CONTRA COSTA HEALTH SERVICES

CPAW MEETING

Date of Meeting: Thursday, April 5th 2012
3:00 PM to 6:00 PM
Location: 2425 Bisso Ln. Concord CA 94520

Staff Lead: Mary Roy
Staff Support: Jeromy Collado

Facilitators: Grace Boda, Leigh Marz

AGENDA

TIME	TOPIC	PRESENTER	DESIRED OUTCOMES	MINUTES
3:00 PM	1. Opening, Agenda Review, Announcements	*Grace Boda* *Leigh Marz*	*On-Time Start*	15'
3:15 PM	2. Public Comment			5'
3:20 PM	3. Increased Allocation Introduction	*Mary Roy*		15'
3:35 PM	4. Overview of Strategies for Increased Allocation	*Staff*		30'
4:05 PM	5. Dot-input Process	*Maria Pappas*		20'
4:25 PM	6. Break			10'
4:35 PM	7. Small Groups Discussions—	*Grace Boda* *Leigh Marz*		30'
5:05 PM	8. Report Back & Next Steps	*Grace Boda* *Leigh Marz*		30'
5:35 PM	9. CSS Program 1 – Children's FSP	*Holly Page*		10'
5:45 PM	10. CSS Program 6 – System Development Strategies	*Holly Page*		10'
5:55 PM	11. Public Comment			5'
6:00 PM	12. Close	*Grace Boda* *Leigh Marz*		

CPAW Ground Rules

1. Agendas and minutes of the previous meeting will be emailed before each meeting,
2. Meetings will start and stop on time.
3. One speaker at a time; allow the facilitator to "direct traffic."
4. Speaker's remarks should be brief to allow for others to speak.
5. Listen to and value other points of view, even if they differ from yours.
6. To the greatest extent possible, system interests should trump personal interests.
7. Declare potential conflicts of interest before the topic is discussed.

- *The person(s) having a conflict with a topic being discussed will refrain from participating in any group discussion on the matter and will physically leave the room for the period of time the topic is considered.*

8. Focus on past stakeholder processes to the extent that it helps the CPAW move forward.
9. When the group makes a decision, seek consensus 1st; a simple majority is the second option.
10. Turn off cell phones, unless your job requires you to be readily available.

Priority Survey for Behavioral Health Staff (Homeless, AOD) & Contract Providers

Contra Costa Mental Health Services

Research & Evaluation Unit

March 2012

CONTRA COSTA
HEALTH SERVICES

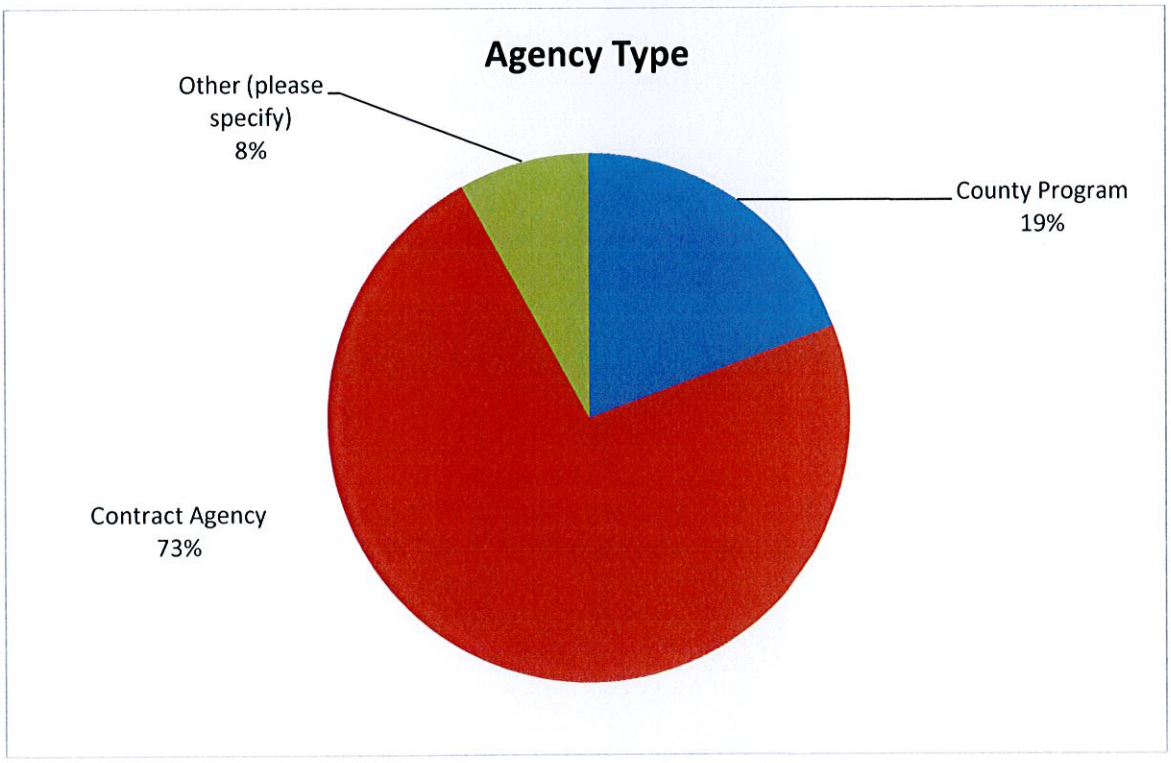
Background

Senior staff identified 10 priority areas for both the adult system of care and the children's system of care. An online survey was developed initially for Contra Costa County Mental Health staff then expanded to Contra Costa Behavioral Health partners and contract agencies to see how these priority areas would rank in terms of importance to enhance the system of care and improve needed services to consumers. The survey was conducted in March of 2012. A total of 61 partners and contractors completed the survey.

Results from the survey will be reviewed and discussed with a number of key stakeholders, including the Mental Health Executive Staff (MHES), the Mental Health Commission and Mental Health Commission Quality of Care Committee, the Mental Health Quality Management Committee, Mental Health Staff, and the Consolidated Planning and Advisory Workgroup (CPAW) Data Committee.

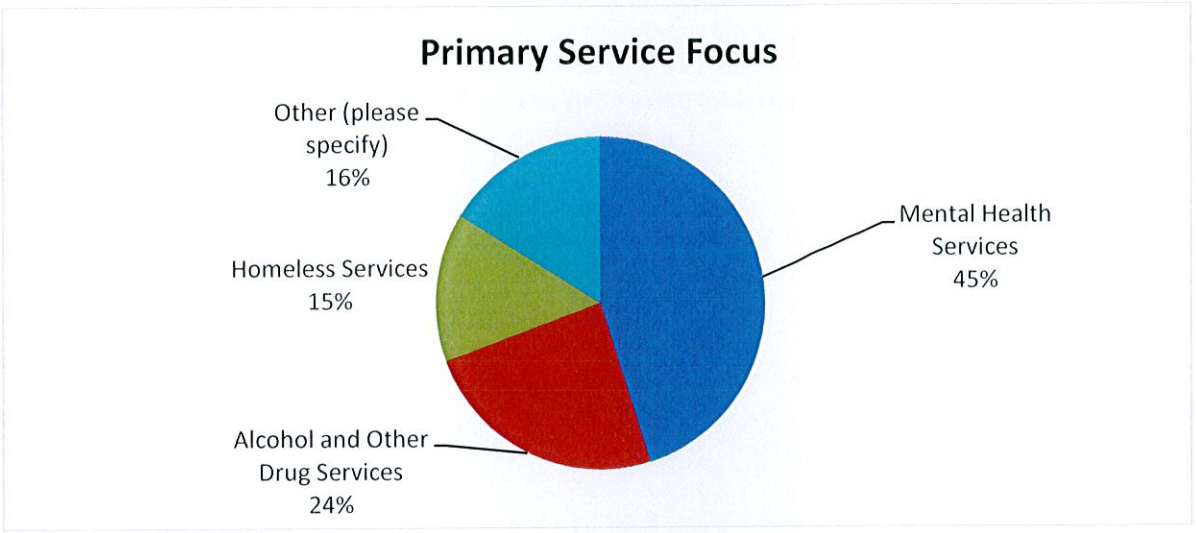
Agency Type

Survey respondents were asked to identify the type of agency in which they work. Seventy three percent worked for contract agencies and 19 percent worked for a county program. For the 8 percent who responded 'Other', their agencies included *Adult and Juvenile Drug Court, non-profit agency, contract program, and the Department of Veterans Affairs*.



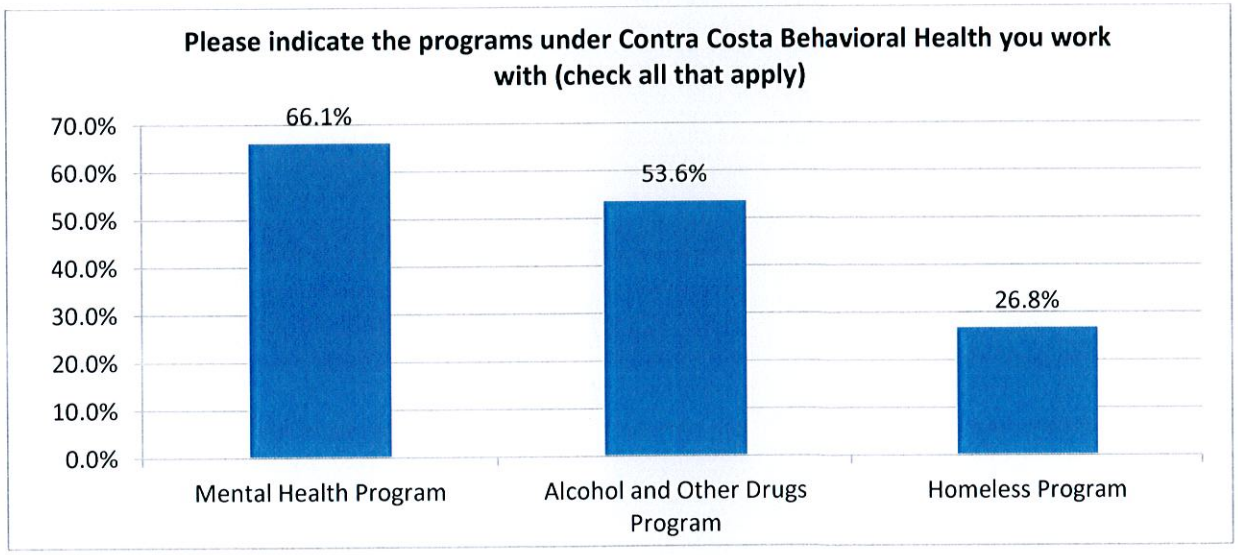
Primary Service Focus

About half of survey respondents (45 percent) identified mental health as their primary service focus. Twenty four percent identified Alcohol and Other Drugs and 15 percent identified Homeless services as their primary service focus. For respondents who identified as 'Other', their responses include *parenting classes, residential care, prevention and brief intervention, community engagement/advocacy, child abuse prevention, and wellness and recovery.*



Programs

Partners and contractors were asked to identify the different programs under Contra Costa Behavioral Health in which they work. Because some agencies work with more than one County program, such as ANKA or Shelter Inc who work across county programs, respondents were allowed to choose more than one response. About 60 percent of respondents worked with the Mental Health program, 53.6 percent worked with Alcohol and Other Drugs, and 26.8 percent worked with Homeless programs.



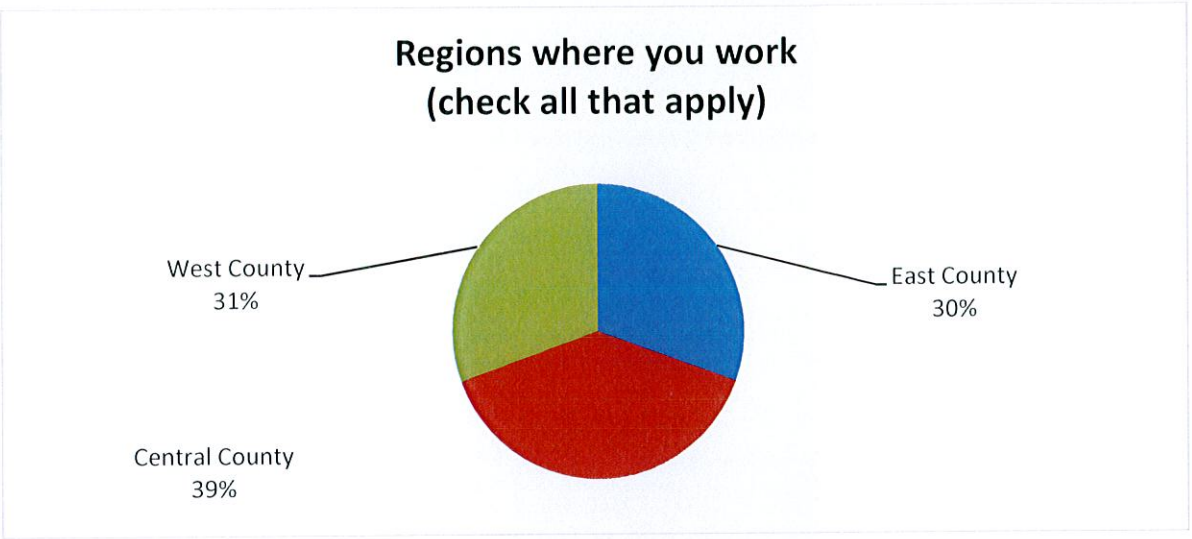
Agency Name

Partners and contractors were asked to identify their agency. Twenty respondents selected an Alcohol and Other Drug agency. Eight respondents selected an agency under Homeless Programs. Thirty four respondents selected an agency under Mental Health. For those respondents who answered 'other', their agencies were identified as *Center for Human Development, AOD Administrative Screen and Brief Intervention Hospital and clinics, Center for Human Development, Building Blocks for Kids Collaborative, Discovery House, Contra Costa County Alcohol and Other Drugs, Juvenile Drug Courts and Drug Court, Department of Veterans Affairs, and Brookside Homeless Shelter.*

AOD Providers	
DISCOVERY COUNSELING CENTER	7
ANKA BEHAVIORAL HEALTH INC.	4
REACH PROJECT	4
BAY AREA COMMUNITY GATEWAY PROJECT	2
COMMUNITY HEALTH FOR ASIAN AMERICANS	1
FAUERSON RECOVERY	1
THUNDER ROAD	1
TOTAL	**20**
Homeless Providers	
ANKA	5
CCIH - Garden Park Apartments	2
Concord Shelter	1
TOTAL	**8**
Mental Health Providers	
Mental Health Consumer Concerns	9
ANKA	5
Alternative Family Services	1
BACR	1
Child Abuse Prevention Council	1
Contra Costa Crisis	1
Contra Costa Interfaith Housing	1
COFY	1
COPE	1
La Cheim- Day Treatment	1
Ducre's Residential Care	1
Family Court Yard	1
Fred Finch	1
Modesto Living Center (Out of County)	1
Portia Bell Hume BHC	1
Rainbow Center	1
Rubicon, Inc.	1
Seneca	1
STAND!	1
Thunder Road	1
We Care	1
Youth Homes	1
TOTAL	**34**

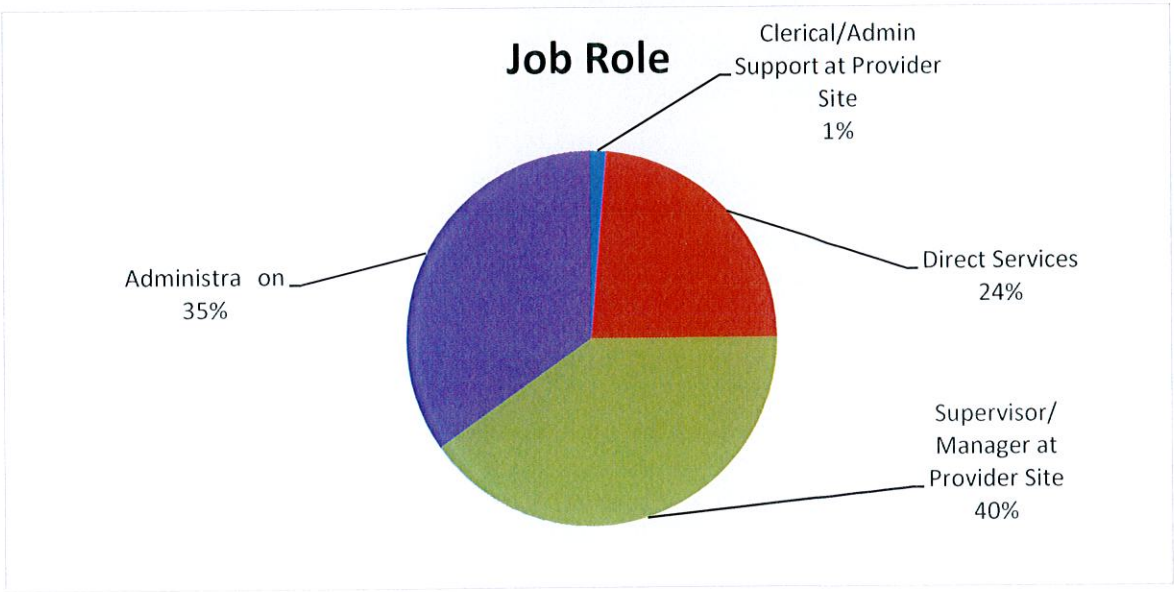
Region

Partners and contractors were asked which region of the county they worked. Since some staff work in multiple areas of the county, they were asked to check all applicable areas. All regions of the county ranked relatively equal, with 39 percent identifying working in Central County, 31 percent working in West and 30 percent in East County.



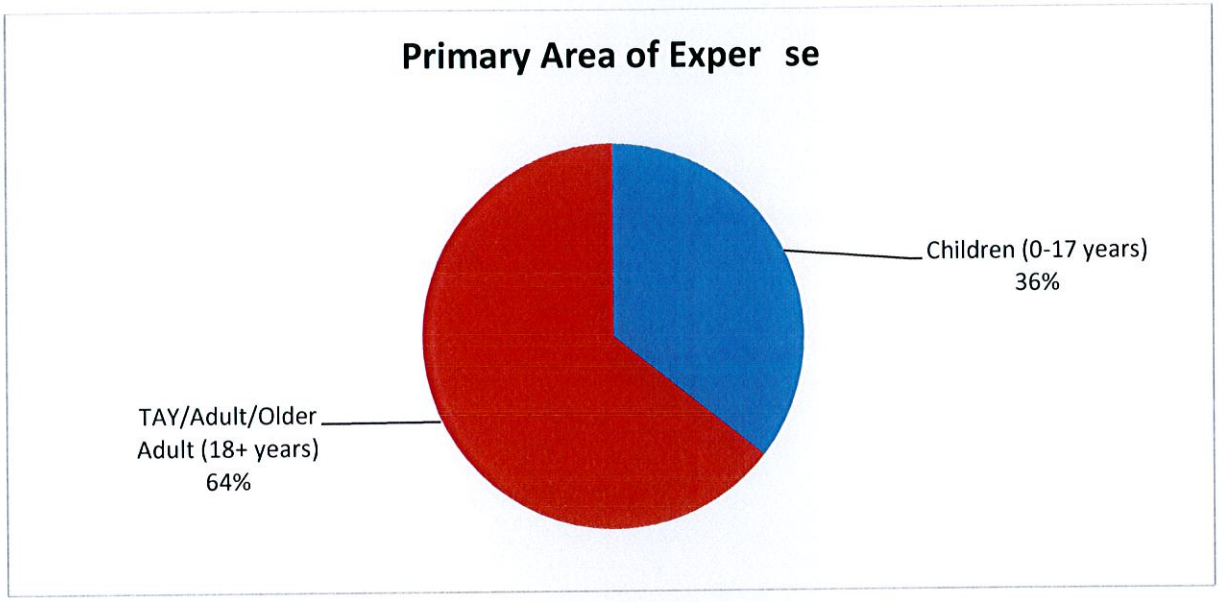
Job Role

Survey respondents were asked to identify their job role. Forty percent of respondents were in a supervisory or managerial position. Administrative staff accounted for 35 percent of respondents, direct service staff accounted for 24 percent and clerical/administrative support accounted for 1 percent of survey respondents.



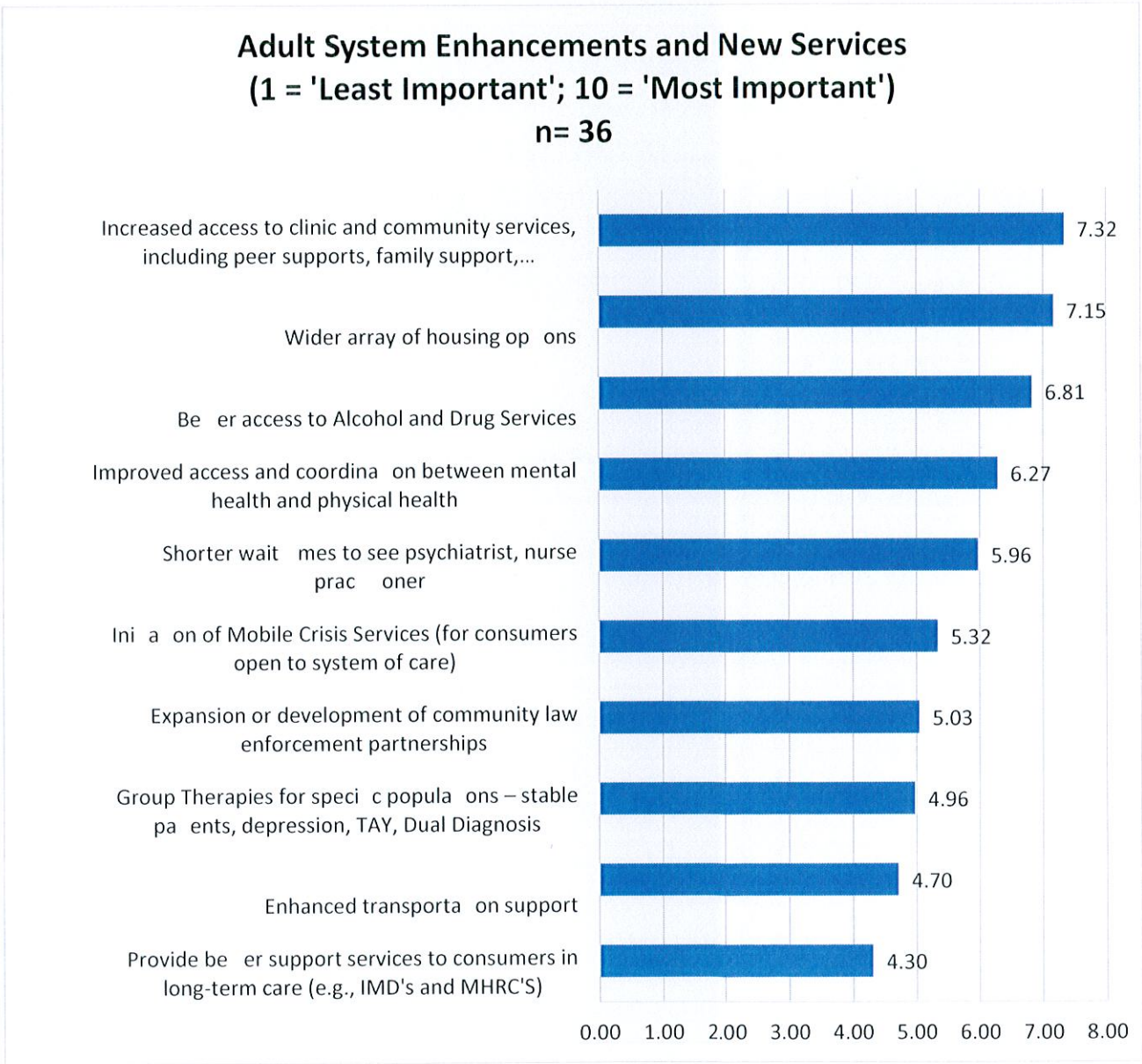
Area of Expertise

Sixty four percent of respondents stated their primary area of expertise was with Transitional Age Youth, Adults or Older Adults. The remaining 36 percent had expertise providing services to Children.



Adult System of Care Priority Areas

A total of 36 staff rank ordered the Adult System of Care priority areas on a scale of 1 equaling 'Least Important' to 10 equaling 'Most Important'. Staff ranked "Increased access to clinic and community services…" as the top priority area with an average rating of 7.32. Offering a wider array of housing options ranked as the second highest priority with an average rating of 7.15. There was some clustering of the next highest ranked areas, ranging from 6.81 to 6.27, which included having better access to Alcohol and Drug Services and improved access and coordination between mental health and physical health. The next clustering of priority areas ranged from 5.96 to 5.03 and included shorter appointment wait times, initiation of mobile crisis services and expansion/development of community law enforcement partnerships. The lowest ranking items were group therapies for specific populations, transportation support, and support services for clients in long term care.



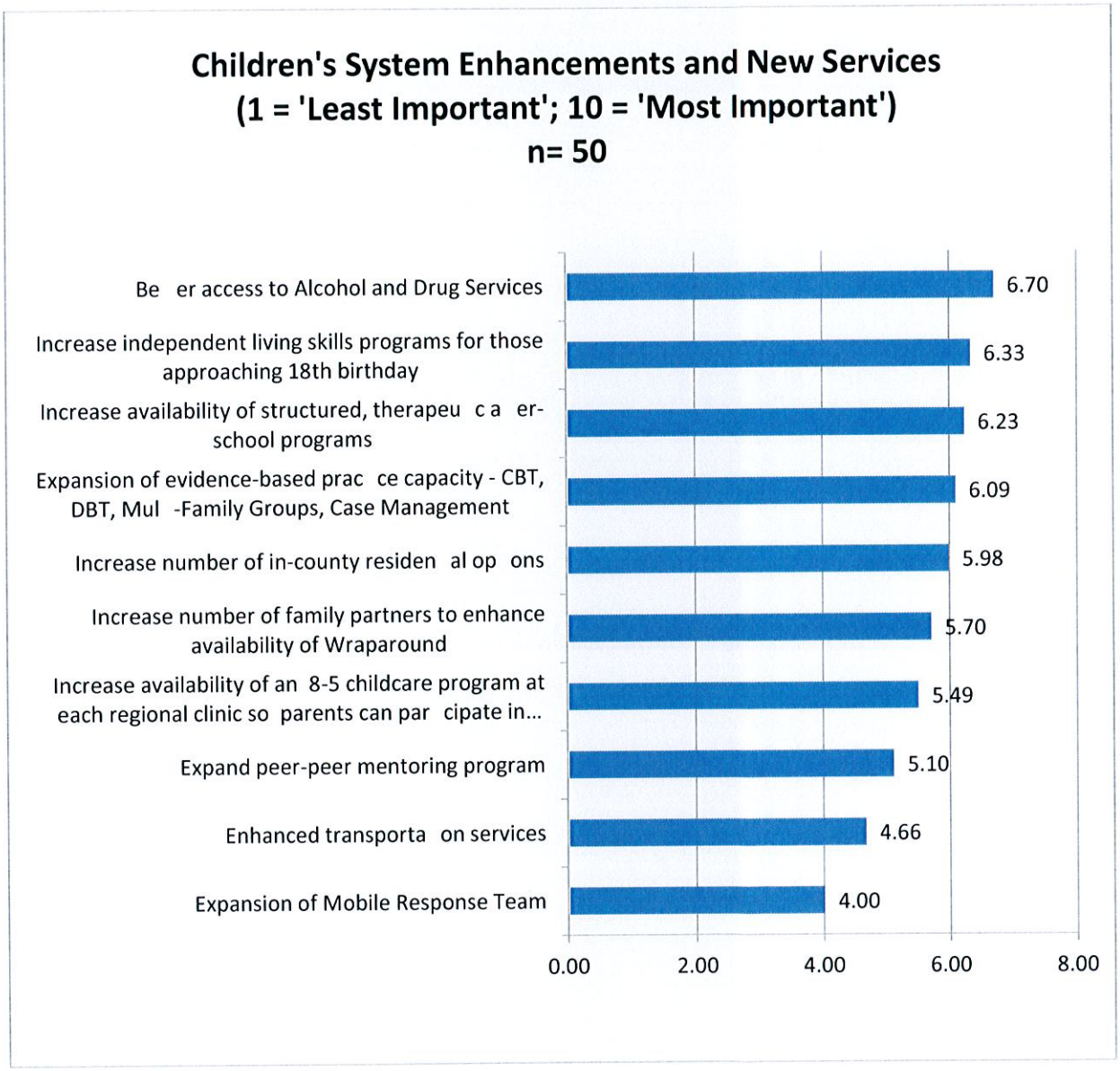
Comparison with County Mental Health Staff Survey results

The priority area survey was initially administered to Contra Costa Mental Health staff in December 2011. Mental Health staff were asked to rank the same priority areas as partners and contractors and provide open-ended feedback on their perception on the County's needs for behavioral health services. Below is a comparison of the top five areas from both surveys. In general, the results of the partner/contractors survey and the CCMH staff survey seem to align, prioritizing the same items as priority areas with slight variation on the order of importance. Increasing access to clinic and community services ranked as the top priority for partners and contractors however ranked fourth for CCMH staff. Both groups seem to agree that providing a wider array of housing options is important for the County's clients, ranking second with partners/contractors and first with CCMH staff. Providing better access to Alcohol and Drug services ranked third for partners/contractors and slightly lower for CCMH staff at fifth. With almost similar ranking, improved access and coordination between mental and physical health ranked fourth with partners/contractors and third for CCMH staff. Addressing shorter wait times to see a psychiatrist ranked higher for CCMH staff, ranking second, while partners and contractors ranked the same item fifth on the priority list.

Survey Item	**Partner/Contractor Ranking**	**CCMH Staff Ranking**
Increased access to clinic and community services, including peer supports, family support, vocational support/training opportunities, and individual therapy	**1**	**4**
Wider array of housing options	**2**	**1**
Better access to Alcohol and Drug Services	**3**	**5**
Improved access and coordination between mental health and physical health	**4**	**3**
Shorter wait times to see psychiatrist, nurse practitioner	**5**	**2**

Children System of Care Priority Areas

A total of 50 staff rank ordered the Children's System of Care priority areas. The four highest ranked priority areas included better access to Alcohol and Drug Services (6.70), increase independent living skills programs (6.33), increase availability of structured therapeutic afterschool programs (6.23) and expansion of evidence-based practice capacity (6.09). Among the lowest priority areas ranked were enhanced transportation services (4.66) and expansion of mobile response team (4.00).



Comparison with MH Staff Survey results

CCMH staff was also surveyed about the children's system enhancements and new services in the initial survey in December 2011. In order to evaluate the results, the comparison of the top five areas from the partners and contractors and CCMH staff surveys is displayed below. Although respondents ranked improving access to alcohol and drug services as a top priority, CCMH staff ranked the same item sixth

on the list. Increasing independent living skills programs ranked similarly with both survey groups, ranking second. Increasing the availability of structured, therapeutic afterschool programs were among the top five priorities for both groups, differing slightly in ranking (third for partners/contractors, first for CCMH staff). Similarly, the expansion of evidence-based practice capacity was among the top five, ranking fourth for partners/contractors and third for CCMH staff.

Survey Item	Partner/Contractor Ranking	CCMH Staff Ranking
Better access to Alcohol and Drug Services	1	6
Increase independent living skills programs for those approaching 18th birthday	2	2
Increase availability of structured, therapeutic after-school programs	3	1
Expansion of evidence-based practice capacity - CBT, DBT, Multi-Family Groups, Case Management	4	3
Increase number of in-county residential options	5	5

Open ended Responses

Partners and contractors were asked if they had other suggestions for priority areas outside of the ones identified by Mental Health senior staff. The following are priority areas and comments provided by respondents from the Adult and Children System of Care.

Priority Area Survey for Partners/Contractors Continuum for the Adult System of Care (SOC) Open ended Responses (n=9)
Aftercare for residential/outpatient treatment in a form of affordable sober living or sliding scale for those seriously trying to get their recovery process stabilized
Facilitate transfer of documentation, i.e. medical insurance, PCP, psychiatrist for newly admitted residents coming from another county.
It is not clear whether you want to know what we NEED to do, what we have ALREADY STARTED doing, or what?? Plus, at the top of the page it SEEMS to be assuming that we [I'm at Discovery House of AODS] are a Mental Health contract service provider. While we do serve clients with co-occurring disorders, we are not part of MH and we are not a contractor. So this page does not seem to apply. I'll try again if you clarify.
Workforce services for mental health consumers
AOD and mental health services for working poor. Improved culturally competent care for LGBTQ consumers. Enhanced culturally competent care for people of color and bilingual consumers.
More housing of all types (in addition to a wider array)
Why does only one of these 10 questions explicitly address AOD services? Is improved access and coordination between AOD and physical health unimportant? This survey is biased and the results will not tell the true story of *[incomplete]*
Having access to formerly homeless, addicted, or mentally ill persons now in recovery at licensed facilities even when there is a past criminal record given there is evidence of recovery and stability. Why should people who have experienced problems in the past be refused access to employment at licensed facilities when they are not refused access to employment at AOD or Homeless programs but make less money at those programs and serve the same people? Let's not talk about wellness and recovery while we exclude many from the benefits that those who have no past have access to. This stigma is also a disservice to consumers as there is a benefit from receiving services to those who have also experienced adversity.

I recommend helping clients work with one psychiatrist rather than several primary care physicians in order to receive psychotropic medications. I think it would be helpful to form partnerships with psychiatrists in order to reduce the likelihood of clients being overmedicated or abusing prescription drugs, such as pain killers or benzodiazepines. Also, I recommend offering dialectical behavioral group and individual therapy at all sites to aide individuals with borderline personality disorders. I also recommend using seeking safety which is a treatment to aide clients who are dually-diagnosed with PTSD and substance abuse problems. Furthermore, I recommend having several groups to treat chronic pain or chronic fatigue syndrome in alternative ways rather than just use medication. Meditation or mindfulness groups could also be helpful for all clients in moving forward in their lives. Lastly, I also recommend staff prompting and reminding clients to take their medications to alleviate symptoms. I also recommend that clients should complete chores at all sites if they are physically capable. Finally, more attention should be directed at the initial phase of their stay in setting up parameters and expectations as well as consequences for failure to meet expectations as well as more attention is needed during the end of their stay where there is follow-up and necessary support to reduce recidivism and repeated episodes of homelessness.

Priority Areas Survey for Partner & Contractor Enhancement for the Child and Youth System of Care (SOC) Open-ended Responses (n=3)
Better and increased access to mental health services
AOD needs to address tobacco usage (for adults too). More culturally appropriate services for LGBTQ youth. Most county services are not culturally competent or welcoming. Front desk and intake staff in particular need sustained training.
Are all these services going to be funded for youth with substance abuse problems??

Increased Allocation
Funding Ideas by MHSA Component

A. *CSS Full Service Partnership Funding (at least 51% of CSS dollars)*

- TAY FSP (Voting category 1 – 2 dots)
  - Expansion of TAY FSP to all regions of the county
  - Addition of "step-down" Personal Service Coordinators to FSP Programs
  - Increase employment opportunities for TAY FSP

- Adult FSP (Voting category 2 – 2 dots)
  - Expansion of TAY FSP to all regions of the county
  - Addition of "step-down" Personal Service Coordinators to FSP Programs
  - Increase employment opportunities for TAY FSP

B. *CSS Systems Development (Non-Full Service Partnership) Funding*

- Children Systems Development (Voting category 3 – 3 dots)
  - In-home, individualized, intensive behavioral service for those between the ages of 0 to 5 who are uninsured.
  - Implementation of evidence based dual diagnosis treatment program
  - Create a Family Resource Center similar to the program in Alameda County
  - Increase access to transportation via cars, shuttle services, vouchers, etc. to assist consumers in making their scheduled appointments including primary care appointments, and to support consumers participation in MHSA planning and empowerment activities.
  - Increase consumer- and family-voice in all programs – parent partners, family partners, etc.
  - Create a Family Resource Center similar to the program in Alameda County

- TAY Systems Development (Voting category 4 – 4 dots)
  - Transitional residential program at the Oak Grove facility
  - Development of a youth advisory team
  - Clinical staff and peer support team to visit consumers in out of county Mental Health Rehabilitation Centers (MHRC).
  - Expand assessment services within homeless shelters to identify those with serious mental illness
  - Implementation of evidence based dual diagnosis treatment program
  - Vocational program at the Oak Grove facility
  - Increase access to transportation via cars, shuttle services, vouchers, etc. to assist consumers in making their scheduled appointments including primary care appointments, and to support consumers participation in MHSA planning and empowerment activities.
  - The establishment of money managers to free up case managers for additional client care
  - Increase consumer- and family-voice in all programs – parent partners, family partners, etc.
  - Create a Family Resource Center similar to the program in Alameda County

- Adult Systems Development (Voting category 5 – 5 dots)
  - Rapid access in each of the adult mental health outpatient clinics
  - Expand capacity of peer services and peer-support programs
  - Structured Community and Mobile Response Teams
  - Increase the number of Clinic Case Managers including the infrastructure (space) needed.
  - Clinical staff and peer support team to visit consumers in out of county Mental Health Rehabilitation Centers (MHRC).
  - Expand assessment services within homeless shelters to identify those with serious mental illness
  - Implementation of evidence based dual diagnosis treatment program
  - Increase access to transportation via cars, shuttle services, vouchers, etc. to assist consumers in making their scheduled appointments including primary care appointments, and to support consumers participation in MHSA planning and empowerment activities.
  - The establishment of money managers to free up case managers for additional client care
  - Increase consumer- and family-voice in all programs – parent partners, family partners, etc.
  - Create a Family Resource Center similar to the program in Alameda County

- Older Adult Systems Development (Voting category 6 – 3 dots)
  - Increase capacity of Intensive Care Management Teams in all regions of the County
  - Clinical staff and peer support team to visit consumers in out of county Mental Health Rehabilitation Centers (MHRC).
  - Expand assessment services within homeless shelters to identify those with serious mental illness
  - Implementation of evidence based dual diagnosis treatment program
  - Increase access to transportation via cars, shuttle services, vouchers, etc. to assist consumers in making their scheduled appointments including primary care appointments, and to support consumers participation in MHSA planning and empowerment activities.
  - The establishment of money managers to free up case managers for additional client care
  - Increase consumer- and family-voice in all programs – parent partners, family partners, etc.
  - Create a Family Resource Center similar to the program in Alameda County

C. *CSS Housing*

- *CSS Housing (Voting category 7 – 1 dot)*
  - What percentage of new MHSA revenue should be allocated to housing?
    - ✓20%
    - ✓30%

D. *Prevention and Early Intervention (PEI)*

- *PEI Children (at least 51% of PEI dollars)* (Voting category 8 – 3 dots)
  - Increase availability of structured, therapeutic after-school programs
  - Increase independent living skills programs for those approaching their 18th birthday
  - Offer child care in the clinic to facilitate parental participation in treatment
  - Offer short-term mental health support in schools following crisis situations
  - Expansion of Triple P Parenting evidence-based practice
  - Expansion of alternative education programs that integrate mental health and substance abuse treatment into the school program

- Behaviorist in ambulatory care to screen, provide short term treatment and refer to appropriate treatment services or groups as indicated

- *PEI - All other programming* (Voting category 9 – 3 dots)
  - Whole Health Peer Support, or other evidence-based programming, to improve physical health outcomes for individuals with a serious mental illness
  - Additional support for families accessing PES services, such as a family partner or a Mental Health Chaplain/spiritual care provider
  - Behaviorist in ambulatory care to screen, provide short term treatment and refer to appropriate treatment services or groups as indicated
  - Expansion of peripartum depression program in Central County
  - Expansion of the assessment and treatment program in primary care/ FQHC's.
  - Continuation of funding for successful innovation projects

E. Innovation (INN)

- Priority areas for future Innovation Planning (Voting category 10 – 1 dot)
  - Access (in general)
  - Access to underserved cultural communities
  - Integration
  - Improve Outcomes

F. ***Workforce Education and Training (WET)***

- Workforce Education and Training (Voting category 11 – 2 dots)
  - Training for mental health staff in co-occurring AOD treatment and assessment
  - Evidence-based practice training in trauma
  - Training in Evidence based practice of Motivational Interviewing
  - Evidence-based practice training in Cognitive Behavioral Therapy for Depression (CBT-Depression)
  - Clinical Supervisors in each regional clinic to monitor fidelity to EBPs

Children's FSP Planning

March 1, 2012

Overall goal: In an effort to work towards systems integration and elimination of treatment silos, the planning for the Children's FSP took into consideration the current programs in the children's system of care, the gaps in service and opportunities for improvement and creativity.

County-wide Assessment Team:

Develop and implement a county-wide assessment team. This team would consist of 3 FTE Mental Health Clinical Specialist, 0.5 FTE of time assigned from 3 existing family partners (one in each region), and 0.5 FTE of clerical support in each region. This team would complete a comprehensive assessment on all youth Level 3 and above. The team would present treatment recommendations to the family based on diagnosis, environmental stressors and likelihood of treatment adherence among other factors.

The county-wide assessment team will complete the CALOCUS and other assessment tools during the initial assessment. They will also participate in reauthorization of services to help facilitate movement through the system and ensure youth are receiving the appropriate level of care. There may be 4 points of entry to the assessment team: Access Line, MRT, Hospital and Residential and the Clinics.

FSPs and Personal Service Coordinators:

Entry into a Full Service Partnership would occur through the mobile county-wide assessment team. In addition to treatment referrals, for those youth and families who are experiencing severe stressors, such as out-of-home placement, juvenile justice system, repeated presentations at PES or hospitalizations, and those experiencing co-occurring disorders may be referred to a Personal Service Coordinator (PSC) and will be considered a Full Service Partner. The previous FSP model was program-based meaning if the youth was a participant of a particular program they were considered a FSP regardless of current level of need. The new FSP model attaches the FSP-status to the individual and not to any particular program. Individuals who are FSP's would receive additional support such as 24/7 contact with their PSC, transportation support, flexible funds, but would access the same treatment services as children/youth who are not FSPs.

Evidence-based Practices:

There are two EBP that would provide services not currently being provided in any organized fashion in our system of care. These programs would serve both FSPs and non-FSPs and would receive their referrals from the county-wide assessment team.

Multidimensional Family Therapy (MDFT)

Source: SAMHSA - http://nrepp.samhsa.gov/ViewIntervention.aspx?id=16

MDFT is a comprehensive and multisystemic family-based outpatient or partial hospitalization program for substance-abusing adolescents, adolescents with co-occurring substance use and mental disorders,

and those at high risk for continued substance abuse and other problem behaviors such as conduct disorder and delinquency. Treatment is delivered across a series of 12 to 16 weekly or twice weekly 60- to 90-minute sessions. Treatment modules target the following four areas of social interaction:

1. The youth's interpersonal functioning with parents and peers;
2. The parents' parenting practices and level of adult functioning independent of their parenting role;
3. Parent-adolescent interactions in therapy sessions;
4. Communication between family members and key social systems (e.g., school, child welfare, mental health, juvenile justice.)

Multisystemic Therapy (MST) for Juvenile Offenders

Source: SAMHSA - http://nrepp.samhsa.gov/ViewIntervention.aspx?id=26

MST for Juvenile Offenders focuses on those factors in each youth's social network that are contributing to his or her antisocial behavior. The ultimate goal of MST is to empower families to build a healthier environment through the mobilization of existing child, family and community resources. Additionally, there are three primary goals of this treatment model:

1. Decrease rates of antisocial behavior and other clinical problems;
2. Improve functioning (e.g., family relations, school performance, peer interactions)
3. Reduce the use of out-of-home placements such as incarceration, residential treatment, and hospitalization.

The typical duration of home-based MST services is approximately 4 months, with multiple therapist-family contacts occurring weekly. Specific treatment techniques used to facilitate these gains are based on empirically supported therapies, including behavioral, cognitive behavioral, and pragmatic family therapies.

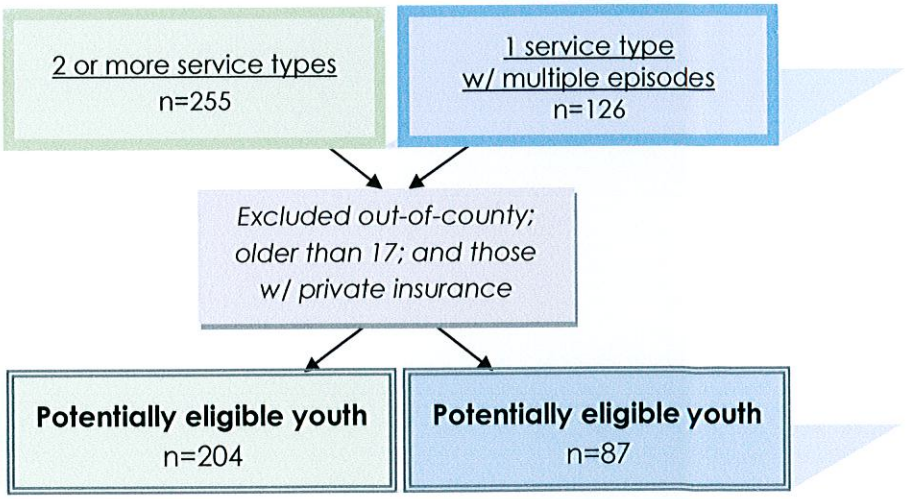
Children's Full Service Partnership
Planning Information and Data

PLANNING & CONCEPT:

- Direct money towards the youth who are utilizing crisis services most frequently, including MRT; PES and Hospitalizations, regardless of region of residence.
- Children and youth participants must meet the eligibility criteria in Welfare and Institutions Code (WIC) Section 5600.3(a) which states participants must be "seriously emotionally disturbed (SED) children and youth". WIC Section 5600.3(a)(2) defines SED as having a DSM-IV diagnosis and meeting one of the following criteria:
    1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care; school functioning; family relationships; or ability to function in the community; and either one of the following occur:
        - The child is at risk of removal from home or has already been removed from the home.
        - The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
    2. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.
    3. The child meets special education eligibility requirements under Chapter 26.5 of Division 7 of Title 1 of the Government Code.
- Additionally, the original planning process identified the following three issues as priority for the Children's FSP: Failure in learning environments; out-of-home placements; and involvement in child welfare or juvenile justice systems.

DATA:

- We reviewed data from FY 10-11 of all youth who encountered the Children's System of Care including CBO's at least one time. (n=6,359)
- A total of 1,092 from the 6,359 had at least one crisis visits at any of the following: MRT - crisis; PES; Hospitalization.
- To narrow it down further, we analyzed those with multiple crisis visits by looking at the data in two ways: those with episodes in two or more service types; and those with multiple episodes within one service type. (Service Type is defined as any of the following: PES visit; hospitalization or MRT crisis procedure.)



SUMMARY:

- By reviewing data from FY 10-11, there are approximately 291 youth who are experiencing frequent crisis situations and may be potential Full Service Partners.
- The average age of the youth is 14.5 years; majority are Caucasian; followed by African American and Latino; 97% are English speaking; and approximately 36% have an identified substance abuse issue.
- A substantial portion of the youth are foster youth and/or have involvement in the Juvenile Justice System.
- These youth are fairly evenly distributed throughout the County.
- Most are linked to some degree of services while others haven't established a relationship with County mental health.
- Diagnoses of the youth are those that would fall under the category of Seriously Emotionally Disturbed.

CPAW
Increased Allocation Planning
Community Services and Supports (CSS)
Budget Summary - FY 10-11

SUMMARY

CSS Program	Expenses
CHILDREN'S FSP	$2,138,294
TAY FSP	$1,569,282
ADULT FSP	$3,673,831
OLDER ADULT MENTAL HEALTH	$2,588,951
HOUSING	$5,182,117
SYSTEMS DEVELOPMENT	$5,133,159
BUDGET	**$17,715,750**
TOTAL EXPENSES	**$20,285,634**
REVENUE (Medi-Cal)	**$2,825,859**
NET BUDGET POSITION	**(+) $255,975**

PROGRAM DETAILS

1. Program 1: Children's Full Service Partnership (FSP) - $2,138,294
   - ✓ $2,138,294 is available for planning for the new Children's FSP. The money is a combination of contractor and county positions.

2. Program 2: Transition Age Youth Full Service Partnership (FSP) - $1,569,282
   - ✓ $1,425,642 is allocated to Fred Finch for the FSP Program
   - ✓ $143,640 is used for a County Program Supervisor position

3. Program 3: Adult Full Service Partnership (FSP) - $3,673,831
   - ✓ $2,421,793 is allocated to contractors who operate the Adult FSP Programs
   - ✓ $1,252,038 is used for County positions

4. Program 4: Older Adult Mental Health - $2,588,951
   - ✓ $351,162 goes towards the IMPACT program
   - ✓ $1,758,810 goes towards the Intensive Care Management Teams
   - ✓ $478,980 goes towards Administration and Operating expenses

5. Program 5: Housing - $5,182,117 (See Attachment)
   - ✓ $372,705 funds the County Housing Coordinator and 3 MH Clinical Specialist positions that will support the efforts of the Housing Coordinator.
   - ✓ $297,475 is provided to Transitional Residential facilities
   - ✓ $1,259,083 is provided to Shelter, Inc. for subsidies of up to 120 units
   - ✓ $1,679,274 is provided to the Homeless programs
   - ✓ $1,473,580 goes to Board and Cares
   - ✓ $100,000 is provided to AOD – Discovery House

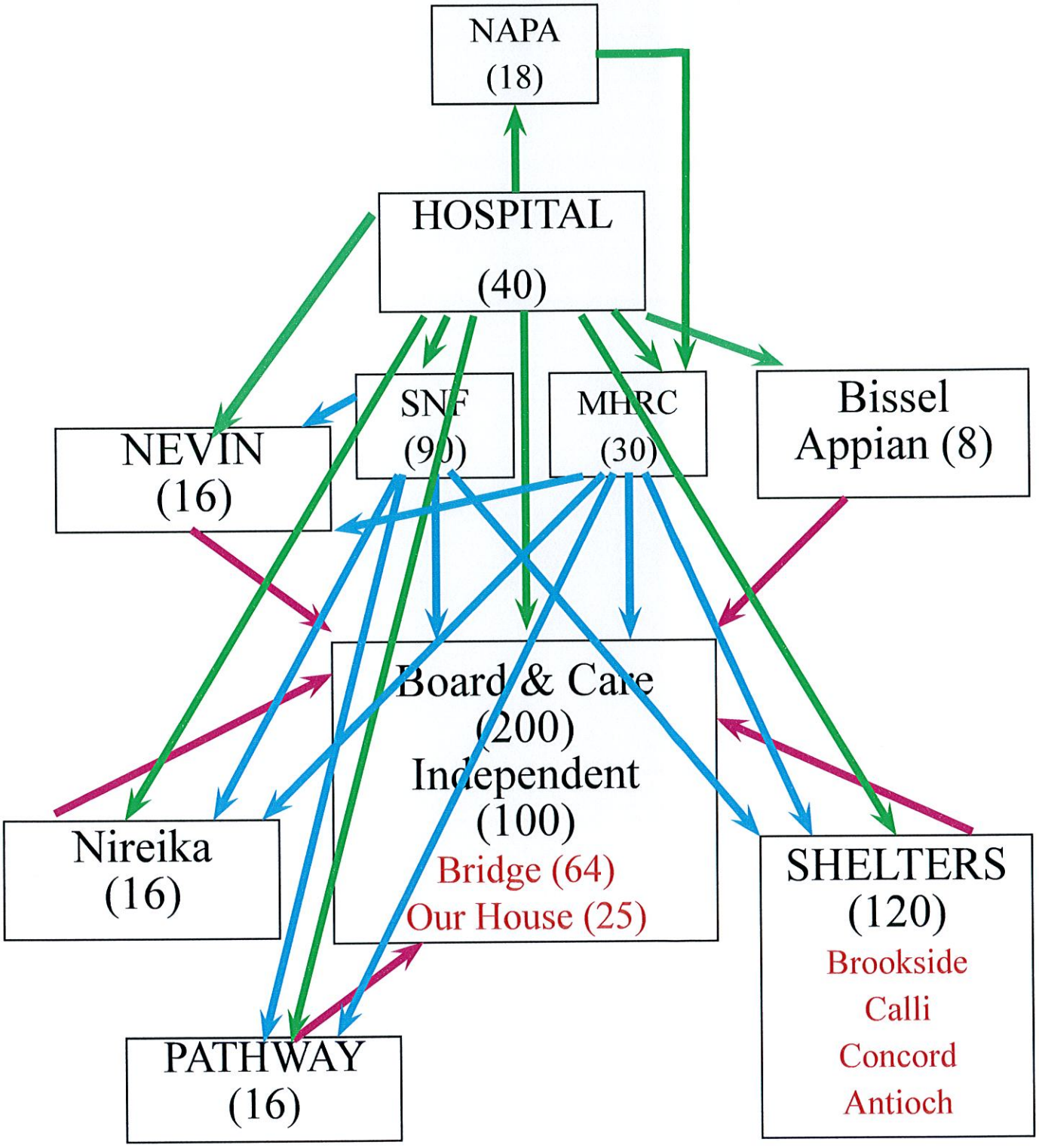
6. Program 6: Systems Development Strategies - $5,133,159
   - ✓ Direct Service Providers - $1,613,808
   - ✓ Peer Providers - $1,171,138
   - ✓ Administrative Supports - $2,137,213
   - ✓ Consultation/Facilitation - $150,000
   - ✓ Other - $61,000

MHSA HOUSING-FY 2011-2012
PROPOSED BUDGET

FACILITY	# OF CLIENTS	DAILY RATE	ANNUAL $
BOARD & CARE-AUGMENTATION			
Licensed Board & Cares	14		$95,220.00
ADULT TRANSITIONAL RES. FACILITY (MEDI-CAL)			
Pathway, The	10	$77.50	$282,875.00
ORGANIZATIONAL BOARD & CARE			
Bridge, The	22	$100.00	$803,000.00
Our House-Vallejo	4	$100.00	$146,000.00
Modesto Residential Living Center	6	$60.00	$122,760.00
Family Courtyard	42	$20.00	$306,600.00
SHELTER, INC.	100		$1,259,083.00
HOMELESS SHELTER SERVICES	97		$1,679,274.00
CLAYTON WAY (TRANSISTIONAL HOUSIN	2	$20.00	$14,600.00
HOUSING AUTHORITY			
Housing Authority-CCC	5		$0.00
Housing Authority-Richmond	3		$0.00
SHELTER+CARE	10		$0.00
TOTAL	**315**		**$4,709,412.00**

Facility	Daily Rate	Annual Cost for 1 Bed
Shelters - Adult	$50	$18,250
Shelters - Respite	$95	$34,675
The Bridge	$100	$36,500
Shelters - Bissell & Appian	$144	$52,560
Pathway	$155	$56,575
Angwin	$249	$90,885
CPT	$300	$109,500
Napa	$503	$183,595
Acute Hospital	$1,500	$365,000

Housing Placement Decision Tree



Acute Care

Long Term Care

Community

SNF - Skilled Nursing Facility

MHRC - Mental Health Rehab Center