CONTRA COSTA
MENTAL HEALTH COMMISSION

CONTRA COSTA
MENTAL HEALTH
COMMISSION
1340 Arnold Drive, Suite 200
Martinez, CA 94553
Ph (925) 313-9553
Fax (925) 957-5156
cchealth.org/mentalhealth/mhc

Mental Health Commission
Quality of Care Committee Meeting
Thursday, March 18, 2021, 3:30-5:30 pm
Via: Zoom Teleconference:

https://cchealth.zoom.us/j/6094136195
Meeting number: 609 413 6195

Join by phone:
1 646 518 9805 US
Access code: 609 413 6195

AGENDA

I. **Call to order/Introductions**

II. **Public comments**

III. **Commissioner comments**

IV. **Chair comments**

V. **APPROVE minutes from February 18, 2021 Quality of Care meeting**

VI. **REVIEW and DISCUSS list of Mental Health Services Act (MHSA) funded facilities and programs, Behavioral Health Services (BHS) owned and operated facilities, and contracted facilities for children and transitional age youth (TAY). Topics to include priorities for site visits, size of facilities and typical number of county clients. Jennifer Bruggeman, MHSA Program Manager and Gerold Loenicker, BHS Children and Adolescent Program Chief**

VII. **REVIEW and DISCUSS Site Visit report instructions and template**

(Agenda continued on Page Two)

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

Quality of Care Committee Agenda (Page Two)

Thursday, March 18th, 2021 ◊ 3:30 pm - 5:30 pm

VIII. DISCUSS HUME site visit test status

IX. DISCUSS sources and strategies for identifying health care insurance company representatives for discussion of mental and physical health parity

X. Adjourn

MHSA Program Review Schedule FY 2017-20

	Program/Plan Element	Lead Staff	Month	Site Visit Date	MHC/CPAW Volunteers	Final	Reviewed by MHC
1.	RYSE	Jennifer Bruggeman	OCT 2017	Oct. 26	*	YES	x
2.	Fred Finch Youth Center	Stephanie Chenard	NOV 2017	Nov. 8	*	YES	x
3.	Child Abuse Prevention	Jennifer Bruggeman	NOV 2017	Nov. 13		YES	x
4.	Youth in Juvenile Justice	Jennifer Bruggeman	DEC 2017	Dec. 19		YES	x
5.	Rainbow Center	Jennifer Bruggeman	JAN 2018	Jan. 25	*	YES	x
6.	Building Blocks for Kids	Jennifer Bruggeman	FEB 2018	Feb. 13		Yes	
7.	James Morehouse	Jennifer Bruggeman	MAR 2018	Mar 2		Yes	
8.	Native American Health	Jennifer Bruggeman	APR 2018	Apr 19		Yes	
9.	Center Human Development	Jennifer Bruggeman	MAY 2018	May 11		Yes	
10	Familias Unidas	Windy Taylor	MAY 2018	May 21		Yes	
11	STAND!	Jennifer Bruggeman	JUN 2018	June 25		Yes	
12	Vicente Briones Continuation High School (MUSD)	Jennifer Bruggeman	SEP 2018	Sept 12		Yes	
13	Anka	Windy Taylor	SEP 2018	Oct 1		Yes	
14	Jewish Family Services	Jennifer Bruggeman	OCT 2018	Nov 19		Yes	
15	Hume Center - West	Windy Taylor	OCT 2018	Oct 31		Yes	x
16	Hume Center - East	Windy Taylor	NOV 2018	Nov 15		Yes	x
17	Recovery Innovations	Genoveva Zesati	NOV 2018	Nov 29	*	Yes	
18	People Who Care	Jennifer Bruggeman	DEC 2018	Nov 7		Yes	
19	OCE	Jennifer Bruggeman	JAN 2019	Jan 18		Yes	
20	Mental Health	Windy Taylor	JAN 2019	Jan 31	*	Yes	x

As of: March 5, 2020

	Program/Plan Element	Lead Staff	Month	Site Visit Date	MHC/CPAW Volunteers	Final	Reviewed by MHC
	Systems						
21	Asian Family Center	Jennifer Bruggeman	FEB 2019	Feb 28		Yes	x
22	Suicide Prevention	Jennifer Bruggeman	MAR 2019	Mar 27		Yes	
23	CC Interfaith Housing	Jennifer Bruggeman	APR 2019	Apr 18	*	Yes	x
24	Youth Homes	Windy Taylor	APR 2019	APR 11		Yes	
25	CC Crisis Center	Jennifer Bruggeman	JUN 2019	Jul 11	*	Yes	
26	NAMI	Genoveva Zesati	NOV 2019	Nov 20		PEND	
27	Telecare	Windy Taylor	AUG 2019	Aug 22		Yes	
28	The Latina Center	Jennifer Bruggeman	SEP 2019	Sep 30		Yes	
29	Lifelong Medical Care	Jennifer Bruggeman	OCT 2019	Oct 24		Yes	
30	La Clinica de la Raza	Jennifer Bruggeman	NOV 2019	Dec 13		Yes	
31	COFY	Windy Taylor	DEC 2019	Dec 10	*	Yes	
32	Putnam Clubhouse	Jennifer Bruggeman	FEB 2020	Feb 25		Yes	x
33	Rainbow	Jennifer Bruggeman	FEB 2020	Feb 28		YES	x
34	COPE and First Five	Jennifer Bruggeman	~~MAR 2020~~				
35	First Hope	Jennifer Bruggeman	~~APR 2020~~		*		
36	Lincoln Child Center	Windy Taylor	~~APR 2020~~				
37	Seneca	Windy Taylor	~~MAY 2020~~				
38	Crestwood	Peter Ordaz	~~JUN 2020~~		*		
39	Older Adult Program	Windy Taylor	~~JUN 2020~~				
40	Miller Wellness Center	Windy Taylor	~~JUN 2020~~				
41	LAO	Jennifer Bruggeman	~~June 2020~~				

Appendix B
Program and Plan Element Profiles

Table of Contents

Anka Behavioral Health, Inc.

www.ankabhi.org
Point of Contact: Chris Withrow, Chief Executive Officer.
Contact Information: 2975 Treat Blvd Suite C-5, Concord, CA 94518
(925) 219-9009, cwithrow@ankabhi.org

1. General Description of the Organization

Anka's mission is to eliminate the impact of behavioral health problems for all people. Anka serves more than 15,000 individuals annually and employs nearly 1,000 professional, specialized staff members. Anka's philosophy is to treat the whole person by fully integrating care of both mind and body, always using clinically-proven, psycho-social models designed to promote health and wellness while containing costs.

2. Program: Adult Full Service Partnership - CSS

The Adult Full Service Partnership (FSP) joins the resources of Anka Behavioral Health and Costa County Behavioral Health Services, and utilizes a modified assertive community treatment model.

The program serves adults who reside in Contra Costa County, who experience a serious mental illness/serious emotional disturbance.

a. Scope of Services: Services use an integrated multi-disciplinary team approach, based on a modified Assertive Community Treatment (ACT) model of care. Services include outreach and engagement, case management, outpatient mental health services, including services for individuals with co-occurring mental health and alcohol and other drug problems, crisis intervention, medication support, housing support, flexible funds, vocational services, educational services, and recreational and social activities. Anka staff are available to consumers on a 24/7 basis.
b. Target Population: Adults in Central County who are diagnosed with a serious mental illness, are at or below 300% of the federally defined poverty level, and are uninsured or receive Medi-Cal benefits.
c. Payment Limit: FY 18/19 $815,540
d. Number served: In FY 17/18 Anka Central FSP served 39 individuals.
e. Outcomes: Below are the FY 17/18 outcomes for Anka Central FSP.

- Reduction in incidence of psychiatric crisis
- Reduction of the incidence of restriction

Table 1. Pre- and post-enrollment utilization rates for 60 Anka Central FSP participants enrolled in the FSP program during FY 17-18

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	% change
PES episodes	167	102	0.283	0.158	-44.1%
Inpatient episodes	55	47	0.061	0.058	-4.92
Inpatient days	567	578	0.783	0.853	+8.93

** Data on service utilization were collected from the county's internal billing system, PSP. To assess the effect of FSP enrollment on PES presentations and inpatient episodes, this methodology compares clients' monthly rates of service utilization pre-enrollment to clients' post-enrollment service utilization rates. Using PES usage as an example, the calculations used to assess pre- and post-enrollment utilization rates can*

be expressed as:

- *(No. of PES episodes during pre- enrollment period)/ (No. of months in pre-enrollment period) =Pre-enrollment monthly PES utilization rate*
- *(No. of PES episodes during post-enrollment period)/ (No. of months in post-enrollment period) =Post-enrollment monthly PES utilization rate*

Asian Community Mental Health Services (ACMHS)

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

1. General Description of the Organization

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

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

a. Scope of Services: Asian Family Resource Center (AFRC), a satellite site of Asian Community Mental Health Services (ACMHS), will provide comprehensive and culturally-sensitive education and access to mental health services for Asian and Asian Pacific Islander (API) immigrant and refugee communities, especially the Southeast Asian and Chinese population of Contra Costa County. ACMHS will employ multilingual and multidisciplinary staff from the communities which they serve. Staff will provide the following scope of services:
   i. Outreach and Engagement Services: Individual and/or community outreach and engagement to promote mental health awareness, educate community members on signs and symptoms of mental illness, provide mental health workshops, and promote mental health wellness through community events. Engage community members in various activities to screen and assess for mental illness and/or assist in navigating them into the service systems for appropriate interventions: community integration skills to reduce MH stressors, older adult care giving skills, basic financial management, survival English communication skills, basic life skills, health and safety education and computer education, structured group activities (on topics such as, coping with adolescents, housing issues, aid cut-off, domestic violence, criminal justice issues, health care and disability services), mental health education and awareness, and health/mental health system navigation. ACMHS, in collaboration with community-based organizations, will participate in 3-5 mental health and wellness events to provide wellness and mental health outreach, engagement, and education to immigrants and refugees in the Contra Costa County.
   ii. Individual Mental Health Consultation: This service will also be provided to those who are exhibiting early signs of mental illness, to assess needs, identify signs/symptoms of mental health crisis/trauma, provide linkages/referrals or assist in navigation into the mental health system, provide wellness support groups, access essential community resources, and linkage/referral to mental health services. Peer Navigators will be utilized to support participants in accessing services in a culturally sensitive manner. These services will be provided for a period of less than one year unless psychosis is present. ACMHS will serve a minimum of 75 high risk and underserved Southeast Asian community members within a 12 month period, 25 of which will reside in East County with the balance in West and Central County.

b. Target Population: Asian and Pacific Islander immigrant and refugee communities (especially Chinese and Southeast Asian population) in Contra Costa County

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

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

Building Blocks for Kids (BBK)

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

1. General Description of the Organization

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

2. Program: Not Me Without Me - PEI

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

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

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

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

e. Outcomes:

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

Center for Human Development (CHD)

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

1. General Description of the Organization

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

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

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

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

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

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

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

e. Outcomes:

i. Wellness Program

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

ii. Empowerment Program

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

Central County Adult Mental Health Clinic
(Contra Costa Behavioral Health)

https://cchealth.org/mentalhealth/#simpleContained4
Point of Contact: Kennisha Johnson, Mental Health Program Manager
Contact Information: 1420 Willow Pass Road, Suite 200, Concord, CA 94520
(925) 646-5480, Kennisha.Johnson@CCHealth.org

1. General Description of the Organization

The Behavioral Health Services Division of Contra Costa Health Services combines Mental Health, Alcohol & Other Drugs and Homeless Program into a single system of care. The Central Adult Mental Health Clinic operates within Contra Costa Mental Health's Adult System of Care, and provides assessments, case management, therapy, groups, psychiatric services, crisis intervention, peer support, housing services, and benefits assistance. Within the Adult Mental Health Clinic are the following MHSA funded programs and plan elements:

2. Plan Element: Adult Full Service Partnership Support - CSS

Contra Costa Mental Health has dedicated clinical staff at each of the three adult mental health clinics to provide support, coordination and rapid access for full service partners to health and mental health clinic services as needed and appropriate. Rapid Access Clinicians offer drop-in screening and intake appointments to clients who have been discharged from the County Hospital or Psychiatric Emergency Services but who are not open to the county mental health system of care. Rapid Access Clinicians will then refer clients to appropriate services and, when possible, follow-up with clients to ensure a linkage to services was made. If a client meets eligibility criteria for Full Service Partnership services, the Rapid Access Clinician will seek approval to refer the client to Full Service Partnership services. Clinic management acts as the gatekeepers for the Full Service Partnership programs, authorizing referrals and discharges as well as providing clinical oversight to the regional Full Service Partnership programs. Full Service Partnership Liaisons provide support to the Full Service Partnership programs by assisting the programs with referrals and discharges, offering clinical expertise, and helping the programs to navigate the County systems of care.

3. Plan Element: Clinic Support - CSS

General Systems Development strategies are programs or strategies that improve the larger mental health system of care. These programs and strategies expand and enhance the existing service structure to 1) assist consumers in obtaining benefits they are entitled to, educate consumers on how to maximize use of those benefits and manage resources, and 2) provide transportation support for consumers and families.

a. Clinic Target Population: Adults aged 18 years and older, who live in Central County, are diagnosed with a serious mental illness and are uninsured or receive Medi-Cal benefits.
b. Total Number served by clinic: For FY 17-18: Approximately 2,157 Individuals.

Central County Children's Mental Health Clinic
(Contra Costa Behavioral Health)

https://cchealth.org/mentalhealth/#simpleContained4
Point of Contact: Betsy Hanna, Psy.D, Mental Health Program Manager
Contact Information: 2425 Bisso Lane, Suite 200, Concord, CA 94520
(925) 521-5767, Betsy.Hanna@CCHealth.org

1. General Description of the Organization

The Behavioral Health Services Division of Contra Costa Health Services combines Mental Health and Alcohol & Other Drugs into a single system of care. The Central Children's Mental Health Clinic operates within Contra Costa Behavioral Health's Children's System of Care, and provides psychiatric and outpatient services, family partners, and Wraparound services. Within the Children's Mental Health Clinic are the following MHSA funded plan elements:

2. Plan Element: Clinic Support - CSS

General Systems Development strategies are programs or strategies that improve the larger mental health system of care. These programs and strategies expand and enhance the existing service structure to assist consumers in the following areas:

- Family Partners and Wraparound Facilitation. The family partners assist families with advocacy, transportation assistance, navigation of the service system, and offer support in the home, community, and county service sites. Family partners support families with children of all ages who are receiving services in the children. Family partners are located in each of the regional clinics for children and adult services, and often participate on wraparound teams following the evidence-based model.
- A Clinical Specialist in each regional clinic who provides technical assistance and oversight of evidence-based practices in the clinic.
- Support for full service partners.

a. Target Population: Children aged 17 years and younger, who live in Central County, are diagnosed with a serious emotional disturbance or serious mental illness, and are uninsured or receive Medi-Cal benefits.
b. Number served by clinic: For FY 17/18: Approximately 969 Individuals.

Child Abuse Prevention Council (CAPC)

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

1. General Description of the Organization

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

2. Program: The Nurturing Parenting Program - PEI

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

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

Community Options for Families and Youth, Inc. (COFY, Inc.)

www.cofy.org
Point of Contact: David Bergesen
Contact Information: 3478 Buskirk Avenue, Suite 260, Pleasant Hill CA 94523
(925) 943-1794, d.bergesen@cofy.org

1. General Description of the Organization

Community Options for Families and Youth (COFY) is a multi-disciplinary provider of mental health services. COFY's mission is to work with youth whose high-intensity behaviors place them at risk of hospitalization or residential treatment. Their mental health clinicians work collaboratively with caregivers, educators, and social service professionals to help exasperated families restore empathic relationships and maintain placement for their children.

2. Program: Multisystemic Therapy (MST) – Full Service Partnership (FSP) - CSS

Multisystemic Therapy ("MST") in an intensive family and community based treatment that addresses the multiple determinants of serious anti-social behavior. The MST approach views individuals as being surrounded by a network of interconnected systems that encompasses individual, family, and extra familial (peers, school, community) factors. Intervention may be necessary in any one or a combination of these systems, and using the strengths of each system to facilitate positive change. The intervention strives to promote behavioral change in the youth's natural environment. Family sessions are provided over a three to five month period. These sessions are based on nationally recognized evidence based practices designed to decrease rates of anti-social behavior, improve school performance and interpersonal skills, and reduce out-of-home placements. The ultimate goal is to empower families to build a healthier environment through the mobilization of existing child, family, and community resources.

a. Scope of Services: Services include but are not limited to outreach and engagement, case management, outpatient mental health services, crisis intervention, collateral services, flexible funds. COFY MST staff must be available to consumer on a 24/7 basis.
b. Target Population: Children who have a serious emotional disturbance or serious mental illness, and have been identified as a juvenile offender or are at risk of involvement with Probation due to delinquent behavior. Services are county-wide.
c. Payment Limit: FY 18/19 $650,000
d. Number served: In FY17/18 COFY FSP served 97 individuals.
e. Outcomes:

- Reduction in incidence of psychiatric crisis
- Reduction of the incidence of restriction
- Increase in incidence of psychiatric crisis

Table 1. Pre- and post-enrollment utilization rates for 139 Community Options for Families and Youth, Inc. participants enrolled in the FSP program during FY 17-18

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	2	5	0.002	0.005	+15%
Inpatient episodes	0	1	0.000	0.001	0
Inpatient days	0	6	0.000	0.004	0
JACS	33	24	0.037	0.026	-29.7%

Contra Costa Crisis Center

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

1. General Description of the Organization

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

2. Program: Suicide Prevention Crisis Line - PEI

a. Scope of Services:

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

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

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

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

Contra Costa Interfaith Housing (CCIH)

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

1. General Description of the Organization

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

2. Program: Strengthening Vulnerable Families - PEI

a. Scope of Services:

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

- CCIH staff is also able to help community providers be aware of early signs of mental illness in their clients, and support sensitive care and timely treatment for these issues.

b. Target Population: Formerly homeless/at-risk families and youth.
c. Payment Limit: FY 18-19: $72,100
d. Number served: In FY 17-18: 428 clients
e. Outcomes:

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

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

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

1. General Description of the Organization

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

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

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

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

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

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

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

e. Outcomes:

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

Crestwood Behavioral Health, Inc.

https://crestwoodbehavioralhealth.com/
Point of Contact: Travis Curran, Campus Administrator for Pleasant Hill Campus
Contact Information: 550 Patterson Boulevard, Pleasant Hill, CA 94523
(925) 938-8050, tcurran@cbhi.net

1. General Description of the Organization

The mission at Crestwood Healing Center is to partner with Contra Costa County clients, employees, families, business associates, and the broader community in serving individuals affected by mental health issues. Together, they enhance quality of life, social interaction, community involvement and empowerment of mental health clients toward the goal of creating a fulfilling life. Clients are assisted and encouraged to develop life skills, participate in community based activities, repair or enhance primary relationships, and enjoy leisure activities. A supportive, compassionate, and inclusive program increases motivation and commitment.

2. Program: The Pathway Program (Mental Health Housing Services – CSS

The Pathway Program provides psychosocial rehabilitation for 16 clients who have had little, if any, previous mental health treatment. The program provides intensive skills training to promote independent living. Many clients complete their high school requirements, enroll in college or are participating in competitive employment by the end of treatment.

a. Scope of Services:
- Case management
- Mental health services
- Medication management
- Crisis intervention
- Adult residential

b. Target Population: Adults aged 18 years and older, who live in Central County, are diagnosed with a serious mental illness and are uninsured or receive Medi-Cal benefits.
c. Annual MHSA Payment Limit: $1,210,356
d. Number served For FY 17/18: 64 beds available at The Bridge in Pleasant Hill. 30 beds available at Our House in Vallejo.
e. Outcomes: To be determined.

Desarrollo Familiar, Inc. (Familias Unidas)

http://www.familias-unidas.org/
Point of Contact: Lorena Huerta, Executive Director.
Contact Information: 205 39th Street, Richmond, CA 94805
(510) 412–5930, LHuerta@Familias-Unidas.org.

1. General Description of the Organization

Familias Unidas exists to improve wellness and self-sufficiency in Latino and other communities. The agency accomplishes this by delivering quality mental health counseling, service advocacy, and information/referral services. Familias Unidas programs include: mental health, education and prevention, youth development, and wrap-around services.

2. Program: Familias Unidas – Full Service Partnership - CSS

Familias Unidas provides a comprehensive range of services and supports in Contra Costa County to adults with serious emotional disturbance/serious mental illness who are homeless or at serious risk of homelessness. Services are based in West Contra Costa County.

a. Scope of Services:

- Services are provided using an integrated team approach, based on a modified Assertive Community Treatment (ACT) model of care. Services include:
- Outreach and engagement
- Case management
- Outpatient Mental Health Services, including services for individuals with co-occurring mental health & alcohol and other drug problems
- Crisis Intervention
- Collateral services
- Medication support (may be provided by County Physician)
- Housing support
- Flexible funds
- Contractor must be available to the consumer on a 24/7 basis

b. Target Population: Adults in West County, who are diagnosed with a serious mental illness, are homeless or at imminent risk of homelessness, are at or below 300% of the federally defined poverty level, and are uninsured or receive Medi-Cal benefits.

c. Payment Limit: FY 18/19 $219,708

d. Number served: For FY 17/18: 17 Individuals

e. Outcomes: For FY 17/18:

- Program participants will experience a net reduction in their Psychiatric Emergency Services utilization rate of at least 40% when the annual utilization rate for the clients' most recent 12 months of service, or total number of months the client has been enrolled for less than 12 months, is compared to the pre-enrollment rate.*
- Program participants will experience a net reduction in their inpatient utilization rate of at least 60% when the annual utilization rate for the clients' most recent 12 months of service, or total number of months if a client has been enrolled for less than 12 months, is compared to the pre-enrollment rate.*
- 75% of FSP participants placed into housing will receive housing support to maintain housing stability or be progressively placed into more independent living environments, as appropriate.

- 75% of FSP participants will rank Familias Unidas FSP services with a score of 4 or higher in the Client Satisfaction Questionnaire (CSQ-8), twice annually, or upon client discharge from the program.
- Less than 25% of active Familias Unidas FSPs will be arrested or incarcerated post-enrollment measured at the end of the fiscal year.
- Collect baseline data utilizing an engagement in meaningful activity/quality of life assessment tool (tool to be determined).
- No change in incidence of psychiatric crisis
- Increase of the incidence of restriction

Table 1. Pre-and post-enrollment utilization rates for 23 Familias Unidas (Desarrollo Familiar, Inc.) FSP Participants enrolled in the FSP program during FY 17-18

	No. pre-Enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	% change
PES episodes	23	15	0.094	0.058	-38.3%
Inpatient episodes	9	2	0.033	0.007	-78.8%
Inpatient days	36	366	0.130	1.326	+920%

** Data on service utilization were collected from the county's internal billing system, PSP. To assess the effect of FSP enrollment on PES presentations and inpatient episodes, this methodology compares clients' monthly rates of service utilization pre-enrollment to clients' post-enrollment service utilization rates. Using PES usage as an example, the calculations used to assess pre- and post-enrollment utilization rates can be expressed as:*

- *(No. of PES episodes during pre- enrollment period)/ (No. of months in pre-enrollment period) =Pre-enrollment monthly PES utilization rate*
- *(No. of PES episodes during post-enrollment period)/ (No. of months in post-enrollment period) =Post-enrollment monthly PES utilization rate*

Divine's Home

Point of Contact: Maria Riformo
Contact Information: 2430 Bancroft Lane, San Pablo, CA 94806
(510) 222-4109, HHailey194@aol.com

1. General Description of the Organization

The County contracts with Divine's Home, a licensed board and care operator, to provide additional staff care to enable those with serious mental illness to avoid institutionalization and enable them to live in the community.

2. Program: Augmented Board and Cares – MHSA Housing Services - CSS

a. Scope of Services: Augmented residential services, including but not limited to:

- Medication management
- Nutritional meal planning
- Assistance with laundry
- Transportation to psychiatric and medical appointments
- Improving socialization
- Assist with activities of daily living (i.e., grooming, hygiene, etc.)
- Encouraging meaningful activity
- Other services as needed for individual residents

b. Target Population: Adults aged 60 years and older, who live in Western Contra Costa County, are diagnosed with a serious mental illness and are uninsured or receive Medi-Cal benefits.

c. Annual MHSA Payment Limit: $ 5,340

d. Number served: For FY 17/18: Capacity of 6 beds.

East County Adult Mental Health Clinic
(Contra Costa Behavioral Health)

https://cchealth.org/mentalhealth/#simpleContained4
Point of Contact: Beverly Fuhrman, Program Manager
Contact Information: 2311 Loveridge Road, Pittsburg, CA 94565
(925) 431-2621, Beverly.Fuhrman@CCHealth.org

1. General Description of the Organization

East County Adult Mental Health Services operates within Contra Costa Mental Health's Adult System of Care. Services are provided within a Care Team model that is comprised of a team of psychiatrists, nurses, therapists, community support workers and family support worker. The initial assessment, Co-Visit, is provided jointly by a psychiatrist and a therapist where both mental health and medication needs are addressed at this initial visit. Other services include crisis intervention, individual/group therapy, case management, housing services, benefits assistance, vocational services, and linkage to community-based programs and agencies.

2. Plan Element: Adult Full Service Partnership Support - CSS

Contra Costa Mental Health has dedicated clinicians at each of the three adult mental health clinics to provide support, coordination and rapid access for full service partners to health and mental health clinic services as needed and appropriate. Rapid Access Clinicians offer drop-in screening and intake appointments to clients who have been discharged from the County Hospital or Psychiatric Emergency Services but who are not open to the county mental health system of care. Rapid Access Clinicians will then refer clients to appropriate services and, when possible, follow-up with clients to ensure a linkage to services was made. If a client meets eligibility criteria for Full Service Partnership services, the Rapid Access Clinician will seek approval to refer the client to Full Service Partnership services. Clinic management act as the gatekeepers for the Full Service Partnership programs, authorizing referrals and discharges as well as providing clinical oversight to the regional Full Service Partnership programs. Full Service Partnership Liaisons provide support to the Full Service Partnership programs by assisting the programs with referrals and discharges, offering clinical expertise, and helping the programs to navigate the County systems of care.

3. Plan Element: Clinic Support - CSS

General Systems Development strategies are programs or strategies that improve the larger mental health system of care. These programs and strategies expand and enhance the existing service structure to assist consumers in 1) obtaining benefits they entitled to, educate consumers on how to maximize use of those benefits and manage resources, and 2) provide transportation support for consumers and families.

a. Clinic Target Population: Adults aged 18 years and older, who live in East County, are diagnosed with a serious mental illness and are uninsured or receive Medi-Cal benefits.
b. Total Number served by clinic: For FY 17-18 Approximately 2,231 Individuals.

4. Plan Element: Coaching to Wellness - INN

The Coaching to Wellness program provides an additional level of support for adult mental health consumers with certain chronic health conditions through intensive peer and nurse support. With components from intensive peer support coupled with leveraging existing resources in the County, the Coaching to Wellness program provides a holistic team approach to providing care to our consumers. The goals of the

program are to: 1) Improve consumer perception of their own wellness and well-being; 2) Increase healthy behaviors and decrease symptoms for consumers; and 3) Increase cross-service collaboration among primary and mental health care staff.

a. Target Population: Adults aged 18 years and older who are currently receiving psychiatric-only services at a County-operated Adult clinic; Diagnosed with a serious mental illness (but at a stage to be engaged in recover); Diagnosed with a chronic health risk condition of cardiac, metabolic, respiratory, and/or have weight issues; Expressed an interest in the program; and indicated a moderate to high composite score on mental health and medical levels of support needed.
b. Total Budget: $222,752
c. MHSA-funded Staff: 5.0 Full-time equivalents
d. Total Number served: For FY 17/18: 46 individuals
e. Outcomes: Evaluation of the program includes pre- and post-surveys that measure key indicators in areas such as: perceived recovery, functioning, and quality of life. Self-rated health and mental health data is collected by the Wellness Coaches and Nurses at most individual contacts and vitals collected and levels of support assessed by the Wellness Nurses as needed. Satisfaction and achievement on self-identified wellness goals recorded at post-program. Other proposed indicators include primary care and mental health appointment attendance, and utilization rate of involuntary psychiatric emergency admissions and/or acute psychiatric admissions.

East County Children's Mental Health Clinic
(Contra Costa Behavioral Health)

https://cchealth.org/mentalhealth/#simpleContained4
Point of Contact: Eileen Brooks, Program Manager
Contact Information: 2335 Country Hills Drive, Antioch, CA 94509
(925) 608-8735, Eileen.Brooks@CCHealth.org

1. General Description of the Organization

The Behavioral Health Services Division of Contra Costa Health Services combines Mental Health, Alcohol & Other Drugs and Homeless Program into a single system of care. The East Children's Mental Health Clinic operates within Contra Costa Behavioral Health's Children's System of Care, and provides psychiatric and outpatient services, family partners, and wraparound services. Within the Children's Behavioral Health Clinic are the following MHSA funded plan elements:

2. Plan Element: Clinic Support - CSS

General Systems Development strategies are programs or strategies that improve the larger mental health system of care. These programs and strategies expand and enhance the existing service structure to assist consumers in the following areas:

- Family Partners and Wraparound Facilitation. The family partners assist families with advocacy, transportation assistance, navigation of the service system, and offer support in the home, community, and county service sites. Family partners support families with children of all ages who are receiving services in the clinic. Family partners are located in each of the regional clinics for children and adult services, and often participate on wraparound teams following the evidence-based model.
- A Clinical Specialist/EBP Team Leader in each regional clinic who provides technical assistance, clinical consultation, and oversight of evidence-based practices in the clinic.
- Support for full service partnership programs.

a. Target Population: Children and youth aged 5 through 22 years, who live in East County, are diagnosed with a serious emotional disturbance or serious mental illness, and are uninsured or receive Medi-Cal benefits.
b. Number served by clinic: For FY 17/18: Approximately 774 Individuals.

First Five Contra Costa

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

1. General Description of the Organization

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

2. Programs: Triple P Positive Parenting Program - PEI

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

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

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

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

e. Outcomes:

- Completed 17 parenting classes for East and West County parents of children age 0–5 (C.O.P.E.)

i. Clinical Highlights for FY 17-18:

- **Depression** – parents self-report on symptoms such as hopelessness and dysphoria, decreased by 41% overall
- **Anxiety** – parents self-report on symptoms such as anxiousness and situational anxiety, decreased by 34% overall
- **Stress** – parents self-report on symptoms such as nervousness, muscle tension and inability to relax, decreased by 33% overall
- **Intensity of Behavior Problems** which measures the frequency of each problem behavior, decreased by 19% as indicated by the chart above
- **Behavior Problems** which reflect parent tolerance of the behaviors and the distress, decreased by 43%

First Hope
(Contra Costa Behavioral Health)

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

1. General Description of the Organization

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

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

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

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

b. Target Population: 12-25 year old transition age youth and their families
c. Total Budget: FY 18-19: $2,463,474
d. Staff: 14 FTE full time equivalent multi-disciplinary staff
e. Number served: FY 17-18: 118 clients and their families served (assessments and clinical services). On any given day, between 55 and 70 clients and their families are open to services. Additionally, First Hope provided ongoing outreach education reaching 224 participants in the community and 179 initial phone screenings and consultation to at risk individuals, families, or providers.
f. Outcomes:

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

g. Long Term Public Health Outcomes:

- Reduce conversion rate from Clinical High Risk symptoms to schizophrenia
- Reduce incidence of psychotic illnesses in Contra Costa County

- Increase community awareness and acceptance of the value and advantages of seeking mental health care early

Forensic Mental Health
(Contra Costa Behavioral Health)

Point of Contact: Marie Scannell, Program Manager
Contact Information: 1430 Willow Pass Road, Suite 100, Concord CA 94520
(925) 288-3915, Marie.Scannell@CCHealth.org

1. General Description of the Organization

The Behavioral Health Services Division of Contra Costa Health Services combines Mental Health, Alcohol & Other Drugs and Homeless Program into a single system of care. The Forensic Services team operates within Contra Costa Mental Health's Adult System of Care, and works closely with Adult Probation, *the courts, and local police departments.*

2. Program: Forensic Services - CSS

The Forensics Services team is a multidisciplinary team comprised of mental health clinical specialists, registered nurses and community support workers. The purpose of the team is to engage and offer voluntary services to participants who are seriously and persistently mentally ill and are involved in the criminal justice system. Forensic Services hosts office hours at the three regional probation offices to enhance the opportunity for screening and service participation. The co-located model allows for increased collaboration among the participants, service providers, and Deputy Probation Officers.

The Forensic MHCS, CSWs, and nurses coordinate to offer Case Management services, individual therapy, and evidence based group therapies (CBSST, Seeking Safety and WRAP). WRAP services are also provided on an individual basis.
In addition, monthly Case Coordination meetings are held for each probation department (east, west, and central) with the Probation Officers, Forensic MH staff, and other community providers. These meetings are used to discuss and coordinate services for individual probationers that are facing challenges in engaging and utilizing services.

The forensic staff participates in continuation of care by initiating contacts with probationers while in custody. These contact are both pre-release and during probation violations. In addition the Forensic CSW and clinicians provides WRAP & CBSST groups in MDF. The Forensic MHCS located at east county probation has begun coordination of, and providing, services for the TAY population in conjunction with re-entry services.

AOT: The Forensic Mental Health Team (FMHT) manages and provides an Assistant Outpatient Treatment Program, aka Laura Law AB 1421. The FMHT works in conjunction with Mental Health Systems (MHS) to provide contracted services. All requests for potential AOT services come through the FMHT.

The FMHT is responsible to determine if the requestors meet the requirements as stated in the Welfare and Institution code and if the person for whom the request is being made meets the 9 criteria for eligible AOT services. The FMHT also provides linkage to other services for individuals that do not meet all the criteria for AOT.

a. Scope of Services: Authorized in Fiscal Year 2011-12 four clinical specialists were funded by MHSA to join Forensics Services Team. This team works very closely with the criminal justice system to assess referrals for serious mental illness, provide rapid access to a treatment plan, and work as a team to provide the appropriate mental health, substance abuse and housing services needed.
b. Target Population: Individuals who are seriously and persistently mentally ill who are on probation and at risk of re-offending and incarceration.
c. Budget: $982,245
d. MHSA-Funded Staff: 4.0 Full-time equivalent
e. Number Served in FY 17/18: 270

Fred Finch Youth Center

https://www.fredfinch.org/
Point of Contact: Kimberly Powers, LMFT, Program Director
Contact Information: 2523 El Portal Drive, Suite 201, San Pablo, CA 94806
(510) 439–3130 Ext. 6107, kimberlypowers@fredfinch.org

1. General Description of the Organization

Fred Finch Youth Center (FFYC) seeks to provide innovative, effective, caring mental health and social services to children, young adults, and their families that allow them to build on their strengths, overcome challenges, and live healthy and productive lives. FFYC serves children, adolescents, young adults, and families facing complex life challenges. Many have experienced trauma and abuse; live at or below the poverty line; have been institutionalized or incarcerated; have a family member that has been involved in the criminal justice system; have a history of substance abuse; or have experienced discrimination or stigma.

2. Program: Contra Costa Transition Age Youth Full Service Partnership - CSS

Fred Finch Youth Center is the lead agency that collaborates with the Contra Costa Youth Continuum of Services, The Latina Center and Contra Costa Mental Health to provide a Full Service Partnership program for Transition Age Youth in West and Central Contra Costa County.

a. Scope of Services: Services will be provided using an integrated team approach, based on a modified Assertive Community Treatment (ACT) model of care. The team includes a Personal Service Coordinator working in concert with a multi-disciplinary team of staff, including a Peer Mentor and Family Partner, a Psychiatric Nurse Practitioner, staff with various clinical specialties, including co-occurring substance disorder and bi-lingual capacity. Services include:

- Outreach and engagement
- Case management
- Outpatient Mental Health Services, including services for individuals with co-occurring mental health & alcohol and other drug problems
- Crisis Intervention
- Collateral
- Medication support (may be provided by County Physician)
- Housing support
- Flexible funds
- Referrals to Money Management services as needed
- Supported Employment Services
- Available to consumer on 24/7 basis

a. Target Population: Young adults with serious mental illness or serious emotional disturbance. These young adults exhibit key risk factors of homelessness, limited English proficiency, co-occurring substance abuse, exposure to trauma, repeated school failure, multiple foster-care or family-caregiver placements, and experience with the juvenile justice system and/or Psychiatric Emergency Services. FFYC serves Central and West County.

b. Payment Limit: FY 18/19 $1,485,941

c. Number served: For FY 17/18: 54

d. Outcomes: For FY 17/18:

- Reduction in incidence of psychiatric hospitalizations

- School enrollment increased in the Fall and Housing decreased.
- Although Employment dropped somewhat, Competitive Employment remained steady.
- ANSA data: Individual Strengths and Depression Domains goals were met, exceeding the targeted goal percentage. Life Domain Functioning, Behavioral/Emotional Needs and Improvement in at least one Domain all decreased respectively and appear in range of meeting the stated goal.
- Continued contributing factors include: Active Socialization and Community building efforts that address communication/interpersonal skills, symptom management, identity development and holistic incorporation such as Workshops that target specific needs such as: Planned Parenthood (Healthy Sexuality) & Nutrition and bringing in 2018; New Laws, Immigration, Current Events Impact, etc. CCTAY continues to offer social outings, community connection, advocacy and participant led activities to promote confidence, build self-esteem, leadership and independent living skills, communication, etc. in order to increase overall treatment success and outcomes.

Table 1. Pre- and post-enrollment utilization rates for 56 Fred Finch FSP participants enrolled in the FSP program during FY 17-18

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	% change
PES episodes	50	25	0.101	0.046	-54.5%
Inpatient episodes	24	6	0.050	0.013	-74%
Inpatient days	162	30	0.334	0.001	-99.7%

** Data on service utilization were collected from the county's internal billing system, PSP. To assess the effect of FSP enrollment on PES presentations and inpatient episodes, this methodology compares clients' monthly rates of service utilization pre-enrollment to clients' post-enrollment service utilization rates. Using PES usage as an example, the calculations used to assess pre- and post-enrollment utilization rates can be expressed as:*

- *(No. of PES episodes during pre- enrollment period)/(No. of months in pre-enrollment period) =Pre-enrollment monthly PES utilization rate*
- *(No. of PES episodes during post-enrollment period)/(No. of months in post-enrollment period) =Post-enrollment monthly PES utilization rate*

George and Cynthia Miller Wellness Center
(Contra Costa Behavioral Health)

https://cchealth.org/centers/mwc.php
Point of Contact: Thomas Tighe, Mental Health Program Manager
Contact Information: 25 Allen Street, Martinez CA 94553
(925) 890-5932, Thomas.Tighe@CCHealth.org

1. General Description of the Organization

The Behavioral Health Services Division of Contra Costa Health Services combines Mental Health, Alcohol & Other Drugs and Homeless Program into a single system of care. The George and Cynthia Miller Wellness Center is a Federally Qualified Health Center under the Contra Costa Health Services Hospital and Clinics Division.

2. Program: George and Cynthia Miller Wellness Center (Formerly the Assessment and Recovery Center) - CSS

a. Scope of Services: The George and Cynthia Miller Wellness Center (Miller Wellness Center) provides a number of services to the Contra Costa Behavioral Health Services' system of care consumers that includes the diversion of children and adults from Psychiatric Emergency Services (PES). Children and adults who are evaluated at PES may step-down to the Miller Wellness Center if they do not need hospital level of care. The Miller Wellness Center offers urgent same-day appointments for individuals who are not open to the Contra Costa Mental Health System, or who have disconnected from care after previously being seen. Services include brief family therapy, medication refills, substance abuse counseling, and general non-acute assistance. In addition, the Center provides appointments for patients post psychiatric inpatient discharge. This provides the opportunity for a successful transition that ensures that medications are obtained and appointments are scheduled in the home clinic. The behavioral health service site is located in a Federally Qualified Health Center with separate entrances from the physical health side.
b. Target Population: Children and adults who are being diverted from PES, transition from inpatient, and consumers not yet connected to the outpatient system of care.
c. Total Budget: $319,819
d. Staff funded through MHSA: 3 FTE – A Program Manager, and two Community Support Workers.
e. Number Served: To Be Determined
f. Outcomes: To Be Determined

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

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

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

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

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

b. Target Population: At-risk students at El Cerrito High School
c. Payment Limit: FY 18-19: $102,900
d. Numbers Served: For FY 17-18: 413
e. Outcomes:

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

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

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

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

1. General Description of the Organization

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

2. Program: Community Bridges - PEI

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

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

- Provided 4 (2-hour) mental health education classes to 10-12 Russian-speaking seniors.
- Referred 27 high-risk individuals to bilingual therapy services with JFCS East Bay's bilingual therapist.

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

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

1. General Description of the Organization

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

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

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

a. Scope of Services:

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

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

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

- Help youth address mental health and substance abuse issues that may underlie problems with delinquency

- Increased access to mental health services and other community resources for at risk youth
- Decrease of symptoms of mental health disturbance
- Increase of help seeking behavior; decrease stigma associated with mental illness.

La Clínica de la Raza

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

1. General Description of the Organization

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

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

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

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

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

- 100% of parents reported increased knowledge about positive family communication
- 100% of parents reported improved skills, behavior, and family relationships
- Offered 1,618 screenings for youth, 151 assessments for youth, 287 follow-up visits with families

LAO Family Community Development

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

1. General Description of the Organization

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

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

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

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

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

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

e. Outcomes:

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

The Latina Center

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

1. General Description of the Organization

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

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

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

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

Lifelong Medical Care

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

1. General Description of the Organization

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

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

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

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

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

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

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

Lincoln Child Center

http://lincolnfamilies.org/
Point of Contact: Allison Staulcup Becwar, LCSW President & CEO
Contact Information: 1266 14th St, Oakland CA 94607
(510) 867-0944 allisonbecwar@lincolnfamilies.org

1. General Description of the Organization

Lincoln was founded in 1883 as the region's first volunteer-run, non-sectarian, and fully integrated orphanage. As times and community needs evolved, Lincoln's commitment to vulnerable children remained strong. In 1951, Lincoln began serving abused, neglected and emotionally challenged children. Today, as a highly respected provider of youth and family services, Lincoln has a continuum of programs to serve challenged children and families throughout the Bay Area. Their community based services include early intervention programs in the Oakland and Pittsburg School Districts as well as family based services aimed at stopping the cycle of violence, abuse and mental health problems for at-risk children and families.

2. Program: Multi-Dimensional Family Therapy (MDFT) – Full Service Partnership CSS

Multidimensional Family Therapy (MDFT), an evidence-based practice, is a comprehensive and multi-systemic family-based outpatient program for adolescents with co-occurring substance use and mental health disorders who may be at high risk for continued substance abuse and other challenging behaviors, such as emotional dysregulation, defiance and delinquency. Working with the youth and their families, MDFT helps youth develop more effective coping and problem solving skills for better decision making, and helps the family improve interpersonal functioning as a protective factor against substance abuse and related problems. Services are delivered over 4 to 6 months, with weekly or twice-weekly, face-to-face contact, either in the home, the community or in the clinic with a 4 to 6 weeks after care component.

a. Scope of Services:

- Services include but are not limited to:
- Outreach and engagement
- Case management
- Outpatient Mental Health Services
- Crisis Intervention
- Collateral Services
- Group Rehab
- Flexible funds
- Contractor must be available to consumer on 24/7 basis

b. Target Population: Children in West, Central and East County experiencing co-occurring serious mental health and substance abuse disorders. Youth and their families can be served by this program.

c. Payment Limit: FY 18/19 $874,417

d. Number Served: The program served 61 clients in FY17/18.

e. Outcomes: For FY 17/18:

- Reduction in incidence of juvenile justice involvement
- Reduction of the incidence of restriction
- Reduction in incidence of psychiatric crisis

Table 1. Pre- and post-enrollment utilization rates for 61 Lincoln Child Center, participants enrolled in the FSP program during FY 17-18

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	9	6	0.017	0.015	-11.8%
Inpatient episodes	5	3	0.012	0.006	-50%
Inpatient days	27	11	0.066	0.025	-62.1%
JACS	17	21	0.042	0.050	+19.0%

PH Senior Care, LLC (Pleasant Hill Manor)

Point of Contact: Evelyn Mendez-Choy
Contact Information: 40 Boyd Road, Pleasant Hill CA, 94523
(925) 937-5348, emendez@northstarsl.com

1. General Description of the Organization

The County contracts with Pleasant Hill Manor, a licensed board and care operator, to provide additional staff care to enable those with serious mental illness to avoid institutionalization and enable them to live in the community.

2. Program: Augmented Board and Cares – MHSA Housing Services - CSS

a. Scope of Services: Augmented residential services, including but not limited to:

- Medication management
- Nutritional meal planning
- Assistance with laundry
- Transportation to psychiatric and medical appointments
- Improving socialization
- Assist with activities of daily living (i.e., grooming, hygiene, etc.)
- Encouraging meaningful activity
- Other services as needed for individual residents

b. Target Population: Adults aged 60 years and older, who live in Western, Central, and Eastern Contra Costa County, are diagnosed with a serious mental illness and are uninsured or receive Medi-Cal benefits.

c. Annual MHSA Payment Limit: $ 95,481

d. Number served: For FY 17/18: 26 beds available.

Mental Health Services Act Housing Services
(Contra Costa Health, Housing, and Homeless – H3)

https://cchealth.org/h3/
Point of Contact: Jenny Robbins, LCSW, Housing and Services Administrator
Contact Information: 2400 Bisso Lane, Suite D2, Concord, CA 94520
(925) 608-6000, Jenny.Robbins@CCHealth.org

1. General Description of the Organization

The Behavioral Health Services Division partners with the Health, Housing and Homeless Division to provide permanent and temporary housing with supports for person experiencing a serious mental illness and who are homeless or at risk of being homeless.

2. Program: Homeless Programs - Temporary Shelter Beds - CSS

The County's Health Housing and Homeless Services Division operate a number of temporary bed facilities in West and Central County for transitional age youth and adults. CCBHS, maintains a Memorandum of Understanding with the Health Housing and Homeless Services Division that provides additional funding to enable up to 64 individuals with a serious mental illness per year to receive temporary emergency housing for up to four months.

a. Target Population: Individuals who are severely and persistently mentally ill or seriously emotionally disturbed, and are homeless.
b. Total MHSA Portion of Budget: $2,048,912
c. Number Served in FY 17/18: 75 beds fully utilized for 365 days in the year.

3. Program: Permanent Housing - CSS

Having participated in a specially legislated MHSA Housing Program through the California Housing Finance Agency the County, in collaboration with many community partners, the County completed a number of one-time capitalization projects to create 50 permanent housing units for individuals with serious mental illness. These individuals receive their mental health support from Contra Costa Behavioral Health contract and county service providers. The sites include Villa Vasconcellos in Walnut Creek, Lillie Mae Jones Plaza in North Richmond, The Virginia Street Apartments in Richmond, Robin Lane apartments in Concord, Ohlone Garden apartments in El Cerrito, Third Avenue Apartments in Walnut Creek, Garden Park apartments in Concord, and scattered units throughout the County operated by Anka Behavioral Health.

a. Target Population: Individuals who are severely and persistently mentally ill or seriously emotionally disturbed and are homeless or at risk of homelessness.
b. Total MHSA Portion of Budget: One Time Funding Allocated.
c. Number Served in FY 17/18: 50 units.

4. Program: Coordination Team - CSS

The CCBHS Health Housing and Homeless Services Coordinator and staff work closely with County's Homeless Services Division staff to coordinate referrals and placements, facilitate linkages with other Contra Costa mental health programs and services, and provide contract monitoring and quality control of 26 augmented board and care providers to provide permanent supportive housing for chronically homeless disabled individuals.

a. Target Population: Individuals who are severely and persistently mentally ill or seriously emotionally disturbed and are homeless or at risk of homelessness.

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

Mental Health Systems, Inc.

https://www.mhsinc.org/listing/contra-costa-action-team/
Point of Contact: Alicia Austin-Townsend, MA
Contact Information: 2280 Diamond Blvd., #500, Concord, CA 94520
(925) 483-2223, atownsend@mhsinc.org

1. General Description of the Organization

Mental Health Systems (MHS) provides mental health services and substance abuse treatment designed to improve the lives of individuals, families and communities. MHS operates over 80 programs throughout central and southern California and has recently contracted with Contra Costa Behavioral Health to provide Assisted Outpatient Treatment/Assertive Community Treatment services to residents of Contra Costa County.

2. Program: MHS Contra Costa ACTion Team - CSS

Mental Health Systems, Inc. (MHS) will provide Assisted Outpatient Treatment (AOT) services and subsequent Assertive Community Treatment (ACT) Full Service Partnership (FSP) services for up to 75 eligible adults in Contra Costa County. Program services shall meet the requirements of AB 1421 (Laura's Law) while respecting the choice, autonomy and dignity of individuals struggling with the symptoms of serious mental illness (SMI) and/or co-occurring substance abuse disorders.

The Contra Costa ACTion program will be inclusive of outreach, engagement and support in the investigatory process of AOT determination and the subsequent provision of ACT services. MHS' FSP program model will incorporate an ACT Team whose multidisciplinary members will provide intensive community-based services to adults with SMI and co-occurring substance abuse disorders, who a) establish an AOT court settlement agreement, b) are court-ordered to receive these services, or c) meet the criteria and agree to voluntarily accept services.

a. Scope of Services: The AOT/ACT Adult Full Service Partnership is a collaborative program that joins the resources of Mental Health Systems, Inc. and Contra Costa County Behavioral Health Services in a program under the auspices of the Mental Health Services Act (MHSA). ACT is an evidence-based treatment model approved by Substance Abuse and Mental Health Services Administration (SAMHSA). The primary goal of ACT is recovery through community treatment and rehabilitation.
b. Target Population: Adults diagnosed with serious mental illness and co-occurring substance abuse disorders, who a) establish an AOT court settlement agreement, b) are court-ordered to receive these services, or c) meet the criteria for FSP services and agree to voluntarily accept services.
c. Payment Limit: FY 18/19 $2,015,710
d. Number Served: The program served 47 clients during the16/17 fiscal year and 68 clients during the 17/18 fiscal year.
e. Outcomes: For FY 17/18

- ACT treatment adherence was 66% overall.
- Consumers receiving ACT services had a decrease in crisis episodes from 91% to 52%.
- Consumers had a decrease in psychiatric hospitalizations from 55% to 31%.
- Consumers had a decrease in jail bookings from 67% to 31%.
- 62% of consumers obtained or maintained housing while in ACT.
- 21% of consumers were employed between July and August 2018.

Table 1. Pre-and post-enrollment utilization rates for 39 Mental Health Systems FSP participants enrolled in the FSP program during FY 17-18

	No. pre-Enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	241	69	0.694	0.205	-70.5%
Inpatient episodes	42	13	0.107	0.036	-66.4%
Inpatient days	536	330	1.235	0.795	-35.6%

** Data on service utilization were collected from the county's internal billing system, PSP. To assess the effect of FSP enrollment on PES presentations and inpatient episodes, this methodology compares clients' monthly rates of service utilization pre-enrollment to clients' post-enrollment service utilization rates. Using PES usage as an example, the calculations used to assess pre- and post-enrollment utilization rates can be expressed as:*

- *(No. of PES episodes during pre- enrollment period)/ (No. of months in pre-enrollment period) =Pre-enrollment monthly PES utilization rate*
- *(No. of PES episodes during post-enrollment period)/ (No. of months in post-enrollment period) =Post-enrollment monthly PES utilization rate*

Modesto Residential Living Center, LLC.

Point of Contact: Dennis Monterosso
Contact Information: 1932 Evergreen Avenue, Modesto CA, 95350
(209)530-9300, info@modestoRLC.com

1. General Description of the Organization

The County contracts with Modesto Residential, a licensed board and care operator, to provide additional staff care to enable those with serious mental illness to avoid institutionalization and enable them to live in the community.

2. Program: Augmented Board and Cares – MHSA Housing Services - CSS

The County contracts with Modesto Residential Living Center, a licensed board and care provider, to provide additional staff care to enable those with serious mental illness to avoid institutionalization and enable them to live in the community.

a. Scope of Services: Augmented residential services, including but not limited to:

- Medication management
- Nutritional meal planning
- Assistance with laundry
- Transportation to psychiatric and medical appointments
- Improving socialization
- Assist with activities of daily living (i.e., grooming, hygiene, etc.)
- Encouraging meaningful activity
- Other services as needed for individual residents

b. Target Population: Adults aged 18 years to 59 years who lived in Contra Costa County, are diagnosed with a serious mental illness and are uninsured or receive Medi-Cal benefits, and accepted augmented board and care at Modesto Residential Living Center.

c. Annual MHSA Payment Limit: $ 73,310

d. Number served: For FY 17/18: Capacity of 6 beds.

National Alliance on Mental Illness Contra Costa (NAMI CC)

http://www.namicontracosta.org/
Point of Contact: Gigi Crowder
Contact Information: 2151 Salvio Street, Suite V, Concord, CA 94520
(925) 942-0767, Gigi@namicontracosta.org

1. General Description of the Organization

NAMI CC has been assisting people affected by mental illness for over 30 years now. Services provide support, outreach, education, and advocacy to those affected by mental illness. NAMI's office is located in central Contra Costa County and the program has partnerships with other community and faith based organizations throughout the county that allow them to utilize their space and meet with people in their communities.

2. Program: Family Volunteer Support Network (FVSN) - WET

NAMI CC will recruit, train and manage a network of volunteers with lived experience to support families and loved ones of people experiencing mental health issues. These volunteers will be an extended support network of resources, while assisting families in navigating the behavioral health system. This group of subject matter experts will help families gain a basic understanding of various mental health and substance abuse issues, learn to advocate for themselves or their loves one's needs and become a network to other families experiencing similar situations.

a. Scope of Services: Operate a main site in the Central region of the county and utilize satellite sites to extend outreach to other regions for the purpose of conducting volunteer training, support groups, and other educational activities that will build and maintain a cadre of volunteers.

- Continuously recruit volunteers from all county regions, communities, economic levels, age groups, cultures, race/ethnicities and sexual preferences
- Partner with organizations who specifically prepare individuals for volunteer service in community; such as CCBHS's SPIRIT program.
- Develop and maintain training curriculum as defined in Service Work Plan that prepares volunteers for their role in supporting family members and loved ones of persons experiencing mental health issues.
- Establish partnerships with CCBHS and community and faith-based organizations; as well as ethnic and culturally specific agencies to coordinate family support efforts, assist CCBHS's connectivity with families of consumers, stay abreast and adapt to current and future needs. Key CCBHS partnerships include the Family Partner (Children's System of Care), Family Support Worker (Adult System of Care) Programs, and the Office for Consumer Empowerment.

b. Target Population: Family members and care givers of individuals with lived mental health issues.
c. Payment Limit: $600,000
d. Number served in FY 17-18: N/A – Program opened doors August 2018.
e. Outcomes:

- Staff, and pilot the FVSN Program.
- Open one administrative office in central Contra Costa County, and maintain three satellite locations in east, west, and south Contra Costa County.
- Partner with other CCBHS, community, and faith-based organizations to support families affected by mental health issues.
- Develop training curriculum for FVSN Program.

- Start recruitment of volunteers.

3. Program: Family Psycho Education Program (Family to Family: Spanish, Mandarin, and Cantonese, FaithNet, and NAMI Basics) - WET

a. Scope of Services: Family to Family is an evidence based NAMI educational training program offered throughout the county in Spanish, Mandarin and Cantonese languages to family members and caregivers of individuals experiencing mental health challenges. This training is designed to support and increase a family member's/care giver's knowledge of mental health, its impact on the family, navigation of systems, connections to community resources; and coping mechanisms. NAMI FaithNet is an interfaith resource network of NAMI members, friends, clergy and congregations of all faith traditions who wish to encourage faith communities to be welcoming and supportive of persons and families living with mental illness. NAMI Basics is aimed to give an overview about mental health, how best to support a loved one at home, at school and when in getting medical care. The course is taught by a trained team of individuals and loved ones with lived experience.

- Develop and implement a training program to help address the unique needs of the specified population, helping to serve Spanish, Mandarin and Cantonese speaking communities to help families develop coping skills to address challenges posed by mental health issues in the family, and develop skills to support the recovery of loved ones.
- Instruction related to the mental health concepts, wellness and recovery principles, symptoms of mental health issues; as well as education on how mental illness and medications affect loved ones.
- The training will be augmented by utilizing sites, such as faith centers and community based organizations throughout the county on an as needed basis in order to enable access to diverse communities with the goal of reaching the broadest audiences

b. Target Population: Family members, care givers and loved ones of individuals who have experienced or are experiences mental health issues.

c. Payment Limit: $64,851

d. Number served: For FY 17/18: 890

e. Outcomes:

- Deliver six Family-to-Family (12) week trainings during FY 17-18.
- Hold four FaithNet events during FY 17-18.
- Deliver four NAMI Basics (6) session trainings during FY 17-18.
- All trainings will educate individuals on how to manage crises, solve problems, communicate effectively, learn the importance of self-care, and assist in developing confidence and stamina to provide support with compassion, and learn about the impact of mental illness on the family.
- Feedback will inform decision making. Family member participation surveys will be created, administered and collected on a regular basis. Information collected will be analyzed to adjust methods to better meet the needs of all involved. Surveys will gauge participant knowledge, and level of confidence and understanding of mental health, advocacy and the public mental health system.

Native American Health Center (NAHC)

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

1. General Description of the Organization

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

2. Program: Native American Wellness Center – PEI

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

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

b. Target Population: Native American residents of Contra Costa County (mainly west region), who are at risk for developing a serious mental illness.
c. Payment Limit: FY 18-19: $241,831
d. Number served: In FY 17-18: 162
e. Outcomes:

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

Oak Hills Residential Facility

Point of Contact: Rebecca Lapasa
Contact Information: 141 Green Meadow Circle, Pittsburg, CA 94565
(925) 709-8853, Rlapasa@yahoo.com

1. General Description of the Organization:

The County contracts with Oak Hills, a licensed board and care operator, to provide additional staff care to enable those with serious mental illness to avoid institutionalization and enable them to live in the community.

2. Program: Augmented Board and Cares – MHSA Housing Services - CSS

a. Scope of Services: Augmented residential services, including but not limited to:

- Medication management
- Nutritional meal planning
- Assistance with laundry
- Transportation to psychiatric and medical appointments
- Improving socialization
- Assist with activities of daily living (i.e., grooming, hygiene, etc.)
- Encouraging meaningful activity
- Other services as needed for individual residents

b. Target Population: Adults aged 18 years to 59 years who live in Western, Central, and Eastern Contra Costa County, are diagnosed with a serious mental illness and are uninsured or receive Medi-Cal benefits.

c. Annual MHSA Payment Limit: $16,604

d. Number served: For FY 17/18: 6 beds.

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

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

1. General Description of the Organization

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

2. Program: Reducing Stigma and Discrimination – PEI

a. Scope of Services:

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

3. Program: Mental Health Career Pathway Program - WET

a. Scope of Services:

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

4. Program: Overcoming Transportation Barriers – INN

a. Scope of Services:

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

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

c. Total MHSA Funding for FY 2018-19: $894,671

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

e. Outcomes:

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

Older Adult Mental Health
(Contra Costa Behavioral Health)

https://cchealth.org/mentalhealth/#simpleContained4
Point of Contact: Heather Sweeten-Healy, LCSW, Mental Health Program Manager or Ellie Shirgul, PsyD, Mental Health Program Supervisor
Contact Information: 2425 Bisso Lane, Suite 100, Concord, CA 94520
(925)-521-5620, Heather.Sweeten-Healy@cchealth.org, Ellen.Shirgul@cchealth.org

1. General Description of the Organization

The Older Adult Mental Health Clinic is in the Adult System of Care and provides mental health services to Contra Costa's senior citizens, including preventive care, linkage and outreach to under-served at risk communities, problem solving short-term therapy, and intensive care management for severely mentally ill individuals.

2. Program: Intensive Care Management Teams - CSS

The Intensive Care Management Teams (ICMT) provides mental health services to older adults in their homes, in the community and within a clinical setting. Services are provided to Contra Costa County residents with serious psychiatric impairments who are 60 years of age or older. The program provides services to those who are insured through Medi-Cal, dually covered under Medi-Cal and MediCare, or uninsured. The primary goal of these teams is to support aging in place as well as to improve consumers' mental health, physical health, prevent psychiatric hospitalization and placement in a higher level of care, and provide linkage to primary care appointments, community resources and events, and public transportation in an effort to maintain independence in the community. Additionally, the teams provide services to those who are homeless, living in shelters, or in residential care facilities. There are three multi-disciplinary Intensive Care Management Teams, one for each region of the county that increases access to resources throughout the county.

3. Program: Improving Mood Providing Access to Collaborative Treatment (IMPACT) - CSS

IMPACT is an evidence-based practice which provides depression treatment to individuals age 55 and over in a primary care setting. The IMPACT model prescribes short-term (8 to 12 visits) Problem Solving Therapy and medication consultation with up to one year of follow-up as necessary. Services are provided by a treatment team consisting of licensed clinicians, psychiatrists, and primary care physicians in a primary care setting. The target population for the IMPACT Program is adults age 55 years and older who are receiving health care services at a federally qualified health center. The program focuses on treating older adults with late-life depression and co-occurring physical health impairments, such as cardio-vascular disease, diabetes, or chronic pain. The primary goals of the Impact Program are to prevent more severe psychiatric symptoms, assist clients in accessing community resources as needed, reducing stigma related to accessing mental health treatment and providing access to therapy to this underserved population.

4. Program: Senior Peer Counseling - WET

This program reaches out to isolated and mildly depressed older adults in their home environments and links them to appropriate community resources in a culturally competent manner. Services are provided by Senior Peer Volunteers, who are trained and supervised by the Senior Peer Counseling Coordinators. Both the Latino and Chinese Senior Peer Counseling Programs are recognized as a resource for these

underserved populations. This program serves older adults age 55 and older who are experiencing aging issues such as grief and loss, multiple health problems, loneliness, depression and isolation. Primary goals of this program are to prevent more severe psychiatric symptoms and loss of independence, reduce stigma related to seeking mental health services, and increase access to counseling services to these underserved populations.

a. Target Population: Depending on program, Older Adults aged 55 or 60 years and older experiencing serious mental illness or at risk for developing a serious mental illness.
b. Total Budget: Intensive Care Management - $2,995,707; IMPACT - $392,362; Senior Peer Counseling - $370,479.
c. Staff: 28 Full time equivalent multi-disciplinary staff.
d. Number served: For FY 17/18: ICMT served 238 individuals; IMPACT served 440 individuals; Senior Peer Counseling Program trained and supported 34 volunteers and served 267 individuals.
e. Outcomes: For IMPACT and ICM: Changes in Level of Care Utilization System (LOCUS) scores, reductions in Psychiatric Emergency Service visits, reductions in hospitalizations, decreased Patient Health Questionnaire (PHQ-9) scores, and reduced isolation, which is assessed by the PEARLS (ICM only). The SPC Program is in the process of implementing the Depression Anxiety Stress Scales (DASS) that will be administered at intake, and at the end of counseling to assess levels of anxiety and depression.

5. Program: Partners in Aging - INN

Partners in Aging is an Innovation Project that was implemented on September 1st, 2016. Partners in Aging adds up to two Community Support Workers, up to 3 Student Interns and 8 hours/week of Psychiatric Services to the IMPACT program. The project is designed to increase the ability of the IMPACT program to reach out to underserved older adult populations through outreach at the Miller Wellness Center and Psychiatric Emergency Services. Through Partners in Aging, IMPACT has provided more comprehensive services, including providing linkage to Behavioral Health, Ambulatory Care, and community resources. Peer support, rehab, and in-home and in-community coaching will allow the skills learned through psychotherapy to be practiced in the community.

a. Scope of Services**:** Community Support Workers and Student Interns provided linkage, in-home and in-community peer support, and health/mental health coaching to consumers open to or referred to the IMPACT program. In addition, the CSW and Student Intern provide outreach to staff at Psychiatric Emergency Services and Miller Wellness Center. They are available to meet with consumers at PES and MWC that meet the criteria for IMPACT to provide outreach, and linkage to services. The Student Intern conducts intakes, assessments, and provides individual psychotherapy. Additionally, a Geropsychiatrist will be available 8 hours/week to provide consultation, and in-person evaluations of IMPACT clients.
b. Target Population: The target population receiving health care services at the Federally Qualified Health Center for the IMPACT Program is adults age 55 years and older. The program focuses on treating older adults with late-life depression or anxiety and co-occurring physical health impairments, such as cardio-vascular disease, diabetes, or chronic pain. Partners in Aging also focused on providing

outreach and services to older adults who are experiencing both mental health symptoms and alcohol or drug misuse.

c. Annual Payment Limit: $250,000
d. Number served: For FY 17/18: 38 individuals
e. Outcomes: Reductions in Level of Care Utilization System (LOCUS) scores, reductions in Psychiatric Emergency Service visits, reductions in hospitalizations, and decreased Patient Health Questionnaire (PHQ-9) scores would indicate the effectiveness of this program.

People Who Care (PWC) Children Association

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

1. General Description of the Organization

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

2. Program: PWC Afterschool Program (PEI)

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

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

Portia Bell Hume Behavioral Health and Training Center

https://www.humecenter.org/
Point of Contact: Reynold Fujikawa, PsyD, Program Manager (Community Support Program East)
Contact Information: 555 School Street, Pittsburg, CA 94565
(925) 384.7727, rfujikawa@humecenter.org
Point of Contact: Miguel Hidalgo-Barnes, PsyD, Program Manager (Community Support Program West)
Contact Information: 3095 Richmond Pkwy #201, Richmond, CA 94806
(925) 481-4412, mhidalgo-barnes@humecenter.org

1. General Description of the Organization

The Hume Center is a Community Mental Health Center that provides high quality, culturally sensitive and comprehensive behavioral health care services and training. The agency strives to promote mental health, reduce disparities and psychological suffering, and strengthen communities and systems in collaboration with the people most involved in the lives of those served. They are committed to training behavioral health professionals to the highest standards of practice, while working within a culture of support and mutual respect. They provide a continuity of care in Contra Costa that includes prevention and early intervention, comprehensive assessment services, behavioral consultation services, outpatient psychotherapy and psychiatry, case management, Partial Hospitalization services, and Full Service Partnership Programs.

2. Program: Adult Full Service Partnership - CSS

The Adult Full Service Partnership is a collaborative program that joins the resources of Hume Center and Contra Costa County Behavioral Health Services.

a. Goal of the Program:

- Prevent repeat hospitalizations
- Transition from institutional settings
- Attain and/or maintain medication compliance
- Improve community tenure and quality of life
- Attain and/or maintain housing stability
- Attain self-sufficiency through vocational and educational support
- Strengthen support networks, including family and community supports
- Limit the personal impact of substance abuse on mental health recovery

b. Referral, Admission Criteria, and Authorization:

i. Referral: To inquire about yourself or someone else receiving our Full Service Partnership Services in our Community Support Program (CSP) East program, please call our Pittsburg office at (925) 432-4118. For services in our CSP West program, please contact our Richmond office at (510) 778-2816.

ii. Admission Criteria: This program serves adult aged 26 and older who are diagnosed with severe mental illness and are:

- Frequent users of emergency services and/or psychiatric emergency services
- Homeless or at risk of homelessness
- Involved in the justice system or at risk of this
- Have Medi-Cal insurance or are uninsured

iii. Authorization: Referrals are approved by Contra Costa Behavioral Health Division.

c. Scope of Services: Services will be provided using an integrated team approach called Community Support Program (CSP). Our services include:

- Community outreach, engagement, and education to encourage participation in the recovery process and our program
- Case management and resource navigation for the purposes of gaining stability and increasing self-sufficiency
- Outpatient Mental Health Services, including services for individuals with co-occurring mental health & alcohol and other drug problems
- Crisis Intervention, which is an immediate response to support a consumer to manage an unplanned event and ensure safety for all involved, which can include involving additional community resources
- Collateral services, which includes family psychotherapy and consultation. These services help significant persons to understand and accept the consumer's condition and involve them in service planning and delivery.
- Medication support, including medication assessment and ongoing management (may also be provided by County Physician)
- Housing support, including assisting consumers to acquire and maintain appropriate housing and providing skill building to support successful housing. When appropriate, assist consumers to attain and maintain MHSA subsidized housing.
- Flexible funds are used to support consumer's treatment goals. The most common use of flexible funds is to support housing placements through direct payment of deposit, first/last month's rent, or unexpected expenses in order to maintain housing.
- Vocational and Educational Preparation, which includes supportive services and psychoeducation to prepare consumers to return to school or work settings. This aims to return a sense of hope and trust in themselves to be able to achieve the goal while building the necessary skills, support networks, and structures/habits.
- Recreational and Social Activities aim to assist consumers to decrease isolation while increasing self-efficacy and community involvement. The goal is to assist consumers to see themselves as members of the larger community and not marginalized by society or themselves.
- Money Management, which is provided by sub-contractors, aims to increase stability for consumers who have struggled to manage their income. Services aim to increase money management skills to reduce the need for this service.
- 24/7 Afterhours/Crisis Line is answered during non-office hours so that consumers in crisis can reach a staff member at any time. Direct services are provided on weekends and holidays as well.

d. Target Population: Adults diagnosed with severe mental illness in East, Central and West County who are diagnosed with a serious mental illness, are at or below 300% of the federally defined poverty level, and are uninsured or receive Medi-Cal benefits.

e. Payment Limit: For FY 17-18 (East and West CSP): $1,948,137

f. Number served: For FY 17/18: 48 individuals (East); and 68 individuals (West)

g. Outcomes: For FY 17/18 (East):

- Reduction in incidence of psychiatric crisis
- Reduction of the incidence of restriction
- For FY (West): 1. Reduction in incidence of psychiatric crisis 2. Reduction of the incidence of restriction

Table 1. Pre- and post-enrollment utilization rates for 51 Hume East FSP participants enrolled in the FSP program during FY 17-18

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	279	140	0.495	0.263	-36.1%
Inpatient episodes	44	10	0.075	0.016	-60.2%
Inpatient days	572	519	0.966	0.848	-12.2%

Table 1. Pre- and post-enrollment utilization rates for 76 Hume West FSP participants enrolled in the FSP program during FY 17-18

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	127	81	0.140	0.089	-36.4%
Inpatient episodes	21	13	0.023	0.014	-39.1%
Inpatient days	287	232	0.315	0.254	-19.4%

** Data on service utilization were collected from the county's internal billing system, PSP. To assess the effect of FSP enrollment on PES presentations and inpatient episodes, this methodology compares clients' monthly rates of service utilization pre-enrollment to clients' post-enrollment service utilization rates. Using PES usage as an example, the calculations used to assess pre- and post-enrollment utilization rates can be expressed as:*

- *(No. of PES episodes during pre- enrollment period)/ (No. of months in pre-enrollment period) =Pre-enrollment monthly PES utilization rate*
- *(No. of PES episodes during post-enrollment period)/ (No. of months in post-enrollment period) =Post-enrollment monthly PES utilization rate*

Primary Care Clinic Behavioral Health Support
(Contra Costa Behavioral Health)

https://cchealth.org/mentalhealth/#simpleContained4
Point of Contact: Kelley Taylor, Ambulatory Care Clinic Supervisor
Contact Information: 3052 Willow Pass Road, Concord, CA 94519
(925) 681-4100, Kelley.Taylor@CCHealth.org

1. General Description of the Organization

Behavioral health clinicians staff the county Primary Care Health Centers in Concord. The goal is to integrate primary and behavioral health care. Two mental health clinicians are part of a multi-disciplinary team with the intent to provide timely and integrated response to those at risk, and/or to prevent the onset of serious mental health functioning among adults visiting the clinic for medical reasons.

2. Plan Element: Clinic Support - CSS

a. Scope of Services: Perform brief mental health assessment and intervention with adults, children, and their families. Provide short term case management, mental health services, individual and family support, crisis intervention, triage, coordination of care between primary care and Behavioral Health Services. Tasks also include linkage to schools, probation, social services and community services and lead groups at County Primary Care Center.
b. Target Population: Adults in central county, who present at the clinic for medical reasons
c. Number served by clinic: For FY 17/18: 200+.
d. Outcomes: Improve overall health for individuals through decrease medical visit and increase coping with life situations.

Putman Clubhouse

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

1. General Description of the Organization

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

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

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

b. Target Population: Contra Costa County residents with identified mental illness and their families.
c. Payment Limit: FY 18-19: $598,468
d. Number served: In FY 17-18: 308
e. Outcomes (FY17-18):

- 70 new members enrolled and participated in at least one activity

- Held 4 career workshops
- Prepared 9,000 meals for members
- Provided 54,437 hours of Clubhouse programming to members
- Clubhouse membership made a positive impact by decreasing hospitalizations

Rainbow Community Center

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

1. General Description of the Organization

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

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

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

b. Target Population: LGBTQ community of Contra Costa County who are at risk of developing serious mental illness.

c. Payment Limit: FY 18-19: $759,362 for PEI, including counseling and case management services onsite and at Contra Costa schools.

d. Number served: In FY 17-18: 1460

e. Outcomes:

- Rainbow held 28 trainings during the year
- Rainbow's Inclusive School Coalition served the following four districts: Mt. Diablo, Pittsburg, Acalanes, West Contra Costa Unified.
- Youth Support Programming served: 144 youth via outreach; 176 youth in groups; 43 through one on one work; 387 through school-based outreach; 118 through mental health services, and 65 through psycho-social groups.

- Pride & Joy program reached 1,054 members of the community through events/groups; 387 through brief intervention; and 204 through individual services.

RI International Inc. (formerly known as Recovery Innovations)

https://riinternational.com/our-services/california/contra-costa/
Point of Contact: April Langro, Recovery Services Administrator
Contact Information: 3701 Lone Tree Way, Antioch, CA 94509
2975 Treat Boulevard C-8, Concord, CA 94518
2101 Vale Road #300, San Pablo, CA 94806
(925) 494-4008, April.Langro@RIIinternational.com

1. General Description of the Organization

RI International was founded as META Services, an Arizona non-profit corporation. It has developed and provided a range of traditional mental health and substance abuse services for adults with long term mental health and addiction challenges. RI International pioneered an innovative initiative: the creation of the new discipline of Peer Support Specialist. This experience has transformed the RI International workforce to one in which Peer Support Specialists and professionals work together on integrated teams to deliver recovery-based services. The RI International experience has had a global impact on the mental health field serving as a demonstration that recovery from mental illness and/or addiction is possible. Based on transformation experience, RI International operates recovery-based mental health services in over 20 communities in five states and one location in New Zealand. RI International has provided recovery training and transformation consultation in 27 states and five countries abroad.

2. Program: RI International Wellness Cities – CSS

RI International provides Adult Wellness Cities that serve individuals or *citizens* experiencing mental and/or behavioral health challenges in west, central and east Contra Costa County. Wellness Cities provide a variety of wellness and recovery-related classes and groups, one-on-one coaching, vocational opportunities, links to community resources, and recreational opportunities in a peer supported environment. The classes, groups and coaching are recovery-oriented and facilitated by peer recovery coaches. Coaches work with citizens to establish individualized goals, a wellness recovery action plan (WRAP), self-help and coping skills, support networks and a commitment to overall wellness. All services provided are related to at least one of the nine dimensions of wellness; physical, emotional, intellectual, social, spiritual, occupational, home and community living, financial and recreation/leisure. Participants seeking services become citizens of the city. Citizens develop a 6 month partnership with RI International and are assigned a Peer Recovery Coach who has experienced their own success in recovery by obtaining education, coping skills, self-management and/or sobriety. They share what they have learned and walk alongside each citizen on their individualized and strength-based path to recovery.

Other services provided are case management support by the Recovery Care Coordinator. The position assists individuals with linkages that provide independence, education and support in the community. The Employment Services Coordinator also helps RI citizens that are ready in their path to recovery with support of positive employment opportunities; whether it be paid or volunteer work.

a. Scope of Services:

- Peer and family support
- Personal recovery planning using the seven steps of Recovery Coaching
- Monthly one on one coaching and meaningful outcome tracking

- Workshops, education classes, evidence-based IMR groups, community based activities using the 9 Dimensions of Wellness (physical, emotional, intellectual, social, spiritual, occupational, home/community living, financial, recreation/leisure)
- Community outreach and collaboration
- Assist participants to coordinate medical, mental health, medication and other community services through Care Coordination
- Supportive employment program through the use of an Employment Specialist position as well as the Employment Prep & Placement (E3P) Program
- Wellness Recovery Action Plan (WRAP) classes
- Snacks and lunch meals during weekdays for participants
- Further enhance services by providing transportation to community based activities using the 9 Dimensions of Wellness (physical, emotional, intellectual, social, spiritual, occupational, home/community living, financial, recreation/leisure)
- Community Outreach and Collaboration with Mental Health Partners and Providers – NAMI, HUME, WET team, Project Homeless Connect, WREACH, SPIRIT, CORE, etc.
- Links to Resources - Assist participants to coordinate medical, mental health, medication, housing, and other community services
- SPIRIT Program – obtain attendance records from the OCE and process reimbursement (stipend) for SPIRIT students.

b. Target Population: Adult mental health participants in Contra Costa County. RI International services will be delivered within each region of the county through Wellness Cities located in Antioch, Concord and San Pablo.
c. Annual MHSA Payment Limit: $973,583.33
d. Number served: FY 17/18: 363 (340 were active, regular participants)
e. Outcomes: For FY 17-18, RI International served a total of 363 citizens, of which 71.2% or 258 developed a Wellness Recovery Action Plan (WRAP). 93.9% or 340 also met with a Recovery Coach at least once a month while receiving services. Attendance numbers for the four core classes during FY 17-18 are as follows:

- 63 attended WRAP classes
- 57 attended WELL classes
- 48 attended Facing up to Health classes
- 65 attended the 9 Dimensions of Wellness classes
- RI International was also able to offer Illness Management Recovery (IMR) classes to RI Citizens; funded through Substance Abuse and Mental Health Services Administration (SAMHSA).

RYSE Center

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

1. General Description of the Organization

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

1. Program: Supporting Youth – PEI

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

b. Target Population: West County Youth at risk for developing serious mental illness.
c. Payment Limit: FY 18-19: $488,368
d. Unique Number served: In FY 17-18: 680 young people
e. Outcomes:

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

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

Seneca Family of Agencies

http://www.senecafoa.org/
Point of Contact: Jennifer Blanza, Program Director
Contact Information: 3200 Clayton Road, Concord, CA, 94519
(415) 238-9945; jennifer_blanza@senecacenter.org

1. General Description of the Organization

Seneca Family of Agencies is a leading innovator in the field of community-based and family-based service options for emotionally troubled children and their families. With a continuum of care ranging from intensive crisis intervention, to in-home wraparound services, to public school-based services, Seneca is one of the premier children's mental health agencies in Northern California.

2. Program: Short Term Assessment of Resources and Treatment (START) - Full Service Partnership - CSS

Seneca Family of Agencies (SFA) provides an integrated, coordinated service to youth who frequently utilize crisis services, and may be involved in the child welfare and/or juvenile justice system. START provides three to six months of short term intensive services to stabilize the youth in their community, and to connect them and their families with sustainable resources and supports. The goals of the program are to 1) reduce the need to utilize crisis services, and the necessity for out-of-home and emergency care for youth enrolled in the program, 2) maintain and stabilize the youth in the community by assessing the needs of the family system, identifying appropriate community resources and supports, and ensuring their connection with sustainable resources and supports, and 3) successfully link youth and family with formal services and informal supports in their neighborhood, school and community.

a. Scope of Services:

- Outreach and engagement
- Linkage
- Assessment
- Case management
- Plan development
- Crisis Intervention
- Collateral
- Flexible funds
- Contractor must be available to consumer on 24/7 basis

b. Target Population: The target population for the program includes youth with a history of multiple psychiatric hospitalizations and crisis interventions, imminent risk of homelessness, who have a serious mental illness and/or are seriously emotionally disturbed, and are not being served, or are being underserved, by the current mental health system. Youth in the program can be Medi-Cal eligible or uninsured.

c. Payment Limit: FY 18/19 $ 1,000,203

d. Number served: Number served in FY 17/18: 61 individuals

e. Outcomes:

- Establish linkage with ongoing resources/support.
- Reduction in incidence of psychiatric crisis
- Reduction of the incidence of restriction

Table 1. Pre-and post-enrollment utilization rates for 60 Seneca Start FSP Participants enrolled in the FSP program during FY 17-18

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	86	39	0.167	0.092	-44.9%
Inpatient episodes	24	22	0.047	0.05	-6.38%
Inpatient days	145	135	0.278	0.301	-8.27%

** Data on service utilization were collected from the county's internal billing system, PSP. To assess the effect of FSP enrollment on PES presentations and inpatient episodes, this methodology compares clients' monthly rates of service utilization pre-enrollment to clients' post-enrollment service utilization rates. Using PES usage as an example, the calculations used to assess pre- and post-enrollment utilization rates can be expressed as:*

- *(No. of PES episodes during pre- enrollment period)/ (No. of months in pre-enrollment period) =Pre-enrollment monthly PES utilization rate*
- *(No. of PES episodes during post-enrollment period)/ (No. of months in post-enrollment period) =Post-enrollment monthly PES utilization rate*

SHELTER, Inc.

https://shelterinc.org/
Point of Contact: John Eckstrom, Chief Executive Officer
Contact Information: P.O. Box 5368, Concord, CA 94524
(925) 957-7595, john@shelterinc.org

1. General Description of the Organization

The mission of SHELTER, Inc. is to prevent and end homelessness for low-income, homeless, and disadvantaged families and individuals by providing housing, services, support, and resources that lead to self-sufficiency. SHELTER, Inc. was founded in 1986 to alleviate Contra Costa County's homeless crisis, and its work encompasses three main elements: 1) prevent the onset of homelessness, including rental assistance, case management, and housing counseling services, 2) ending the cycle of homelessness by providing housing plus services including employment, education, counseling and household budgeting to help regain self-sufficiency and 3) providing permanent affordable housing for over 200 low-income households, including such special needs groups as transition-age youth, people with HIV/AIDS, and those with mental health disabilities.

2. Program: Supportive Housing - CSS

SHELTER, Inc. provides a master leasing program, in which adults or children and their families are provided tenancy in apartments and houses throughout the County. Through a combination of self-owned units and agreements with landlords SHELTER, Inc. acts as the lessee to the owners and provides staff to support individuals and their families move in and maintain their homes independently. Housing and rental subsidy services are provided to residents of the County who are homeless and that have been certified by Contra Costa Behavioral Health as eligible. This project is committed to providing housing opportunities that provide low barriers to obtaining housing that is affordable, safe and promotes independence to MHSA consumers.

a. Scope of Services.

- Provide services in accordance with the State of California Mental Health Service Act (MHSA) Housing Program, the Contra Costa County Behavioral Health Mental Health Division's Work Plan, all State, Federal and Local Fair Housing Laws and Regulations, and the State of California's Landlord and Tenants Laws.
- Provide consultation and technical support to Contra Costa Behavioral Health with regard to services provided under the housing services and rental subsidy program.
- Utilize existing housing units already on the market to provide immediate housing to consumers through master leasing and tenant based services.
- Acquire and maintain not less than 100 master-leased housing units throughout Contra Costa County.
- Negotiate lease terms and ensure timely payment of rent to landlords.
- Leverage housing resources through working relationships with owners of affordable housing within the community.
- Integrate innovative practices to attract and retain landlords and advocate on behalf of consumers.
- Leverage other rental subsidy programs including, but not limited to, Shelter Plus Care and HUD Housing Choice Voucher (Section 8).
- Reserve or set aside units of owned property dedicated for MHSA consumers.

- Ensure condition of leased units meet habitability standards by having Housing Quality Standard (HQS) trained staff conduct unit inspections prior to a unit being leased and annually as needed.
- Establish maximum rent level to be subsidized with MHSA funding to be Fair Market Rent (FMR) as published by US Department of Housing and Urban Development (HUD) for Contra Costa County in the year that the unit is initially rented or meeting rent reasonableness utilizing the guidelines established by HUD and for each year thereafter.
- Provide quality property management services to consumers living in master leased and owned properties.
- Maintain property management systems to track leases, occupancy, and maintenance records.
- Maintain an accounting system to track rent and security deposit charges and payments.
- Conduct annual income re-certifications to ensure consumer rent does not exceed 30% of income minus utility allowance. The utility allowance used shall be in accordance with the utility allowances established by the prevailing Housing Authority for the jurisdiction that the housing unit is located in.
- Provide and/or coordinate with outside contractors and SHELTER, Inc. maintenance staff for routine maintenance and repair services and provide after-hours emergency maintenance services to consumers.
- Ensure that landlords adhere to habitability standards and complete major maintenance and repairs.
- Process and oversee evictions for non-payment of rent, criminal activities, harmful acts upon others, and severe and repeated lease violations.
- Work collaboratively with full service partnerships and/or County Mental Health Staff around housing issues and provide referrals to alternative housing options.
- Attend collaborative meetings, mediations and crisis interventions to support consumer housing retention.
- Provide tenant education to consumers to support housing retention.

b. Target Population: Consumers eligible for MHSA services. The priority is given to those who are homeless or imminently homeless and otherwise eligible for the full service partnership programs.
c. Annual Payment Limit: $2,349, 929
d. Number served: For FY 17/18 Shelter, Inc. served 118 consumers.
e. Outcomes: SHELTER, Inc. reports on the following outcomes:

- Quality of life: housing stability.
    i. Goal: 70% of MHSA Consumers residing in master leased housing shall remain stably housed for 18 months or longer. In FY16-17, the vast majority of consumers in master-leased units remained housed for the entire year, and many had been stably housed for 3 plus years. One new consumer moved in during FY16/17, and remained housed at the end of the fiscal year. For those who moved out during the fiscal year, 90% of the consumers who exited the program had been stably housed for 18 months or longer.
    ii. Goal: 70% of MHSA Consumers residing in SHELTER, Inc. owned property shall remain stably housed for 12 months or longer. In FY16-17, the majority of consumers in agency-owned units remained housed for the entire year, and many had been stably housed for 2-5 years. Six new consumers moved in

during FY16/17, and five remained housed at the end of the fiscal year. For those who moved out during the fiscal year, 90% of the consumers who exited the program had been stably housed for 12 months or longer.

STAND! For Families Free of Violence

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

1. General Description of the Organization

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

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

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

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

Telecare Corporation

https://www.telecarecorp.com/
Point of Contact: Clearnise Bullard, Program Administrator and Jim Christopher, Clinical Director
Contact Information: 300 Ilene Street, Martinez, CA 94553
(925) 313-7980, cbullard@telecarecorp.com, jchristopher@telecarecorp.com

1. General Description of the Organization

Telecare Corporation was established in 1965 in the belief that persons with mental illness are best able to achieve recovery through individualized services provided in the least restrictive setting possible. Today, they operate over 100 programs staffed by more than 2,500 employees in California, Oregon, Washington, Arizona, Nebraska, North Carolina, Texas, New Mexico and Pennsylvania and provide a broad continuum of services and supports, including Inpatient Acute Care, Inpatient Non-Acute/Sub-Acute Care, Crisis Services, Residential Services, Assertive Community Treatment (ACT) services, Case Management and Prevention services.

2. Program: Hope House Crisis Residential Facility - CSS

Telecare Corporation operates Hope House, a voluntary, highly structured 16-bed Short-Term Crisis Residential Facility (CRF) for adults between the ages of 18 and 59. Hope House is serves individuals who require crisis support to avoid hospitalization, or are discharging from the hospital or long-term locked facilities and need step-down care to transition back to community living. The focus is client-centered and recovery-focused, and underscores the concept of personal responsibility for the resident's illness and independence. The program supports a social rehabilitation model, which is designed to enhance an individual's social connection with family and community so that they can move back into the community and prevent a hospitalization. Services are recovery based, and tailored to the unique strengths of each individual resident. The program offers an environment where residents have the power to make decisions and are supported as they look at their own life experiences, set their own paths toward recovery, and work towards the fulfillment of their hopes and dreams. Telecare's program is designed to enhance client motivation to actively participate in treatment, provide clients with intensive assistance in accessing community resources, and assist clients develop strategies to maintain independent living in the community and improve their overall quality of life. The program's service design draws on evidence-based practices such as Wellness Action and Recovery Planning (WRAP), motivational interviewing, and integrated treatment for co-occurring disorders.

a. Scope of Services:

- Individualized assessments, including, but not limited to, psychosocial skills, reported medical needs/health status, social supports, and current functional limitations within 24 hours of admission.
- Psychiatric assessment within 24 hours of admission.
- Treatment plan development with 72 hours of admission.
- Therapeutic individual and group counseling sessions on a daily basis to assist clients in developing skills that enable them to progress towards self-sufficiency and to reside in less intensive levels of care.
- Crisis intervention and management services designed to enable the client to cope with the crisis at hand, maintaining functioning status in the community, and prevent further decompensation or hospitalization.

- Medication support services, including provision of medications, as clinically appropriate, to all clients regardless of funding; individual and group education for consumers on the role of medication in their recovery plans, medication choices, risks, benefits, alternatives, side effects and how these can be managed; supervised self-administration of medication based on physician's order by licensed staff; medication follow-up visit by a psychiatrist at a frequency necessary to manage the acute symptoms to allow the client to safely stay at the Crisis Residential Program, and to prepare the client to transition to outpatient level of care upon discharge.
- Co-occurring capable interventions, using the Telecare Co-Occurring Education Group materials for substance use following a harm reduction modality as well as availability of weekly AA and NA meetings in the community.
- Weekly life skills groups offered to develop and enhance skills needed to manage supported independent and independent living in the community.
- A comprehensive weekly calendar of activities, including physical, recreational, social, artistic, therapeutic, spiritual, dual recovery, skills development and outings.
- Peer support services/groups offered weekly.
- Engagement of family in treatment, as appropriate.
- Assessments for involuntary hospitalization, when necessary.
- Discharge planning and assisting clients with successful linkage to community resources, such as outpatient mental health clinics, substance abuse treatment programs, housing, full service partnerships, physical health care, and benefits programs.
- Follow-up with client and their mental health service provider following discharge to ensure that appropriate linkage has been successful.
- Daily provision of meals and snacks for residents.
- Transportation to services and activities provided in the community, as well as medical and court appointments, if the resident's case manager or county worker is unavailable, as needed.

b. Target Population: Adults ages 18 to 59 who require crisis support to avoid psychiatric hospitalization, or are discharging from the hospital or long-term locked facilities and need step-down care to transition back to community living.
c. Payment Limit: $2,077,530.00
d. Number served: Hope House had 255 client admissions in FY17/18 and an unduplicated client count of 232.
e. Outcomes:

- Reduction in severity of psychiatric symptoms: Discharge at least 90% of clients to a lower level of care.
- Consumer Satisfaction: Maintain an overall client satisfaction score of at least 4.0 out of 5.0.

United Family Care, LLC (Family Courtyard)

Point of Contact: Juliana Taburaza
Contact Information: 2840 Salesian Avenue, Richmond CA 94804
(510) 235-8284, JuTaburaza@gmail.com

1. General Description of the Organization

The County contracts with United Family Care, LLC (Family Courtyard), a licensed board and care provider, to provide additional staff care to enable those with serious mental illness to avoid institutionalization and enable them to live in the community.

2. Program: Augmented Board and Care Housing Services - CSS

a. Scope of Services: Augmented residential services, including but not limited to:

- Medication management
- Nutritional meal planning
- Assistance with laundry
- Transportation to psychiatric and medical appointments
- Improving socialization
- Assist with activities of daily living (i.e., grooming, hygiene, etc.)
- Encouraging meaningful activity
- Other services as needed for individual residents

b. Target Population: Adults aged 60 years and older who live in Western, Central, and Eastern Contra Costa County, are diagnosed with a serious mental illness and are uninsured or receive Medi-Cal benefits.

c. Annual MHSA Payment Limit: $467,455

d. Number served: For FY 17/18: 50 beds available.

Vicente Martinez High School - Martinez Unified School District

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

1. General Description of the Organization

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

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

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

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

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

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

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

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

ii. Goals: During the 17-18 School Year:

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

West County Adult Mental Health Clinic
(Contra Costa Behavioral Health)

https://cchealth.org/mentalhealth/#simpleContained4
Point of Contact: Robin O'Neill, Mental Health Program Manager
Contact Information: 2523 El Portal Drive, San Pablo, CA 94806
(510) 215-3700, Robin.ONeill@CCHealth.org

1. General Description of the Organization

The Behavioral Health Services Division of Contra Costa Health Services combines Mental Health, Alcohol & Other Drugs and Homeless Program into a single system of care. The East Adult Mental Health Clinic operates within Contra Costa Mental Health's Adult System of Care, and provides assessments, case management, psychiatric services, crisis intervention, housing services, and benefits assistance. Within the Adult Mental Health Clinic are the following MHSA funded programs and plan elements:

2. Plan Element: Adult Full Service Partnership Support - CSS

Contra Costa Mental Health has dedicated clinicians at each of the three adult mental health clinics to provide support, coordination and rapid access for full service partners to health and mental health clinic services as needed and appropriate. Rapid Access Clinicians offer drop-in screening and intake appointments to clients who have been discharged from the County Hospital or Psychiatric Emergency Services but who are not open to the county mental health system of care. Rapid Access Clinicians will then refer clients to appropriate services and, when possible, follow-up with clients to ensure a linkage to services was made. If a client meets eligibility criteria for Full Service Partnership services, the Rapid Access Clinician will seek approval to refer the client to Full Service Partnership services. Clinic management acts as the gatekeepers for the Full Service Partnership programs, authorizing referrals and discharges as well as providing clinical oversight to the regional Full Service Partnership programs. Full Service Partnership Liaisons provide support to the Full Service Partnership programs by assisting the programs with referrals and discharges, offering clinical expertise, and helping the programs to navigate the County systems of care.

3. Plan Element: Clinic Support - CSS

General Systems Development strategies are programs or strategies that improve the larger mental health system of care. These programs and strategies expand and enhance the existing service structure to 1) assist consumers in obtaining benefits they entitled to, educate consumers on how to maximize use of those benefits and manage resources, and 2) provide transportation support for consumers and families.

a. Clinic Target Population: Adults aged 18 years and older who live in West County, are diagnosed with a serious mental illness and are uninsured or receive Medi-Cal benefits.
b. Total Number served by clinic: For FY 17-18: Approximately 2,435 Individuals.

West County Children's Mental Health Clinic
(Contra Costa Behavioral Health)

https://cchealth.org/mentalhealth/#simpleContained4
Point of Contact: Chad Pierce, Mental Health Program Manager
Contact Information: 303 41st Street, Richmond, CA 94805
(510) 374-7208, Chad.Pierce@CCHealth.org

1. General Description of the Organization

The Behavioral Health Services Division of Contra Costa Health Services combines Mental Health, Alcohol & Other Drugs and Homeless Program into a single system of care. The West Children's Mental Health Clinic operates within Contra Costa Mental Health's Children's System of Care, and provides psychiatric and outpatient services, family partners, and wraparound services. Within the Children's Mental Health Clinic are the following MHSA funded plan elements:

2. Plan Element: Clinic Support - CSS

General Systems Development strategies are programs or strategies that improve the larger mental health system of care. These programs and strategies expand and enhance the existing service structure to assist consumers in the following areas:
Family Partners and Wraparound Facilitation. The family partners assist families with advocacy, transportation assistance, navigation of the service system, and offer support in the home, community, and county service sites. Family partners support families with children of all ages who are receiving services in the children. Family partners are located in each of the regional clinics for children and adult services, and often participate on wraparound teams following the evidence-based model.
A Clinical Specialist in each regional clinic who provides technical assistance and oversight of evidence-based practices in the clinic.
Support for full service partners.

a. Target Population: Children aged 17 years and younger, who live in West County, are diagnosed with a serious emotional disturbance or serious mental illness, and are uninsured or receive Medi-Cal benefits
b. Number served by clinic: For FY 1718: Approximately 473 Individuals.

Williams Board and Care

Point of Contact: Frederick Williams, Katrina Williams
Contact Information: 430 Fordham Drive, Vallejo CA
(707) 731-2326, Fred_Williams@b-f.com

1. General Description of the Organization

The County contracts with Williams Board and Care, a licensed board and care operator, to provide additional staff care to enable those with serious mental illness to avoid institutionalization and enable them to live in the community.

2. Program: Augmented Board and Care - Housing Services - CSS

a. Scope of Services: Augmented residential services, including but not limited to:

- Medication management
- Nutritional meal planning
- Assistance with laundry
- Transportation to psychiatric and medical appointments
- Improving socialization
- Assist with activities of daily living (i.e., grooming, hygiene, etc.)
- Encouraging meaningful activity
- Other services as needed for individual residents

b. Target Population: Adults aged 18 years to 59 years who live in Western, Central, and Eastern Contra Costa County, are diagnosed with a serious mental illness and are uninsured or receive Medi-Cal benefits.

c. Annual MHSA Payment Limit: $32,846

d. Number served: For FY 17/18: 6 beds available.

Woodhaven

Point of Contact: Milagros Quezon
Contact Information: 3319 Woodhaven Lane, Concord, CA 94519
(925) 349-4225, Rcasuperprint635@comcast.net

1. General Description of the Organization

The County contracts with Woodhaven, a licensed board and care operator, to provide additional staff care to enable those with serious mental illness to avoid institutionalization and enable them to live in the community.

2. Program: Augmented Board and Care - Housing Services - CSS

a. Scope of Services: Augmented residential services, including but not limited to:

- Medication management
- Nutritional meal planning
- Assistance with laundry
- Transportation to psychiatric and medical appointments
- Improving socialization
- Assist with activities of daily living (i.e., grooming, hygiene, etc.)
- Encouraging meaningful activity
- Other services as needed for individual residents

b. Target Population: Adults aged 18 years to 59 years who live in Western, Central, and Eastern Contra Costa County, are diagnosed with a serious mental illness and are uninsured or receive Medi-Cal benefits.

c. Annual MHSA Payment Limit: $ 12,731

d. Number served: For FY 17/18: 4 beds available.

Youth Homes, Inc.

https://www.youthhomes.org/
Point of Contact: Candy Espino, Chief Executive Officer or
Kim Chilvers, Chief Program Officer
Contact Information: 3480 Buskirk Ave #210, Pleasant Hill, CA 94523
(925) 933–2627, Candye@youthhomes.org: Kimc@youthhomes.org

1. General Description of the Organization

Youth Homes, Inc. is committed to serving the needs of abused and neglected children and adolescents in California's San Francisco Bay Area. Youth Homes provides intensive residential treatment programs and community-based counseling services that promote the healing process for seriously emotionally abused and traumatized children and adolescents.

2. Program: Transition Age Youth Full Service Partnership - CSS

Youth Homes implements a full service partnership program using a combination of aspects of the Integrated Treatment for Co-Occurring Disorders model (also known as Integrated Dual Disorders Treatment – IDDT) and aspects of the Assertive Community Treatment model. These models are recognized evidence based practice in which the Substance Abuse and Mental Health Services Administration (SAMHSA) has created a tool kit to support implementation. Integrated Treatment for Co-Occurring Disorders is an evidence-based practice for treating clients diagnosed with both mental health and a substance abuse disorders. Through Integrated Treatment for Co-Occurring Disorders, consumers receive mental health and substance abuse treatment from a single "integrated treatment specialist" so consumers do not get lost in the health care system, excluded from treatment, or confused by going back and forth between separate mental health and substance abuse programs. It is not expected that all full service partners will be experiencing a substance use issue; however, for those who have co-occurring issues, both disorders can be addressed by one single provider.

a. Scope of Services:

- Outreach and engagement
- Case management
- Outpatient Mental Health Services, including services for individuals with co-occurring mental health & alcohol and other drug problems
- Crisis Intervention
- Collateral
- Medication support (may be provided by County Physician)
- Housing support
- Flexible funds
- Money Management
- Vocational Services
- Contractor must be available to consumer on 24/7 basis

b. Target Population: Young adults ages 16 to 25 years with serious emotional disturbance/serious mental illness, and who are likely to exhibit co-occurring disorders with severe life stressors and are from an underserved population. Services are based in East Contra Costa County as well as Central Contra Costa County.

c. Annual MHSA Payment Limit: $ 705,499

d. Number served: For FY 17/18: 39 individuals

e. Outcomes: For FY 17/18:

- Reduction in incidence of psychiatric crisis
- Reduction of the incidence of restriction

Table 1. Pre- and post-enrollment utilization rates for 40 Youth Homes FSP Participants enrolled in the FSP program during FY 17-18

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	137	95	0.388	0.252	-35.0%
Inpatient episodes	56	17	0.171	0.045	-73.6%
Inpatient days	437	252	1.402	0.606	-56.8%

** Data on service utilization were collected from the county's internal billing system, PSP. To assess the effect of FSP enrollment on PES presentations and inpatient episodes, this methodology compares clients' monthly rates of service utilization pre-enrollment to clients' post-enrollment service utilization rates. Using PES usage as an example, the calculations used to assess pre- and post-enrollment utilization rates can be expressed as:*

- *(No. of PES episodes during pre- enrollment period)/ (No. of months in pre-enrollment period) =Pre-enrollment monthly PES utilization rate*
- *(No. of PES episodes during post-enrollment period)/ (No. of months in post-enrollment period) =Post-enrollment monthly PES utilization rate.*

Contact Information for Child/Adolescent Contract Providers

Program Name	Program Address	CEO/Executive Director	Phone #	E-mail	Age range	Program Service Type
A Better Way	3001 International Blvd, Oakland, CA 94603	David Channer, LCSW	510-207-8825	dchanner@abetterwayinc.net	0-21st birthday	Outpatient, Crisis Intervention
Alternative Family Services	401 Roland Way, Suite 100 Oakland, CA 94621	Jay Berlin	707-576-7700	jberlin@afs4kids.org	0-21st birthday	Outpatient, Crisis Intervention, Multidimensional Treatment Foster Care (MTFC), Intensive Care Coordination (ICC), Intensive Home based Services (IHBS)
Amador Institute, Inc	3701 Lone Tree Way, Suite 7 & 4A Antioch, Ca 94509	Dr. Patsy Phillips	925-778-3800	drphillips@amadorinstitute.com amadorinstitute@cs.com	6-21st birthday	Outpatient/TAY
Aspiranet	420 E. Canal Drive Turlock, Ca 95380	Mike De Rose	209-668-6121	Mderose@aspiranet.org	up to 21st birthday	TBS
Bay Area Community Resources (BACR)	11175 San Pablo Avenue El Cerrito, CA 94530	Marty Weinstein	415-444-5580	mweinstein@bacr.org	0-18	School-Based services, outpatient, crisis intervention
Berkeley Youth Alternatives	1255 Allston Way Berkeley, Ca 94702	Niculia Williams	510-845-9010	nwilliams@byaonline.org	5-18	Outpatient
Catholic Charities/ St. Vincent's Home for Boys	1 St. Vincent Drive San Rafael, Ca 94903	Jilma Menese	415-972-1200	Jilma@catholiccharitiessf.org JMenesesCEO@catholiccharitiessf.org	7-18	Residential /TBS/Outpatient/Crisis
Center For Psychotherapy	509 W. 10th St Antioch, Ca 94509	Wesley Robinson, PhD	925-777-9540	cfp@centerforpsych.org	7-21st birthday	Outpatient
Chamberlain's Children Center	1850 San Benito Street Holister, CA 95023	Patrick Ellis	813- 636-2121	pellis@chamberlainsyouth.org	school-age	Residential
Child Therapy Institute	Various sites	Brian Lukas, PhD	510-508-8039	Dr4psyche@aol.com childtherapyinstitute@gmail.com	school-age	Outpatient
Community Health for Asian Americans- CHAA	Various sites	John Jiwon Chung	510-835-2777	chaa.board@chaaweb.org john.chung@chaaweb.org	5-21st birthday	Outpatient, Wrap around services
Community Options for Families & Youth, Inc.	3478 Buskirk Ave Suite#260 Pleasant Hill, Ca 94523	Gabriel Eriksson	925-943-1794	g.eriksson@cofy.org	school-age	Outpatient/TBS
CCARC/Lynn Center/Vistability	300 East Leland Rd #100 Pittsburg, Ca 94565	John Bolle	925-370-1818	jbolle@vistability.org	0-21st birthday	Outpatient, ICC, IHBS, Crisis
Early Childhood Mental Health	200 24th St Richmond, Ca 94804	Jeff Sloan	510 412-9204	jsloan@ecmhp.org	0-6	Outpatient, Wrap
Familias Unidas	205 39th St Richmond, Ca 94805	Lorena Huerta	510-412-5930	lhuerta@familias-unidas.org	school-age	Outpatient
Fred Finch Youth Center	Various Sites	Tom Alexander	510-485-5214	tomalexander@fredfinch.org	school-age to 21+	Residential, outpatient, school-based, TBS, TAY
Hope Solutions, fka Contra Costa Interfaith	2387 Lisa Lane Pleasant Hill, Ca 94523	Deanne Pearn	925-278-1788	dpearn@hopesolutions.org	school-age and families	Home/shelter/mental health services
La Cheim School, Inc.	4892 San Pablo Dam Rd El Sobrante, Ca 94519	Dr. Amila Chapman	510-243-2360	ceo@lacheim.org carizma@lacheim.org	school-age	outpatient, school-based, TBS, residential
La Clinica Oakley	2005 C Main St Oakley, Ca 94561	Jane Garcia, CEO	510-535-4000	Jgarcia@laclinica.org	school-age	outpatient
Lincoln	Various Sites	Allison Becwar, CEO	510-273-4700	allisonbecwar@lincolnfamilies.org	school-age	school-based mental health servcies, outpatient
Mountain Valley Child and Family Services	various locations	Daniel Petrie, CEO	530-292-3450	dan@mv.email	school-age	Residential/Outpatient/TBS
MDUSD	1936 Carlotta Way, Concord, CA 94519	Dr. Wendi Aghily, Director of Special Ed.	925-682-8000	aghilyw@mdusd.org	school-age	School-based mental health servcies

Contact Information for Child/Adolescent Contract Providers

Program Name	Program Address	CEO/Executive Director	Phone #	E-mail	Age range	Program Service Type
Rainbow Counseling Services	2118 Willow Pass Rd Suite 500 Concord, Ca 94520	Kiku Johnson	925-692-2056	kikujohnson@rainbowcc.org	all ages	outpatient, LGBTQ, TAY
Seneca Family of Agencies	3200 Clayton Road Concord, Ca 94520	Ken Berrick	510-654-4004	ken@senecacenter.org	6-21st birthday	Outpatient, School-based, TBS, Wraparound, START, Mobile Response Team/MRT, Therapeutic Foster Care/TFC
We Care Services for Children	2191 Kirker Pass Road, Concord, CA 94521	Pete Caldwell, Executive Director	925-671-0777	pcaldwell@wecarechildren.org	0-10	Outpatient, Wrap, ICC, IHBS, Katie-A
West Contra Costa Unified School District	2465 Dolan Way San Pablo, CA 94806	Dr. Jodi Couick, Director of Special Ed.	510-307-4639	jcouick@wccusd.net	school-age	School-based
West Contra Costa Youth Service Bureau	186 Broadway, Richmond, CA 94804	Kim Catanzano, LCSW	510-215-4670	Kcatanzano@wccysb.org	school-age	Outpatient, WRAP
Youth Homes	3480 Buskirk Ave, Suite #210 Pleasant Hill, CA 94523	Cameron Safarloo	925-286-5684	camerons@youthhomes.org	6-21+	Residential, outpatient, TBS, ICC, Katie-A, TAY
YWCA of Contra Costa County & Sacramento	Various sites	Nancy Atkinson	925-323-5106	njabirds@aol.com	0-21st birthday	Outpatient

Site Visit Report Instructions and Template

I. Instructions

The Site Visit report is the culmination of the site visit. It's a summary of the most important insights that the site review team has to share. Ultimately it will provide input into how the county mental health system of care can improve.

Suggestion:

- Write the report as soon as you can so that the information is fresh in your mind.
- Assign report writing tasks between Commissioners.

a. Organize and transcribe notes (Commissioners, Executive Assistant or volunteer Commissioner if help is needed)

For each interview, organize and type notes into a Word questionnaire template document (see Program Director, Staff, Consumer, Youth, Child, Family/Care-giver Interview questionnaires). They are now legible and accessible to everyone. Email copies to the Executive Assistant. In the case of Zoom interviews, if necessary, make use of the Zoom recording / audio recording to fill in gaps. Note that the recordings should be viewed by the interviewers and scribes only???

b. Draft report narrative (Commissioners, Executive Assistant if help needed)

- Choose one person to write the report or assign different sections to different Commissioners
- Draft a narrative report using the Site Visit Report Template document to help stay organized and address the main points
- Keep the narrative report brief – readable in under five minutes??? and presentable in a meeting in under five minutes???. If the reader wants more detail they can refer to the interview notes
- If assistance is needed, contact the Executive Assistant for help – he or she may help or may connect you with a site visit volunteer Commissioner

c. Review and edit (Commissioners, Executive Assistant, Chair)

- Review and edit the report with the Executive Assistant and a site visit volunteer Commissioner who is available to assist
- Provide the MHC Chair with a review copy and update the report with any clarifications
- Sign off on the final draft

II. Template

(Note: This is a first pass brain dump. We have to look back at the surveys to map questions back to report template.)

Report date
Site name
Site visit date

1. Summary of Consumer Questionnaire Findings

Number and type of interviewees
__ Adults
__ Youths
__ Children
__ Family Members

General observations??? (This is typically the hardest thing for people to write. We could give examples of things to comment on. Or skip this and have "Other observations" and perhaps "Miscellaneous" at the bottom.) For example…

Strengths:
For example:

1. Description and example
2. Description and example
3. Description and example

Challenge areas:
For example

1. Description and example and suggestions by interviewee
2. Description and example and suggestions by interviewee
3. Description and example and suggestions by interviewee

Consumer magic wishes (big desires)???

Other observations (if no "General Observations")

Miscellaneous comments (is this necessary???)

2. Summary of Staff Survey Findings

Number and type of interviewees
__ Program Director

__ Clinical Director
__ Clinical staff and roles
__ Other staff and roles
__ Peers???

Strengths:

1. Description and example
2. Description and example
3. Description and example

Challenge areas

1. Description and example and suggestions by interviewee
2. Description and example and suggestions by interviewee
3. Description and example and suggestions by interviewee

Magic wishes???

3. Physical Site

Brief description:
Cleanliness
Comfort
Functional
Everything needed there e.g. furnishings, supplies
Well maintained
Food (if comments by consumers positive or negative)
Other: Calm, quiet, upbeat

4. Miscellaneous Issues???

General health of the organization???
Suggestions

5. Recommended areas for action plans
    1. Problem to solve: Description
    2. Problem to solve: Description
    3. Problem to solve: Description

Any situation requiring immediate attention by Program Director or CCBHS/CBO/CCRMC staff

HUME Test Site Visit

1. SCHEDULE SITE VISIT (Executive Assistant)

- Scheduling in progress.
- Send "Program Director Letter" right away (Chris can review it.)

2. PREPARE FOR SITE VISIT

a. Arrange training for Commissioners (Executive Assistant and experienced Commissioners)
n/a – Barbara and Laura will do the interviewing

b. Notify MHC and Administration leadership of site visit and request current contract (Executive Assistant)
Currently scheduling.

- When we have the final date, copy CCBHS administration (Chief of Adult Division, Jan Cobaleda-Kegler, and Director of BHS, Suzanne Tavano) to apprise them of the test site visit.
- Request contract for the site.

c. Secure site visit interviews with the Program Director (Executive Assistant)
Immediately:

- Decide how many consumer interviews to target based on size of program
- Send Consumer Notice of site visit interview opportunity (see "Consumer Notice Letter") to be posted by the Program Director at the site
- Send invitation to consumers to interview (see "Letter to Consumer") to Program Director to send to all consumers
- Ask Program Director to contact likely interview candidates
- Let Program Director know how many consumer interviews we are targeting

One week before the visit:

- Obtain the names of consumers to interview
- Obtain the names of staff to interview (target Program Director and 2 staff)
- Confirm TWO private, quiet spaces for conducting interviews, one for each interviewer; use two Zoom accounts for hosting interviews.
- Coordinate final schedule of interviews: Name of consumers and staff (including Program Director), interview times and who will interview and scribe, if scribe is available.

d. Prepare and send site visit packets (Executive Assistant)
Put together and email packets for the Commissioners containing:

- Schedule--List of consumers, Program Director and staff to interview; the time of the interview; which Commissioner (and possibly Scribe) is conducting the interview.
- Background information on the Program e.g., brochure, link to web-site, MHSA report, if available, (eliminate and, if possible, known strengths, challenges, any outstanding issues)

- Copy of Consumer, Staff and Program Director Interview forms.
- Instructions/script for during interviews
- Report template and instructions

e. Make final confirmations (Executive Assistant and Program Director)

A week before the visit:

- Confirm with Program Director and Commissioners.
- Ask Program Director to confirm with interviewees.

f. Prepare for site visit (Executive Assistant and Commissioners)

A week before the visit:

- Hold MHC site visit team meeting to confirm details and answer questions.
- Commissioners should review their packets and research the site more if necessary.

3. CONDUCT SITE VISIT

- There will be no physical site visit – just Zoom meetings with Program Director and interviews.
- Begin Zoom site visit with a brief meeting with all Commissioners on the site visit and the Program Director (and anyone else he/she wants to include)
  - Thank Program Director for the site visit
  - Double-check which consumers are actually present and adjust who is interviewing who, if not all scheduled interviewees are available
  - Go over any other last-minute details/changes
- Conduct interviews
  - Interviews should begin with a warm greeting, explanation of the Mental Health Commission, explanation of the purpose of the site visit and interview, and an assurance of privacy (Instructions and Script document)
  - One Commissioner interview the Program Director for background information
  - One Commissioner interview one to two staff members
  - Interview consumers
  - Take legible notes as they need to be readable by other people: One interviewer will have Executive Assistant/scribe for note-taking; the second will take her own notes
  - Record Zoom session: first get permission from interviewee to be recorded
- De-brief with partner Commissioner
  - Share and jot down big picture take-aways, unexpected findings, lasting impressions – anything that will help make writing a report easier and more insightful
  - Share any issues that require an action plan
- Email a thank you, a brief summary of how things went (not summary of interview content), and any issues that the Program Director should be aware of from the interviews if any.

4. PREPARE REPORTS

Using the "Report Instructions and Template" document, write report and have it reviewed by the Executive Assistant; Program Director of site, MHC Chair and Committee Chair and Jan Cobaleda-Kegler, and/or Suzanne Tavano. (If MHSA site, include Jennifer Bruggeman.) Answer any questions and make revisions. Final copy signed off on by interviewers/report authors.

5. DETERMINE ACTION PLAN IF NECESSARY

If an action plan is felt to be necessary, there will be a transparent and cooperative process of creating a plan, getting agreement, executing and validating the plan. The action plan will be a key component of the report.

The relevant MHC Committee Chair will contact the site Program Director and CCBHS, MHSA or CCRMC site liaison to share the issue and request their assistance in creating an action plan. The Program Director, ideally, should lead the problem-solving. The action plan should be approved by the relevant standing committee, the Program Director, and the CCBHS, MHSA or CCRMC administration; successful completion of the plan must likewise be signed off on by the above group.

The action plan should include:

- Description of problem
- Recommended change(s)
- Steps for implementing the change
- A measurement(s) for determining the outcome of the change
- Method for validating successful change
- Time-frame
- Responsible parties

The action plan will be included in the Report.

6. PREPARE SITE VISIT REPORT PACKAGE

a. Prepare the report package (Executive Assistant).

The report package should include:

- The narrative report
- Action plan(s) if any as appendix
- The electronic version of the interview written responses as an appendix (scanned if not typed up)

7. DISSEMINATE REPORT

The final report needs to be promptly distributed electronically (Executive Assistant)

- All Commissioners
- The site Program Director
- CCBHS, MHSA and/or CCRMC administration
- The Public

There are different venues for distribution:

- A report should be presented at a full Commission meeting
- All reports with an action plan(s) should be presented at the relevant standing Committee meeting, typically Quality of Care but sometimes Finance-MHSA or Justice Systems Committees
- All reports should be posted on the MHC website
- A few key reports may be included in the Annual Report to the Board of Supervisors

8. TRACK ON ACTION PLAN(S)

The work defined by an action plan rests in the hands of the Program Director and CCBHS, MHSA and/or CCRMC administration. They should drive the process and keep the MHC apprised of progress on a regular basis.

a. Assign action plan to a Committee (MHC Chair)

Action plans will be assigned to and tracked at the Committee level. For example, site Program Directors may be invited to a Quality-of-Care meeting to discuss their site action plan.

b. Communicate successful completion of action plan (Executive Assistant)

When an Action Plan comes to a close it should be noted as an addendum to the site visit report. An email should be sent to the MHC Chair and the Chair of the relevant committee. The topic can be agendized at an upcoming full Commission or Committee meeting.

c. Follow up in case an action plan doesn't resolve according to the plan time-table (MHC Chair or Committee Chair)

If an action plan doesn't resolve in a timely manner, the MHC Chair or the responsible Committee Chair should follow up with the CCBHS, MHSA and/or CCRMC administrator responsible for the action plan. Agendize the action plan at a Committee meeting if necessary, to learn about challenges and promote successful problem-solving.

9. ARCHIVE FINAL REPORT (Executive Assistant)

Archive a copy of the file in MHC electronic records