Innovation Annual Report FY 19/20

Contra Costa Behavioral Health Services

Mental Health Services Act

Table of Contents

Innovation Introduction…………………………………………………………..3

Aggregate Demographics………………………………………………………..A1

Program Profiles…………………………………………………………………B1

Innovation Project Annual and Final Reports…………………………………C1

Innovation Introduction

Innovation is the component of the Three-Year Program and Expenditure Plan that funds new or different patterns of service that contribute to informing the mental health system of care as to best or promising practices that can be subsequently added or incorporated into the system. Innovative projects for CCBHS are developed by an ongoing Community Program Planning Process that is sponsored by the Consolidated Planning Advisory Workgroup (CPAW) through its Innovation Committee.

New Innovation Regulations went into effect in October 2015. As before, Innovative projects accomplish one or more of the following objectives: a) increase access to underserved groups, b) increase the quality of services, to include better outcomes, c) promote interagency collaboration, or d) increase access to services. While Innovation projects have always been time-limited, the Innovation Regulations have placed a five-year time limit on all projects. During FYs 2015-16 and 16-17, CCBHS staff and stakeholders reviewed and ensured that all existing and emerging Innovation projects complied with the Innovation Regulations.

Approved Programs

The following programs have been approved, implemented, and funds have been allocated for Fiscal Year 2019-20:

1) Center for Recovery and Empowerment (CORE). CCBHS recognizes substance abuse/dependence in adolescence as it negatively affects physical, social, emotional and cognitive development. Early onset of alcohol or other drug use is one of the strongest predictors of later substance dependence. This is a priority because CCBHS does not have a coordinated system of care to provide treatment services to youths with substance use and co-occurring mental health disorders. The CORE Project is an intensive outpatient treatment program offering three levels of care: intensive, transitional, and continuing care to adolescents with co-occurring substance use and mental health disorders. Services are provided by a multi-disciplinary team, and include individual, group, and family therapy, as well as linkage to community services. The Center for Recovery and Empowerment project began implementation in FY 2018-19.

2) Cognitive Behavioral Social Skills Training (CBSST). Many consumers spend years residing at County augmented Board and Care (B&C) facilities with little or no mental health treatment provided, and little or no functional improvement taking place. Often this lack of progress results in multiple admissions to the County's Psychiatric Emergency Services and other, more costly, interventions. Cognitive Behavioral Social Skills Training (CBSST) is an emerging practice with demonstrated positive results for persons with severe and persistent mental illness. The CBSST Project applies this therapeutic practice to the population of individuals that have been placed in augmented Board and Care facilities. The CBSST Project includes a clinical team, consisting of a licensed clinician and peer support worker, to lead Cognitive Behavioral Social Skills Training groups at Board and Care facilities. Adults with

serious mental illness learn and practice skills that enable them to achieve and consolidate recovery-based skills. The Cognitive Behavioral Social Skills Training project began implementation in FY 2018-19.

3) Overcoming Transportation Barriers. Transportation challenges provide a constant barrier to accessing mental health services. A comprehensive study was completed via the County's Community Program Planning Process, and a number of needs and strategies were documented. Findings indicated a need for multiple strategies to be combined in a systemic and comprehensive manner. These strategies include training consumers to independently navigate public transportation, providing flexibleresources to assist with transportation costs, educating consumers regarding schedules, costs, and means of various modes of public transportation, and creating a centralized staff response to coordinate efforts and respond to emerging transportation needs. Two Peer Specialists address these needs and provide a means to inform the mental health system of care regarding solutions for improving transportation access to care. The Overcoming Transportation Barriers Project began implementation in FY2016-17.

4) Partners in Aging. Older adults who are frail, homebound, and suffer from mental health issues experience higher rates of isolation, psychiatric emergency interventions, and institutionalization that could be prevented. When fully implemented, this project will field three field-based peer support workers to engage older adults who have been identified by their IMPACT clinicians, primary care providers, or Psychiatric Emergency Services as individuals who need additional staff care in order to avoid repeated crises, engage in ongoing mental health treatment, increase their skills in the activities of daily living, and engage appropriate resources and social networks. The Partners in Aging Projectbegan implementation in FY 2016-17.

The allocations for these projects are summarized below:

Project	County/Contract	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 19-20
Partners in Aging	County Operated	Countywide	45	176,222
Overcoming Transportation Barriers	County Operated	Countywide	200	191,842
Center for Recovery and Empowerment	County Operated	West	80	614,467
Cognitive Behavioral Social Skills Training	County Operated	Countywide	240	168,334
Administrative Support	County	Countywide	Innovation Support	430,184
		Total	*565*	*$1,581,049*

The above concepts have been recommended by the Innovation Committee for development and submittal to the Mental Health Services Oversight and Accountability (MHSOAC) for approval. Detailed project descriptions were submitted to the MHSOAC for approval in a separate document. These concepts have been discussed by stakeholders in this year's Community Program Planning Process and are consistent with stakeholder identified priorities.

The Mental Health Services Act (MHSA) states that five percent of MHSA funds will be used for Innovation Projects. In order to meet this five percent requirement, additional funds will be set aside for the emerging projects listed above.

Innovation (INN) Component Yearly Program Budget Summary for FY 19-20

Projects Implemented			1,581,049
		Total	*$1,581,049*

Aggregate Innovation Demographics

In response to the new Innovative Project Regulations issued in July 2015, per California Code of Regulations, Title 9, Section 3580 and 3580.010, Contra Costa County begun collecting new outcome indicators for all innovation projects. Starting in July 2016, projects started capturing demographic data, such as age group, race/ethnicity, primary language and sexual orientation. This data defines outreach to all underserved populations for the current fiscal year. Data not included in this report can be found within the innovation annual reports submitted in this document.

Total Served FY 19/20 = 128

Out of 128 total clients served 6 Demographics Forms were submitted for current fiscal year.

Table 1. Age Group

	# Served	
Child (0-15)	0	
Transition Age Youth (16-25)	0	
Adult (26-59)	3	
Older Adult (60+)	3	
Decline to State	0	

Table 2. Primary Language

	# Served	
English	6	
Spanish	0	
Other	0	
Decline to State	0	

Table 3. Race		
	# Served	
More than one Race	1	
American Indian/Alaska Native	0	
Asian	0	
Black or African American	1	
White or Caucasian	3	
Hispanic or Latino/A	1	
Native Hawaiian or Other Pacific Islander	0	
Other	0	
Decline to State	0	

Table 4. Ethnicity (If Non-Hispanic or Latino/A)		
	# Served	
African	0	
Asian Indian/South Asian	0	
Cambodian	0	
Chinese	0	
Eastern European	0	
European	2	
Filipino	0	
Japanese	0	
Korean	0	
Middle Eastern	0	
Vietnamese	0	
More than one Ethnicity	2	
Decline to State	0	
Other	0	

Table 5. **Ethnicity (If Hispanic or Latino/a)**		
	# Served	
Caribbean	0	
Central American	1	
Mexican/Mexican American /Chicano	1	
Puerto Rican	0	
South American	0	
Other	0	

Table 6. **Sexual Orientation**		
	# Served	
Heterosexual or Strait	4	
Gay or Lesbian	1	
Bisexual	0	
Queer	0	
Questioning or Unsure of Sexual Orientation	0	
Another Sexual Orientation	0	
Decline to State	1	

Table 7. **Gender Assigned Sex at Birth**		
	# Served	
Male	2	
Female	4	
Decline to State	0	

Table 8. **Current Gender Identity**		
	# Served	
Man	2	
Woman	4	
Transgender	0	
Genderqueer	0	

Questioning or Unsure of Gender Identity	0	
Another Gender Identity	0	
Decline to State	0	

Table 9. Active Military Status

	# Served	
Yes	0	
No	6	
Decline to State	0	

Table 10. Veteran Status

	# Served	
Yes	0	
No	6	
Decline to State	0	

Table 11. Disability Status

	# Served	
Yes	4	
No	2	
Decline to State	0	

Table 12. Description of Disability Status

	# Served	
Difficulty Seeing	0	
Difficulty Hearing or Having Speech Understood	0	
Physical/Mobility	1	
Chronic Health Condition	1	
Other	2	

Table 13. Cognitive Disability

	# Served	
Yes	0	
No	0	

Program Profiles

Center for Recovery and Empowerment B2

Cognitive Behavioral Social Skills Training in Augmented Board and Cares........ B3

Overcoming Transportation Barriers B4

Partners in Aging… B5

Program: Center for Recovery and Empowerment (CORE)

The Center for Recovery and Empowerment (CORE) program is an intensive outpatient treatment program that contains three levels of care: intensive, transitional, and continuing care. Because recovery is not linear, teens are able to move between these levels of care depending on their need. These levels of care begin with an Intensive Care phase of treatment, where teens attend the program four days a week and family members attend twice weekly. An individual treatment plan and attendance contract with the teen is developed, and they are drug tested weekly to encourage honesty and accountability. The 12-Step principles of recovery are introduced through educational presentations and weekly individual and group sessions facilitated by therapists and counselors. Teens are then linked with Young People's 12-Step in the community to begin building connections with a sober peer group that will continue to be a support for ongoing recovery. Phone contact is maintained between CORE staff and client on offsite days.

a. **Target Population:** Adolescents between the ages of 14-17 with substance use disorders and co-occurring mental health disorders will be the targeted group.
b. **Total MHSA Funding for FY 2019/20:** $619,579
c. **MHSA-funded Staff:** 5.0 Full-time 1.0 Part-time equivalents
d. **Total Number served**: For FY 19/20: 11 individuals
e. **Outcomes**:
    - Evaluation of the program included pre- and post-enrollment of T-ASI indicators.
    - Other proposed indicators include utilization rate of involuntary Psychiatric Emergency Services admissions and/or acute psychiatric admissions.
    - Child and Adolescent Level of Care Utilization System (CALOCUS).

Program: Cognitive Behavioral Social Skills Training in Augmented Board and Cares (CBSST)

The CBSST project will involve having a team designed of one Mental Health Clinical Specialist (MHCS) and one Community Support Worker (CSW) whose primary responsibility will be to lead CBSST groups at Board and Care's (B&C's) that house Contra Costa County (CCC) consumers. CBSST is a combination of Cognitive Behavioral Therapy (CBT) Social Skills Training (SST) and Problem-Solving Therapy (PST). This differs from traditional CBT because it not only includes the general concepts of CBT, which focus on the relationships between thoughts, but works with improving communication skills through SST and basic problem-solving skills through (PST). This intervention will be new to the public mental health system and currently has only been implemented in private hospitals or universities.

f. **Target Population:** Adults aged 18 years and older who are currently living in Board and Care Homes, receiving services at a County-operated Adult clinic, and are diagnosed with a serious mental illness.
g. **Total MHSA Funding for FY 2019/20:** $168,334
h. **MHSA-funded Staff:** 2.0 Full-time equivalents
i. **Total Number served**: For FY 19/20: 30
j. **Outcomes**:
    - Patient Health Questionnaire (PHQ-9) and Generalized Anxiety Disorder (GAD-7) will be given to all group participants.
    - Additional measuring tools would include the Recovery Assessment Scale (RAS) and the Independent Living Skills Survey (ILSS).
    - Clinic and agency case managers are asked to fill out the Level of Care Utilization System (LOCUS).
    - 5150's will be tracked for pre/post data and length of hospital stay.

Program: Overcoming Transportation Barriers

The Overcoming Transportation Barriers (OTB) program is a systemic approach to develop an effective consumer-driven transportation infrastructure that supports the entire behavioral 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 consumers. The program targets consumers throughout the behavioral health system of care.

a. **Target Population:** Consumers of public mental health services and their families; the general public.
b. **Total MHSA Funding for FY 2019/20:** $191,842
c. **MHSA-funded Staff:** 2.0 full-time equivalents
d. **Total Number served**: For FY 19/20: 55 encounters
e. **Outcomes**:
    - Increased access to wellness and empowerment knowledge and skills by consumers of mental health services.
    - Decreased stigma and discrimination associated with mental illness.
    - Increased acceptance and inclusion of mental health consumers in all domains of the community.

Program: Partners in Aging

Partners in Aging is an Innovation Project that was implemented on September 1, 2016. Partners in Aging consists of up to two Community Support Workers (CSWs), up to three 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 Alcohol and Other Drugs services. Peer support, rehab, and in-home and in-community coaching will allow the skills learned through psychotherapy to be practiced in the community. Partners in Aging also to provided SBIRT (Screening, Brief Intervention, and Referral to Treatment) services and referrals to IMPACT consumers who screen positive for alcohol or drug misuse.

Community Support Workers and Student Interns provide linkage, in-home and community-based peer support, and health/mental health coaching to consumers open to or referred to the IMPACT program. In addition, the CSWs and Student Interns provided outreach to staff at Psychiatric Emergency Services (PES) and Miller Wellness Center (MWC). They were available to meet with consumers at PES and MWC that meet the criteria for IMPACT to provide outreach, and linkage to services. The Student Interns also provide brief AOD screening and referrals, as well as conducting intakes, assessments, and providing individual psychotherapy. Additionally, a Gero-psychiatrist is available 8 hours/week to provide consultation, and in-person evaluations of IMPACT clients.

a. **Target Population:** The target population for the IMPACT Program is adults age 55 years and older who are insured by Medi-Cal, Medi-Cal and MediCare, or are uninsured. The program focused on treating older adults with moderate to severe 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.
b. **Total MHSA Funding for FY 2019/20:** $176,222
c. **MHSA-funded Staff:** 2.0 full-time equivalents
d. **Total Number served**: For FY 19/20: 32
e. **Outcomes**:
    - Reductions in Level of Care Utilization System (LOCUS) scores.
    - Reductions in Psychiatric Emergency Service visits and hospitalizations.
    - Decreased Patient Health Questionnaire (PHQ-9) scores.

Innovation Project Annual and Final Reports

Center for Recovery and Empowerment C2

Cognitive Behavioral Social Skills Training in Augmented Board & Cares C9

Overcoming Transportation Barriers C17

Partners in Aging C24

CONTRA COSTA
HEALTH SERVICES

Contra Costa Behavioral Health
Mental Health Services Act
1340 Arnold Dr, Suite 126
MARTINEZ, CA 94553-4639
PH: (925) 313-9525 FAX: (925) 957-5156 E-MAIL:
Jennifer.bruggeman@cchealth.org

INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: 2019/20

Agency/Project Name: **Center for Recovery and Empowerment (CORE)**

INNOVATIVE PROJECT TYPE:

*Please check **all** that apply:* ☐PEI – *services for individuals at risk of SMI/SED* **X** CSS – *services for individuals with SMI/SED*

SERVICES PROVIDED:

Please describe the services you provided in the past reporting period.

The Center for Recovery and Empowerment (CORE) Project is an intensive outpatient treatment program located in West Contra Costa County for adolescents with co-occurring substance use (SUD) and mental health disorders. CORE follows the disease model of addiction describing addiction as a disease associated with biological and neurological sources of origin. CORE provides a multitude of full-day services to youth that include individual therapy, family therapy, group therapy, nursing (including medication management and toxicology screening), social skills training, high school education support, adventure therapy, connection to community recovery services, transportation, and healthy meal and nutrition education.

Referrals to the CORE program are made by psychiatrists, social workers, school counselors and nurses, probation, Kaiser, John Muir Behavioral Health Center, community-based organizations or self-referrals. Referrals are initially screened over the phone by the Program Supervisor or other dedicated staff and then the client and/or family member are asked to come to the center for an assessment. To be accepted into the project, clients need to meet an appropriate mental health diagnosis, SUD level of need and willingness/ability of client and family (if appropriate) to participate in program. Once admitted, program enrollment and on-site treatment begin.

Day program schedule is as follows:

1) Transportation provided by van pick-up
2) Check-in with teacher for Golden Gate School Program
3) Complete Daily Goals Worksheet
4) School
5) Lunch and social skills integration

CONTRA COSTA
HEALTH SERVICES

Contra Costa Behavioral Health
Mental Health Services Act
1340 Arnold Dr, Suite 126
MARTINEZ, CA 94553-4639
PH: (925) 313-9525 FAX: (925) 957-5156 E-MAIL:
Jennifer.bruggeman@cchealth.org

6) Individual therapy – clients are pulled from milieu twice a week, or as needed throughout the day.
7) Group therapy: Moral Reconation Therapy – 1x/week, Recovery Assignments are done in group 5x/week
8) Toxicology screening and individual consultation with nurse to discuss results 1x/week
9) Adventure Therapy – ecotherapy, mindfulness, and recreational activities for youth after lunch
10) Family therapy – Family therapy is conducted 1x/week per client in the late afternoon or evening
11) Community recovery meetings – Clients are transported to and from Young People in Alcoholics Anonymous (YPAA) meetings 2x/week. They attend with Recovery Coach and work with an individual sponsor from YPAA
12) Sober social events – Clients attend social sober events, weekly, in order to develop and establish a sober peer group. These events are sponsored by YPAA and linkage is provided by Recovery Coach. They include events such as sober dances, parties, bowling, dinners, camping, etc.

Service Impact from Shelter-in-Place Restrictions (COVID-19)

Services offered through the CORE program were significantly impacted by COVID-19. In-person programming was suspended when the Shelter-In-Place went into effect on March 16, 2020. Clients were provided with telephonic support and resources while the center was temporarily closed. In June 2020, half-day in-person services commenced, as permitted by safety protocols, and the program was able to resume a modified curriculum. In-person services primarily included the adventure therapy component, including bike rides and other outdoor activities. Education support through Golden Gate Schools and YPAA meetings were offered daily via Zoom. Individual therapy was provided via telehealth. Some key services such as sober social events were difficult to provide during COVID, due to public safety precautions. In addition, the program experienced high staff turn-over.

LESSONS LEARNED:

Please describe any lessons learned (positive and negative) throughout the implementation of this project. If applicable, how have you used these lessons to change the model?

Many obstacles were faced for this project during the 19-20 fiscal year, particularly around staffing. A new Mental Health Clinical Specialist started on July 5, 2019 which brought the program to a nearly full staffing pattern as outlined in the concept. Unfortunately, in January and February of 2020 both the original Mental Health Clinical Specialist and the Psychiatric Nurse Practitioner left the program, making it very challenging to continue providing the full scope of services. Problems with staffing continued to develop and it became difficult to fill positions, particularly during COVID. At the time this report was written, all of the original staff left the program. A workgroup has been established which includes leadership from Behavioral Health Services and Substance Use Disorder departments, to create a strategy and plan around filling positions and restructuring the project. Future goals for CORE include providing more direct clinical and administrative support and oversight, as the program is in a stand-alone location. Workflows and policies are being reviewed to allow for greater enrollment and program completion/success. In addition, feedback has been solicited from former

families and participants, in an effort to improve parent & family support and engagement.

Another obstacle that developed due to COVID was the inability to deliver core elements of the program that were not conducive to telehealth or virtual platforms. Many work-arounds had to be implemented to keep clients present and engaged. For example, there was low attendance when YPAA meetings initially went to a virtual platform and students were asked to participate from home. The Community Support Worker began picking kids up and offering YPAA Meetings on the large screen television in main room at the CORE site. Another work around involved the food program, which occurred on Wednesdays prior to COVID. An agency called White Pony delivered food to the CORE site for youth and their families. When the center closed due to COVID, staff began delivering food to families at home. This helped keep families engaged in the program and provided some support to those struggling financially due to the pandemic.

PROJECT CHANGES: ☐ No changes

Please explain whether any changes were made to the Innovative Project during the reporting periodand the reasons for the changes, if applicable.

Many staffing changes have occurred over the project's term, particularly during the reported fiscal year. High staff turnover created challenges in providing services to fidelity of the model. This was particularly true for substance use related programming, and such services sometimes had to be referred out to other agencies.

Regarding groups, staff learned that certain formats worked better than others. Mindfulness was introduced into groups, following the guidelines of the UCLA Mindfulness Project. The group therapist was trained in the project and began providing many new techniques including meditation and different creative measures to use as coping tools. Groups also resumed outside on the patio with families and caregivers. Moving forward, staff want to incorporate further parent-to-parent support groups that include a psycho-education feature.

Originally, the project outline consisted of three levels, in which the clients would be in each level for 12-weeks. As the project progressed, it was determined that this duration should be shortened to eight weeks. This would allow for quicker movement into the next phase and also allow for the mentorship portion of the project to be rolled out sooner to increase flow between levels.

At the time this report was written, further minor modifications to the program were being considered. A workgroup was established to review existing policies and procedures. Changes will be reflected in the next (FY20-21) annual report. Stakeholder involvement and feedback related to the project is additionally garnered through the Consolidated Planning and Advisory Workgroup (CPAW) meeting and Innovation CPAW Sub-Committee meeting.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- *What are the learning goals of theproject?*

Contra Costa Behavioral Health
Mental Health Services Act
1340 Arnold Dr, Suite 126
MARTINEZ, CA 94553-4639
PH: (925) 313-9525 FAX: (925) 957-5156 E-MAIL:
Jennifer.bruggeman@cchealth.org

- *Which elements of the project are contributing to outcomes?*
- *List of indicators measured; including results and an explanation as to how often data was collected and analyzed.*

The learning goals of the project are to see if treating adolescents with substance related and co-occurring mental health conditions in an ASAM compliant intensive outpatient program will 1) result in abstinence or reduced use of substance; 2) reduce symptoms of mental illness; 3) reduce/prevent need for/or return to inpatient mental health/substance dependence treatment; 4) increase academic success.

Assessment Tool. This project used the Teen Addiction Severity Index (T-ASI) to measure many of its outcome goals upon enrollment and at discharge. The T-ASI can be defined as a semi-structured interview tool that was developed to fill the need for a reliable, valid, and standardized instrument for a periodic evaluation of adolescent substance abuse. The T-ASI uses a multidimensional approach to assessment and is an age-appropriate modification of the Addiction Severity Index. It yields 70 ratings in seven domains: chemical (substance) use, school status, employment/support status, family relations, peer/social relationships, legal status, and psychiatric status.[1]

Demographics. During the 19-20 FY, the program served a total of 11 youth (four males and seven females). They ranged in age from 14 – 17 years old, with an average age of 15.4 years. Nine of the youth enrolled (82%) identified as being of LatinX/Hispanic decent and 2 (18%) identified as African American. Approximately 90% were from the West County (Richmond) region of the county and 10% from Central County (Martinez). Duration of time enrolled in the program ranged from approximately one week to one year, with an average enrollment of 3.5 months.

Learning Goal Outcomes:

Learning Goal #1: Abstinence or reduced substance use
All clients enrolled in the program during the reporting period who completed both a pre- and post- T-ASI assessment (n=7) reported a reduction in substance use. All were able to attain stretches of sobriety that were longer than reported in the year prior to enrollment in the program. Program leadership is considering moving to a harm reduction model, to allow clients to stay enrolled in the program (if they are motivated to so), even if they have a relapse or if a family member is using substances.

Learning Goal #2: Reduce symptoms of mental illness
Of clients enrolled in the program during the reporting period who completed both a pre- and post- T-ASI assessment (n=7), 57% reported a reduction in number of days during the month that they experienced symptoms of a mental illness. The remaining 42% reported no change in mental health symptoms. None reported an increase in symptoms.

Learning Goal #3: Reduce the need for in-patient mental health/substance abuse treatment
Of the clients enrolled in the program during the reporting period (n=11), three (or 27%) had contact with the Mobile Crisis Response Team or were evaluated at Psychiatric Emergency Services (PES)

CONTRA COSTA HEALTH SERVICES

Contra Costa Behavioral Health
Mental Health Services Act
1340 Arnold Dr, Suite 126
MARTINEZ, CA 94553-4639
PH: (925) 313-9525 FAX: (925) 957-5156 E-MAIL:
Jennifer.bruggeman@cchealth.org

during enrollment or within one year post enrollment. One was connected to Juvenile Probation within the year following discharge from CORE.

Learning Goal #4: Increase academic success
Of clients enrolled in the program during the reporting period who completed both a pre- and post- T-ASI assessment (n=7), six (86%) reported an improvement in school attendance and/or grades. One reported no change.

Other observations regarding data. Peer & Family Relationships are another key data point measured in the T-ASI. The majority of students reported an improvement in peer and family relationships, marked by less conflict with parents and friends. Youth who were enrolled for longer periods of time also reported choosing friends who engage in less substance use.

LINKAGE AND FOLLOW-UP: ☐ Not applicable
Please explain how participants are linked to mental health and/or support services, including, how the INN program follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

CORE provides an extensive intake process upon enrollment. If the program cannot meet the needs of the client, they may be referred out to various other services. Besides residential SUD, CORE refers youth and parents/providers on behalf of youth to the following:

- WCCAS (West County Child & Adolescent Services) mental health
- WCCAS outpatient SUD
- PES
- Seneca Mobile Response Team
- Kaiser CDRC
- John Muir Behavioral Health
- EBYPAA
- Young People Narcotics Anonymous
- REACH
- Hanna Boys Center (residential but not primarily SUD)
- Rebekah House (residential but not primarily SUD)
- RYSE Center
- MISSEY (for CSEC youth)
- Golden Gate Schools/County Office of Education - Alternative Education
- Contra Costa County Child & Family Services (CFS)
- First Hope
- James Morehouse Project
- Behavioral Health Access Line
- West County Health Center
- Richmond Works Program
- West County High Schools Health Centers

Contra Costa Behavioral Health
Mental Health Services Act
1340 Arnold Dr, Suite 126
MARTINEZ, CA 94553-4639
PH: (925) 313-9525 FAX: (925) 957-5156 E-MAIL:
Jennifer.bruggeman@cchealth.org

- Monument Crisis Center
- Familias Unidas
- Latina Center

If a client is enrolled in the program and needs additional services specifically in phase two, they may be referred to activities such as sports, art, dance, summer jobs and other similar programs. There is no lapse in referral time therefore this is not a measured outcome.

VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of project participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

Case Vignette 1:

Al (pseudonym) is a 17-year-old Latinx male. His preferred pronouns are he/him/his.
Al lives with his mother and a younger sibling. He has minimal contact with his biological father. Al had been expelled for using substances at school. He had several physical altercations with peers at school. He was failing all of his classes. Per parent's report, client was leaving home without permission. Al and his mother would argue frequently about his grades and cannabis use. His mother found cannabis vape pens in his room. Parent contacted the program in the fall. Al agreed to participate and attend the intensive outpatient program at CORE. Al's attendance was inconsistent in the beginning. CORE staff met with Al and his mother to problem-solve regarding his attendance. Al and his mother agreed they would make a commitment to participate. Al would attend the program daily. Parent would wait with Al for the CORE van to arrive at his home. Al took an interest in his classes with the help of a tutor from the Golden Gate Day school. He started earning his high school credits and improved his grades. He participated in daily bike rides, walks and hikes with the adventure therapist. Al shared he enjoys riding bikes with the group. He participated in a weekly mindfulness group. He participated in a bi-weekly peer recovery group. He participated in individual therapy as well as family sessions with his parent. He met with the peer recovery coach daily. He reduced his use of cannabis and eventually stopped using cannabis daily. Per parent report, the client no longer leaves home without permission, and they argue less. Al has a goal to participate in a youth employment program this summer. Al wants to apply for Job Corps next fall.

Case Vignette 2:

Andrea (pseudonym) is a 17-year-old Latinx female. Her preferred pronouns are her/she/hers.
Andrea lives with her parents. She is an only child. Andrea was skipping school, stealing money from her parents, and failing her classes. She was rude and disrespectful to teachers and school staff. She would leave her house when her family was sleeping. Andrea would go out with peers to parties. She would use alcohol, methamphetamine and cannabis. Andrea's parents were extremely worried about her safety and substance use. Andrea had conflicts with her parents daily. She would yell, curse, and leave home. Her parents called CORE and scheduled an intake. Andrea denied having issues with substances. She blamed her parents for making such a big deal. Andrea had challenges when she

Contra Costa Behavioral Health
Mental Health Services Act
1340 Arnold Dr, Suite 126
MARTINEZ, CA 94553-4639
PH: (925) 313-9525 FAX: (925) 957-5156 E-MAIL:
Jennifer.bruggeman@cchealth.org

started the CORE program. She would refuse to participate in the groups. She would yell at staff. It took her a month to adjust to the routine and schedule of CORE. She met with the substance use counselor and the peer recovery coach daily. She participated in socialization groups, mindfulness groups and recovery groups daily. She slowly started to share in the recovery groups and learned about the 12 steps of recovery. Andrea became interested in school. Andrea would turn in her assignments and took pride in her work. The teacher shared that Andrea was a quick learner and a good student. Andrea responded well to praise from the teacher and staff at CORE. Andrea participated in individual and family sessions weekly. Andrea and her parent's relationship improved over time. She set a goal for herself of getting in good physical shape. She participated in daily hikes and bike rides with the adventure therapist. She enjoyed the once-a-week visits to the gym. Andrea became a leader among her peers. She started talking about her recovery and not wanting to use substances. She showed off the 30-day chip she earned at a recovery meeting. Andrea has a year and six months of being sober. Andrea's grades are A's, and she is on track to graduate from high school. She is interested in going to college. Andrea participated in the summer Youth Works program. She received positive feedback from the work site. Andrea was invited to return next summer.

---

1. Kaminer, Y., Wagner, E., Plumer, B. & Seifer, R. (1993). Validation of the teen addiction severity index (T-ASI): Preliminary findings. *American Journal on Addictions, 2(3)*, 250-254.

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA MENTAL HEALTH
Mental Health Services Act
1340 Arnold Dr. Suite#200
Martinez, CA 94553-4639
E-mail::Windy.Taylor@cchealth.org

INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: 19/20

Agency/Program Name: Contra Costa Behavioral Health/Cognitive Behavioral Social Skills Training in Augmented Board and Cares

INNOVATIVE PROJECT TYPE:

*Please check **all** that apply:* ☐PEI – services for individuals at risk of SMI/SED X CSS – services for individuals with SMI/SED

SERVICES PROVIDED:
Please describe the services you provided in the past reporting period.

Cognitive Behavioral Social Skills Training (CBSST) in Augmented Board and Cares can be described as a new emerging practice that consists of a combination of Cognitive Behavioral Therapy (CBT), Social Skills Training (SST) and Problem Solving Therapy (PST) in the County's Board and Care Homes (B&C's). The project involves a team designed of one Mental Health Clinical Specialist (MHCS) and one Community Support Worker (CSW) whose primary responsibility is to lead CBSST groups at B&C's that house Contra Costa County (CCC) consumers.

At the beginning of this fiscal year, the project was underway and serving six B&C's located throughout the county. This included both group and individual rehabilitation services. The individual services were provided by either the MHCS or the CSW. The team completed the first module during February and were beginning to start the second module in March when the risk of COVID-19 impacted further care. Through June there was still a mix of supportive contact with individual rehabilitation. Additionally, the team continued to work with clients for crisis informed care.

The CBSST project is designed to enhance the quality of life for those residing in B&C's by incorporating meaningful activity and skills into their daily routines and increasing overall functional improvement. As of this fiscal year, the project has provided the following services:

- Served six small (6-bed) ARF's (adult residential facilities)
- Served 1 large (70-bed) RCFE (residential center for the elderly)
- Provided CBSST individual and group rehabilitation services to 30 individuals
- Support to Board and Care operators (psychoeducation, partnering on goals utilizing CBSST framework and skills, consultation re: concerns/consumer needs)
- Collateral with Board and Care Operators

From April - June the team received training around how to talk with the B&C operators about best practices for infection control due to the risk of COVID-19. This included site visits and working with

CONTRA COSTA MENTAL HEALTH
Mental Health Services Act
1340 Arnold Dr. Suite#200
Martinez, CA 94553-4639
E-mail::Windy.Taylor@cchealth.org

B&C's to ensure survey completion. The surveys included information about Personal Protective Equipment (PPE) needs. The team delivered PPE to the sites to ensure safety and helped manage fears around new Shelter-in-Place guidelines by providing psycho-education and support.

LESSONS LEARNED:
Please describe any lessons learned (positive and negative) throughout the implementation of this project. If applicable, how have you used these lessons to change the model?

The process of working with working with B&C operators (from engagement to completion of all three modules) expanded from ten months to one year. This was due to the engagement period taking longer than initially anticipated, as well as the length of time it took to work through each module. The goal setting process took approximately three weeks and then module content was repeated to consolidate learning, due to a significant number of clients presenting with cognitive impairment and/or symptoms interfering with learning. Going at a slower pace improved clients' ability to absorb and retain information, as well as strengthening the therapeutic relationship.

During the Shelter-in-Place restrictions, there was more opportunity to work with individuals one on one. Staff discovered some people did better with this type of engagement. It signified to the team that this service should be investigated further because it provided more time for individual processing of the modules. It also allowed those who were reluctant or less able to participate in group due to symptoms of their mental illness such as paranoia, thought blocking, or active auditory hallucinations, to engage more successfully with providers and better learn content. Individual rehabilitation with people through telehealth (virtual) platform also worked very well. In some cases, it was a preference for clients. Some challenges did arise around using Zoom, such as access to electronic devices or wi-fi, a learning curve around how to navigate the platform, and low-quality audio or video connection.

The team held some in-person sessions in backyards or other outdoor settings. Some clients had challenges with social distancing and mask requirements, and for some, in-person meetings increased their anxiety. Excessive heat also led to cancelling outdoor sessions. The team decided that overall Zoom seem to work better for most encounters.

PROJECT CHANGES: ☐ No changes
Please explain whether any changes were made to the Innovative Project during the reporting periodand the reasons for the changes, if applicable.

The project has experienced a decrease in the number of B&C's served, due to only one client being involved in the project at a particular site. When that client transitioned out of the project to work directly with his case manager, there was no longer a need to include that B&C.

When Shelter-in-Place restrictions began, the team figured out how to successfully work with clients to use technology and operate Zoom. They shared these resources with the mental health clinics which helped to continue additional services within the system.

CONTRA COSTA MENTAL HEALTH
Mental Health Services Act
1340 Arnold Dr. Suite#200
Martinez, CA 94553-4639
E-mail::Windy.Taylor@cchealth.org

The closing of one B&C required the team to transition clients to other living situations. These clients were stepped down and the team used the Problem-Solving Skills module to help with this transition. Clients were transitioned to alternative housing such as MHSA Housing, Room and Board, other B&C's and one client moved in with her family.

When clients got to module three, the team started to incorporate outings into the curriculum. Two trips included picnics that were located at local regional parks. As a group, they would plan the event including, menu, transportation, and any activities they wanted to do while there. This involved coordinating with staff and using skills they learned in the modules. Two outings were planned to visit different museums right before COVID, but plans had to be postponed due to the Shelter-in-Place.

OUTCOMES AND PROJECT EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- *What are the learning goals of the project?*
- *Which elements of the project are contributing to outcomes?*
- *List of indicators measured; including results and an explanation as to how often data was collected and analyzed.*

The goals of the project are to learn the following:

1) Will the modality of CBSST have an effect on the consumer's mental stability and growth?

2) Will the intervention lead to a higher overall functionality and quality of life?

3) Will the intervention reduce 5150 involuntary holds?

4) Will a client change level of service within placement?

5) Will client maintain placement?

In the first stages of this project we explored the use of four surveys to measure impact on participants' symptoms, self-perception and functioning. These include:

- **PHQ-9 (Patient Health Questionnaire)** assessment monitoring presence/severity of depressive symptoms (self-report, self-administer) – Pre and post each module
- **GAD-7 (Generalized Anxiety Disorder)** assessment monitoring presence/severity of anxiety symptoms (self-report, self-administer) pre and post each module
- **RAS (Recovery Assessment Scale)** assessment measuring aspects of recovery with focus on hope and self-determination (self-report) Pre and post each module
- **ILSS (Independent Living Skills Survey)** assessment obtaining individual's view of his/her own community adjustment (self-report structured interview) Pre and post for all three modules. Only administered once all three modules were completed.

CONTRA COSTA MENTAL HEALTH
Mental Health Services Act
1340 Arnold Dr. Suite#200
Martinez, CA 94553-4639
E-mail::Windy.Taylor@cchealth.org

We adopted the PHQ-9 and GAD-7 to align with tools utilized in the regional specialty mental health clinics to track symptoms for all clients. Use of the ILSS aligns with the clinics' use of this tool to assess functional impairment primarily for individuals with schizophrenia-related diagnoses. Using the RAS aligns with our goal of increasing recovery orientation for project participants. In line with the recovery model, this assessment looks beyond "what's wrong" to participants' view of their own capabilities, hopes and sense of self. We met with an Evidence Based Practice Workgroup and CBSST lead staff in the clinics and discussed adding an addendum to the ILSS. We came up with additional questions for specific components such as leisure and community, that seemed more relevant to consumers' actual experiences.

We attempted to have participants complete all assessments prior to beginning the program, as well as after completing the program (all 3 modules). We also implemented the PHQ-9/GAD-7/RAS after completion of the first and second modules.

Strengths of the tools used: Surveys create an opportunity and platform that has a consistent structure, for more in-depth conversation about participants' well-being. The PHQ-9/GAD-7 in particular seemed most helpful as a way to flag any uptick in symptoms. The RAS provides insight into cognitions/beliefs that may be "unhelpful thoughts" that CBSST participants can work on challenging, while also insight into participants' own view of strengths they can tap into. And the ILSS identifies issues to tackle and because it is an interview format, can allow for space to discuss where participants hope to make changes and build independent skills. These discussions can relate directly to the goal setting work of CBSST.

Lessons learned: Surveys, especially PHQ-9/GAD-7, may feel intrusive and are better completed when not linked to group sessions. The responses are less likely to be genuine until trust is gained. Completing with an individual one on one and reviewing each question out loud supports comprehension of the questions, increases completion rate and hopefully validity of responses, and also fosters the aforementioned conversations. For the ILSS, the questions provided are at times outdated and do not capture as wide a range of independent living skills as we observe in participants (e.g., education-related activities).

Table 1: Percent Change in Average PHQ 9 Scores, July 1, 2019 through June 30, 2020

Fiscal Year	Average Score of First Survey of this Fiscal Year	Range	Average Score of Second Survey of this Fiscal Year	Range	Average Score of Third Survey of this Fiscal Year	Range	Percentage of Change
2019/2020 (n=19)	6	(0 to 15)	2.8	(0 to 8)	2.5	(0 to 4)	-58.3%
Board and Care Homes that were not calculated in the totals were missing surveys due to modules not completed.							

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA MENTAL HEALTH
Mental Health Services Act
1340 Arnold Dr. Suite#200
Martinez, CA 94553-4639
E-mail::Windy.Taylor@cchealth.org

PHQ 9 Score Key: 1-4 Minimal Depression, 5-9 Mild Depression, 10-14 Moderate Depression, 15-19 Moderately Severe Depression, 20-27 Severe Depression

Data samples included in this reporting period were minimal due to Shelter-in-Place restrictions from March to end of the fiscal year. All Board and Care homes were included in the sample, but Menona only had one client during the reporting period. Client was only able to complete one round of surveys. Additionally, Family Courtyard did not complete the PHQ-9 during reporting period.

Table 2: Percent Change in Average GAD-7 Scores, July 1, 2019 through June 30, 2020

Fiscal Year	Average Score of First Survey of this Fiscal Year	Range	Average Score of Last Survey of this Fiscal Year	Range	Percentage of Change
2019/2020 (n=26)	5.7	(0 to 17)	4.5	(0 to 17)	-21.0%
Board and Care Homes that were not calculated in the totals were missing surveys due to modules not completed.					
GAD-& Score Key: 0-4 Minimal Anxiety, 5-9 Mild Anxiety, 10-14 Moderate Anxiety, 15-21 Severe Anxiety					

LINKAGE AND FOLLOW-UP: ☐ Not applicable

Please explain how participants are linked to mental health and/or support services, including, how the INN Project follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

All clients that participate in the CBSST group sessions are clients that are connected to the County behavioral health clinics. Many have psychiatrists and/or case managers and have regularly scheduled visits. If a client is not participating in services and needs to be linked the CBSST provider will proceed with linking the client with necessary services toward improving treatment outcomes. This can include the CBSST provider reaching out to clients' assigned clinic and collaborating to engage client with different types of service connections. The CBSST team also advocates with clinics for providing the appropriate level of service (i.e. case management services instead of money management services), as well as the optimal level of housing.

VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of Project participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

Perspectives: Board and Care Operator
Feedback on working with program, provided by an owner/operator (Evangeline C.)

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA MENTAL HEALTH
Mental Health Services Act
1340 Arnold Dr. Suite#200
Martinez, CA 94553-4639
E-mail::Windy.Taylor@cchealth.org

I just want to tell you that Johnson Care Home is so fortunate to have you continue to provide us with your program. Working with the CBSST team has made an impact on the residents. It helps them to stay motivated with their future goals. They feel supported. My experience of working with Contra Costa Behavioral Health has been different since working with the CBSST team because we are receiving additional support for our residents. I observed that having CBSST group has helped residents to be connected and get a chance to engage and be able to express themselves in ways because of the group. The residents are comfortable with the CBSST team and if they need to speak to anyone about an issue or need someone to talk to, the CBSST team is the first one they want to call. CBSST team is doing a wonderful job!! We really appreciate having the CBSST team to continue to provide us help for our Board and Care. The team is always responsive.

Perspectives: Janet, CBSST group participant

Janet began participating in a CBSST group at her 6-bed Board and Care in May 2019. As we got started, Janet let us know that she "hadn't enjoyed" CBSST when doing group prior at a different location. She demonstrated some suspiciousness/paranoia regarding engagement with people she didn't know including providers. It's likely that group being held at her home made it easier to give CBSST a second chance.

In December 2019, the operator determined to close the home and retire. Residents had six weeks to find alternative housing. We utilized the "Problem Solving Skills" module of CBSST to help group participants through this transition. Janet initially discussed going back to her previous placement, an enhanced Board and Care, due to fear that she would not have a place to live. Through exploring options in group, however, she became open to the idea of applying for a spot in MHSA-funded shared housing. Historically it has been difficult for consumers living in licensed Board and Cares to access these limited spots, in part because it can be hard to assess whether an applicant is ready when they have not been living independently and demonstrating the necessary skills. We knew Janet well enough due to the intensive nature of our work with her, to advocate with the clinic to consider this level of care. Additionally, we could support her referral directly, rather than wait for a case manager to be assigned in order to refer and possibly lose the bed. Ultimately Janet was approved for the shared housing, avoiding a return to a level of care that she no longer needs.

Janet moved to her new residence, a house she shares with three other women in February 2020, right before the COVID-19 pandemic and Shelter-in-Place began. She has done amazingly well adjusting to her new home, especially given the context of the pandemic. The CBSST team shifted to providing Janet support as an "alumna" of CBSST, through a combination of individual check-ins and joint calls with another alumna/former housemate, who moved to a room and board. We thus could help Janet consolidate what she learned in our program and apply this to her new situation.

As restrictions have recently eased and everyone is vaccinated, Janet was able to invite the CBSST team to her home in April 2021 for an in-person visit. Her pride in a well-maintained living space, the lovely garden she cares for, the meals she shops for and cooks, was wonderful to see.

CONTRA COSTA MENTAL HEALTH
Mental Health Services Act
1340 Arnold Dr. Suite#200
Martinez, CA 94553-4639
E-mail::Windy.Taylor@cchealth.org

Q&A with Janet regarding our program:

What was helpful about group on site at Concord Hill Home? "Catch up on my goals and my wishes, a place to open up and get to know each other, safely."

How was it different from going to a group at the clinic or RI? "More personable and more enjoyable, and I like the subjects. They're good for my health."

What has been helpful about working with our team, including through the move to a new place? "Keeping up the support I needed, and I was able to re-locate safely. I was made sure to be comfortable."

What did or do you like about the curriculum for group? What did you not like? "Every day that we (providers) came and the goals and the three C's." (*There's nothing she didn't like about group)*

What changes would you recommend? "The only changes I would recommend is for you to come more often to have more visits"

Case vignette: Richard

Richard is a 74-year-old male living in Family Courtyard, Residential Center for the Elderly, a 70-bed facility. He participated in CBSST group from the outset in January 2019 through March 2020 when this group ceased due to Covid-19 restrictions. Richard initially had a difficult time identifying personal meaningful goals. He focused instead of his physical health issues that he wanted to manage but did not feel would ever go away. Richard had symptoms of anxiety and depression and a demonstrated sense of hopelessness about his life holding possibility of positive change.

Richard did share, upon assessment and later during group, that he loved music, and had been a performing singer. He talked about his experiences as a young adult doing auditions in Hollywood, as well as performing more recently as a street performer near the UC Berkeley campus. These were fond memories for Richard and clearly a core part of his identity. However, he was pessimistic about having any way to perform again, and dismissive of setting this as a goal.

Richard began to demonstrate confidence in the group as a leader, in terms of understanding the concepts and practicing the skills taught. This shift was particularly noticeable as group focused on the Social Skills module. He also became a leader and a voice amongst the residents who had multiple complaints about feeling unheard by staff in the facility. Richard practiced voicing these concerns in group, in preparation for resident council meetings where he shared complaints with staff.

This confidence developed during the Social Skills module served as a foundation for Richard to turn toward his music as a goal. The (third and final) Problem Solving module saw Richard working on ways to perform again. His girlfriend, another group member, became his "manager" and together they tackled questions of what venues he could approach to perform, how to advertise, even developing a stage name. Richard had always frequented the local library for reading, but often complained about

CONTRA COSTA MENTAL HEALTH
Mental Health Services Act
1340 Arnold Dr. Suite#200
Martinez, CA 94553-4639
E-mail::Windy.Taylor@cchealth.org

the noise level there and wondering if it was worth going. His goal of being a performer rejuvenated his relationship with the library—he printed fliers there, and successfully set up a performance to be held onsite there.

"Rick Starr" was scheduled to perform at the library on March 17th, 2020. This unfortunately was the day before Shelter-in-Place went into effect, and the libraries had already shut down all services. Still, Richard remained hopeful in the weeks to follow that he may have another chance in the future.

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA BEHAVIORAL HEALTH
1340 Arnold Dr Suite#200
MARTINEZ, CA 94553-4639
PH: (925) 957-5148
E-MAIL: windy.taylor@cchealth.org

INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: 2019/20

Agency/Project Name: Contra Costa Behavioral Health/Overcoming Transportation Barriers

INNOVATIVE PROJECT TYPE:

*Please check **all** that apply:* ☐PEI – services for individuals at risk of SMI/SED X CSS – services for individuals with SMI/SED

SERVICES PROVIDED:

Please describe the services you provided in the past reporting period.

The Overcoming Transportation Barriers (OTB) innovation project began implementation in September 2016 and started providing services by April 2017. This project was established to help clients build self-sufficiency and apply independent travel skills while increasing access to mental health services. As of June 30, 2020, 40 clients accessed help from the OTB team for this fiscal year. A total of 15 inquiries were also made by staff in various programs.

Client services received from the OTB team range from peer support, mapping bus routes, links to resources, referrals, and fare information. Application assistance is provided for discount/disabled transit passes, Regional Transit Connection (RTC), Senior Youth Cards and Paratransit. Clients typically access these services by calling the dedicated phone line for transportation assistance. A Commute Navigation Specialist (CNS) assesses their needs and provides one-on-one support on how to access services and get to appointments.

LESSONS LEARNED:

Please describe any lessons learned (positive and negative) throughout the implementation of this project. If applicable, how have you used these lessons to change the model?

During Shelter-in-Place, OTB moved the Community Sub-Committee meetings to a virtual platform via Zoom. The program continued bi-weekly planning meetings and facilitated four of six Community Sub-Committee meetings. At these meetings, it was noted that new participants were gained, while some ongoing participants were lost for various reasons. Sub-Committee members were asked their preferences about continuing meetings via Zoom after Shelter-in-Place. Members requested to have the option of attending either in person or virtually, to accommodate instances in which a participant felt unwell yet wanted to still receive support and stay informed while not having to leave their home.

In the early summer, one of the two Commute Navigation Specialists left her position due to a promotion. Currently the program is operating with 1 FTE and has requested freeze approval to backfill the other position. The OTB workgroup continues to monitor concerns shared by clients while accessing public transit and other transportation resources, as well as staffing a transportation hotline for clients and families/caregivers to seek support.

PROJECT CHANGES: ☐No changes

Please explain whether any changes were made to the Innovative Project during the reporting period and the reasons for the changes, if applicable.

In January 2020, OTB rolled out a Flex Fund initiative at the Central County Adult Mental Health Clinic to helps support clients in attending their mental health appointments. Through a collaboration with a community-based organization, clients receive financial support to cover transportation costs when there is no alternative funding source. Flex funds are for time-limited transportation services or supports and are not intended to pay for ongoing expenditures. Flex funding requests are tracked in a database and reviewed by the OTB team before funding is approved and distributed. It is required that clients have an upcoming appointment and attendance is confirmed. Flex fund distribution is detailed below in the outcomes section.

In March 2020, the Flex Fund effort was suspended due to COVID-19. However, in that short period requests were processed in approximately one week. This is significant because previous flex fund efforts took an excessive amount of time and often did not meet expectations for clients in need.

During the pandemic, and as the project was adjusting to changes, the Commute Navigation Specialists acted as liaisons between County Behavioral Health staff and transit authorities. They analyzed existing County transportation and public transit resources and kept participants up-to-date on the changes in transit systems. This happened via email, as well as announcements at Social Inclusion meetings and Overcoming Transportation Barriers Community Sub-Committee meetings.

Per feedback by clients in the Transportation Sub-Committee, physical wallet/pocket cards were created for clients who experience high-stress situations or need a quick coping strategy. Referenced coping strategies on the cards included: meditation, deep breathing, riding with friends, prayer, listening to music, journaling, reading, and practicing a hobby. Cards were distributed at all CCBHS outpatient clinics and included bus vouchers upon request. Per recommendations from the Sub-Committee, the OTB workgroup revised the wallet cards into trifold wallet cards in both English and Spanish. The OTB brochure that outlines the available services and resources continues to be distributed throughout the clinics and in the welcoming packets for new clients.

Additionally, a request was made to pilot transportation packets for new clients to be provided in the East County Adult Mental Health Clinic. The packets were prepared in English and Spanish and contained a welcoming letter from the Commute Navigation Specialists and an ADA Paratransit application, introduction to BART, transit schedules, Reduced Transit Card application, OTB brochure

CONTRA COSTA BEHAVIORAL HEALTH
1340 Arnold Dr Suite#200
MARTINEZ, CA 94553-4639
PH: (925) 957-5148
E-MAIL: windy.taylor@cchealth.org

and OTB trifold cards.

Posters were also created that depicted transportation services available within the County. These posters were distributed in East County Adult and Children's Clinics. Posters were printed in both English and Spanish and reflected important information around support for filling out transportation paperwork, available peer support, and mapping bus routes. Contact information was also included.

OUTCOMES AND PROJECT EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- *What are the learning goals of the project?*
- *Which elements of the project are contributing to outcomes?*
- *List of indicators measured; including results and an explanation as to how often data was collected and analyzed.*

The goals of the project are to learn the following:

1) To improve service access through client education on transportation usage and encouragement of independent living skills in getting to and from services.

2) To promote efficient use of transportation resources through navigation support: how to use public transit, read transit schedules, plan travel routes, and apply for discount passes.

3) To foster clients' life skills for social engagement, increase productive and meaningful activity, and reduce isolation through the application of learned transportation skills.

4) To increase attendance rates at County-operated clinics by addressing both physical and emotional barriers with the development of solution-focused transportation skills.

5) To reduce stigma through ongoing peer support from Commute Navigation Specialists.

The OTB project started collecting data on April 25, 2017. The data collected for the project provided outcomes showing the type of support provided by the OTB team and where referrals originated. The support included providing resources, referrals and other types of educational training around different modes of transportation.

Exploring a new transportation intervention in the adult system.

Analysis of service improvement survey data and data from our non-clinical PIP has shown that transportation is one of the most frequently identified barriers to appointment adherence. To help address clients' transportation needs, the MHP is planning to pilot a new transportation intervention, providing clients rides to clinic appointments using Round-trip Lyft. In 2019, Contra Costa Health Plan (CCHP)

CONTRA COSTA BEHAVIORAL HEALTH
1340 Arnold Dr Suite#200
MARTINEZ, CA 94553-4639
PH: (925) 957-5148
E-MAIL: windy.taylor@cchealth.org

piloted this intervention with clients enrolled in Whole Person Care (WPC) and found that among clients who were open to Behavioral Health clinics, those who had round-trip Lyft rides scheduled no-showed to appointments at lower rates than those who did not have rides scheduled. CCMHP is working on implementing this intervention with clients scheduled for a co-visit appointment at East County Adult Clinic, the clinic with one of highest no-show rates and most limited transportation options. The pilot is scheduled to begin in early 2020.

Table 1., below included data for client and staff encounters for the last fiscal year. This table defines the types of services the CNS is providing. Additional types of encounters that were added included peer support as well as "other" encounters. Other can be explained as contacts that didn't have a specific outcome. Although, the team made numerous attempts to contact clients they were not always able to provide adequate contact or assistance.

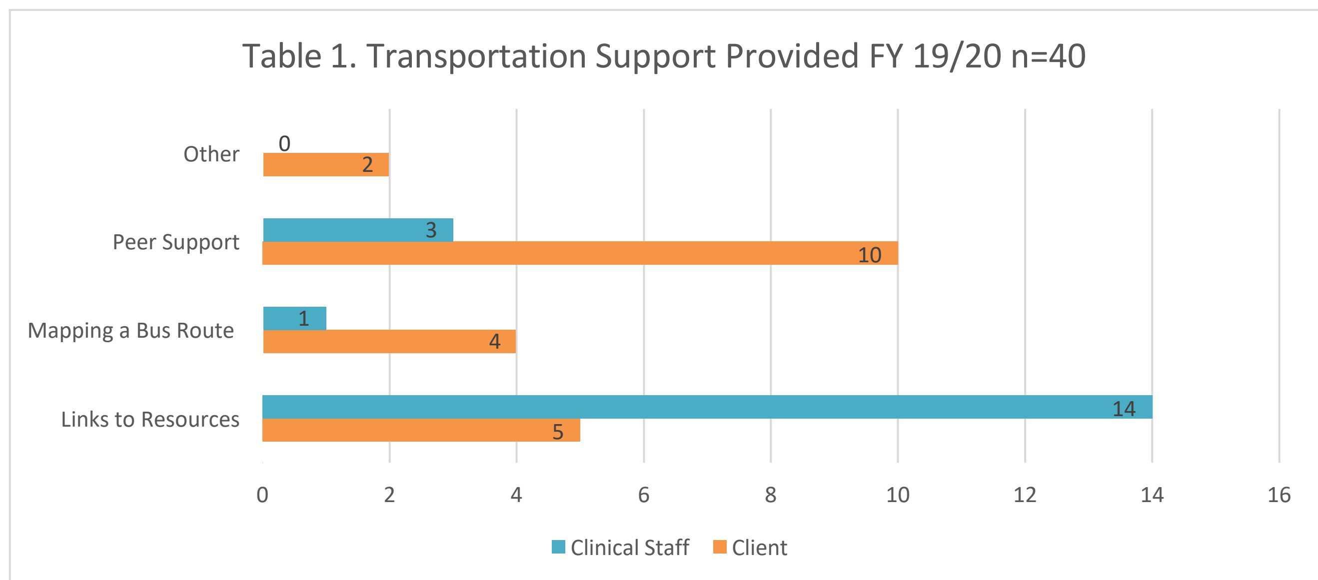


Table 2., below shows total number of calls received by clients and where the referral source originated. Referral source known as "other" describes sources such as family members, friends, word of mouth, presentations or outside therapists.

CONTRA COSTA BEHAVIORAL HEALTH
1340 Arnold Dr Suite#200
MARTINEZ, CA 94553-4639
PH: (925) 957-5148
E-MAIL: windy.taylor@cchealth.org

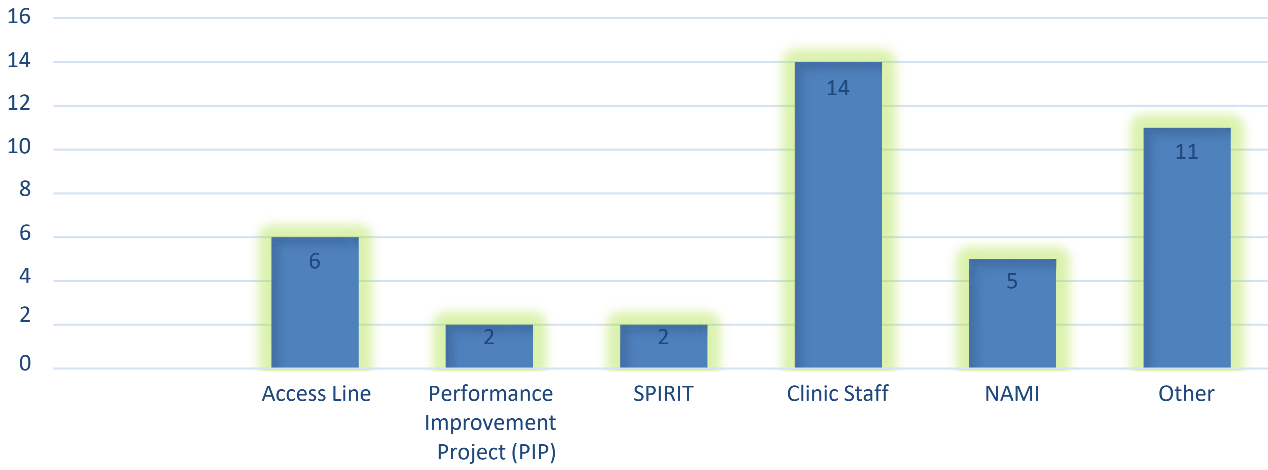
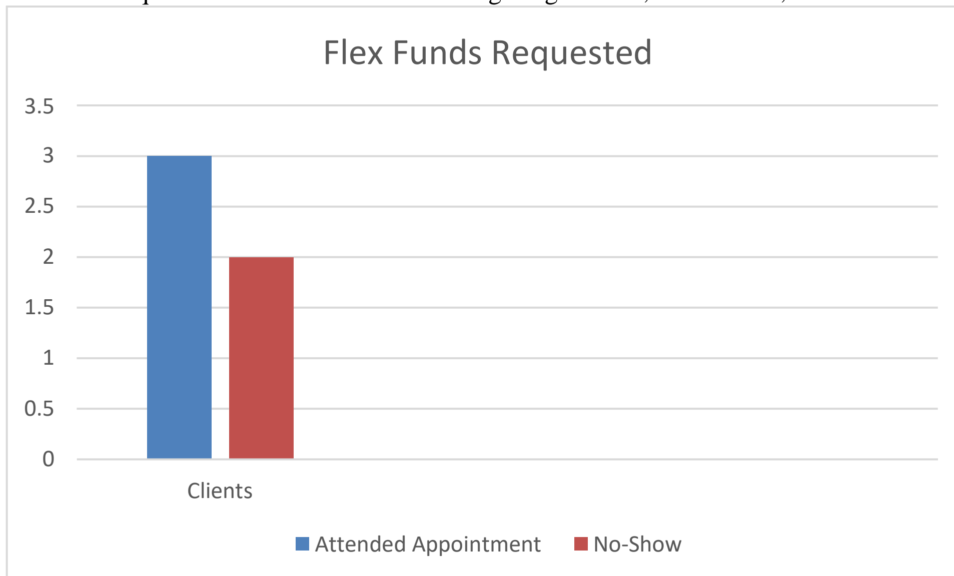


Table 3., below shows the total number of Flex Fund Forms submitted and funds requested in order for clients to access services. Requests submitted included funding for gas cards, transit fares, and DMV fees.



LINKAGE AND FOLLOW-UP: ☐Not applicable

Please explain how participants are linked to mental health and/or support services, including, how the INN Project follows up with the referral to support successful engagement in services.

CONTRA COSTA BEHAVIORAL HEALTH
1340 Arnold Dr Suite#200
MARTINEZ, CA 94553-4639
PH: (925) 957-5148
E-MAIL: windy.taylor@cchealth.org

Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

In order to provide support services, the Overcoming Transportation Barriers project reached out to various transportation agencies, and service providers located throughout the County. This action established a process to help provide a connection between these entities and the project's team. During this process, improved access to resources and materials became available to clients and the team was better able to support clients.

The project also has a system in place that allows the project's staff to follow up on all service contacts if an outcome is not reached. Many times, a client may leave a message after hours and the team will log the contact and then make sure to get the information requested to the client. All client contacts are documented, and extensive outreach is pursued.

VALUABLE PERSPECTIVES:

Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

The project was able to collect valuable perspectives from staff during the current fiscal year. Collection was difficult due to the restrictions in place, so alternative methods of collection were utilized. Staff working the OTB project sent out questionnaires with the following questions:

1) To what extent did your client find the services received from OTB helpful?
2) Would you recommend our services to other clients in the future?
3) How did the services provided by OTB benefit your client's ability to make it to their future appointments?
4) Was the turnaround time fast enough for your client to get the most benefit from the services from OTB?
5) Is there anything you would like to have seen done differently in your experience with OTB?

Responses were received from staff at various locations. Included below are two examples:

1)**To what extent did your client find the services received from OTB helpful?**
Due to OTB's help, my client was able to attend in-person appointments without the fear and anxiety of breaking down on the side of the road or being in an accident. Overall, it has helped the client attend to other basic needs as well, such as getting groceries and going to medical appointments. The client has expressed deep gratitude for OTB's assistance.

2) Would you recommend our services to other clients in the future?
I would absolutely recommend the services of OTB. OTB immensely helped my client manage and reduce their environmental stressors while ensuring my client can use their funds for other necessities.

CONTRA COSTA BEHAVIORAL HEALTH
1340 Arnold Dr Suite#200
MARTINEZ, CA 94553-4639
PH: (925) 957-5148
E-MAIL: windy.taylor@cchealth.org

3) How did the services provided by OTB benefit your client's ability to make it to their future appointments?
Without this financial support, my client would likely have had to continually choose between driving an unsafe vehicle and obtaining necessary in-person care.

4) Was the turnaround time fast enough for your client to get the most benefit from the services from OTB?
OTB was incredibly responsive to questions, followed up, and was quick to act.

5) **Is there anything you would like to have seen done differently in your experience with OTB?**
Understandably, there were some questions the car mechanic had that I could not answer as a case manager/the person not in charge of billing. Since there were four parties involved (client, case manager, OTB, auto shop) it took some additional coordination. Perhaps in the future, if schedules allow, there could be a conference call between some of the parties. However, the auto shop may become more familiar with the process in the future as well.

Questionnaire 2:

1) To what extent did your client find the services received from OTB helpful?
Client found the service extremely helpful to be able to get around to not only appointments but other activities to improve his independent living skills.

2) **Would you recommend our services to other clients in the future?** Absolutely!

3) How did the services provided by OTB benefit your client's ability to make it to their future appointments?
Client lives a good distance from Bart and bus stops, so it helps cut the travel time drastically.

4) Was the turnaround time fast enough for your client to get the most benefit from the services from OTB?
Yes, turnaround was about 2 weeks which I thought was fast.

5) **Is there anything you would like to have seen done differently in your experience with OTB?**
Yes, once an order is submitted and approved it should not be changed. My client has a disability that requires a key lock and that was changed to a much cheaper combo lock, I had to purchase out of pocket a new key lock for my client because I wanted him to have a lock he could use.

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA MENTAL HEALTH
1340 Arnold Dr, SUITE 200
MARTINEZ, CA 94553-4639
PH: (925) 957-5148
E-MAIL: WINDY.TAYLOR@CC.HEALTH.ORG

FINAL INNOVATIVE PROJECT REPORTING FORM

FISCAL YEAR: 2019/20

Agency/Project Name: Contra Costa Behavioral Health/Partners in Aging

INNOVATIVE PROJECT TYPE:

*Please check **all** that apply:* ☐ PEI – services for individuals at risk of SMI/SED services X CSS – for individuals with SMI/SED

INNOVATION:
Please provide a brief summary of the priority issue related to mental illness or to an aspect of the mental health system for which this program/project tests the idea of an innovative concept.

The Partners in Aging Innovation Project was based on the innovative idea to add Community Support Workers (CSWs) and Interns to the IMPACT Program. The goals were to find out if clients of the IMPACT Program would benefit from these new additions to the treatment team. Community Support Workers are able to provide linkage to community resources, advocacy and in-home and in-community rehab support and coaching. This addition expands the reach of the IMPACT Program beyond the therapy session. The addition of an Intern expanded the ability to serve additional clients and develop a workforce that has skills and passion for working with older adults.

Our IMPACT Program provides psychotherapy services to older adults, who are 55 and above. During FY 19/20 we were serving older adults with mild to moderate depression, anxiety and Post-Traumatic Stress Disorder (PTSD), who were eligible to receive services at a Federally Qualified Health Center. We had a clinician located at Concord Health Center 2, Pittsburg Health Center and West County Health Center.

Due to the COVID-19 Pandemic in March 2020 our IMPACT clinicians began to provide telehealth services by phone or Zoom to their clients. In January 2021 the eligibility for the IMPACT Program changed. Currently, we are serving older adults 55 and above, who have moderate to severe depression, anxiety and PTSD, who have Medi-Cal or Medicare/Medi-Cal benefits. Services are provided through telehealth, and in-person at the West County WIC Building adjacent to West County Health Center, Pittsburg Adult Mental Health and Older Adult Mental Health in Concord.

PROJECT OVERVIEW:
Please provide an overview of the innovative project.

The Partners in Aging Innovation Project began on September 1, 2016 with the hiring of one Community Support Worker (CSW), and one Intern. Every Fall we welcome a new Intern into our

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA MENTAL HEALTH
1340 Arnold Dr, SUITE 200
MARTINEZ, CA 94553-4639
PH: (925) 957-5148
E-MAIL: WINDY.TAYLOR@CC.HEALTH.ORG

program. Most of our Interns have chosen a dual track for the Internship with Older Adult Mental Health. They have split their time between our Intensive Care Management Program and IMPACT. This has given our Interns a breadth of experience by providing services to clients ranging from mild to severe and persistent mental illness. They have also been able to provide services that are clinic based and home or community based. They have provided a wide range of services, including individual therapy, case management, collateral contacts and crisis intervention. Our Interns have also frequently engaged in outreach or research projects, including outreach to West County, and the development of a binder of resources for clients experiencing cognitive decline. Interns always bring a spark of curiosity and passion to our clinic and we are happy to be able to increase the mental health workforce that can specialize in providing services to older adults. We were able to hire one of our Interns as a Permanent Full-Time Mental Health Clinical Specialist in January 2021.

Our first Community Support Worker joined the Partners in Aging Program on 9/1/2016. She left our program on 1/31/19 due to her extensive commute and finding a job closer to her home. We filled her position in June 2019 and expanded the program to hire a second CSW in July 2019. These two CSWs have continued with our program. One of the CSWs transitioned to a Permanent CSW II position in February 2021 on our East County Intensive Care Management Team. We have not filled her position due to not knowing whether or not this position would be funded past August 31, 2021.

Our CSWs and Interns served 27 clients during the 2019-2020 fiscal year. Most of these clients received multiple services. Our CSWs are able to build rapport and provide peer support, coaching, multiple linkage and mental health rehabilitation services. They connect with clients in different ways than our clinicians since they are in the community with the clients and can relate to them as a peer. They collaborate with the clinicians and provide a valuable perspective. The CSWs have aided in linking clients to important resources such as In-Home Support Services, legal services, Social Security Administration, housing resources (including linking to Housing Navigators at Care Centers and linking to organizations that assist with rent payments), Monument Crisis Center, food banks and medical appointments. They also provide several reminder calls to improve attendance at appointments, and link clients to their appointments with their IMPACT clinicians. They can also check in with the clients in between their sessions with their IMPACT clinician. Our CSWs have become quite knowledgeable on support service resources for older adults. The CSW that was hired in June 2019 maintains an online resource binder that is used by all of the Older Adult Mental Health staff. During the COVID-19 pandemic our CSWs have been providing weekly food deliveries to several of our vulnerable older adult clients.

We continue to see the incredible benefits of the collaborative relationship between our CSW, Intern and IMPACT clinicians. Our CSW can provide a different perspective on client functioning based on her experiences with clients in the community. This has had a positive impact on client functioning, progress towards treatment goals, and maintaining client safety.

When our original CSW left the Partners in Aging Program in January 2019 we lost the frequent communication that she was having with the CSWs at Psychiatric Emergency Services (PES). We did not receive referrals from PES during this reporting period. The lack of referrals from PES was also impacted by the switch in the IMPACT program to seeing clients with mild to moderate symptoms in

CONTRA COSTA
HEALTH SERVICES

CONTRA COSTA MENTAL HEALTH
1340 Arnold Dr, SUITE 200
MARTINEZ, CA 94553-4639
PH: (925) 957-5148
E-MAIL: WINDY.TAYLOR@CC.HEALTH.ORG

November 2017.

Our Intern served a caseload of approximately 5 IMPACT clients during FY 19/20. He completed intakes and provided psychotherapy. He was able to develop rapport with a range of clients and make progress towards therapeutic goals. Prior to terminating with his clients he provided them with community referrals, and made recommendations for the next Intern regarding next steps for treatment, or discharge from IMPACT.

PROJECT CHANGES: ☐No changes
Please explain whether any changes were made to the Innovative Project during the reporting period and the reasons for the changes, if applicable.

The Partners in Aging Project was impacted during FY 19/20 by the COVID-19 Pandemic. In March 2020 therapy and intake assessment services rapidly shifted from in-person to telehealth. Many IMPACT clients chose to continue receiving services through telehealth (primarily by phone). The majority of our clients preferred to use the phone rather than Zoom, which seems to reflect some older adults having difficulty with technology. This digital divide has impacted our ability to connect with clients. We continue to provide services primarily through telehealth. We began increasing our In-Person services in the Spring of 2021.

OUTCOMES AND PROJECT EVALUATION:
Please provide quantitative and qualitative data regarding your services.

- *What is the evaluation methodology?*
- *What are outcomes of the project that focus on what is new or changed compared to established mental health practices?*
- *If applicable, was there any variation in outcomes based on demographics of participants?*
- *List of indicators measured, including how often data was collected and analyzed, as well as how the project evaluation reflects cultural competency and includes stakeholder contribution.*
- *Assessment of any activities or elements of the Innovative Project which contributed to successful outcomes.*

We have evaluated the success of this project using several different methods. We began utilizing the PEARLS (Program to Encourage Active and Rewarding LiveS) Questionnaire in approximately August 2017 with Partners in Aging clients. The PEARLS is administered when the client begins receiving a service from our Partners in Aging Intern or CSW, every 6 months, and at closing. The PEARLS Questionnaire includes the Patient Health Questionnaire-9 (PHQ-9), and also includes questions on general health, social activities, physical activities and pleasant activities. This questionnaire was developed by researchers at the University of Washington to be used in their community-based, evidence-based treatment program designed to reduce depression in physically impaired and socially isolated people. We worked collaboratively with the Business Intelligence Team to develop a report that

CONTRA COSTA MENTAL HEALTH
1340 Arnold Dr, SUITE 200
MARTINEZ, CA 94553-4639
PH: (925) 957-5148
E-MAIL: WINDY.TAYLOR@CC.HEALTH.ORG

would show differences in PEARLS scores over time. Additional indicators that we have used include PHQ-9 scores, chart review, Monthly Service Summaries, and qualitative interviews with our staff. The PHQ-9 are administered frequently by the IMPACT clinicians. We are waiting for the Business Intelligence team to complete the report that tracks the PHQ-9 scores over time.

We have not formally requested stakeholder evaluation of this project. Our clients are invited to participate in the MHSIP Consumer Perception Surveys and Focus Groups, but we are not able to determine which results may be coming from IMPACT or Partners in Aging clients. In general, these results have shown that our clients are happy with the services that they are receiving.

Cultural competency is an essential element of all our programs at Older Adult Mental Health. In addition to required yearly trainings our staff frequently engages in additional trainings and discussions related to cultural competency. We serve a diverse group of older adults and provide services in the client's native language through the use of the Language Line. We also have clinicians who speak languages other than English, including Korean, Spanish and Arabic. We are open to feedback from our clients and staff related to cultural competency and committed to continuous growth in this area.

Preliminary results of the PEARLS data indicates that all participants showed a decrease in depressive symptoms as measured by the PHQ-9. These decreases ranged an average of 1 point for clients with mild and moderate depression to 5 points for clients with severe depression, which was about 25% of the clients. Clients with severe depression were shown to improve in their overall evaluation of their physical health. Clients with mild to moderate depression were shown to improve their social connections and activities. Unfortunately, we do not have demographic data linked to this report. Demographic data was collected but was not used to create the report. This would be an area to improve in future reports and projects.

These results indicate that the Partners in Aging Program had a positive impact on these clients with different trends depending on the level of severity of the client. It is notable that clients with the most severe depression benefited the most in terms of the reduction in depressive symptoms. This indicates that the current focus of the IMPACT and Partners in Aging Programs on serving clients with moderate to severe depression is likely to lead to significant benefits for the clients served as we go forward with this project.

The outcomes that we are observing appear to be related to the combined efforts of our CSW, Intern, and IMPACT clinicians. Our CSW has expanded our ability as a program to provide linkage and rehab support, increase the independence of our clients by linking them to resources, and increase their ability to learn and utilize new life skills and self-management tools. Since clients are able to obtain a sense of safety and security through the resources offered by the CSWs they are able to focus on their mental health treatment and work towards obtaining their goals. Adding this level of support to the IMPACT model was an innovative way to improve service delivery, meet the needs of clients in the community, and integrate the peer perspective into treatment planning. Our CSWs have become critical to the functioning of all our Older Adult Mental Health Programs!

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA MENTAL HEALTH
1340 Arnold Dr, SUITE 200
MARTINEZ, CA 94553-4639
PH: (925) 957-5148
E-MAIL: WINDY.TAYLOR@CC.HEALTH.ORG

FUNDING:
Please explain whether and how the project will be sustained after Innovation funding. Include the source of ongoing funding, if applicable, the reason for the decision, and how stakeholders are involved in the decision-making process.

The plan for continued funding for the Partners in Aging Project is still being developed. Our Intern will be able to be funded through MHSA WET Funds. Our goal is to secure funding to continue to have two Community Support Workers in the Partners in Aging Program. These CSWs have become vital to the functioning of all of our Older Adult Mental Health programs and can continue to support IMPACT as well as our Intensive Care Management Program. We are working with the MHSA Team to determine how these positions will be funded beginning 9/1/21. The MHSA funding would be supplemented by the Medi-Cal billing that our CSWs and Intern complete for all billable services. We are planning to attend the Innovations Committee Stakeholder Meeting on 5/24/21 to advocate for the continuation of the Partners in Aging Program. We are also meeting with the MHSA Team on 6/1/21. We have also been discussing these plans during annual meetings with the MHSA Team.

LEARNING GOALS:
Please explain whether the project achieved its intended outcomes or learning goals and a summary of what was learned.

The goals of the project were to learn the following:

1) Do older adults access IMPACT services with the assistance of peer support workers?

   Yes. Our CSWs successfully provided services to approximately 22 IMPACT clients to improve their access to IMPACT services during FY 19/20.

2) Do older adults engage in SBIRT?

   All patients seen at the health centers engage in SBIRT evaluation.

3) Do older adults develop life skills with the assistance of peer support workers?

   Yes, our Partners in Aging clients have developed numerous life skills with the assistance of our CSWs, including obtaining free phones and learning to utilize these phones, ensuring that medical needs are met, being able to utilize transportation resources, working towards financial independence, learning ways to manage clutter and increasing comfort with asking for help from others when needs arise. Our CSWs, in conjunction with the IMPACT clinicians, have been able to empower clients to engage in new activities and activities that they thought were no longer possible for them, and have been able to increase independence.

   - Do clients use them regularly and how can we increase utilization?

1340 Arnold Dr, SUITE 200
MARTINEZ, CA 94553-4639
PH: (925) 957-5148
E-MAIL: WINDY.TAYLOR@CC.HEALTH.ORG

Yes, they are using these skills regularly, and our CSW can continue to encourage clients, and provide reminders and support.

4) Do clients develop self-management goals?

   Yes, our Partners in Aging clients have been able to identify and carry out self-management goals with the assistance of our CSWs and IMPACT clinicians. For example, clients have been utilizing sleep hygiene tools, are learning to set reminders to eat at regular intervals and also learning the benefits of creating a schedule. CSWs have also been coaching clients in decluttering their homes and organizing paperwork. In addition, clients have been assisted in setting up myccLink profiles to improve communication with their medical providers through their smartphones.

   - Do clients use them regularly and how can we increase their utilization?

     Yes, some clients use these skills regularly, including going for walks. We can encourage them, remind them and provide support.

5) Does the use of peer support workers increase the number of linkages made between clients and community resources?

   Yes, prior to the implementation of Partners in Aging, IMPACT clients were not being linked to community resources. Referrals were provided, but it was up to the clients to obtain transportation and follow through on these referrals. Our PIA CSW has greatly expanded the scope of the IMPACT Program, and the ability to provide linkage.

6) Does the 60-day recidivism rate of older adults being readmitted to PES decrease?

   Yes, our client that was referred from PES in March 2017 has not returned to PES. She was linked to psychotherapy through an IMPACT clinician and participated from June 2017 to June 2018. A review of ccLink indicate that she continues to participate in Health Coaching services.

7) Does social isolation decrease?

   Yes, we have observed that social isolation decreases through the support of Partners in Aging. Our CSWs connect clients to community resources, including Senior Centers and Adult Day Health Care Programs. In addition, we have connected clients to support groups, including grief support groups. Our CSWs have formed positive rapport with many of our clients and have become important sources of support, which has also reduced social isolation.

8) Does quality of life increase?

   Yes, we have observed increases in quality of life, including clients feeling more able to

1340 Arnold Dr, SUITE 200
MARTINEZ, CA 94553-4639
PH: (925) 957-5148
E-MAIL: WINDY.TAYLOR@CC.HEALTH.ORG

engage in activities, and increase the range of activities that are available to them. For example, clients have increased their ability to use transportation independently through coaching and peer support. This greatly increases their ability to engage in social, medical and self-management activities. In addition, we have assisted one client with signing up for classes at a local community college.

9) Do older adults have improved depression scores?

   Yes, over the 17/18 fiscal year on average 75.8% of IMPACT clients experienced an improvement in depressive symptoms based on their PHQ-9 scores, and 51.6% of these clients experienced a significant improvement (5 points or more). We have requested a new report to evaluate the PHQ-9 scores over time. When IMPACT started using the Ambulatory Medicine documentation tools, and the Federally Qualified Health Center model of billing in November 2017, they gradually stopped using a PHQ-9 tracker since this data was entered in ccLink. We are hoping that this report can separate the clients who received Partners in Aging services from the other IMPACT clients to see if there is a difference in the change in the scores over time between these two groups.

   The initial results that we have received from the PEARLS report show that depression was reduced in all the cases with a range from approximately one point on the PHQ-9 to five points showing a small to significant decrease in depressive symptoms.

INFORMATION SHARING:
Please describe how the results of this Innovative Project have been shared with stakeholders, and if applicable, beneficial to other mental health systems or counties.

The Partners in Aging Project has been shared with stakeholders throughout Contra Costa County. We have presented on our programs to several groups, including presenting twice to the Adult Protective Services Multi-Disciplinary Team Meeting. This MDT brings together providers from several disciplines who serve older adults together to discuss complex cases. We also present our programs to newly hired Adult Protective Services Social Workers. We have also presented to the SPIRIT Program on a yearly basis. We have presented our programs to the Behavioral Health Access Line approximately once a year. In addition, we have presented our programs to the West County Senior Coalition and have presented twice to the Advisory Council on Aging.

VALUABLE PERSPECTIVES:
Please include the stories and diverse perspectives of project participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

One of our Partners in Aging clients was a 61 year old Afghan-American female who was primarily Dari speaking. She reported a history of severe trauma, which resulted in a traumatic brain injury for herself and the death of her husband. When she began therapy, she expressed feeling inadequate and depressed. Our CSW supported this client with taking the necessary steps towards receiving Disability benefits from Social Security. She assisted the client with making medical and psychiatric appointments to obtain needed documentation and assisted and accompanied her to Social Security

CONTRA COSTA MENTAL HEALTH
1340 Arnold Dr, SUITE 200
MARTINEZ, CA 94553-4639
PH: (925) 957-5148
E-MAIL: WINDY.TAYLOR@CC.HEALTH.ORG

appointments. This client now has a steady income and has expressed significant relief of her symptoms. She described herself as "doing much better." The CSW also assisted her with the intake process for joining groups at Choices in Aging. This is an example of the ways that our CSW was invaluable in assisting this client in obtaining the services that she needed to be able to focus on her mental health treatment, and significantly improve her quality of life.

Another client was a 66-year-old Caucasian woman who was referred for depressive symptoms. She scored an 18 on PHQ-9 at intake. She had just lost one of her dogs and was wheelchair dependent due to pain. She was very isolated despite living with family friends who often relied on her for childcare. She was estranged from her biological family, felt like a burden, had low self-esteem and would often cancel appointments due to transportation issues. Both of our CSWs helped her get set up with transportation through Contra Costa Health Plan to get free taxi vouchers to her medical appointments and Paratransit services. They also eventually helped her navigate public transportation systems (before COVID) to give her a better sense of independence. They connected her with food resources, such as Meals on Wheels, Monument Crisis Center, and food banks, so she was no longer dependent on her family friends for groceries. They also helped her get other supplies such as adult diapers through her PCP. She was also linked to Friendly Visitors which helped with her sense of isolation. During COVID they helped her apply for her stimulus check and encouraged her to engage in social activities with her housemates such as going for walks and working in her garden. At the end of treatment client was able to express needs and healthy boundaries to her housemates, engage in more independent activities which decreased her depressive symptoms and was also able to independently socialize more.