CONTRA COSTA
MENTAL HEALTH COMMISSION

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MENTAL HEALTH
COMMISSION
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Mental Health Commission
Quality of Care Committee Meeting
Thursday, July 15, 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 June 17, 2021 Quality of Care meeting.**

VI. **DISCUSS Site Visit Program updates and upcoming steps**
- **BHS Board and Care site list file updated with contract amount and review dates**
- **Recommended sites to visit through end of 2021**
- **Process for Commissioners to sign up for site visits**
- **Commissioner site visit training content and delivery**
- **What needs to be in place and/or updated administratively for these initial site visits**
- **Prioritization of suggested site visit elements, including site visit program objectives, evaluation of grievances, evaluation of contracted objectives and targets, scope to include non-licensed board and cares**

VII. **REVIEW Executive Summary of "Housing That Heals" document authored by prior Commissioners Teresa Pasquini and Lauren Rettagliata**

VIII. **DISCUSS objectives and strategy for advancing the "Housing that Heals" agenda.**

IX. **Adjourn**

Housing That Heals:
Finding a Place Like Home for Families Like Ours

Housing That Heals Summary

For decades, thousands of families have been trying to build housing that will save our loved ones from living on the streets, jails, and grim care homes with untrained staff. The status quo forces clients, families, providers and communities to suffer needlessly.

The purpose of the Housing That Heals mission is to change the narrative and shatter the status quo by: 1. Defining the problem and forgotten population, 2. Sharing solutions and strategies to reform systems, 3. Educating and advocating for a shared action plan that will start building more housing that heals in order to stop the suffering.

A full continuum of psychiatric care includes all levels of Housing That Heals. That continuum must include Institutions for Mental Diseases (IMDs) and Adult Residential Facilities (ARFs) and congregate communities of tiered care that provide clinical and social supports on-site for those who cannot survive in supported independent living and do not deserve to be housed in a jail pod or a cardboard tent. In order to have a full continuum of the right care, at the right time and in the right place, housing and facilities for those with serious brain disorders and mental illness must be created to provide health, safety, and dignity.

A health care system that includes a tiered array of Housing That Heals as part of a full continuum of psychiatric care will help save lives, improve communities, and save money. Authentic partnerships must be encouraged to design systems that include a continuum of psychiatric care from crisis, acute, subacute, and an array of supported housing that allows everyone to live and die with dignity - Housing That Heals.

The problems of California's system for the seriously mental ill have resulted in the tragedy of untreated seriously mentally ill individuals on the streets and in jails. The lack of appropriate housing and treatment facilities denies the right to treatment before tragedy, incarceration, institutionalization, or homelessness - a reality that has occurred over and over again since California's deinstitutionalization wave. The State must move beyond the current fail-first / housing-first mentality.

- California must de-silo funding and delivery systems to provide true community integration for both SMI and SUD populations.
- California must ensure that any new waivers, policies, or legislation will not incentivize a Homeless Continuum of Care or the Drug Medi-Cal Organized Delivery System to displace vulnerable SMI residents who are currently living in ARFs or Board and Cares.
- California must stabilize the current supply of community-based beds.
- California must allow resources and funding to follow the patient. California must hospitalize those who need it and create community pathways to support assisted outpatient treatment for people who do not need hospital-based care.

- California must focus on getting FSPs, AOT clients, and those on LPS Conservatorship access to appropriate levels of housing and supports to intervene and prevent ongoing crises. Keep the promise of "whatever it takes."

Defining the Problem:

The key drivers of despair and disparity in California care and treatment for the SMI population are:

- **No shared definition of SMI in the medical, social justice, courts, detention, and community health delivery systems.**
  - **The lack of a common definition complicates analyzing and reporting the role and impact of SMI on the quality and need for care and treatment.**
  - **The multiplicity of definitions contributes to confusion among service providers and government programs of who will receive treatment and what that treatment will be.**
- **Fiscal discrimination codified in the California Welfare and Institution Code and Federal Medicaid Rules.**
- **Unlike any other illness, California manages care of SMI populations "only to the extent resources are available."**
  - **SMI and SUD populations are managed in two separate delivery systems with separate waivers and funding streams.**
  - **The California behavioral health system provides separate and unequal access to medically necessary care and appropriate housing for the SMI and SUD populations.**
  - **Diverting dedicated funding to other social entitlement programs prevents counties from providing adequate and medically necessary treatment in a Mental Health Rehabilitation Center (MHRC) or IMD for people living with SMI.**
  - **California law provides a right to shelter, a right to treatment, and a right to in-home supportive services to those with developmental disabilities. No equal entitlement exists for the SMI population.**
- **Bias towards the Recovery model vs the Medical model – prevents true system transformation for the SMI population. Marry the two models. Both/And, not Either/or:**
  - **Many in the SMI population are so ill that they do not respond to treatment in a voluntary community setting.**
  - **Due to the severity of one's mental illness, some will experience acute episodes that require inpatient treatment.**
  - **Not all with SMI can achieve recovery to the point where they can live on their own without an intensive support system.**
  - **One size fits all fails many. Therefore, state programs and funds should support both the recovery and medical models of treating those with SMI.**
- **Lack of a tiered levels of care.**
  - **County jails are the largest providers of mental health services.**
  - **Gaps in access to housing options for individuals living with SMI have made that population most at risk of experiencing homelessness.**
  - **A lack of understanding and transparency exists about how housing placement decisions are made and prioritized for the SMI population.**
  - **The lack of a housing continuum of care for the most seriously mentally ill population has resulted in a humanitarian crisis of people with SMI flooding medical emergency rooms, psychiatric emergency rooms, psychiatric inpatient units, homeless shelters, IMDs, county jails, and courtrooms.**

The longstanding dearth of therapeutic care facilities and affordable permanent supportive homes in our communities for the thousands of California adults living with the effects of serious mental illnesses and substance use disorders. Their needs are not addressed by current policies and homelessness initiatives. This glaring gap in our system of care is increasing homelessness, exhausting family and public resources, and worse, it is perpetuating untold human suffering.

We ask that sufficient funding be devoted to fixing this gap now by investing in more therapeutic care facilities and affordable permanent supportive homes in our communities.

Many vulnerable individuals are ignored and unserved in current legislation and policies meant to solve homelessness.

- **A growing population of mentally ill adults at risk of homelessness is not being counted in any Point in Time Count, and will not meet the "coordinated entry" guidelines.**
- **People in this population don't qualify for Project Roomkey or Project Homekey because they don't meet Continuum of Care Criteria.**
- **Project Roomkey helped Covid-vulnerable street people during the pandemic, but our loved ones were forced to stay in Covid-risky congregate settings.**
- **Housing First policies fail those at imminent risk of homelessness, and keep those ready for discharge stuck in restrictive and costly locked institutions.**

Who are these forgotten people, and what happens to them now?

- **No-fault chronic brain disorders like schizophrenia, schizoaffective and bipolar disorders typically strike in late adolescence or early adulthood, just when a person is set to launch a successful life, robbing him/her of the chance to establish a career, a home, and a network of friends.**
- **It can take years to find the right treatment, if it is available at all. Some turn to street drugs for relief.**
- **Though functional recovery can happen over time, this is impossible without a stable home and help, impossible with a monthly income less than $1000/month Social Security.**
- **Too many are unjustly sent away to locked institutions because there is no place for them in their home communities. Others end up on the street or incarcerated.**
- **Aging parents who've depleted their resources trying to help are asking themselves "where will my adult child live, and who will help him when I am gone?**

Comparative Needs and Cost Benefit Assessments:

Psychiatric respite centers like the one that opened recently in San Francisco will serve some people with mental illnesses and co-occurring substance use disorders. However, people living with chronic mental illnesses often require higher levels of medically necessary and clinically appropriate care. Homes for those living with a serious mental illness receive a maximum of $1,069 a month per person, without a patch. Homes for the IDD population receive a maximum of $9,515 a month per person. Board and Care operators have no incentive to serve those with a serious mental illness.

Additionally, recent investigative reports have suggested that the cost of Project Roomkey hotel rooms are not cost effective when compared with some of the Adult Residential Facilities (ARF) and Residential Care Facilities for the elderly (RCFE) that are discussed in the Housing That Heals paper.

For example, Psynergy, Inc. has created a cost comparison for their ARF/RCFE programs with other IMD/MHRCs across the state. However, you can not compare the quality of the therapeutic community services provided at Psynergy at approximately $160/day to those provided at a Roomkey Hotel. And, their MediCal Specialty Mental Health Clinic services adjacent to the residential facility allow a resident access to a psychiatrist and therapist as needed. Counties are able to recoup FFP for these billable services which adds to the cost benefit.

Fairness and Equity:

While the state rightfully focuses on racial and other health disparities, we must not forget the population that is living with the greatest health disparity. According to the National Council of Behavioral Health, "People with serious mental illness die an average of 15 to 30 years younger than those without. This difference represents the largest health disparity in the U.S.; larger than gender, racial or socioeconomic differences. And unlike some of the other gaps that are slowly closing it isn't shrinking."

Homes for the most seriously mentally ill people must be adequately funded at par with other vulnerable populations so that there will be no financial incentive to pick and choose who is helped first or who won't be helped at all.

There are solutions.

Successful models of Housing That Heals do exist, and can be replicated, with adequate funding. Below are examples from the Housing That Heals journey from the most restrictive to a least restrictive options:

- **California Psychiatric Transitions (CPT):** is a 98-bed fully licensed Mental Health Rehabilitation Center, the equivalent of an Institute of Mental Disease/ commonly referred to as an IMD. It is not a state or county facility; instead it is privately owned and contracts with many California counties who need a secured treatment and housing placement. The program is highly structured in a tiered level system and is a step down from hospitalization at a State hospital. Clients must attend groups based on treatment plan goals. The highest level of clinical and staffing support is provided. Offsite recreation and social activities are offered as appropriate. This is a treatment center that prepares people to enter an unsecured facility in a community setting. **There should be a CPT in every region of the state.**
- **Psynergy Programs are prime examples of subacute, unlocked, therapeutic care facilities that can accommodate up to 90 residents. This "modified therapeutic community" model successfully helps people who may have been institutionalized become ready for more independent living in the community. We call it Housing that Heals because it offers so many health-promoting elements: deeply nutritious food, lovely surroundings, caring staff and (all too rare in such places) talk therapy, even equine therapy, and ready access to psychiatric and counseling help. We've seen our loved ones get their lives back while at Psynergy, even return to college classes. 27 counties now have a contractual relationship with Psynergy. Amazingly, the base cost for Psynergy care is only $135/day (compared to $350 at other long term care facilities). We need a network of Psynergy Programs up and down the state. https://psynergy.org/**
- **John Henry Foundation is a permanent home where** residents find a home in a community that is not cut off from the larger community; yet, provides the support needed to participate fully in life. It is a private non-profit. The quality of life and the stability of those who chose John Henry was an understatement. In California. A Full Service Partnerships may lower the number of times an individual needs hospitalization, but what is the quality of life like for those who need to be surrounded by daily supportive services and people who they can easily interact with. Would it be possible to create programs like this in our public system? The yearly charge for someone to live here is $42,000 a year. In California, the cost to keep someone on the street is estimated at $41,000 a year, to keep someone incarcerated is about $81,000+ a year. Both the human benefits and cost effectiveness of this program demand a focused policy to support scaling up therapeutic, enclave communities like this across the state. **https://www.johnhenry.org/**
- **Garden Park Apartments, whose provider is the nonprofit organization, Hope Solutions, has developed a model of converting a rundown apartment complex into an oasis for families. Hope Solutions has used MHSA funds to build a Community Center that anchors the complex where all of the clinical services needed to support the residents are located. This model is safe with locked gates. The Community Center on-site allows both mothers and children efficient and effective access to licensed mental health providers in a timely manner. There are educational programs that support family life and enrich the future of both the children and mothers who live there. This residential program gets a gold star when it comes to being person and family-centered. The only problem is that so many more programs and residential opportunities like this are needed.This model needs to be duplicated for SMI 5600.3(b) adults between the ages of 25-65. Using available MHSA funds to build a Community Center provides access to effective, person and family-centered care that is efficient. The Psynergy Program, described earlier in this document, is an excellent comparable model.**

- **Kirker Court is a safe apartment community with pristine grounds. It is a person and family-centered facility located next to the faith community who donated the land upon which the community sits. For residents who are able to live here in total independence, these residences are efficient, conveniently located in an area where daily life needs are within walking distance. Kirker Court also has a ten-year wait list; this points to stability that is provided to the residents. The resident we spoke to wanted to re-establish a relationship with his case manager. Case managers can help provide**

necessary supportive services for many who live with a serious mental illness, so the effectiveness of housing for the SMI population at Kirker Court depends on whether they are connected with the supportive services they need. Kirker Court has an oasis-like feeling similar to the John Henry Foundation. However, it serves a different population and does not include the same clinical supports as JHF. Kirker Court is more of an independent living environment for people with any disability that falls along the moderate spectrum.

The California Behavioral Health Continuum of Care must include a range of person-centered solutions that include the needs of the "forgotten population." A complete and effective care continuum would enable people living with special mental health and medical needs to live and die with dignity. It must include a variety of quality acute community hospitals, sub-acute secured residential treatment facilities, and permanent supported homes with all the necessary medical, clinical, rehabilitative, and social supports over the lifespan. Please see Housing That Heals report for additional example, https://namica.org/community-voices/team-nami-spotlight-housing-that-heals-project-report/.
California must move from "scarcity to abundance" to shatter the status quo. And, quantity must be balanced with quality standards to achieve the Housing That Heals vision.

Appendix: A Spotlight on Contra Costa County Contra Costa

Families have been on a long mission to build a continuum of care that includes Housing That Heals for our seriously mentally ill loved ones. We have successfully built strong partnerships with our public health and safety systems, community partners, the faith-based community, and policy and decision-makers. Together we have created a vision of hope for optimal health for all. However, in spite of the best intentions and tireless efforts, we have a small, vulnerable population that needs more focus and a new way to live at home in Contra Costa County.

We are encouraged by recent efforts of our County Behavioral Health leadership to join us on two site visits and consider housing and program options such as Psynergy and Ever Well. We are hopeful that we will see a tightly-scoped formal analysis in the coming months that addresses the housing gaps for the adult SMI specialty mental health population of Contra Costa. We are grateful that the Contra Costa Mental Health Commission adopted our recommendation in concept.

Recommendations to Contra Costa Health Services, Contra Costa Mental Health Commission, and All Community Stakeholders:

We ask that the following recommendations be considered as our community continues to work towards solutions for Housing That Heals:

1. Convene a Value Stream Mapping Event to co-create a community Action Plan that will focus on building increased access to a full continuum of care with all levels of Housing That Heals for the 5600.3(b) adult SMI population.

• Review recommendations from previous Contra Costa County Housing Reports (1994 & 2013) cited in this paper along with recent reporting, housing needs assessments, and housing goals developed by California Mental Health Boards and Commissions and the California Mental Health Planning Council.

• Perform a cost benefit case study analysis for high cost users of Specialty Mental Health Services. Focus on access to clinically appropriate level of care, not the least expensive or least restrictive. Allow a person the ability to move within the continuum of care and seamlessly access more intense levels of support, treatment when needed, and a less restrictive care environment when ready.

• Consider the need for an in-county IMD/MHRC/PHF facility. Consider the cost to clients, families, conservators, and case managers who travel to out-of-county placements.

• Assure equity of access to addiction treatment and primary care for all those who meet the 5600.3(b) definition.

• Establish quality assurance standards on all 5600.3(b) housing programs. Improve care coordination and transitions to community-based care and include community oversight, accountability, and transparency.

2. Appoint a Contra Costa Behavioral Health Housing Czar/Chief who has in-depth experience with housing development, proposal and grant writing, and knowledge of the 5600.3(b) Specialty Mental Health system of care.

• Serve as a liaison to all county departments, divisions, and community-based organizations.

• Develop contractual relationships with multiple providers to develop a system of abundance, quality, safety, stability, and choice across the lifespan of a person.

• Oversee quality assurance standards. Ensure that every member of a "care team" receives the training and education required to ensure high quality treatment and that all Department of Labor regulations are being met.

• Track the progress of the Action Plan with public monthly updates to community partners.

• Support and advocate for legislation that will increase funding to build Housing That Heals for those living heroically with a serious mental illness.

The intention of this spotlight on Contra Costa is to provide an overview of our community's Specialty Mental Health system of care with a focus on quality housing access. We have great pride in the public health system of Contra Costa and in no way want to diminish the hard work of our community stakeholders and county partners. We believe that we have one of the best public safety net systems in the state and nation. However, like all other counties, we have failed to bend the harm curve and provide adequate housing solutions for this most vulnerable SMI specialty mental health population. And, there is still no agreement on who the most vulnerable population is or the public data to identify it.

The mission of Contra Costa Health Services is "to care for and improve the health of all people in Contra Costa County with special attention to those who are the most vulnerable to health problems." As two moms who have worked with pride and purpose to support this mission, we urge all community partners to spotlight the specialty mental health population of Contra Costa and include the WIC 5600.3(b) population among the most vulnerable to health problems.

Together, let us build a system of care that includes Housing That Heals in Contra Costa County.

Housing That Heals:
Finding a Place Like Home for Families Like Ours

April, 29, 2021

Department of Health Care Services
Director's Office
Attn: Angeli Lee and Amanda Font
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

RE: CalAIM Section 1115 & 1915(b) Waivers

Dear Ms. Lee and Ms. Font:

As the co-authors of the Housing That Heals white paper issued in May, 2020, we write to share our support for the overall CalAIM concept. We recognize the intent to build off the success of the previous 1115 and 1915 b Waivers and understand the benefits to many county health systems, including our own of Contra Costa. However, we strongly disagree with the decision to postpone the inclusion of the SMI/SED IMD Exclusion Waiver until July 2022. A place holder without promise is unacceptable.

At a time when equity and anti-discrimination are a local, state and national priority, California must move to implement the demonstration waiver that will help to reduce the discrimination and suffering caused by the lack of appropriate treatment beds at all levels of care for our loved ones living with SMI and SED. Our Housing That Heals paper defined the drivers of despair and disparity with both system data and what we call "data of the soul," which is our lived experience in trying to save our sons and families from falling off every carved out cliff in California's continuum of care. We also defined a system of solutions. Our focus was not only on our families, but on all California communities that have human beings waiting for access to a bed instead of a tent, trauma, torture and tragedy. Our families and communities simply cannot continue to wait for the state to fix every social, economic, and bureaucratic barrier to care.

The state has had years to innovate, integrate and investigate the finance and delivery arms of the behavioral health systems. We see the good intentions of this effort. As former Mental Health Commissioners, MHSA Stakeholders, state and national activists, we have been part of that journey and have partnered with patience with anyone who will help families like ours. We intend to continue collaborative conversations with all local and state partners who have authentically welcomed us to their tables to consider shared agendas, visions and priorities. We were proud to co-sign the letter of support for the Governor's proposed $750 million infrastructure budget item that will signal our state's intent to build up our community based residential infrastructure. However, we don't see the IMD Waiver opportunity and the infrastructure investments as either/or decisions. We need a both/and approach to the current crisis of care in California.

Part of our Housing That Heals journey was about finding alternatives to IMDs and locked facilities. We wanted to shatter the myth that moms like us just want to lock up their seriously mentally ill adult children and throw away the key. We wanted to show that it is the system that is designed to lock them up either in solitary cells, IMDs, or in their untreated minds on skid rows. We wanted to find the key that would open doors to healing homes. But, many of those homes will not accept people who are too sick and not medically stabilized enough to live in the community.

As moms of sons who were diagnosed early, received access to multiple public and private services and were deemed disabled by the state and federal government's guidelines, we are concerned about CalAIM's lack of focus on the current SPMH adult population. We acknowledge the spectrum of solutions needed to end suffering in California for those heroically living along the continuum of behavioral health care. We do understand the need to align our Managed Care Plans and Mental Health Plans. However, we don't understand the need to wait any longer for focused attention on the population that has too often been forgotten and "underfunded from the start."

We are still being told that it is just too much of a "heavy lift" to include the SMI/SED IMD Waiver in the current proposal. We were told that in November 2018 when this waiver opportunity first became available. So, we waited. Then the pandemic hit our world and we saw very heavy lifting taking place to save lives. We saw freedoms withheld to protect the safety of our communities. We saw our loved ones rise to top of the most at risk populations to die from COVID. We saw our loved ones forgotten again in the equity discussions. We saw them left in solitary. We saw them locked in State Hospitals or IMDs longer than was medically necessary waiting for a step down bed. We saw them dumped from hospital beds and returned to inappropriate lower levels of care. We saw them suffering on the streets. Everyone sees them now. There is no place left to hide.

Our families know all about heavy lifts. We have been carrying and sharing the weight of the broken, bureaucratic barriers to a continuum of care along with our seriously mentally ill loved ones. We do not want "anyone, anywhere or anytime" to be denied access to the right door. But, without access to both medically necessary and recovery-based services, the human log jam will grow and our loved ones will continuously cycle through the wrong doors.

If we want a California for all, then all must mean all. If we want equity for all, then all must mean all. If we want parity for all, then California cannot wait to apply for the IMD Exclusion Waiver opportunity. If we want a right to shelter and treatment for all, then California must stop waiving the right care at the right time for the stage 4 adult specialty mental health population.

Families like ours and allies across the state strongly support application for the SMI/SED waiver now (see attached.)

Respectfully,

Teresa Pasquini and Lauren Retagliatta
Housing That Heals
https://hth.ttinet.com/Housing_That_Heals_2020.pdf

Moms on a Mission are back on the road together again after the COVID hiatus. On Monday, June 28, 2021, we drove into the beautiful Napa Valley together to attend an Open House for Gray Haven, a residential treatment facility for families like ours. As we traveled from Contra Costa County into Napa, we saw some stark reminders of why the Bay Area needs a system of Housing That Heals for families like ours.
We headed towards Napa County on Highway 29 and immediately noticed the tent city that had been built in the burrows of the freeway overpass. Scattered garbage heaps were evidence of scattered lives and the forgotten population, many of who would likely thrive in a place like Gray Haven.

We decided to detour past Napa State Hospital, the place where Teresa's Danny had been placed on a civil commitment before being criminalized there and arrested as a patient. That landed him in the Napa County jail where he was deemed Incompetent to Stand (IST). This would be the first time for Teresa to be back in Napa County since luck and heroics got Danny transferred to California Psychiatric Transitions, a Housing That Heals facility in Merced County. It was traumatic for Teresa to be back in a place that carried the memories of so much pain and lost time for her son.

We turned into the NSH grounds only to be stopped at a new gate with a guard telling us to turn around. We clicked a picture of one of the many bungalows that we believe are empty while people are living in cages or the corners of our communities. People have wondered why the state and counties don't partner to innovate and renovate the empty buildings located on these state hospital grounds to create capacity for an onsite continuum of care and ease the human log jam up and down our state. But, instead, we are remodeling jails all over the state while hospital beds and residential treatment beds sit empty.

Next, we headed to our destination. Since we were the first to arrive a little early, we lingered outside of the beautifully restored mansion taking in the grandeur of the grounds. We headed in to reunite with a friend and colleague, Roberta Chambers of the Indigo Project, https://www.indigoproject.net/about-us. Roberta has been an early champion of our Housing That Heal's mission and was the first person we trusted with our draft paper. She had been telling us about her work with Gray Haven for many months and was excited to show us the results. We were excited to see it too!

As you step up onto the porch and walk through the front doors, you know you are entering a special place. We were graciously welcomed and quickly introduced to all of the special people who were responsible for tucking healing and hospitality into every detail of every room and their health and wellness program. We met Dr. Patricia Gray, Luis, Miriam, Christy, and many other amazing staff. We immediately started sharing our stories with each other and learning about the Gray Haven vision while being served incredible hors d'oeuvres prepared onsite by the chefs.

Before touring the upper floors, a separate health and wellness clinic, apartments, pool, and game room, we were joined by Mary Francis Walsh, the Executive Director of NAMI

Sonoma County, and her husband. We are so grateful for all of the NAMI connections we have made during the Housing That Heals journey. We are all entwined by a synergistic passion to stop the suffering of so many. The tour bonded us all in the promise and purpose for housing vulnerable populations with dignity and providing a real chance for healing, health, and home.

The Gray Haven program has opened with 6 beds which is the maximum that can be housed without a use permit. But because of bureaucracy and barriers, those beds are now empty even though they are being offered PRO BONO. Lauren and I are determined to help remove those barriers and fill those beds. We are already making suggested referrals.

Before we left the open house, Teresa shared a story recently told by Dr. Ralph Aquila, the former Medical Director of Fountain House in NY. He had recently told a panel assembled by the Greenburger Center about the new clients who were coming to their program from Rikers Island. He said that the look on their faces when they entered Fountain House after being at Rikers was a look of awe at their new surroundings. Teresa shared that she knows that the same look of awe will be present when the residents walk through the front door and every other door on the Gray Haven property.

To say that we were impressed with Gray Haven is an understatement. But, while our hearts were filled with hope and joy after this tour, they were also broken because of the “Stop Gray Haven” signs that lined the neighborhood streets as we drove away. There are future plans for expansion that would add additional beds and programs to build a big campus of greatness for families like ours. We see a "Moms On a Mission" campaign to Save Gray Haven in our future.

It should not have to so hard to help desperate people who live heroically with no-fault brain illnesses. We must all continuously focus on educating our communities about how and why our loved ones are diverted to, not from, jails, street corners, and institutions because of systemic discrimination.

We can and must build an understanding of the dire need for safe, secure, dignified, therapeutic housing that heals. We have seen it happen. We know it is possible.

Housing That Heals = Gray Haven

Please see @ https://grayhavennapa.org/ for more information.

Families like ours and allies from over 20 counties across the state strongly support the application for the SMI/SED IMD Demonstration Waiver now:

Alameda County

Dianne Lam
Oakland, Ca.
Alameda County

Patricia Fontana
Family Advocate Alameda County
Voices of Mothers co,-founder
Families Advocating for the Seriously Mental Ill (FASMI)

Candy and Al De Witt
Alameda County

Alison Monroe
Alameda County, CA

Gloria Vasconcellos
Alameda County

Amador County

Samuel David Ferrise
Amador County

Contra Costa County

Kim Mai
contra costa county

Debbie Walsh
Contra Costa

Tamara Hunter
Contra Costa County

Rebekah Sparling Cooke
Danville, CA
Contra Costa County

Laura Fryer
Contra Costa County

Rick Fryer
Contra Costa county

Jack Fryer
Contra Costa County

Mike Cooke
Contra Costa County

Paula Bull
contra Costa county

Laurie Bothwell
Contra Costa county

Jacquie Kunsman
Contra Costa County

Lauren Downes
Contra Costa County

Daniel Wilson
Contra Costa County

El Dorado County

Diane Rabinowitz
El Dorado County

Kern County

Deborah Fabos
Kern County

Fawn Kennedy Dessy
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Jean Marie Harris
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Anna Penido
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Mark Gale
Los Angeles County

Barbara B Wilson LCSW EDPNA
Los Angeles County

Shelley Hoffman
Los Angeles County

Susan Levi
Los Angeles, CA

Gail Evanguelidi
TREATMENT PREVENTS STIGMA
LA County

Cheryl Perkins
Mother Advocates for the SMI,LAC
Los Angeles County

Marin County

Denise Spencer
Marin County

Nevada County

Tomi Riley
Nevada County

Orange County

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Plumas County

Denise Pyper
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Lynn Whitney
Carmichael, CA
Sacramento County

Mary Ann Bernard
Sacramento, CA

Nancy Brynelson
Sacramento County

Kelli Butler
Sacramento County

San Diego County

Linda L. Mimms, MA Public Policy
Schizophrenia & Psychosis Action Alliance
San Diego County

Dr. Larry T Mimms, CEO Procise Dx, Inc.
San Diego County

Mary Courtney-Sheldon
San Diego County

Katherine Smith-Brooks
San Diego County

San Francisco County

Sheila Ganz, family member
San Francisco

Virginia Lewis, LCSW
San Francisco. 94123,
California

Dale Milfay
San Francisco, CA

San Mateo County

Claire Harrison
San Mateo County

Santa Barbara County

Lynne Gibbs
Santa Barbara

Santa Clara County

Ed and Lisa Baumann
Santa Clara County

Alison Morantz
Santa Clara County

Santa Cruz County

Lynda Kaufmann
Santa Cruz County

Solano County

Susanne Geotz
Solano County CA

Sherrie Byrum Rasmussen
Solano County

Catherine J. Rippee-Hanson (**CJ Hanson**)
Solano County, California

Lynn Root
Solano County

Linda Rippee Privette
Solano County

Judith Baldwin
Solano County

Cathleen Forte
Solano County CA

Pamela Wilcoxson
Solano County CA

Karen Newton
Solano County

Sarah Privette
Solano County, CA

Sonoma County

Margaret Pasquini
Sonoma County

Stanislaus County

Linda Mayo
Stanislaus County
MHSA Stakeholder
California Advocates for SMI
Mother of twins with schizophrenia

Ventura County

Mary Haffner
Ventura

Jeffery Hayden PHD
Ventura County

Serving Multiple Counties

Psynergy Programs, Inc.

CCBH Contrated Licensed Facilities

Updated 5/19/2021

Home Name	Address	City	Total Beds	CCC Beds	Gender	License Type	Type	Contract #	Contract Amount	Term	Contract Review Date	Notes
Afu's One Voice Care	180 Oak Point Court	Bay Point	6	6	Female	ARF	Small B&C	24-681-91	$ 38,193	4/1/21-3/30/22	10/1/2021	
Baltic Sea Manor	311 Baltic Sea Court	Pittsburg	6	1	Co-ed	RCFE	Small B&C	24-681-93	$ 66,093	3/1/21-2/28/22	9/1/2021	
Baltic Sea Manor II	2237 Lynbrook Drive	Pittsburg	6	1	Co-ed	RCFE	Small B&C	24-681-93	$ 66,093	3/1/21-2/28/22	9/1/2021	
Blessed Care Home	72 Riverview Drive	Pittsburg	6	6	Co-ed	ARF	Small B&C	24-681-79	$ 38,193	10/1/20-9/30/21	3/1/2021	
Camino Ramon Home for Seniors	931 Camino Ramon	Danville	6	2	Female	RCFE	Small B&C	24-681-96	$ 275,268	8/1/21-7/31/22	2/1/2022	in the same contract with Harmony Homes
Concord Royale	4230 Clayton Road	Concord	160	1	Co-ed	RCFE	Large B&C	24-681-59	$ 23,856	7/1/21-6/30/22	1/1/2022	
Crestwood Hope Center	115 Oddstad Drive	Vallejo	24	4	Co-ed	RCFE	Large B&C	24-933	$ 8,389,976	7/1/21 -6/30/22	1/1/2022	Part of a larger contract
Crestwood Pathways	550 Patterson Blvd	Pleasant Hill	16	16	Co-ed	Social Rehab	Enhanced B&C	74-286	$ 703,688	1/1/21 - 6/30/21	1/1/2022	Auto Extension
Crestwood The Bridge Program	550 Patterson Blvd	Pleasant Hill	64	64	Co-ed	ARF	Enhanced B&C	24-933	$ 8,389,976	7/1/21-6/30/22	1/1/2022	Part of a larger contract
Crestwood Our House	2201 Tuolumne Street	Vallejo	46	30	Co-ed	ARF	Enhanced B&C	24-933	$ 8,389,976	7/1/21-6/30/22	1/1/2022	Part of a larger contract
Delly's Care Home IV	2125 Holbrook Drive	Concord	6	1	Female	RCFE	Small B&C	24-681-66	$ 19,200	7/1/21-6/30/22	1/1/2022	
Divine's Home	2430 Bancroft Lane	San Pablo	6	3	Co-ed	RCFE	Small B&C	24-681-25	$ 107,148	7/1/21-6/30/22	1/1/2022	
Ducre's Residential Care	4400 Bell Avenue	Richmond	6	5	Female	RCFE	Small B&C	24-681-78	$ 47,117	7/1/21-6/30/22	1/1/2022	
Everwell / Foothills at the Alta	550 N. Lillie Avenue	Dinuba	40	1	Co-ed	RCFE	Enhanced B&C	74-627	$ 375,585	12/1/20-12/31/21	7/1/2021	
Everwell / Enclave at the Delta	4951 E. 8 Mile Road	Stockton	45	4	Co-ed	ARF	Enhanced B&C	74-627	$ 375,585	12/1/20-12/31/21	7/1/2021	
Everwell / Delta at the Sherwoods	1215 W. Swain Road	Stockton	40	0	Co-ed	ARF	Enhanced B&C	74-627	$ 375,585	12/1/20-12/31/21	7/1/2021	
Family Courtyard	2840 Salesian Avenue	Richmond	70	40	Co-ed	RCFE	Large B&C	24-681-84	$ 315,725	12/1/20-11/30/21	7/1/2021	
Friendship Care Home	1907 Cavallo Road	Antioch	35	1	Co-ed	RCFE	Large B&C	24-681-92	$ 29,684	3/1/20-2/28/21		Contract not renewed
Gine's Residential Care Home III	2565 Stone Valley Road	Alamo	6	1	Female	RCFE	Small B&C	24-681-77	$ 37,080	7/1/21-6/30/22	1/1/2022	
God's Grace	629 Hampton Road	Hayward	23	11	Male	ARF	Large B&C	24-681-2	$ 380,651	7/1/21-6/30/22	1/1/2022	
God's Grace Caring Home II	2223 Beckham Way	Hayward	6	1	Co-ed	ARF	Small B&C	24-681-2	$ 380,651	7/1/21-6/30/22	1/1/2022	
Harmony Home	1621 Third Avenue	Walnut Creek	22	5	Co-ed	RCFE	Large B&C	24-681-96	$ 275,268	8/1/21-7/31/22	2/1/2022	
Johnson Care Home	1801 Johnson Drive	Antioch	6	6	Male	ARF	Small B&C	24-681-67	$ 39,338	7/1/21-6/30/22	1/1/2022	
Margarita's Villa of Care II	2195 Esperanza Drive	Concord	6	6	Male	ARF	Small B&C	24-681-81	$ 39,193	2/1/21-1/31/22	8/1/2022	
Menona Drive Care Home	4586 Menona Drive	Antioch	6	6	Male	ARF	Small B&C	24-681-86	$ 91,728	5/1/21-4/30/22	10/1/2021	
Menona Drive Care Home II	1 Clearbrook Road	Antioch	6	6	Male	ARF	Small B&C	24-681-86	$ 91,728	5/1/21-4/30/22	10/1/2021	
Modesto Residential Living Center	1932 Evergreen Avenue	Modesto	100	12	Co-ed	ARF	Large B&C	24-681-82	$ 306,567	9/1/20-8/31/21	2/1/2021	
Nevin House	3221/3215 Nevin Avenue	Richmond	16	16	Co-ed	Social Rehab	Large B&C	24-751	$ 2,627,206	7/1/20-6/30/21	1/1/2021	Extension/Larger Contract
Oak Hills Residential Facility	141 Green Meadow Circle	Pittsburg	6	6	Male	ARF	Small B&C	24-681-48	$ 39,338	7/1/21-6/30/21	1/1/2021	
Paraiso Homes	3840 Knightsen Road	Oakley	6	6	Male	ARF	Small B&C	24-681-45	$ 39,192	7/1/21-6/30/21	1/1/2021	
Pleasant Hill Manor	40 Boyd Road	Pleasant Hill	44	26	Co-ed	RCFE	Large B&C	24-681-94	$ 867,775	12/1/20-11/31/21	5/1/2021	
Psynergy-Gilroy/Morgan Hill	18225 Hale Avenue	Morgan Hill	72	1	Co-ed	ARF	Enhanced B&C	74-571	$ 125,259	7/1/20-6/30/21	1/1/2021	Auto Extension
Psynery-Nueva Vista/Sacramento	4604 Roosevelt Ave	Sacramento	60	0	Co-ed	ARF	Enhanced B&C	74-571	$ 125,259	7/1/20-6/30/21	1/1/2021	Auto Extension
Ramona Care Home	2160 Ramona Drive	Pleasant Hill	6	2	Co-ed	RCFE	Small B&C	24-681-96	$ 275,268	8/1/21-7/31/22	2/1/2022	
Springhill Home	1387 Springhill Drive	Pittsburg	6	6	Male	ARF	Small B&C	24-681-58	$ 47,232	7/1/21-6/30/22	1/1/2022	
Williams Board and Care Home II	4229 Taft Street	Richmond	6	6	Co-ed	ARF	Small B&C	24-681-20	$ 78,676	7/1/21-6/30/22	1/1/2022	
Williams Board and Care Home	430 Fordham Drive	Vallejo	6	6	Male	ARF	Small B&C	24-681-20	$ 78,676	7/1/21-6/30/22	1/1/2022	
Woodhaven Home	3319 Woodhaven Lane	Concord	6	6	Male	ARF	Small B&C	24-681-87	$ 25,462	1/1/21-12/31/21	7/1/2021	
Yvonne's Home Care Services	2856 Shane Drive	Richmond	6	6	Male	ARF	Small B&C	24-681-24	$ 76,385	10/1/20-9/30/21	3/1/2021	
Walnut Creek Willows	2015 Mt Diablo Blvd	Walnut Creek	72	7	Co-ed	RCFE	Large B&C	24-681-95	$ 279,414	7/1/20-6/30/21	1/1/2021	

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						
2	Asian Family Center	Jennifer Bruggeman	FEB 2019	Feb 28		Yes	x
2	Suicide Prevention	Jennifer Bruggeman	MAR 2019	Mar 27		Yes	
2	CC Interfaith Housing	Jennifer Bruggeman	APR 2019	Apr 18	*	Yes	x
2	Youth Homes	Windy Taylor	APR 2019	APR 11		Yes	
2	CC Crisis Center	Jennifer Bruggeman	JUN 2019	Jul 11	*	Yes	
2	NAMI	Genoveva Zesati	NOV 2019	Nov 20		PEND	
2	Telecare	Windy Taylor	AUG 2019	Aug 22		Yes	
2	The Latina Center	Jennifer Bruggeman	SEP 2019	Sep 30		Yes	
2	Lifelong Medical Care	Jennifer Bruggeman	OCT 2019	Oct 24		Yes	
3	La Clinica de la Raza	Jennifer Bruggeman	NOV 2019	Dec 13		Yes	
3	COFY	Windy Taylor	DEC 2019	Dec 10	*	Yes	
3	Putnam Clubhouse	Jennifer Bruggeman	FEB 2020	Feb 25		Yes	x
3	Rainbow	Jennifer Bruggeman	FEB 2020	Feb 28		YES	x
3	COPE and First Five	Jennifer Bruggeman	~~MAR 2020~~				
3	First Hope	Jennifer Bruggeman	~~APR 2020~~		*		
3	Lincoln Child Center	Windy Taylor	~~APR 2020~~				
3	Seneca	Windy Taylor	~~MAY 2020~~				
3	Crestwood	Peter Ordaz	~~JUN 2020~~		*		
3	Older Adult Program	Windy Taylor	~~JUN 2020~~				
4	Miller Wellness Center	Windy Taylor	~~JUN 2020~~				
4	LAO	Jennifer Bruggeman	~~June 2020~~				

Appendix B
Program and Plan Element Profiles

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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.*