Contra Costa
Health Services

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The Contra Costa County Mental Health Commission has a dual mission: 1) To influence the County's Mental Health System to ensure the delivery of quality services which are effective, efficient, culturally relevant and responsive to the needs and desires of the clients it serves with dignity and respect; and 2) to be the advocate with the Board of Supervisors, the Mental Health Division, and the community on behalf of all Contra Costa County residents who are in need of mental health services.

Current (2017) Members of the Contra Costa County Mental Health Commission
Duane Chapman, District I (Chair);, Barbara Serwin, District II (Vice Chair); Douglas Dunn, District III; Diana MaKieve, District II; District III; Lauren Rettagliata, District II; Connie Steers, District IV; Gina Swirsding, District I; Jason Tanseco, District III; Meghan Cullen, District V; Michael Ward, District V; Sam Yoshioka, District IV; Candace Andersen, District II, BOS Representative; Diane Burgis, District III, BOS Representative.
Commissioners Emeritus
Marie A. Goodman ♦ David Kahler

Contra Costa County Mental Health Commission Monthly Meeting
Wednesday, February 1, 2017 ♦ 4:30pm to 6:30 p.m.
AT: 550 Ellinwood Way, Pleasant Hill, CA 94523

AGENDA

I. Call to Order / Introductions/Roll call- Chair

II. Chair Report, Announcements and Comments- Chair
The MHC meeting, on March 1, will be held in West County at the: San Pablo Community Center, in the Community Hall, in San Pablo, on 2450 Road 20, San Pablo, CA 94806

III. Public Comments (3 minutes per speaker)

IV. Commissioner's comments

V. APPROVE minutes from January 4, 2017 meeting

VI. RECEIVE, West County Detention Facility, (WCDF), grant update by Captain Tom Chalk, Contra Costa County Law Enforcement representative.

VII. REVIEW AND RECEIVE, Needs Assessment for 2016, presentation by Warren Hayes from Behavioral Health

VIII. RECEIVE, Community Planning Process, presentation by Warren Hayes, from Behavioral Health

IX. RECEIVE Commission Representative Reports
1) AOD Advisory Board – Sam Yoshioka
2) CPAW General Meeting – Lauren Rettagliata
3) Children's Committee – Gina Swirsding
4) Housing Committee – Lauren Rettagliata

X. Adjournment

The Contra Costa County Mental Health Commission is appointed by the Board of Supervisors to advise them on all matters related to the county's mental health system, in accordance with mandates set forth in the California State Welfare & Institutions Code, Sections 5604 (a)(1)-5605.5. Any comments or recommendations made by the Mental Health Commission or its individual members do not represent the official position of the county or any of its officers.

The Commission will provide reasonable accommodations for persons with disabilities planning to participate, please call (925) 957-5140 to arrange.

MENTAL HEALTH COMMISSION
MONTHLY MEETING MINUTES
January 4, 2017 – First Draft

	Agenda Item / Discussion	Action / Follow-Up
I.	**Call to Order / Introductions** Commission Chair, Duane Chapman, called the meeting to order at 4:37pm. <u>Commissioners Present:</u> Candace Andersen, BOS Representative Duane Chapman, District I –Chair Barbara Serwin, District II –Vice Chair Gina Swirsding, District I Meghan Cullen, District V Douglas Dunn, District III Diana MaKieve, District II Lauren Rettagliata, District II <u>Commissioners Absent:</u> Michael Ward, District V Jason Tanseco, District III Sam Yoshioka, District IV Connie Steers, District IV <u>Other Attendees:</u> Cynthia Belon, Behavioral Health Services Director Adam Down, Behavioral Health Admin Jill Ray, Supv. Andersen's office Robert Thigpen, Adult Family Services Coordinator Warren Hayes, MHSA Program Manager Teresa Pasquini, Previous Commissioner Liza A. Molina-Huntley, Executive Assistant	Transfer recording to computer Update MHC Attendance Chart Update MHC Database
II.	**Item II- Chair Report, Announcements, and Public Comments by Duane Chapman:** • Robert Thigpen announced that Commissioner Connie Steers has been absent to the meetings due to the illness and recent passing of her mother. A service will be held, honoring her mother, on Monday, January 9 at 1pm at the Frist Episcopal Lutheran Church on 4000 Concord Blvd in Concord. • The Executive Assistant for the Commission will send everyone an email with the details, for those who wish to attend.	

III.	**Public Comments- none**	
IV.	**Commissioners comments:** • Lauren stated that individuals with mental illnesses do not receive parity at the State or County level, or with their health plans. She feels it is important to work towards parity with those who are suffering with mental illnesses and that the term "behavioral health" does not support this. • Letter/comment from Commissioner, Sam Yoshioka, who was not present, was read by Executive Assistant, Liza A. Molina-Huntley, (see attachment).	
V.	**Approval of the December 14, 2016, Minutes.** Noted: Corrections are needed to be made, as follows: • Pg. 1 of 6 Stated "Dave Lyons, Supervisor Gioa" (incorrect), should be James Lyons from Supervisor John Gioia's office, District I. • Page 2: second bullet: BOS "authorized" AOT program, not MHC. • Page 2: strike, at the top, second bullet point "staffing and expenses…" ref made by Jill Ray. • Page 3: second bullet: "CCC has been previously spending on average, for the last 3 years, over $1million, in providing services for 17 consumers." RDA report of AOT speaks of 108 people in study- 17 people had gone into ACT- should read 108 people were responsible for the $1M, not just 17. • Page 3: third bullet, average amount of days ….5-52 days…. The word "average" should be removed, because it's too wide of a range • Page 5: 3rd sentence –"within or in" (decide which one and change it) • Page 5: Correct the spelling of Barbara's name • Lauren moved, seconded by Gina, to approve the December 14, 2016, minutes. • The motion passed by a vote of 8-0-0. Vote: Ayes: Lauren, Barbara, Supv. Andersen, Diana, Douglas, Duane, Meghan, Gina Nays: None. Abstain: None. Absent: Sam, Connie, Michael, Jason	
VI.	**RECEIVE Report and Recommendations – by Director of Behavioral Health, Cynthia Belon.** • Regarding the Medical Director recruitment, BHD met with Merritt Hopkins, a professional recruitment agency, to assist in a nationwide search. • Regarding the MEDI CAL drug waiver, it has been approved by DHCS,	

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pending a contract. Once the contract is received, it will be forwarded to the Board of Supervisors for approval.

- EQRO will be coming to Contra Costa County, for the annual review, from January 31 through February 2 to complete an external quality review survey that will cover various aspects of the work being done by Behavioral Health.
- The Director invites the Chair and the Vice Chair of MHC, to join BHS in an open session which will be held on 1/31/17. Duane and Barbara will attend the open session. A report will be issued to the MHC, upon receipt from EQRO. Commissioner Lauren Rettagliata will serve as an alternate, in case the Chair or Vice Chair cannot attend.
- Other Commissioners are interested in attending or accompanying EQRO on onsite visits to the clinics and asked the Director of BHS to inquire if there is a possibility, if not for this year, for the following year, for the entire MHC to meet with EQRO during their visit. The Director will inform EQRO and express the MHC's desires to meet.
- Informed that the triannual audit will be coming to perform the inpatient review. It will be held at CCRMC on January 9 through the 13, 2017.
- The "Sobering Center," will be a 24 bed facility, and hopes to open in July of the current year. Informed that she did have the opportunity to visit Houston's, San Antonio's and assisted in the opening of the center in San Francisco. Looking forward to the opening of the center in Concord. The center will provide a safe place to do outreach and engagement.
- In regards to the IT plan, there are two main parts to it, as follows: the first part is the billing process and the second part is the documentation process (charting). The PSP system will be replaced with "Share Care" which is an updated system from the same vendor, starting in the current month.
- A new Project Manager will assist in the transition~~,~~ from PSP to Share Care billing. This process will take approximately 12 to 14 months to complete.
- The second part, the documentation portion of the IT plan, is for BHS to move onto the EPIC system, otherwise known as CCLINK.
- A second Project Manager will be hired for the EPIC portion of the IT Plan which will be conducted simultaneously with the "Share Care" implementation. The EPIC portion will take 12 to 18 months to complete implementation.
- It was clarified that MHSA funds can be used for IT purposes. The clarification was made by DMH, stating that the funds can be used for entire electronic infrastructure development.

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VII. Consider a motion, as forwarded by the Executive Committee, to create a Task Force, by the Commission to implement continuous oversight of the AOT program, as follows:

Specified in the Commission Bylaws a Task Force shall consist of a minimum of 3-5 members (a Committee must only be Commissioners.) Non-Commissioners may be appointed from the community as non-voting members when special expertise, advice or opinion is desired; it shall not exceed ½ of the membership of the Task Force.

5 Commissioners would be on the Task Force with:

1. A CCBHS member who is in-charge of outreach and engagement
2. A member of the service provider, Mental Health Systems
3. A member from the hospital who could assist with PES, 4C, Miller Wellness and jail interfacing.
4. Law Enforcement liaison
5. A Community Advocate

- Lauren moved, seconded by Gina, to create a Task Force, as an oversight group for the AOT program.
- **Discussion:**
- Supervisor Andersen referred to the BOS meeting in December, regarding the discussion of the RDA presentation of the new AOT program. Aware of the capacity constraints of the BHSD, requested that BHS, make a recommendation regarding the best vehicle to provide input to MHC and the community for ongoing dialogue. BHS is working diligently on a vast amount of projects and programs, creating a Task Force, may not be the most efficient way to proceed. Refers the question to the Director of BHS to respond.
- Director, Cynthia: Thanked MHC for putting the item on the agenda and recognizes that it is important to have ongoing dialog, discussion and input that the community is involved with. The AOT workgroup, in existence, was created to serve this purpose for the community dialogue to continue with the implementers of the program. The goal was to bring updates, on a quarterly basis, to MHC and the public. BHS apologizes for not continuing the AOT workgroups and would like to move forward with the AOT workgroup, in place and meet on an ongoing basis. The current workgroup includes the public, Commissioners, Unions, Law Enforcement and those involved in the program, along with others who wish to attend to participate.

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• BHS does not have the resources in staff, or otherwise, to start, assist, or commit to a new oversight group or Task Force to convene, in addition to the AOT workgroup in place. • Both, Commissioners Doug and Gina, attended prior AOT workgroup meetings. Gina found the meetings helpful and engaging. • Commissioners, Lauren and Doug, strongly encourage the creation of a Task Force, controlled by the MHC, to enforce changes to trouble areas or issues that might arise. The purpose of the Task Force would be to have new smaller group meetings on a monthly basis to better assist the new AOT program. The time frame of the new group would be to serve for three years. To problem solve specific issues that might arise, in lieu of the larger AOT workgroup in place. • The primary reason for the Commissioners concern is, according to the RDA evaluation of the AOT program, it was shown that a significant amount of people that were unable to be located. The primary reason for the inability to locate the individuals was due to the homelessness of these individuals. Since the RDA evaluation was completed, various issues have been identified and mostly resolved. The AOT program is more effective and efficient in providing services. • Supervisor Andersen's office supports the reestablishment and continuance of the AOT workgroup, in place, as advised by the Director of BHS, Cynthia Belon. Does not agree with a creation of a new group, especially an oversight sight group that does not have the resources or authority to enforce changes. The purpose of MHC is to advise and make recommendations to the BOS, not to make decisions or enforce changes. BHS is overworked with many projects and does not see a possibility to commit to participating or assisting in a new workgroup. • All present do agree they desire a successful outcome of the AOT program, regardless of the differences in workgroup formats. • It was clarified that Los Angeles County does utilize their MHSA stakeholder group for their oversight program. • Other Commissioners were unclear if creating a new group, that meets more frequently, would be the best and most efficient way to assure the success of the AOT program. The group in place invites feedback and questions to be answered, and also includes all key groups invited to the meetings. • Discussion advocating for the creation of a new oversight group for AOT, included Teresa Pasquini's view points. Although, she did clarify that she cannot serve as a member of the new Task Force.	

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	• Supervisor Andersen invited everyone, to actively participate in communicating issues or problems directly to BHS staff or the AOT staff, as they arise, not to wait until a meeting to convene to bring issues to light. • Moving forward, the MHC CHAIR would like any format of workgroup to start and continue. The purpose is for all to have a voice regarding any problems or issues that might arise and have the problems resolved and MHC to be updated on the progress on a regular basis. • **MOTION to create a TASK FORCE**, as an oversight group for the AOT program: • ROLL CALL VOTE: Barbara- ABSTAIN Meghan- ABSTAIN Supervisor Andersen- NO Diana- NO Lauren- Yes Duane- Yes Doug- Yes Gina- Yes VOTE: 4-2-2 ABSENT: Sam, Connie, Jason, Michael • THE MHC Chair hopes, moving forward, to develop a partnership. The Chair also requests that all who wish to share information at MHC meetings to please put the information in writing and forward the information to the Executive Assistant for the information to be included in the minutes.	
VIII.	**RECEIVE the Contra Costa Mental Health System of Care Needs Assessment presentation by Warren Hayes.** Due to the time constraints, stated presentation was voted to be postponed to the February agenda. Barbara moved to motion that item VIII on the agenda be moved to the February agenda. Invited Commissioners to address, in writing, comments or questions directly to Warren Hayes, prior to the February meeting so they may be addressed during his presentation. Gina seconds the motion. All in favor to move the presentation to February. VOTE: 8-0-0 Attendees: Duane, Supervisor Andersen, Barbara, Diana, Gina, Doug, Lauren and Meghan Absent: Sam, Michael, Jason, Connie	

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IX.	**Receive Chair Committee reports:** **1) Justice Systems Committee- Chair Gina** **2) Quality of Care Co- Chair Barbara** **3) MHSA/Finance Committee- Chair Lauren** **4) Executive Committee- Chair Duane** MHSA/Finance Committee Chair, Lauren, has submitted a 2016 year-end report. All others are pending.	
X.	**Receive Commission Representative reports:** **1) AOD- Sam, not present** **2) CPAW- Lauren** **3) Children's Committee- Gina** **4) Housing Committee- Lauren** • Lauren noted that during her visit in East County, she met with Fatima Matal Sol, AOD Program Chief, at the Community Participation Committee. The AOD Program Chief actively participated in the group discussions and the community was receptive and thankful for the Chief's involvement. Lauren encourages that more administrative staff participate in community events. • Chair: Moving forward, request for all information to be put in writing to be included as an attachment, to the minutes. This includes all Committee and Commission Representative reports or updates. • Chair will be attending the CISBH, Commissioner's Statewide meeting, in San Diego, from January 19 through the 21; will not be present at the MHSA Finance nor at the Quality of Care Committee meetings. • Supervisor Andersen noted that she will be attending the "STEPPING UP" conference in Sacramento next week and will update MHC at the February meeting. Unfortunately, was unable to obtain additional reservations for other members or for her staff to attend. Space was limited. • Doug announced that the 51/50 Summit will be held on Wednesday February 22 and will forward the information to the Executive Assistant, to forward to the Commissioners.	
VI.	**Adjourn Meeting** The meeting was adjourned at 6:28 pm.	

Respectfully submitted,
Liza Molina-Huntley
Executive Assistant to the Mental Health Commission
CCHS Behavioral Health Administration

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Contra Costa Mental Health System of Care Needs Assessment

November 2016

Contra Costa Behavioral Health Services

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Executive Summary

Contra Costa Behavioral Health Services (CCBHS) conducted a quantitative assessment of public mental health need in preparation for developing the Fiscal Year 2017-20 Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan (Three Year Plan). This data driven analysis complements the Community Program Planning Process (CPPP), where interested stakeholders provided input on priority needs and suggested strategies to meet these needs.

Data was obtained to determine whether CCBHS was a) reaching the people it is mandated to serve, b) appropriately allocating its resources to provide a full spectrum of care, and c) experiencing any significant workforce shortfalls.

Benchmarks for the CCBHS target population were established for the county and county regions (East, Central, West) as well as by race/ethnicity, age group and identified gender to determine whether CCBHS was serving more or less than these benchmarks. Benchmarks for appropriate resourcing by level of mental health care, ranging from locked facilities to basic services for prevention and health maintenance, were also established to determine whether the level of funding CCBHS spent on each level met recommended standards. Finally, all CCBHS position classifications were reviewed to determine whether any significant shortfalls existed between authorized versus filled positions, staffing demographics, and bi-lingual staff.

Data analysis supports that CCBHS is serving the number of clients that approximate the estimated number of individuals requiring services, and serves more eligible clients than the majority of counties in California. This is based upon prevalence estimates and penetration rates of low income children with serious emotional disturbance and adults with a serious mental illness as compared with other counties. In addition, regions and sub-populations within Contra Costa County are generally appropriately represented, with the exception of Asian/Pacific Islanders, Latina/os, children ages 0-5 years, and adults ages 60 and over as being somewhat underrepresented in each region when compared to other sub-populations within Contra Costa County.

Fiscal Year 2015-16 expenditure data indicate services were available at every level of care as defined by the Level of Care Utilization System (LOCUS/CALOCUS). However, compared to benchmarks, CCBHS over spends on the most acute level of in-patient care (Level 6), and is below the benchmark in expenditures related to programs providing high intensity community-based services (Levels 4 and 5).

Workforce analysis indicates a significant shortage of psychiatry time, both in county positions as well as contract psychiatrists. Compounding the issue of filling vacant psychiatrist positions is that Contra Costa County reimburses psychiatrists at a lower rate than neighboring counties. Latina/o and Asian/Pacific Islander populations are under-represented among county staff when compared to the county population. Finally, CCBHS has incrementally increased the number of bilingual staff each year, and has made available as needed phone, in-person and video interpretation services.

This quantitative needs assessment suggests attention in the following areas:

- Outreach and engagement strategies for identified underserved populations across the county
- Improve capacity to assist consumers move from locked facilities to community based services

- Explore strategies to recruit and retain psychiatrists and staff representing underserved populations

I. Introduction

This report addresses three questions:

a. Is Contra Costa Behavioral Health Services (CCBHS) reaching the target population it is mandated to serve?
b. Is CCBHS apportioning its funding to ensure it is providing a full spectrum of mental health care and meeting established allocation benchmarks?
c. Is CCBHS adequately addressing its Mental Health Plan workforce needs?

The Mental Health Services Act (MHSA) directs county mental health programs to prepare and submit an integrated three year program and expenditure plan (Plan) for services funded by MHSA. Furthermore, each county shall provide for a community program planning process as the basis for developing Three Year Plans and Annual Plan Updates. In partnership with stakeholders, the planning process is to 1) identify community issues related to mental illness resulting from lack of community services and supports, 2) analyze the mental health needs in the community, and 3) identify and re-evaluate priorities and strategies to meet those mental health needs.

CCBHS is currently undertaking a community program planning process to inform the development of the MHSA Three Year Program and Expenditure Plan for Fiscal Years 2017/2018 through 2019/2020. The community program planning processes which informed the MHSA Three Year Program and Expenditure Plan for Fiscal Years 2014/2015 through 2016/2017 and its Annual Updates primarily utilized qualitative data studies to identify system needs. While qualitative data provides useful descriptions and observations, quantitative data is needed to provide a more objective complement to subjective experiences and observations. Qualitative data is often used to inform the type and amount of quantitative data to be collected to inform an evaluation. Therefore, in combination with qualitative information gathered through community engagement events, a quantitative needs assessment will ascertain if there are any discrepancies, or gaps, in the Mental Health System of Care, and to identify unserved or underserved populations.

A needs assessment is a systematic set of procedures used to determine if there are differences between current and desired conditions. Often, it also examines the nature and causes of the discrepancies and assists agencies in setting priorities for operations. Such information is fundamental for the community program planning process as it assists CCBHS and stakeholders to determine if the system of care is serving the target populations it is mandated to serve with a spectrum of services that address basic needs for care.

This needs assessment was guided by the findings of previous community program planning processes, which included key informant interviews, focus groups, and community forums. Stakeholders participating in the community program planning processes identified the following significant shortfalls as priority needs, and weighed in on strategies to improve access to services, quality and levels of

service provided, integration of effort, accountability, and stakeholder participation in planning and evaluation[1]:

- Getting to and from services
- Navigating the system
- Culturally/linguistically appropriate outreach and engagement
- Serve those who need it the most
- Crisis response
- Housing and homeless services
- Assistance with meaningful activity
- Children in-patient beds
- Supporting family members and significant others
- Support for peer and family partners
- Care for homebound frail and elderly
- Intervening early in psychosis
- Integration between levels of care
- Integration between service providers
- Trauma informed care
- Education through social media
- Improved program response
- Increased funding
- Persons with developmental and mental health issues
- Youth with co-occurring mental health and substance abuse issues
- Support our behavioral health workers

Additionally, the extensive outreach and data collection effort conducted as part of the 2005 MHSA planning process identified a number of specific barriers to care in Contra Costa County, to include issues related to cultural and linguistic competencies. Related barriers were identified as[2]:

1. Not enough linguistically and/or culturally/ethnically diverse staff
2. Not enough culturally appropriate/culturally specific services and interventions
3. Lack of integration of mental health outreach and services with existing ethnic communities, agencies and faith-based organizations
4. Difficult location of services – often far from lower income, ethnically diverse neighborhoods.
5. Lack of culturally/linguistically based outreach efforts
6. Lack of staff trained to be sensitive to different cultures

These barriers and suggested system improvements have guided the development of this needs assessment, meant to enhance the community program process by addressing three questions, 1) is CCBHS reaching the target population it is mandated to serve, 2) is CCBHS apportioning its funding to

[1] Contra Costa Behavioral Health Services. "Mental Health Services Act Plan Update Fiscal Year 2016-2017". 2016. Available at: http://cchealth.org/mentalhealth/pdf/2016-0920-MHSA-Plan.pdf .

[2] Contra Costa Mental Health Administration. "Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan Community Services and Supports Fiscal Years 2005-06, 2006-07, and 2007-08". 2005.

ensure it is providing a full spectrum of mental health care and meeting established allocation benchmarks, and 3) is CCBHS adequately addressing its Mental Health Plan workforce needs?

When appropriate, the data outlined below will also provide recommendations for further research as well as for addressing identified system needs with existing resources. The needs assessment report includes a detailed description of the methodology used to analyze data, a results section outlining major findings, the limitations of this report, and recommendations for addressing findings.

II. Methodology

Qualitative needs assessments conducted during prior years' community programming planning processes were reviewed and general findings used to identify appropriate indicators for this quantitative needs assessment. When appropriate, citations from previous needs assessments were used to identify data sources. An extensive literature search was conducted to establish service and expenditure benchmarks for public mental health systems of care. A methodology was then developed to collect and analyze data to answer the three research questions posed by this needs assessment. When appropriate, a determination was made as to whether data collected through prior community programming planning processes supported the findings of the current needs assessment and, if not, the reasons for the discrepancies.

The methodology section below is divided into three parts. The first, *Prevalence, Numbers Served, and Penetration Rates*, addresses the question, "is CCBHS reaching the target population it is mandated to serve?" The second, *Spectrum of Services and Service Expenditures*, addresses the question, "is CCBHS apportioning its funding to ensure it is providing a full spectrum of mental health care and meeting established allocation benchmarks?" The third, *Contra Costa Behavioral Health Services Staffing*, addresses the question, "is CCBHS adequately addressing its Mental Health Plan workforce needs?"

i. *Prevalence, Numbers Served, and Penetration Rates*

In order to address the question, "is CCBHS reaching the target population it is mandated to serve?", county prevalence[3] and penetration[4] rates were analyzed and compared to state benchmarks. As part of the planning process for implementation of the Affordable Care Act, the California Department of Health Care Services utilized existing mental health prevalence studies to create prevalence estimates

[3] Prevalence is the proportion of people in a population who have a particular disease at a specified point in time.

[4] Penetration rates are used by CCBHS Mental Health to evaluate the accessibility of services for different populations of MediCal eligible clients. Penetration rate refers to the proportion of eligible MediCal service units being utilized by mental health consumers in Contra Costa County. CCBHS Mental Health calculates penetration rates by dividing the number of MediCal eligible clients who accessed services from CCBHS Mental Health by the total number of MediCal eligible clients in the county. This calculation results in the proportion of MediCal eligible clients who access services.

$$Penetration\ Rate = \left(\frac{Number\ of\ MediCal\ eligible\ clients\ who\ accessed\ services\ from\ CCMH}{Total\ number\ of\ MediCal\ eligible\ clients\ in\ CCC}\right)$$

for each county in California[5]. The prevalence estimate for Contra Costa County was applied to census estimates to determine an estimate of the number of individuals with serious mental illness in Contra Costa County. This number was then compared to the number of individuals served by CCBHS Mental Health to determine what proportion of potential clients have been served by CCBHS. Estimates for three years (2013-2015) were compared to identify trends. PSP/INSYST[6] billing data was used to identify the number of individuals served by CCBHS Mental Health. No filters[7] were used when extracting the total number of clients served from the PSP/INSYST billing system so all providers and service types were included in this data.

However, the benchmark described above is for the total population. CCBHS Mental Health is primarily responsible for providing mental health services to individuals with moderate to severe mental illness who are MediCal eligible, indigent, or uninsured, not the entire population of individuals with serious mental illness. In order to create benchmarks to be used to ascertain whether CCBHS is reaching its target population, prevalence rates for serious mental illness for Contra Costa County's population below 200 percent poverty[8] were applied to estimates of the County's population below 200 percent poverty level based upon population statistics taken from the Healthcare Workforce Development Division of Office of Statewide Health Planning and Development (OSHPD) "Medical Service Study Areas (MSSA)" county census data. With the purpose of establishing estimates for the population below 200 percent poverty, the 2010 OSHPD census data was used to determine the proportion of the Contra Costa County population that was below 200 percent poverty in 2010. This proportion was then applied to the census estimates for total population to establish estimates for the population below 200 percent poverty for the years 2013 through 2015. The estimated number of individuals with serious mental illness who are below 200 percent poverty was compared to the total number of individuals served by CCBHS Mental Health

PSP/INSYST billing data was also used to identify the number of individuals served by CCBHS Mental Health who were MediCal eligible at least one month during the calendar year. No filter was placed on MediCal type when the data was extracted from the billing system; all eligible clients were included regardless of MediCal type. The number of MediCal eligible clients was compared to the prevalence estimates for the population below 200 percent poverty.

Next, penetration rates, the percentage of individuals' eligible for services actually served by CCBHS Mental Health, were used to identify if any populations were underserved. CCBHS Mental Health penetration rates were compared to statewide average penetration rates to verify whether CCBHS Mental Health was reaching populations at the same rate as other counties. CCBHS Mental Health penetration rates were analyzed by racial/ethnic group, age group, gender, and region of the county to

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[5] Department of Health Care Services Task Team. "California Mental Health Prevalence Estimates". 2012. Available at: http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf . Accessed on 8/10/2016.

[6] PSP (Poolman, Shih and Platton) INSYST is a patient tracking and billing computer system created for county behavioral health providers in California.

[7] Filters are used when extracting data from the PSP/INSYST billing system to obtain subsets of data. When no filters are used, an entire data set is extracted.

[8] This refers to the population whose income is 200 of the federal poverty level or below. It is a common benchmark used to define low income populations.

establish if any subpopulations were underserved or unserved. PSP/INSYST billing data was used to calculate the number of individuals within each subpopulation served by CCBHS Mental Health. Note, the business logic[9] used to extract penetration rate data from PSP/INSYST was different from the business logic used to determine the total number of clients served. Since the PSP/INSYST penetration rate reports showed Mental Health MediCal eligible clients versus the MediCal eligible population county-wide, the report is based entirely on MediCal eligibility data, regardless of services. Therefore, the penetration rate numbers do not exactly match the total number served, which is based on service data. MediCal eligibility data was used as the denominator for penetration rates since the majority of low-income individuals were eligible for MediCal, and, therefore, a potential client for the public mental health system.

ii. Spectrum of Services and Program Expenditures

In order to address the question, "is CCBHS apportioning its funding to ensure its providing a full spectrum of mental health care and meeting established allocation benchmarks?", county mental health expenditures were compared to benchmarks established by the Mental Health Association in California in 1981[10]. Additionally, these expenditure benchmarks were mapped to the Level of Care Utilization Services/Child and Adolescent Level of Care Utilization Serves (LOCUS/CALOCUS) levels of care to assist in identifying service gaps in the CCBHS Mental Health continuum of care. Mental Health Association in California recommended expenditures for each service level were divided by the total recommended expenditures for a public mental health system of care to calculate the recommended percentage to be allocated to each level of care. The Mental Health Association in California levels of care were mapped to the LOCUS/CALOCUS levels of care. Because many of the same clients were served by Level 4 and Level 5 programs, the decision was made to combine the expenditures for these levels of care. Additionally, Level 1 and Level 2 expenditures were combined because many of the programs included in these levels of care provide services to both Level 1 and Level 2 clients, making it difficult to credibly attribute expenditures to a single level of care.

CCBHS Mental Health expenditures for FY 15/16 were extracted from the Contra Costa County Auditor's Intranet Site by Organizational Number. When all programs within an Organizational Number fell within a single LOCUS/CALOCUS level of care, the total expenditures were assigned to the level of care. When programs within an Organizational Number aligned with different levels of care, expenditures were grouped by program and the program expenditures were assigned to the appropriate levels of care. Total expenditures were calculated for each level of care and compared to the FY 15/16 Expenditure Report for Department Code 0467 (CCBHS Mental Health) to ensure all costs were included. Approximately $25 was unaccounted for when adding up costs by level of care as compared to the FY 15/16 Expenditure Report. Because this discrepancy was insignificant, it was disregarded. Administrative costs were evenly distributed across each level of care (from 0 to 6). Expenditures for each

[9] Business logic describes the specific sequence of procedural steps required to extract data from the database. It is the programming that manages the communication between a user and a database.

[10] Mental Health Association in California. "A Model for California Community Mental Health Programs". 1981. Pages 27-29. Available at: http://histpubmh.semel.ucla.edu/sites/default/files/archival/d8485804_Doc_7._1981_California_Model.pdf .

LOCUS/CALOCUS level of care was divided by the total expenditures to calculate a percentage of expenditures for each level of care. This percentage was then compared to the benchmark for recommended expenditures for each level of care. When the CCBHS Mental Health percentage expenditures did not match the benchmark, the difference was noted. This comparison allowed over and under expenditures to be highlighted.

iii. Contra Costa Behavioral Health Services Staffing

To address the question, "is CCBHS adequately addressing its Mental Health Plan workforce needs?", psychiatry vacancies, psychiatrist salaries, staff demographics, and staff language capacity were analyzed.

Qualitative data gathered during previous community program planning processes and quality improvement activities indicated Contra Costa County struggles to fill and retain psychiatrist positions. To assess the validity of this finding, the total number of psychiatrist positions, both county and contract, were compared to filled positions as well as actual hours worked. To aid in identifying possible reasons for hiring challenges, psychiatric salary ranges were taken from the county human resource websites of Contra Costa County and its neighbors to determine if there is parity in compensation. High and low steps of each classification were averaged to determine the mid-range salary for each classification. Alameda County had five psychiatry classifications, Marin County had two classifications, San Francisco County had three classifications, and Solano County had four classifications. An average of each county's mid-range salaries was calculated using all relevant classifications. Note, Contra Costa County only had one relevant classification.

The qualitative data also indicated language as well as cultural barriers and staff demographics may have been impediments to care for underserved populations. To verify these findings with quantitative data, a study of staff demographics was taken from the Workforce Education and Training Plan study presented in the 2010 Cultural Competency Plan[11] and inserted into this report. Finally, the findings from a quality improvement study of the bilingual capacity of CCBHs Mental Health staff and interpretation use was inserted into this report.

III. Results

The results section below is divided into three parts. The first, *Prevalence, Numbers Served, and Penetration Rates*, addresses the question, "is CCBHS reaching the target population it is mandated to serve?" The second, *Spectrum of Services and Service Expenditures*, addresses the question, "is CCBHS apportioning its funding to ensure it is providing a full spectrum of mental health care and meeting established allocation benchmarks?" The third, *Contra Costa Behavioral Health Services Staffing*, addresses the question, "is CCBHS adequately addressing its Mental Health Plan workforce needs?"

i. Prevalence, Numbers Served, and Penetration Rates

[11] Contra Costa County Mental Health Services. "Cultural Competence Plan Three Year Plan Fiscal Year 2010-11, 2011-12, 2012-13". 2010 (Revised). Page 91. Available at: http://cchealth.org/mentalhealth/pdf/2010_cultural_competence_plan.pdf

Contra Costa County Mental Health Prevalence Rates

Table 1: Estimated Prevalence of Serious Mental Illness in Contra Costa County, Calendar Years 2013-2015 outlines the prevalence, or frequency, of serious mental illness among the total population of Contra Costa County.

Table 1: Estimated Prevalence of Serious Mental Illness in Contra Costa County, Calendar Years 2013-2015

Calendar Year	Total Population[12]	County Prevalence Rate for SMI (Total Population)[13]	Estimated Prevalence of SMI (Total Population)	Total Number Served by CCBHS Mental Health	Percent of Estimated Individuals with SMI Served by CCBHS Mental Health (All Mental Health Clients)
2013	1,095,959	4.26%	46,688	21,497	46.0%
2014	1,111,710		47,359	22,716	48.0%
2015	1,126,745		47,999	22,848	47.6%

The Contra Costa County prevalence rate for serious mental illness is 4.26 percent. In 2013, an estimated 46,688 individuals had a serious mental illness, the total number of individuals served by CCBHS Mental Health was 21,497, and the percent of estimated individuals with serious mental illness served by CCBHS Mental Health was 46.0 percent. In 2014, the percent of estimated individuals with serious mental illness served by CCBHS Mental Health increased to 48.0 percent. In 2015, the percent of estimated individuals with serious mental illness served by CCBHS Mental Health was 47.6 percent. CCBHS Mental Health consistently serves just under half of the estimated county population with serious mental illness.

However, CCBHS Mental Health is primarily responsible for providing mental health services to individuals with moderate to severe serious mental illness who are Medi-Cal eligible, indigent, or uninsured, not the entire population of individuals with serious mental illness. *Table 2: Estimated Prevalence of Serious Mental Illness in Contra Costa County for Households Below 200% Poverty, Calendar Years 2013-2015* outlines the prevalence of serious mental illness among households in Contra Costa County below 200% poverty, the target population for CCBHS Mental Health.

[12] United States Census. Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2015. 2015 Population Estimates. Available at: http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk . Accessed on 8/10/2016.

[13] Department of Health Care Services Task Team. "California Mental Health Prevalence Estimates". 2012. Available at: http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf . Accessed on 8/10/2016.

Table 2: Estimated Prevalence of Serious Mental Illness in Contra Costa County for Households Below 200% Poverty, Calendar Years 2013-2015							
Calendar Year	**Population Households Below 200% Poverty**[14]	**County Prevalence Rate for SMI (Households Below 200% Poverty)**[15]	**Estimated Prevalence of SMI (Households Below 200% Poverty)**	**Total Number Served by CCBHS Mental Health**	**Percent of Estimated Individuals with SMI Served by CCBHS Mental Health (All Mental Health Clients)**	**Total MediCal Clients Served by CCBHS**	**Percent of Estimated Individuals with SMI Served by CCBHS Mental Health (MediCal Clients)**
2013	237,823	8.13%	19,335	21,497	111.2%	14,886	77.0%
2014	241,241		19,613	22,716	115.8%	18,889	96.3%
2015	244,504		19,878	22,848	114.9%	19,733	99.3%

Low income populations have greater prevalence of serious mental illness than the general population, 8.13 percent in Contra Costa County. In 2013, the estimated number of individuals below 200 percent poverty with serious mental illness was 19,335, the total number of individuals served by CCBHS Mental health was 21,497, and the percent of estimated number of individuals below 200 percent poverty with serious mental illness served by CCBHS Mental Health was 111.2 percent. In 2014, the percent of estimated number of individuals below 200 percent poverty with serious mental illness served by CCBHS Mental Health increased to 115.8 percent. In 2015, the percent of estimated number of individuals below 200 percent poverty with serious mental illness served by CCBHS Mental Health was 114.9 percent. CCBHS consistently served more than 100 percent of the estimated number of individuals with serious mental illness who were below 200 percent poverty. If one only considers clients eligible for MediCal, the percent of estimated number of individuals below 200 percent poverty with serious mental illness served by CCBHS increased from 77.0 percent in 2013 to 99.3 percent in 2015. Note, while the number of individuals with MediCal eligibility served by CCBHS Mental Health increased, from 14,886 in 2013 to 19,733 in 2015, there was still a proportion of clients who were uninsured.

Contra Costa County Penetration Rates

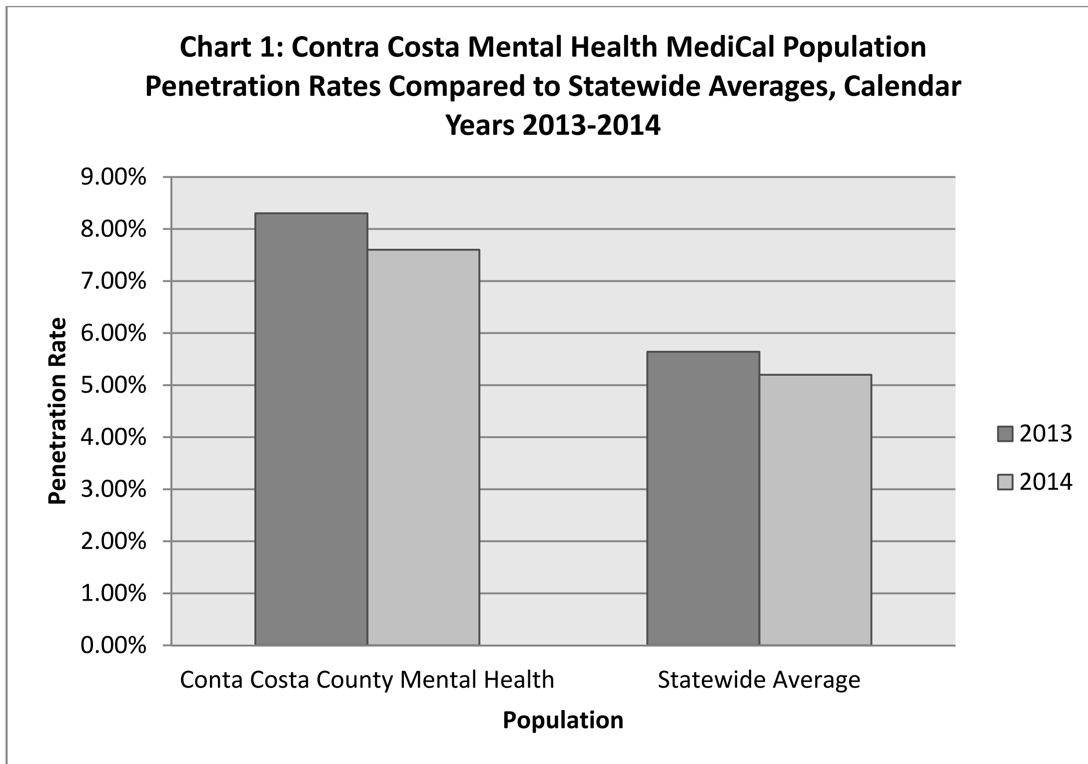
CCBHS Mental Health penetration rates, the percentage of individuals' eligible for services actually served by CCBHS Mental Health, were compared to statewide averages for the same populations to determine if CCBHS Mental Health is serving a similar proportion of clients as other counties in

[14] Healthcare Workforce Development Division of Office of Statewide Health Planning and Development. "Medical Service Study Areas (MSSA)". 2013. Available at: http://www.oshpd.ca.gov/hwdd/MSSA/index.html . Accessed on 8/10/2016.

[15] Department of Health Care Services Task Team. "California Mental Health Prevalence Estimates". 2012. Available at: http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf . Accessed on 8/10/2016.

California. *Table 3 and Chart 1: Contra Costa Mental Health MediCal Population Penetration Rates Compared to Statewide Averages, Calendar Years 2013-2014*, outline overall county penetration rates.

Table 3: Contra Costa Mental Health MediCal Population Penetration Rates Compared to Statewide Averages, Calendar Years 2013-2014				
Calendar Year	**Number MediCal Eligible Population Served by Mental Health**	**MediCal Eligible Population, Countywide**	**Penetration Rate**	**Statewide Average Penetration Rate[16]**
2013	15,341	185,417	8.3%	5.64%
2014	19,343	254,658	7.6%	5.2%



The CCBHS Mental Health penetration rates for the MediCal population in 2013, 8.3 percent, and 2014, 7.6 percent, were greater than the statewide average penetration rates for the same population, 5.64 percent and 5.2 percent respectively.

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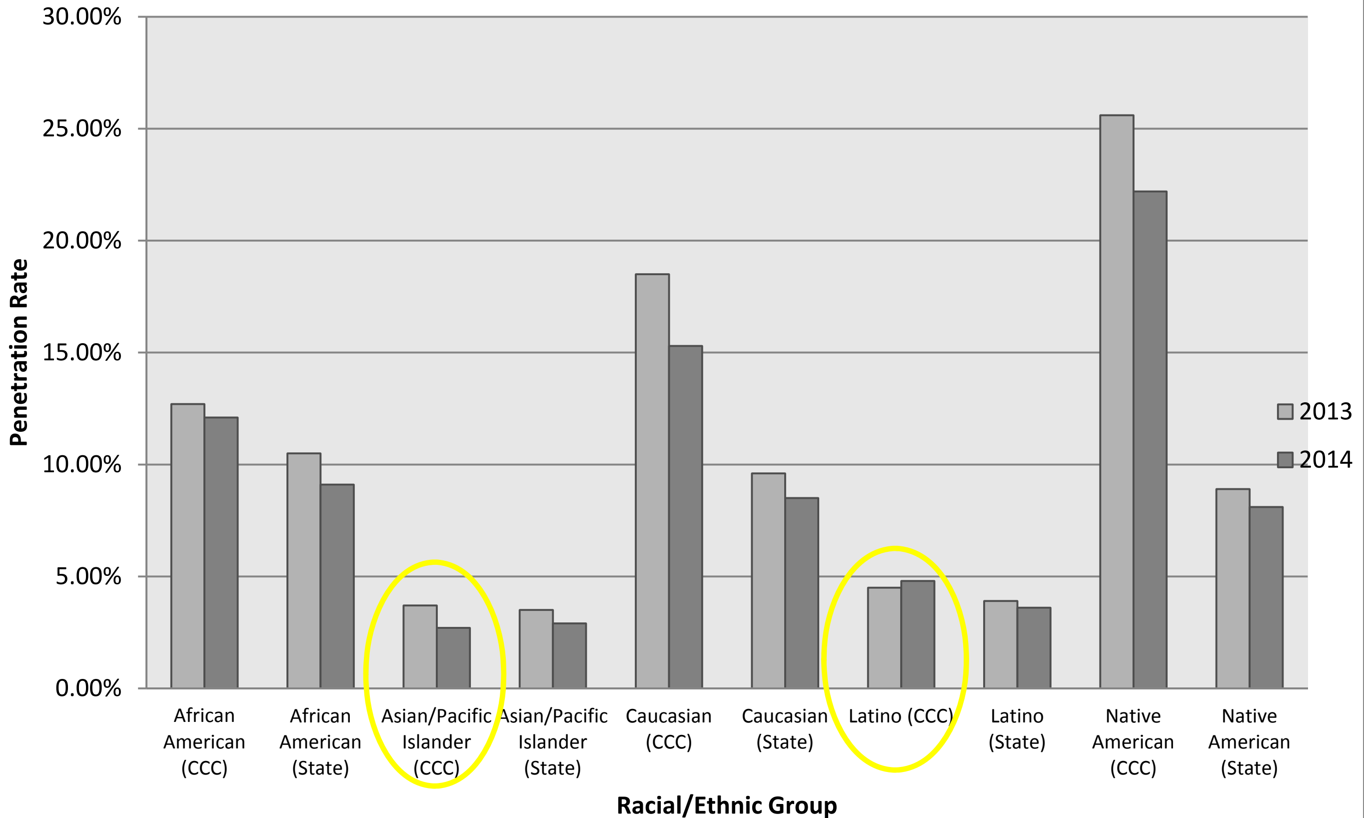
[16] APS Healthcare. "Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2013". 2014. And Behavioral Health Concepts. "Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2014". 2015.

Next, penetration rates were compared by racial/ethnic group and compared to statewide averages for the same populations (*Table 4: Contra Costa Mental Health MediCal Population Penetration Rates by Racial/Ethnic Group, Calendar Years 2013-2015 and Chart 2: Contra Costa Mental Health MediCal Population Penetration Rates by Racial/Ethnic Group, Calendar Years 2013-2014*).

Table 4: Contra Costa Mental Health MediCal Population Penetration Rates by Racial/Ethnic Group, Calendar Years 2013-2015

Race/Ethnicity	Calendar Year	Number MediCal Eligible Population Served by Mental Health	MediCal Eligible Population, Countywide	Penetration Rate for Racial/Ethnic Group	Statewide Average Penetration Rate for Racial/Ethnic Group[17]
African American					
	2013	4,248	33,526	12.7%	10.5%
	2014	4,963	41,104	12.1%	9.1%
	2015	5,085	45,445	11.2%	
Asian/Pacific Islander					
	2013	776	20,996	3.7%	3.5%
	2014	1,028	37,743	2.7%	2.9%
	2015	1,110	44,862	2.5%	
Caucasian					
	2013	6,091	32,907	18.5%	9.6%
	2014	8,021	52,433	15.3%	8.5%
	2015	8,587	59,085	14.5%	
Latino					
	2013	3,280	72,503	4.5%	3.9%
	2014	4,032	84,244	4.8%	3.6%
	2015	4,518	90,490	5.0%	
Native American					
	2013	154	601	25.6%	8.9%
	2014	178	801	22.2%	8.1%
	2015	191	934	20.4%	
Other					
	2013	327	15,415	2.1%	5.9%
	2014	436	26,139	1.7%	6.1%
	2015	441	32,116	1.4%	
Unknown					
	2013	465	9,469	4.9%	
	2014	685	12,194	5.6%	
	2015	725	12,479	5.8%	
Total					
	2013	15,341	185,417	8.3%	5.64%
	2014	19,343	254,658	7.6%	5.2%
	2015	20,657	285,411	7.2%	

[17] APS Healthcare. “Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2013”. 2014. And Behavioral Health Concepts. “Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2014”. 2015.

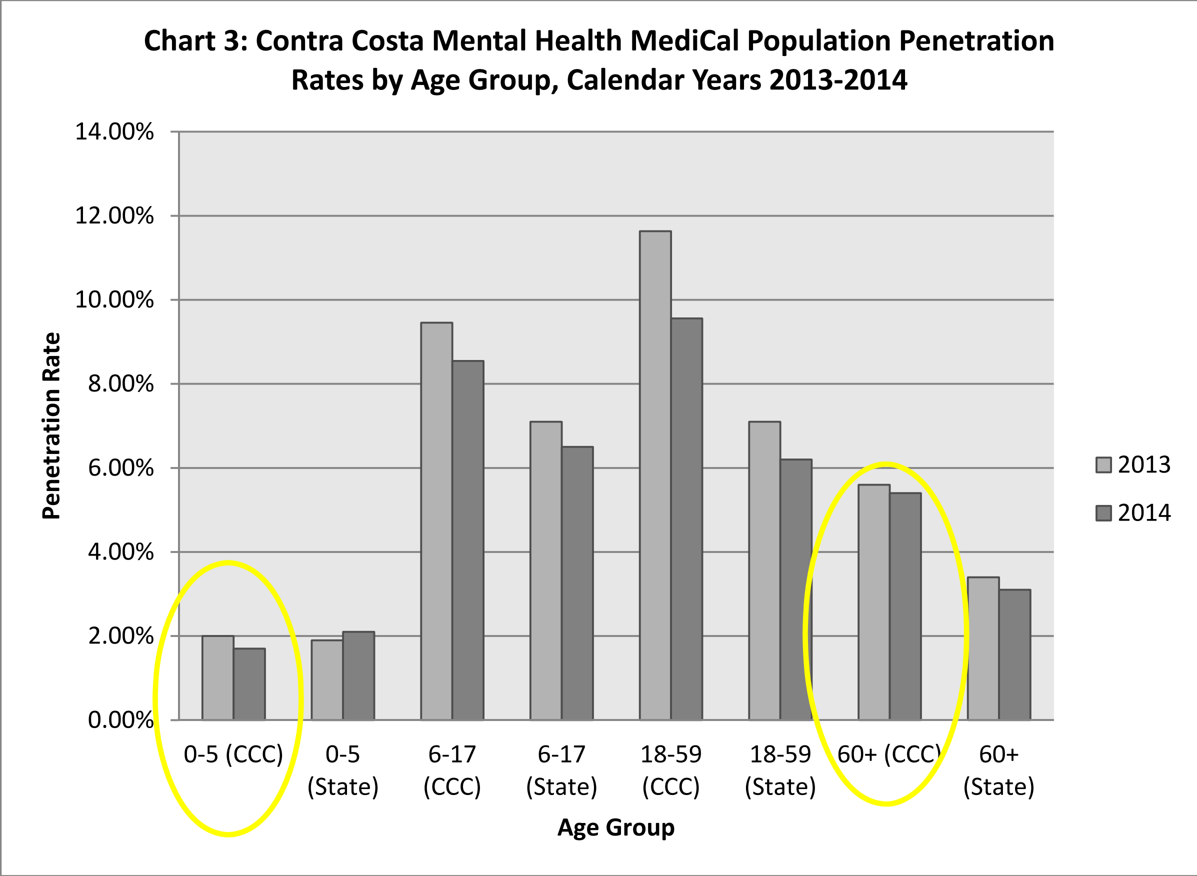


With the exception of the "Other" population, which is comprised of individuals of mixed race/ethnicity as well as individuals who identify with a racial/ethnic group not listed in the table and whose composition varies from county to county, CCBHS Mental Health penetration rates for racial/ethnic groups were greater than or equal to the statewide average penetration rates for the same groups. The Caucasian (18.5 percent in 2013, 15.3 percent in 2014, and 14.5 percent in 2015) and Native American (25.6 percent in 2013, 22.2 percent in 2014, and 20.4 percent in 2015) populations had the highest penetration rates in Contra Costa County. The Asian/Pacific Islander (3.7 percent in 2013, 2.7 percent in 2014, and 2.5 percent in 2015) and Latino (4.5 percent in 2013, 4.8 percent in 2014, and 5.0 percent in 2015) populations had the lowest penetration rates among the racial/ethnic groups. Penetration rates at the local and state level decreased between 2013 and 2015, likely due to the increase in individuals eligible for MediCal as part of the Medicaid expansion.

Contra Costa Mental Health penetration rates were then compared by age group and compared to statewide averages for the same populations (*Table 5: Contra Costa Mental Health MediCal Population Penetration Rates by Age Group, Calendar Years 2013-2015 and Chart 3: Contra Costa Mental Health MediCal Population Penetration Rates by Age Group, Calendar Years 2013-2014*).

Table 5: Contra Costa Mental Health MediCal Population Penetration Rates by Age Group, Calendar Years 2013-2015					
Age Group	**Calendar Year**	**Number MediCal Eligible Population Served by Mental Health**	**MediCal Eligible Population, Countywide**	**Penetration Rate for Age Group**	**Statewide Average Penetration Rate for Age Group**[18]
0-5					
	2013	770	37,853	2.0%	1.9%
	2014	698	39,910	1.7%	2.1%
	2015	743	38,844	1.9%	
6-12					**6-17**
	2013	2,428	32,789	7.4%	7.1%
	2014	2,521	38,106	6.6%	6.5%
	2015	2,575	37,566	6.9%	
13-17					
	2013	2,547	19,817	12.9%	
	2014	2,794	24,080	11.6%	
	2015	2,876	23,656	12.1%	
18-21					**18-59**
	2013	891	10,852	8.2%	7.1%
	2014	1,109	15,841	7.0%	6.2%
	2015	1,214	18,036	6.7%	
22-59					
	2013	7,348	59,965	12.3%	
	2014	10,594	106,587	9.9%	
	2015	11,422	132,828	8.6%	
60+					
	2013	1,357	24,141	5.6%	3.4%
	2014	1,627	30,134	5.4%	3.1%
	2015	1,827	34,481	5.3%	
Total					
	2013	15,341	185,417	8.3%	5.64%
	2014	19,343	254,658	7.6%	5.2%
	2015	20,657	285,411	7.2%	

[18] APS Healthcare. "Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2013". 2014. And Behavioral Health Concepts. "Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2014". 2015.

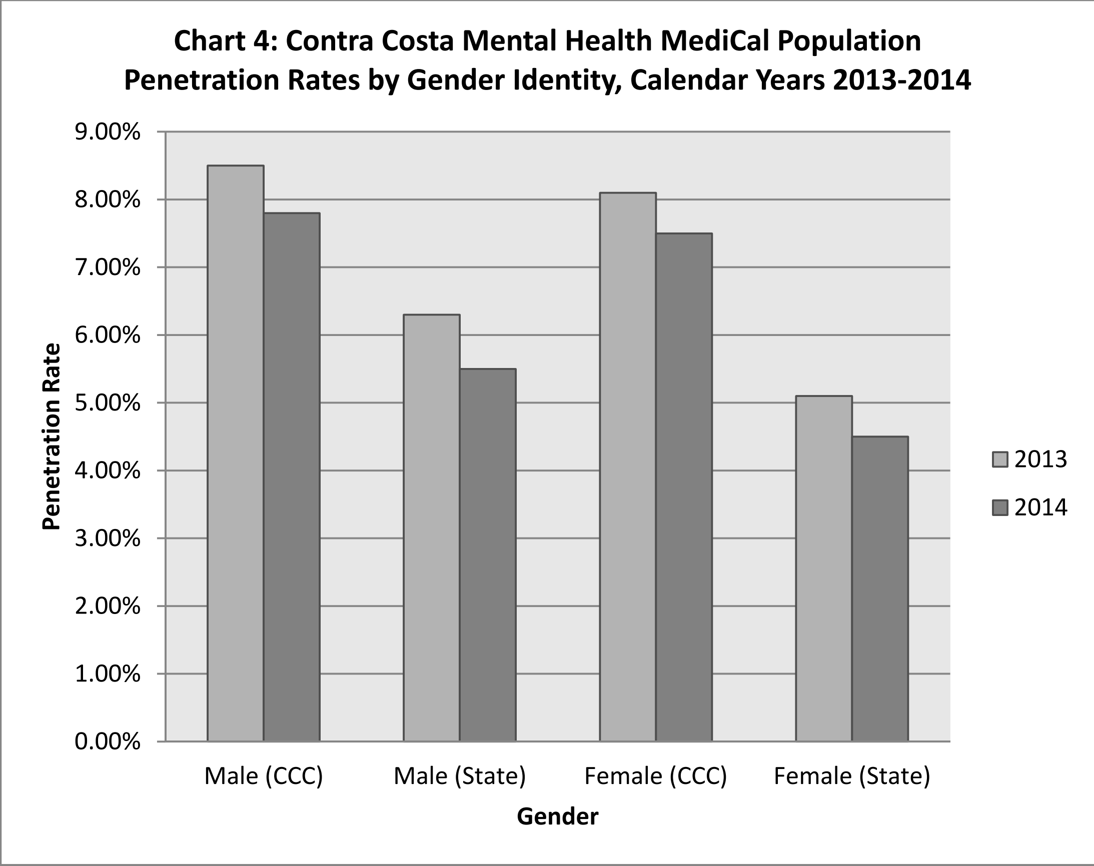


For all but one population, the 0 to 5 in 2014, CCBHS Mental Health penetration rates for all age groups were greater than the statewide average penetration rates for the same groups. The 13 to 17 (12.9 percent in 2013, 11.6 percent in 2014, and 12.1 percent in 2015) and 22 to 59 (12.3 percent in 2013, 9.9 percent in 2014, and 8.6 percent in 2015) populations had the highest penetration rates in Contra Costa County. The 0 to5 (2.0 percent in 2013, 1.7 percent in 2014, and 1.9 percent in 2015) and 60+ (5.6 percent in 2013, 5.4 percent in 2014, and 5.3 percent in 2015) populations had the lowest penetration rates among the age groups. Penetration rates at the local and state level decreased between 2013 and 2015, likely due to the increase in individuals eligible for MediCal as part of the Medicaid expansion.

Contra Costa Mental Health penetration rates were compared by gender group and compared to statewide averages for the same populations (*Table 6: Contra Costa Mental Health MediCal Population Penetration Rates by Gender Identity, Calendar Years 2013-2015 and Chart 4: Contra Costa Mental Health MediCal Population Penetration Rates by Gender Identity, Calendar Years 2013-2014*).

Table 6: Contra Costa Mental Health MediCal Population Penetration Rates by Gender Identity, Calendar Years 2013-2015					
Gender Identity	**Calendar Year**	**Number MediCal Eligible Population Served by Mental Health**	**MediCal Eligible Population, Countywide**	**Penetration Rate for Gender Group**	**Statewide Average Penetration Rate for Gender[19]**
Male					
	2013	6,884	81,046	8.5%	6.3%
	2014	8,954	115,386	7.8%	5.5%
	2015	9,555	130,244	7.3%	
Female					
	2013	8,457	104,371	8.1%	5.1%
	2014	10,388	139,272	7.5%	4.5%
	2015	11,100	155,167	7.2%	
Unknown					
	2013	0	0	N/A	
	2014	1	0	N/A	
	2015	2	0	N/A	
Total					
	2013	15,341	185,417	8.3%	5.64%
	2014	19,343	254,658	7.6%	5.2%
	2015	20,657	285,411	7.2%	

[19] APS Healthcare. “Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2013”. 2014. And Behavioral Health Concepts. “Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2014”. 2015.



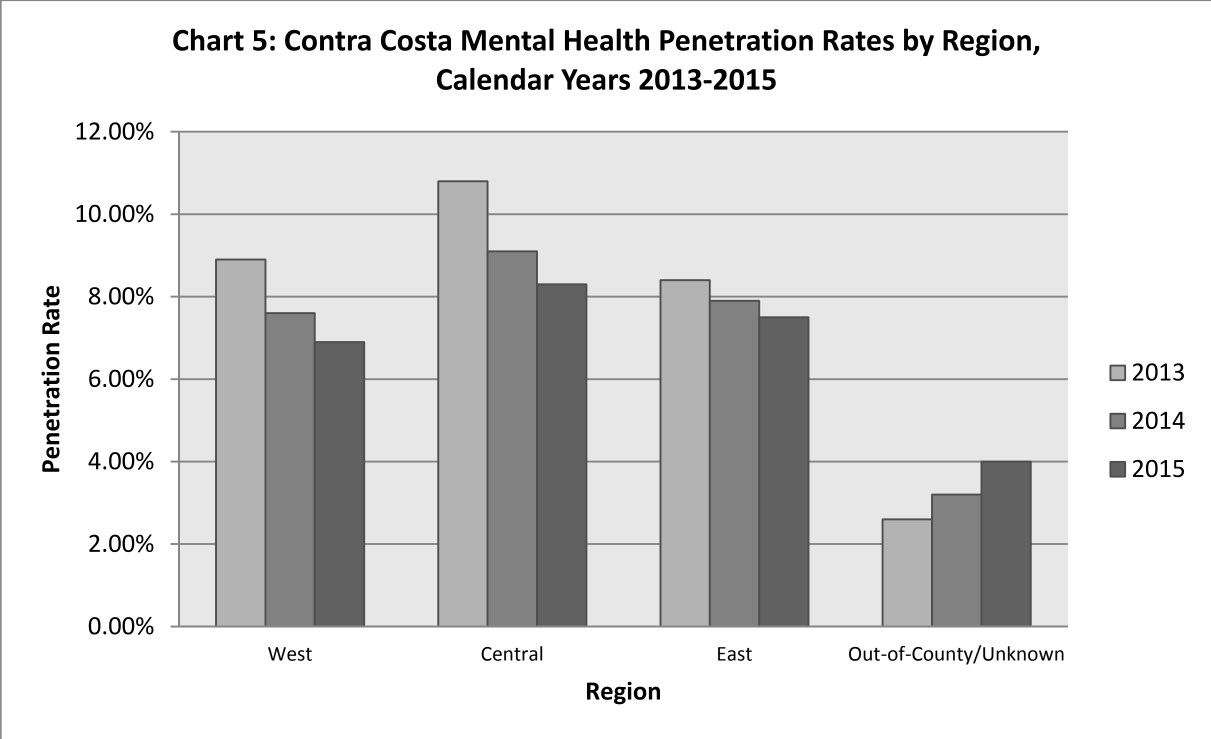
The penetration rate for the Male population was 8.5 percent in 2013, 7.8 percent in 2014, and 7.3 percent in 2015. The statewide penetration rate for the Male population was 6.3 percent in 2013, and 5.4 percent in 2014. The penetration rate for the Female population was 8.1 percent in 2013, 7.5 percent in 2014, and 7.2 percent in 2015. The statewide penetration rate for the Female population was 5.1 percent in 2013, and 4.5 percent in 2014.

CCBHS Mental Health penetration rates for all gender groups were greater than the statewide average penetration rates for the same groups. The Male and Female populations had similar penetration rates in Contra Costa County, with Females being served at a slightly lower rate than Males. Penetration rates at the local and state level decreased between 2013 and 2015, likely due to the increase in individuals eligible for MediCal as part of the Medicaid expansion.

Finally, Contra Costa Mental Health penetration rates were compared by region and compared to statewide averages (*Table 7 and Chart 5: Contra Costa Mental Health MediCal Population Penetration Rates by Region, Calendar Years 2013-2015*).

Table 7: Contra Costa Mental Health MediCal Population Penetration Rates by Region, Calendar Years 2013-2015					
Region	**Calendar Year**	**Number MediCal Eligible Population Served by Mental Health**	**MediCal Eligible Population, Countywide**	**Penetration Rate**	**Statewide Average Penetration Rate[20]**
West					
	2013	4,642	52,142	8.9%	5.64%
	2014	5,524	72,274	7.6%	5.2%
	2015	5,759	83,531	6.9%	
Central					
	2013	4,127	38,220	10.8%	5.64%
	2014	5,459	60,012	9.1%	5.2%
	2015	5,820	69,974	8.3%	
East					
	2013	5,925	70,607	8.4%	5.64%
	2014	7,501	95,163	7.9%	5.2%
	2015	8,104	107,788	7.5%	
Out-of-County/ Unknown					
	2013	647	24,448	2.6%	
	2014	859	27,209	3.2%	
	2015	974	24,118	4.0%	
Total					
	2013	15,341	185,417	8.3%	5.64%
	2014	19,343	254,658	7.6%	5.2%
	2015	20,657	285,411	7.2%	

[20] APS Healthcare. "Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2013". 2014. And Behavioral Health Concepts. "Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2014". 2015.



The penetration rate for the West County population was 8.9 percent in 2013, 7.6 percent in 2014, and 6.9 percent in 2015. The penetration rate for the Central County population was 10.8 percent in 2013, 9.1 percent in 2014, and 8.3 percent in 2015. The penetration rate for the East County population was 8.4 percent in 2013, 7.9 percent in 2014, and 7.5 percent in 2015. The penetration rate for the Out-of-County/Unknown population was 2.6 percent in 2013, 3.2 percent in 2014, and 4.0 percent in 2015.

CCBHS Mental Health penetration rates for all regions of the county were greater than the statewide average penetration rates for the same groups. The Central County region had the highest penetration rates in Contra Costa County, while the East County region had the lowest penetration rates; however, all regional penetration rates were within a few percentage points of each other. Penetration rates at the local and state level decreased between 2013 and 2015, likely due to the increase in individuals eligible for MediCal as part of the Medicaid expansion.

In order to determine if there are differences within sub-populations of each region of the county, CCBHS Mental Health regional penetration rates were analyzed by racial/ethnic group and age group. These penetration rates were then compared to county as well as statewide average rates for the same populations. The results for each region of the county are outlined below.

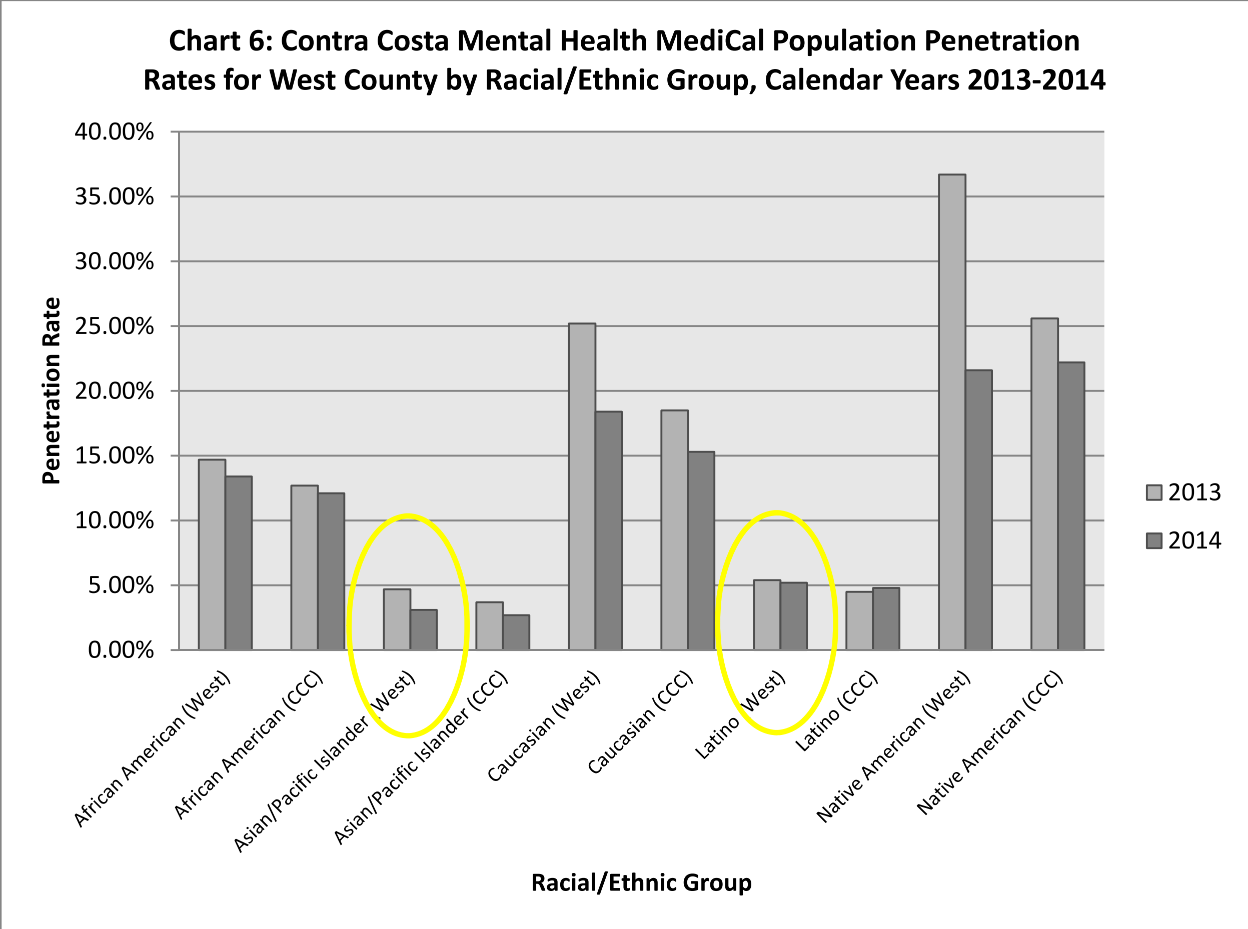
West County Penetration Rates

CCBHS Mental Health penetration rates for West County were compared by racial/ethnic group and compared to county penetration rates and statewide averages for the same populations (*Table 8: Contra Costa Mental Health MediCal Population Penetration Rates for West County by Racial/Ethnic Group, Calendar Years 2013-2015 and Chart 6: Contra Costa Mental Health MediCal Population Penetration Rates for West County by Racial/Ethnic Group, Calendar Years 2013-2014*).

Table 8: Contra Costa Mental Health MediCal Population Penetration Rates for West County by Racial/Ethnic Group, Calendar Years 2013-2015

Race/Ethnicity	Calendar Year	Number MediCal Eligible Population Served by Mental Health, West County	MediCal Eligible Population, West County	Penetration Rate	County Penetration Rate for Racial/ Ethnic Group	Statewide Average Penetration Rate for Racial/ Ethnic Group[21]
African American						
	2013	1,719	11,657	14.7%	12.7%	10.5%
	2014	2,020	15,079	13.4%	12.1%	9.1%
	2015	1,974	17,174	11.5%	11.2%	
Asian/Pacific Islander						
	2013	328	7,011	4.7%	3.7%	3.5%
	2014	405	12,859	3.1%	2.7%	2.9%
	2015	409	15,661	2.6%	2.5%	
Caucasian						
	2013	1,025	4,075	25.2%	18.5%	9.6%
	2014	1,280	6,955	18.4%	15.3%	8.5%
	2015	1,356	8,157	16.6%	14.5%	
Latino						
	2013	1,252	23,307	5.4%	4.5%	3.9%
	2014	1,438	27,743	5.2%	4.8%	3.6%
	2015	1,618	30,889	5.2%	5.0%	
Native American						
	2013	47	128	36.7%	25.6%	8.9%
	2014	40	185	21.6%	22.2%	8.1%
	2015	51	233	21.9%	20.4%	
Other						
	2013	82	3,680	2.3%	2.1%	5.9%
	2014	114	6,456	1.8%	1.7%	6.1%
	2015	109	8,232	1.3%	1.4%	
Unknown						
	2013	189	2,284	8.3%	4.9%	
	2014	227	2,997	7.6%	5.6%	
	2015	242	3,185	7.6%	5.8%	
Total (Region)						
	2013	4,642	52,142	8.9%		5.64%
	2014	5,524	72,274	7.6%		5.2%
	2015	5,759	83,531	6.9%		

[21] APS Healthcare. "Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2013". 2014. And Behavioral Health Concepts. "Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2014". 2015.

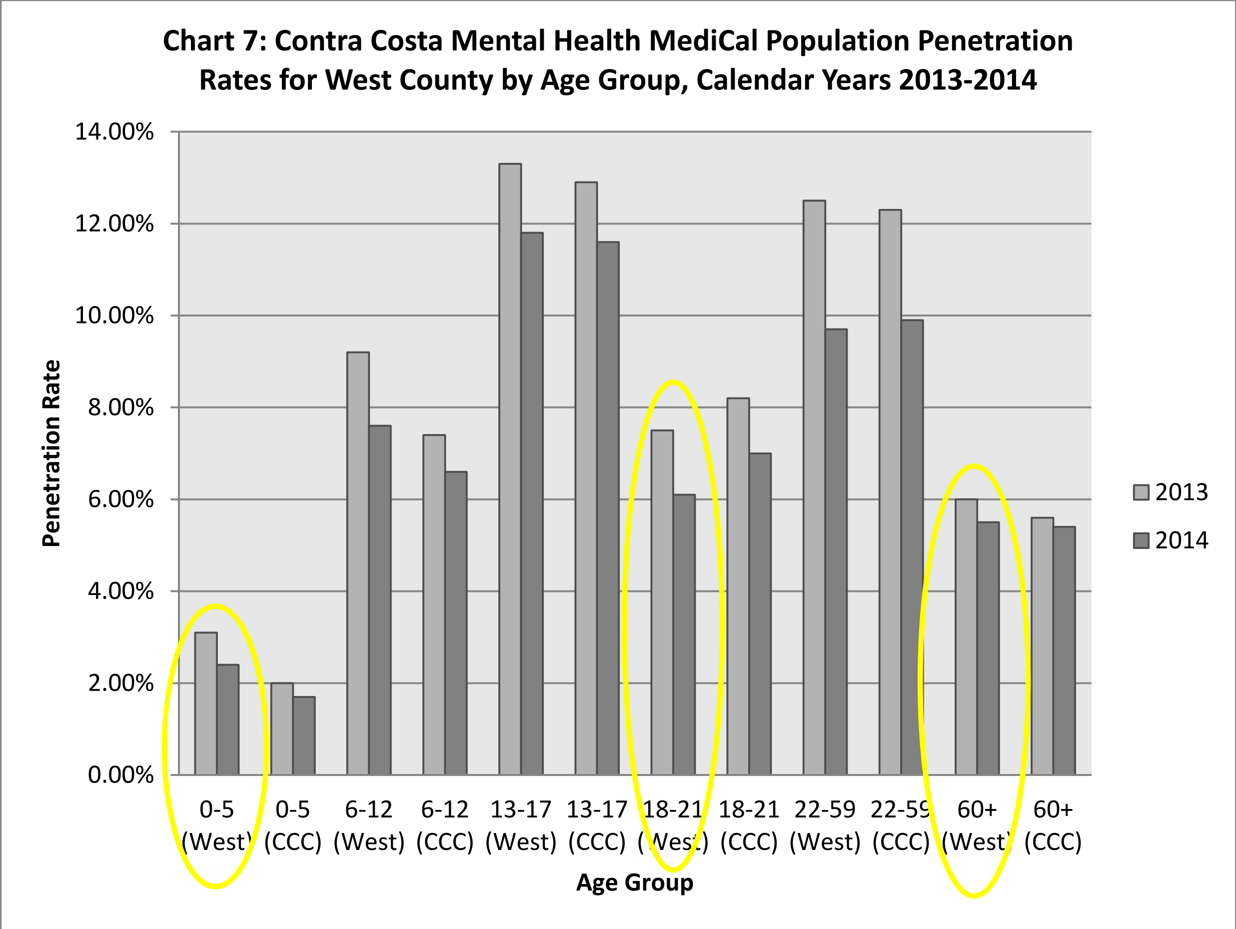


With the exception of the "Other" population, which is comprised of individuals of mixed race/ethnicity as well as individuals who identify with a racial/ethnic group not listed in the table, West County penetration rates for racial/ethnic groups were greater than or equal to the CCBHS Mental Health penetration rates. The Caucasian (25.2 percent in 2013, 18.4 percent in 2014, and 16.6 in 2015) and Native American (36.7 percent in 2013, 21.6 percent in 2014, and 21.9 percent in 2015) populations had the highest penetration rates in West County. The Asian/Pacific Islander (4.7 percent in 2013, 3.1 percent in 2014, and 2.6 percent in 2015) and Latino (5.4 percent in 2013, 5.2 percent in 2014, and 5.2 percent in 2015) populations had the lowest penetration rates among the racial/ethnic groups in West County.

CCBHS Mental Health penetration rates for West County were compared by age group and compared to CCBHS Mental Health and statewide average penetration rates for the same populations (*Table 9: Contra Costa Mental Health MediCal Population Penetration Rates for West County by Age Group, Calendar Years 2013-2015 and Chart 7: Contra Costa Mental Health MediCal Population Penetration Rates for West County by Age Group, Calendar Years 2013-2014*).

Table 9: Contra Costa Mental Health MediCal Population Penetration Rates for West County by Age Group, Calendar Years 2013-2015						
Age Group	**Calendar Year**	**Number MediCal Eligible Population Served by Mental Health, West County**	**MediCal Eligible Population, West County**	**Penetration Rate**	**County Penetration Rate for Age Group**	**Statewide Average Penetration Rate for Age Group[22]**
0-5						
	2013	344	10,939	3.1%	2.0%	1.9%
	2014	284	11,901	2.4%	1.7%	2.1%
	2015	294	11,902	2.5%	1.9%	
6-12						**6-17**
	2013	858	9,331	9.2%	7.4%	7.1%
	2014	839	10,974	7.6%	6.6%	6.5%
	2015	880	11,297	7.8%	6.9%	
13-17						
	2013	735	5,520	13.3%	12.9%	
	2014	795	6,712	11.8%	11.6%	
	2015	783	6,916	11.3%	12.1%	
18-21						**18-59**
	2013	222	2,953	7.5%	8.2%	7.1%
	2014	265	4,371	6.1%	7.0%	6.2%
	2015	287	5,082	5.6%	6.7%	
22-59						
	2013	2,070	16,505	12.5%	12.3%	
	2014	2,862	29,581	9.7%	9.9%	
	2015	2,979	38,167	7.8%	8.6%	
60+						
	2013	413	6,894	6.0%	5.6%	3.4%
	2014	479	8,735	5.5%	5.4%	3.1%
	2015	536	10,167	5.3%	5.3%	
Total (Region)						
	2013	4,642	52,142	8.9%		5.64%
	2014	5,524	72,274	7.6%		5.2%
	2015	5,759	83,531	6.9%		

[22] APS Healthcare. “Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2013”. 2014. And Behavioral Health Concepts. “Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2014”. 2015.



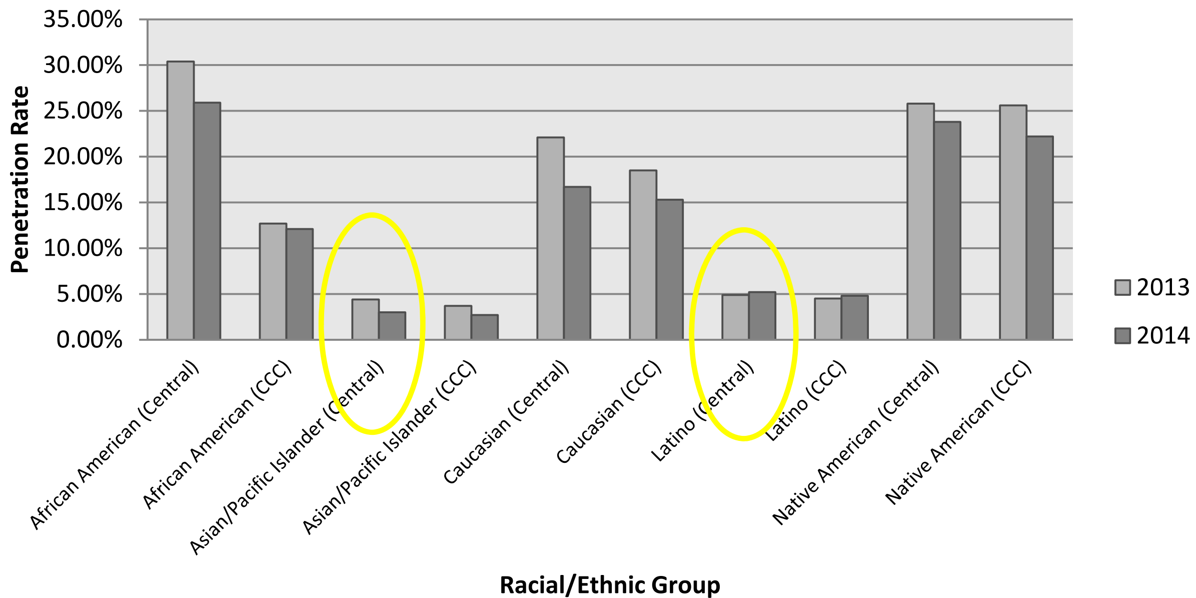
For all but the 18 to 21 and 22 to 59 populations, the West County penetration rates were greater than or equal to the CCBHS Mental Health penetration rates for the same age groups. That being said, the 18 to 21 and 22 to 59 penetration rates in West County are within a percentage point of the county penetration rates for the same age groups. The 13 to 17 (13.3 percent in 2013, 11.8 percent in 2014, and 11.3 percent in 2015) and 22 to 59 (12.5 percent in 2013, 9.7 percent in 2014, and 7.8 percent in 2015) populations had the highest penetration rates in West County, while the 0 to5 (3.1 percent in 2013, 2.4 percent in 2014, and 2.5 percent in 2015) and 60+ (6.0 percent in 2013, 5.5 percent in 2014, and 5.3 percent in 2015) populations had the lowest penetration rates among the age groups in West County.

Central County Penetration Rates

CCBHS Mental Health penetration rates for Central County were compared by racial/ethnic group and compared to county penetration rates and statewide averages for the same populations (*Table 10: Contra Costa Mental Health MediCal Population Penetration Rates for Central County by Racial/Ethnic Group, Calendar Years 2013-2015 and Chart 8: Contra Costa Mental Health MediCal Population Penetration Rates for Central County by Racial/Ethnic Group, Calendar Years 2013-2014*).

Table 10: Contra Costa Mental Health MediCal Population Penetration Rates for Central County by Racial/Ethnic Group, Calendar Years 2013-2015						
Race/Ethnicity	**Calendar Year**	**Number MediCal Eligible Population Served by Mental Health, Central County**	**MediCal Eligible Population, Central County**	**Penetration Rate**	**County Penetration Rate for Racial/Ethnic Group**	**Statewide Average Penetration Rate for Racial/ Ethnic Group[23]**
African American						
	2013	526	1,729	30.4%	12.7%	10.5%
	2014	609	2,347	25.9%	12.1%	9.1%
	2015	617	2,813	21.9%	11.2%	
Asian/Pacific Islander						
	2013	228	5,141	4.4%	3.7%	3.5%
	2014	299	9,924	3.0%	2.7%	2.9%
	2015	339	12,078	2.8%	2.5%	
Caucasian						
	2013	2,473	11,195	22.1%	18.5%	9.6%
	2014	3,371	20,217	16.7%	15.3%	8.5%
	2015	3,573	23,921	14.9%	14.5%	
Latino						
	2013	654	13,256	4.9%	4.5%	3.9%
	2014	819	15,756	5.2%	4.8%	3.6%
	2015	905	17,084	5.3%	5.0%	
Native American						
	2013	41	159	25.8%	25.6%	8.9%
	2014	50	210	23.8%	22.2%	8.1%
	2015	44	247	17.8%	20.4%	
Other						
	2013	119	4,527	2.6%	2.1%	5.9%
	2014	165	8,416	2.0%	1.7%	6.1%
	2015	176	10,487	1.7%	1.4%	
Unknown						
	2013	86	2,213	3.9%	4.9%	
	2014	146	3,142	4.6%	5.6%	
	2015	166	3,344	5.0%	5.8%	
Total (Region)						
	2013	4,127	38,220	10.8%		5.64%
	2014	5,459	60,012	9.1%		5.2%
	2015	5,820	69,974	8.3%		

[23] APS Healthcare. “Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2013”. 2014. And Behavioral Health Concepts. “Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2014”. 2015.

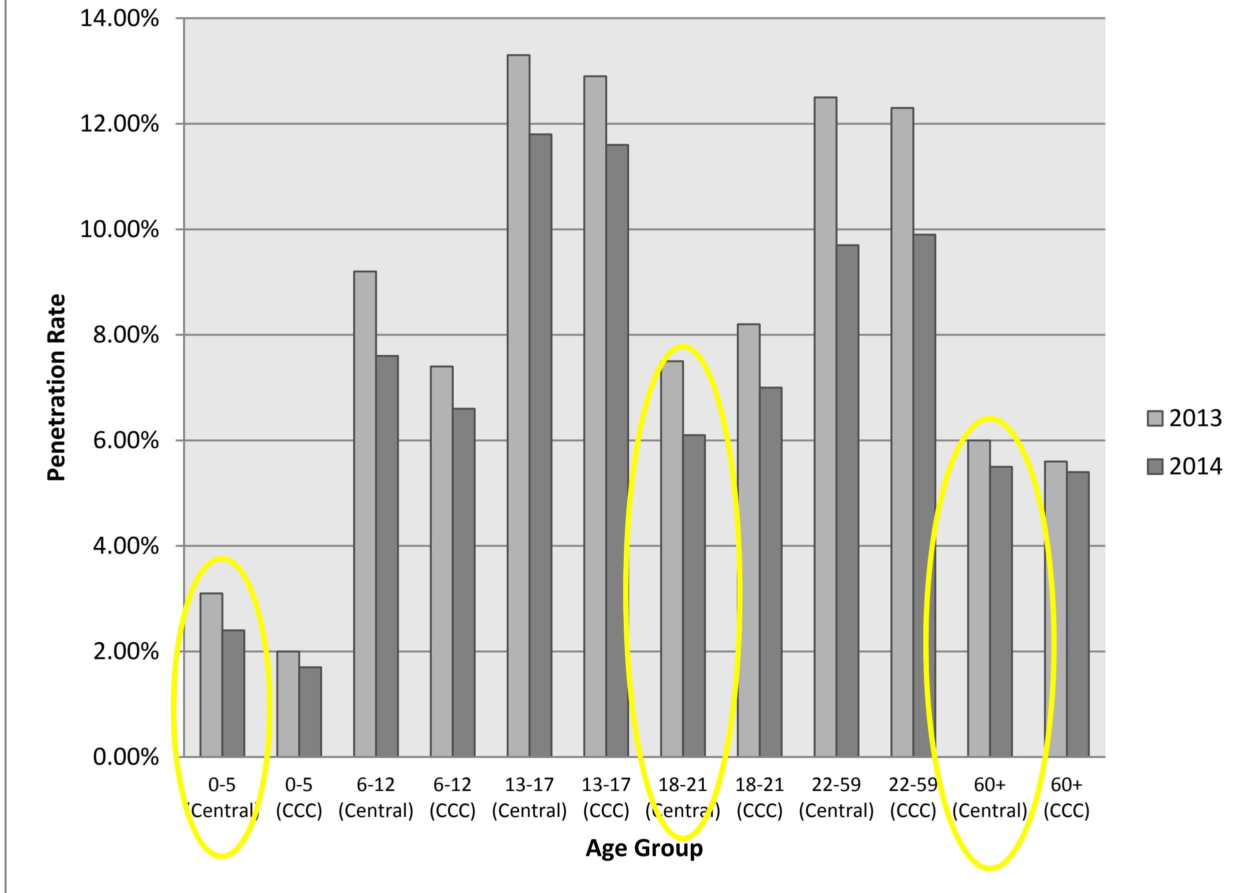


With the exception of the "Other" population, which is comprised of individuals of mixed race/ethnicity as well as individuals who identify with a racial/ethnic group not listed in the table, and the Native American population in 2015, Central County penetration rates for racial/ethnic groups were greater than or equal to the CCBHS Mental Health penetration rates for the same groups. The African American (30.4 percent in 2013, 25.9 percent in 2014, and 21.9 percent in 2015) and Native American (25.8 percent in 2013, 23.8 percent in 2014, and 17.8 percent in 2015) populations had the highest penetration rates in Central County. The Asian/Pacific Islander (4.4 percent in 2013, 3.0 percent in 2014, and 2.8 percent in 2015) and Latino (4.9 percent in 2013, 5.2 percent in 2014, and 5.3 percent in 2015) populations had the lowest penetration rates among the racial/ethnic groups in Central County.

CCBHS Mental Health penetration rates for Central County were compared by age group and compared to CCBHS Mental Health and statewide average penetration rates for the same populations (*Table 11: Contra Costa Mental Health MediCal Population Penetration Rates for Central County by Age Group, Calendar Years 2013-2015 and Chart 9: Contra Costa Mental Health MediCal Population Penetration Rates for Central County by Age Group, Calendar Years 2013-2014*).

Table 11: Contra Costa Mental Health MediCal Population Penetration Rates for Central County by Age Group, Calendar Years 2013-2015						
Age Group	**Calendar Year**	**Number MediCal Eligible Population Served by Mental Health, Central County**	**MediCal Eligible Population, Central County**	**Penetration Rate**	**County Penetration Rate for Age Group**	**Statewide Average Penetration Rate for Age Group**[24]
0-5						
	2013	120	6,789	1.8%	2.0%	1.9%
	2014	121	7,687	1.6%	1.7%	2.1%
	2015	127	7,620	1.7%	1.9%	
6-12						**6-17**
	2013	493	6,057	8.1%	7.4%	7.1%
	2014	515	7,793	6.6%	6.6%	6.5%
	2015	514	7,667	6.7%	6.9%	
13-17						
	2013	695	3,787	18.4%	12.9%	
	2014	722	5,252	13.7%	11.6%	
	2015	768	5,069	15.2%	12.1%	
18-21						**18-59**
	2013	256	1,797	14.2%	8.2%	7.1%
	2014	336	3,199	10.5%	7.0%	6.2%
	2015	364	3,867	9.4%	6.7%	
22-59						
	2013	2,114	12,293	17.2%	12.3%	
	2014	3,215	26,392	12.2%	9.9%	
	2015	3,450	34,502	10.0%	8.6%	
60+						
	2013	449	7,497	6.0%	5.6%	3.4%
	2014	550	9,689	5.7%	5.4%	3.1%
	2015	597	11,249	5.3%	5.3%	
Total (Region)						
	2013	4,127	38,220	10.8%		5.64%
	2014	5,459	60,012	9.1%		5.2%
	2015	5,820	69,974	8.3%		

[24] APS Healthcare. "Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2013". 2014. And Behavioral Health Concepts. "Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2014". 2015.



For all but the 0 to 5 population, the Central County penetration rates were greater than or equal to the CCBHS Mental Health penetration rates for the same age groups. The 13 to 17 (18.4 percent in 2013, 13.7 percent in 2014, and 15.2 percent in 2015) and 22 to 59 (17.2 percent in 2013, 12.2 percent in 2014, and 10.0 percent in 2015) populations had the highest penetration rates in Central County. The 0 to5 (1.8 percent in 2013, 1.6 percent in 2014, and 1.7 percent in 2015) and 60+ (6.0 percent in 2013, 5.7 percent in 2014, and 5.3 percent in 2015) populations had the lowest penetration rates among the age groups in Central County.

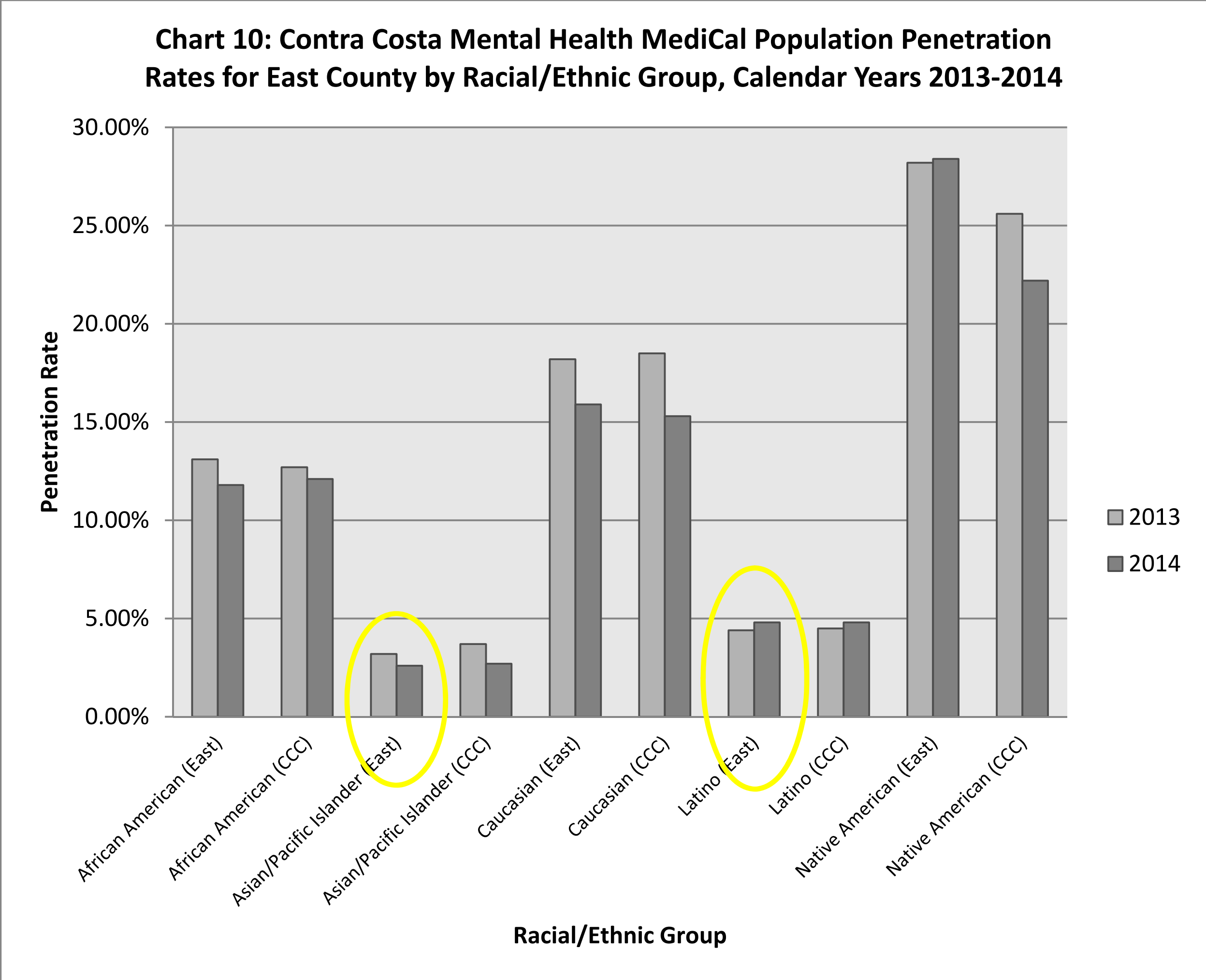
East County Penetration Rates

CCBHS Mental Health penetration rates for East County were compared by racial/ethnic group and compared to county penetration rates and statewide averages for the same populations (*Table 12: Contra Costa Mental Health MediCal Population Penetration Rates for East County by Racial/Ethnic*

Group, Calendar Years 2013-2015 and Chart 10: Contra Costa Mental Health MediCal Population Penetration Rates for East County by Racial/Ethnic Group, Calendar Years 2013-2014).

Table 12: Contra Costa Mental Health MediCal Population Penetration Rates for East County by Racial/Ethnic Group, Calendar Years 2013-2015						
Race/Ethnicity	**Calendar Year**	**Number MediCal Eligible Population Served by Mental Health, East County**	**MediCal Eligible Population, East County**	**Penetration Rate**	**County Penetration Rate for Racial/Ethnic Group**	**Statewide Average Penetration Rate for Racial/Ethnic Group[25]**
African American						
	2013	1,784	13,664	13.1%	12.7%	10.5%
	2014	2,042	17,321	11.8%	12.1%	9.1%
	2015	2,167	19,781	11.0%	11.2%	
Asian/Pacific Islander						
	2013	196	6,211	3.2%	3.7%	3.5%
	2014	289	11,318	2.6%	2.7%	2.9%
	2015	324	13,935	2.3%	2.5%	
Caucasian						
	2013	2,298	12,641	18.2%	18.5%	9.6%
	2014	2,977	18,724	15.9%	15.3%	8.5%
	2015	3,215	21,097	15.2%	14.5%	
Latino						
	2013	1,310	29,585	4.4%	4.5%	3.9%
	2014	1,680	35,120	4.8%	4.8%	3.6%
	2015	1,898	37,843	5.0%	5.0%	
Native American						
	2013	59	209	28.2%	25.6%	8.9%
	2014	83	292	28.4%	22.2%	8.1%
	2015	89	340	26.2%	20.4%	
Other						
	2013	115	5,376	2.1%	2.1%	5.9%
	2014	142	8,622	1.6%	1.7%	6.1%
	2015	137	10,821	1.3%	1.4%	
Unknown						
	2013	163	2,921	5.6%	4.9%	
	2014	288	3,766	7.6%	5.6%	
	2015	274	3,971	6.9%	5.8%	
Total (Region)						
	2013	5,925	70,607	8.4%		5.64%
	2014	7,501	95,163	7.9%		5.2%
	2015	8,104	107,788	7.5%		

[25]APS Healthcare. “Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2013”. 2014. And Behavioral Health Concepts. “Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2014”. 2015.



The majority of the East County African American penetration rates are less than the CCBHS Mental Health penetration rate for the same population. Additionally, the East County Asian/Pacific Islander and Other population penetration rates are less than the CCBHS Mental Health penetration rates for the same populations. The majority of the East County Caucasian, Latino, Native American, and Unknown population penetration rates are greater than or equal to the CCBHS Mental Health penetration rates for the same populations. The Caucasian (18.2 percent in 2013, 15.9 percent in 2014, and 15.2 in 2015) and Native American (28.2 percent in 2013, 28.4 percent in 2014, and 26.2 percent in 2015) populations have the highest penetration rates in East County. The Asian/Pacific Islander (3.2 percent in 2013, 2.6 percent in 2014, and 2.3 percent in 2015) and Latino (4.4 percent in 2013, 4.8 percent in 2014, and 5.0 percent in 2015) populations have the lowest penetration rates among the racial/ethnic groups in East County.

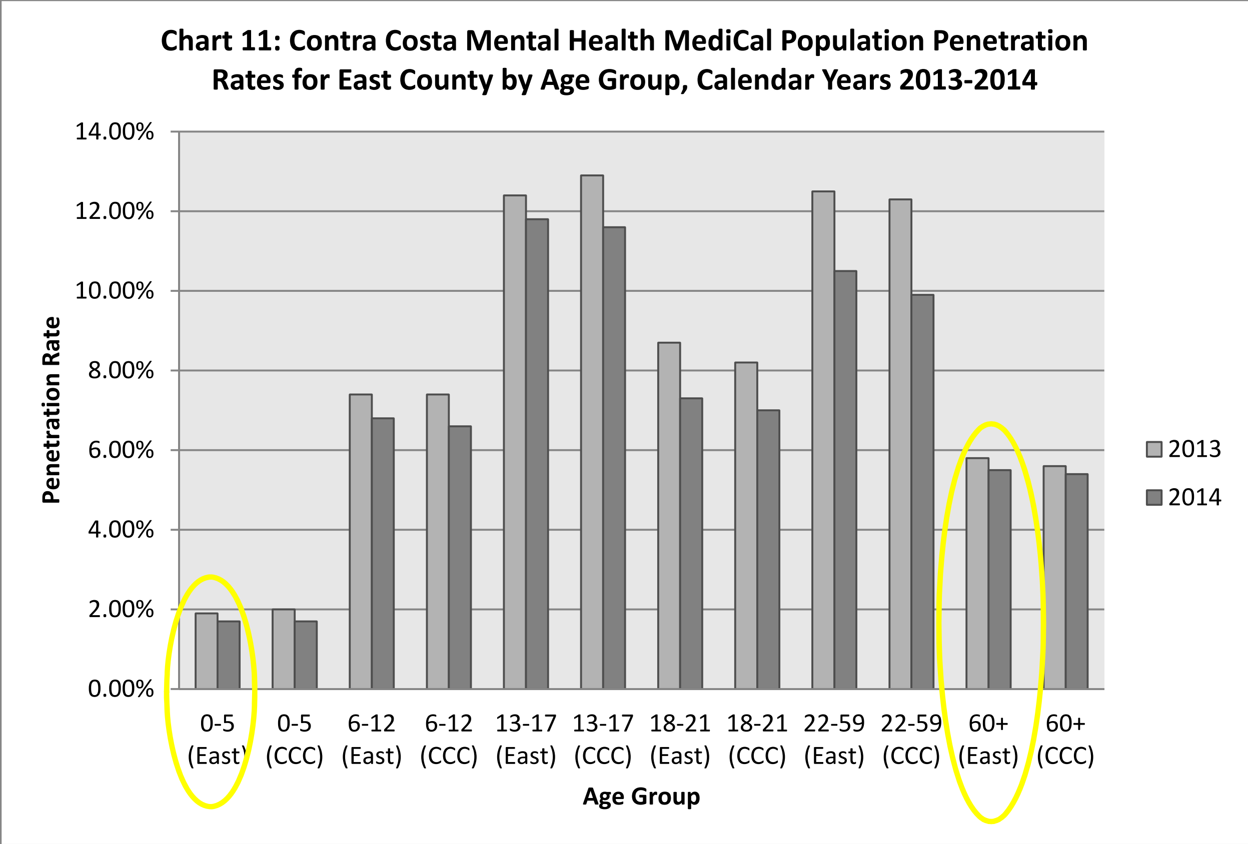
CCBHS Mental Health penetration rates for East County were compared by age group and compared to CCBHS Mental Health and statewide average penetration rates for the same populations (*Table 13: Contra Costa Mental Health MediCal Population Penetration Rates for East County by Age Group,*

Calendar Years 2013-2015 and Chart 11: Contra Costa Mental Health MediCal Population Penetration Rates for East County by Age Group, Calendar Years 2013-2014).

Table 13: Contra Costa Mental Health MediCal Population Penetration Rates for East County by Age Group, Calendar Years 2013-2015

Age Group	Calendar Year	Number MediCal Eligible Population Served by Mental Health, East County	MediCal Eligible Population, East County	Penetration Rate	County Penetration Rate for Age Group	Statewide Average Penetration Rate for Age Group[26]
0-5						
	2013	280	14,723	1.9%	2.0%	1.9%
	2014	260	15,728	1.7%	1.7%	2.1%
	2015	279	15,761	1.8%	1.9%	
6-12						**6-17**
	2013	1,023	13,786	7.4%	7.4%	7.1%
	2014	1,079	15,798	6.8%	6.6%	6.5%
	2015	1,108	15,903	7.0%	6.9%	
13-17						
	2013	1,025	8,271	12.4%	12.9%	
	2014	1,187	10,065	11.8%	11.6%	
	2015	1,242	10,132	12.3%	12.1%	
18-21						**18-59**
	2013	373	4,281	8.7%	8.2%	7.1%
	2014	458	6,276	7.3%	7.0%	6.2%
	2015	510	7,438	6.9%	6.7%	
22-59						
	2013	2,826	22,650	12.5%	12.3%	
	2014	4,025	38,361	10.5%	9.9%	
	2015	4,379	48,006	9.1%	8.6%	
60+						
	2013	398	6,896	5.8%	5.6%	3.4%
	2014	492	8,935	5.5%	5.4%	3.1%
	2015	586	10,548	5.6%	5.3%	
Total (Region)						
	2013	5,925	70,607	8.4%		5.64%
	2014	7,501	95,163	7.9%		5.2%
	2015	8,104	107,788	7.5%		

[26] APS Healthcare. "Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2013". 2014. And Behavioral Health Concepts. "Medi-Cal Approved Claims Data for Contra Costa County Mental Health Plan Calendar Year 2014". 2015.



For all but the 0 to 5 population, the East County penetration rates were greater than or equal to the CCBHS Mental Health penetration rates for the same age groups. The 13 to 17 (12.4 percent in 2013, 11.8 percent in 2014, and 12.3 percent in 2015) and 22 to 59 (12.5 percent in 2013, 10.5 percent in 2014, and 9.1 percent in 2015) populations had the highest penetration rates in East County. The 0 to5 (1.9 percent in 2013, 1.7 percent in 2014, and 1.8 percent in 2015) and 60+ (5.8 percent in 2013, 5.5 percent in 2014, and 5.6percent in 2015) populations had the lowest penetration rates among the age groups in East County.

ii. Spectrum of Services and Service Expenditures

In order to address the question of whether CCBHS is apportioning its funding to ensure its providing a full spectrum of mental health care and meeting established allocation benchmarks, FY 2015-16 CCBHS Mental Health expenditures were grouped by Level of Care Utilization System/ Child and Adolescent Level of Care Utilization System (LOCUS/CALOCUS) level of care and compared to benchmarks developed by the Mental Health Association in California.

Percentage Spent on Levels of Care in Mental Health System of Care

Table 14: Contra Costa Mental Health Expenditures by Level of Care, Fiscal Year 2015-2016, defines each level of care as well as, lists the FY 15/16 expenditures, percentage of expenditures, and the difference between the percentage of expenditures and recommended benchmark for each level of care.

Table 14: Contra Costa Mental Health Expenditures by Level of Care, Fiscal Year 2015-2016[27]

Level of Care	Description of Level of Care	LOCUS/ CALOCUS Level of Care	LOCUS / CALOCUS Score Range	Contra Costa Mental Health Expenditures FY 15/16[28]	Percentage of Expenditures	Recommended Percentage of System Care[29]	Difference Between Percentage of Expenditures and Recommended Benchmark
Locked Facilities	Medically Managed Residential Services	6	28-30	$ 38,907,909.73	22%	17%	+5
24-Hour Community Care and Residential Services	Medically Monitored Residential Services and Medically Monitored Non-Residential Services	4 and 5	20-27	$ 43,768,180.49	24%	33%	-9
Outpatient Services for Seriously Mentally Ill/Severely Emotionally Disturbed	High Intensity Community Based Services	3	17-19	$ 42,310,062.27	24%	22%	+2
Therapy	Low Intensity Community Based Services and Recovery and Maintenance and Health Management	1 and 2	10-16	$ 45,722,415.87	25%	22%	+3
Outreach and Engagement	Basic Services for Prevention and Health Maintenance	0	7-9	$ 7,996,715.78	4%	5%	-1
Training/ Staff Development	Training/ Staff Development	N/A	N/A	$ 613,994.69	0.3%	1%	-0.7
Total				$ 179,319,278.84	100%	100%	

[27] Administrative costs, $14,558,808.13, were evenly distributed across expenditures for each level of care, 0-6. Administrative costs were included in the benchmark percentages as well so percentages are comparable.
[28] Data from the Auditor's Intranet Site. FY 15/16 expenditure data was extracted by organization number for all organization numbers listed under Department Number 0467 in the Auditor's Codebook for FY 15/16.
[29] Mental Health Association in California. "A Model for California Community Mental Health Programs". 1981. Pages 27-29. Available at: http://histpubmh.semel.ucla.edu/sites/default/files/archival/d8485804_Doc_7._1981_California_Model.pdf .

Level 6 of the LOCUS/CALOCUS levels of care, score range 28-30, provides medically managed residential services. CCBHS Mental Health FY 15/16 expenditures for Level 6 were $38,907,909.73, which was 22 percent of expenditures. The recommended percentage of expenditures for Level 6 is 17 percent, 5 percentage points less than CCBHS currently expends on Level 6 services. Level 5 of the LOCUS/CALOCUS levels of care, score range 23-27, provides medically monitored residential services. Level 4 of LOCUS/CALOCUS levels of care, score range 20-22, provides medically monitored non-residential services. CCBHS Mental Health FY 15/16 expenditures for Levels 4 and 5 were $43,768,180.49, which was 24 percent of expenditures. The recommended percentage of expenditures for Levels 4 and 5 is 33 percent, 9 percentage points more than CCBHS currently expends on Level 4 and 5 services. Level 3 of the LOCUS/CALOCUS levels of care, score range 17-19, provides high intensity community based services. CCBHS Mental Health FY 15/16 expenditures for Level 3 were $42,310,062.27 which was 24 percent of expenditures. The recommended percentage of expenditures for Level 3 is 22 percent, 2 percentage points less than CCBHS currently expends on Level 3 services. Level 2 of the LOCUS/CALOCUS levels of care, score range 14-16, provides low intensity community based services. Level 1 of LOCUS/CALOCUS levels of care, score range 10-13, provides recovery maintenance health management. CCBHS Mental Health FY 15/16 expenditures for Levels 1 and 2 were $45,722,415.87, which was 25 percent of expenditures. The recommended percentage of expenditures for Levels 1 and2 is 22 percent, 3 percentage points less than CCBHS currently expends on Level 1 and2 services. Level 0 of the LOCUS/CALOCUS levels of care, score range 7-9, provides basic services for prevention and health maintenance. CCBHS Mental Health FY 15/16 expenditures for Level 0 were $7,996,715.78, which was 4 percent of expenditures. The recommended percentage of expenditures for Level 0 is 5 percent, 1 percentage point more than CCBHS currently expends on Level 0 services. CCBHS Mental Health spent $613,994.69 on training and staff development in FY 15/16, which is 0.3 percent of expenditures. The recommended percentage of expenditures for training and staff development is 1 percent, 0.7 percentage points more than CCBHS currently expends on training and staff development.

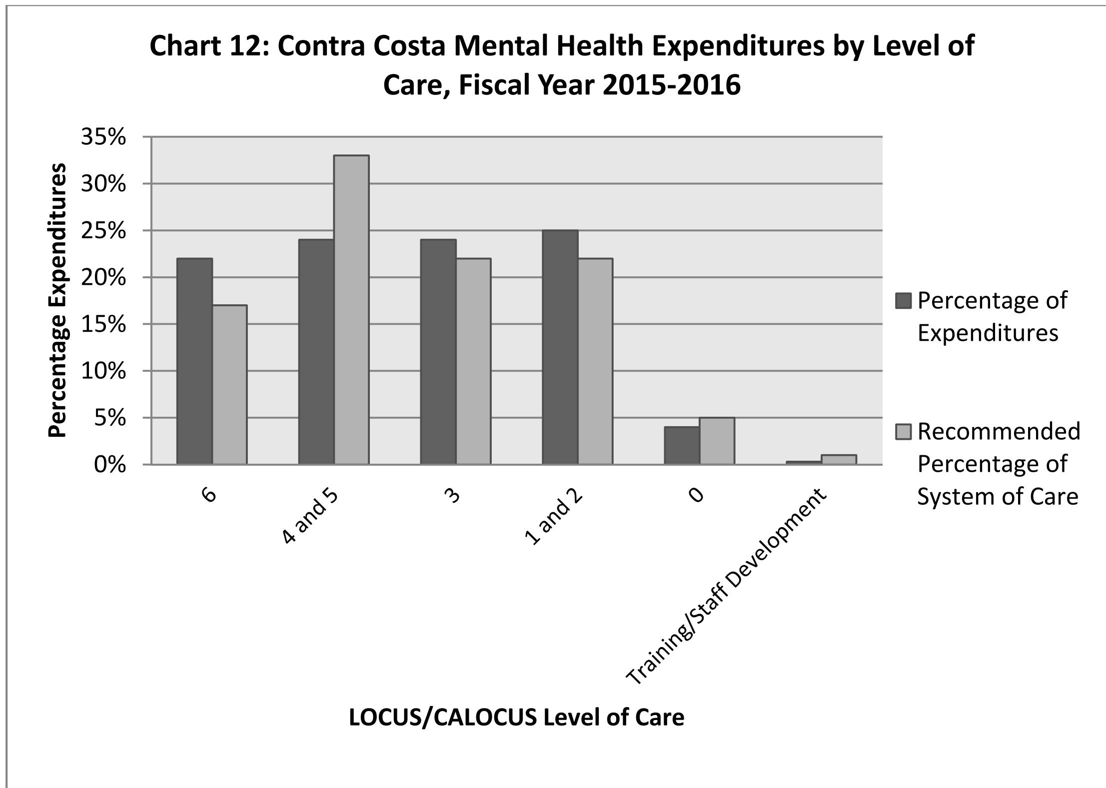


Chart 12: Contra Costa Mental Health Expenditures by Level of Care, Fiscal Year 2015-2016 graphically depicts the comparison of FY 15/16 expenditures with the benchmark for each type of expenditure. As noted above, in comparison to the benchmarks, CCBHS Mental Health over-expends on Levels 6, 3, and 1 and 2. CCBHS Mental Health under-expends on Levels 4 and 5, 0, and training/staff development. That being said, the differences between Level 3 and Level 1 and 2 expenditures are within a couple of percentage points of the benchmarks.

Appendix A: Mental Health Service Maps outlines CCBHS programs by region and age-related system of care. *Appendix B* groups the CCBHS programs included in the expenditure s described in *Table 14: Contra Costa Mental Health Expenditures by Level of Care, Fiscal Year 2015-2016* by level of care, from Level Six to Level Zero.

iii. Contra Costa Behavioral Health Services Staffing

In order to establish if CCBHS is adequately addressing its Mental Health Plan workforce needs, psychiatric vacancies, psychiatric compensation, staff demographics, and bilingual capacity were analyzed.

Psychiatric Staffing

Staffing levels of key positions has a significant impact on the County's ability to provide mental health care. The most prominent shortfall is the lack of county psychiatrists to participate as multi-disciplinary team members at the County's children and adult clinics. *Table 15: Contra Costa County Behavioral Health Service Mental Health Full Time Equivalent Psychiatrist Positions*, outlines the number of approved full time equivalent positions, the positions filled, the equivalent hours worked, and current vacancies for both county and contract psychiatrists.

Table 15: Contra Costa County Behavioral Health Services Mental Health Full Time Equivalent Psychiatrist Positions

Type of Psychiatrist	Approved Full Time Equivalent	Filled Full Time Equivalent	Full Time Equivalent Worked	Approved Full Time Equivalent Currently Vacant or Not Being Utilized
County	18.925	10.425	8.175	10.75
Contract	25.035	25.035	21.35	3.685
Total	43.96	35.46	29.525	14.435

CCBHS Mental Health has been authorized 20 full-time equivalent (FTE) psychiatrists to serve children and adults who experience moderate to severe mental illness or serious emotional disturbance. However, only 10 positions are filled by County employees, with their actual aggregate work time equaling 8.2 FTEs. Part-time non-county psychiatry time is contracted out in order to ensure that essential psychotropic medications are prescribed. Quality of care is compromised, as fewer psychiatrists are available to actively participate as staff team members in the long term recovery of consumers.

In order to identify factors contributing the psychiatric vacancies, CCBHS salaries were compared to neighboring counties. *Table 16: Comparison of Neighboring Bay Area County Psychiatrist Salaries*, describes the salary ranges for psychiatrists employed by Contra Costa, Alameda, Marin, San Francisco, and Solano counties.

Table 16: Comparison of Neighboring Bay Area County Psychiatrist Salaries[30]		
County	**Annual Salary (Midrange)**	**Difference from Contra Costa County**
Contra Costa	$ 155,497.80	$ -
Alameda	$ 194,190.88	$ 38,693.08
Marin	$ 170,347.50	$ 14,849.70
San Francisco	$ 208,086.67	$ 52,588.87
Solano	$ 210,050.85	$ 54,553.05

Contributing to this situation is that Contra Costa County pays approximately 82 percent of the salary of the average paid to psychiatrists in Alameda, Marin, San Francisco, and Solano counties. Consequently Contra Costa County has difficulty competing with neighboring Bay Area counties in recruiting and retaining psychiatrists.

Staffing Demographics

As part of the needs assessment conducted to inform the Workforce Education and Training (WET) Plan, CCBHS Mental Health compared its staff demographics to the county demographics to determine if staffing matched the population being served by CCBHS Mental Health or if discrepancies exist. This data was again included in the 2010 Cultural Competency Plan[31] to inform recommendations for staffing policies to ensure clients are appropriately served (*Table 17: Comparison of WET Assessment Data and County Population*).

[30] Data from County Human Resource Websites:
https://www.governmentjobs.com/careers/contracosta/classspecs ,
https://www.jobaps.com/alameda/auditor/ClassSpecs.asp,
http://www.marincounty.org/depts/hr/divisions/classification-and-compensation/job-classification ,
http://sfdhr.org/classification-and-compensation-database,
https://www.solanocounty.com/depts/hr/classifications.asp

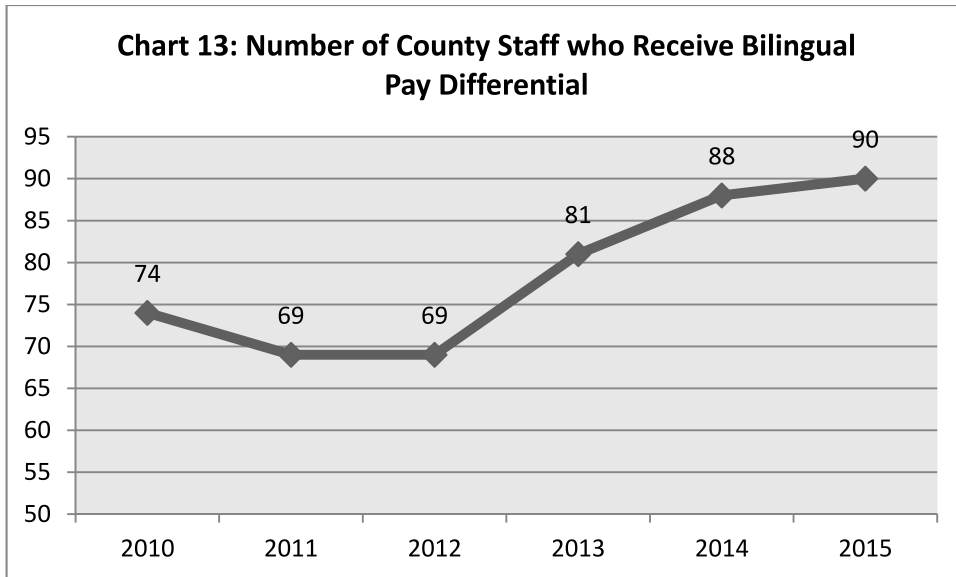
[31] Contra Costa County Mental Health Services. "Cultural Competence Plan Three Year Plan Fiscal Year 2010-11, 2011-12, 2012-13". 2010 (Revised). Page 91. Available at:
http://cchealth.org/mentalhealth/pdf/2010_cultural_competence_plan.pdf .

Table 17: Comparison of WET Assessment Data and County Population			
	2010 Cultural Competency Plan	WET Assessment	
Race/Ethnicity	County Population	Consumers Served	County Staff
White	48.63%	35.65%	46.01%
Hispanic	24.23%	17.94%	11.15%
African-American	9.29%	30.23%	19.00%
Asian/Pacific Islander	13.82%	6.15%	7.42%
Native American	0.43%	0.64%	0.35%
Other	3.61%	9.40%	16.06%

Latina/os are underrepresented in the county staff population when compared to all the populations listed in the table. Latina/os in the county population comprise of 24.2 percent of those populations respectively; and yet only make up 11.15 percent of the county staff population. African Americans are over-represented when comparing the county staff population to the county general population. African Americans represent 9.3 percent of the general population and 19 percent of the county staff population. However, the African American group is underrepresented when comparing the county staff population to that of the consumers served. In this case, this ethnic group comprises of 30.2 percent of the consumers served and only 19 percent of the county staff. Asians and Pacific Islanders are underrepresented in the County Staff population when compared to the general population. This group represents 7.42 percent of the County staff population but 13.82 percent of the general population. However, this ethnic group is represented when the County Staff population is compared to the Consumers served. White county staff are over represented, 46.01 percent, when compared to consumers served, 35.65 percent.

Bilingual Pay Differential and Flagged Positions

CCBHS understands the importance of quality, prompt and accurate translation and interpretation services to increase access for all mental health clients. As a part of monitoring the rate and quality of language services across the County, CCBH collects data on the number of requests for all modes of translation as well as the costs. *Chart 13: Number of County Staff who Receive Bilingual Pay Differential* shows data for a 7 year period, from 2009 through 2015.



Data from 2009-2015 for all County Mental Health Clinics[32]

The number of staff with the differential increased from 74 staff in 2010 to 90 staff in 2015. A majority of staff who receive bilingual pay speak Spanish, followed by Punjabi and Chinese; other languages include Dari, Farsi, Hindi, Ibo, Khum, Korean, Lao, Russian, Tagalog, Tamil, Thai, Urdu, Vietnamese and American Sign Language (ASL). Currently, there are 36 positions that are flagged Spanish-speaking, 2 flagged for Vietnamese, 1 for Chinese, and 1 for American Sign Language; this is slightly lower than the average of 38 positions flagged in recent years (2011-2014)[33].

Interpretation services were available to meet the language needs of clients when bilingual staff were unavailable. All of the interpretation requests in 2010 were for in-person interpretation. After alternate modes of interpretation services began to be offered, by 2015 approximately 50 percent of all requests were phone language line requests, approximately 25 percent were for video Healthcare Interpreter Network requests, and slightly less than 25 percent of requests were for in-person interpretation. The most notable development in recent years is the utilization of video interpretation machines through the Healthcare Interpreter Network, which in turn has decreased the costs spent on in-person interpretation. Although CCBH has adopted video as the primary mode of interpretation, the in-person option is still available for clients for whom video is not appropriate.

iv. Comparison of Findings from Needs Assessment to Findings from Previous Community Program Planning Process Assessments

Previous community program planning processes indicated there were underserved populations in Contra Costa County. As outlined in this needs assessment, based upon prevalence estimates of the number of individuals below 200 percent poverty with a serious mental illness, CCBHS Mental Health is

[32] Research and Evaluation Unit. “Interpretation Usage Summary”. Contra Costa Mental Health Services. FY 2015/2016. Note, 2015 Data reflects January through October only.
[33] Research and Evaluation Unit. “Service Accessibility and Availability Reflective of Cultural Competency Principles”. Contra Costa Mental Health Services. FY 2015/2016.

serving a number of clients approximate to the estimated number of individuals requiring CCBHS Mental Health services. Additionally, CCBHS Mental Health penetration rates are equal to or greater than statewide average penetration rates, indicating CCBHS Mental Health serves more eligible clients than the majority of counties in California. However, when comparing subpopulations within Contra Costa County, there are a few with lower penetration rates than other subpopulations. These populations include Asian/Pacific Islanders, Latina/os, children ages zero to five years, and adults ages 60 years and older. When comparing subpopulations regionally, these trends continue, with Asian/Pacific Islanders, Latina/os, children ages zero to five years, and adults ages 60 years and older, having the lowest penetration rates in each region of the county.

Previous community program planning processes also raised questions about whether services were available at all levels of care and whether services were going to those with the highest acuity. FY 15/16 CCBHS Mental Health expenditures indicate services are available at every level of care as defined by the LOCUS/CALOCUS. However, compared to benchmarks, CCBHS MH over spends on the most acute level of inpatient care (Level 6), and is below the benchmark in expenditures related to programs providing high intensity community-based services (Levels 4 and 5).

Finally, previous community program planning processes indicated there was a shortage of mental health staff, particularly psychiatrists, as well as staff with bilingual capacity to serve CCBHS Mental Health's diverse target population. CCBHS Mental Health does have psychiatrist vacancies as well as psychiatrists who do not maximize the number of hours available in their contracts, leading to an ongoing shortage in psychiatrists. Compounding the issue of filling vacant psychiatrist positions is the fact that CCBHS Mental Health reimburses psychiatrists at a lower rate than neighboring counties. Latina/o and Asian/Pacific Islander populations are under-represented among county staff when compared to the county population. However, CCBHS Mental Health has incrementally increased the number of bilingual individuals on staff each year. Additionally, CCBHS Mental Health has phone, in-person, and video interpretation services available as needed.

IV. Limitations

This needs assessment is meant to assist CCBHS Mental Health determine the system's capacity to serve its target populations; it does not assess the quality of the services being provided to clients. Quality assessments are performed through utilization and program reviews as well as through CCBHS' contract monitoring process.

The following are the limitations of this quantitative needs assessment. First, the prevalence data was based upon population and prevalence rate estimates. This means the prevalence benchmarks are approximate calculations, they are not exact figures. Therefore, the benchmarks may be over or under representations of the county's true prevalence rate for serious mental illness. Additionally, because no filters were used to exclude clients when extracting the numbers served by CCBHS Mental Health, this may be an over-representation of the number of clients with serious mental illness served by the system as some of these clients may not have met medical necessity for services. Because CCBHS Mental Health does not have an electronic health record system, client and service data are strictly based upon billing records, not health records.

Second, different logic methodologies were used to extract the total number served by CCBHS Mental Health for the prevalence and penetration data; as a result, the numbers vary slightly. This applies to the number of MediCal eligible clients as well. Different logic methodologies were used to extract the MediCal eligibility data for the prevalence and penetration data, resulting in slightly different figures. Furthermore, the denominator of the penetration rates includes all individuals in Contra Costa County who are eligible for MediCal, not only individuals with a serious mental illness who are eligible for MediCal. This reduces the penetration rates, creating an underrepresentation of the proportion of eligible clients accessing CCBHS Mental Health's services. Finally, the majority of individuals served by Prevention and Early Intervention programs contracted to outreach to and engage underserved populations are not included in the penetration rate data as these programs do not enter client information into the PSP/INSYST billing system.

Third, the public mental health systems of care expenditure benchmarks recommended by the Mental Health Association in California were established in 1981. As a result, the benchmarks do not fully reflect the impact of the movement to decrease institutional services and increase community-based outpatient services. Therefore, the recommended expenditures for Level 6 may be greater than is appropriate for standards of care in 2016. Also, for convenience, some of the programs, such as the CCBHS Mental Health Clinics and the Board and Care facilities, included in a single level of care may actually be providing services to clients representing more than one level of care. It is recommended further study determine the proportion of these program expenditures that should be allocated to each level of care. Administrative costs were evenly distributed across each level of care (from 0 to 6); however, administrative costs may not be evenly attributed to each level of care. For example, higher levels of care require more utilization review staff time than lower levels of care. Additionally, the decision to combine Levels 4 and 5 was made because many of the clients served by these programs receive care from both levels of care. Levels 1 and 2 were combined because many of the programs included in these levels of care provide services to both Level 1 and Level 2 clients, making it difficult to credibly attribute expenditures to a single level of care. It is recommended service data be analyzed and compared to expenditure data to tease apart Level 4 and 5 expenditures as well as Level 1 and 2 expenditures. Finally, a small discrepancy of approximately $20,000 in expenditures was found when extracting expenditure data by organization code as compared to the total expenditure report. Because this figure is insignificant in comparison the approximately $170 million in total CCBHS expenditures, the expenditure data was presented with the discrepancy included.

Fourth, the staff demographic data was taken directly from the Contra Costa Mental Health Services, "Cultural Competence Plan Three Year Plan Fiscal Year 2010-11, 2011-12, 2012-13". The data used to inform the Cultural Competency Plan was collected as part of the 2009 Workforce Education and Training Plan. Therefore, as populations have migrated, both the county and staff demographics may have changed since the Plan was published.

V. Summary of Findings and Recommendations

This needs assessment addressed three questions: 1) is CCBHS reaching the target population it is mandated to serve?; 2) is CCBHS apportioning its funding to ensure its providing a full spectrum of

mental health care and meeting established allocation benchmarks?; and 3) is CCBHS adequately addressing its Mental Health Plan workforce needs?

First, overall, CCBHS Mental Health is reaching the target population it is mandated to serve. Based upon prevalence estimates of the number of individuals under 200 percent poverty with a serious mental illness, CCBHS Mental Health is serving a number of clients approximate to the estimated number of individuals requiring CCBHS Mental Health services. Additionally, CCBHS Mental Health penetration rates are equal to or greater than statewide average penetration rates, indicating CCBHS Mental Health serves more eligible clients than the majority of counties in California. However, when comparing subpopulations within Contra Costa County, there are a few with slightly lower penetration rates than other subpopulations. These populations include Asian/Pacific Islanders, Latina/os, children ages zero to five years, and adults ages 60 years and older. When comparing subpopulations regionally, these trends continue, with Asian/Pacific Islanders, Latina/os, children ages zero to five years, and adults ages 60 years and older, having the lowest penetration rates in each region of the county.

Second, CCBHS Mental Health is apportioning its funding to ensure it is providing a full spectrum of mental health care. However, it is not meeting recommended allocation benchmarks. CCBHS Mental Health spends more money on Level 6, Medically Managed Residential Services, than recommended (22 percent versus 17 percent respectively). At the same time, CCBHS Mental Health spent less on Levels 4 and 5, Medically Monitored Residential Services and Medically Monitored Non-Residential Services (24 percent versus 33 percent respectively).

Third, CCBHS Mental Health is not adequately addressing its psychiatry staffing needs. CCBHS Mental Health has psychiatrist vacancies as well as psychiatrists who do not maximize the number of hours available in their contracts, leading to an ongoing shortage in psychiatrists. Compounding the issue of filling vacant psychiatrist positions is the fact that CCBHS Mental Health reimburses psychiatrists at a significantly lower rate than neighboring counties. Latina/o and Asian/Pacific Islander populations are under-represented among county staff when compared to the county population. However, CCBHS Mental Health has incrementally increased the number of bilingual individuals on staff each year. Additionally, CCBHS Mental Health has phone, in-person, and video interpretation services available as needed.

Recommendations

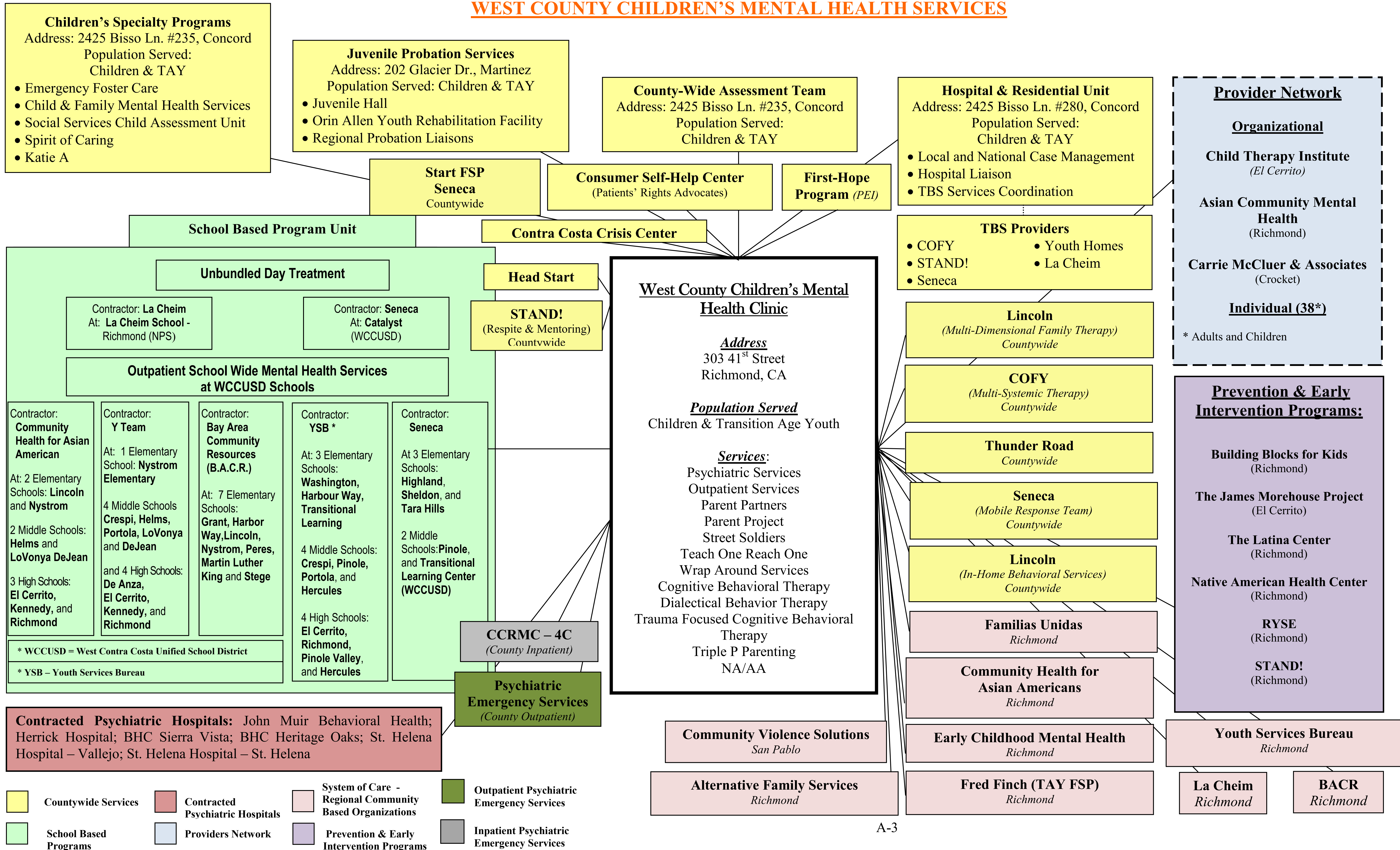
1) CCBHS Mental Health is, overall, serving the population it is mandated to serve and has penetration rates that are equal to or greater than statewide averages. That being said, to better approximate parity among subpopulations, it is suggested that CCBHS Mental Health strengthen outreach and engagement strategies for the underserved populations identified in this needs assessment (Asian/Pacific Islanders, Latina/os, children ages 0 to 5, and adults ages 60+).
2) CCBHS Mental Health should further research program expenditures, separating Level 4 and Level 5 expenditures as well as Level 1 and Level 2 expenditures. Additionally, research should be conducted to determine service utilization associated with each level of care to determine if an adequate range of services is available within each level. It is suggested that CCBHS Mental

Health continue to improve its capacity to assist consumers move from higher levels of care, such as locked facilities, to lower levels of care that are community based.

3) CCBHS Mental Health should explore strategies for increasing authorized psychiatry time and increasing the number of bi-lingual staff, such as increasing psychiatry contract rates and county pay, focused recruitment of bi-lingual clinical interns, and establishing workforce incentives, such as establishing loan forgiveness programs for hard to fill or retain classifications.

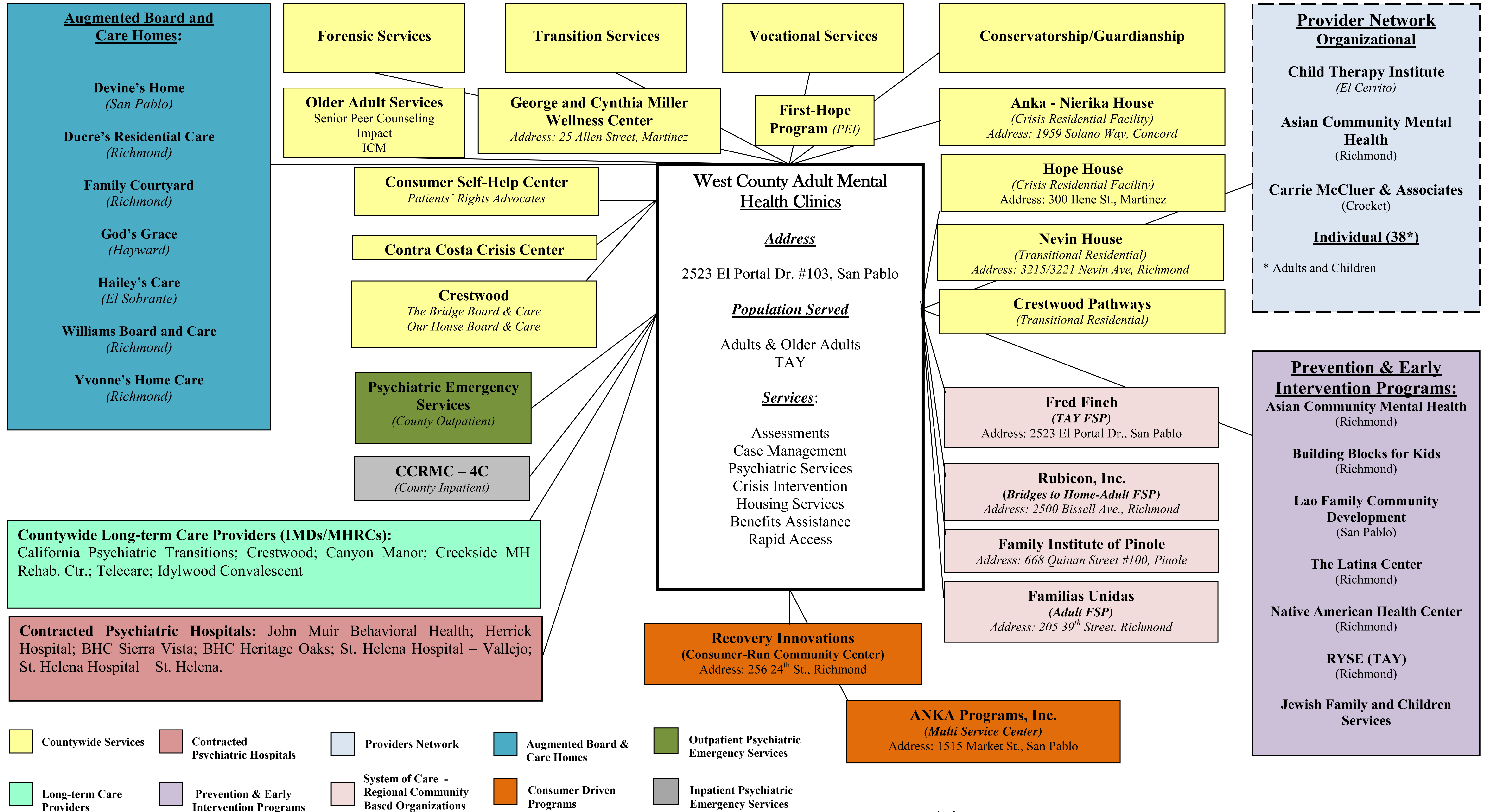
Appendix A: Mental Health Service Maps

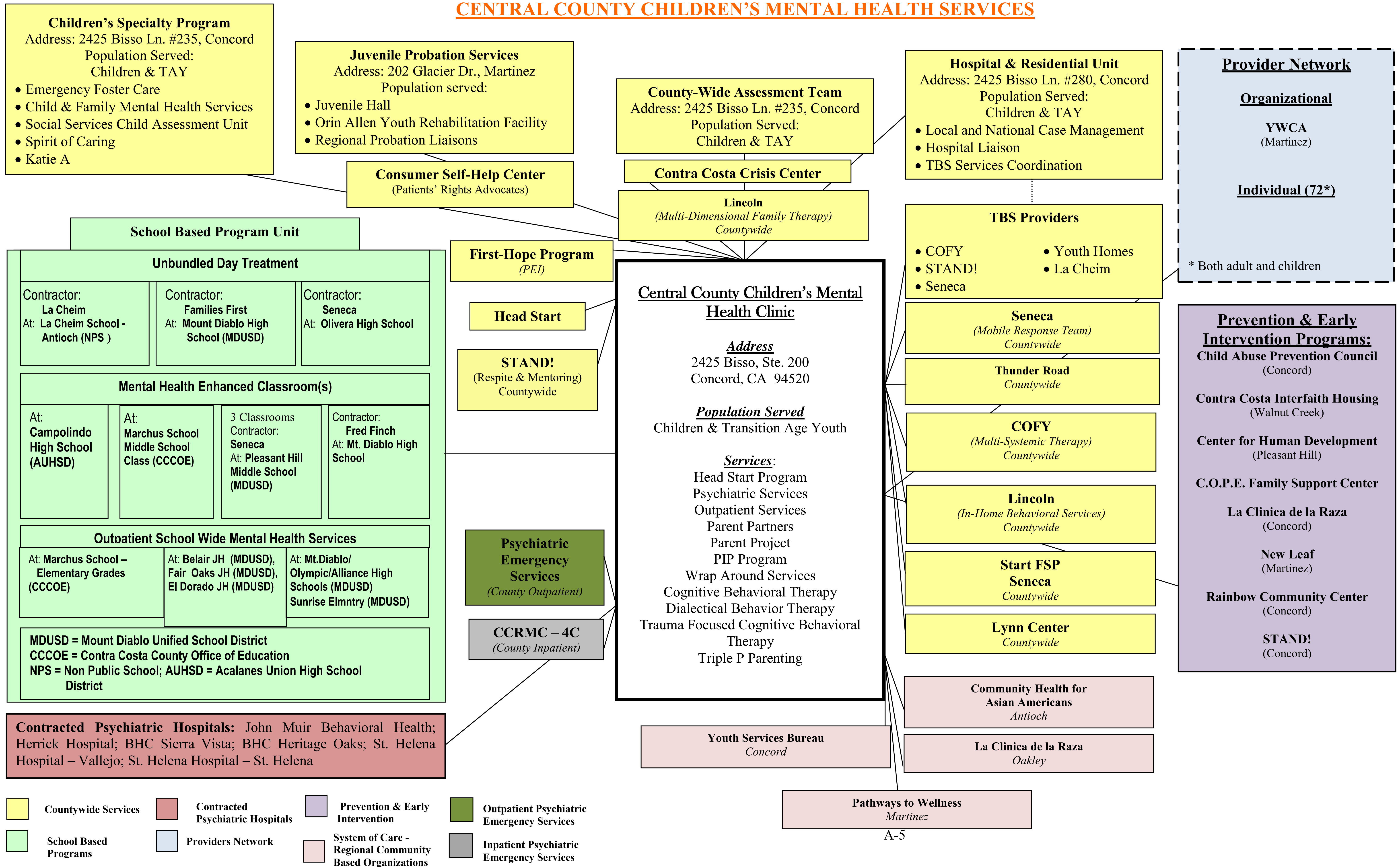
The following six service maps provide a visual picture, or architecture, of the constellation of types of Contra Costa Mental Health's programs.



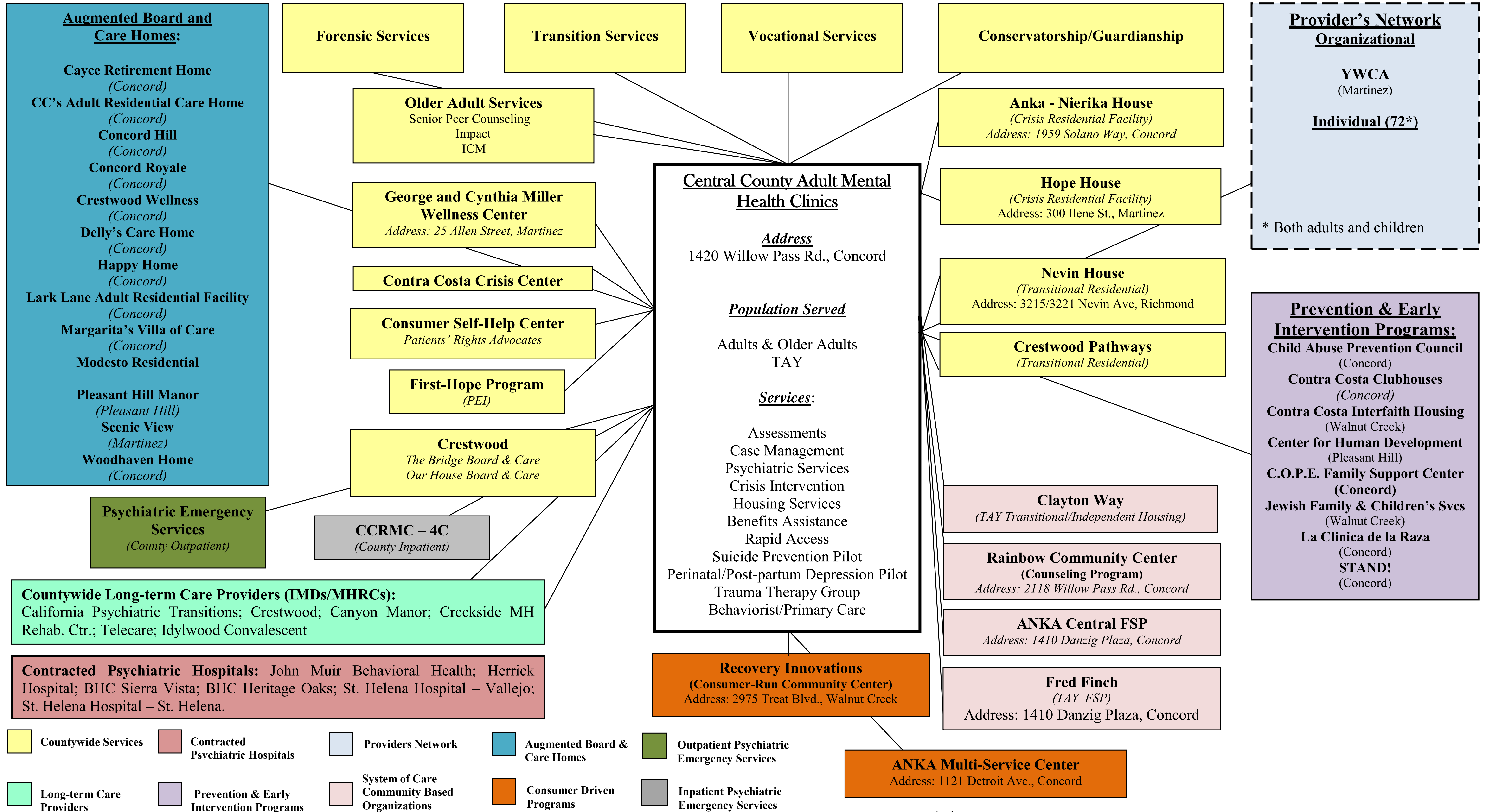
WEST COUNTY CHILDREN'S MENTAL HEALTH SERVICES
Children's Specialty Programs
Address: 2425 Bisso Ln. #235, Concord
Population Served:
Children & TAY
• Emergency Foster Care
• Child & Family Mental Health Services
• Social Services Child Assessment Unit
• Spirit of Caring
• Katie A
Juvenile Probation Services
Address: 202 Glacier Dr., Martinez
Population Served: Children & TAY
• Juvenile Hall
• Orin Allen Youth Rehabilitation Facility
• Regional Probation Liaisons
County-Wide Assessment Team
Address: 2425 Bisso Ln. #235, Concord
Population Served:
Children & TAY
Hospital & Residential Unit
Address: 2425 Bisso Ln. #280, Concord
Population Served:
Children & TAY
• Local and National Case Management
• Hospital Liaison
• TBS Services Coordination
Provider Network
Organizational
Child Therapy Institute
(El Cerrito)
Asian Community Mental Health
(Richmond)
Carrie McCluer & Associates
(Crocket)
Individual (38*)
* Adults and Children
Start FSP
Seneca
Countywide
Consumer Self-Help Center
(Patients' Rights Advocates)
First-Hope Program (PEI)
School Based Program Unit
Contra Costa Crisis Center
TBS Providers
• COFY
• STAND!
• Seneca
• Youth Homes
• La Cheim
Unbundled Day Treatment
Head Start
Contractor: La Cheim
At: La Cheim School - Richmond (NPS)
Contractor: Seneca
At: Catalyst
(WCCUSD)
STAND!
(Respite & Mentoring)
Countywide
West County Children's Mental Health Clinic
Address
303 41st Street
Richmond, CA
Population Served
Children & Transition Age Youth
Services:
Psychiatric Services
Outpatient Services
Parent Partners
Parent Project
Street Soldiers
Teach One Reach One
Wrap Around Services
Cognitive Behavioral Therapy
Dialectical Behavior Therapy
Trauma Focused Cognitive Behavioral Therapy
Triple P Parenting
NA/AA
Lincoln
(Multi-Dimensional Family Therapy)
Countywide
Outpatient School Wide Mental Health Services at WCCUSD Schools
COFY
(Multi-Systemic Therapy)
Countywide
Prevention & Early Intervention Programs:
Contractor: Community Health for Asian American
At: 2 Elementary Schools: Lincoln and Nystrom
2 Middle Schools: Helms and LoVonya DeJean
3 High Schools: El Cerrito, Kennedy, and Richmond
Contractor: Y Team
At: 1 Elementary School: Nystrom Elementary
4 Middle Schools Crespi, Helms, Portola, LoVonya and DeJean
and 4 High Schools: De Anza, El Cerrito, Kennedy, and Richmond
Contractor: Bay Area Community Resources (B.A.C.R.)
At: 7 Elementary Schools: Grant, Harbor Way, Lincoln, Nystrom, Peres, Martin Luther King and Stege
Contractor: YSB *
At: 3 Elementary Schools: Washington, Harbour Way, Transitional Learning
4 Middle Schools: Crespi, Pinole, Portola, and Hercules
4 High Schools: El Cerrito, Richmond, Pinole Valley, and Hercules
Contractor: Seneca
At 3 Elementary Schools: Highland, Sheldon, and Tara Hills
2 Middle Schools: Pinole, and Transitional Learning Center (WCCUSD)
Thunder Road
Countywide
Building Blocks for Kids
(Richmond)
Seneca
(Mobile Response Team)
Countywide
The James Morehouse Project
(El Cerrito)
The Latina Center
(Richmond)
Lincoln
(In-Home Behavioral Services)
Countywide
Native American Health Center
(Richmond)
CCRMC – 4C
(County Inpatient)
Familias Unidas
Richmond
RYSE
(Richmond)
* WCCUSD = West Contra Costa Unified School District
* YSB – Youth Services Bureau
Psychiatric Emergency Services
(County Outpatient)
Community Health for Asian Americans
Richmond
STAND!
(Richmond)
Contracted Psychiatric Hospitals: John Muir Behavioral Health; Herrick Hospital; BHC Sierra Vista; BHC Heritage Oaks; St. Helena Hospital – Vallejo; St. Helena Hospital – St. Helena
Community Violence Solutions
San Pablo
Early Childhood Mental Health
Richmond
Youth Services Bureau
Richmond
Alternative Family Services
Richmond
Fred Finch (TAY FSP)
Richmond
La Cheim
Richmond
BACR
Richmond
Countywide Services
Contracted Psychiatric Hospitals
System of Care - Regional Community Based Organizations
Outpatient Psychiatric Emergency Services
School Based Programs
Providers Network
Prevention & Early Intervention Programs
Inpatient Psychiatric Emergency Services

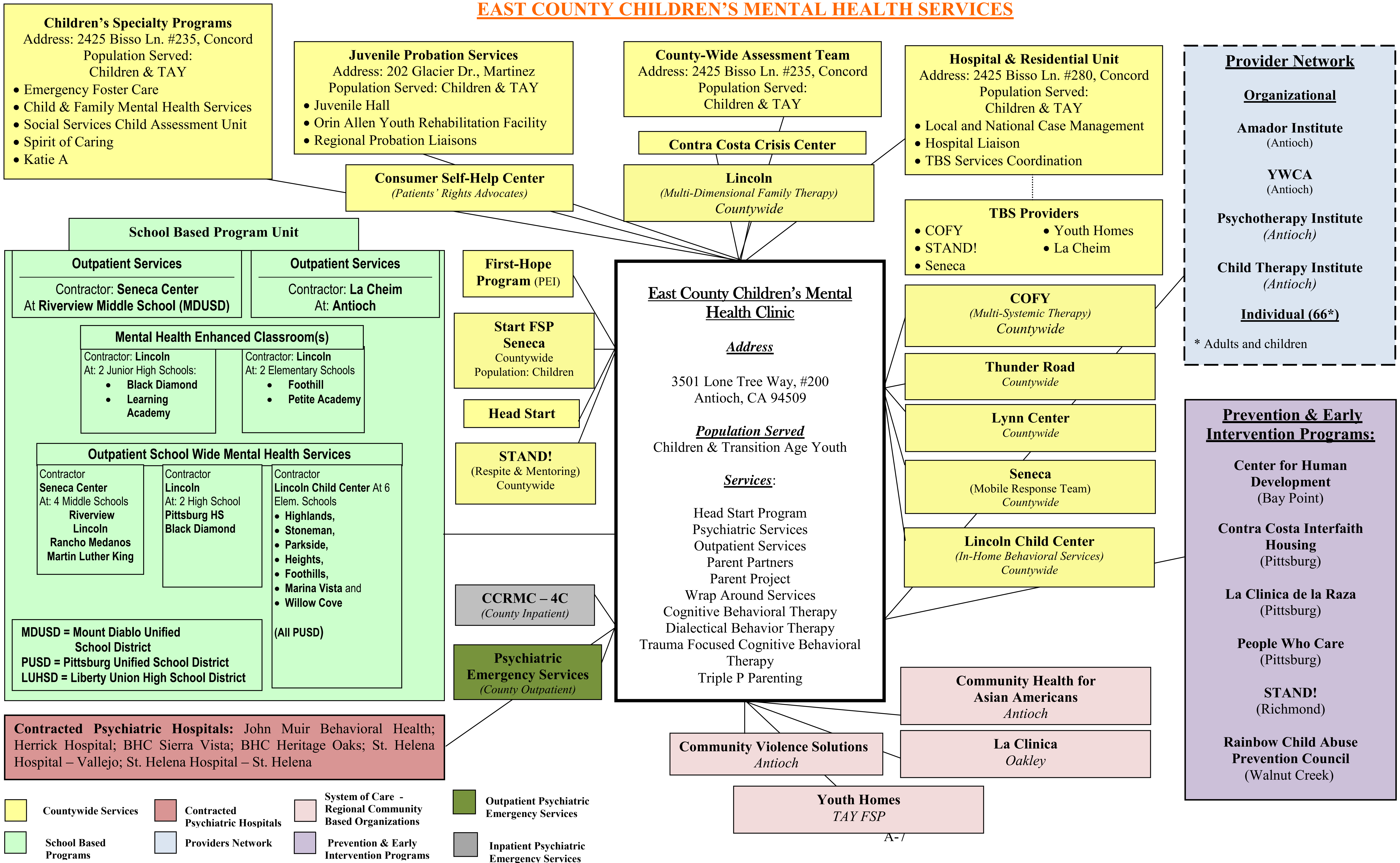
WEST COUNTY ADULT MENTAL HEALTH SERVICES




CENTRAL COUNTY CHILDREN'S MENTAL HEALTH SERVICES
Children's Specialty Program
Address: 2425 Bisso Ln. #235, Concord
Population Served:
Children & TAY
• Emergency Foster Care
• Child & Family Mental Health Services
• Social Services Child Assessment Unit
• Spirit of Caring
• Katie A
Juvenile Probation Services
Address: 202 Glacier Dr., Martinez
Population served:
• Juvenile Hall
• Orin Allen Youth Rehabilitation Facility
• Regional Probation Liaisons
County-Wide Assessment Team
Address: 2425 Bisso Ln. #235, Concord
Population Served:
Children & TAY
Hospital & Residential Unit
Address: 2425 Bisso Ln. #280, Concord
Population Served:
Children & TAY
• Local and National Case Management
• Hospital Liaison
• TBS Services Coordination
Provider Network
Organizational
YWCA
(Martinez)
Individual (72*)
* Both adult and children
Consumer Self-Help Center
(Patients' Rights Advocates)
Contra Costa Crisis Center
Lincoln
(Multi-Dimensional Family Therapy)
Countywide
TBS Providers
• COFY
• STAND!
• Seneca
• Youth Homes
• La Cheim
School Based Program Unit
Unbundled Day Treatment
Contractor: La Cheim At: La Cheim School - Antioch (NPS)
Contractor: Families First At: Mount Diablo High School (MDUSD)
Contractor: Seneca At: Olivera High School
First-Hope Program
(PEI)
Head Start
STAND!
(Respite & Mentoring)
Countywide
Central County Children's Mental Health Clinic
Address
2425 Bisso, Ste. 200
Concord, CA 94520
Population Served
Children & Transition Age Youth
Services:
Head Start Program
Psychiatric Services
Outpatient Services
Parent Partners
Parent Project
PIP Program
Wrap Around Services
Cognitive Behavioral Therapy
Dialectical Behavior Therapy
Trauma Focused Cognitive Behavioral Therapy
Triple P Parenting
Seneca
(Mobile Response Team)
Countywide
Thunder Road
Countywide
COFY
(Multi-Systemic Therapy)
Countywide
Lincoln
(In-Home Behavioral Services)
Countywide
Start FSP
Seneca
Countywide
Lynn Center
Countywide
Prevention & Early Intervention Programs:
Child Abuse Prevention Council
(Concord)
Contra Costa Interfaith Housing
(Walnut Creek)
Center for Human Development
(Pleasant Hill)
C.O.P.E. Family Support Center
La Clinica de la Raza
(Concord)
New Leaf
(Martinez)
Rainbow Community Center
(Concord)
STAND!
(Concord)
Mental Health Enhanced Classroom(s)
At: Campolindo High School (AUHSD)
At: Marchus School Middle School Class (CCCOE)
3 Classrooms Contractor: Seneca At: Pleasant Hill Middle School (MDUSD)
Contractor: Fred Finch At: Mt. Diablo High School
Outpatient School Wide Mental Health Services
At: Marchus School – Elementary Grades (CCCOE)
At: Belair JH (MDUSD), Fair Oaks JH (MDUSD), El Dorado JH (MDUSD)
At: Mt.Diablo/ Olympic/Alliance High Schools (MDUSD) Sunrise Elmntry (MDUSD)
MDUSD = Mount Diablo Unified School District
CCCOE = Contra Costa County Office of Education
NPS = Non Public School; AUHSD = Acalanes Union High School District
Psychiatric Emergency Services
(County Outpatient)
CCRMC – 4C
(County Inpatient)
Contracted Psychiatric Hospitals: John Muir Behavioral Health; Herrick Hospital; BHC Sierra Vista; BHC Heritage Oaks; St. Helena Hospital – Vallejo; St. Helena Hospital – St. Helena
Community Health for Asian Americans
Antioch
Youth Services Bureau
Concord
La Clinica de la Raza
Oakley
Pathways to Wellness
Martinez
Countywide Services
Contracted Psychiatric Hospitals
Prevention & Early Intervention
Outpatient Psychiatric Emergency Services
School Based Programs
Providers Network
System of Care - Regional Community Based Organizations
Inpatient Psychiatric Emergency Services

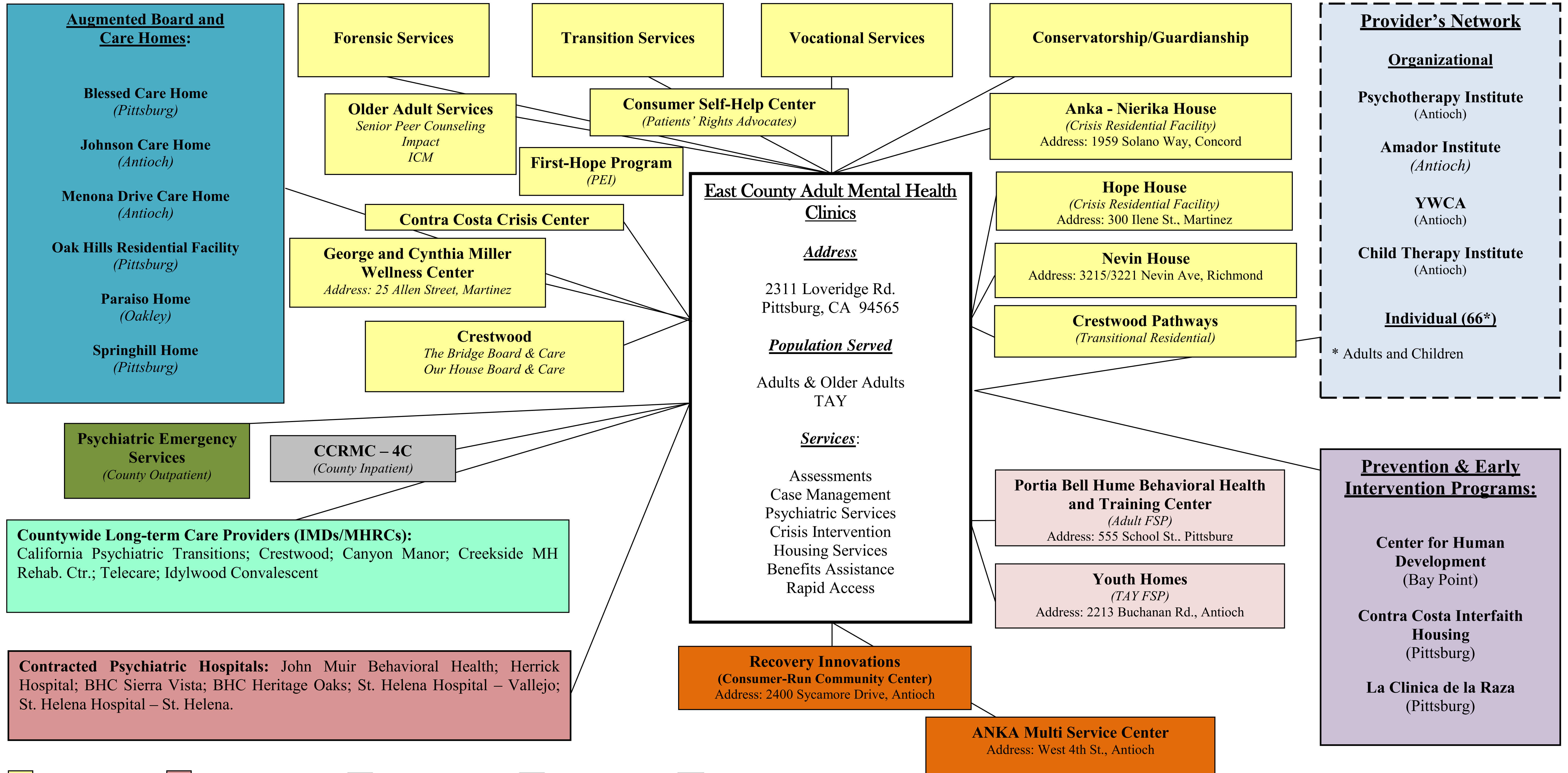
CENTRAL COUNTY ADULT MENTAL HEALTH SERVICES





EAST COUNTY CHILDREN'S MENTAL HEALTH SERVICES
Children's Specialty Programs
Address: 2425 Bisso Ln. #235, Concord
Population Served:
Children & TAY
• Emergency Foster Care
• Child & Family Mental Health Services
• Social Services Child Assessment Unit
• Spirit of Caring
• Katie A
Juvenile Probation Services
Address: 202 Glacier Dr., Martinez
Population Served: Children & TAY
• Juvenile Hall
• Orin Allen Youth Rehabilitation Facility
• Regional Probation Liaisons
County-Wide Assessment Team
Address: 2425 Bisso Ln. #235, Concord
Population Served:
Children & TAY
Contra Costa Crisis Center
Hospital & Residential Unit
Address: 2425 Bisso Ln. #280, Concord
Population Served:
Children & TAY
• Local and National Case Management
• Hospital Liaison
• TBS Services Coordination
Provider Network
Organizational
Amador Institute
(Antioch)
YWCA
(Antioch)
Psychotherapy Institute
(Antioch)
Child Therapy Institute
(Antioch)
Individual (66*)
* Adults and children
Consumer Self-Help Center
(Patients' Rights Advocates)
Lincoln
(Multi-Dimensional Family Therapy)
Countywide
TBS Providers
• COFY
• STAND!
• Seneca
• Youth Homes
• La Cheim
School Based Program Unit
Outpatient Services
Contractor: Seneca Center
At Riverview Middle School (MDUSD)
Outpatient Services
Contractor: La Cheim
At: Antioch
Mental Health Enhanced Classroom(s)
Contractor: Lincoln
At: 2 Junior High Schools:
• Black Diamond
• Learning Academy
Contractor: Lincoln
At: 2 Elementary Schools
• Foothill
• Petite Academy
Outpatient School Wide Mental Health Services
Contractor
Seneca Center
At: 4 Middle Schools
Riverview
Lincoln
Rancho Medanos
Martin Luther King
Contractor
Lincoln
At: 2 High School
Pittsburg HS
Black Diamond
Contractor
Lincoln Child Center At 6 Elem. Schools
• Highlands,
• Stoneman,
• Parkside,
• Heights,
• Foothills,
• Marina Vista and
• Willow Cove
(All PUSD)
MDUSD = Mount Diablo Unified School District
PUSD = Pittsburg Unified School District
LUHSD = Liberty Union High School District
First-Hope Program (PEI)
Start FSP
Seneca
Countywide
Population: Children
Head Start
STAND!
(Respite & Mentoring)
Countywide
CCRMC – 4C
(County Inpatient)
Psychiatric Emergency Services
(County Outpatient)
East County Children's Mental Health Clinic
Address
3501 Lone Tree Way, #200
Antioch, CA 94509
Population Served
Children & Transition Age Youth
Services:
Head Start Program
Psychiatric Services
Outpatient Services
Parent Partners
Parent Project
Wrap Around Services
Cognitive Behavioral Therapy
Dialectical Behavior Therapy
Trauma Focused Cognitive Behavioral Therapy
Triple P Parenting
COFY
(Multi-Systemic Therapy)
Countywide
Thunder Road
Countywide
Lynn Center
Countywide
Seneca
(Mobile Response Team)
Countywide
Lincoln Child Center
(In-Home Behavioral Services)
Countywide
Prevention & Early Intervention Programs:
Center for Human Development
(Bay Point)
Contra Costa Interfaith Housing
(Pittsburg)
La Clinica de la Raza
(Pittsburg)
People Who Care
(Pittsburg)
STAND!
(Richmond)
Rainbow Child Abuse Prevention Council
(Walnut Creek)
Contracted Psychiatric Hospitals: John Muir Behavioral Health; Herrick Hospital; BHC Sierra Vista; BHC Heritage Oaks; St. Helena Hospital – Vallejo; St. Helena Hospital – St. Helena
Community Health for Asian Americans
Antioch
Community Violence Solutions
Antioch
La Clinica
Oakley
Youth Homes
TAY FSP
Countywide Services
Contracted Psychiatric Hospitals
System of Care - Regional Community Based Organizations
Outpatient Psychiatric Emergency Services
School Based Programs
Providers Network
Prevention & Early Intervention Programs
Inpatient Psychiatric Emergency Services

EAST COUNTY ADULT MENTAL HEALTH SERVICES



Appendix B: Contra Costa Behavioral Health Services Mental Health Programs Grouped by Level of Care

Programs Included in Level Six (Medically Managed Residential Services)

Table B-1: Programs Included in Expenditures for Level Six (Medically Managed Residential Services)			
Program Name	**Agency**	**Region(s) Served**	**Target Population**
Contra Costa Regional Medical Center Inpatient Psych and Psychiatric Emergency Services	Contra Costa Health Services	Countywide	All
Hospital/Residential Services (Children's System of Care)	Contra Costa Behavioral Health Services	Countywide	Children
Psychiatric Health Facility	Central Star Behavioral Health	Countywide	Children
Probable Cause Hearing Officer	Dawdy	Countywide	Adult
Institute for Mental Disease	Various Contractors	Countywide	Adult
Contract Hospitals	Various Contractors	Countywide	All
State Hospitals	Contra Costa Behavioral Health Services	Countywide	Adult

Programs Included in Levels Four (Medically Monitored Non-Residential Services) and Five (Medically Monitored Residential Services)

Table B-2: Programs Included in Expenditures for Levels Four (Medically Monitored Non-Residential Services) and Five (Medically Monitored Residential Services)			
Program Name	**Agency**	**Region(s) Served**	**Target Population**
Assisted Outpatient Treatment	Mental Health Systems	Countywide	Adult
Assisted Outpatient Treatment Support	Contra Costa Behavioral Health Services	Countywide	Adult
Full Service Partnership Clinic Support	Contra Costa Behavioral Health Services	Countywide	All
Full Service Partnership Program	Seneca Family Agencies	Countywide	Children
Full Service Partnership Program	Community Options for Family and Youth	Countywide	Children
Full Service Partnership Program	Lincoln Center	Countywide	Children
Full Service Partnership Program	Youth Homes	Central and East County	Transition Age Youth
Full Service Partnership Program	Fred Finch Youth Center	West and Central County	Transition Age Youth
Full Service Partnership Program	Rubicon Programs	West County	Adult
Full Service Partnership Program	Anka Behavioral Health	Central County	Adult
Full Service Partnership Program	Desarrollo Familiar	West County	Adult
Full Service Partnership Program	Portia Bell Hume Center	West and East County	Adult
Full Service Partnership Program Supports	Recovery Innovations	Countywide	Adult
Older Adult Mental Health	Contra Costa Behavioral Health Services	Countywide	Older Adult
Vocational Services for High Needs Clients	Contra Costa Clubhouse	Countywide	Adult
Transition Team	Contra Costa Behavioral Health Services	Countywide	Adult
Outpatient Services in Residential Treatment Facility	Victor Treatment Centers	Countywide	Children
Residential Day Treatment Services	Summit View	Countywide	Children
Residential Day Treatment Services	Milhouse	Countywide	Children
Skilled Nursing Care, Medication Support	Brightstar	Countywide	Children
SB 163 WRAPAROUND	Contra Costa Behavioral Health Services	Countywide	Children
Wraparound Program - East	Contra Costa Behavioral Health Services	East County	Children
Wraparound Program - Central	Contra Costa Behavioral Health Services	Central County	Children
Wraparound Program- West	Contra Costa Behavioral Health Services	West County	Children
24th St Partial Hospitalization Day Treatment	Contra Costa Behavioral Health Services	West County	Adult
Crisis Residential Facility	Telecare Corporation and County	Countywide	Adult
Adult Full Service Partnership Housing Services, Residential Services	Crestwood	Countywide	Adult
Housing Support for High Needs Clients	Contra Costa Behavioral Health Services	Countywide	Adult
Residential Treatment Services	Various Contractors	Countywide	Children
Chris Adams Group Home	Contra Costa Behavioral Health Services	Countywide	Children
Supplemental Residential/Emergency Board and Care Contractors	Various Contractors	Countywide	Adult
Residential Treatment Services	Anka Behavioral Health	Countywide	Adult

Programs Included in Level Three (High Intensity Community Based Services)

Table B-3: Programs Included in Expenditures for Level Three (High Intensity Community Based Services)			
Program Name	**Agency**	**Region(s) Served**	**Target Population**
PEI First Hope	Contra Costa Behavioral Health Services	Countywide	Children, Transition Age Youth
County-Operated Innovation Programs	Contra Costa Behavioral Health Services	Countywide	All
Mental Health Services Act, General Systems Development	Contra Costa Behavioral Health Services	Countywide	All
Criminal Justice System Alcohol and Other Drugs	Contra Costa Behavioral Health Services	Countywide	All
AB-109 Realignment	Contra Costa Behavioral Health Services	Countywide	All
Central County Children's Mental Health Clinic	Contra Costa Behavioral Health Services	Central County	Children
Child/Family Mental Health Services	Contra Costa Behavioral Health Services	Countywide	Children
West County Children's Mental Health Clinic	Contra Costa Behavioral Health Services	West County	Children
Juvenile Probation Mental Health Services	Contra Costa Behavioral Health Services	Countywide	Children
Miscellaneous County Related Contracts and Costs	Contra Costa Behavioral Health Services	Countywide	All
County-Operated School-Based Mental Health Services	Contra Costa Behavioral Health Services	Countywide	Children
East County Children's Mental Health Clinic	Contra Costa Behavioral Health Services	East County	Children
Child Social Services Assessment	Contra Costa Behavioral Health Services	Countywide	Children
Family Partnership	Contra Costa Behavioral Health Services	Countywide	Children
Mental Health Calworks	Various Contractors	Countywide	Adult
Uninsured Clients	Contra Costa Behavioral Health Services	Countywide	Adult
Dual Diagnosis Project	Contra Costa Behavioral Health Services	Countywide	Adult
Adult Vocational Services	Contra Costa Behavioral Health Services	Countywide	Adult
Conrep Mental Health Services	Contra Costa Behavioral Health Services	Countywide	Adult
Adult Mental Health El Portal Clinic	Contra Costa Behavioral Health Services	West County	Adult
38th St Adult Mental Health Clinic	Contra Costa Behavioral Health Services	West County	Adult
West County Adult Mental Health 24 St	Contra Costa Behavioral Health Services	West County	Adult
East County Adult Mental Health Clinic	Contra Costa Behavioral Health Services	East County	Adult
Central County Adult Mental Health Clinic	Contra Costa Behavioral Health Services	Central County	Adult

Programs Included in Levels One (Recovery and Maintenance and Health Management) and Two (Low Intensity Community Based Services)

Table B-4: Programs Included in Expenditures for Levels One (Recovery and Maintenance and Health Management) and Two (Low Intensity Community Based Services)			
Program Name	**Agency**	**Region(s) Served**	**Target Population**
Patients Rights Support Services	Consumer Self Help Center	Countywide	All
Miller Wellness Center	Contra Costa Health Services	Countywide	All
Mental Health Services	Rainbow Community Center	Countywide	Lesbian, Gay, Bisexual, Transgender, and Questioning Communities
School-Based Mental Health Services, Mental Health Services, Intensive Home-Based Services	Lincoln Center	Countywide	Children
School-Based Mental Health Services	Mount Diablo Unified School District	Central County	Children
School-Based Mental Health Services, Outpatient Mental Health Services	Community Health for Asian Americans	Countywide	Children
School-Based Mental Health Services	West Contra Costa Youth Services Bureau	West County	Children
Mental Health Services	Contra Costa Interfaith Housing	Central County	Children
School-Based Mental Health Services, Outpatient Mental Health Services	Fred Finch Youth Center	Countywide	Children
School-Based Mental Health Services	West Contra Costa Unified School District	West County	Children
School-Based Mental Health Services	Families First	Central County	Children
Mental Health Services	La Clinica del a Raza	East County	Children
Mental Health Services	Desarrollo Familiar	Countywide	All
School-Based Mental Health Services, Outpatient Mental Health Services	Bay Area Community Resources	West County	Children
School-Based Mental Health Services	Young Men's Community Association	West County	Children
School-Based Mental Health Services, Outpatient Mental Health Services, Mobile Response	Seneca Family Agencies	Countywide	Children
Mental Health Services	Victor Community Support Services	Countywide	Children
Mental Health Services	Casa Serena Eating Disorders	Countywide	Children
School-Based Mental Health Services	Berkeley Youth Alternatives	West County	Children
Mental Health Services	Contra Costa Associate for Retarded Citizens	Countywide	Children, Ages 0 to 5
Mental Health Services, Respite Mentoring Services	STAND!	Countywide	Children
Mental Health Services	We Care	Central County	Children, Ages 0 to 5
Mental Health Services	Apspiranet	Countywide	Children
Mental Health Services	Community Options for Family and Youth	Countywide	Children
Mental Health Services	Alternative Family Services	West County	Children
Mental Health Services	Early Childhood Mental Health Program	West County	Children, Ages 0 to 5
Head Start Mental Health Services	Community Services Bureau of the Contra Costa County Employment and Human Services Department	Countywide	Children
Mental Health Services	Portia Bell Hume Center	West County	Adult
Mental Health Services	Pathways to Wellness	Central County	All
Mental Health Services	Rubicon Programs	West County	Adult
Outpatient Mental Health Services, Support Services, and Multi-Service Centers	Anka Behavioral Health	Countywide	Adult
Medi-Cal Outpatient Managed Care (Network Providers)	Various Contractors	Countywide	All

Programs Included in Level Zero (Basic Services for Prevention and Health Maintenance)

Table B-5: Programs Included in Expenditures for Level Zero (Basic Services for Prevention and Health Maintenance)

Program Name	Agency	Region(s) Served	Target Population
Prevention and Early Intervention, Supporting Youth	Contra Costa County Behavioral Health Services	Countywide	Youth and Families Experiencing Juvenile Justice System
Prevention and Early Intervention, Supporting Families	First Five Contra Costa	Countywide	Families
Prevention and Early Intervention, Supporting Families	Contra Costa Health Services	Central County	Adults
Prevention and Early Intervention, Supporting Older Adults	Contra Costa Behavioral Health Services	Countywide	Older Adults
Prevention and Early Intervention, Stigma Reduction	Contra Costa Behavioral Health Services	Countywide	All
Prevention and Early Intervention, Suicide Prevention	Contra Costa Behavioral Health Services	Countywide	All
Prevention and Early Intervention, Supporting Families	Contra Costa County Interfaith Housing	Central and East County	Formerly Homeless Families
Prevention and Early Intervention, Supporting Youth	People Who Care	East County	Youth
Prevention and Early Intervention, Supporting Older Adults	Lifelong	West County	Older Adults
Prevention and Early Intervention, Underserved Communities	La Clinica de la Raza	Central and East County	Latino Communities
Prevention and Early Intervention, Preventing Relapse	Putnam Clubhouse	Countywide	Adults
Prevention and Early Intervention, Supporting Families	Child Abuse Prevention Council	Central and East County	Families
Prevention and Early Intervention, Supporting Youth	James Morehouse Project	West County	Youth
Prevention and Early Intervention, Underserved Communities	Native American Health Center	Countywide	Native American Communities
Prevention and Early Intervention, Supporting Youth	The Latina Center	West County	Latino Families
Prevention and Early Intervention, Underserved Communities	Building Blocks For Kids	West County	At Risk Families
Prevention and Early Intervention, Underserved Communities	Lao Family Community Development	West County	Asian and Southeast Asian Communities
Prevention and Early Intervention, Suicide Prevention	Contra Costa Crisis Center	Countywide	All
Prevention and Early Intervention, Underserved Communities	Jewish Family and Children's Services	Central and East County	Immigrants and Refugees of Latino, Afghan, Bosnian, Iranian, and Russian Communities
Prevention and Early Intervention, Underserved Communities	Center for Human Development	East County	African American Communities
Prevention and Early Intervention, Supporting Youth	New Leaf	Central County	At Risk Youth
Prevention and Early Intervention, Supporting Youth	STAND! Against Domestic Violence	Countywide	At Risk Youth
Prevention and Early Intervention, Supporting Youth	Counseling Options Parenting Education	Countywide	Families
Prevention and Early Intervention, Underserved Communities	Rainbow Community Center	Countywide	Lesbian, Gay, Bisexual, Transgender, and Questioning Communities
Prevention and Early Intervention, Underserved Communities	Asian Community Mental Health	Countywide	Immigrant Asian Communities
Prevention and Early Intervention, Supporting Youth	RYSE	West County	At Risk Youth
Innovation, Reluctant to Rescue	Community Violence Solutions	West and East County	At Risk Youth

Contra Costa Mental Health System of Care Needs Assessment

Mental Health Services Act (MHSA)

Three Year Program and Expenditure Plan
Fiscal Year 2017-20

Needs Assessment

- Data driven quantitative analysis to supplement the MHSA Community Program Planning Process for FY 2017-20
- Addresses three areas of inquiry - is Contra Costa Behavioral Health Services (CCBHS):
  - Serving the people it should?
  - appropriately allocating its resources to provide a full spectrum of care?
  - experiencing any significant workforce shortfalls?

CONTRA COSTA
HEALTH SERVICES

1. Serving Target Population?

Method

- Compare the estimated number of Contra Costa County individuals who are poor and experience serious mental health issues with the number served by CCBHS (prevalence rate)
- Compare the proportion of actual total Medi-Cal eligible clients who access CCBHS services by County regions (West, Central, East) as well as by race/ethnicity, age group and gender, and compare to statewide averages for the same population (penetration rate)

Prevalence

- 1,126,745 = total Contra Costa County population in 2015
- 19,878 or 8.13% = estimated prevalence of individuals at or below 200% of the federal poverty level with serious mental health issues
- 19,733 = total Medi-Cal eligible clients served by CCBHS in 2015, or 99.3% estimated prevalence
- 99.3% represents an increase from 77% in 2013.

Penetration Rate

- 19,343 = total Medi-Cal eligible population served by CCBHS in 2014
- 254,658 = total Medi-Cal eligible population countywide in 2014
- 7.6% penetration rate for Contra Costa
- 5.2% statewide penetration rate

CONTRA COSTA
HEALTH SERVICES

Penetration Rates

Contra Costa compared to statewide average:

- Race/Ethnicity – Contra Costa's penetration rates exceed the statewide average in every category except those self-identifying as "Other" (1.7% to 6.1%)
- Age Group – Contra Costa exceeds the statewide average for every age group except ages 0-5 (1.7% to 2.5%)
- Gender Identity – Contra Costa exceeds the statewide average for every self-identified gender.

Penetration Rates within County Regions (2014)

	West	Central	East	County	Statewide
Total	7.6	9.1	7.9	7.6	5.2
By Race/Ethnicity:					
African American	12.1	25.9	11.8	12.1	9.1
Asian/Pacific Islander	2.7	3.0	2.6	2.7	2.9
Caucasian	15.3	16.7	15.9	15.3	8.5
Latino	5.2	5.2	4.8	4.8	3.6
Native American	22.2	23.8	28.4	22.2	8.1
By Age Group:					
0-5	2.4	1.6	1.7	1.7	2.1
6-12	6.6	6.6	6.8	6.6	6.5
13-17	11.8	13.7	11.8	11.6	N/A
18-21	6.1	10.5	7.3	7.0	6.2
22-59	9.7	12.2	10.5	9.9	N/A
60+	5.5	5.7	5.5	5.4	3.1

Discussion

- Data analysis supports that the number of clients served by CCBHS approximates the estimated number of individuals requiring services
- Contra Costa serves Medi-Cal eligible clients at a rate higher than the majority of counties in California.
- Regions and sub-populations within the County are generally appropriately represented
- Persons who identify as Asian/Pacific Islanders, Latina/os, children under the age of five, and adults over 60 appear to be somewhat underrepresented in each region.

2. Allocating Resources Appropriately?

<u>Method</u>

- Grouped CCBHS FY 2015-16 expenditures by LOCUS/CALOCUS levels of care definitions and compared to funding allocation benchmarks established by “A Model for California Community Mental Health Programs”, published by the Mental Health Association of California.
- Levels of care include locked facilities, 24 hour community care, outpatient services for the seriously mentally ill, therapy, outreach and engagement and training/staff development.

Results

Level of Care	Expenditures	Percentage	Recommended Percentage
Locked Facilities	$38.9m	22	17
24 hour Community Care	43.8	24	33
Outpatient Services for SMI	42.3	24	22
Therapy	45.7	25	22
Outreach and Engagement	8.0	4	5
Training/Staff Development	.6	.3	1
Total:	$179.2m	100	100

Discussion

- The full spectrum of mental health services is made available, as significant resources are allocated at every level of care
- Expenditures indicate that more funding is provided at the most acute level of in-patient care (locked facilities) than is ideally recommended, while
- High intensity community based services, to include 24 hour residential care, appear to be below the recommended benchmark
- Workforce development, to include recruiting, training and retention efforts appear to be underfunded

3. Significant Workforce Shortfalls?

Method

- Staff vacancies reviewed to determine focus of analysis of staff position shortages - revealed a significant lack of available psychiatry time
  - Analysis of authorized versus filled positions
  - Comparison of psychiatrist pay with neighboring county mental health programs
- Staff demographics compared to county demographics to determine any significant variances
- Bi-lingual pay differential and interpretation services reviewed for staff capacity

Psychiatry Time/Pay

Psychiatrist Full-Time Equivalent Positions (FTEs)

	authorized	filled	% filled
County:	authorized = 18.925	filled = 8.175	% filled = 43
Contract:	authorized = 25.035	filled = 21.35	% filled = 85
Total:	43.96	29.525	67

Annual Psychiatrist Mid-Range Salary

County	Salary
Alameda:	$194,191
Marin:	170,348
San Francisco:	208,087
Solano:	210,051
Average:	$195,669

Contra Costa: $155,498

Demographics/Bi-Lingual Capacity

Race/Ethnicity	County Population	Consumers	County Staff
White	49%	36%	46%
Hispanic	24	18	11
African American	9	30	19
Asian/Pacific Islander	14	6	7
Native American	.4	.6	.4
Other	4	9	16

- Staff receiving bi-lingual pay in 2010 = 74; in 2015 = 90
- 75% of requests for language interpretation now provided by telephone or video Healthcare Interpreter Network

Discussion

- Significant shortage of psychiatrists contribute to compromising mental health care
- Contra Costa pays psychiatrists significantly less than neighboring counties
- County staff identifying as Latina/o and Asian Pacific Islander are underrepresented when compared to all county staff
- County staff receiving differential pay for bi-lingual capacity are increasing.
- Interpretation services appear to be available to meet the needs of clients when bi-lingual staff are unavailable

Summary

- CCBHS is reaching the target population it is mandated to serve; penetration rates are greater than the statewide average, and are consistent across county regions
- Sub-populations of Latina/os, Asian Pacific Islanders, children up to age five, and adults over the age of 60 have slightly lower penetration rates than other sub-populations
- CCBHS is apportioning its funding to provide a full spectrum of services, while spending more than the recommended benchmark for locked facilities, and less on intensive community based services
- There is a significant shortage of psychiatry time that appears to be due in part to lack of pay parity with neighboring counties

Recommendations

Suggest CCBHS:

- strengthen outreach and engagement strategies for the underserved populations of Asian Pacific Islanders, Latina/os, children ages 0 to 5, and adults over 60.
- Improve capacity to assist consumers move from higher levels of care, such as locked facilities, to lower levels of care in the community
- Explore strategies for increasing psychiatry time, such as increasing county psychiatry pay and contract rates, and establishing workforce incentives, such as loan forgiveness programs

Study Limitations

- This assessment of need does not assess the quality of care provided to consumers
- Prevalence benchmarks are approximate calculations, not exact figures
- Numbers of clients served may have included some who may not have met medical necessity
- Client and service data are based on billing records, not mental health records, as CCBHS does not have an electronic health record system
- Individuals served by most contract Prevention and Early Intervention programs are not included in the penetration rate data, as these programs do not enter client data in the PSP/INSYST billing system
- The expenditure benchmarks recommended by the Mental Health Association of California were established in 1981, and may not accurately reflect the impact of the movement to decrease institutional services and increase community-based outpatient services
- Some programs listed for one level of care may actually be providing services to clients representing more than one level of care
- Levels of care 4 and 5 was combined, as was levels 1 and 2 due to many programs providing both levels of care and making it difficult to attribute expenditures to a single level of care.
- Staffing demographic data was taken directly from FY 2010-13, and may not accurately reflect today's demographics

Needs Assessment

Contra Costa Behavioral Health Services (CCBHS) conducted a quantitative assessment of public mental health need in preparation for developing the Fiscal Year 2017-20 Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan (Three Year Plan). This data driven analysis complements the Community Program Planning Process (CPPP), where interested stakeholders provided input on priority needs and suggested strategies to meet these needs.

Data was obtained to determine whether CCBHS was a) reaching the people it is mandated to serve, b) appropriately allocating its resources to provide a full spectrum of care, and c) experiencing any significant workforce shortfalls.

Benchmarks for the CCBHS target population were established for the county and county regions (East, Central, West) as well as by race/ethnicity, age group and identified gender to determine whether CCBHS was serving more or less than these benchmarks. Benchmarks for appropriate resourcing by level of mental health care, ranging from locked facilities to basic services for prevention and health maintenance, were also established to determine whether the level of funding CCBHS spent on each level met recommended standards. Finally, all CCBHS position classifications were reviewed to determine whether any significant shortfalls existed between authorized versus filled positions, staffing demographics, and bi-lingual staff.

Data analysis supports that CCBHS is serving the number of clients that approximate the estimated number of individuals requiring services, and serves more eligible clients than the majority of counties in California. This is based upon prevalence estimates and penetration rates of low income children with serious emotional disturbance and adults with a serious mental illness as compared with other counties. In addition, regions and sub-populations within Contra Costa County are generally appropriately represented, with the exception of Asian/Pacific Islanders, Latina/os, children ages 0-5 years, and adults ages 60 and over as being somewhat underrepresented in each region when compared to other sub-populations within Contra Costa County.

Fiscal Year 2015-16 expenditure data indicate services were available at every level of care as defined by the Level of Care Utilization System (LOCUS/CALOCUS). However, compared to benchmarks, CCBHS over spends on the most acute level of in-patient care (Level 6), and is below the benchmark in expenditures related to programs providing high intensity community-based services (Levels 4 and 5).

Workforce analysis indicates a significant shortage of psychiatry time, both in county positions as well as contract psychiatrists. Compounding the issue of filling vacant psychiatrist positions is that Contra Costa County reimburses psychiatrists at a lower rate than neighboring counties. Latina/o and Asian/Pacific Islander populations are under-represented among county staff when compared to the county population. Finally, CCBHS has incrementally increased the number of bilingual staff each year, and has made available as needed phone, in-person and video interpretation services.

This quantitative needs assessment suggests attention in the following areas:

- Strengthen outreach and engagement strategies for identified underserved populations across the county.
- Improve capacity to assist consumers move from locked facilities to community based services.
- Explore strategies to recruit and retain psychiatrists and staff representing underserved populations.

The Community Program Planning Process

Each year CCBHS utilizes a community program planning process to 1) identify issues related to mental illness that result from a lack of mental health services and supports, 2) analyze mental health needs, and 3) identify priorities and strategies to meet these mental health needs.

CPAW. CCBHS continues to seek counsel from its ongoing stakeholder body, entitled the Consolidated Planning Advisory Workgroup (CPAW). Over the years CPAW members, consisting of consumers, family members, service providers and representative community members, have provided input to the Behavioral Health Services Director as each Three Year Plan and Yearly Update has been developed and implemented. CPAW has recommended that the Three Year Plan provide a comprehensive approach that links MHSA funded services and supports to prioritized needs, evaluates their effectiveness and fidelity to the intent of the Act, and informs future use of MHSA funds. CPAW has also recommended that each year's Community Program Planning Process build upon and further what was learned in previous years. Thus the Three Year Plan can provide direction for continually improving not only MHSA funded services, but also influencing the County's entire Behavioral Health Services Division.

Community Forums. CPAW has been the central planning and implementation resource for fielding each year's Community Program Planning Process. Last year's venue was to engage consumers and family members who participate in MHSA funded Prevention and Early Intervention programs that provide outreach and engagement to underserved populations in their respective communities. This year's venue was to bring together via three community forums consumers, family members, service providers and interested community members by Contra Costa County region (West, Central, and East).

Over 300 individuals attended these three forums (October 6 in San Pablo, November 3 in Pleasant Hill, December 1 in Bay Point), and self-identified as one or more of the following:

- 23% - a consumer of mental health services
- 32% - a family member of a consumer of services
- 39% - a provider of mental health services
- 14% - an interested member of the community

Discussions. Participants actively discussed in small groups ten topical issues that were developed by consumer, family member and service provider representatives before the forums. Highlights of the discussions include:

- **What should services in my culture look like?**
  - Diversity is important, and cultural differences should be understood and respected in a non-judgmental way – need to be culturally humble. A diverse mental health workforce sends a message to non-dominant cultures that difference is honored.
  - We are getting more immigrants who need more support in understanding our laws.
  - Many of our immigrants come from war torn countries and suffer from post-traumatic stress disorder. Care providers need to understand how specific cultures deal with this disorder, as a common tendency is to hide mental illness.
  - Suggest using non-traditional means to gain trust and acceptance, such as music, art, multi-media, and gardening.
  - Suggest developing a cadre of paid and volunteer care providers of the same culture to go to people's homes, as people need to develop trust, and are often fearful of being subjected to legal action.
  - Youth, especially those with a non-heterosexual gender identity, are prone to bullying and are vulnerable to suicidal behavior.
  - For African and Hispanic Americans mental health care should be family centered and/or faith based.
  - Clinicians should understand the ramifications of assigning a mental illness diagnosis.
  - We need more clinicians who speak multiple languages – we are losing them to neighboring counties because of pay disparity.
  - The County should be current with race/ethnicity trends, where Latina/os are moving to the West and African Americans are moving to the Eastern part of the County.
  - Organizations, such as the Native American Health Center, should be educating mental health providers about the various Native American cultures.
  - Medication prescribers need to be sensitive to potential ethnic specific reactions.
  - We need to ensure that translated materials and language interpreters are sensitive to and being understood by the people needing this accommodation.

- **How can I get housing that I can afford?**

- The housing market is way too high to enable low income people to afford rents. We need rent control.
- Section 8 housing is too difficult to navigate to be a resource.
- Affordable housing often means unsafe housing.
- People need access to the internet and help navigating the application process.
- People searching for housing often need some form of stable short-term housing. Sometimes they may need to get help cleaning up and resting at these places so they can be presentable for interviews.
- The east end of the County has the fastest growing population of people not being able to afford housing, and has the least resources to help with this problem.
- Suggest a clearinghouse to assist individuals and their families to find affordable housing. Need to do a better job of sharing housing opportunity information. Need a one stop shopping approach, with a single application.
- More shelter beds needed, especially in the wintertime when it is full.
- Public dollars should go to non-profits with supportive housing expertise, rather than banks and developers.
- More shared housing capacity should be developed, such as elders pooling resources, and families with mental health experience taking in individuals into their homes. Cities should permit “mother-in-law” units.
- Re-purpose abandoned or foreclosed structures for affordable housing.
- Increase the number of board and care homes.
- Advocate for the Board of Supervisors to spend more dollars for housing.
- Flexible funding needed to pay for credit checks, first/last month’s rent, moving in and out, and other expenses to enable individuals to obtain housing.
- Organizations should partner to help people get and keep housing.

- **What should care look like for persons with serious mental illness who live in supportive housing?**
  - Services should be provided on site, or have a multi-disciplinary mobile team come to the sites. Mental health, substance abuse and primary health issues should be addressed holistically and in a coordinated fashion.
  - Include life skills support, such as budgeting and money management, cooking, cleaning, home maintenance and conflict resolution skills in order for individuals to keep their residence.
  - Care providers should partner with property managers to deal with behavior issues that might threaten an individual keeping their residency.

- For augmented board and cares specific attention should be given to medication regimens, if professional staff are not located on site.
- Family members living off site should be welcomed and included, as appropriate, and emphasis and rules should be supportive of family reunification.
- Support groups, such as twelve step, should be encouraged.
- Daily meaningful activities, such as self-care regimens, hobby groups, parenting classes, field trips, gardening, site maintenance, pre-vocational activities, before and after school programs and social/cultural activities should be built in, whether at the site or arranged.
- Case management should not drop off when a consumer is placed, but should complement on-site services.
- Housing problems, such as bad food and bed bugs, can trigger mental health problems.
- Before being discharged from psychiatric hospitals persons should have dedicated attention to preparation for living in a less restricted environment, even if it means prolonging their stay to acquire these skills and coping mechanisms.
- It is important not to place supported living residences in high crime and drug environments.
- Each supportive living arrangement should build into all of their activities the goal of improving a consumers living situation, to include moving out to better, more independent housing.
- All of the above would require many more dollars allocated than is currently being budgeted.

- **What does help getting to and from services look like?**
    - Services are too spread out in the County to be accessible. Many countywide services are located in central county, where public transportation is not available to the east and west ends of the County.
    - Using BART/buses can be daunting. Coaching to use public transportation independently would be helpful, to include coping with fears, safety concerns, and responding appropriately to bullying and discrimination.
    - Becoming eligible for discount passes can be difficult. Assistance in becoming eligible would be helpful, as well as the funding to be able to afford vouchers.
    - Suggest a shuttle service that stops at common safe stops, and coordinates with people who live in close proximity to each other, and when people have health/mental health appointments.
    - Assist individuals connect with each other so they can ride together.

- Coordinate appointment scheduling around public transportation schedules.
- Explore voucher system with Uber/Lyft as a means of ride sharing door to door. Expand their business model to include minors.
- Continue moving mental health care out to common safe spots, such as schools, colleges, health centers, so that care is brought closer to where consumers live.
- Assist individuals connect with each other so they can ride together.
- Coordinate appointment scheduling around public transportation schedules.
- Explore voucher system with Uber/Lyft as a means of ride sharing door to door. Expand their business model to include minors.
- Continue moving mental health care out to common safe spots, such as schools, colleges, health centers, so that care is brought closer to where consumers live.
- Expand volunteer services so that drivers can transport consumers.
- Advocate with transit authorities for more accessible public transportation routes and provide more benches and shelters.
- Use smart phones to assist with linking to directions and public transportation availability.

- **Helping family members navigate mental health, medical, and alcohol and drug services – what should that look like?**
  - These services are housed separately, have different eligibility requirements, have different treatment approaches, are poorly coordinated both within themselves and with the education, social services and criminal justice systems, and often have differing, lengthy waiting periods before treatment happens. This is overwhelming for family members.
  - Care providers should work together to provide a more coordinated, whole person team approach that considers and responds to all co-occurring disorders that affect a person simultaneously, to include mental illness, developmental disabilities, health issues, and drug and alcohol problems.
  - Funding streams for these resources should be coordinated such that eligibility does not interfere with or prevent appropriate response and treatment by care providers.
  - Family members of consumers should be included as part of the treatment team, with assistance provided for them to become powerful natural supports in the recovery of their loved ones.
  - Resources should be allocated to establish paid staff to 1) support family members access and navigate current treatment systems, 2) develop family members with lived experience to act as subject matter experts in a volunteer capacity to educate and support other family members in understanding and

best participating in the different systems of care, 3) provide outreach and education to the community to reduce stigma and discrimination pertaining to mental illness, and 4) partner with other organizations to increase community involvement and support in the care of persons with mental illness.
  - Support and education groups for families specific to different cultures and languages need to be increased throughout the County.
  - Family supports need to be developed in and by the various communities in the County, and need to be culturally and linguistically accessible to the families served, irrespective of their ability to pay.
  - Provide a single place of contact in each region of the county for family members to obtain assistance with mobilizing treatment resources for their loved ones.

- **What should emotional support for family members look like?**
  - The biggest support comes from families who have been through similar experiences and who understand what a family is going through.
  - Mental illness affects the entire family, so emotional support should be for everyone, including the siblings.
  - Families often see disturbing behavior and don’t recognize that there is a mental illness going on. Early education and awareness is key to de-stigmatizing, learning coping mechanisms and getting loved ones the help they need. When first encountering mental illness they don’t know what to do.
  - Learning self-care is empowering.
  - Most helpful is respite care for parents to have a break.
  - Help in understanding, accessing and navigating services is a tremendous emotional support.
  - It is important for people providing emotional support to families to be culturally humble and honor a family’s personal beliefs.
  - NAMI has perfected how to support family members and should be funded to expand this support to paid staff. Operating with only volunteers, NAMI has been limited in what they can do; especially providing family support in the east, west and southern portions of the county.
  - Providing NAMI funding would enable expanding outreach to families of youth and adults in the criminal justice system.
  - Recommend providing psychotherapy for family members who have a loved one experiencing mental illness.

- **How should public mental health partner with the community when violence and trauma occur?**

- Schools can identify children traumatized and at risk, but teachers and staff are not equipped to adequately care for the child and their family. Via wraparound funding behavioral health should partner with education on site and in the homes to provide needed mental health services.
- Children under five and kids with special needs are particularly vulnerable, and are often overlooked.
- Persons who are homeless are in continuous trauma.
- There appears to be a recent increase in violence toward immigrants, Muslims and persons who identify themselves as lesbian, gay, bi-sexual, transgender or who question their sexual identity or gender. There is increased fear among these individuals.
- Mental health care should be extended to teachers, police, church staff, and other community organization first responders, as they are dealing with trauma as well. Working closely with the police is especially helpful.
- Care should be brought to the community by staff who are trusted and culturally and linguistically responsive. Non-labeling and confidentiality are most important.
- Care providers who are not properly trained, ill-suited, or abuse the power of their position can do more damage than the trauma itself.
- Relationships and trust should be established with community first responders before violence occurs, through training, workshops and community events.
- First responders need better information regarding what mental health resources are present in their community, and how to access and navigate them.
- The key role of drugs and alcohol leading to violence need to be recognized and included as part of the mental health care.
- Attention should be focused on the perpetrators, in order to break the cycle of violence.
- Some sort of infrastructure needs to be built such that mental health professionals can respond quickly when community trauma occurs.
- Service should be provided immaterial of whether the family has insurance.
- Mental health professionals should be aware and prepared to address learned desensitization, stigma of discussing feelings regarding experienced violence, and distrust of authority figures.
- All behavioral health staff should stay current with the latest in trauma informed response and care.
- Ending up in the County's psychiatric in-patient ward does not help the person, and often signals a failure to prevent hospitalization.

- **How do we care for young people who have both mental health and alcohol and drug problems?**
    - Currently there is no coordinated outpatient mental health and alcohol/drug treatment services for adolescents, and very limited in-patient treatment. This often leads to juvenile hall.
    - We should be providing all levels of care in one place, from intensive to continuing care.
    - First responders, such as mental health probation liaisons, delinquency boards, faith based groups and teachers trained to recognize symptoms can act as referral sources.
    - Should engage the whole family. Part of the therapy is education regarding addiction as being a "family disease". Also, there is the reality of relapse when returning a youth to a family that is still using and abusing drugs and alcohol.
    - Successful graduates of treatment are ideal to act as peer mentors.
    - Best practices should be determined by the culture the youth is a part of.
    - Mental health and substance use disorder professionals need to be cross trained in each other's disciplines, as well as how to work together as team.
    - Medi-Cal eligibility should not be a barrier, as the need in this age group is overwhelming and cuts across all levels of society.
    - Mental health providers should be able to bill Medi-Cal for substance use disorder treatment the same as they do for mental health disorders.
    - There should be a substance use disorder professional co-located at each regional mental health clinic.
    - School district administrators should be partnered with to establish as part of the district's educational plan curricula regarding mental health/substance use disorders and the neuropsychiatry of addiction.
    - Marketing and education efforts should utilize more social media modes than current the method of flyers and other hard copy materials.

- **How do we help people who get better move to lower levels of care?**
    - There should be discussion of and planning for use of less acute levels of service right from the beginning, so that consumers are prepared to demonstrate higher levels of self-care as they move to lower levels of professional care.
    - Systems of care should be as flexible and non-judgmental as possible to reduce resistance (stigma and embarrassment) when higher levels are needed due to external factors. These setbacks, when properly handled, enable greater learning and better use of lower levels of care when the person is ready.

- All of our various programs need to do a better job of coordinating care and "warm hand offs" with each other.
- Mentoring plays an important role in people's success. A single mentor with lived experience reinforcing the goal of self-sufficiency and supporting movement to different levels helps.
- As many levels of care in one place helps. Permanent supportive housing, with many levels of care on site, is a good model.
- Make sure that there is a lower level of care to go to and utilize. For example, returning to a gang as the only means for social connectivity is not helpful.
- Emphasizing spirituality as part of the healing process at all levels facilitates a deeper and unified approach to wellness, and assists in seeing a level of care as a milestone, and not an end in itself.
- Incorporating meaningful activity at all levels focuses on strengths, and can be built upon as one navigates care.
- Varying levels of employment, from volunteering, to subsidized employment, to competitive jobs in the community can support recovery.
- Recommend utilizing today's tools of apps and social media to facilitate incorporation of self-care into daily health and mental health habits.
- Teaching life and social skills at all levels also is key to the recovery process.
- Inclusion and involvement of the family and other natural supports are important.
- The current model of state and federal reimbursements need to be addressed in order to incentivize counties to facilitate appropriate movement of consumers to lower cost treatment based upon their recovery progress, and not on the need of the system to save money. Current Medi-Cal billing makes this difficult.

- **What community mental health needs and strategies would you like to discuss that have not been mentioned?**
    - Pre-employment services need to be expanded so that people have the whole range of activities that can prepare them for employment, to include volunteer experiences and internships. These services are particularly lacking for transitional age youth. Suggest partnering with the Career Resource Centers throughout the county.
    - Aging felons are coming out of prison after experiencing many years of trauma and do not have any place to go or any support system.
    - Young people experiencing a first psychotic break can receive effective treatment that enables recovery. This county needs funding to establish a first break program.
    - NAMI should receive financial support to support and educate families of persons with mental health issues.

- The hearing impaired need mental health services.
- Many immigrants and undocumented persons are now fearful and distrustful of the system. We need to provide safe spaces for them to get the care they need.
- We need a substance use detoxification program in each region of the county that includes mental health treatment.
- We cannot get any psychiatry time in our part of the county.
- Would like one stop centers that are inclusive and inviting, such as senior centers and the Family Justice Center.
- People need to have services and supports in their native language.
- Children with special needs, such as learning and developmental disabilities have a hard time getting mental health services.
- Money management, or benefits counseling is no longer offered and is sorely need for consumers so that they can access and navigate financial benefits, manage their money, and not get taken advantage of.
- Faith based spiritual work should be included as part of the recovery process.
- Foster youth mental health services are lacking.
- Youth need safe places to go where they see other youth that look like them and mental health discussions are normalized to reduce stigma and discrimination.
- Expand the SPIRIT program to support internships outside of behavioral health settings. Consider internships before as well as after the classroom training.
- More adequate psychiatric emergency facilities are needed.
- Children out of county placements are a hardship for the family.
- Parents of adult children with serious mental illness could use respite care.

As part of the event participants were then asked to prioritize via applying dot markers the following identified needs from previous years' community program planning processes. This provides a means for evaluating perceived impact over time of implemented strategies to meet prioritized needs. Needs are listed in order of priority as determined by forum participants, with previous Three Year Plan rankings provided for comparison.

1. **More housing and homeless Services.** (Previous rank: 1) The chronic lack of affordable housing make this a critical factor that affects the mental health and well-being of all individuals with limited means. However, it is especially deleterious for an individual and his/her family who are also struggling with a serious mental illness. A range of strategies that would increase housing availability include increasing transitional beds, housing vouchers, supportive housing services, permanent housing units with mental health supports, staff

assistance to locate and secure housing in the community, and coordination of effort between Health, Housing and Homeless Services and CCBHS.

2. **More support for family members and loved ones of consumers.** (Previous rank: 11) Critical to successful treatment is the need for service providers to partner with family members and significant others of loved ones experiencing mental illness. Stakeholders continued to underscore the need to provide families and significant others with education and training, emotional support, and assistance with navigating the system.

3. **Better coordination of care between providers of mental health, substance use disorders, homeless services and primary care.** (Previous rank: 3) Integrating mental health, primary care, drug and alcohol, homeless services and employment services through a coordinated, multi-disciplinary team approach has been proven effective for those consumers fortunate to have this available. Often cited by consumers and their families was the experience of being left on their own to find and coordinate services, and to understand and navigate the myriad of eligibility and paperwork issues that characterize different service systems. Also cited was the difficulty of coordinating education, social services and the criminal justice systems to act in concert with the behavioral health system.

4. **Children and youth in-patient and residential beds.** (Previous rank: 6) In-patient beds and residential services for children needing intensive psychiatric care are not available in the county, and are difficult to find outside the county. This creates a significant hardship on families who can and should be part of the treatment plan, and inappropriately strains care providers of more temporary (such as psychiatric emergency services) or less acute levels of treatment (such as Children's' clinics) to respond to needs they are ill equipped to address. Additional funding outside the Mental Health Services Fund would be needed to add this resource to the County, as in-patient psychiatric hospitalization is outside the scope of MHSA.

5. **Finding the right services when you need it.** (Previous rank: 8) Mental health and its allied providers, such as primary care, alcohol and other drug services, housing and homeless services, vocational services, educational settings, social services and the criminal justice system provide a complexity of eligibility and paperwork requirements that can be defeating. Just knowing what and where services are can be a challenge. Easy access to friendly, knowledgeable individuals who can ensure connection to appropriate services is critical.

6. **Improved response to crisis and trauma.** (Previous rank: 4) Response to crisis situations occurring in the community needs to be improved for both adults and children. Crisis response now primarily consists of psychiatric emergency services located at the Contra Costa Regional Medical Center (CCRMC). There are few more appropriate and less costly alternatives.

7. **Support for peer and family partner providers.** (Previous rank: 7) CCBHS was acknowledged for hiring individuals who bring lived experience as consumers and/or family members of consumers. Their contributions have clearly assisted the County to move toward a more client and family member directed, recovery focused system of care. However, these individuals have noted the high incidence of turnover among their colleagues due to exacerbation of mental health issues brought on by work stressors, and lack of support for career progression. Individuals in recovery who are employed need ongoing supports that assist with career progression, and normalizes respites due to relapses.

8. **Intervening early in psychosis.** (Previous rank: 5) Teenagers and young adults experiencing a first psychotic episode are at risk for becoming lifelong consumers of the public mental health system. Evidence based practices are now available that can successfully address this population by applying an intensive multi-disciplinary, family based approach. A proposed strategy is to expand the target population now served by Project First Hope from youth at risk for experiencing a psychotic episode to include those who have experienced a "first break".

9. **Getting care in my community, in my culture, in my language.** (Previous rank: 9) Focus groups underscored that mental health stigma and non-dominant culture differences continue to provide barriers to seeking and sustaining mental health care. Emphasis should continue on recruiting and retaining cultural and linguistically competent service providers (especially psychiatrists), training and technical assistance emphasis on treating the whole person, and the importance of providing on-going staff training on cultural specific treatment modalities. Also, culture-specific service providers providing outreach and engagement should assist their consumers navigate all levels of service that is provided in the behavioral health system. Transition age youth, to include lesbian, gay, bi-sexual, transgender and questioning youth, who live in at-risk environments feel particularly vulnerable to physical harassment and bullying. Stakeholders

continued to emphasize MHSA's role in funding access to all levels of service for those individuals who are poor and not Medi-Cal eligible.

10. **Assistance with meaningful activity.** (Previous rank: 2) Stakeholders underscored the value of engaging in meaningful activity as an essential element of a treatment plan. Youth in high risk environments who are transitioning to adulthood were consistently noted as a high priority. For pre-vocational activities, suggested strategies include providing career guidance, assistance with eliminating barriers to employment, and assistance with educational, training and volunteer activities that improve job readiness. Stakeholders highlighted the need for better linkage to existing employment services, such as job seeking, placement and job retention assistance. For daily living skills, suggested strategies include assistance with money and benefits management, and improving health, nutrition, transportation, cooking, cleaning and home maintenance skill sets.

11. **Getting to and from services.** (Previous rank: 10) The cost of transportation and the County's geographical challenges make access to services a continuing priority. Flexible financial assistance with both public and private transportation, training on how to use public transportation, driving individuals to and from appointments, and bringing services to where individuals are located, are all strategies needing strengthening and coordinating.

12. **Care for homebound frail and elderly.** (Previous rank: 14) Services for older adults continue to struggle with providing effective treatment for those individuals who are homebound and suffer from multiple physical and mental impairments. Often these individuals cycle through psychiatric emergency care without resolution.

13. **Serve those who need it the most.** (Previous rank: 12) Through MHSA funding the County has developed designated programs for individuals with serious mental illness who have been deemed to be in need of a full spectrum of services. These are described in the full service partnership category of the Community Services and Supports component. In spite of these programs, stakeholders report that a number of individuals who have been most debilitated by the effects of mental illness continue to cycle through the most costly levels of care without success.

14. **Help with moving to a lower level of care as people get better.** (Previous rank: 13) Levels of care range from in-patient hospitalization to intensive case

management to therapy and medication to self-care recovery services. Stakeholders (both care providers and receivers) consistently cited the difficulty in moving from one level of care to another. Consumers often cited the disincentive to getting better, as it meant loss of care altogether. Consumers and their families indicated that this system inattention to level of care movement often interfered with the important work of minimizing or eliminating the level of psychotropic medications needed to maintain recovery and wellness. Often a "meds only" service response was not responsive to appropriate lower levels of medication and/or psychosocial support alternatives. Care providers indicated that they faced the choice of either ending service or justifying continuance of a more intensive level of care than was needed. Continuity of care from a more intensive to a less intensive level and vice-versa need to be improved.

15. **Better communication, program and fiscal accountability to enable stakeholder participation.** (Previous rank: 15) The stakeholder community has requested CCBHS to provide more transparent and ongoing program and fiscal information and decision-making in order to better understand what is working well, what needs to improve, and what needs to change in order to address identified priority needs. This would enable a better working partnership in planning, implementation and evaluation between consumers, their families, service providers, and administration.

Summary. The community program planning process identifies current and ongoing mental health service needs, and provides direction for MHSA funded programs to address these needs. It also informs planning and evaluation efforts that can influence how and where MHSA resources can be directed in the future.

The full complement of MHSA funded programs and plan elements described in this document are the result of current as well as previous community program planning processes. Thus, this year's planning process builds upon previous ones. It is important to note that stakeholders did not restrict their input to only MHSA funded services, but addressed the entire health and behavioral health system. The MHSA Three Year Program and Expenditure Plan operates within the laws and regulations provided for the use of the Mental Health Services Act Fund. Thus, the Three Year Plan contained herein does not address all of the prioritized needs identified in the community program planning process, but does provide a framework for improving existing services and implementing additional programs as funding permits.