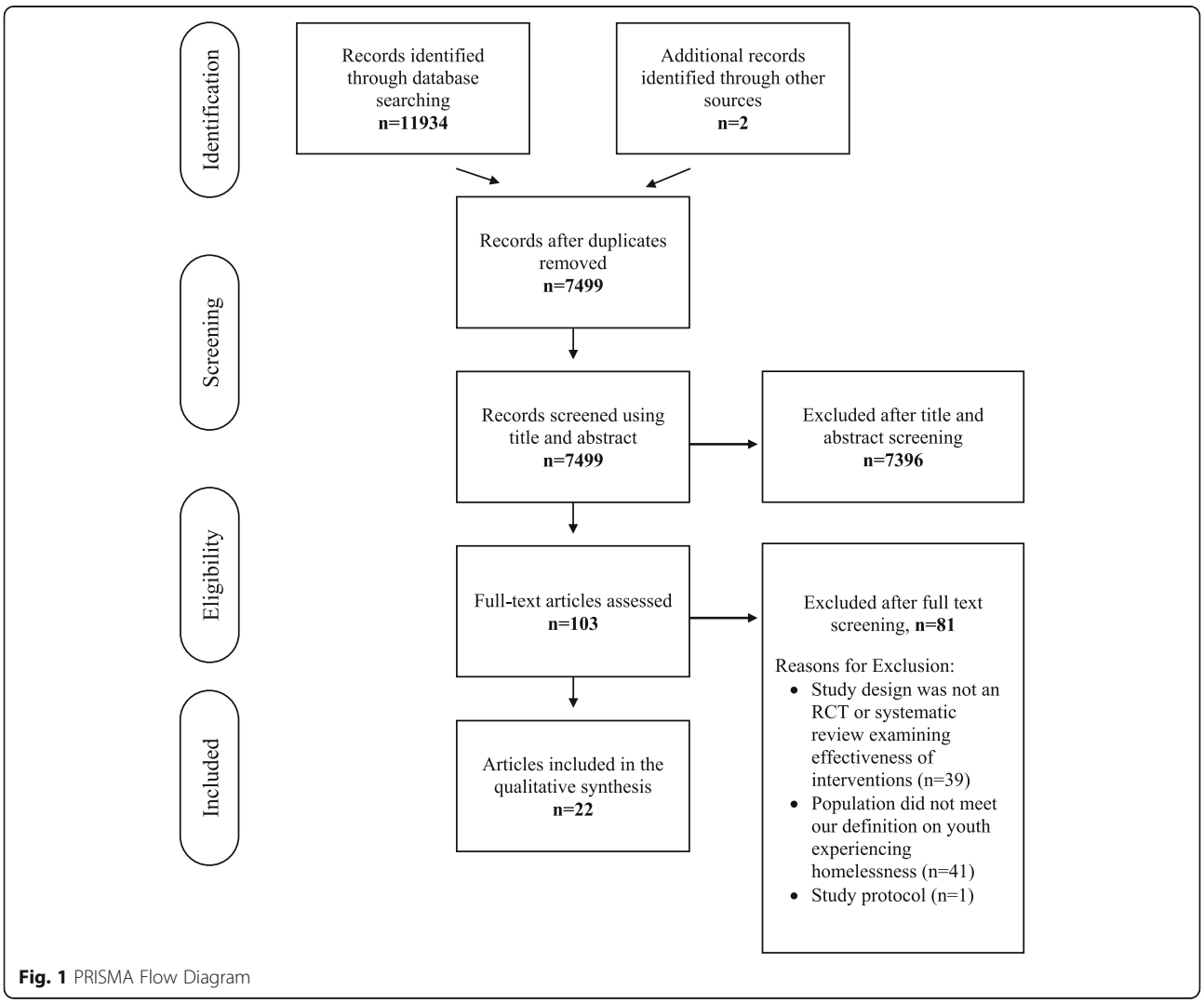

Fig. 1 PRISMA Flow Diagram

Table 2 Characteristics of Included RCTs

Study	Population	Sample Size (n)	Setting & Country	Intervention	Control	Outcome Measures and Follow-Up Time Intervals (Follow up rates)	Conclusions of the paper
Baer 2007	Youth, ages 13 to 19, vulnerably housed Mean age 17.9 Males 56%- Females 44% Ethnicity was reported as 58% Caucasian, 19% multiracial, 9% Native American, 8% African American, 4% Hispanic or Latino, and 2% Asian or Pacific Islander.	*n* = 117	Community Drop in Center- USA	Brief Motivational Intervention; up to 4 sessions; Average session length was 17 mins for 1st and 35 mins for 2nd session (*n* = 66)	Service as Usual (*n* = 51)	1. Substance use 2. Service use 3. Counsellor ratings of engagement 4. Treatment exposure and satisfaction Measurements were conducted at 1 month (82.9%) and 3 months (76.1%) post intervention.	The purpose of this study was to build upon previous mixed findings. However, the Brief Motivational Intervention did not lead to any improved outcomes in youth compared to those in the treatment as usual group.
Bender 2015	Youth, ages 18–21, Mean age 19 homeless 68.9%- housed 31.1% Males 60.8%- Female 36.5%- Other 2.7% Ethnicity was reported as White 41.9%- Black 20.3%- Latino 5.4%- other 32.4%	*n* = 97	Youth homeless Shelter -USA	SAFE (Safety Awareness for Empowerment); 3 day group intervention of 6–8 youth; focus areas include mindfulness, skill-building (*n* = 56)	Shelter services as usual, which includes case management services (*n* = 41)	1. Mindfulness scores (total, observing, describing, acting with awareness, accepting without judgement) Measurements completed as posttest at the end the intervention. The control group youth completed the interview approximately 5 to 7 days after their baseline interview (F/U for control 90.2% and for intervention 94.9%)	The SAFE intervention led to a significant increase in mindfulness, defined as observation skills, compared to those receiving services as usual. This suggests that youth experiencing homelessness are likely to engage in mindfulness training in shelters.
Greeson 2015/ Courtney 2008	youth age 17; in out of home care- Males 41.15%- Females 58.85%- Ethnicity was reported as White 8.97%- Black 40.17%- Hispanic 43.38%- Other 7.48%	*n* = 482	Independent living programs for youth in foster care- USA	Life skills training course (LST); two 3 h sessions per week for 5 weeks at community college (*n* = 234)	Services as usual aimed at preparing youth at risk of aging out of foster care (*n* = 248)	1. Interventions and service use 2. Job preparedness and preparedness 3. Education and employment 4. Economic well-being 5. Housing 6. Delinquency 7. Pregnancy 8. Documentation and accounts 9. Social support Measured over three time points (baseline, 1 year (91%), and 2 years (88%))	The in-class life skills training course did not appear to be more effective than services as usual to improve social support and other reported outcomes in youth. More research is required to determine the types of youth based interventions that lead to an improvement of the desired outcomes.
Guo 2016 / Slesnick 2013a / Slesnick 2013b)	youth 12–17 years; met DSM-IV criteria for alcohol/drug abuse; Mean age 15.4	*n* = 179	Short term Crisis Center for Run-away adolescents- USA	1. Community Reinforcement Approach (CRA) - 12 sessions, operant conditioning approach to	Three arm study, see interventions	1. Family cohesion and conflict 2. Internalizing behaviours and externalizing	Ecologically-based Family Therapy is more effective and has longer lasting effects on family dynamics

Table 2 Characteristics of Included RCTs *(Continued)*

Study	Population	Sample Size (n)	Setting & Country	Intervention	Control	Outcome Measures and Follow-Up Time Intervals (Follow up rates)	Conclusions of the paper
	Males 47.5%- Female 52.5% Ethnicity reported as White non- Hispanic 25.7%- African American 65.9%- Hispanic 1.7%- Native American 1.1%- Asian American 0.6%- Other 5%			teach methods of addressing life problems without alcohol or drugs ($n = 61$) 2. Ecologically-based Family Therapy (EFT) - 12 sessions, works with youth and family to identify dysfunctional interactions and improve social interactions ($n = 57$) 3. Motivational Enhancement Therapy (MET) - 2 therapy sessions, improve intrinsic motivation to change drug and alcohol use ($n = 61$)		behaviours 3. Substance use Measurements were conducted at baseline and at 3, 6, 9, 12, 18, and 24 months post intervention (F/U rates ranged from 69 to 79% across 6 time points and did not differ statistically between groups)	compared to individual therapies. While there are many challenges in the implementation of family-based therapies, overcoming these barriers will lead to improved family outcomes in youth.
Hyun 2005	male youth; residence in shelter; mean age 15.5; without psychiatric disorders-100% male- 0% female Ethnicity not specified	$n = 27$	Shelter for runaway and homeless youth-South Korea	Cognitive behavioural therapy - 8 sessions over 8 weeks ($n = 14$)	Service as usual, no cognitive behavioural therapy ($n = 13$)	1. Self-esteem and self-efficacy 2. Depression Measurement interval was a Pretest- posttest design (F/U rates 87.5% for experimental group and 81.2% for control group)	This study shows that CBT is a useful intervention to increase self-efficacy and decrease depression in youth compared to no treated. These results are in agreement with previous studies showing the effectiveness of CBT in youth to improve mental health outcomes.
Kozloff 2016	youth aged 18–24; homeless or vulnerably housed; with mental disorder Mean age 21.5 Gender reported as Non- male 39% Ethnicity was reported as White 38% -Ethnoracial 36%- Aboriginal 26%	$n = 156$	Participants were recruited from community agencies that serve homeless people, institutions, including health care facilities and prisons, and directly from the street- Canada	Housing first with Assertive Community Treatment or Intensive Case Management ($n = 87$)	Service as usual ($n = 69$)	1. Housing stability 2. Quality of life 3. Employment Measured at baseline, 6, 12, 18 and 24 months post intervention (89.7% F/U for the intervention and 72.3% for the control)	Housing First significantly improved housing stability in homeless youth with mental illness compared to those in the treatment as usual group. This is an effective intervention to improve the stability of homeless youth and reduce the long-term negative outcomes of this population. However, since the intervention did not have a significant effect on the other measured outcomes, it is recommended to adjust the intervention to better meet the needs of youth.

Table 2 Characteristics of Included RCTs *(Continued)*

Study	Population	Sample Size (n)	Setting & Country	Intervention	Control	Outcome Measures and Follow-Up Time Intervals (Follow up rates)	Conclusions of the paper
Krabbenborg 2017	Homeless youth aged 17 to 26 Average age 20 68.1% male- 31.9 female Ethnicity reported as 51% had a Dutch background	*n* = 251	Shelters for Homeless young adults- Netherlands	Houvast: A strengths-based intervention focusing on improving quality-of-life of homeless youth (*n* = 134)	Services as usual, such as housing, social network, education and finances (n = 117)	1. Mental and physical health 2. Quality of life 3. Violence 4. Income security 5. Satisfaction with family relations 6. Substance use 7. Autonomy 8. Competence 9. Resilience Measured in two waves at baseline as youth enter shelter and as the youth existed the homeless shelter, between 27 and 238 days – mean 156 days post baseline. (F/U 77.6% for control and 80.3% for intervention group)	Both the strength-based intervention and care as usual improve outcomes of homeless youth. No significant differences were found between the two groups. This suggests that youth benefit from receiving care services in general.
Milburn 2012	Families with youth ages 12 to 17; vulnerably housed; no current abuse or neglect Mean age 15.6 Males 33.8%- Females 66.2% Ethnicity reported as White 11.3%- African American 20.5%- Hispanic 61.6%- Other Mixed 6.6%	*n* = 151	Community based organizations- USA	STRIVE: 5 weekly home-based sessions focused on family conflict resolution and problem solving (*n* = 68)	Standard care received from the agencies that referred them (*n* = 83)	1. Substance use 2. Delinquent behaviour 3. Risky sexual behaviours Measured at baseline, 3 (71%), 6 (58%), and 12 months (46%) post intervention	Youth receiving the STRIVE intervention had a significantly decreased number of sexual partners and decreased usage of substances, excluding marijuana, compared to those receiving standard care. Youth receiving the intervention may have increased their marijuana use to replace alcohol and hard drugs.
Peterson 2006	youth; 14–19 years; vulnerably housed; recent binge drinking episode without recent alcohol or drug treatment Mean age 17.4 Males 54.7%- Female 45.3% Ethnicity reported as Caucasian 72.3%- African American 3.2%- Native American 3.2% -	*n* = 285	Street or community agencies -USA	Brief Motivational Intervention: 1 session lasting on average 30 mins, provide information about patterns and risks (*n* = 92)	2 control groups: 1. Assessment only (*n* = 99) 2. Assessment at follow up only (*n* = 94)	1. Alcohol and drug use 2. Stage of change for substance use Measured at baseline, 1 month (82%) and 3 months (80%) post intervention	The Brief Motivational Intervention led to a decrease in illicit drug use, apart from marijuana, after one month of follow-up compared to those in the control group. Other results of the study were inconclusive and future research should focus on how and when desired out comes are achieved.

Table 2 Characteristics of Included RCTs *(Continued)*

Study	Population	Sample Size (n)	Setting & Country	Intervention	Control	Outcome Measures and Follow-Up Time Intervals (Follow up rates)	Conclusions of the paper
	Hispanic/Latino 3.2% mixed race 15.9%- Asian/Pacific Islander or other race less than 1%						
Slesnick 2016	youth; 14–24 years; recent alcohol use; homeless; did not receive drop in, mental health, substance use services in past 3 months Mean age 20.8 Male 53.2% Female46.8% Ethnicity reported as White, not of Hispanic origin 57.0% Other 43.0%	*n* = 79	Drop in Center and Shelter- USA	1. 6 months of strengths-based outreach approach linked with drop-in center (n = 40)	1. 6 months of strengths-based outreachapproach linked with crisis center (*n* = 39)	1. Contact with services 2. Alcohol use 3. Personal control/self-efficacy 4. Depressive symptoms 5. Health (physical and mental) Measured at baseline 3,6,9 months post intervention (3,6,9 month F/U rates were 87,87,90% for the shelter linkage and 88,90,93% for the drop-in linkage conditions, respectively)	This study showed that the drop-in center intervention was more effective to link youth to services and led to an overall increase in service usage than the crisis center intervention. Youth in both groups reported an improvement in mental health and substance use outcomes, with no significant difference between the groups. However, youth in the intervention group demonstrated a reduction in drinking to the point of intoxication.
Slesnick 2015	youth; 14–20 years, vulnerably housed; met DSM IV criteria for abuse or substance disorder Mean age 18.74 Males 52.59% Females 47.41% Ethnicity reported as White non Hispanic 19.6% African American 65.56% Hispanic 2.22% Native American 0.74% Asian American 0.37% Other 11.48%	*n* = 270	Drop in Center- USA	1. Community reinforcement approach provided through a drop-in center 2. Motivational enhancement technique – two 1 h sessions through a drop-in center 3. Case management - 12 1 h sessions through a drop-in center	Three arm study, see interventions	1. Substance use 2. Depressive symptoms 3. Internalizing and externalizing problems 4. Coping 5. Victimization during the last 3 months 6. Homelessness (12 months) Measured at baseline 3,6, and 12 months post intervention (F/U 58.1% for CRA, 88.4% for MET, and 63.7% for case management)	Youth receiving the community reinforcement approach had improved substance use outcomes compared to those in the other two groups. However, while youth in all three arms had an improvement in the other reported outcomes, there was no significant difference between groups.
Slesnick 2009	Youth; 12–17 years; primary alcohol problem; family reside within 60 miles of research site; parents must have agreed to	*N* = 119	Runaway shelters- USA	1. Home-based ecologically based family therapy (EBFT) (*n* = 37), 2. Office-based functional family therapy (FFT) (*n* = 40)	Service as usual case management through a drop-in centre (*n* = 42)	1. Substance use 2. Psychological functioning 3. Family functioning Measured at baseline, 3 (75%), 9 (76%),15 (76%) months follow up post	Youth in all three groups showed improvement in substance use, psychological functioning and family functioning. Family therapy has a

Table 2 Characteristics of Included RCTs *(Continued)*

Study	Population	Sample Size (n)	Setting & Country	Intervention	Control	Outcome Measures and Follow-Up Time Intervals (Follow up rates)	Conclusions of the paper
	the possibility of family therapy. Mean age 15.1 years males 45% females 55% Ethnicity reported as African American 5% Anglo 29% Hispanic 44% Native American 11% Other 11%					intervention. There were no statistically significant differences between groups in attrition	greater impact on decreasing days of substance use compared to service as usual. Mixed results were obtained in the comparison of home-based family therapy com pared to office-based. Therefore, more research is necessary to identify the most effective context of family therapy.
Slesnick 2007	youth; 14–22 years; vulnerably housed; met DSM-IV criteria for Alcohol or other Psychoactive Substance Use Disorders Mean age 19.21 Males 66% Females 34% Ethnicity reported as Native American 13% Asian 1% African American 3%, Hispanic 30% Anglo 41%, and mixed ethnicity/race 12%	*n* = 180	Drop in Center- USA	Community Reinforcement Approach: 16 treatment sessions offered, average 6.8 per participant (*n* = 96)	Service as usual through the drop-in center. The center offered a place to rest, food, showers, clothing and case management (*n* = 84)	1. Substance use 2. Mental Health (Individual functioning, depression) 3. Social stability Measured at baseline and at 6 months post intervention. (F/U 84% for CRA, and 88% for control)	Youth who received the community reinforcement approach had statistically significant improvements in mental health and substance use outcomes compared to those receiving treatment as usual. While youth in the control group also demonstrated improvements in certain areas, the effects of the intervention were more significant and long-lasting since it aimed to improve the relationship between homeless youth and their environments.
Thompson 2017	youth; 17–22 years; engaged in unprotected sex or heavy drinking Mean age 19.3 Females 58.3% Ethnicity reported as Hispanic 47.5% African American 36.1% Other race/ethnicity 16.4%	n = 61	Crisis center- USA	Two session individual brief intervention (45–60 min): focused on changing alcohol and HIV risk behavior (*n* = 30)	Two session educational comparison (*n* = 31)	1. Alcohol use 2. HIV sexual risk behaviours 3. Alcohol related sexual risk 4. Readiness to change alcohol use 5. Readiness to change HIV sexual risk behaviors 6. HIV preventive knowledge Measured at baseline and at 1 month (87.1%) post intervention	The brief intervention did not improve alcohol use outcomes in youth compared to those in the educational comparison group. However, it did improve the willingness of youth to change their alcohol behaviour. Future research is necessary to demonstrate how to translate willingness to change behaviour to an actual change in behaviour.
Tucker 2017	youth 18–25 years Mean age 21.81	*n* = 200	Drop in Centers-USA	AWARE: 16 weekly 45-min sessions of group	Service as usual which includes access to food,	1. Alcohol, marijuana and drug use	Youth in the AWARE group had decreased frequency in

Table 2 Characteristics of Included RCTs *(Continued)*

Study	Population	Sample Size (n)	Setting & Country	Intervention	Control	Outcome Measures and Follow-Up Time Intervals (Follow up rates)	Conclusions of the paper
	Male 73% Female 27% Ethnicity reported as 31% non-Hispanic white 31% African American 25% Hispanic 24% multiracial/other 21%			motivational interviewing ($n = 100$)	hygiene services, case management and other programs available at the drop-in center (n = 100)	2. Sex related outcomes Measured at baseline and 3 months post interventions. (95% F/U for intervention and 86% for control)	alcohol use and unprotected sex compared to those in the treatment as usual group. While there was an improvement of willingness to reduce marijuana and other drug use, there were no improvements in the frequency of use. This may be because the intervention did not make specific references to marijuana or other drugs.

Table 3 Characteristics of Included Systematic Reviews

Study	Design and Quality	Objective	Included Studies	Population	Interventions	Results/Outcomes
Altena 2010	Systematic Review AMSTAR 5/13 Critically low quality review	"To provide a summary of effective interventions for homeless youth by collecting, summarizing, categorizing, and evaluating quantitative studies."	n = 11 Cauce (1998) [RCT, 150, USA] Slesnick (2007) [RCT, 180, USA] Peterson (2006) [RCT, 285, USA] Baer (2007) [RCT, 117, USA] Hyun (2005) [RCT, 32, South Korea] Upshur (1985) [Quasi-experimental, 57, USA] Upshur (1986) [Quasi-experimental, 22, USA] Ferguson (2008) [Quasi-experimental, 28, USA] Fors (1995) [Quasi-experimental, 221, USA] Kisely (2008) [Quasi-experimental, 45, Canada] Slesnick (2008) [Uncontrolled pre- post-, 172, USA]	Youth experiencing homelessness between the ages of 10 and 24 years, regardless of location or subgroup, whether living on the street or in service accommodations. This typically included more males than females. The proportion of youth with mental health or substance use issues varied greatly.	• Intensive case management • Independent living programs • Brief motivational intervention • Intensive case management, • cognitive behavioral intervention • living skills/vocational intervention • peer-based intervention • supportive housing.	The authors found that there was insufficient evidence to claim any clinical effectiveness in any of the interventions.
Coren 2016	Meta-analysis AMSTAR 14/16 Low quality review	"To evaluate and summarize the effectiveness of interventions for street-connected children and young people that aim to promote inclusion and re integration, increase literacy and numeracy, facilitate ac cess to education and em ployment, promote mental health, including self-esteem, reduce harms asso ciated with early sexual ac tivity and substance misuse"	n = 13 Baer (2007) [RCT, 127, USA] Carmona (2014)/Slesnick (2015) [RCT, 270, USA] Cauce (1994) [RCT, 115, USA] Hyun (2005) [RCT, 27, South Korea] Milburn (2012) [RCT, 151, USA] Nyamathi (2012/13) [RCT, 100,USA] Peterson (2006) [RCT, 285, USA] Rew (2007) [Quasi-RCT, 572, USA] Rotheram-Borus (2003) [CBA, USA, 311] Slesnick (2005) [RCT, 124, USA] Slesnick (2007/08) [RCT, 580, USA] Slesnick (2009) [RCT, 129, USA] Slesnick (2013)/Guo (2014) [RCT, 179, USA]	Street-connected children and young people between birth and 24 years of age regardless of location, reason for street connectedness or gender, including those living or working on the street or in public places, and returning to the family home at different times.	• harm-reduction • inclusion programs • reintegration programs • shelter • housing • drop in support • any type of intervention interventions explicitly aimed at reducing risky sexual activity and substance misuse • Individual • Family • Small groups • Entire communities. • Multi-faceted interventions that incorporate a range of approaches, including housing, education, training and health."	There appeared to be no difference in effect between focused therapies and standard services for street-connected children and young people.

Table 3 Characteristics of Included Systematic Reviews *(Continued)*

Study	Design and Quality	Objective	Included Studies	Population	Interventions	Results/Outcomes
Noh 2018	Meta-analysis AMSTAR 8/13 Critically low quality review	"To examine the literature for psychological interventions directed toward runaway and homeless youth and to evaluate the effectiveness of these interventions in terms of mental health outcomes."	n = 11 Baer (2007) [RCT, 127, USA] Brillantes-Evangelista (2013) [non-RCT, 29, Philippines] Hyun (2005) [RCT, 27, South Korea] McCay (2011) [non-RCT, 15, Canada] McCay (2015) [non-RCT, 89, Canada] Milburn (2012) [RCT, 151, USA] Peterson (2006) [RCT, 285, USA] Rew (2017) [non-RCT, 80, USA] Slesnick (2005) [RCT, 124, USA] Slesnick (2007) [RCT, 180, USA] Slesnick (2009) [RCT, 119, USA]	Youth experiencing housing instability that are 12–24 years of age. Most of the included studies included both males and females. Two of the studies included only females or males.	• Art therapy • Cognitive behavioral therapy (CBT) umbrella • Family therapy • Motivational interviewing • Strengths-based interventions	None of the psychological interventions appeared to have any effect on mental health outcomes. However, substance use appeared positively affected by Family Therapy, and depression appeared positively affected by CBT.
Xiang 2013	Systematic Review AMSTAR 7/13 Critically low quality review	"Primary: to summarize evidence on interventions for substance use among homeless youth Secondary: to draw implications for practice, to provide a critical appraisal of the methodologies in existing literature, and to suggest avenues for future research."	n = 15 Peterson et al. (2006) [RCT, 185, USA] Baer et al. (2007) [RCT, 127, USA] Slesnick, Prestopnik, Meyers, et al. (2007) [RCT, 180, USA] Slesnick, Kang et al. (2008) [Longitudinal, 172, USA] Booth et al. (2008) [Crossover, 147, USA] Ferguson & Xie (2008) [Prospective, 28, USA] Cauce et al. (1994, 1998) [RCT, 304, USA] Souza et al. (2011) [Longitudinal, 400, Honduras] Stewart et al. (2009) [Prospective, 70, Canada] Slesnick, Bartle-Haring, et al. (2006)/Slesnick & Prestopnik (2005, 2009) [RCT, 243, USA] Milburn et al. (2012) [RCT, 151, USA] Steele & O'Keefe (2001) [Longitudinal, 106, USA] Rotheram-Borus (2003)	Youth experiencing homelessness between the ages of 12 and 24	• Brief motivational intervention • Community reinforcement approach • Knowledge and skills training • Case management • Peer support interventions • Family therapy • Shelter services • Supportive housing	Most studies showed improvements in substance use outcomes, however, improvements rarely varied between the treatment group and the control group. The only treatment shown to have greater relative efficacy was family therapy.

Table 3 Characteristics of Included Systematic Reviews *(Continued)*

Study	Design and Quality	Objective	Included Studies	Population	Interventions	Results/Outcomes
			[Prospective, 187, USA] Pollio et al. (2006) [Longitudinal, 371, USA] Kisely et al. (2008) [Retrospective, 45, Canada]			

First Author, Year	Random sequence generation	Allocation Concealment	Baseline outcome measurements similar	Baseline characteristics similar	Incomplete outcome data	Knowledge of the allocated interventions	Protection against contamination	Selective outcome reporting	Other risks of bias	Overall Risk of Bias
Baer 2007	Low	Low	Low	Low	Unclear	Low	Unclear	Low	Low	Not serious
Bender 2015	Low	Low	High	High	High	High	Unclear	Low	High	Very serious
Courtney 2008	High	Low	Low	Low	Low	Low	Unclear	Low	Low	Serious
Greeson 2015	High	Low	Low	Low	Unclear	Low	Unclear	Low	Low	Serious
Guo 2016	Low	Unclear	Low	Low	Low	Unclear	Low	Low	High	Serious
Hyun 2005	Unclear	Unclear	Low	Low	Unclear	High	High	Low	High	Very serious
Kozloff 2016	Low	Low	Low	Low	Low	High	Low	Low	High	Serious
Krabbenborg 2017	Unclear	Low	Low	Low	Low	Unclear	Low	Low	High	Serious
Milburn 2012	Unclear	Low	Unclear	Low	Low	Unclear	Low	Low	Low	Serious
Peterson 2006	Low	Low	Low	Low	Low	High	Unclear	Low	Low	Serious
Slesnick 2013	Low	Unclear	Low	Low	Low	Unclear	Low	Low	Low	Not Serious
Slesnick 2016	Unclear	Unclear	Low	Low	Low	High	Unclear	Low	Unclear	Serious
Slesnick 2015	Low	low risk	Low	Low	Low	Unclear	Low	Low	Low	Not Serious
Slesnick 2013	Low	Unclear	Unclear	Low	High	Unclear	Low	Low	Low	Serious
Slesnick 2009	Low	Unclear	Low	Low	Low	Unclear	Low	Low	Low	Not serious
Slesnick 2007	Low	Low risk	Low	Low	Low	High	High	Low	High	Very Serious
Thompson 2017	Low	Unclear	Low	Low	Low	High	Unclear	Low	Low	Serious
Tucker 2017	Low	Unclear	Low	Low	Low	Unclear	Low	Low	Unclear	Serious

Fig. 2 Methodological Quality of Included RCTs using Cochrane Risk of Bias Tool

interviewing (MI), family therapy), 2) skills building (e.g. life skills, mindfulness), 3) case management and 4) structural interventions (e.g. housing support, drop-in centres, shelters). See Table 5 for the definitions of interventions. The results of RCTs have been summarized using a visual map (see Fig. 3).

Individual and family therapy

Cognitive Behavioural therapy

CBT led to improvements in substance use and depression, and one systematic review also reported improvements in internalizing behaviours and self-efficacy [33–36]. When a CBT-based therapy (community reinforcement approach) was delivered with case management in one study, there were improvements in percentage of days being housed, psychological distress, and substance use [33]. Two systematic reviews conducted meta-analyses on CBT and CBT-based interventions and found no statistically significant difference in mental health outcomes compared to services as usual, but noted that lack of a statistically significant difference may be due to heterogeneity between studies [34–36].

Family therapy

Family-based therapy was delivered in an office setting, known as functional family therapy, or in the home setting, called ecologically-based family therapy. Systematic reviews reported that all three family therapy RCTs showed a reduction in substance use [34–36]. However, Noh (2018) conducted a subgroup meta-analysis on two family intervention studies and found no significant effect on substance use [34]. Another meta-analysis found a statistically significant improvement in family cohesion, but called it a clinically marginal effect [36]. In a three arm RCT comparing home-based family therapy with MI and a CBT-based therapy, all three groups improved over time in internalizing and externalizing behaviours, family cohesion, and substance use [47–49]. Furthermore, when an RCT compared functional family therapy, home-based family therapy, and services as usual, all treatments showed improvements in days living at home at three, nine and 15 months, but no group was superior to another [52].

Motivational interviewing

Brief or group MI interventions were primarily designed to address substance use and/or risky sexual behaviours. A brief intervention showed declines in non-marijuana drug use at 1-month follow up, but the reduction was no longer significant after 3 months [33–35]. In another RCT, both the service as usual and intervention groups showed significant improvements over time, but there were no significant and durable results in favour of the experimental group [21]. A 16-week group MI intervention found significant declines in alcohol use and increased motivation to change drug use, but no significant decreases in marijuana use [37]. A two-session individual brief MI intervention compared to an education program reported significant improvements in readiness to change alcohol use [38].

Skill building

The interventions focused on vocational and life skills, mindfulness, and strengths-based skill building. One

Table 4 Methodological Quality of Included Systematic Reviews using AMSTAR II

AMSTAR II Criteria	Quality Ratings for Systematic Reviews			
	Altena 2010	Coren 2016	Noh 2018	Xiang 2013
1. Did the research questions and inclusion criteria for the review include the components of PICO?	Yes	Yes	Yes	Yes
2. Did the report of the review contain an explicit statement that the review methods were established prior to the conduct of the review and did the report justify any significant deviations from the protocol? (critical)	No	Yes	No	No
3. Did the review authors explain their selection of the study designs for inclusion in the review?	No	No	Yes	Yes
4. Did the review authors use a comprehensive literature search strategy? (critical)	Partial yes	Yes	Partial yes	Partial yes
5. Did the review authors perform study selection in duplicate?	Yes	Yes	No	No
6. Did the review authors perform data extraction in duplicate?	No	Yes	No	No
7. Did the review authors provide a list of excluded studies and justify the exclusions? (critical)	No	Yes	No	No
8. Did the review authors describe the included studies in adequate detail?	Yes	Yes	Partial yes	Yes
9. Did the review authors use a satisfactory technique for assessing the risk of bias (RoB) in individual studies that were included in the review? (critical)	No	Yes	Yes	No
10. Did the review authors report on the sources of funding for the studies included in the review?	No	Yes	No	No
11. If meta-analysis was performed did the review authors use appropriate methods for statistical combination of results? (critical)	No meta-analysis was performed	Yes	Yes	No meta-analysis was performed
12. If meta-analysis was performed, did the review authors assess the potential impact of RoB in individual studies on the results of the meta-analysis or other evidence synthesis?	No meta-analysis was performed	Yes	No	No meta-analysis was performed
13. Did the review authors account for RoB in individual studies when interpreting/ discussing the results of the review? (critical)	No	Yes	Yes	Yes
14. Did the review authors provide a satisfactory explanation for, and discussion of, any heterogeneity observed in the results of the review?	No	Yes	Yes	Yes
15. If they performed quantitative synthesis did the review authors carry out an adequate investigation of publication bias (small study bias) and discuss its likely impact on the results of the review? (critical)	No meta-analysis was performed	No	No	No meta-analysis was performed
16. Did the review authors report any potential sources of conflict of interest, including any funding they received for conducting the review?	Yes	Yes	No	Yes
Overall Assessment of Quality	Critically low quality	Low quality	Critically low quality	Critically low quality

systematic review included one study evaluating a life skills intervention and found improvements in family contact and near significant improvements in depressive symptoms [33]. Another systematic review reported similar results but noted an increase in substance use over 6 months which could not be explained [35]. A training program based on a peer influence model showed non-statistically significant decreases in drug use in the treatment group. One study evaluated a strengths-based program deployed in a shelter to identify and make use of strengths in each youth [39]. This program showed no significant differences between groups but found improvements over time in depression, substance use, and satisfaction with family relations [39]. Two RCTs evaluated a vocational and life skills program and a mindfulness skills program, though did not report promising treatment effects [40–42].

We attempted to conduct meta-analyses whenever possible, but due to the heterogeneity between studies, it was inappropriate to pool the results into a combined

Table 5 Definitions of Interventions

Categories of Interventions	Intervention Type	Definition
1. Individual and family therapies	1a. Cognitive Behavioural Therapy (CBT)	A type of short-term psychotherapy, based on a pro-active and shared therapeutic relationship between a therapist and client, that enables an individual to develop skills and strategies to make sense of the present [19]. CBT is structured and time-limited (i.e. typically 6–20 sessions), and allows the client to identify, challenge and change thoughts, attitudes and beliefs that may trigger emotional and behavioural difficulties [46, 47, 49, 50]. Usually, CBT is effective in treating anxiety and depression, but also conditions such as bipolar disorder, schizophrenia and psychosis [19]. Includes: - *Community reinforcement approach* (CRA): a CBT-based therapy that recognizes the impact that the environment/community (i.e. family, hobbies, work, friends, etc.) can have on an individual. CRA permits the individual to modify environmental factors such as developing communication, problem solving and job skills, in order to support the recovery process [54]. - *Dialectical behaviour therapy*: the client is taught that their experiences and behaviours are valid (i.e. acceptance), and that, in order to move on and manage their emotions, they must make positive changes (i.e. change) [55].
	1b. Family Therapy	A type of psychotherapy that aims for family preservation by promoting support and understanding among family members during times of instability, uncertainty, anger, grief, or trauma [20, 29]. By providing a safe environment, Family Therapy focuses on intrapersonal factors that support family cohesion and re-establishing connections; it seeks to understand in dividual behaviour and interactions between the individual and their family in order to reduce defensive communication patterns. The duration of sessions is client-dependent, varying from a few sessions (2–3) to longer. Ecologically Based Family Therapy is a home-based model, while Functional Family Therapy is provided in a professional setting [46, 47, 49].
	1c. Motivational Interviewing	A collaborative, person-centered counselling approach based on empathy and self-efficacy that is often used to address risky sexual health behaviours, alcohol and drug use, and mental health issues [21, 48]. Motivational interviewing can be a single session or multiple sessions with a clinical psychologist or other trained health workers, with the objective of building self-confidence and developing independence to strengthen the motivation for change [56].
2. Skill building programs	Life skills training program Mindfulness Strengths-based	Life Skills Training enables youth 16 years and older to adopt and develop key competency skill areas in education, employment, daily living skills, survival skills, choices and consequences, and interpersonal/social domains. Life Skills Training also includes an extensive outreach component in order to recruit youth into the program and provide short-term case management support [40, 41]. Mindfulness (SAFE intervention): Through a three-day workshop, youth are invited to adapt concepts of mindfulness, with a focus on internal, interpersonal, and environmental cues, and fostering assertiveness and problem- solving skills, and strategies for asking for help [42]. Strengths-based intervention (Houvast) enables and promotes self-agency in his or her own recovery process, by goal-setting, identifying ineffective strategies and problems in the way of achieving set goals [39].
3. Case management		Case management is health and social service where an individual is assigned a case manager who plans and facilitates access to health and social care services required for recovery [22]. Intensive case management is provided to individuals with serious mental health disorders and struggling with addictions [57]. The case manager accompanies the service user to meetings and can be available for up to12 hours per day, 7 days a week. One form of time-limited intensive case management is critical time intervention, which supports continuity of care and facilitates access to services for clients during transitions (e.g. from a shelter to independent housing or following discharge from a hospital) [43]. Critical time intervention is often offered for a period of 6–9 months.
4. Structural Support	4a. Housing Programs	Housing First is a housing model that provides immediate access to permanent independent housing in the community and is not contingent on sobriety or abstinence or treatment. Individuals enrolled in the Housing First program are typically given access to scattered-site housing of their choice with mobile and off-site mental health services. Supported Housing: safe and affordable housing with integrated health and social support services [35]. The supportive service (usually Assertive community treatment) is provided by a multidisciplinary team. Independent Living Programs aim is to provide homeless and vulnerably housed youth with life skills through a structured and supervised residential [33].
	4b. Drop-in Centre 4b. Shelter Services	Drop-in Centers: offered for youth 24 h/7 days a week, and provides access to food, laundry, and shower facilities, as well as recreational activities (e.g. television, books, board games or video games), and opportunities for socialization [44]. Drop-in staff often link youth with community resources (i.e. counseling and housing programs). Shelter Services: provide a temporary overnight alternative to street living, and is open 24 h/day, 7 days a week [44].

	Intervention	Study	What are the results of the intervention(s) on each outcome category? Mental Health	Substance Use	Housing	Family Cohesion and Conflict
Cognitive behavioural therapy	CBT	Hyun 2005***	Significant improvements over time in the intervention group for depression whereas SAU did not improve significantly over time. However, effects between groups was not statistically significant	Not measured	Not measured	Not measured
	CBT-based intervention	Slesnick 2007***	The intervention group showed significantly improved depression and internalizing behaviours compared to SAU	Intervention group showed a significant decrease in percent days of alcohol and drug use compared to SAU	Not measured	Not measured
Motivational Interviewing	Brief MI	Baer 2007	Not measured	No significant improvements compared to SAU, but there were significant decreases over time in both groups for alcohol, drug, and marijuana use, and increases in abstinence	Not measured	Not measured
	Brief MI	Peterson 2006	Not measured	There was a decrease in illicit drug use other than marijuana at 1 month follow up in intervention compared to SAU, but no other differences between groups in alcohol and drug use	Not measured	Not measured
	Brief MI	Thompson 2017	Not measured	No significant differences between groups on alcohol use outcomes	Not measured	Not measured
	Group MI	Tucker 2017	Not measured	The intervention group showed significant decreases in alcohol use over three months compared to SAU. There were no significant treatment effects noted for marijuana and other drug use.	Not measured	Not measured
Family Based Therapy	Family based therapy	Milburn 2012	Not measured	Significant decrease in number of times using alcohol and hard drugs in the intervention compared to SAU, but increase in marijuana use in intervention compared to SAU	Not measured	Not measured
Skills and Knowledge Buildling Interventions	Mindfulness Skills Intervention	Bender 2015***	No difference in total mindfulness scores between groups, but intervention group showed improvements in observing subscale compared to SAU	Not measured	Not measured	Not measured
	Life skills intervention	Greeson 2015/ *Courtney* 2008	Not measured	Not measured	No significant differences between groups in housing stability	Not measured
	Strengths based skills intervention	Krabbenborg 2017	No significant differences between groups, but significant improvements over time in depression in both groups	Not measured	Not measured	No statistically significant differences between groups, but significant improvements over time in both groups in satisfaction with family relations
Structural Interventions	Housing first	Kozloff 2016	No significant differences between groups in self-rated mental health	Not measured	Significant improvements in housing stability in the intervention group compared to SAU	Not measured
Studies comparing multiple interventions						
	FBT vs CBT-based Therapy (CRA) vs MI	Guo 2016 / Slesnick 2013a / Slesnick 2013b	Significant reductions over time in all groups, but no differences between groups on internalizing and externalizing behaviours	Significant reductions in substance use over time in all three interventions but no differences between groups	Not measured	Home FBT had significant improvements in family conflict and more long-term effects on family cohesion compared to CRA and MI. All three interventions showed improvements over time in family cohesion and improvements in family conflict
	Shelter vs drop-in linkage	Slesnick 2016	Significant improvements in depressive symptoms and self-rated mental health in all groups but no differences between groups	Significant decrease in alcohol and marijuana use variables in all groups but no differences between groups	Not measured	Not measured
	CBT based therapy (CRA) vs MI vs Case management	Slesnick 2015	Significant decreases in depressive symptoms over time in all groups. Case management showed significant decreases over time in internalizing behaviours while MI and CRA did not.	Significant decreases in alcohol use in all treatment conditions over time, and CBT showed significant decreases in frequency of drug use compared to case management.	Significant decrease in percent days of homelessness in all treatment conditions, but no differences between groups	Not measured
	Office FBT vs Home FBT vs TAU	Slesnick 2009	Significant decreases over time in number of psychiatric diagnoses and externalizing problems in all groups, but no significant differences between groups on any mental health outcomes	Both family therapies improved alcohol and drug use outcomes compared to SAU	Not measured	Family cohesion and conflict decreased over time in all groups

Legend:
= Favours intervention
= No significant differences between groups
= Favours services as usual
= Not measured
*** results should be interpreted with caution given the very high risk of study bias

Fig. 3 Visual Summary of Results of RCTs by Outcome

effect size. As such, we developed a forest plot for short-term mental health outcomes of a mindfulness intervention, CBT intervention, strengths-based intervention, and CBT-based intervention [39, 42, 50–53]. The figure depicts a general trend favouring the interventions but none reaching statistical significance compared to control (see Fig. 4).

Case management

Two systematic reviews reported on several case management programs, including intensive case management and multidisciplinary case management, and reported minimal additional benefit of the programs relative to their comparison interventions [33–35]. They noted that one program showed favourable results for substance use, but the study quality was very low due to low retention rates [33]. In a three-arm RCT, case management, a CBT-based intervention, and MI all showed significant improvements over time in housing stability, depression, and substance use, but no significant differences between groups [45]. Case management led to improvements over time in internalizing behaviours while the other groups did not [45]. Overall, there is evidence to suggest that case management may have impacts on substance use, depression, and housing stability, but different control conditions in each of the studies made it difficult to assess overall effectiveness of the intervention.

Structural support

Housing programs

A subgroup analysis of young adults in an RCT of the housing first model for adults with mental illness found that, compared to treatment as usual, housing first significantly increased the proportion of days stably housed over the 24-month trial, but had no impact on self-rated mental health [43]. One systematic review included an independent living program and reported marginal results on psychological measures, however reported some positive outcomes on housing status [33]. The same systematic review also included a study evaluating a supportive housing program, which reported lower rates of substance abuse and improvements in self-reported health, but the study quality was noted to be low. Xiang evaluated the same supportive housing program and also concluded that the lower rates of substance use may be attributed to baseline differences between control and intervention groups instead of treatment effect [35].

Drop-in and shelter services

A systematic review included three shelter services studies, two evaluating residential services and one evaluating emergency shelter and crisis services [35]. The review showed some improvements in substance use but this was not consistent over the various studies and there were no enduring effects over time. An RCT compared referrals from case management made to drop-in versus shelter services programs [44]. There were no differential treatment effects, as both groups showed decreases in depression and substance use over time [44]. However, individuals assigned to the drop-in service had greater service contacts and access to care over 6 months [44].

Gender and equity analysis

Equity variables were not consistently measured, reported, or analyzed across studies. Several studies measured equity and PROGRESS+ factors with baseline sample characteristics, but very few included them as covariates. The most examined factors were gender and ethnicity/race, with some studies mentioning place of residence and occupation. A number of RCTs included equity variables in their analysis [21, 37, 39–41, 43–49], as did three systematic reviews [34–36].

A number of studies indicated that females responded differently to services than males. Slesnick's studies have showed that females initially reported higher rates of depression than males, with a greater reduction throughout the study [44–46]. Female adolescents showed a greater improvement in family cohesion subsequent to treatment regardless of the treatment condition [47] and appeared to derive greater benefit from shelter services than males [35].

Some variance in relation to ethnicity and employment emerged as well. While youth from ethnic minorities had greater reductions in substance use, they also relapsed more quickly than white youth [49] and had more HIV risk behaviours [44]. African Americans showed a greater reduction in percent days homeless than other ethnic groups [45]. Non-Hispanic white youth more quickly reduced their number of days drinking to intoxication [44]. Those employed or in

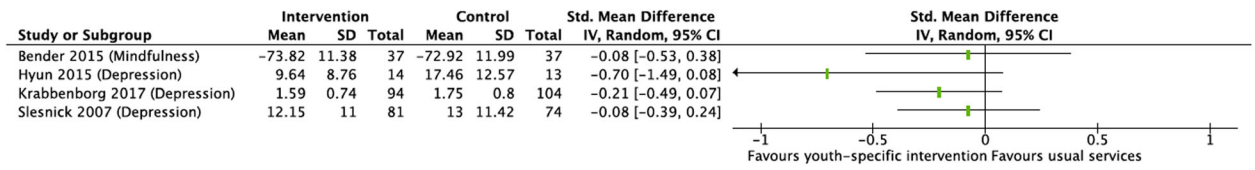

Fig. 4 Intervention vs. Usual services for Short Term (0-6 months) Mental Health Outcomes)

school at baseline were more likely to remain employed at follow-up [39].

Discussion

This review identified a wide variety of interventions for youth experiencing housing instability. Regarding individual and family therapies, CBT interventions showed improvements in depression and substance use outcomes [33–36]. Family interventions led to improvements in alcohol and drug use measures and may have had an impact on family cohesion [34–36]. Motivational interviewing, skill-building programs and case management showed inconsistent effects on mental health and substance use when compared with services as usual and other interventions [21, 33, 35–42, 45–49]. Among the structural support interventions, housing first led to improved housing stability outcomes, while drop-in and shelter services led to inconsistent effects [43, 44]. The equity analysis revealed differential treatment effects based upon gender and ethnicity, with females often deriving more treatment benefit than males [44, 45, 47–49]. Equity analyses were limited, with very little mention of important considerations such as sexual orientation status, as LGBTQ+ youth are disproportionately represented in the homeless population [58, 59].

While in many circumstances, differences were not statistically significant between treatment groups, this does not preclude the lack of effectiveness of these interventions. It is important to note that a treatment as usual group was not the absence of an intervention, but rather involved referral to other community services and follow-up with researchers. This may lessen the differences between the intervention and control arms, and decrease the detectable effect of the intervention. Providing non-specific support for youth may be enough to improve outcomes and reduce the toxic effects of adverse childhood experiences. However, that regression to the mean may also potentially explain the changes observed over time [60]. As participants may enter the research studies during a point of crisis, they may naturally improve over time regardless of the study group, and this effect may lessen the observed differences between intervention and control groups.

Tailoring interventions to the needs of youth

The dynamics of youth homelessness are complex; pathways to housing are precarious, sociocultural backgrounds are becoming increasingly diverse and available resources are inconsistent. Research has shown that unstable family relationships underlie youth homelessness, and many youth have left homes where they experienced interpersonal violence and abuse [3–5, 61]. Among these difficult family issues, other personal factors arise as a result of their environmental contexts, which can interplay and lead to increased distress. These challenges include substance use, depression, and disability, and can compoundly contribute to strain [10]. The interventions identified in this review may help to address the specific needs of youth and may be tailored to their situation.

One important consideration to note is that while we have defined youth as those ages 13 to 24 for the purposes of this study, this grouping brings together minors as well as young adults of legal age. While this age categorization is reflective of the literature on the youth population, we recognize that there are differences between the experiences of younger versus older youth. Furthermore, there are medicolegal implications of the mature minor and capacity to consent. Clinicians and program implementers who work directly with this population need to consider the ethical considerations of consent for treatment participation with mature minors as well as the legal obligations provided by their governing college [62].

Strengths and limitations of the review

We conducted a high quality search, complying to PRISMA-E guidelines [26]. This review included only high quality study designs: RCTs and systematic reviews. This may, however, have limited the types of interventions that were included. Limitations include a broad range of outcomes and, thus, too few studies available for meta-analyses. There was heterogeneity in the interventions, and the available evidence was insufficient to use network meta-analysis to answer the question of the relative advantages of the different types of interventions. In our systematic review, the studies did not use placebo designs and, instead, used several different interventions/comparisons. However, there was considerable heterogeneity in the outcome measures and this prevented a pooling of the effects. The services-as-usual comparisons were often not adequately described in the primary studies, limiting the comparisons that could be made across different studies. Furthermore, our definition of youth experiencing homelessness focused on unaccompanied youth and did not include accompanied youth that enter homeless situations along with their families, as this youth population has quite distinct circumstances and needs.

Implications for future research, policy, and practice

The results suggest that tailored interventions for youth may have impacts on depression, substance use and housing. Given the diverse pathways to youth homelessness, health care policy-makers, practitioners and other stakeholders should consider the specific needs of youth during prevention and delivery of care. Furthermore, we recommend additional high quality research to be

conducted in the area of family-based therapies, CBT, and housing interventions, which have shown some positive results thus far. We further recommend additional considerations for equity factors. Few studies examined equity factors, and those that did were limited largely to gender and ethnicity. There remains a large gap in data regarding the intersectionality between a variety of PROGRESS+ factors contributing to youth experiences.

There is also a large gap in research on the impact of structural interventions such as housing and case management on youth experiencing homelessness. The predominance of psychological and family interventions in this paper suggests that more work could be done to study an area in which it may be more difficult to design studies. Nonetheless, future research on these interventions are important to addressing the root causes of poverty and homelessness. Furthermore, there are emerging models of housing which have not yet been evaluated rigorously in the literature. For instance, host homes provide safe and temporary housing for up to 6 months for youth while supporting them with a case manager to identify long term solutions [63]. Rapid re-housing programs provide short-term subsidies to allow persons experiencing homelessness to acquire stable housing as quickly as possible [64, 65]. The landscape on housing models continues to evolve and future research will need to evaluate these in the context of youth experiencing homelessness.

Conclusion

This review identifies a variety of interventions targeted towards the unique needs of youth experiencing homelessness. CBT interventions may lead to improvements in depression and substance use, and family-based therapy may impact substance use and family outcomes. Housing programs may lead to improvements in housing support and stability. Other interventions such as skill building, case management, show inconsistent results on health and social outcomes.

Supplementary information

Supplementary information accompanies this paper at https://doi.org/10.1186/s12889-019-7856-0.

Additional file 1. Search Strategy.

Additional file 2. Interventions for Social, Personal, Health and Social Service Utilization, and Sexual Health Outcomes.

Additional file 3. PRISMA Equity Checklist.

Abbreviations

AMSTAR II: A MeaSurement Tool to Assess systematic Reviews; CBT: Cognitive Behavioural Therapy; MI: Motivational Interviewing; PRISMA-E: Preferred Reporting Items for Equity-Focused Systematic Reviews and Meta-analyses; PROGRESS+: Place of Residence- Race/ethnicity/culture/language- Occupation- Gender/sex- Religion- Education- Socioeconomic status- Social capital + refers to: 1) personal characteristics associated with discrimination (e.g. age, disability). 2) features of relationships (e.g. smoking parents, excluded from school). 3) time-dependent relationships (e.g. leaving the hospital, respite care, other instances where a person may be temporarily at a disadvantage); RCT: Randomized Control Trial

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Protocol

Published on Cochrane Equity Methods Website - https://methods.cochrane.org/equity/projects/homeless-health-guidelines

Authors' contributions

JZW, SM, CM, OM, KP and AA were involved in the conception and funding of this study. JZW, SM, CM, AM, KP and AA helped screen articles and determine their inclusion and exclusion in this study. JZW, SM, CM, OM, AM, NK, KP, and AA were involved in extracting data from randomized control trials and systematic reviews on relevant outcomes. JZW, SM, OM, AM, VK, PG, NK, KP, and AA were involved in critical appraisal of the quality of articles using AMSTAR and Cochrane risk of bias tool. All authors were involved in data analysis, writing the manuscript, and revisions. All authors read and approved the final manuscript.

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This study was funded by the Inner City Health Associates. ICHA was not involved in conducting the study including study design, data collection, analysis, interpretation, and writing the manuscript.

Availability of data and materials

Not applicable.

Ethics approval and consent to participate

This article was a review of published primary studies, ethics approval not required.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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Publisher's Note

Please ignore the last one and see this one from Commissioner Fine

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From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Monday, October 11, 2021 1:19 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: To Send - BMH Access to AC Systems-Integrated Community Health Records

Hi Jamie - I hope you enjoyed a lovely holiday weekend. Would you please be so kind and forward this email to the Mental Health Commissioners and the public? Thank you so much. Best wishes, Margaret

Hi All,

Last June 24, 2021, the Director of Program Development and the Director of Strategy and Implementation for Alameda County Care Connect presented the Whole Person Care model and demonstrated the computer dashboard display information available from multiple well-integrated systems in the Community Health Records (CHR). Not long after the City Attorney and IT departments approved the contract to implement this system. Currently the Division of Mental Health and Alameda County are taking next steps for implementation.

As it stands right now the Division of Mental Health staff have access to mental health information through Clinician's Gateway (assessment, treatment plans, progress notes, encounters in ACBH) that is connected to InSyst (Medi-Cal billing). In conjunction with Alameda County Care Connect and the onboarding and training company, below please find the updated computer dashboard displays (and short attachments about the CHR). There multiple well-integrated data sources from housing, medical,

mental health, public benefits, crisis response services, incarceration, and much more. The model is below.

In addition to the Community Health Records dashboards, providers can generate analytical utilization and encounter reports to evaluate service delivery (examples shown below but far more can be generated). Attached is a 2-pager on navigating analytical reports. We can potentially invite Alameda County Care Connect and the onboarding/training company to a future meeting to further explore evaluating service delivery and additional features if desired.

Whole Person Care Model

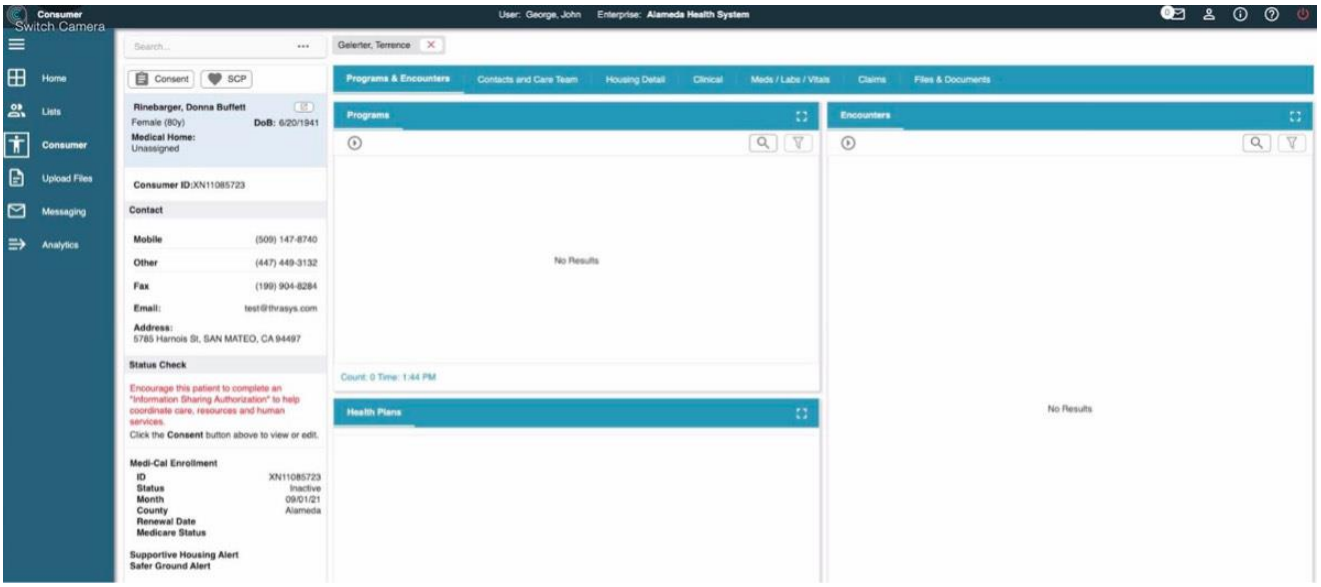
Who is Served?

- **People experiencing homelessness**
- **People with complex physical, behavioral and social conditions (SDOH)**
- **People with needs for care across multiple systems, especially to eliminate interactions with police, criminal legal & incarceration systems**
- **People with needs for equitable, tailored culturally safe and responsive services**

SOME DATA SOURCES AVAILABLE and FREQUENCY UPDATED:

DATA SOURCE		ORGANIZATION TYPE	FREQUENCY UPDATED
Alameda Alliance		Health Plan	Daily
Anthem Blue Cross		Health Plan	Membership-daily
St. Rose Hospital		Physical Health	Real Time
ESO (Emergency Medical Services)		Emergency Response	Real Time
Sutter: Sutter Campus and Eden Hospital		Physical Health	Real Time
Alameda Health System: Highland, San Leandro, Alameda, John George, all outpatient clinics		Physical & Behavioral Health	Real Time
Collective Medical Technologies (Admission/Discharge)		Physical & Behavioral Health	Real Time
AC Behavioral Health		County	Weekly
HMIS (Housing Management Information System)		Housing	Daily
Social Services Agency (Public Benefits)		County	Twice a month
Santa Rita Jail		Jail	Hourly

CLIENT INFORMATION on the LANDING PAGE DASHBOARD (below):
A summary of demographic and contact information: Name, gender, age, DOB, mobile and other phone number, fax, email, address; status check alert to sign consent form for data sharing; Medi-Cal enrollment information (ID, active/inactive status, month, county, renewal date); and other alerts when available such as housing alerts or an indication that the client is currently incarcerated.

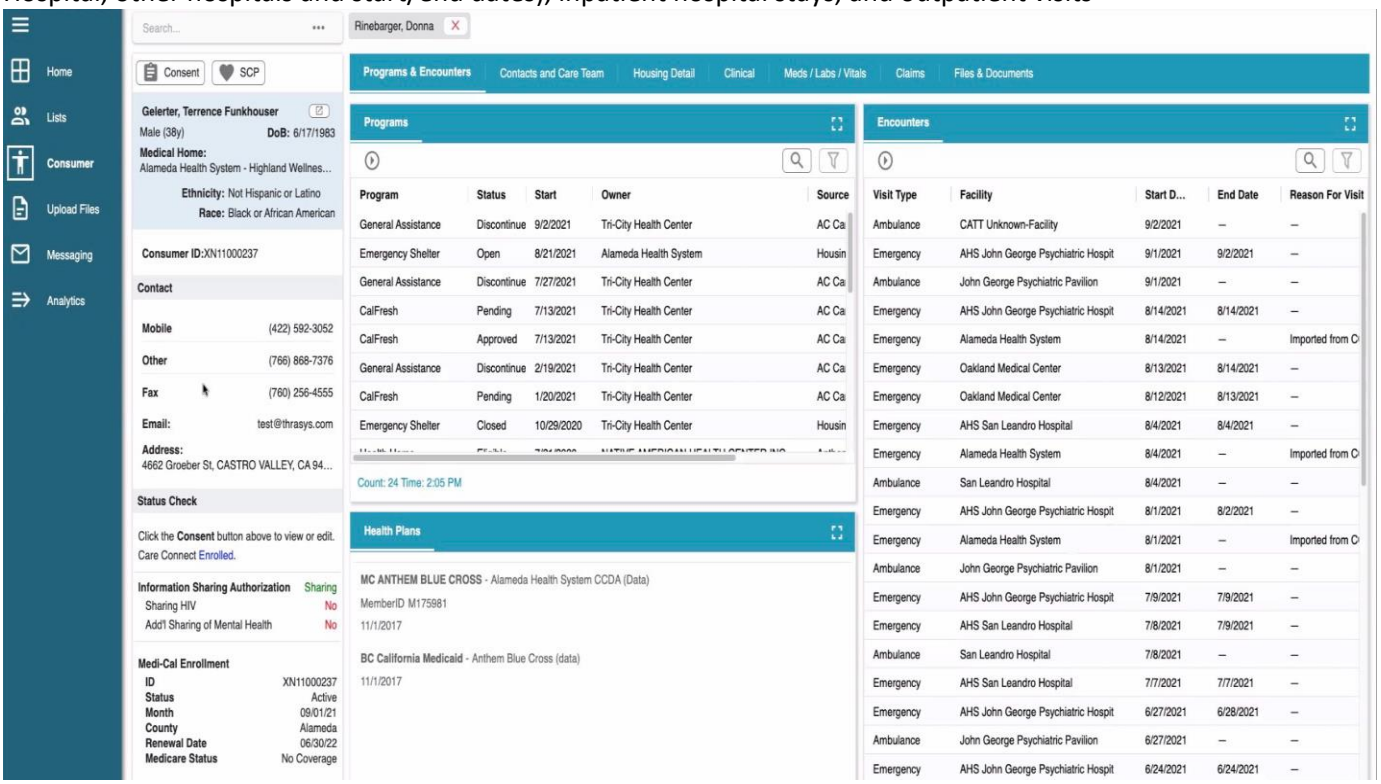


PROGRAMS, HEALTH PLAN & ENCOUNTERS DASHBOARD (below):

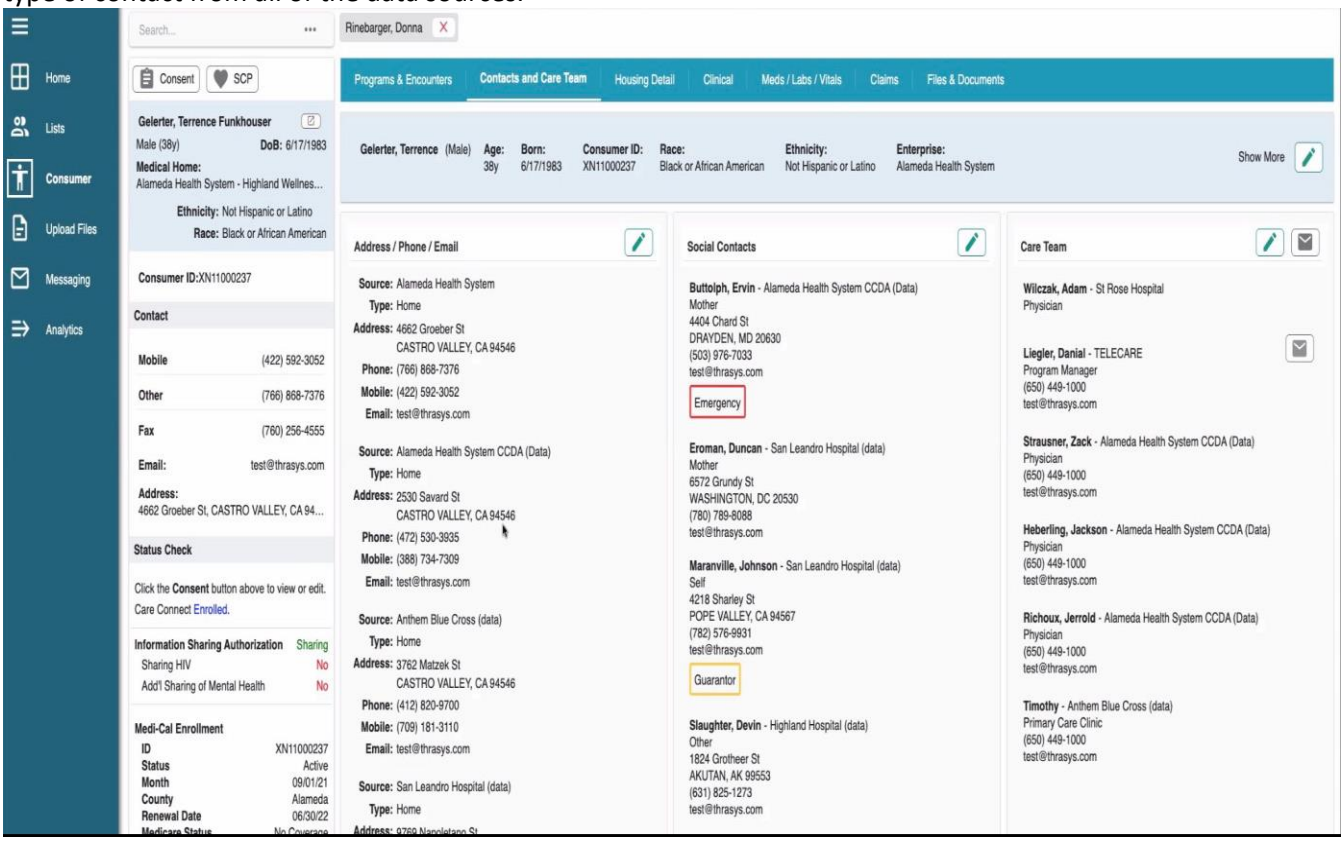
PROGRAMS: general assistance, CalFresh, housing, case management programs

HEALTH PLAN INFO: Medi-Cal Anthem Blue Cross, Alliance Health Plan, Blue Cross California Medicaid

ENCOUNTERS: ambulance, CATT - non-police mobile crisis, psychiatric emergency room (John George Psychiatric Hospital); emergency rooms (Alameda Health System, Oakland Medical Center, San Leandro Hospital, other hospitals and start/end dates), inpatient hospital stays, and outpatient visits



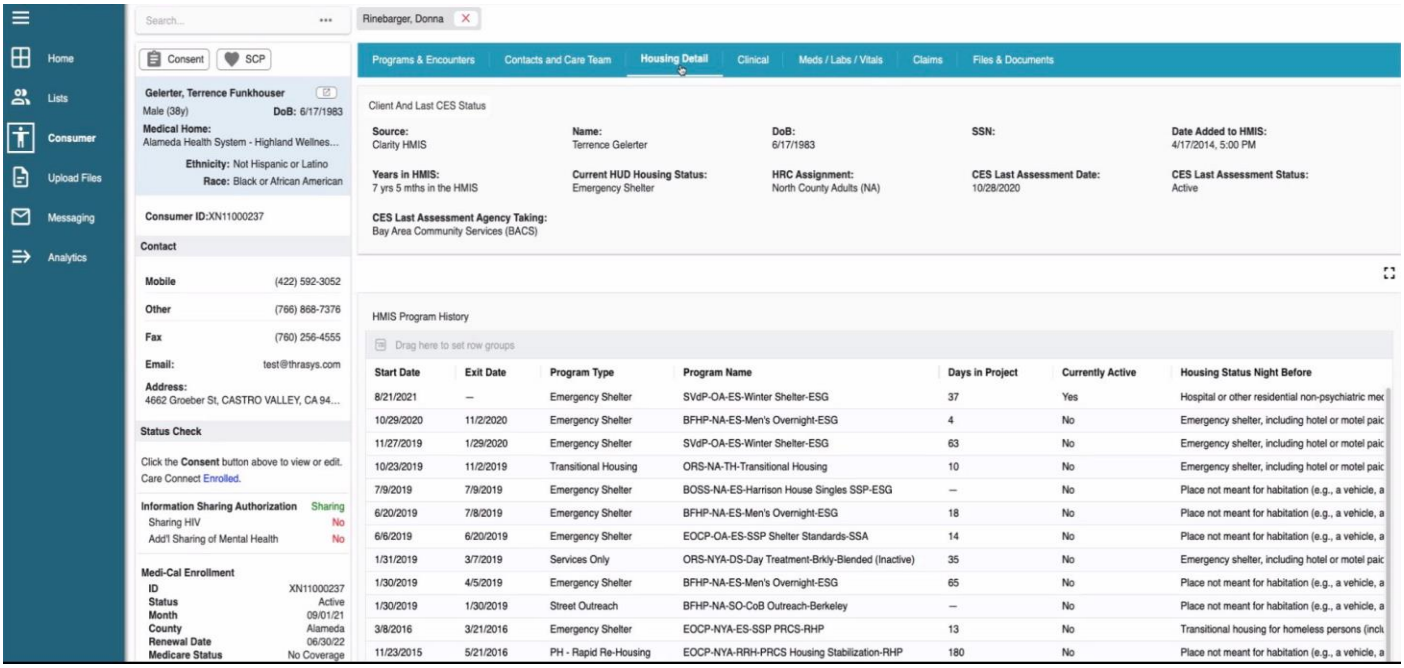
CONTACTS & CARE TEAM DASHBOARD (below):
Contact information for the consumer, social care team contacts, address, phone, mobile, email address, type of contact from all of the data sources.



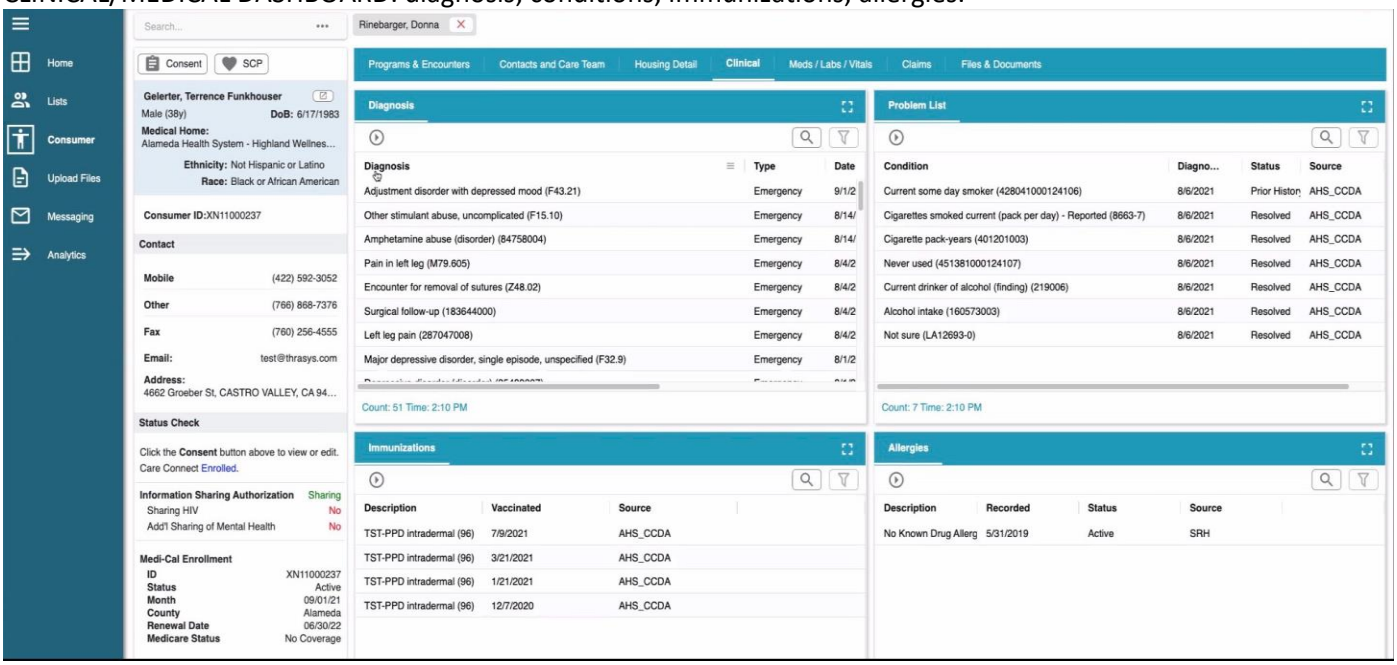
HOUSING DETAIL DASHBOARD (below) - information from Clarity HMIS (housing management information system):

A summary at the top: years in HMIS, CES (coordinated entry system) last assessment date and the agency taking the assessment, current HUD housing status, HRC (Housing Resource Center) assignment, CES last assessment date, date added to HMIS; CES last assessment status.

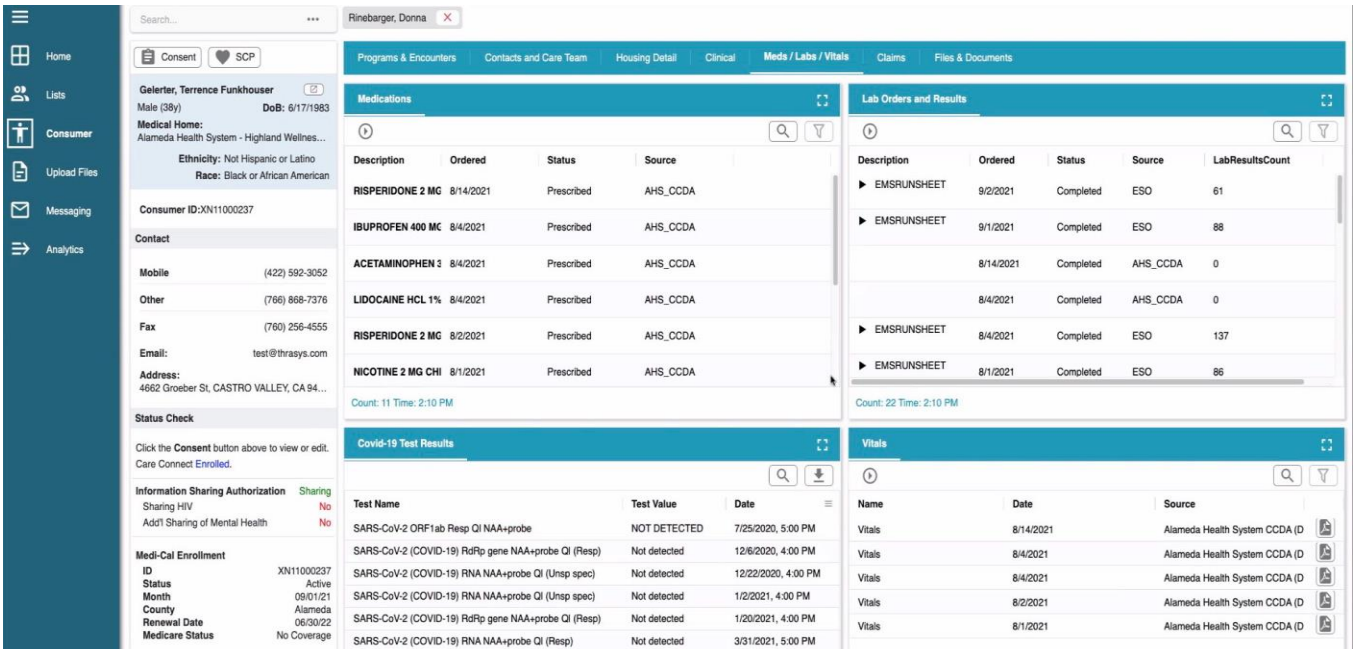
HMIS PROGRAM HISTORY: start, exit, type program, date in project, active, housing status night before. (Note: Information will be updated next year to better reflect the new Coordinated Entry process.)



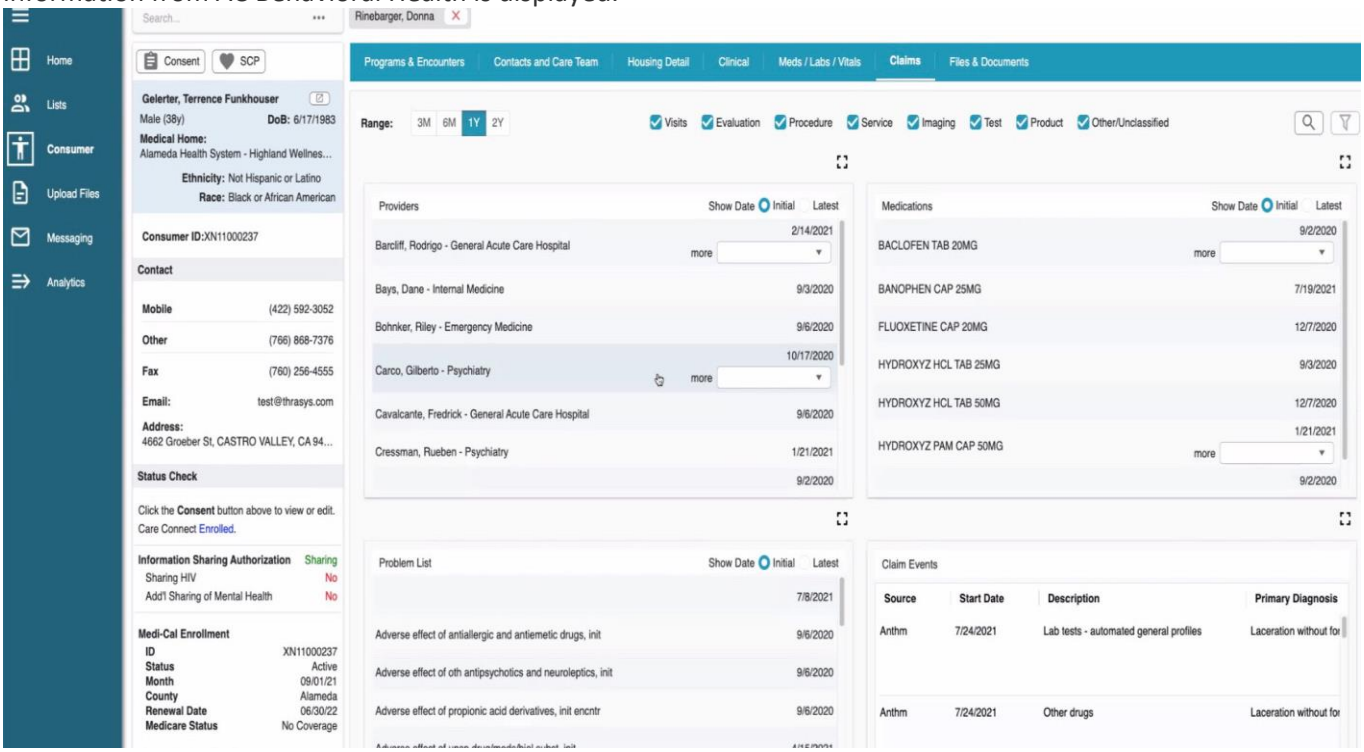
CLINICAL/MEDICAL DASHBOARD: diagnosis; conditions; immunizations; allergies.



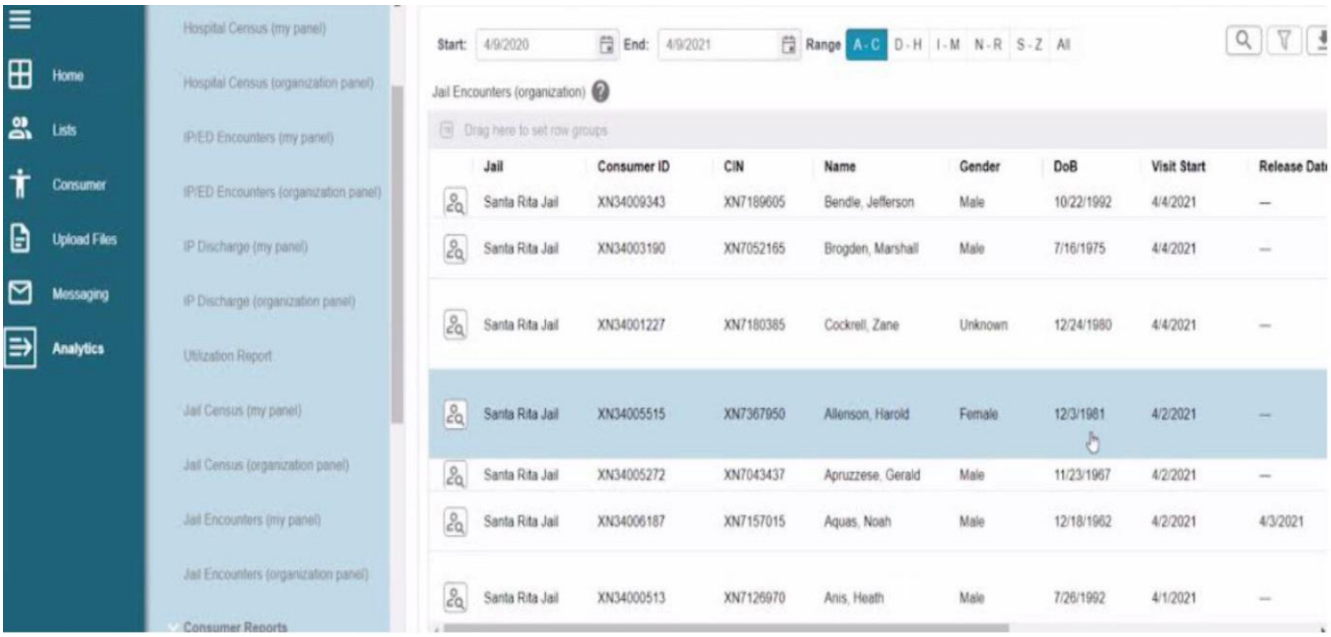
MEDS/LABS/VITALS DASHBOARD: Medications; Lab orders; EMS Transport Notes; COVID test results; vitals.



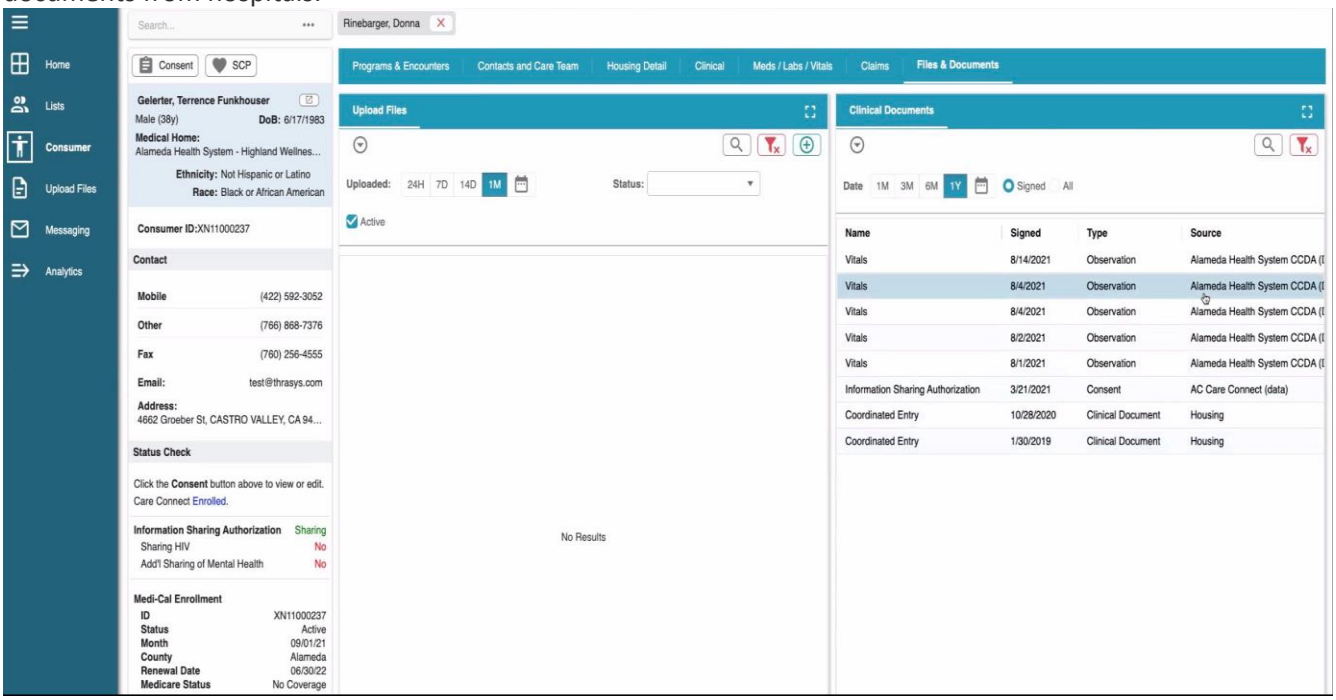
CLAIMS DASHBOARD: Providers; medications; problems list; claim events. This dashboard is where information from AC Behavioral Health is displayed.



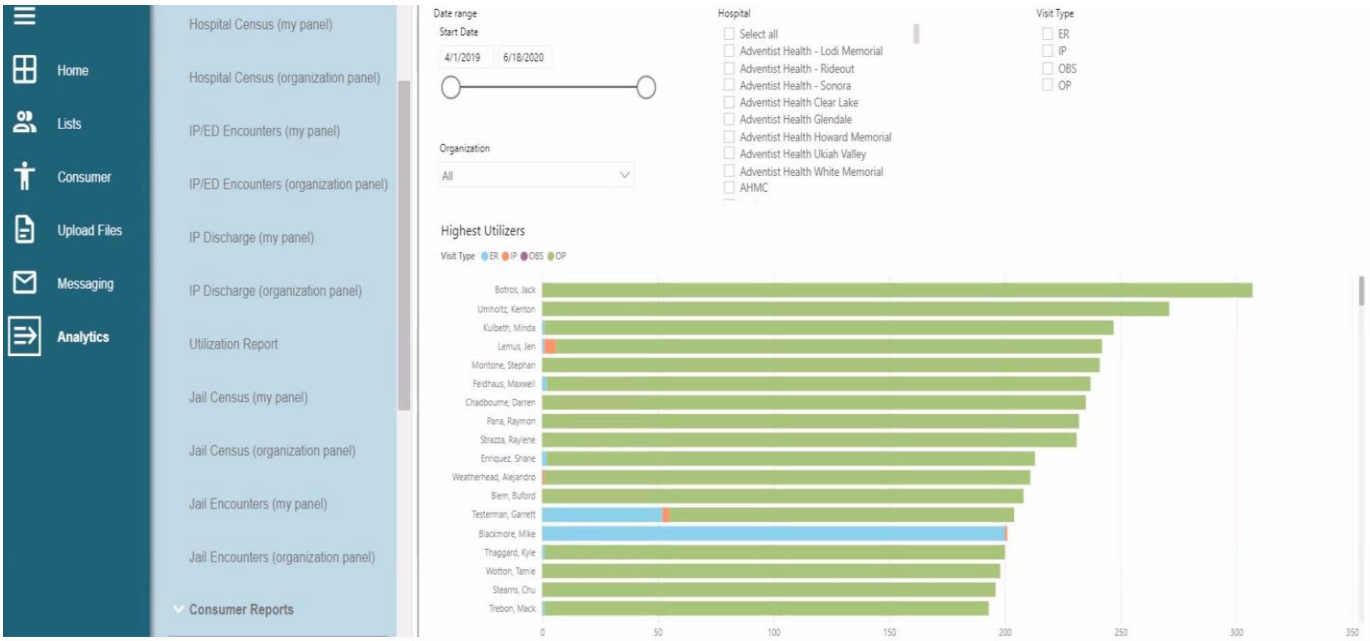
SANTA RITA JAIL REPORT:
Consumers who are incarcerated and those incarcerated in the past



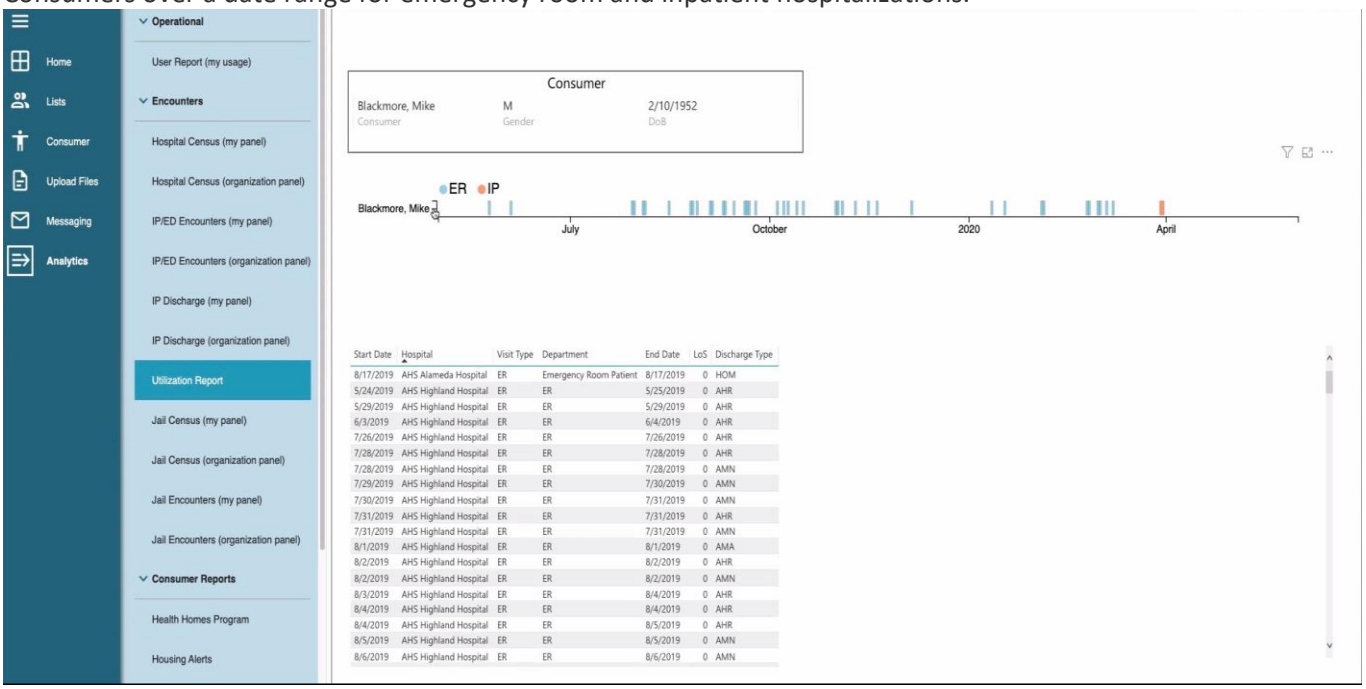
FILES & DOCUMENTS: This section includes consent forms, uploaded documents and continuity of care documents from hospitals.



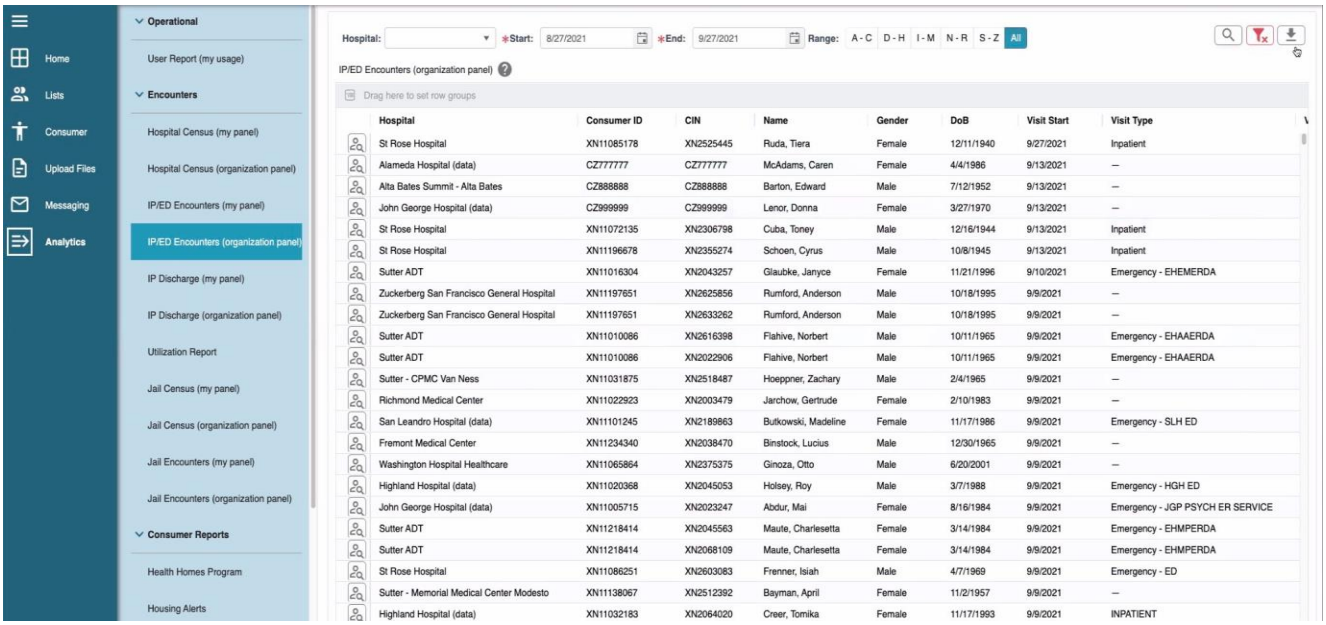
UTILIZATION REPORT:
Highest Service Utilizers over a date range by hospital and visit type.



UTILIZATION REPORT:
Consumers over a date range for emergency room and inpatient hospitalizations.



ENCOUNTER REPORT:
For a consumer by inpatient or emergency department visit at a specific hospital over a date range.



Best wishes,
Margaret

Margaret Fine
Pronouns: she/her
Chair, Mental Health Commission
Berkeley, CA
Cell: 510-919-4309
LinkedIn: Margaret Fine

Alameda County Care Connect Community Health Record (CHR)

OVERVIEW

In the fall of 2019, Alameda County's Whole Person Care Pilot launched the Community Health Record (CHR) application powered by the Social Health Information Exchange (SHIE).

The application was developed with significant input from providers and consumer focus groups, in partnership with Thrasys, Inc.

This electronic record summarizes data so care team members can see a comprehensive, "whole person" view of a consumer's utilization (clinical, housing, social and community services), enabling more efficient care and a streamlined consumer experience.

More information about the SHIE can be obtained from the Alameda County Care Connect Social Health Information Exchange (SHIE) handout.

KEY DATA & FEATURES

- Client Demographics
- Care Team Members
- Consumer Consent
- Shared Care Plan
- Encounter Information
- Self-Service Reports and Data Visualizations
- Housing Information
- Lists & Panels
- Hospital Alerts (Emergency and In-Patient)
- Secure Messaging

USER ONBOARDING

All programs that wish to get CHR access are required to go through a standard onboarding process once the organization's Data Sharing Agreement is signed. This process includes a readiness assessment, program workflow assessment, and training (3 hours).

CONSUMER RECORDS & ACCESS

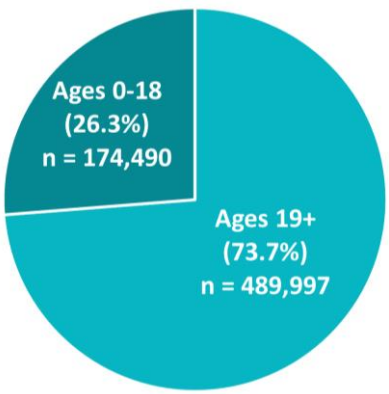
Before starting the COVID-19 pandemic, consumer records in the CHR were limited to those Medi-Cal clients that were AC Care Connect eligible. In conjunction with the emergency order by the County Public Health Officer, the Data Governance Committee voted to approve an Emergency Request to expand CHR/SHIE records to include all Medi-Cal and uninsured consumers in Alameda County to support an effective, county-wide public health response.

This expansion resulted in an increase in CHR records from about 60,000 to more than 700,000 individuals. We expect continued enhanced usability of the CHR for users via access to the broader number of individual records. Our ultimate vision is that all Alameda County residents benefit from improved care coordination supported through SHIE and CHR data integration efforts. Note that users do not automatically see all records; for more information about the privacy and security framework, refer to the SHIE Informational Flyer.

ABOUT THE SHIE/CHR POPULATION

About a quarter of the consumers in the CHR/SHIE are between 0 – 18 years of age. For more information regarding demographics of the total population, contact the Help Desk.

Population Breakdown by Age



Note: Based on a report from January 2021.
Total n = 664,487

COMMUNITY PARTNERSHIP

30+ ORGANIZATIONS | **600+** ACTIVE USERS | **120+** PROGRAMS | **1,000+** TRAINED USERS

Users represent county, clinics, hospitals, health plans, mental health, housing, and substance use treatment organizations.

Participating Organizations

- Abode Services
- Alameda Alliance for Health
- Alameda Health System (AHS)
- Alameda County Health Care Services (Behavioral Health, Public Health, Office of Homeless Care and Coordination)
- Anthem Blue Cross
- Asian Health Services
- Axis Community Health
- Bay Area Community Health (formerly Tri-City)
- Bay Area Community Services (BACS)
- Bonita House
- City of Fremont
- Community Health Center Network (CHCN)
- East Bay Innovations
- Family Bridges
- Five Keys
- Fred Finch
- Horizon Services, Inc.
- La Clinica de la Raza
- La Familia Counseling Service
- LifeLong Medical Care
- Native American Health Center
- Pathways to Wellness
- Roots Community Health Center
- Stars Community Services
- Sutter Health
- Telecare Corporation
- Tiburcio Vasquez Health Center
- Titanium Healthcare
- West Oakland Health

We continue to expand and add new partners.

Participating Programs & Target Users

Target CHR end users are those care team members who play a key role in consumers' care coordination, supporting care transitions, working primarily with consumers in the Care Connect focus population, and/or who address social determinants of health.

Programs include Street Health Teams, Full-Service Partnership and Service Teams, Health Homes Programs, Housing Resource Centers, Crisis Response Providers, *and more*.

End users include staff who are Care Managers, Community Health Workers, Housing Navigators, Social Workers, Nurse Case Managers, Crisis Response Staff, *and more*.

INTEGRATING THE CHR INTO CARE COORDINATION

Benefits of Using the CHR

- Housing navigators can better support clients in accessing health care services and social services benefits
- Users can get Emergency Department/inpatient alerts for their clients so they can coordinate with the consumer and hospital/acute care to support transitions of care
- Primary care teams can coordinate with housing case managers to support consumers getting matched to permanent supportive housing
- Mental health providers can follow up after psychiatric emergency visits to connect clients to outpatient care
- Users can find lost to follow-up consumers and reconnect them to critical services
- Users can identify and coordinate with other care team members to connect consumers with appropriate services

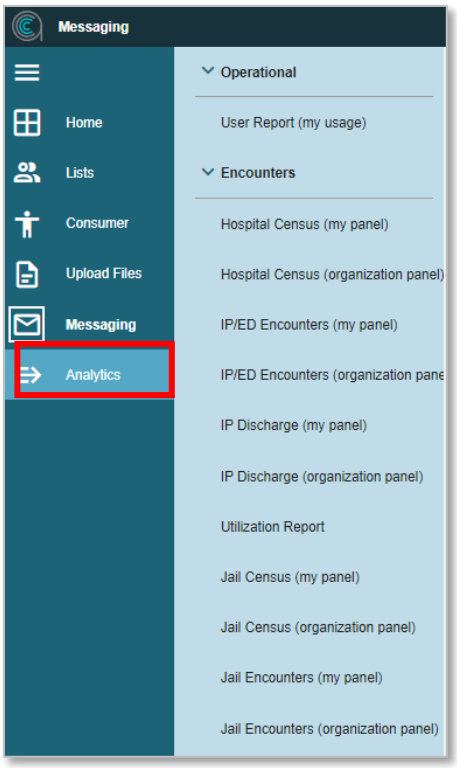
CHR Super Users

The success of the CHR hinges on engagement from community partner organizations. Care Connect asks each participating organization to identify a Super User(s) to participate in a monthly Super User Workgroup. Super Users receive advanced training to provide other users at their organization with technical support and guidance on how to incorporate the CHR into their workflow.

Analytics feature allows staff with appropriate permissions to View, Filter and Export Operational, Encounter and Consumer reports. Most users of the CHR will use the Encounter and Consumer reports as main sources of data.

Navigate to the Analytics > Main Side Menu

1 Navigate to the Analytics icon

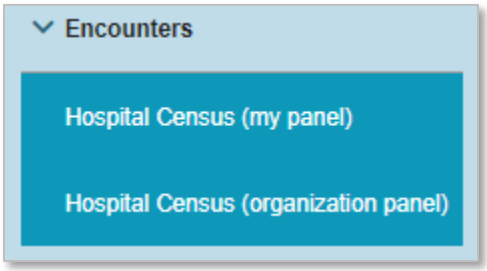


- Navigate to the **ANALYTICS** icon 

on the Main Side menu and click to open up the window
  - A list of available reports will display
  - Click on the report that you would like to view

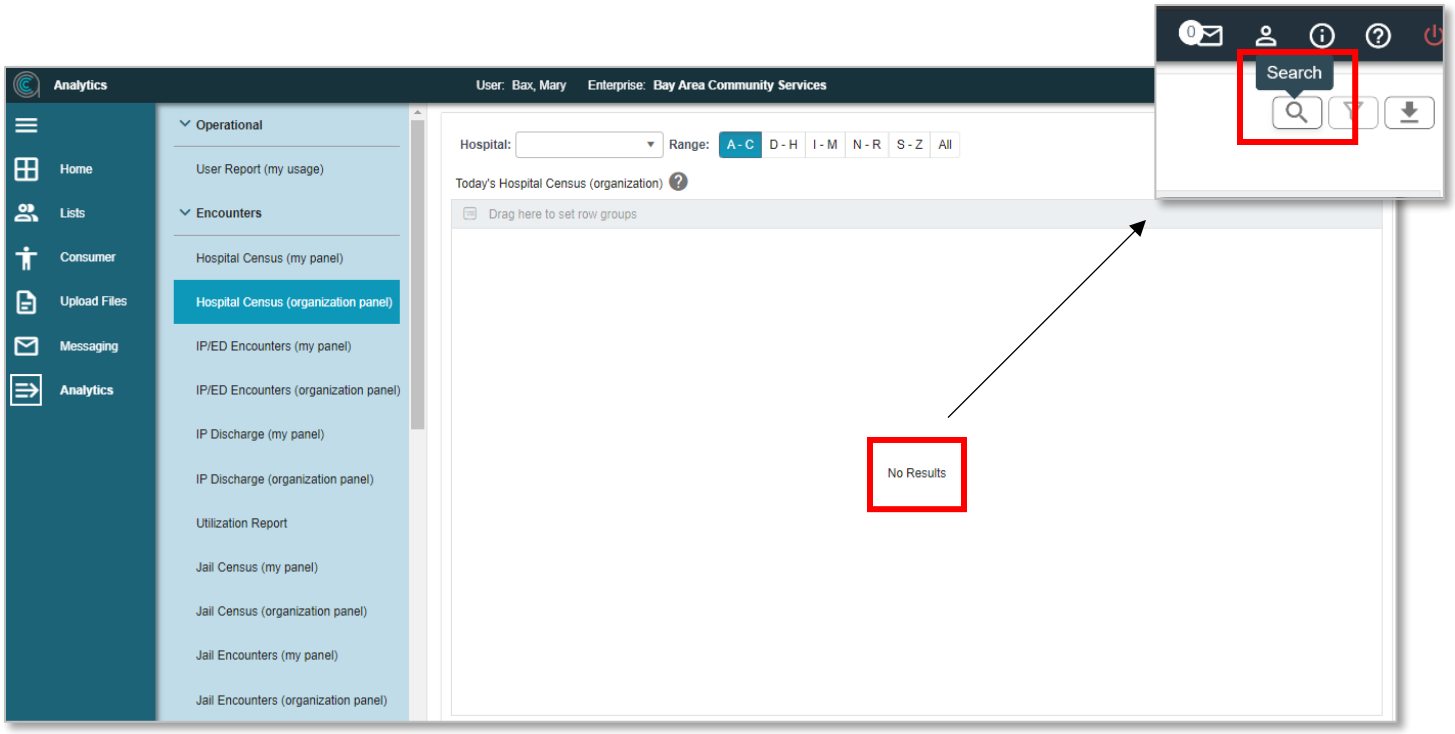
2 Encounter Reports

The *Encounter Reports* are a list of reports providing information for the various consumer encounters. These reports are organized and presented based on both "organization panel" and "my panel" lists. A report organized by "organization panel" lists consumer data for those consumers attributed to the logged in user's organization. A report organized by "my panel" lists consumers attributed to the logged in user's organization and where the user has placed themselves as a member of the specific consumer's care team.



3 Select Search Filters to Populate Data

- User must either select desired filters for displaying data or use default filters and then click the **SEARCH** icon to populate results.
  - Different reports will have different data filters
  - "NO RESULTS" does not necessarily mean no data. Click **SEARCH** to trigger a search for data



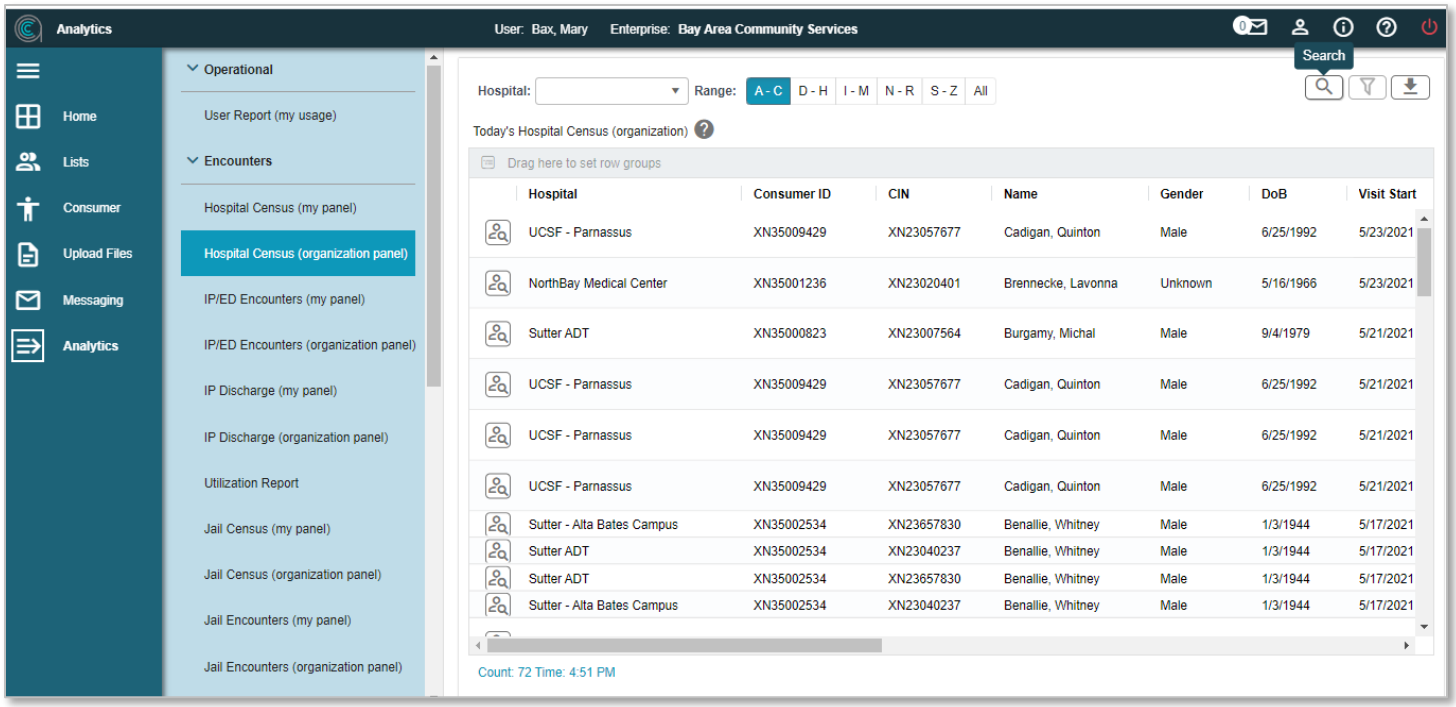
For Example: Hospital Census Report

The Hospital Censure Report lists all consumers who are currently enrolled as inpatient in the selected hospitals for and attributed to the logged-on user's organization.

- Note, any lag in data for this report is due to a lag in hospital discharge data

<u>Hospital Census (organization panel)</u>

- Select **HOSPITAL CENSUS (ORGANIZATIONAL PANEL)**
  - Select Hospital from drop down when applicable
  - Select alphabetic range of the last name of the consumer you are searching for, when applicable
    - Click the **SEARCH** icon
      - Selected consumers display
- Click the **CLEAR** icon to clear filters and reset search for report
- Select **CONSUMER** icon to go directly to the consumer's record
- Select the **EXPORT** icon to download the report



5 Consumer Reports

A list of multiple reports that that provide information for the various consumer specific data.

For Example: Housing Alerts Report

This report lists all active Housing Alerts, such as eligibility for a FEMA shelter, as well as ones that have expired in the last 30 days.

- Select **HOUSING ALERTS**
  - Click the **SEARCH** icon
    - Selected consumers display
  - Select **CONSUMER** icon to go directly to the consumer's record
  - Select the export icon to download the report

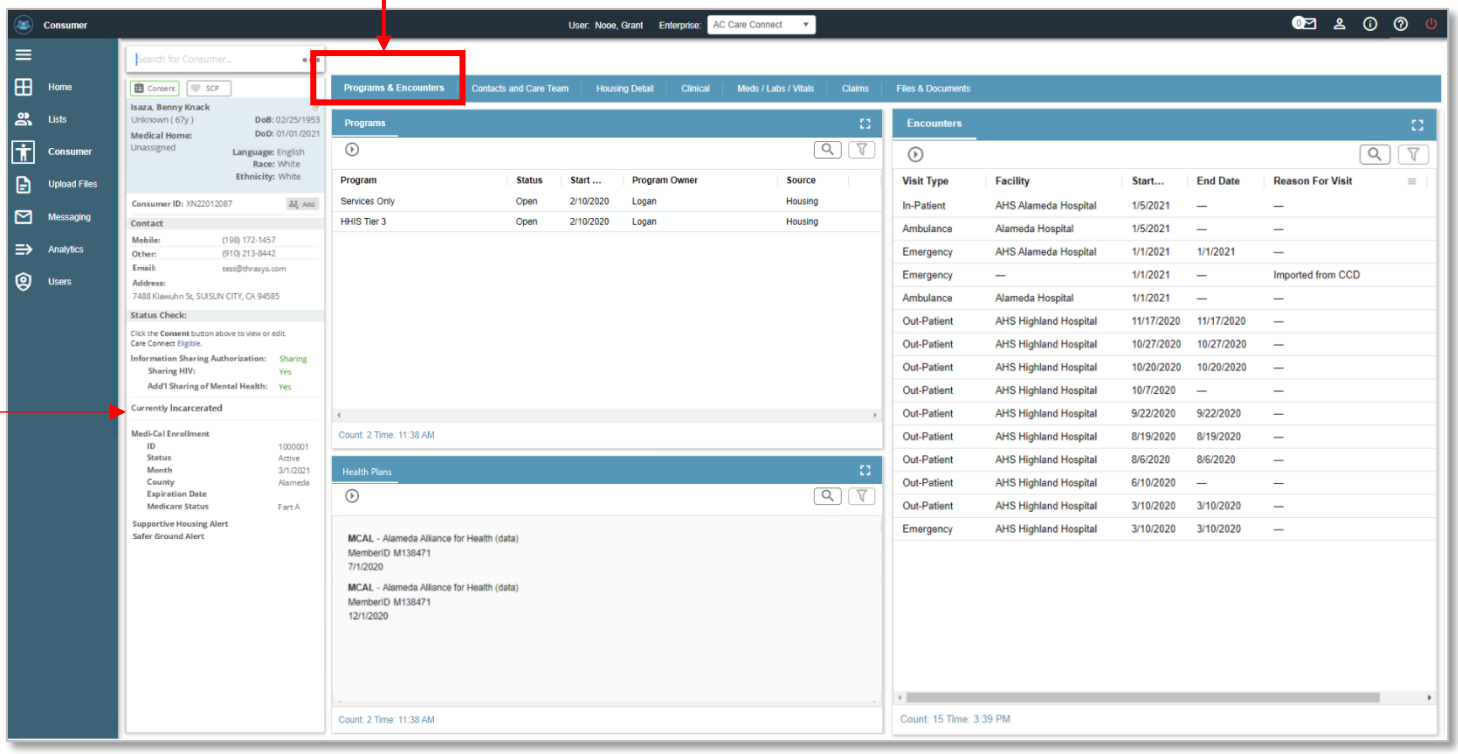
TIP SHEET: CHR Display Update

AC Care Connect worked with users to better organize information in the CHR. The following tip sheet walks you through the new tabs in the CHR. There is also space for new information that users have been asking for in the re-organized tabs!

New Consumer Record Layout

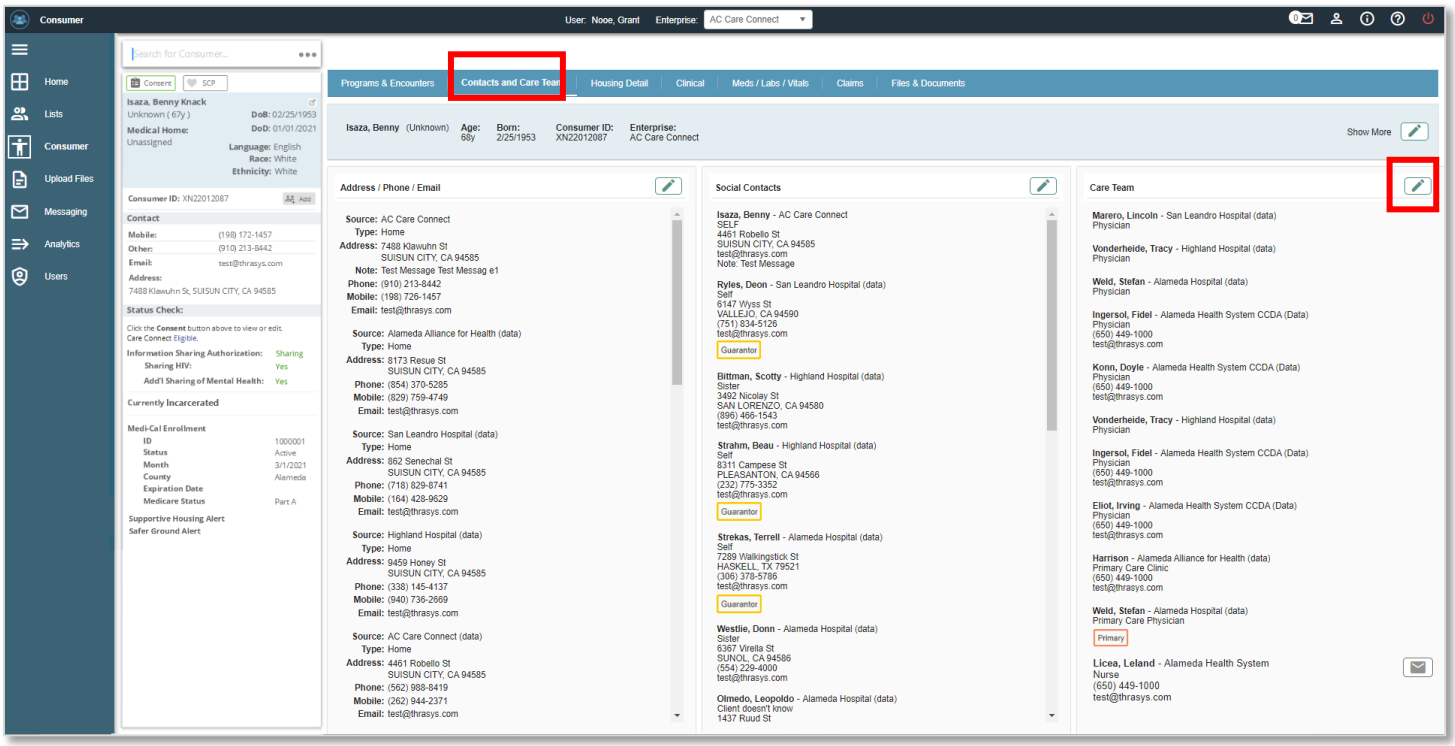
1 The Landing Page; Programs and Encounters

- More information may be visible on the left-hand column such as additional demographic information, incarceration status if the consumer is *currently* incarcerated, Medi-Cal enrollment, and any current housing alerts. This left-hand column does not disappear as you navigate through other parts of the consumer's record.
- The first screen in the consumer record opens to the tab called **"Programs and Encounters"**. This screen includes all of the consumers program enrollments, recent encounters and health plan information.



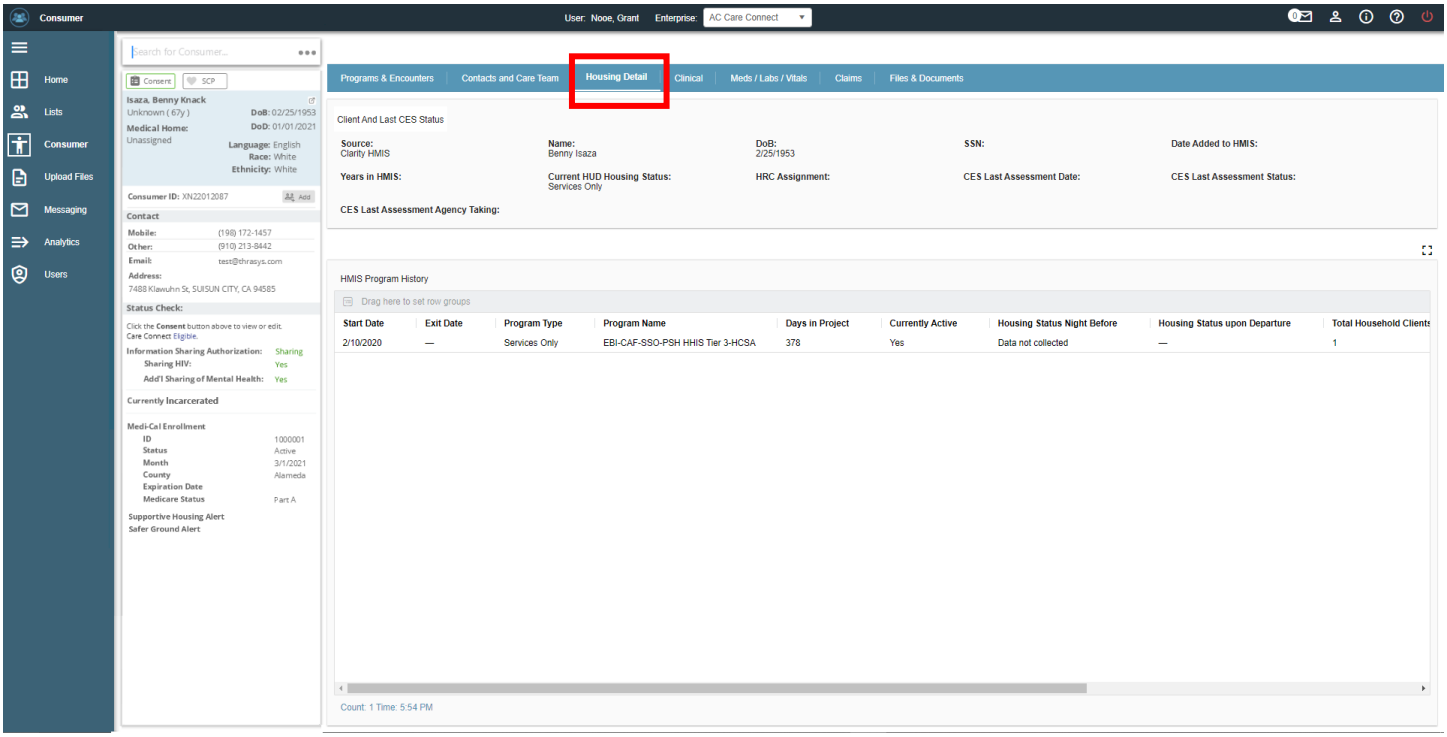
2 Contacts and Care Team

The second tab now compiles all of the consumer's contacts, social contacts, and care team contacts on one screen. This is where you would add yourself to the care team by clicking on the green pencil in the Care Team column (see tip sheet on Adding yourself to the care team for full instructions).



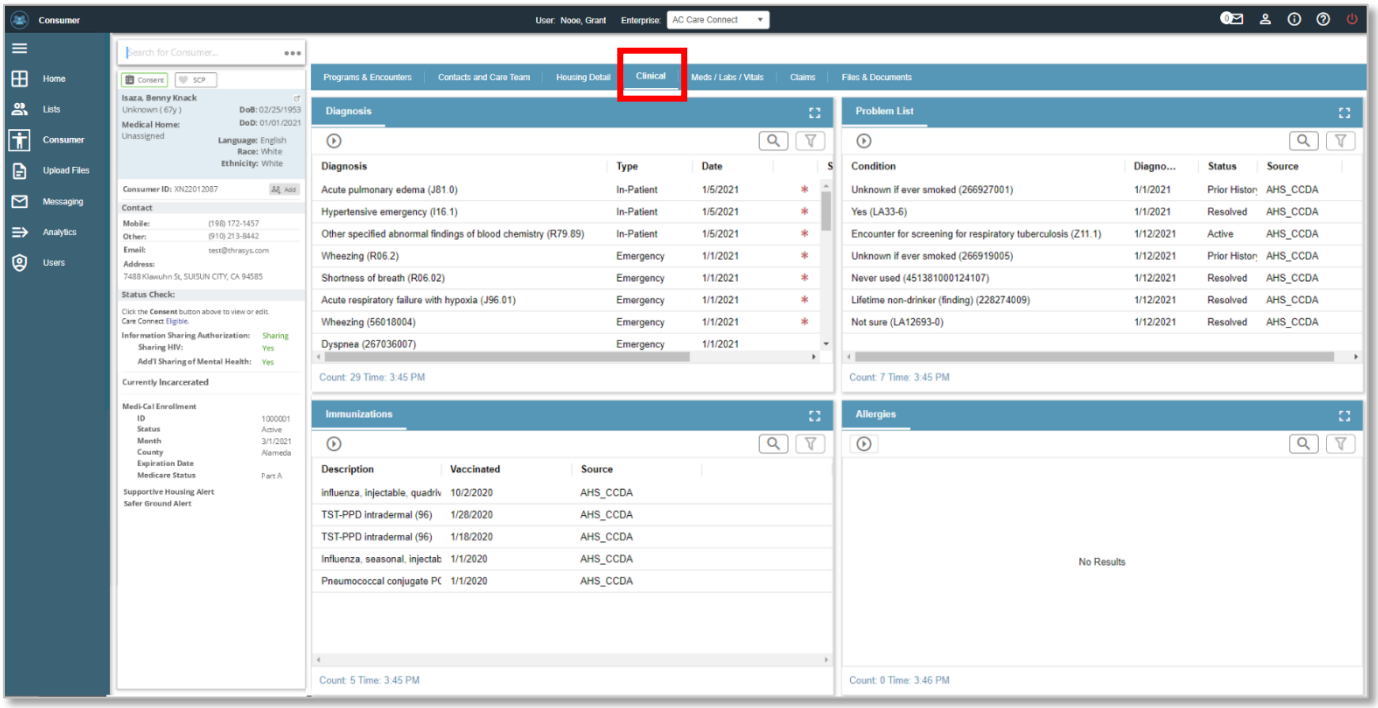
3 Housing Detail

The third tab still displays both the current housing and assessment status and housing program history.



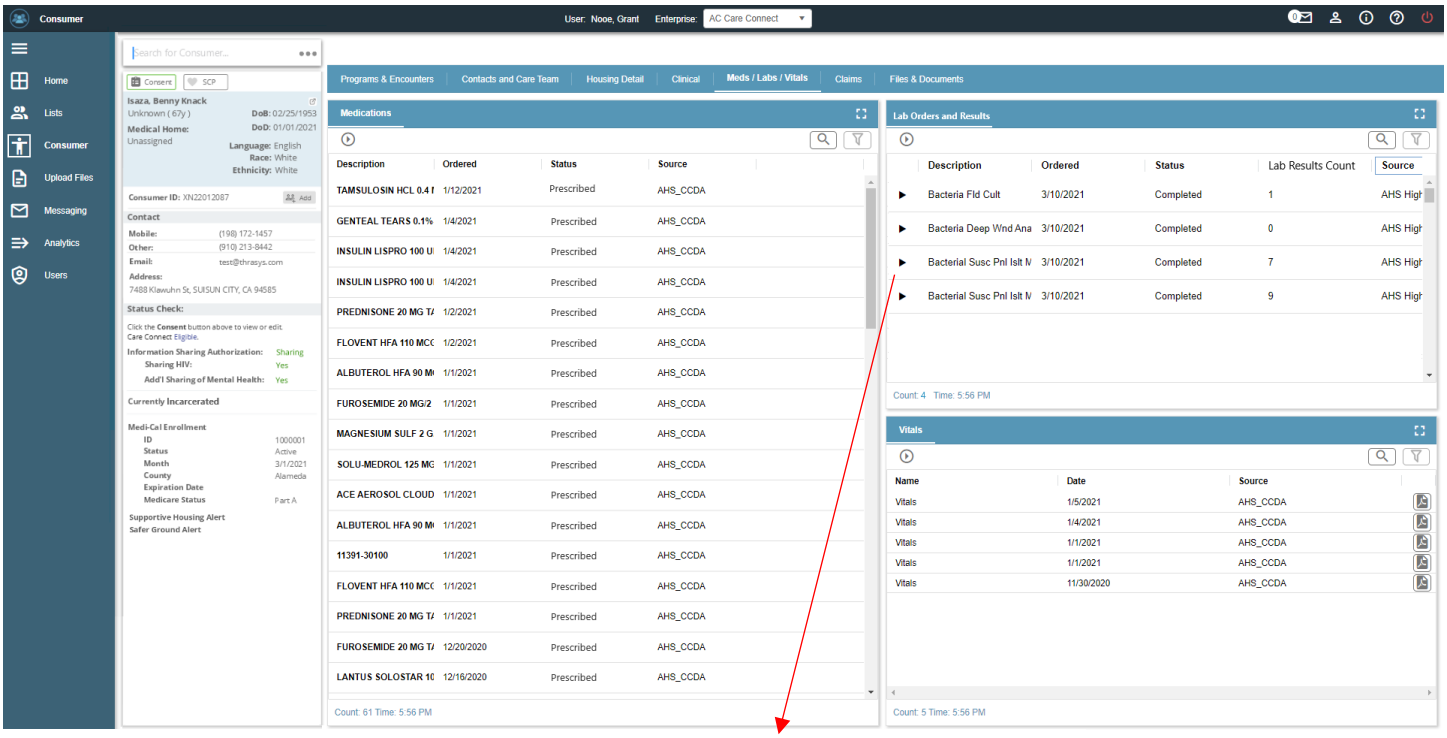
4 Clinical Information

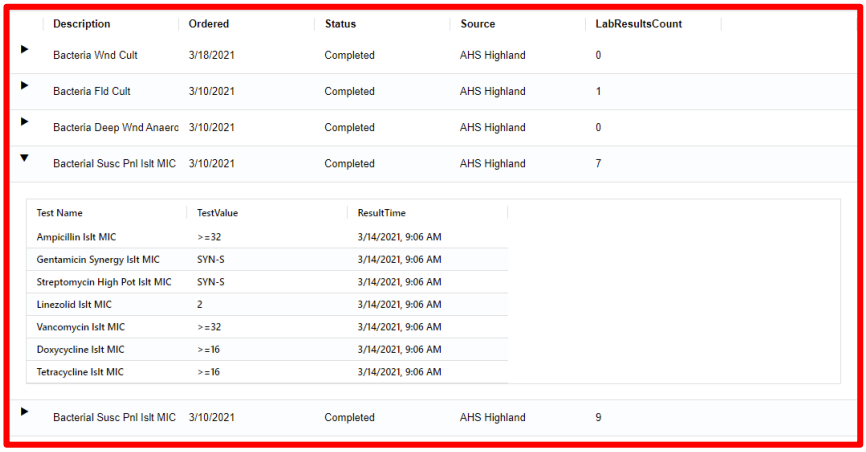
Diagnosis, problem list, immunizations and allergies are grouped together on the **Clinical** tab.



5 Meds/Labs/Vitals

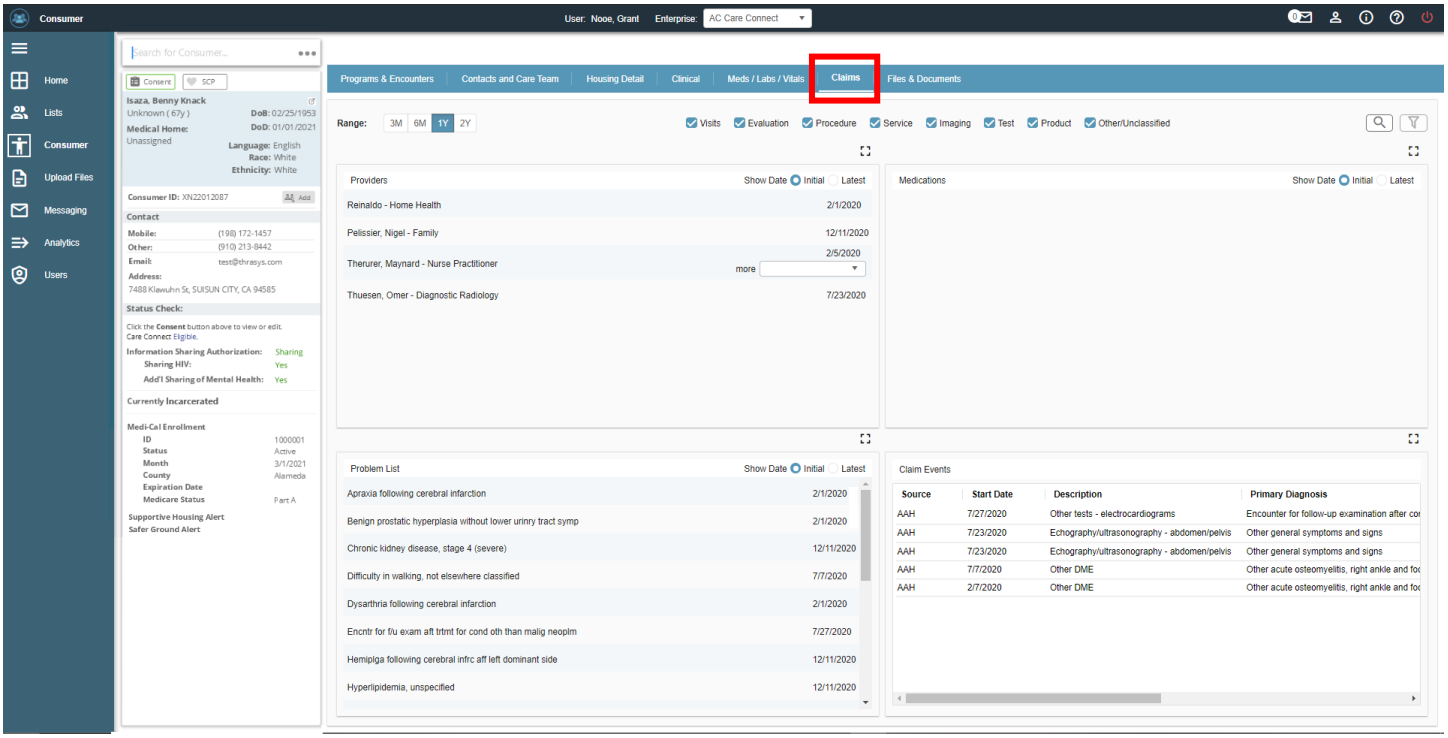
Medications, Labs, and Vitals are also organized on one tab. Anywhere you see an arrow on this tab, click to unveil additional information. COVID-19 Test results will also be on this tab.





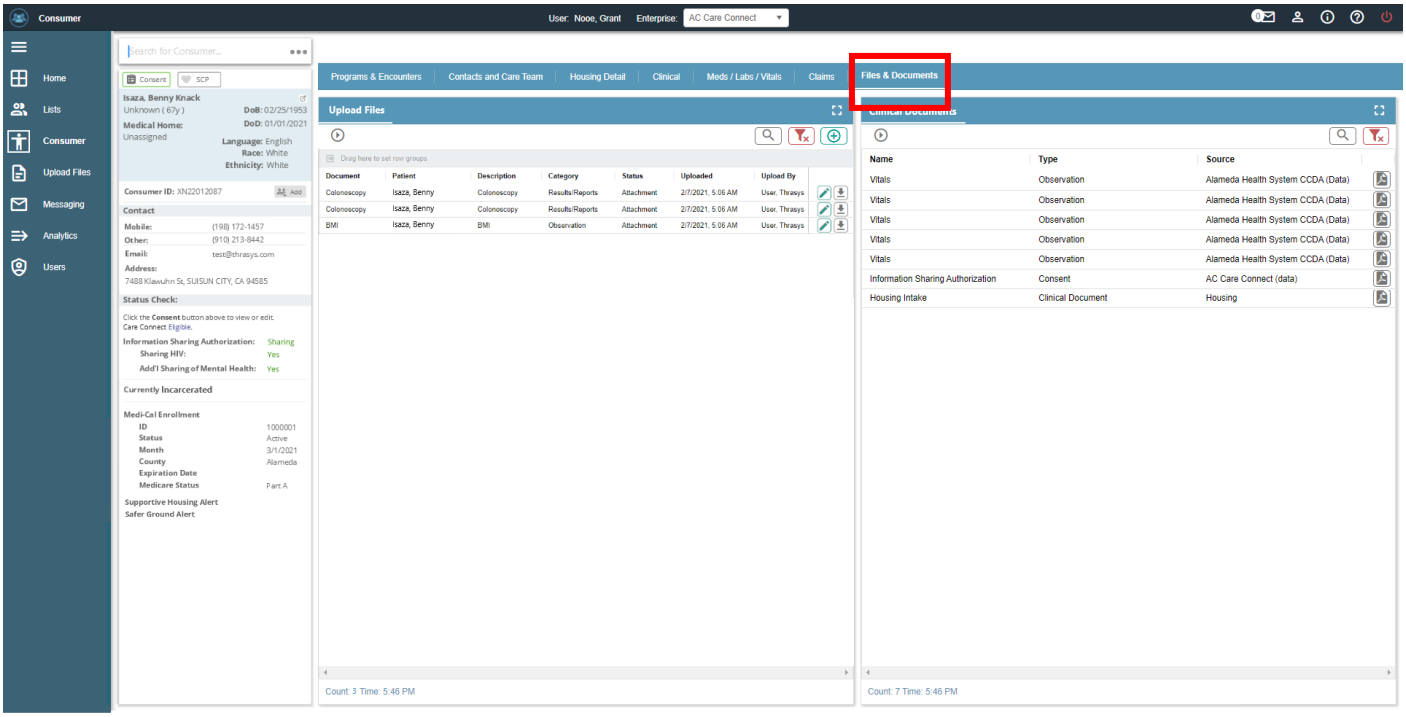
7 Claims

Contains information from health plan and ACBH claims.



8 Files and Documents

Documents coming in from data sources (such as continuity of care documents (CCDs) from hospitals) as well as files that CHR users upload to share with other care team members.



Works-Wright, Jamie

From: Wyant, Jenny
Sent: Thursday, October 7, 2021 6:59 PM
To: Castrillon, Richard; Bednarska, Dominika; Berkeley/Albany Mental Health Commission; Carnegie, Brittany
Subject: City of Berkeley HTF RFP - Commission notice
Attachments: 2021 HTF RFP Commissions Memo.pdf

Dear Commission Secretaries,

Please share the attached notice of the recent Housing Trust Fund Request for Proposals with your Commissions. The notice includes summaries of the applications for funding we received. Feel free to email me with any questions.

Thank you,
Jenny

Jenny Wyant
Senior Community Development Project Coordinator
City of Berkeley
Department of Health, Housing, and Community Development

** Please note: I work a 9/80 schedule and am off every other Friday. **

MEMORANDUM

To: Commission on Aging
Commission on Disability
Homeless Commission
Mental Health Commission

From: Jenny Wyant, Senior Community Development Project Coordinator

Date: October 7, 2021

Subject: **2021 Housing Trust Fund Request for Proposals and Educator Housing NOFA**

The City's Housing Trust Fund (HTF) program pools affordable housing funds from a variety of local and federal sources. The City loans HTF funds to nonprofit developers for the creation of new affordable housing or the preservation of existing affordable housing units. In exchange for City funding, projects are restricted as affordable housing for at least 55 years. The HTF Guidelines (available online at: http://www.ci.berkeley.ca.us/ContentDisplay.aspx?id=6532) direct the funding proposal process, and require staff to provide summaries of the proposals received to select Commissions. This memo includes information on proposals received in response to two processes: the 2021 HTF Request for Proposals (RFP) and the Educator Housing Notice of Funding Availability (NOFA). The Housing Advisory Commission is expected to review the proposals at their November 4, 2021 meeting, though that timeline may change at the City's discretion.

Commissioners may email me at jwyant@cityofberkeley.info with questions.

Housing Trust Fund RFP Proposals

Ashby Lofts - 2909 and 2919 9th Street

Applicant: Satellite Affordable Housing Associates
Funds Requested: $850,000
Target Population: people with physical, developmental, or mental disabilities
Activity Proposed: Renovation of existing, 54-unit affordable property occupied by households earning between 30-80% of the Area Median Income (AMI). The proposed renovation scope includes substantial upgrades to the exterior decks and stairs to address water intrusion damages, roof repairs, exterior painting, and improvements to the photovoltaic system. The project has collaborated with the

Berkeley Office of Energy and Sustainable Development and will move the building towards electrification.

Ephesians Legacy Court – 1708 Harmon Street

Applicant: Community Housing Development Corporation
Funds Requested: $12,902,599
Target Population: seniors, formerly homeless
Activity Proposed: New construction of a 5-story, 82-unit affordable senior housing development serving households earning between 30-50% AMI. The units will be split between two buildings on a site owned by Ephesians Church of God in Christ. The proposed project includes 20 units set aside for people experiencing homelessness.

Homeless to Housed – Scattered Sites (2207 Haste, 1349 Hearst, and 1340-48 Blake)

Applicant: Northern California Land Trust
Funds Requested: $3,450,000
Target Population: formerly homeless
Activity Proposed: Operating funds to provide a 15-year operating subsidy for 10 units in order to serve formerly homeless people up to 30% AMI (though likely at or below 15% AMI). NCLT would leverage the operating support to fund renovations at 2207 Haste Street.

MLK House - 2942-2944 Martin Luther King Jr. Way

Applicant: Resources for Community Development
Funds Requested: $1,128,974
Target Population: formerly homeless, people with mental illness
Activity Proposed: Renovation of an occupied, 12-room affordable property housing Berkeley Mental Health and Shelter + Care clients. The project is restricted to residents earning up to 60% AMI, though the actual AMIs are much lower. The proposed renovation scope includes upgrades to the exterior envelope (roof, windows, gutters), kitchen and bath upgrades, ADA improvements, and security upgrades.

Supportive Housing at People's Park - Address

Applicant: Resources for Community Development
Funds Requested: $14,359,593
Target Population: formerly homeless
Activity Proposed: New construction of a 119-unit building for households earning between 10%-50% AMI. More than half of the units will be set aside for permanent supportive housing, serving formerly homeless households. The project includes onsite supportive services.

St. Paul Terrace – 2024 Ashby Avenue

Applicant: Community Housing Development Corporation
Funds Requested: $9,840,000
Target Population: family, formerly homeless
Activity Proposed: New construction of a 52-unit affordable housing development serving families earning up to 50% AMI. The proposal also includes setting aside 11 units for formerly homeless households. The project will be developed on land owned by St. Paul AME, and will include areas for both the apartment residents and the church. City funds would not be used for any church spaces.

Educator Housing NOFA Proposal

Please note: This NOFA was only open to the development team selected by Berkeley Unified School District through their competitive process.

BUSD Workforce Housing – 1701 San Pablo Avenue

Applicant: Satellite Affordable Housing Associates and Abode Communities
Funds Requested: $24,500,000
Target Population: BUSD employees
Activity Proposed: New construction of approximately 110 affordable housing units serving households earning between 30% and 120% AMI. Employees of BUSD would have a leasing preference. The project would be developed on BUSD-owned land, located adjacent to the Adult School.

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Monday, October 4, 2021 10:05 AM
To: Works-Wright, Jamie
Subject: FW: Invitation: CALBHB/C 10/8 Training and/or 10/22 Meeting - Please Share!

Please see the email below

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: CAL BHBC <cal@calbhbc.com>
Sent: Monday, October 4, 2021 8:07 AM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>; Grolnic-McClurg, Steven <SGrolnic-McClurg@cityofberkeley.info>; margaretcarolfine@gmail.com
Subject: Re: Invitation: CALBHB/C 10/8 Training and/or 10/22 Meeting - Please Share!

Just a reminder about the upcoming training and meeting. Please share with other mental/behavioral health board members and staff. Thanks!

On Tue, Sep 21, 2021 at 10:00 AM CAL BHBC <cal@calbhbc.com> wrote:

> **Invitation in PDF Format**

CALBHB/C Teleconferences Invitation
Training: October 8, 12:30 pm - 2:30 pm
Meeting: October 22, 12:30 pm - 2:30 pm

Registration Link

We invite you to join us for our quarterly training *and/or* meeting! There is no fee to register.

TRAINING: October 8, 12:30 pm - 2:30 pm
Local Mental/Behavioral Health Board/Commission (LMBHBC) Training

- Duties & Best Practices
- Mental Health Services Act (MHSA)
  - Definition
  - Role of LMBHBC
  - Community Program Planning
- Meeting Rules and Procedures
- Membership Rules and Strategies

MEETING: October 22, 12:30 pm - 2:30 pm
Updates/Presentations from:

- CA Association of Local Behavioral Health Boards & Commissions (CALBHB/C)
- CA Behavioral Health Planning Council (CBHPC)
- Mental Health Services Oversight & Accountability Commission (MHSOAC)
- United Parents (MHSOAC Advocacy Stakeholder Contractor)
- CA Association of Mental Health Peer Run Organizations (CAMHPRO): Peer Provider Certification Progress & Implementation in CA (Tentative)
- Local Issues Discussion

CALBHB/C teleconferences are open to members of CA's 59 local mental and behavioral health boards and commissions, and local agency staff. There is no fee to register.

Registration Link

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Tuesday, September 28, 2021 1:24 PM
To: Works-Wright, Jamie
Subject: FW: Presentation - Calls for Service, Call Handling & Dispatch - RPSTF Meeting, Sept. 30, 6 pm
Attachments: Calls for Service and Dispatch Questions for RPSTF Meeting 30 Sept 2021.pdf; Zoom Link to RPSTF Meeting 30 Sept 2021.pdf

Please see the email below and the attachments from Margaret Fine

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Tuesday, September 28, 2021 10:51 AM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Presentation - Calls for Service, Call Handling & Dispatch - RPSTF Meeting, Sept. 30, 6 pm

Hi Jamie - Would you please be so kind and send this email to the Mental Health Commissioners? The attachments are 6 pages. Thank you so much!

Hi All,

As you may know, there will be a public meeting of the Reimagining Public Safety Task Force (RPSTF) on Thursday, September 30, 2021 at 6 pm. I would like to ensure everyone on the Mental Health Commission has notice about it.

This RPSTF meeting will include a presentation by City of Berkeley Dispatch Staff on calls for service, call handling, and dispatch for 911 emergency and non-emergency systems—which include mental health, substance use, homelessness, and wellness check calls. The presentation will follow preliminary matters and subcommittee reports.

The link is attached below from the Agenda Packet for RPSTF webpage. It is also available at: https://www.cityofberkeley.info/RIPST.aspx Also attached is a list of questions I compiled related to this topic.

Below is a screenshot from the Alternative Responses Report by the commissioned National Institute for Criminal Justice Reform showing the distribution of these types of emergency and non-emergency calls between 2015-2019 in the City of Berkeley.

Thank you so much for reading this email and I hope the information is useful.

Best wishes,
Margaret

Margaret Fine
Pronouns: she/her
Berkeley, CA
Cell: 510-919-4309
Email: margaretcarolfine@gmail.com
LinkedIn: Margaret Fine

Calls for Service and Dispatch Questions

for Reimagining Public Safety Task Force, Thursday, September 30, 2021, 6 pm

Calls for Service & Dispatch Goal from Reimagining Public Safety Task Force website:

- The Berkeley City Council made a historic commitment to reimagine the City of Berkeley's approach to public safety with passage of an omnibus package on July 14, 2020 including to: ***"create plans and protocols for calls for service to be routed and assigned to alternative preferred responding entities and consider placing dispatch in the Fire Department or elsewhere outside the Police Department."***

Public Safety Communications Center - Location and Office Space

- What consideration has been given to placing dispatch in the Fire Department or elsewhere outside the Police Department?

- Does this consideration include the specialties of public safety dispatch operator personnel, including adding behavioural health clinicians to the team (mental health, substance use, homelessness, wellness checks)?

General Questions – Calls for Service & Dispatch

- What education and training do public safety dispatch operators receive to perform their job duties, including responding to a diverse range of emergency and non-emergency calls for service and dispatch in the City of Berkeley?

- What current policies, procedures and protocols do public safety dispatch operators use to screen, assess, prioritize and dispatch calls for service?

- How do BPD policies, procedures and protocols interface with the public safety dispatch operators' response to calls for service in the community?

Crime and Violence – Calls for Service & Dispatch

- How do public safety dispatch operators currently screen, assess and prioritize calls for service as criminal and/or violent in the City of Berkeley, including performing a risk assessment for deciding if there is a public safety threat and the seriousness of that threat?

- The National Institute for Criminal Justice Reform defines "criminal" as any event not identified in the California Penal Code for purposes of dispatching calls for service. How would this proposed standard be implemented for purposes of dispatching calls?

- The National Institute suggests using a "tiered dispatch" model. They have not shown implementation of this model in another locality for it entirely or in part. Where has this model been effective, and how so—particularly in sorting criminal/non-criminal calls?

Mental Health, Substance Use, Homelessness, Wellness Checks – CFS & Dispatch

The Auditor's Report identified more than 63,000+ calls for service relating to mental health (42,000+) and homelessness (21,000+) from 2015-2019 (there may be overlap), and further recommended that the Berkeley Police Department identify **all** calls for service that have an apparent mental health and/or homelessness component (Auditor's Report, 2021; 3, 55, 57). It is also noted that there are substance use and wellness checks that constitute part of these public health related calls for service and dispatch.

- What is the scope and nature of calls for service related to public health involving mental health, substance use, homelessness, and wellness checks?

- How are public safety dispatch operators currently trained to respond to public health calls for mental health, substance use, homelessness, and wellness checks in the community, including using a crisis triage approach to dispatch for treatment and services?

- How will the public safety dispatch consultant for the Fire Department address priority dispatching for public health calls related to mental health, substance use, homelessness, and wellness checks?

- The Auditor's Report shows that there are 28,959 narrative reports for mental health and 20,768 narrative reports for homelessness between 2015 and 2019 (Auditor's Report, 2021; 56-57). There are also substance use and wellness check calls.

    - Will there be a review of narrative reports for these types of calls for service in order to identify emerging patterns about their characteristics, particularly for calls that are more challenging to screen, assess, prioritize and dispatch than using a "tiered dispatch" model? What about substance use and wellness check calls?

- How will the City of Berkeley develop clear identification of mental health, substance use, homelessness and wellness check related calls for purposes of appropriately and consistently categorizing these types of CAD data?

Shifting Calls for Service from Law Enforcement to Alternative Responders/Preferred Entities

- How does the City of Berkeley plan to initiate a program for making alterative responses to alternative entities by public safety dispatch operators who screen, assess, prioritize and dispatch calls for service?

- Are there "soft" calls among the top 10 "non-criminal" call types shown by the National Institute for Criminal Justice Reform that can begin easily routing to alternative responders and alternative entities?

Equitable Crisis Response Services and Access to Emergency and Non-Emergency Responses

- For purposes of screening, assessing, and prioritizing public health related calls and dispatch, how will we ascertain if people are ***equitably*** provided with alternative responses to policing and access to emergency and non-emergency services for diverse demographic populations? What kind of analysis will we do?

- How are other cities and counties screening, assessing, prioritizing, and dispatching calls for service, particularly how are they providing culturally safe and responsive services to different demographic groups across the board?

    - The National Institute for Criminal Justice Reform (NICJR) and Research Development Associates (RDA) have evaluated non-police crisis response models in other cities. There is a need for robust analysis comparing the components among the models, particularly to assess calls handling and dispatch for diverse populations: Black, Latinx, Native American, AAPI, LGBTQIA+, people with disabilities, age and more. Will they address this?

Community Emergency and Non-Emergency Response System (CERN)

- How will the City of Berkeley provide the infrastructure needed to establish a customized, "robust, structured, and well-trained" team of community responders or CERN (as National Institute of Criminal Justice Reform has promised)?

- How do we evaluate the capacity of organizations to participate in a CERN network, particularly for those listed in the Alternative Responses Report and Appendices C and E?

- How do we approach allocating/re-allocating resources to make them available for alternative emergency and non-emergency response from government departments and community-based organizations?

- How do we avoid criminalizing behaviour regarded as "panhandling, loitering and urinating in public" to meet needs with public health service delivery (from Alternative Responses Report in chart)?

- How do we provide emergency and non-emergency mental health, substance use, homelessness, and wellness checks services to alleviate entrenched societal problems in the short and long-term?

Reimagining Public Safety Task Force

REIMAGINING PUBLIC SAFETY TASK FORCE MEETING

Thursday, September 30, 2021
6:00 PM

District 1 - Margaret Fine	Youth Commission - Vacant
District 2 - Sarah Abigail Ejigu	Police Review Commission - Nathan Mizell
District 3 - boona cheema	Mental Health Commission - Edward Opton
District 4 - Paul Kealoha Blake	Berkeley Community Safety Coalition - Jamaica Moon
District 5 - Dan Lindheim	Associated Students of U. California - Alecia Harger
District 6 - La Dell Dangerfield	At-Large - Alex Diaz
District 7 - Barnali Ghosh	At-Large - Liza Lutzker
District 8 - Pamela Hyde	At-Large - Frances Ho
Mayor - Hector Malvido	

PUBLIC ADVISORY: THIS MEETING WILL BE CONDUCTED EXCLUSIVELY THROUGH VIDEOCONFERENCE AND TELECONFERENCE

Pursuant to Section 3 of Executive Order N-29-20, issued by Governor Newsom on March 17, 2020, this meeting of the Reimagining Public Safety Task Force will be conducted exclusively through teleconference and Zoom videoconference. Please be advised that pursuant to the Executive Order, and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, there will not be a physical meeting location available.

To access the meeting remotely using the internet: Join from a PC, Mac, iPad, iPhone, or Android device: Use URL https://us02web.zoom.us/j/81983354907. If you do not wish for your name to appear on the screen, then use the drop down menu and click on "rename" to rename yourself to be anonymous. To request to speak, use the "raise hand" icon on the screen.

To join by phone: Dial **(669) 900 9128** and Enter Meeting ID: **819 8335 4907.** If you wish to comment during the public comment portion of the agenda, press *9 and wait to be recognized by the Chair.

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

AGENDA

Preliminary Matters

1. Roll Call

2. Public Comment *(speakers will be limited to two minutes)*

3. Approval of Minutes
Draft minutes for the Commission's consideration and approval

- Meeting of September 9

Subcommittee Reports

Each report should be limited to 15 minutes.

- Policing, Budget & Alternatives to Policing – Members Opton, Ghosh, cheema, Dangerfield, Lindheim, Mizell, Harger, Hyde
- Community Engagement – Members Fine, Harger, Malvido, Lutzker, Ejigu, Blake
- Improve and Reinvest – Members Ho, Lutzker, Fine, cheema, Malvido, Diaz
- Alternative Solutions to Gender Based Violence – Members Ghosh, cheema, Ho

Discussion/Action Items

The public may comment on each item listed on the agenda. Public comments are limited to two minutes per speaker.

- Dispatch Presentation – City of Berkeley Dispatch Staff
- Task Force Discussion and Facilitation - NICJR

Items for Future Agenda

Adjournment

This meeting will be conducted in accordance with the Brown Act, Government Code Section 54953. Any member of the public may attend this meeting. Questions regarding this matter may be addressed to Mark Numainville, City Clerk, (510) 981-6900.

Any writings or documents provided to a majority of the Reimagining Public Safety Task Force regarding any item on this agenda are on file and available upon request by contacting the City Manager's Office attn: Reimagining Public Safety Task Force at rpstf@cityofberkeley.info, or may be viewed on the City of Berkeley website: http://www.cityofberkeley.info/commissions.

Written communications addressed to the Reimagining Public Safety Task Force and submitted to the City Manager's Office by 5:00 p.m. the Friday before the meeting will be distributed to members of the Task Force in advance of the meeting. Communications to the Reimagining Public Safety Task Force are public record and will become part of the City's electronic records, which are accessible through the City's website. Please note: e-mail addresses, names, addresses, and other contact information are not required, but if included in any communication to the Reimagining Public Safety Task Force, will become part of the public record. If you do not want your e-mail address or any other contact information to be made public, you may deliver communications via U.S. Postal Service to the secretary of the task force. If you do not want your contact information included in the public record, please do not include that information in your communication. Please contact the secretary for further information.

****

COMMUNICATION ACCESS INFORMATION:
To request a disability-related accommodation(s) to participate in the meeting, including auxiliary aids or services, please contact the Disability Services Specialist at (510) 981-6418 (V) or (510) 981-6347(TDD) at least three business days before the meeting date.

Reimagining Public Safety Task Force Contact Information:
Latanya Bellow and Shamika Cole
Co-Secretaries, Reimagining Public Safety Task Force
City of Berkeley
2180 Milvia Street, 5th Floor
Berkeley, CA 94704
rpstf@cityofberkeley.info (email)

Works-Wright, Jamie

From: MHB Communications, ACBH <ACBH.MHBCommunications@acgov.org>
Sent: Friday, September 24, 2021 10:30 AM
Subject: Alameda County Mental Health Advisory Board Public Notice - Adult Committee Meeting (September 28th)
Attachments: Adult Committee Agenda 09-28-21.pdf; Adult Committee Minutes 7.27.21 UNAPPROVED.pdf; Adult Committee Minutes 8.24.21 UNAPPROVED.pdf

Good morning,

Please find attached the September meeting agenda and unapproved minutes from July and August for the **Adult Committee Meeting on September 28, 2021 from 4:00 pm – 6:00 pm.**

Thank you.

Alameda County Mental Health Advisory Board

Alameda County
Mental Health Advisory Board

Mental Health Advisory Board Agenda
Adult Committee
Tuesday, September 28, 2021 ◊ 4:00 PM – 6:00 PM

Teleconference: 1 (571) 317-3116, Access Code: 522-175-645
GoToMeeting Link: https://global.gotomeeting.com/join/522175645

Committee Members:	Lee Davis *(Co-Chair, District 1)* Warren Cushman (*Co-Chair, District 3)*

4:00 PM **Call to Order & Roll Call / Introductions**

4:05 PM **I. Approval of Minutes**

4:10 PM **II. Chair's Report**

4:20 PM **III. Director's Report**

4:30 PM **IV. Discussion**

***Guest speaker*: Lynda Kaufman, Psynergy**
www.psynergy.org

5:30 PM **V. Committee Comment**

5:50 PM **VI. Public Comment**

6:00 PM **VII. Adjourn**

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Adult Committee UNAPPROVED Minutes
July 27, 2021 ◊ 12:00 PM – 2:00 PM
2000 Embarcadero Cove, Oakland, CA
Eden Room
Video Conference Meeting

Alameda County
Mental Health Advisory Board

Committee Members:	☒ **Marsha McInnis** *(Chair, District 1)*
ACBH Staff:	☒ **Kate Jones** *(Adult and Older Adult System of Care Director)*; ☐ **Jennifer Mullane** *(Adult and Older Adult System of Care Director)*; ☒ **Angelica Gums** *(Administrative Liaison and Recording Secretary)*; ☒ **Asia Jenkins** *(Administrative Liaison)*

Meeting called to order @ 12:00 PM by **Chair Marsha McInnis**.

ITEM	DISCUSSION	DECISION/ACTION
Roll Call	Roll Call completed.	
Emergency Action	None.	
Approval of Minutes	April minutes tabled.	
Correspondence	None.	
Chair's Report	**A. Chair McInnis welcomed the Committee and introduced the topic of today's discussion regarding the CalAIM Initiative proposed by the Department of Health Care Services.** **B. Marsha mentioned that next month will be her last month serving on the Board.**	
Director's Report	**C. Kate Jones from Alameda County Behavioral Health, Adult and Older Adult System of Care, provided the Director's report.** Kate thanked Marsha for her advocacy and passion in serving mental health clients. She explained that ACBH will continue to work on three main areas of focus over the next two years: • Better communication and collaboration with Substance use providers and peers and trying to, despite 42 CFR, try to communicate better between our systems and assist around individuals as they transition in and out of SUD treatment and to observe 42 CFR in the process. Kate met with SUD partners to discuss the decision to take people experiencing co-occurring	

ITEM	DISCUSSION	DECISION/ACTION
	disorders to Amber House. Individuals would be voluntarily admitted to Amber House or PES to be evaluated and referred to one of ACBH's crises residential facilities with the idea that we are treating that individual with their mental health crisis and not their SUD concern. • Another focus area is on Older Adults to see how we can provide opportunities for outreach and engagement. The Division wants to increase outreach to these individuals who are eligible for services but aren't receiving any. In addition, the Division is working on system-wide trainings to begin in 2022 on how to provide services to older adults. • Kate is restructuring her weekly care coordination meetings focused on inpatient facilities and individuals who present some sort of systems challenges in finding the right level of care. The restructuring will focus on the top 50 clients who are high need, high cost in either mental health or emergency departments, or forensic. Working with Alameda County Care connect to create reports for shared information exchange, also referred to as community health record. Identified individuals are considered "familiar faces." The goal is to work with individuals to decrease utilization of services in high cost/ high restrictive environments to ideally meet their wants and needs to have a better quality of life. They will begin these meetings in October. **Questions:** 1. **Has ACBH considered the timeframe in which it takes an individual to transition from various levels of care, i.e. from experiencing a psychotic state to becoming balanced?** Kate explained that they have critical care managers who can make decisions on a case by case basis on length of stay for clients. 2. **Is there anyway a family member of one of these 50 individuals can be involved in the weekly care coordination meetings devoted to them?** This is intended to be largely a provider meeting.	

ITEM	DISCUSSION	DECISION/ACTION
	3. Is there a way for a County to reward and incentivize itself for taking care of its familiar faces? I wish Alameda County can give itself credit and encouragement for saving lives especially considering how expensive this process can be. ACBH can reward itself with praise and we do have an incentive program with our Full-Service Partnerships in identifying key metrics with seeing individuals at key times, including how often and quickly etc. Hopefully we'll see a reduction in cost and types of services over time. **4. Is there ever a way the care coordination team committee can report to the MHAB or the BOS on what sorts of facilities or programs are in short supply for familiar faces?** Kate mentioned that she is unsure about this process at this time. **5. With COVID surging, what are the policies in the clinics that protect clients/staff?** There are now rotational schedules for staff and all staff are required to wear masks.	
Presentation on California Advancing & Innovating Medi-Cal (CalAIM) (Eric Yuan, Alameda County Behavioral Health, Office of the Medical Director Integrated Health Care Services)	**D. Chair McInnis introduced Eric Yuan as the presenter to discuss the new CalAIM initiative** CalAIM stands for **California Advancing and Innovating Medi-Cal**. It is a multi-year initiative proposed by DHCS to ultimately improve the health outcomes, quality of life and consumer experience for Medi-Cal beneficiaries. Eric presented on key areas of the initiative including, CalAIM's Goals and Initiatives, the Enhanced Care Management Framework and implementation dates, and In Lieu of Services. **Questions:** **1. Considering the timeline that we have; what kind of consumer involvement are we looking at? How are we going to feed in the consumer voice?**	

ITEM	DISCUSSION	DECISION/ACTION
	Consumers will be involved in the stakeholder planning meetings for CalAIM, which includes helping to create a recovery plan for the client, receiving consumer feedback, and development of a client satisfaction survey. ACBH is not quite ready to put forth a draft proposal yet. There may be a place for peers to do outreach to get people engaged with the program. There is also an emphasis on qualitative services. Eric addressed concerns around basic needs. A couple of years ago the Office of the Medical Director was heading care coordination policies and procedures to improve care coordination for client. This project turned into the mental health system program improvement project that is supported by our department. 2. **People think of Managed Care as a way for a provider to put up resistance to expensive measures that aren't necessary. Might Managed Care theoretically make it more difficult for the SMI to get acute or subacute care quickly? This is not something a client is likely to demand but it is something a client with SMI may need occasionally. Also, it costs $450-3000 a day to my knowledge** Kate started a workgroup that reviews the screening/transition of care process for clients to ensure they are funneled into the right level of services. DLA-20 is a tool to help the individual determine how they are doing. 3. **Will there be state directed rates for outpatient services for mild to moderate and will there be separate rates for EPSTD and other medical services for court clients?** Kate explained that she is not aware of information right now and that there is a workgroup that discusses payment transformation information to DHCS and they are examining many different methodologies for payment reform.	

ITEM	DISCUSSION	DECISION/ACTION
	4. Is the tool at this moment just self-reporting data or does it involve a clinical assessment? DLA-20 is an assessment of the daily functioning of the client. It is a clinical tool that the clinician/providers share with the client and can determine the result together. **5. If a person is in a state of psychosis, is it tracking their perception of how they are doing or is there a separate or additional place for clinician to comment on that thing?** Eric stated that we need a trained clinician to know when to use these tools, such as when the client is facing a psychotic break it may not be the appropriate time for the client to do a co-assessment. **Eric continued the presentation to highlight the ACBH Model of Enhanced Care Management, which included the following information:** • Why ACBH should participate in CalAIM to be enhanced care management providers; Member Experience; Quality of Care; Member Outcomes, • Piloting at ACBH Community Support Centers (CSC) – Outreach, Care Coordination Capacity, and Health Promotion • Four (4) Community Support Centers • ECM Model Workflow: Membership Assignment • ECM Model Workflow: Outreach and Engagement • ECM Model Workflow: Assessment and Plan Development • ECM Model Workflow: Service Provision • ECM Model Workflow: Re-assessment	
Committee Comment	Committee member Warren commented that he appreciates the dialogue and being able to learn from Marsha during these meetings.	
Public Comment	None	
Adjournment	Adjourned at 2:00 PM	

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Adult Committee UNAPPROVED Minutes
August 24, 2021 ◊ 12:00 PM – 2:00 PM
2000 Embarcadero Cove, Oakland, CA
Eden Room
Video Conference Meeting

Alameda County
Mental Health Advisory Board

Committee Members:	☒ **Marsha McInnis** *(Chair, District 1)*
ACBH Staff:	☒ **Kate Jones** *(Adult and Older Adult System of Care Director)*; ☐ **Jennifer Mullane** *(Adult and Older Adult System of Care Director)*; ☒ **Angelica Gums** *(Administrative Liaison and Recording Secretary);* ☒ **Asia Jenkins** *(Administrative Liaison);* ☒ **Dainty Castro** *(Administrative Liaison);* **Necole Goodman** *(Administrative Liaison)*

Meeting called to order @ 12:00 PM by **Chair Marsha McInnis**.

ITEM	DISCUSSION	DECISION/ACTION
Roll Call	Roll Call completed.	
Emergency Action	None.	
Approval of Minutes	July minutes tabled.	
Correspondence	None.	
Chair's Report	**A. Chair McInnis welcomed the Committee and announced that this was her last month serving as chair.** She expressed her gratitude for the education she received and how proud she is of the work that has been accomplished.	
Director's Report	**B. Kate Jones from Alameda County Behavioral Health, Adult and Older Adult System of Care, provided the Director's report.** There has been a delay in the process for reassessing large structural changes of the Department due to the Covid-18 Delta Variant. Additional research is needed regarding bringing the system together and getting data around the protocols set in place. There are no clear trends when it comes to seeking crisis stabilization unit level of care with "familiar faces". Received a report last week on a new definition for an individual who seeks a high volume of care on a frequent basis. The definition has been changed from "frequent flyer" to "familiar face". Kate mentioned that they are still moving forward with the older adult competency training with staff around being more knowledgeable about older adult concerns. Doing care coordination for older adults and bringing those two	

ITEM	DISCUSSION	DECISION/ACTION
	things together, differential diagnosis, for instance. Hope is that they'll see better coordination and higher ANSA score (adult needs and strengths assessment) - done on individuals in the adult system. Working on some codes as a proxy to help us determine if we're getting better at doing coordination for individuals who have substance use disorders. However, given the confidentiality, it's a challenge to interact with substance use and mental health providers. The enhanced care management work continues. That plan starts in January. Directors Kate Jones and Jennifer Mullane wrote a proposal for ACBH to be a direct provider in Enhanced Care Management in our clinics and to be thought-partners on the criteria to give a mental health prospective on who qualifies for the service. Jennifer Mullane provided a report on ACBH IHOT Teams. IHOT stands for in-home outreach teams. They are meant to do nothing but outreach and engage people who are resistant and reluctant to enter treatment. They don't provide treatment but create a linkage to services. Overall, there was a reduction in acute hospitalizations, crisis episodes, and jail episodes/stays at jails. Looking at doing this work with the forensic team.	
Presentations from NAMI Affiliates in Alameda County Joe Rose President, NAMI Alameda County South Gwen Lewis President, NAMI Tri-Valley Peggy Rahman President, NAMI Alameda County Liz Rebensdorf President, NAMI East Bay	**A. Gwen Lewis (President of NAMI Tri-Valley)** They connect people and families to appropriate resources and provide four of the NAMI national signature programs. She briefly covered some of the programs that her organization is working on and the services they provide. **B. Joe Rose (President of NAMI Alameda County South)** Their focus is to figure out how to connect more people with the resources they need. Rather than trying to get people to come to them, they took the programs to where the people were. Some places they are focusing on include: Psychiatric Hospitals, the criminal justice system/probation, and schools/colleges. They typically refer people to the FERC. **C. Liz Rebensdorf (NAMI Alameda County East Bay)** Liz provided a brief background on the history of the organization. Their initial focus was on schizophrenia patients but later broadened their scope to all	

ITEM	DISCUSSION	DECISION/ACTION
	mental health illnesses. As they became a NAMI affiliate, they changed their name. They offer a winter family to family class virtually. We have support groups weekly. Periodically they have observers from the psychiatric medical field come to observe what families are going through. They have a fourth Wednesday, every other month, speaker presentation. They also have a NAMI program on the campus of UC Berkeley. **D. Peggy Rahman (NAMI Alameda County)** Their mission is to enrich the lives of families and individuals in Alameda County who have been affected by mental illness. They host weekly/monthly support groups for individuals in both English and Chinese. Some of their advocacy programs include Community Education/Outreach and a suicide prevention program called Collaborated with NAMI Tri-Valley. **E. Jeffrey Fudena (Executive Director of NAMI Alameda County)** Oversees project management for the Dinobi Project. The Dinobi Project is an app designed to support those in the mental health field needing care and support with the resources they need for success and personal well-being. The app contains different features to help those struggling with mental health issues better manage their own mental health care and gain access to resources. It's in the beta testing phase right now. Peggy Rahman thanked Marsha for bringing all the NAMI affiliates together.	
Committee Comment	None	
Public Comment	**Who is going to replace Marsha McInnis?** Chair Lee Davis of the Mental Health Advisory Board and board member Warren Cushman will be co-chairing the meetings going forward.	
Adjournment	Adjourned at 1:15 PM	

Minutes submitted by A. Gums