Fiscal Year 2012 – 2013
Mental Health Services Act
Plan Update
Director’s Report

During this past year, the Behavioral Health Services Division was created by combining Mental Health, Alcohol and Other Drugs and Homeless Services into a single system of care. With increasing challenges in serving complex populations with multiple disorders, this integration is a response to the growing desire to have improved client outcomes through a systems approach that emphasizes “any door is the right door,” and that provides enhanced coordination and collaboration when caring for the “whole” individual.

Nowhere are health disparities more evident than in the care of vulnerable populations. We recognize that Contra Costa’s culturally diverse individuals and families with complex behavioral health needs are recognized as a population with poorer outcomes and higher costs in multiple clinical domains. In response to these challenges, the Mental Health Services Act served as a catalyst for the creation of a framework where members from our community, working together to facilitate change, established a culture of cooperation, innovation and participation, leading towards the further development of programs and services that offer recovery and resiliency while emphasizing prevention and early intervention opportunities for engagement. As a result of these successes, and all that we have learned thus far, we recognize the need to enhance services for individuals and families where addressing the complex behavioral health needs are an expectation, not an exception as the major strategy for sustainable transformation in Behavioral Health. Therefore, we have agreed to challenge ourselves to design the system to pay particular attention to individuals and families who need us the most, and may have the most difficult time accessing care within our system.

A new vision is emerging towards an accessible, integrated, comprehensive, and compassionate system of care that will be designed at every level to promote physical, emotional, and social well-being. With change comes opportunity! To take advantage of opportunity, we need to embrace change and continue to find promise. With much appreciation and respect for all community members who, through their dedication and commitment to best practices, and participation at any level in the Mental Health Services Act process, have laid the groundwork for the new vision to emerge.

Cynthia Belon, L.C.S.W
The Mental Health Services Act (Proposition 63) is now in its seventh year. The Act has supported expansion of the community mental health system in Contra Costa County, enhanced new and continuing partnerships with community-based organizations, and supported inclusion of more consumer and family voices in the planning and implementation of mental health programs. While Contra Costa became a leader in promoting wellness and recovery principles over 15 years ago, the Act has enabled us to further build a service approach that recognizes the importance of consumer strengths and appreciates the central role consumers and family members play in self-directing care.

The Mental Health Services Act (MHSA) has created a number of significant accomplishments in Contra Costa. These include:

- Full Service Partnerships which provide intensive, in-community supports inclusive of mental health services, vocational and educational supports, and housing.
- Regional mental health teams to serve older adults.
- A variety of health-mental health integration projects that promote whole health.
- Twenty-three Prevention and Early Intervention programs that reach into underserved communities, promoting wellness in adults and increasing resiliency in youth.
- A county-wide suicide prevention plan and treatment interventions.
- Training and development of the mental health work force.
- Innovative programs that encourage new approaches and creativity.
- Hiring and training mental health consumers and their family members to serve as peer providers and to assist other families navigate the mental health system.
- The introduction and expansion of evidence-based practices that improve treatment outcomes.
- Initiatives to decrease health disparities in our culturally and linguistically diverse communities.

The community planning process required by MHSA has highlighted the importance of transparency and community partnership in developing and maintaining an effective specialty mental health system of care. It has reinforced the importance of defining meaningful treatment outcomes and program performance measures as well as using appropriate data in making planning decisions.

It is with heartfelt gratitude we recognize the hard work, commitment and diligence so many community members, consumers, family members, service providers, mental health advocates and staff have demonstrated in guiding the development of services and programs designed to provide appropriate and effective resources to all we serve through the annual planning and review processes.

Suzanne Tavano, PhD
Acting Mental Health Director
“Healthcare is a shared responsibility that is grounded in our common humanity. In the bonds of our family, we are created to be equal. We are guided by divine will to treat each person with dignity and to live together in an inclusive community. Affirming our commitment to the common good, we acknowledge our enduring responsibility to care for one another. As we recognize that society is whole only when we care for the most vulnerable among us, we are led to discern the human right to healthcare and wholeness…”

– Campaign for Better Healthcare, Illinois 2009
COUNTY CERTIFICATION
Exhibit A

County: Contra Costa

<table>
<thead>
<tr>
<th>County Mental Health Director</th>
<th>Project Lead</th>
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<tbody>
<tr>
<td>Name: Suzanne Tavano, PhD</td>
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</tbody>
</table>

Mailing Address:
Contra Costa County
Mental Health Administration
1340 Arnold Dr. #200
Martinez, Ca 94553

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations, laws and statutes for this annual update/update. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

This annual update has been developed with the participation of stakeholders, in accordance with Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft FY 2012/13 annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate.

A.B. 100 (Committee on Budget – 2011) significantly amended the Mental Health Services Act to streamline the approval processes of programs developed. Among other changes, A.B. 100 deleted the requirement that the three year plan and updates be approved by the Department of Mental Health after review and comment by the Mental Health Services Oversight and Accountability Commission. In light of this change, the goal of this update is to provide stakeholders with meaningful information about the status of local programs and expenditures.

The costs of any Capital Facilities renovation projects in this annual update are reasonable and consistent with what a prudent buyer would incur.

The information provided for each work plan is true and correct.

All documents in the attached FY 2012/13 annual update/update are true and correct.

Suzanne Tavano RSN PhD
Mental Health Director/Designee (PRINT)  
Signature

County: Contra Costa
Date: 5/31/12
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The Mental Health Service Act (MHSA), adopted into law in January 2005, challenges communities in California to utilize MHSA resources to facilitate the transformation of their mental health systems. The objective is to create a system which is client and family member driven, focuses on wellness and resiliency, holds a vision in which recovery is possible, and delivers culturally competent and linguistically appropriate services. In order to create an integrated care experience for the whole person, services are planned in collaboration with the community. MHSA services are funded along a continuum from Prevention and Early Intervention programs aimed at identifying emerging mental illness and preventing it from becoming severe and disabling, through supporting the Continuum of Care services for children, transition age youth, adults and older adults.

In Contra Costa County, systems transformation is an ongoing process. The County’s first steps included funding of an Assessment and Recovery Center, currently under development, the addition of housing and housing supports for those with mental illness, the expansion and development of Prevention and Early Intervention services, the capital to fund an electronic medical record system, new opportunities for education and training of the mental health workforce, and an opportunity to create and evaluate innovative approaches to mental health service delivery. The values adopted in MHSA have provided the framework for this systems transformation through community collaboration, stakeholder involvement, reducing health disparities, consumer/client and family member services, wellness, recovery and resiliency, all with the aim to transform the public mental health system.
Community Collaboration

Community collaboration is the process through which various persons, including groups of individuals, families, persons with lived mental health experience, representatives of other public service organizations, staff, providers and others who have an interest in the public mental health system, work together to create a mental health system which best meets the needs of clients in Contra Costa County. These persons are termed stakeholders, as they have an interest in the creation of services under MHSA. These stakeholders are collaborators in designing a shared vision of the system of care. The programs and services described within the Annual Plan have been reviewed and supported by Contra Costa County MHSA stakeholders. Additionally, the stakeholder process, described in the “MHSA Annual Plan Development and the Stakeholder Process” section below, continues to guide and inform the overall vision with an ongoing effort to embrace the principles embodied in MHSA.

In Contra Costa County, MHSA made several notable community collaborations possible. Examples include: the creation of a continuum of mental health services for older adults, the development and expansion of wellness and peer support programs, the development of vocational support programs for those with mental illness, the collaboration of housing developers, service providers and county agencies to build low income housing tied to the provision of mental health and supportive services, support to homeless individuals and families with co-occurring mental illness, collaborations with law enforcement to provide Crisis Intervention Training (CIT) to local law enforcement officers and prevention and early intervention services within educational settings.

Community collaborations and programming involving traditionally underserved populations has been of particular focus over the last year. For example, programs and services were developed for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) youth and their families informed by the work of Caitlin Ryan and the Family Acceptance Project. Spearheaded by Rainbow Community Center and other community-based organizations, a network of agencies throughout Contra Costa County joined efforts to support LGBTQ youth and their families to improve the health outcomes of LGBTQ youth. Another community collaboration effort under the Prevention and Early Intervention program is the creation of a suicide prevention committee. This committee is charged with creating a countywide plan for suicide prevention. This committee exemplifies community collaboration, co-chaired by Behavioral Health and the Contra Costa Crisis Center, a nationally certified crisis line provider, with representatives from other local hospitals, community based organizations and those with lived experience with suicide. Together the committee believes their efforts will make a difference in preventing suicide in Contra Costa County.

MHSA Annual Plan Development and the Stakeholder Process

There has been an ongoing stakeholder process in Contra Costa County that began with the establishment of the following workgroups: Community Services & Supports (CSS), Prevention & Early Intervention (PEI), Workforce Education & Training (WET), and Capital Facilities & Information Technology (CF/IT). Information and input from the initial planning process formed the basis of the initial three-year MHSA Plan. Building on the
initial planning process, in February 2009, a Consolidated Planning Advisory Workgroup (CPAW) was formed to advise the Mental Health Director on the continued transformation of the public mental health system. Care was taken to ensure the knowledge and experience of those involved in the initial planning process would be preserved by inviting representatives of the initial planning process to participate in CPAW. CPAW continues to review and provide input into the development of the MHSA Annual Plan. In Fiscal Year (FY) 2011-12, this included monthly program presentations of the qualitative and quantitative outcomes for all MHSA funded programs. Refinements and revisions of programs, as well as the development of new programs, were reviewed throughout the year at monthly CPAW meetings. This included reviewing the measures and outcomes of MHSA funded services, reviewing proposals for redesign of existing services, and planning for continued development of needed services.

In preparing the Annual Plan for FY 2012-13, the Research and Evaluation Unit provided CPAW with the results of the annual Consumer Satisfaction Survey and the Staff Priority Needs Assessment. In addition, staff and stakeholders compiled and reviewed a list of programs and services from the county’s original stakeholder planning process identified as needs that had not yet received funding. This data formed the basis for the development of a list of funding priorities for consideration for future program development for FY 2012-13. Both members of CPAW and the Mental Health Commission were invited to participate in an input process for prioritizing areas for growth used in the development of the FY 2012-13 Annual MHSA Plan. It is anticipated there will be a 20 percent increase in MHSA funding in Fiscal Year 2012-13.

In accordance with Title 9 of the California Code of Regulations you will find a complete description of the stakeholder process in the Stakeholder Input Opportunities section of this plan.

Reducing Health Disparities

In a continuous effort to reduce health disparities, the Contra Costa County Mental Health Plan (MHP) formed the Reducing Health Disparities (RHD) Workgroup. The RHD Workgroup consists of Behavioral Health staff, stakeholders, consumers and family members - all representing various cultural and ethnic backgrounds. The goal of the work group is to create and implement strategies to reduce racial and ethnic mental health disparities throughout the system of care. Through increased engagement and partnership with racial and ethnic communities, as well as public entities, the MHP seeks to embrace the richness of other cultures and seeks to provide services which understand and utilize the strength of culture in service delivery. Culturally responsive programs and services are viewed as a way to enhance the ability of the whole system to produce the most effective outcomes and create cost effective programs. MHSA has provided funding to outreach to unserved and underserved ethnic populations to assist in elimination of disparities in access to services. Reducing disparities in a culturally and linguistically appropriate manner also applies to cultural groups not defined by language or culture, such as the LGBTQ community and isolated seniors. The goal of RHD is to improve consumers’ experience utilizing Contra Costa Health Services by treating people with respect and responsiveness in a culturally and linguistically appropriate manner.
Consumer/Client/Family Member Services

The inclusion of consumers/clients and family members has been integral to planning and implementation of services. These individuals offer the valuable perspectives of those with lived experience with mental illness and serious emotional disturbance (SED). Client and family member voices have been the driving force behind the development and expansion of MHSA programs and services. Clients/consumers and family members have become an invaluable part of the system of care through the delivery of supportive services by way of peer and family supports. MHSA created the opportunity to expand the Peer Run Wellness and Recovery Centers to each region in Contra Costa County. Additionally, the County’s first evidenced-based Clubhouse Program was established and offers structured workdays, among other services, for consumers/clients. Many consumers and family members are employed by the mental health system and have received training and ongoing support to provide services throughout the system of care, including older adult services, adult services, transition-aged youth services, and services for children and their families.

Another notable development is the Office for Consumer Empowerment (OCE), which spearheads the anti-stigma efforts in the County through the Committee for Social Inclusion. This committee is a place where those with lived mental health experience come together to develop strategies to reduce stigma and promote social inclusion. Additionally, the OCE established a Speakers Bureau to educate professionals and members of the community with the goal of reducing the stigma associated with mental illness through direct, person-to-person contact. OCE and the peer run organization Mental Health Consumer Concerns (MHCC) works with Contra Costa College and local behavioral health organizations to teach the Service Provider Individualized Recovery Intensive Training (SPIRIT) courses taught by peers to peers. This series of three accredited college courses teaches mental health consumers the skills necessary to become peer providers. OCE also provides Peer Wellness Coaches to support the development of self-man-
management skills to enhance recovery from co-occurring behavioral and physical health disorders.

These values guide the provision of services. On an individual level, providers work in full partnership with the clients and families they serve to develop individualized, comprehensive service plans. This increases clients and family members’ choice and involvement, thereby supporting personal responsibility, creating incentive to obtain and sustain recovery and shifting the system to one that promotes learning, self monitoring and accountability.

**Wellness, Recovery and Resiliency**

Recovery refers to the process people who are diagnosed with mental illness undergo to promote their ability to live, work, learn and participate fully in their communities. For some individuals, recovery means regaining certain aspects of their lives and the ability to live a fulfilling, productive life despite a disability. For others, recovery implies the reduction or elimination of symptoms. Focusing on recovery, in service planning encourages and supports hope.

Resilience refers to the personal qualities of optimism and hope as well as the personal traits of good problem solving skills that lead individuals to live, work, and learn with a sense of mastery and competence. Research shows resilience is fostered by positive experiences in childhood at home, at school, and in the community. When children encounter negative experiences in these environments, mental health treatments that teach good problem solving skills, optimism and hope can build and enhance resiliency in children. (Source: California Family Partnership Association, March 2005.)

MHSA supports the philosophy that mental health needs are not defined by symptoms, but rather by a focus on achieving and maintaining and promoting the overall health and well-being of the individual and family. It is a strengths-based philosophy that takes into account and builds on those areas of life in which the client is successful.

**Expanding the Public Mental Health System**

One of the most significant changes that occurred as a result of MHSA has been the development of an expanded continuum of services for individuals living with mental illness or at risk of mental illness.

In many instances, the programs implemented with Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) funds have been used to provide new services. This has allowed for early stages of transformation and the development of a continuum of care, starting from providing services to those individuals who have not yet been diagnosed, to a multi-level service system for adults with serious mental illness and children and youth with serious emotional disturbance. The overall effort within the mental health system is to develop an array of services, enabling clients to obtain the most appropriate level of care.

In addition to the number of levels of care available to consumers, MHSA funding has allowed for an increase in infrastructure. The Capital Facilities funding will finance a state-of-the-art Assessment and Recovery Center (ARC), which will be integrated with primary care at Contra Costa Regional Medical Center. The technological needs funds have allowed the County to make progress towards the establishment of an electronic medical
records system that will enhance and coordinate client care through a more efficient and coordinated health record and information sharing system.

As the County moves forward, change will continue to occur. Within the constraints of the resources available, MHSA will play an important role in strengthening and expanding the transformation of public mental health services in Contra Costa County and throughout California.

The following pages detail the overarching purpose of each of the MHSA programs, the current services delivered, the outcomes of services provided, and areas identified for program expansion in Fiscal Year 2012-2013, in the continuing work of transforming the public mental health system.

Unnamed Poem
A poem by Ralph Hoffmann

For every hill I’ve had to climb,
For every stone that bruised my feet,
For all the blood and sweat and grime,
For blinding storms and burning heat,
My heart sings but a grateful song,
Those were the things that made me strong,
For all the heartaches and the tears,
For all the anguish and the pain,
For gloomy days and fruitless years,
For all the hopes that lived in vain,
I do give thanks for now I know,
These were the things that helped me grow.
It’s not the softer things in life,
Which stimulate our will to strive,
But bleak adversity and strife,
Do most to keep our will alive.
Over rose-strewn paths the weaklings creep,
But brave hearts dare to climb the steep.
Community Services and Supports (CSS) Overview

The first major component to be implemented was Community Services and Supports (CSS). The initial community-driven planning process began in 2005 with the final CSS plan being formally approved by the California Department of Mental Health (DMH) in June 2006. By State regulation, the majority (51% or more) of the CSS funds must be spent on Full Service Partnership Programs. The remaining funds are to be allocated to strengthen the overall infrastructure of the mental health system. The strategies which achieve this objective are part of the CSS Systems Development Strategies.

The final CSS Plan for Contra Costa County included six Work Plans. The first three Work Plans are focused on Full Service Partnership Programs; Work Plan Four includes programs for Older Adults; Work Plan Five is focused on housing for Full Service Partners (FSP); and Work Plan Six includes the six Systems Development Strategies. A brief overview of each of the Work Plans and programs it comprises is below.
## Community Services and Supports

<table>
<thead>
<tr>
<th>CSS Work Plan</th>
<th>Description of Program</th>
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<tbody>
<tr>
<td>Work Plan #1: Children’s Full Service Partnership Program</td>
<td>Currently, the Children’s FSP Program is being redesigned. Work is underway to develop the framework and program design for the new Children’s Full Service Partnership Program. Planning is being driven by data which highlights the children most in need of intensive outpatient services.</td>
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<tr>
<td>Work Plan #2: Transition Age Youth (TAY) Full Service Partnership Program</td>
<td>The TAY FSP Program, operated by Fred Finch, is located in West County and provides services to young adults between the ages of 16 and 25. Eligible youth are those who reside in West County with a Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI). The young adults exhibit key risk factors, especially: homelessness; co-occurring substance abuse; exposure to trauma; repeated school failure; multiple foster-care placements; and experience with the juvenile justice system. Services draw on several evidence-based practices adapted for use with the TAY population. These services may include case management; educational and vocational support; wellness and recovery peer programs; substance abuse treatment; financial counseling; and community integration. The capacity of the TAY FSP Program is 90 young adults.</td>
</tr>
<tr>
<td>Work Plan #3: Adult Full Service Partnership Program</td>
<td>The Adult FSP work plan is comprised of three separate programs: 1) Familias Unidas; 2) Anka Forensic Services; and 3) Bridges to Home, a collaboration between Rubicon, Anka; Community Health for Asian Americans (CHAA) and Mental Health Consumer Concerns (MHCC), providing Wellness and Recovery support. Familias Unidas is located in West County, Anka Forensic Services is located in Central County, and Bridges to Home is located in both West and Central County. Each program’s service delivery model is structured slightly differently; however, all 3 programs provide services to adults over the age of 18 who are diagnosed with a serious mental illness, are at or below 300% poverty and are uninsured or receive Medi-Cal benefits. Services are delivered based on a “what-ever-ittakes” model and include flexible funds; case management; educational and vocational support; crisis intervention; psychotherapy and several other supports. The capacity of all 3 programs combined is 185 FSPs.</td>
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<tr>
<td>CSS Work Plan</td>
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<td>Work Plan #4: Older Adult Systems Development</td>
<td>There are two Older Adult Mental Health Programs funded by CSS: IMPACT and Intensive Care Management Teams. IMPACT, or Improving Mood: Providing Access to Collaborative Treatment (IMPACT), is an evidence-based program delivering services, in collaboration with the primary care clinics, to older adults who are experiencing symptoms of depression. One LCSW staff member located in each region of the County provides services to older adults using problem solving therapy. The Intensive Care Management program is comprised of 3 multi-disciplinary teams consisting of one psychiatrist, one nurse, one mental health clinical specialist, and one mental health community support worker. Services are provided in the home or community and may include: individual therapy; family support; mental health assessments; consultation services, medication monitoring and support; transportation services, and linkages to other necessary resources. The Older Adult Programs have the capacity to provide services to 225 older adults during the fiscal year.</td>
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<tr>
<td>Work Plan #5: Housing (for FSPs)</td>
<td>Housing available in this program is intended for Full Service Partners receiving services under Work Plans #1 - #3. The priority is given to those who are homeless or imminently homeless and otherwise eligible for the FSP programs. Specific housing elements include new facilities, housing vouchers, and development of new housing options for all groups in the future.</td>
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<tr>
<td>Work Plan #6: Systems Development Strategies (SDS)</td>
<td>Systems Development Strategies do not constitute standalone programs; instead, they are a series of strategies for overall systems improvement. There are six Systems Development Strategies included in the approved CSS Plan: • Enhancements to the Office for Consumer Empowerment (OCE) • Planning for Future Systems Development • Peer Benefits Advocates • Expansion of the Family Partner Program • Wellness Services • Transformation Training</td>
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CSS Program #1

Children’s Full Service Partnership Program

Mental Health Administration is in the planning stages of developing a new framework for the Children’s Full Service Partnership Program with a goal of implementation of services by July 1, 2012. The redesign of the Children’s FSP program is driven by data which highlights the children most in need of intensive outpatient services, as evidenced by multiple hospitalizations, psychiatric emergency service visits or mobile response team crisis services. Program services will follow evidence-based practices specific to treatment modalities proven most effective for the target population.

Many people, groups and committees were involved in the redesign of the Children’s FSP Program. Various thoughts and ideas were taken into consideration and worked into the framework described below. In an effort to work towards systems integration and elimination of treatment silos, the planning for the Children’s FSP took into consideration the current programs in the children’s system of care, the gaps in service, and opportunities for improvement and creativity.

County-wide Assessment Team

Develop and implement a County-wide Assessment Team. This team would consist of Mental Health Clinical Specialists, Family Partners and clerical support in each region. The County-wide Assessment Team will serve all regions of the County and will complete a comprehensive assessment on all youth Level 3 and above. The team will present treatment recommendations to the family based on diagnosis, environmental stressors and likelihood of treatment adherence among other factors.

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

FSPs and Personal Service Coordinators:

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

There are two evidence-based practices that will provide services not currently being provided in any organized fashion in our system of care. These programs will serve both FSPs and non-FSPs and will receive their referrals from the County-wide Assessment Team.

Multidimensional Family Therapy (MDFT):


MDFT is a comprehensive and multisystemic family-based outpatient or partial hospitalization program for substance-abusing adolescents, adolescents with co-occurring substance use and mental disorders, and those at high risk for continued substance abuse and other problem behaviors such as conduct disorder and delinquency. Treatment is delivered across a series of 12 to 16 weekly or twice weekly 60 to 90 minute sessions. Treatment modules target the following four areas of social interaction:

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

Multisystemic Therapy (MST) for Juvenile Offenders:


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

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

The typical duration of home-based MST services is approximately 4 months, with multiple therapist-family contacts occurring weekly. Specific treatment techniques used to facilitate these gains are based on empirically supported therapies, including behavioral, cognitive behavioral, and pragmatic family therapies.
CSS Program #2  
**Transition Age Youth Full Service Partnership Program**

The Contra Costa Transition Age Youth program was implemented in March of 2007 and is a partnership between Fred Finch Youth Center, the Contra Costa Youth Continuum of Services (CCYCS)/GRIP, The Latina Center and Contra Costa County Mental Health Services. The program utilizes the Assertive Community Treatment (ACT) model as modified for young adults that includes a multidisciplinary team of staff, including peer/family mentors, a psychiatric nurse practitioner who provides psychiatric services in the field, staff with various clinical specialties, and bilingual staff. In addition to mobile mental health and psychiatric services, the program offers a variety of services designed to promote “wellness and discovery,” including individualized assistance finding housing, benefits advocacy, assistance gaining employment or attending school, and support in connecting with families. All staff are trained in motivational interviewing and to be co-occurring capable and thus able to confidently address the high number of youth who experience both mental health and substance use problems. All clinical staff recently completed training on the evidence-based practice of Cognitive Behavioral Therapy (CBT) for Psychosis, in recognition of the high number of young adults in the program trying to cope with psychosis, and the need to intervene as early and effectively as possible. As well as individual services, the program offers a number of groups which promote connections between otherwise isolated young adults, and vary depending on the needs of the participants. The newest group is “Represent Your Shine,” which is a monthly celebration of participant accomplishments, and is organized by the 18-month-old Youth Advisory Council (YAC), a group of participants who advise the program on its offerings. As part of their leadership skills development, this group has gone to Sacramento to advocate for services for homeless youth. In all, the program is designed to partner with young adults to assist them to “find a life that fits.”

At the time of enrollment, nearly all the TAY FSPs have experienced at least one, if not multiple, of the following: incarceration (48%); hospitalizations (60%); and homelessness (60%). Outcomes are derived by equalizing the pre-enrollment and post-enrollment time periods, thus creating a fair representation of how the consumer has progressed since enrollment. The TAY program participants have experienced a 271 percent increase in living in an apartment of their own and a 42 percent decrease in using emergency shelters as their residence. Below is an illustration of the decrease in Psychiatric Emergency Service (PES) presentations and hospitalizations for FSPs post-enrollment. Additionally, 72 percent of the TAY FSPs participated in at least one meaningful activity during their enrollment. Meaningful activities are defined as participation in any of the following activities: employment, school, volunteerism, and/or vocational training.
MHSA 2012-2013 Annual Update

**Psychiatric Emergency Services (PES)**
**Pre-enrollment vs. Post-enrollment**

- **Pre-enrollment**
  - # of unique visits: 176
  - # of unique people: 42

- **Post-enrollment**
  - # of unique visits: 109
  - # of unique people: 22

- **Decrease**
  - 38% Decrease in # of unique visits
  - 48% Decrease in # of unique people

**Hospitalizations**
**Pre-enrollment vs. Post-enrollment**

- **Pre-enrollment**
  - # of days: 606
  - # of unique hospitalizations: 67
  - # of unique people: 27

- **Post-enrollment**
  - # of days: 527
  - # of unique hospitalizations: 34
  - # of unique people: 11

- **Decrease**
  - 13% Decrease in # of days
  - 49% Decrease in # of unique hospitalizations
  - 59% Decrease in # of unique people
Success through Collaboration

The Contra Costa Transition Age Youth (CCTAY) program wants to celebrate some of the many collaborations necessary for young adults to succeed through the story of one of our participants. CCTAY itself is a collaboration between Fred Finch Youth Center, The Latina Center, and the Contra Costa Youth Continuum of Services (CCYCS) including Bissell Cottages transitional housing. We utilize the evidence-based program model of Assertive Community Treatment to offer a wide range of supports from a wide variety of staff, including Peer Mentors and Family Partners, to our program participants. CCTAY actively works to partner with young adults so they can direct their life decisions and take charge of their mental health care.
Tonnisha Frazier, who is now 21 years old, was referred to Calli House, administered by an MHSA TAY Collaborative, Contra Costa Continuum of Youth Services. Calli House is a youth shelter that was made possible through one-time MHSA funding that paid for its purchase and construction, which allowed sheltered TAYs to be housed in separate quarters from the adult shelter population at Brookside. CCTAY is an MHSA funded full service partnership program and Calli house staffing is supported through MHSA funding. Tonnisha had been on and off staying with relatives and homeless in West Contra Costa County before she sought shelter at Calli House. Like many homeless youth, she had survived a childhood that featured abuse and neglect by family members, resulting in involvement with the foster care system (another common source of referrals to the CCTAY program). Notably, despite these obstacles, Tonnisha managed to get through high school and obtain her GED. One of her strengths is her ability to garner support from adults; her basketball coach took an interest in her welfare and started checking up on her class attendance and performance. She found it embarrassing at the time but ultimately appreciated it.

In June, 2009, Tonnisha was offered an MHSA housing subsidized apartment from another of our partners, Shelter Inc. Moving from West County to Concord helped her to escape from those in her life who were giving her messages of failure; it gave her some important separation, helped her to build her sense of self-sufficiency, and helped provide her with a newfound sense of emotional and physical safety. It also meant she was closer to school and was therefore more able to attend regularly.

Throughout this time, CCTAY staff has worked with her to understand and manage her mental health symptoms and to push herself to succeed, despite the many messages she receives that she could not do it, sometimes from her family and sometimes from herself. In particular, staff motivated her to overcome her own sense of hopelessness and self-doubt, enough that she enrolled in cosmetology school. She occasionally needed to take a couple of months off for self-care, but she persevered and finished in Sept. 2010, and just got her cosmetology license. When she graduated, she chose to celebrate with the CCTAY team – who have in some senses become the supportive family she has lacked. Through various team members and attending CCTAY groups, and most especially her Personal Services Coordinator (PSC), she has learned to find internal strength, to soothe and take care of herself, to calm herself when she is alone or frightened, and even to exercise, which she did at first with her PSC and then by herself. The services emphasize safety, resilience, and good coping skills. Not only has she soaked up knowledge and guidance for herself, but she continues to support her sister and her younger brothers.

In keeping with the program’s value of developing youth leadership, CCTAY offered to help Tonnisha gain experience as an advocate. Last month, this impressive young woman went to Sacramento, supported by staff, to meet with legislators to advocate for more funding for homeless youth programs. She shared her MHSA success story with legislators. Her story was clearly impactful on her audience, and we all hope it will result in additional funding for homeless youth. Tonnisha truly enjoyed her experience and would like to advocate again.
CSS Program #3

The Adult FSP Work Plan is comprised of three separate programs: 1) Familias Unidas; 2) Anka Forensic Services; and 3) Bridges to Home, a collaboration between Rubicon, Anka; Community Health for Asian Americans (CHAA) and Mental Health Consumer Concerns (MHCC), providing Wellness and Recovery support. Familias Unidas is located in West County, Anka Forensic Services is located in Central County, and Bridges to Home is located in both West and Central County.

Each program’s service delivery model is structured slightly differently; however, all 3 programs provide services to adults over the age of 18 who are diagnosed with a serious mental illness, are at or below 300% poverty and are uninsured or receive Medi-Cal benefits. Services are delivered based on a “whatever-it-takes” model and include flexible funds, case management, educational and vocational support, crisis intervention, psychotherapy, and several other supports. The capacity of all three programs combined is 170 FSPs.

During FY 2010-11, a total of 230 consumers were served by the Adult FSP programs. Since implementation, almost 350 adults have received services through the Adult FSP programs. Ninety-eight percent of program participants are diagnosed with either a mood disorder or a psychotic disorder. Over 50 percent of the participants are either African-American or Latino and the average age is 42 years.

Shine Forth with Purpose
A poem by Carl Jones

Each Day I live,
I find more to give,
Be it a smile of such,
To transform and thus,
Be that the blessed touch,
Of love so much,
Shines forth and thus,
Grows more in trust,
Gives more through us,
To learn more we must,
Fear not in us,
Trust more in us,
Be present and thus,
More comes to us,
To share more I trust,
In loves powerful touch,
And thus,
Shine forth with purpose,
Should the sun way up high,
Fall far from the sky,
To teach us,
Shine forth with purpose
The FSP programs have been successful at decreasing the percentage of participants who are homeless (85% decrease) and increasing the number who live in apartments or within other community settings (156% increase). For FSPs who are newer to enroll, the availability of housing is much more limited. This creates challenges for the programs when working with individuals who are homeless or in need of a different living arrangement.

Additionally, the Adult FSP programs have been successful in decreasing the number of hospitalizations and presentations to Psychiatric Emergency Services (PES) when comparing an equal time period from pre-enrollment to post-enrollment.
CSS Program #4
Older Adult Mental Health

Older Adult Mental Health began program implementation in 2008. There are two programs funded under CSS with a primary focus on the Older Adult population: Intensive Care Management Teams and IMPACT. These two programs serve a vital role for older adults in Contra Costa County, as mental health problems among older adults are associated with poor health outcomes, higher health care utilization, increased disability and impairment, compromised quality of life and higher risk of suicide. (Bartels SJ, et. al, 2005).

The Intensive Care Management Teams provide mental health services to older adults in their homes, in the community, and within a clinic setting, in order to support aging in place, improve mental health, physical health and overall quality of life. Additionally, the teams provide services to those who are homeless, living in shelters, or in residential care facilities. Services are provided to Contra Costa County residents with serious psychiatric impairments who are 60 years of age or older. The program provides services to those who are Medicaid beneficiaries, Medicare and Medicare beneficiaries, or uninsured.

Intensive Care Management is comprised of three multi-disciplinary teams consisting of one psychiatrist, one nurse, one Mental Health Clinical Specialist and one Mental Health Community Support Worker. Two of the three psychiatrists are board certified geriatric psychiatrists. The third psychiatrist position is filled by a geriatric/psychiatric nurse practitioner, Contra Costa’s first Mental Health Nurse Practitioner. The geriatric-specific expertise is an invaluable addition to Intensive Care Management. The Community Support Worker positions are filled by consumers of mental health services. They contribute a personal perspective and relatable experience that other members of the team may not provide. The multi-disciplinary team provides intensive care management services which include: individual therapy; family support; mental health assessments; consultation services; linkage to primary care and community programs; advocacy; educational outreach; medication support; medication monitoring; and transportation assistance.

During Fiscal Year 2010-2011, the Intensive Care Management Teams provided services to approximately 160 seniors throughout the county. As illustrated on the graphs below, the participants have experienced a reduction in Psychiatric Emergency Services visits and hospitalizations post-enrollment. Additionally, increased numbers of older adults involved with the Intensive Care Management Teams are participating on a regular basis in walking groups, brown bag lunches, consumer sponsored picnics, wellness centers, and senior centers.
Psychiatric Emergency Services
Pre-enrollment vs. Post-enrollment

- # of visits: Pre-enrollment 102, Post-enrollment 72 (29% Decrease)
- # of people: Pre-enrollment 55, Post-enrollment 36 (35% Decrease)

Hospitalizations
Pre-enrollment vs. Post-enrollment

- # of days: Pre-enrollment 593, Post-enrollment 462 (22% Decrease)
- # of visits: Pre-enrollment 54, Post-enrollment 35 (35% Decrease)
- # of people: Pre-enrollment 35, Post-enrollment 24 (31% Decrease)
IMPACT

In 2009, the second Older Adult program, IMPACT, was implemented. Improving Mood: Providing Access to Collaborative Treatment, also known as IMPACT, is an evidence-based model providing evaluation and treatment of depression in individuals over the age of 60 in a primary care setting. IMPACT is short-term (8 to 12 visits) problem solving therapy with up to one year of follow-up as necessary. Services are provided in primary care clinics by licensed clinicians with supervision and support from the Older Adult psychiatrist. The psychiatrist assesses for and monitors medications as needed and both the clinician and psychiatrist work in collaboration with the primary care physician.

The target population for the IMPACT Program is seniors, age 60 years and older; at 300% of the Federal Poverty Level or below; and are covered by MediCal, MediCal and MediCare, or are uninsured. The focus is on older adults with depression and/or suicidality with co-occurring physical health impairments, including cardio-vascular disease, diabetes, and/or chronic pain.

IMPACT Program participants complete the PHQ-9 at each appointment. The PHQ-9 covers 9 life domains in 9 questions and results in a PHQ-9 depression score ranging from 0 to 27.

During FY 2010-2011 there were approximately 750 PHQ-9 assessments recorded for 160 unique consumers. The data below shows an improvement of approximately 36% in PHQ-9 scores after an average of 6 assessments. On average, at baseline, consumers PHQ-9 score was equivalent to moderate to moderately-severe depression. After an average of 6 assessments, consumers reported mild depression on the PHQ-9 tool. Consumers with only one recorded assessment were excluded from the analysis.

Additionally, the PHQ-9 data can be analyzed by domain area. Each question on the PHQ-9, which refers to a specific domain area, can be scored from a zero to three by the consumer. The question and corresponding scoring below is used to assess a score to each domain.

“Over the past two weeks, how often have you been bothered by any of the following problems?”

- 3 – Nearly everyday
- 2 – More than half the days
- 1 – Several days
- 0 – Not at all
The areas of greatest concern for the consumer at the time of program enrollment, in order of severity, were: Energy, Depressed Mood, Sleep and Negative Thoughts. Although greatly improved, these same 4 domain areas were reported as the most troubling to consumers during the last recorded assessment.

(Graph 1) The PHQ-9 domain areas that show the greatest improvement after an average of 6 assessments were: Suicidality; Movement; and Anhedonia. (Graph 2)
Senior Peer Counseling

Services are short-term in nature and free of charge. Under the supervision of licensed staff, approximately 40 volunteers county-wide provide counseling support to older adults who are isolated and would benefit from someone to talk with. Staff are bilingual and bi-cultural. Services are available in English, Spanish, Mandarin and Cantonese.

Stats

- Microsoft Access database was created in 2012
- Client information gathered during the intake process
- Data elements captured include:
  - Ambulatory status
  - Housing status
  - Language
  - ADL’s
- Database will also capture information about volunteers such as:
  - Travel time
  - Number of individuals served
  - Activities i.e. work supervision, monthly in-service, health fairs, educational work shops

Program Enhancements

In addition to Older Adult Mental Health’s existing services, we are collaborating with agency partners for the following:

Residency Rotation: In July, 2012 we will begin a rotation for 2nd year residency students with CCRMC Family Medicine who will shadow our Intensive Care Management Teams in the community providing outreach services to the chronically mentally ill older adult population. This new rotation is being referred to as “Care of Older and Dependent Adults” or CODA and will be invaluable to both the residents and OAMH staff in an effort to build a healthy partnership for the future.

2012 Internship Program: Older Adult Mental Health is partnering with California State University, East Bay to provide two Master’s level students with the opportunity to experience a clinical setting and to help in the development of a future workforce with a passion and expertise in working with older adults with mental health issues and co-occurring medical conditions.

Reference:
MHSA Housing Overview

CSS Program #5

Housing

The MHSA Housing Program is primarily intended to provide funding to create permanent supportive housing for individuals with serious mental illness who are homeless or at risk of homelessness. The program’s target population is low-income adults, or older adults with serious mental illness, and children with severe emotional disorders and their families who meet the criteria for mental health services and are homeless or at risk of homelessness as defined below:

- Homeless is defined as living on the streets, or lacking a fixed, regular and adequate nighttime residence.
- Individuals who are risk of homelessness include:
  - Transition Age Youth (TAY) exiting the child welfare or juvenile justice systems.
- Individuals discharged from institutional settings including:
  - Hospitals, including acute psychiatric health facilities, skilled nursing facilities with a certified special treatment program for the mentally disordered, and mental health rehabilitation centers.
  - Crisis and transitional residential settings
  - Local city and county jails.
  - Individuals temporarily placed in Residential Care Facilities upon discharge from one of the institutional settings cited above.

- Individuals who have been assessed and are receiving services at the County Behavioral Health Division and who have been deemed to be at imminent risk of homelessness, as certified by the County Mental Health Director.

With the additional funding made available through the MHSA Housing Program, the County has worked collaboratively to produce capitalized MHSA housing units, working closely with Contra Costa County Department of Conservation and Development, Richmond Housing Authority, California Finance Agency, housing consultants and developers.

Completed projects include:

- Villa Vasconcellos – Collaboration with Resource for Community Development. Newly constructed 70 unit complex located in Walnut Creek designated for low income older adults, 55 and older, disabled persons and persons with HIV/AIDS. There are three MHSA dedicated one-bedroom units.
• Lillie Mae Jones Plaza – Collaboration with Community Housing Development Corporation of North Richmond (CHDC) and their development partner East Bay Asian Local Development Corporation (EBALDC). Newly constructed 26-unit complex located in Richmond designated for low income families and adults. There are two 2 bedroom MHSA dedicated units and six 1 bedroom MHSA dedicated units. On-site service coordination is included.

• Virginia Street Apartments – Collaboration with Rubicon Programs. An existing complex located in Richmond that contains six 2 bedroom units. MHSA Housing Program funding was used for rehabilitation of the complex. All six units are dedicated MHSA units.

There are also several housing projects under development as well as a few that are at various stages of development:

• Anka Behavioral Health, scattered sites – Up to six homes of shared housing for those 18 years of age and older.

• Additional MHSA units are in underwriting at various stages of development;

• Robin Lane, Concord – Acquisition and rehabilitation. Five units for families.

• Ohlone Gardens, El Cerrito – New construction. Five units for families.

Thus far, Contra Costa County Behavioral Health has used MHSA Housing Program funds to create an additional 18 rental units and four shared housing beds. At the present time, we have an additional 15 rental units well in development as well as at least 12 more shared housing beds.

Using CSS funding, CCCMH initiated a multi-layered approach to meet the various housing needs of consumers who are at various stages of housing readiness. Funds were used to develop new housing sites and to offer supportive services to those in housing placements. On-site services providers include: physicians, nurses, clinical, and peer support services. Transitional residential programs of varied lengths focusing on TAY and young adults were developed as places for relationship and skill building. Additionally, MHSA dollars have been used to provide temporary shelter for mental health clients who are experiencing homelessness. The shelter beds have established the opportunity for outreach and engagement opportunities to serve the homeless population who may experience co-occurring mental illness and substance. Master-leased scattered site housing is identified as the priority request of consumers and completes our current housing options.
CSS Program #6

Systems Development Strategies

The original six systems development strategies, noted below, were created during the initial planning process in 2005. As the system transforms and moves more towards integration, the categories of Systems Development Strategies are too narrow in scope to be effective in improving the system of care. Systems Development Strategies do not constitute stand-alone programs; instead, they are a series of strategies for overall systems improvement. There are six Systems Development Strategies included in the approved CSS Plan:

Current Strategies

Strategy #1: The Office for Consumer Empowerment (OCE) offers a range of trainings and supports by and for consumers in all regions of the County. The OCE aims to increase access to wellness and empowerment knowledge and skills through the SPIRIT program, Leadership Academy, Advocacy workshops, Mental Health Perspectives program, and by educating staff on the client culture.

Strategy #2: Planning for Future Systems Development: This strategy includes planning for increased access to transportation for consumers to get to services and supports; efforts towards integrating services for consumers experiencing co-occurring disorders; and transforming the system to be culturally competent, recovery oriented, consumer-driven through training, supports and possible changes to organizational structures.

Strategy #3: Peer Benefits Advocates: The Peer Benefits Advocates assist consumers obtain benefits they are entitled to, educate consumers on how to maximize the use of those benefits, and assist consumers to navigate the service system. The Peer Benefits Advocates are located in each of the three Adult County Clinics. They work with and are trained by County Patient Financial Specialists.

Strategy #4: Expansion of the Family Partner Program: The Family Partners assist families with advocacy, transportation, navigation of the service system, and offer support in the home, community, and county service sites. The Family Partner Program supports families with children of all ages who are receiving services in the children or adult system of care. Family Partners are located in each of the regional clinics for children and adult services. The Children’s Services Family Partners often participate on Wraparound teams following the evidence-based model.

Strategy #5: Wellness Nurses: The Wellness Nurses do not provide any direct medical care, but develop wellness supports such as classes, groups, activities and educational materials. The Wellness services aim to help consumers to maximize their well-being and minimize the negative effects of any psychiatric medications they may be on. The purpose of this program is to educate and support adult consumers to proactively take care of themselves for maximum mental health. This includes such issues as fitness, relaxation, and ways to mitigate negative effects of medications.

Strategy #6: Transformation Training: This strategy is aimed at working towards establishing a strong mental health recovery environment throughout the service system and all staff.
Moving Forward: In preparation for creating an integrated MHSA Annual Plan and to make more efficient use of the funds moving forward, including funding as part of the increased allocation, Systems Development Strategies will fall under four major categories:

- Direct Providers for Treatment and Case Management
- Peer Support and Wellness Centers
- Improving the County Mental Health Service Delivery System for all clients and their families

Each of the existing Systems Development Strategies will be included in newly defined categories.
Peer and Family Delivered Services and Supports

Contra Costa Mental Health Plan (CCMHP) brings together a rich array of peer and family-delivered services and supports for children, youth, adults, older adults, and their families. Peers and family members work together to educate the community to decrease stigma and discrimination for people with lived mental health experience and promote social inclusion. The following is an overview of CCMHP peer and family supports, services and training opportunities.
Peer or Family- Operated Mental Health Services

Mental Health Consumer Concerns, Inc. (MHCC) provides a range of recovery-focused, community-based mental health services to adult consumers in Contra Costa County. MHCC maintains three peer-run Wellness and Recovery Centers, located in Antioch, Concord and Richmond. It is a membership-based organization directed and operated by mental health consumers. MHCC also facilitates the Contra Costa Network of Mental Health Clients, to provide opportunities for education, advocacy, and support to local consumers. As a result, MHCC provides extensive systems advocacy on the local and state levels, and participates fully in MHSA planning.

Each MHCC Wellness and Recovery Center offers peer-led, recovery-oriented, behavioral health rehabilitation and self-help groups, which teach self-management and coping skills to visitors and members. The centers also offer Wellness Recovery Action Plan (WRAP) groups, physical health and nutrition education; patient advocacy services and advocacy training, arts and crafts, support groups, community recreational outings, and peer support, in addition to providing breakfast and lunch to consumers that visit each center. Additionally, MHCC collaborates closely with the Adult Full Service Partnerships (FSPs) Programs by offering the Tender Loving Care peer support program for FSPs. Finally, MHCC provides on-going trainings to peers who are interested in becoming WRAP Facilitators. MHCC has two Advanced WRAP Facilitators who offer WRAP Facilitator Training locally to peers, as well as individual and group instruction to prepare for the training, and post-training “in group” experience.

Putnam Clubhouse offers adults recovering from mental illness respect, hope, and unlimited opportunity to access the same worlds of friendship, housing, education, healthcare, and employment as the rest of society. Participants are partners in their own recovery—rather than passive recipients of treatment—and are intentionally called members instead of patients, clients, or consumers. Members share ownership and responsibility for the success of the program by working together as colleagues with peers and a small, trained staff to build on personal strengths, rather than focusing on illness. Recovery is achieved at the Clubhouse through work and work-mediated relationships, which are proven to be restorative and to provide a firm foundation for growth, self-respect, and individual achievement.

Throughout the work-ordered day—weekdays during typical business hours—Putnam Clubhouse members learn and improve vocational and social skills while collaborating on everything involved in operating the program: determining daily tasks and clubhouse policy, office administration, reception, meal planning/preparation, hiring staff, running the career center, producing marketing and advocacy videos, helping each other access services, outreach, and serving on the Board. Putnam Clubhouse offers a full array of programming beyond the work-ordered day: structured support for returning to school or work and a variety of after-hours recreational and wellness activities. Clubhouse participation is voluntary and at no cost to members. Putnam Clubhouse follows the 36 Standards of The International Center for Clubhouse Development (ICCD) and is accredited in the evidence-based ICCD model of social and vocational rehabilitation.
The Contra Costa Behavioral Health Services Office for Consumer Empowerment

Housed within Mental Health Administration of the CCMHP, the Office for Consumer Empowerment (OCE) offers peer-led programs that offer consumers opportunities to use their lived behavioral health experience to support others in their personal recovery and to enhance the behavioral health system of care to be responsive to the diverse community of consumers facing multiple health needs. The Office for Consumer Empowerment seeks to ensure that consumers throughout Contra Costa County have a leadership role in the development of MHSA funded and other clinical services, as well as access to recovery-oriented self-help and peer support services. OCE staff members also seek to encourage and support the role of peers as providers at Contra Costa Behavioral Health Services and throughout the Behavioral Health System of Care.

Peer Provider Training

The Mental Health Service Provider Individualized Recovery Intensive Training (SPIRIT) is a recovery-oriented, peer-led classroom and experiential-based college accredited educational program for peers. SPIRIT was established in 1994, by the OCE and MHCC, for the purpose of increasing collaboration between mental health clients, family members, and county mental health services to improve system planning and to increase employment opportunities for culturally diverse mental health clients in the mental health field. Offered as a series of three semester long courses at Contra Cost College, SPIRIT teaches consumers peer counseling skills, group facilitation, Wellness Recovery Action Plan (WRAP) development, wellness self-management strategies, and other skills they need to gain peer provider positions within community behavioral health and peer or family-run organizations. The program is coordinated and
overseen by the Contra Costa Behavioral Health Services Office for Consumer Empowerment (OCE) in collaboration with Mental Health Consumer Concerns (MHCC), Contra Costa College, and more than thirty other community behavioral/mental health provider organizations and consumer and family support organizations. In addition to supervised six-week internships to allow students to gain hands-on experience working as a peer provider, community partners provide outreach, guest speakers, and instruction to students through site visits to their services. Students receive a total of nine college credits and a SPIRIT certificate upon graduation.

Over the course of the last four years, there have been improved outcomes for SPIRIT graduates. The percentage of graduates who acquired behavioral health employment, volunteered in behavioral health related services, or attended college after graduation increased from 50 percent of graduates in 2008 to 69 percent of graduates in 2011. Graduation from SPIRIT is a requirement for employment as a Community Support Worker (CSW) peer provider at Contra Costa Behavioral Health, and is valued by community behavioral health organizations when hiring peer providers. SPIRIT has increased the employment of consumers throughout the local system of care, as evidenced by the increase in employment of SPIRIT graduates. Evaluation of the effectiveness of the program on personal recovery is accomplished through a recovery and wellness survey given to the students during their first and last days of class, and at one year following graduation.

**Stigma and Discrimination Reduction and Awareness**

Convened in July of 2011, the Mental Health Services Act (MHSA) Committee on Social Inclusion was developed as an alliance of community members, advocates, consumers, family members, behavioral health providers, and community behavioral health and support organizations collaborating to promote social inclusion of persons with lived mental health experience and their family members. The committee guides projects and initiatives designed to reduce stigma and discrimination toward persons with lived behavioral health experience and their family members, and to increase social inclusion and acceptance in the community in which they live and work. The Committee for Social Inclusion employs messages and projects for the community and people who serve mental health consumers in order to: 1) empower children and adults with lived mental health experience to achieve a full and inclusive community life; 2) increase access to client-driven behavioral health services that are respectful to each individual, distinctive to each person’s needs and values, and are inclusive to family members; 3) promote a welcoming and recovery/resiliency-oriented community environment that eliminates barriers in access to medical and mental health treatment, housing, education, employment, and transportation for people facing mental health issues; and 4) reduce stigma and discrimination on both a personal and societal level by creating an organized and unified mental health voice for social inclusion.

Current projects include the planning and coordination of a Social Inclusion Conference to be held in the Fall of 2012, a PhotoVoice project to advocate for connection and acceptance of behavioral health consumers in the community, and a peer-led training for behavioral health providers to educate them on ways to help consumers overcome and cope with stigma.
The Wellness Recovery Education for Acceptance Choice and Hope (WREACH) Speakers’ Bureau is part of the Contra Costa Mental Health Plan Stigma and Discrimination Reduction and Awareness Initiative designed to reduce the internal, external, and institutional stigma surrounding mental illness that mental health consumers often face in the workforce, behavioral and physical health care systems, and in their home communities. Implemented by peers, the WREACH program forms connections between people in the community and people with lived mental health experience by providing opportunities for sharing stories of recovery and current information on mental health treatment and supports. Targeted audiences include behavioral health providers, high school and college staff and students, law enforcement, physical health providers, and community members.

After development of the program in January of 2011 in collaboration with community stakeholders, the OCE began holding two-part workshops, titled “Tell Your Story” in the community to teach mental health consumers how to write and present their recovery story. The ongoing workshops demonstrate how to use examples of personal experiences to encourage peers and give them hope, and for advocacy to address personal needs and improve the mental health system of care. Then, 27 WREACH speakers representing various perspectives, such as parents or caregivers of children who received services, family members of adult clients, providers and consumers, provided 55 presentations to the public by the end of the 2011 calendar year. Presentations were given by request and through referral to community organizations. Additionally, OCE, in collaboration with CCTV and several of the WREACH speakers created a video presentation to increase public awareness of mental health recovery and to decrease stigma and misinformation in the community. The OCE is in the process of working with CCTV to produce several public service announcements using portions of the DVD program to be shown to CCTV audiences in 2012.

Recovery Education and Outreach

The OCE, in collaboration with the Putnam Clubhouse, Mental Health Consumer Concerns, and Rubicon, Inc., developed the Reality Recovery DVD Education Program to provide outreach and education on resources and strategies for wellness and recovery to consumers across Contra Costa County who use behavioral health services from county and community contract providers. In FY 2010/2011 and in FY 2011/2012, collaborative efforts among these organizations resulted in the quarterly production of four 30-minute videos on mental health recovery in a news-show format. The completed videos will be shown on monitors located in the waiting rooms of behavioral health clinics throughout the County and will
also be available for a multitude of other educational uses, including websites, community meetings, public access broadcast, and more.

Each of the first four 30-minute videos includes the following components: an inspirational interview with mental health consumers/providers; a toolbox segment featuring a recovery technique or skill; a healthy cooking demonstration, a stigma-busting PSA, and a facility tour of a local mental health provider. The videos will be first shown in County Adult Behavioral Health Clinics in 2012, along with a bulletin board with information that complements the videos, and a peer newsletter, “The Peer Perspective”, developed by the OCE and distributed in hard copy at the County Behavioral Health Clinics, as well as an electronic version. The videos will also be offered to community behavioral health organizations to show in their waiting areas. The OCE, in collaboration with the Putnam Clubhouse, is developing the next four 30-minute videos in FY 2011/2012.

The OCE also offers behavioral health education workshops and groups to consumers in the community, and to behavioral health care providers. In 2011, the OCE provided 96 training opportunities or groups on mental health recovery to consumers and family members, including presentations to consumers enrolled in the SPIRIT peer provider training program at Contra Costa College and the two-part Tell Your Story Workshops described above. The OCE plans to film OCE recovery trainings and SPIRIT presentations to display in adult behavioral health clinics, beginning in FY 2012/2013.

The OCE collaborates with NAMI Contra Costa to facilitate a monthly Writers’ Group, which provides peer support and instruction to anyone who wishes to learn to write about their experiences. The OCE and NAMI Contra Costa are also planning to partner in providing NAMI Connection support groups for mental health consumers in Contra Costa County, beginning in FY 2012/2013.

Client Involvement in MHSA Planning Processes and Advisory Committees and Commissions:

The OCE provides outreach and support to County Adult Behavioral Health consumers and family members to inform them of upcoming MHSA planning committees and subcommittees, Mental Health Commission meetings, community forums, and opportunities for input into community services planning processes. OCE staff offers mentoring and instruction to consumers who wish to learn how to participate in community planning processes or to give public comments to public advisory bodies. The OCE also collaborates with Contra Costa MHSA support staff to offer orientation to consumers participating in MHSA stakeholder meetings.
County Peer Provider Employees

The CCMHP employs mental health consumers as Community Support Workers (CSWs) and other peer provider positions throughout Behavioral Health. Peer CSWs provide peer support, independent living skills training, transportation, co-facilitation of groups, and other support at the adult mental health clinics, as well as in the community. They also provide phone assistance to clients in Financial Services, and provide support in the Conservatorship, Transition Team, and in the OCE. The OCE CSW positions are funded by the MHSA. The OCE offers monthly group training and peer support to all peer CSWs, as well as individual training in documentation, psychosocial rehabilitation skills, peer support, and group facilitation.

The CCMHP employs parents and caregivers of children and youth who are mental health consumers as Family Partners. Family Partners share their own experiences of navigating multiple systems of care to provide advocacy and support services to parents and families of children and youth with Severe Emotional Disturbance. Family Partners work as members of Wraparound teams and bring their lived experience to support families in their systems navigation, the cultivation and development of natural supports within the community, and the compassionate understanding of one who has successfully made this difficult and rewarding journey.
The Other Side of Winter
A poem by Roberto Roman

As a child, I gazed at the flickering lights of a Christmas tree.
Their colors danced across a horizon of pine needles.
I had found a corner of the universe where I felt safe.
A mother’s voice...a grandmother’s embrace...a father’s example...
They gave me shelter from the winter torrents.
Yet for every season born, one must pass away.
As plumes strove with blazes beneath my feet,
I darted to the front door for the last time.
I watched my sanctuary turn to ashes.
The ones I had loved started to slip away, until they were gone.
So with nowhere to go, I started walking in the rain.
The wind tore my umbrella apart.
I pressed on with the clouds as my canopy.
I kept looking back.
I found a new sanctuary with new ones to love.
I kept looking back.
A new purpose had made my heart its resting place.
I kept looking back.
Then as daylight slipped out of my grasp, a man asked me,
“Why do you keep looking back?”
I answered, “Because there I was safe. There I wasn’t alone.”
He said, “You’re not alone. The only way to be free is to let go.”
I staked out my ground in the balance between seasons.
I looked in both directions.
I made my choice.
As night waned, I came across a mountain and started to climb.
I was afraid to fall, so I kept looking above.
As I stretched out my hand to pull up further, I remembered.
I stopped, and a tear caressed my face.
Then I realized that it had stopped raining.
The air wasn’t so cold anymore.
In the corner of my eye, I saw sunlight break through the fading clouds.
I saw a rainbow trace its arc along the horizon.
I saw an eagle rise, extending its wings into the widening blue of newborn spring.
I yearned to follow, and I knew it was time for me to go on climbing...
Prevention and Early Intervention (PEI) programs were designed to include meaningful involvement and engagement of diverse communities, potential individual participants, their families and community partners. Programs and projects were developed to build capacity for providing prevention and intervention services related to mental health at sites where people go for other routine activities (e.g. education facilities, community based organizations, ethnic specific cultural centers, health providers).

In May 2009, the California Department of Mental Health approved the Contra Costa County MHSA Prevention and Early Intervention (PEI) Plan which consists of nine programs addressing four key community mental health needs and specific priority populations: Fostering Resilience in Communities Initiative, Fostering Resilience in Older Adults, Fostering Resilience in Children and Families, and Fostering Resilience in Youth/Young Adults Initiative.

Program Summary

Building Connections in Underserved Communities focuses on strengthening underserved cultural communities in ways that are relevant to specific communities, with the purpose of increasing wellness, reducing stress and isolation, and decreasing the likelihood of needing services of many types, and to help support strong youth and strong families.

Coping with Trauma Related to Community Violence provides community organizing and a proactive approach to community violence. Raises awareness, engages in culture-building activities, celebrates resilience, creates opportunities for healing and restoration and convenes public forums to respond to specific incidences of violence within the West Contra Costa community.

Reducing Stigma and Awareness Education implements the WREACH (Wellness and Recovery Education for Acceptance, Choice, and Hope) Speakers’ Bureau. Speakers include consumers, family members, and providers, who share their experiences and facts about mental illness and recovery to decrease stigma and increase social inclusion in the community. The Committee for Social Inclusion guides a stigma reduction and awareness initiative.

Suicide Prevention has been an important focus for both our system of care and within our community. Our original Stakeholder Work Group and Steering Committee recognized the need for a suicide prevention effort that was universal at one level and targeted to particularly high risk populations at another. A Suicide Prevention Committee was established to create a comprehensive suicide prevention plan for Contra Costa County. Under this initiative we were able to expand the language and cultural capacity of our crisis line provider, Contra Costa Crisis Center, and have been able to sponsor training on suicide prevention.

Supporting Older Adults in underserved cultural populations who are trauma exposed, isolated, depressed and experiencing onset of serious psychiatric illness. The purpose of the program is to help provide early intervention when warning signs appear, linkage to appropriate community resources in a cultur-
ally competent manner, and prevent mental illness and suicide.

**Parent Education & Support** programs offer effective parenting skills, family communication, health identities/family values, child growth and self-esteem development to caregivers who have responsibility to care for at-risk children and youth in order to reduce incidence of child and substance abuse, juvenile delinquency, gang violence, behavioral problems and emotional disturbances.

**Supporting Families Experiencing the Juvenile Justice System** provides individual and family supports to help the youth become strong, healthy, law abiding members of their communities. Early screening of youth identified as needing mental health support leads to better coordination of after care that assures appropriate linkages to services and supports as youth transition back into their communities. The treatment staff provide direct short term therapy and facilitate warm hand-offs to Community Based Organizations and to County MH Systems.

**Supporting Families Experiencing Mental Illness** provides peer-based programming for adults in recovery from psychiatric disorders to develop support networks, life and vocational skills training, respite and stress reduction for caregivers, restorative community for their loved ones, support for recovery, independence, increased socialization, education, and employment support.

**Youth Development** increases prevention efforts for at risk youth, responding to early signs of emotional and behavioral health problems, strength-based efforts that build on youths’ assets and foster resiliency, as well as to help youth build knowledge and concrete life skills, development of a positive identity, self-esteem and positive community involvement.

**Multi-Family Therapy – An Intensive Early Psychosis Intervention** provides early intervention to transition age youth experiencing or at high risk of the early onset of psychosis providing psycho education, vocational, occupational, and psychiatric supports to the individual and the family.
PEI PROGRAM

Under the Prevention and Early Intervention (PEI) Component of the Mental Health Services Act (MHSA), Contra Costa Mental Health (CCMH) has contracted with twenty agencies for the Fiscal Year 2010 to 2011. Three of the twenty agencies have multiple contracts with CCMH. There are a total of ten programs. Of the initial nine programs in CCMH, eight were available for full or partial funding through the Request for Proposal (RFP) process. Program 10 is a new PEI program that was approved in 2011. The following is a list of the Providers of Services:

Program 1: Building Connections in Underserved Cultural Communities

- Asian Community Mental Health Services: Building Connections in API Communities
- Center for Human Development: African American Health Conductors
- Jewish Family & Children’s Center of East Bay: Community Bridges
- La Clinica de la Raza: Vias de Salud (Pathways to Health)
- Lao Family Community Development, Inc: Health and Well Being for Asian Families
- Native American Health Center: Native American Wellness Center
- Rainbow Community Center: LGBT Community Mobilization & Social Support
- YMCA of the East Bay: One Family at a Time - Building Blocks for Kids Collaborative (BBK)

Program 2: Coping with Trauma Related to Community Violence

- RYSE: Trauma Response & Resilience System

Program 3: Reducing Stigma & Awareness Education

- CCMH Office for Consumer Empowerment

Program 4: Suicide Prevention

- Contra Costa Crisis Center: Suicide Prevention
- Suicide Prevention Pilot (Based on the Henry Ford Health Model)

Program 5: Supporting Older Adults

- CCMH Senior Peer Counseling
- LifeLong Medical Care: SNAP! Senior Network and Activity Program

Program 6: Parenting Education and Support

- Child Abuse Prevention Council: The Nurturing Parenting Program
- Contra Costa Interfaith Housing, Inc.: Strengthening Vulnerable Families
- Counseling Options and Parent Education (COPE): Triple P-Positive Parenting Program
- La Clinica de la Raza: Familias Fuertes (Strong Families)
- The Latina Center: Primo Nuestros Ninos (Our Children First)
Program 7: Families Experiencing the Juvenile Justice System

• Contra Costa Behavioral Health

Program 8: Support for Families Experiencing Mental Illness

• The Contra Costa Clubhouses, Inc.: Supporting Families Experiencing Mental Illness

Program 9: Youth Development

• El Cerrito High School: James Morehouse Program – Youth Development
• Martinez Unified School District: New Leaf – Youth Development
• People Who Care: Youth Development
• RYSE Center: RYSE Health & Wellness
• STAND! Expect Respect

Program 10: Multi-Family Group–An Intensive Early Psychosis Intervention

• Contra Costa Behavioral Health

PEI Program Overview (Demographics)

For Fiscal Year 2010 to 2011, our PEI Programs served 41,870 unduplicated participants ages 0 – 60+ in all regions of the County. Twenty-five percent (25%) of the participants were age 46-59. Sixty percent (60%) of the participants are female. Participant’s primary language spoken is English (77%). Forty percent (40%) of the participants are Caucasian and thirty percent (30%) are Latino / Hispanic. Please see graphs and data descriptions below for a breakdown of age, gender, region, ethnicity, and language:

Ages of the Participants: (n=41,870)

- Ages: 0-5 (2%), 6-12 (3%), 13-17 (7%), 18-21 (4%), 22-25 (3%), 26-35 (10%), 36-45 (16%), 46-59 (25%), 60+ (13%), and Unknown (17%).

Language of the Participants: (n=41,837)

- Language: Predominantly English (77%), Spanish (16%), Asian (1%), and Unknown (6%). Not shown on graph: Am. Sign (2) = (0.005%), Farsi (177) = (0.4%) and Other (192) = (0.5%).
Region: (n=41,837)

- **Unknown**: 29% (11,930)
- **Central**: 29% (12,060)
- **East**: 23% (9,510)
- **West**: 17% (7,315)
- **Other**: 2% (782)
- **Unknown**: 29%

Region: Central (29%), East (23%), West (17%), Other (2%) and Unknown (29%).

Ethnicity of the Participants: (n=41,837)

- **Caucasian**: 40% (16,740)
- **Hispanic/Latino**: 30% (12,493)
- **African American**: 15% (6,054)
- **Asian/Pacific Islander**: 4% (1,832)
- **Other**: 7% (2,920)
- **Unknown**: 4% (1,608)

Ethnicity: Caucasian (40%), Hispanic/Latino (30%), African American (15%), Asian/Pacific Islander (4%), Other (7%) and Unknown (4%). Not shown on graph: American Indian / Alaska Native (190) = (0.5%).

PEI Overview CD Gender Chart

- **Male**: 38% (24,564)
- **Female**: 60% (16,026)
- **Unknown**: 2%

Gender: Male (38%), Female (60%), Unknown (2%). Not shown on graph: Other (15) = (0.04%).

*** See Appendix for specific PEI program outcomes.
Story of Hope  
By Doug Kirk

Over a year ago I quit taking my medication which caused me to decompensate and my symptoms of severe depression and paranoia returned. Because of that I got into trouble with the law and was arrested. I was diagnosed with schizophrenia 25 years ago and have been in jails and institutions on and off since then. After my last time of going off meds, I was in jail for 49 days.

When released, I moved to a Concord board and care home and was referred to Putnam Clubhouse by my case manager. At first I just attended once a week, but I liked it so I started going every day. The people were really supportive there and made me feel accepted and welcome.

During the time I’ve attended the Clubhouse I’ve learned to use a computer and to do data entry. I now enter data for the monthly Clubhouse reporting. For the last year I’ve been trying to resolve my court case from the time I mentioned above when I was off my medication. I am happy to report that due to my improvements since joining the Clubhouse, I’ve been able to get the charges dropped.

I’ve learned to become more positive since attending the Clubhouse and I’m finally satisfied with how my life is going. When I’m not at the Clubhouse, I stay busy working on my motorcycle, which is my hobby. And my relationships have improved with my family, too. My daughters and grandkids have been very supportive and have noticed how much better I’m doing now.

The Clubhouse gives me a purpose, something useful to do every day and a way to contribute to society. Before, I sat around with nothing to do. I also attend some of the evening and weekend programs at the Clubhouse and have made a lot of friends there. I’m satisfied now with the way my life is going on all fronts. I finally believe that recovery is possible.
Suicide Prevention

The formation of the Contra Costa County Suicide Prevention Committee is outlined in the MHSA Initial 3-Year Plan as part of the Prevention and Early Intervention (PEI) efforts. The committee is charged with drafting a county-wide suicide plan aimed at reducing attempted and completed suicides. The membership is a broad representation of many stakeholders. The following groups and/or agencies are represented:

- LGBTQ
- Older Adult Mental Health
- CCRMC
- John Muir Health
- Kaiser Permanente
- Alcohol and Other Drugs
- Veterans Administration
- NAMI
- Mental Health Administration
- Domestic Violence
- Youth Advocate
- Contra Costa Crisis Center
- Family Member
- Lived experience
- Central County Adult Mental Health
- Education (K-12)
The Suicide Prevention Committee has worked tirelessly for the last 18 months on various projects to further the cause of suicide education, awareness and prevention. Focus groups were conducted with various community groups including the faith-based community, older adults and youth, revealing poignant stories of struggle and survival. A smaller sub-group of members worked together to review the medical charts of those who took their own lives and had received a mental health service within six months of their death. This review gave insight into what a person was experiencing prior to their death and highlighted important areas of focus for suicide prevention efforts specifically within our mental health system.

With the philosophy in mind to do things that work, the Committee reviewed many evidence-based practices for suicide prevention. During this process the committee discovered a program which has reduced suicides to zero for over two years. The Perfect Depression Care program was implemented at the Henry Ford Health System in Detroit, Michigan and incorporates suicide assessments for all behavioral health clients, same day psychiatric appointments, a focus on means restriction, follow-up phone calls, and drop-in groups. During the previously mentioned chart review process, the Review Team considered whether aspects of the Henry Ford Heath Model would have made a difference in the life trajectory of those who died by suicide in Contra Costa County. The group unanimously agreed that having services as modeled in the Henry Ford Health System would be beneficial for people at risk for suicide.

Many initiatives have grown from the work and collaboration of the committee members. Among other important projects, Contra Costa Behavioral Health is piloting drop-in groups and follow-up phone calls at the Central County Adult Mental Health Clinic for consumers at an increased risk for suicide. The Committee is in the final stages of determining the prevention strategies to include in the County-wide Suicide Prevention Plan. It is anticipated that the plan will be finalized during Fiscal Year 2012-2013.
Introduction

Contra Costa Behavioral Health’s Workforce Education and Training (WET) Plan was designed to address the shortage of qualified individuals who provide services in our County’s community mental health system. All proposed education, training and workforce development programs and activities contribute to developing and maintaining a culturally competent workforce and to include individuals with client and family member experience, capable to provide client and family driven services.

The goals and objectives of Contra Costa Behavioral Health’s (CCMH) WET plan’s five program areas are consistent with and support the vision and values of the California’s MHSA Workforce Education and Training Strategic Plan.
Program Area 1: Workforce Staffing Support

The first program area of CCBH’s WET plan is focused on activities to provide staffing and support to CCBH’s WET component and to enhance the County’s training infrastructure. CCBH believes it is important to increase the availability of information on regional education and employment activities, including internship opportunities as well as ensure that family members, consumers and underserved and underrepresented communities are included as both trainers and participants. Through this program area, CCBH is responsible for coordinating training and technical assistance efforts for County and community based organization (CBO) staff as well as network providers.

Notable activities during this reporting period include:

- 6 Training Advisory Work Group meetings were held during 2010-11 to support the development of the activities in The Plan.
- Development of CCMH Education and Training Policy and Procedure
- Identification of county staff who are subject matter experts in a variety of topics such as: motivational interviewing, cultural competence, computer training, clinical supervision, etc.
- Identified clinical supervisor to implement and monitor fidelity of Evidence Based Programs

Program Area Outcomes

- Development of 2010 and 2011 Training Calendar
- In-house continuing education units specialists to review training content for CEU appropriateness
- Partnered with California Institute of Mental Health (CiMH) to provide training and ongoing technical assistance for culturally and ethnically focused community based organizations

Program Area 2: Training and Technical Assistance

CCMH is committed to a philosophy of “growing our own” with regard to workforce development. A well-educated and well-prepared public mental health workforce requires access to current clinical, administrative, supervisory and managerial information on best practices in order to effectively serve Contra Costa County’s dynamic and diverse populations and regions. The identification and development of new staff development opportunities that advance staff competencies, contribute to job satisfaction, retention
and service to attract new employees based on personal and professional growth are the goals of this portion of the WET plan. The goal of the Training and Technical Assistance Program area is to provide an array of training opportunities to enhance the skills of current staff. In 2010-2011, CCBH created and coordinated trainings for CCBH staff and contract providers, collaborating with external agencies as well as working with internal subject matter experts, enhancing internal training capacity.

Notable activities during this reporting period include:

- Implemented online learning system for staff, Essential Learning, with over 500 behavioral health courses available
- Implemented community educational website, Community Access Site (CAS)
- Planned and hosted a Recovery and Resiliency Conference at the Crowne Plaza Hotel in Fall of 2011 with over 200 participants that included county and CBO staff, consumers, family members, stakeholders and members of the public.
- Partnered with CiMH to provide ongoing technical assistance to community based organizations
- Offered Mental Health Training for Law Enforcement (CIT Training)

Program Area 3: Mental Health Career Pathways Programs

Contra Costa County has been a leader in the engagement of consumers and family members as employees, offering consumer training programs as well as alternatives to a college degree. The focus of this program area is to provide career track options into the mental health field. Included in this program area are the Service Provider Individualized Recovery Intensive Training (SPIRIT) Program Expansion and Enhancement, Family Member Employment Strategies, and Developing Mental Health Concentration in High School Health Academies. In addition, the development of the Psychosocial Rehabilitation Certificate at Contra Costa College and exploring a Psychiatric Technician Program is also a part of the Work Plan to further develop staff skills.

Notable activities during this reporting period include:

- Five Crisis Intervention Trainings were held during this fiscal year.

Program Area Outcomes

<table>
<thead>
<tr>
<th>Training Type</th>
<th># Offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Trainings Offered in FY 10-11</td>
<td>150</td>
</tr>
<tr>
<td>Cultural Competency Trainings</td>
<td>58</td>
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<tr>
<td>Trainings by internal experts</td>
<td>28</td>
</tr>
<tr>
<td>Online Trainings via Essential Learning</td>
<td>561</td>
</tr>
</tbody>
</table>

MHSA 2012-2013 Annual Update
Workforce Education and Training Overview

• Continuation of SPIRIT Program
• Completion of a pilot program of a Mental Health Concentration in Dozier Libbey Medical High School Health Academy; plan for implementation in additional high schools across the County for FY 2011-12
• CCMH was awarded a Healthcare Career Training Program Grant from the Office of Statewide Health Planning and Development (OSHPD), to support the development of a mental health concentration in high schools across all regions of the County
• Continuation of Psychosocial Rehabilitation Certificate program
• Continuation of the CCMH Internship Program
• The County awarded a grant to the National Alliance of Mental Illness (NAMI) to develop a family psycho-education program targeting Spanish speaking families in Contra Costa County

Program Area Outcomes

• 27 students completed the SPIRIT program
• Over 20 students enrolled in each of the classes required for the Psychosocial Rehabilitation Certificate program
• Over 85 students participated in the mental health program at various high schools in Contra Costa County

Program Area 4: Residency and Internship Programs

Exposure to the community mental health field through residency programs and internships is a key strategy to identify and recruit professional staff. Engaging professionals through training programs not only ensures an infusion of current best clinical practices but provides a replenishment source to balance staff attrition due to retirement. Graduate internship support and development of both the psychiatry and psychiatric nursing workforce are among the programs included in this area.

Notable activities during this reporting period include:

• Graduate-level interns placed in County programs
• Funds were awarded to five (5) community based organizations to recruit interns into their programs [CBO Internship program]

Program Area Outcomes

• 25 Graduate Interns for FY 2010-11 were placed in various County clinic settings for training, including Juvenile Hall, Older Adult Program, Regional Medical Center’s Crisis Unit, and Central County Children’s Clinic.
• Through the CBO internship program for FY 2010/11, 39 interns were hired. Most of the interns represented various cultural backgrounds.
Program Area 5: Financial Incentive Programs

In line with CCMH’s commitment to growing our internal capacity, the County provides financial incentives to support staff that wish to obtain a degree while employed through the WET plan. This program allows for continued development of a proven and qualified workforce, tapping those who already have knowledge of the County mental health system. CCMH plans to provide educational scholarships for those who wish to pursue a bachelor’s or master’s degree, specifically in mental health-related areas. To further support these efforts, CCMH has worked to expand the professional shortage designation areas to include more areas of the county. This state designation allows for incoming psychiatric staff to be eligible for various state loan forgiveness programs, thereby making Contra Costa a more attractive option for employment new for graduates. To further the financial incentive programs for potential County staff, CCMH has also worked to include several clinic sites to be included in the National Healthcare Service Corps (NHSC). As an approved NHSC site, CCMH has the ability to attract NHSC providers to communities who need it the most and provide training opportunities and resources.

Notable activities during this reporting period include:

- Approval of MSSA 17, which includes the cities of Brentwood, Knightsen, Byron, and Discovery Bay to be designated as a Mental Health Professional Shortage Area
- Approval of East County Adult Mental Health Clinic and West County Children’s Mental Health Clinic as National Health Care Corps (NHSC) Approved Sites

Refinements and Revisions to WET Plan in 2010-11

No notable refinements and revisions were made to The Plan.
The CCBH Reducing Health Disparities (RHD) Work Group is structured around the guiding principles of the Health Services Department’s Reducing Health Disparities Initiative (RHDI). The goal of the Work Group is to ensure that all Behavioral Health county staff provides services that respect the values, belief systems and cultural preferences with cultural humility to our consumers and communities. To accomplish this goal, the RHD guiding principles will be incorporated into the work of CCBH.

Below are some of the guiding principles of RHD:

- We are committed to eliminating health disparities because our mission is to care for and improve the health of all who live in Contra Costa County with special attention to those who are most vulnerable to health problems. Disparities based on race, ethnicity, language, socioeconomic status or other similar reasons are inconsistent with our mission.

- We recognize that differences in race, ethnicity, age, gender, sexual orientation, language, physical ability, socioeconomic class, education, and many other factors can affect how we relate to patients, clients, customers, consumers, communities and each other.

- Our employees participate in training and related activities to increase our knowledge and appreciation of diverse cultures and to become comfortable and effective in a diverse environment.

- The RHD structure is designed to ensure RHD efforts are integrated into day-to-day activities of the department and all of its divisions.

- There is a role for every employee, manager, supervisor and Division Director.

The RHD Work Group strives to maintain membership that includes: Consumers and Family Members; Contractors and Network Providers; Community Partners/Leaders; Cultural Groups; Health Conductors; and County Mental Health Staff.

The RHD workgroup is broken down into seven sub-workgroups of which members of the workgroup are spread across. These sub-workgroups include: (i) Linguistic Access; (ii) Workforce Development, Education and Training; (iii) Partnership with Multicultural Communities; (iv) Work Environment; (v) Governance, Systems and Policy; (vi) Data Collection; and (vii) Inclusion Initiative (LG-BTQ).

The CCMH Reducing Health Disparities WorkGroup has a Work Plan that is broken down into different sections with goals and objectives under each of those sections. This Work Plan sets measurable goals for the group to accomplish, with projected completion dates and benchmarks. The Work Group also strives to have representation in all boards, committees and decision-making bodies within the Behavioral Health system.
Innovation Section

Component Overview

Mental Health Services Act (MHSA) Innovation (INN) funds provide counties with opportunities to learn from new approaches that have the potential to transform the mental health system. According to the California Welfare and Institutions Code Section 5830, INN programs must contribute to learning in at least one of four areas by having at least one of the following as an essential purpose for the learning that occurs in the program:

• To increase access to underserved groups
• To increase the quality of services, including better outcomes
• To promote interagency collaboration
• To increase access to services.¹

At this time, Contra Costa County has six INN programs it plans to fund and/or continue to fund in FY 2012/13. Below are summaries of the programs as well as their intended outcomes.

Program Overviews

INN01: Social Supports for Lesbian, Gay Bisexual, Transgender, Questioning, Queer, Intersex and Two-Spirit (LGBTQQI2-S) Youth and Transition Age Youth (TAY)

This project is a three-year pilot currently in its second year. The goal of the project is to determine whether applying a “Social Support Model” (based on the Social Ecological Model²) to services targeting LGBTQQI2-S youth/TAY (up to 29 years of age) will improve their health and wellness and prevent poor health outcomes. The project seeks to attempt to reduce family, peer, and/or community rejecting behaviors and increase accepting behaviors. It will test the effectiveness of various modes of engagement and service provision and will develop best practices toolboxes for engaging/serving youth and their social supports. The program’s target population is LGBTQQI2-S youth/TAY as well as their families and caregivers, straight peers and allies, providers, schools, faith-based organizations and community-based organizations. The program served approximately 1,800 people during its first year.


² The social-ecological model illustrates how spheres of social influences interact and affect an individual’s health.
effective engagement, education and support strategies it will continue to test during Years Two and Three. See appendix for program’s Year One Executive Summary.

INN01 Year One program activities included:

• Development of a Community Collaboration among organizations that provide services to LGBTQ youth
• Development of an LGBTQ-specific Mental Health Counseling Program
• Identifying activities that promote acceptance and safety for LGBTQ youth in their homes, communities and schools. This includes identifying practices currently in place as well as new opportunities to develop social support services for LGBTQ youth
• Learning how organizations can identify and engage LGBTQ youth and their families in community service programs
• Learning how communities, organizations and families can support LGBTQ youth in ways that promote positive identity development
• Learning how organizations and communities can provide education and support to parents of LGBTQ youth to increase accepting behaviors
• Community Map of supportive agencies

The goals for Years Two and Three are 1) to attempt to reduce family, peer, and/or community rejecting behaviors and increase accepting behaviors; and 2) to assess if these changes promote positive health outcomes² for LGBTQQI2-S Youth/TAY. There are no revisions to these goals.

INN01 Year Two and Three program activities include:

• Building the capacity of CCC community-based youth services to promote the health and well-being of LGBTQ youth
• Engaging youth voice and leadership
• Developing, implementing and evaluating core strategies and tools designed to promote positive identity development and reduce health risk factors for LGBTQ youth
• Building County-wide awareness of the risk factors of rejection and role models for acceptance of LGBTQ youth
• Engaging youth and family voice and leadership
• Developing, implementing and evaluating core strategies and tools designed to reduce rejecting behaviors and increase accepting behaviors among families and caregivers
• Building the capacity of CCC schools to create a climate of acceptance for LGBTQ youth
• Engaging youth voice and leadership
• Developing, implementing and evaluating core strategies and tools designed to reduce rejecting behaviors and increase accepting behaviors in the school community
• Community Map of supportive agencies

INN01 outcome measurements include:

• Lessons learned about effective engagement and support strategies from interviews with collaborative partners
• Lessons learned about effective strategies in collaborative partner logs
• Increased service utilization

² In this program, positive health outcomes include outcomes related to physical and mental health as well as wellness and resiliency.
Increased event attendance
Positive feedback from program participants
Increased number of supportive agencies on the Community Map
Improved outcomes on the CC LGBTQ Youth Advocacy Collaborative Youth Survey which assesses:
- demographics
- service utilization
- identity development
- social support
- accepting and rejecting behaviors (from family and peers) experienced by youth
- community involvement
- overall physical health
- overall mental health
- substance use
- risky sexual activity
- knowledge of resources

INNFT01: Promoting Wellness, Recovery and Self-Management through Peers

This 12-month program will pilot using trained Peer Wellness Coaches to provide wellness services in mental health clinics. The target population consists of consumers who receive services in the county-operated adult mental health clinics. The goals of the project are to learn if and how adding Peer Wellness Coaches to health integration projects will: 1) improve wellness and health outcomes for consumers; 2) increase primary and mental health care staffs’ understanding of mental health “consumer culture” and recovery principles; 3) increase the number of consumers with wellness, recovery and/or self-management goals; 4) reduce feelings of stigmatization; and 5) enhance recovery.

This program is currently on hold due to human resource challenges.

INNFT01 program activities may include:

- Peer Wellness Coaches working with clinic staff to:
  - Assist in the provision of wellness education to consumers
  - Facilitate wellness groups
  - Educate consumers about recovery
  - Assist consumers in developing recovery goals and chronic disease self-management plans
  - Provide Wellness Recovery Action Plan (WRAP) training
  - Aid consumers with skill-building, including mental health coping skills, to promote the achievement of their wellness, recovery and chronic disease self-management goals
  - Educate consumers about working with primary and mental health care providers to promote wellness and increase consumer’s participation in physical and mental health treatment
- Link consumers to existing wellness and recovery resources in the community
- Provide peer leadership support
- Educate primary and mental health care staff about mental health recovery principles as well as mental health “consumer culture”

**INNFT01 outcomes measures will include:**
- Increased number of wellness and recovery plans
- Increased use of wellness and recovery plans
- Increased participation in wellness and recovery activities
- Changes in health-related behaviors
- Improved health outcomes
- Improved recovery scores
- Changes in client perceptions of stigma
- Increased number of healthcare linkages
- Changes in primary care providers’ understanding of consumer culture and recovery principles
- Changes in consumer’s perception of primary care providers’ understanding of consumer culture and recovery principles

**INNFT02: Interagency Perinatal Depression Treatment Program**

This 12-month program is a collaboration between Contra Costa Behavioral Health Services, Public Health Nursing and Women Infant and Child (WIC) program. It will pilot the integration of perinatal/post partum depression services into the services currently provided at the Central County WIC office. The target population consists of mothers who receive services from the Central County WIC office who screen positive for perinatal and/or post partum depression. The goals of the program are to learn: 1) which elements of the collaboration are most/least effective and why; 2) if the collaboration leads to an increase in awareness about mental health services and a decrease in the mothers’ perception of stigma associated with depression; and 3) improved health outcomes for the women participating in the collaboration.

This program began implementation in April of 2012.

**INNFT02 program activities will include:**
- Implementing interagency collaboration
- Screening mothers for depression
- Providing one-on-one counseling services
  - Providing group counseling services
- Providing medication services
- Providing referrals as needed

**INNFT02 outcome measures will include:**
- Changes in depression scores
- Improved treatment outcomes
- Positive feedback from mothers and providers
Increased service utilization
Changes in perceptions about stigma related to seeking mental health care
Increased awareness about mental health and mental health services
Progress towards achieving wellness/recovery goals

**INNFT03: Libby Madelyn Collins Trauma Recovery Project**

This 24-month program pilots the use of a Trauma Recovery Group with consumers diagnosed with co-occurring Post-Traumatic Stress Disorder (PTSD) and schizophrenia, schizoaffective disorder, bipolar disorder and/or cluster B personality disorders who receive mental health services at the county-operated adult mental health clinics. The program is currently in its first year. There are seven individuals enrolled in the first group. Three additional groups, each with no more than 10 participants, will begin in Spring of 2012. One of the upcoming groups will be held in a board and care facility and one will target Spanish-speaking consumers. The goals of the project are to determine: 1) if offering this group to consumers will improve mental health outcomes and promote recovery; 2) how peer providers can support the group; and 3) if the group is effective among various cultural populations, particularly Spanish-speaking populations and TAY.

Program implementation began in November of 2011. Therefore, outcome data is not yet available. To date, there have been no refinements or revisions made to the program or program goals.

**INNFT03 program activities include:**

- Implementation of the Trauma Recovery Group
- One-on-one case management services and/or therapy as needed
- Training county and contract staff and consumers about trauma and trauma therapy

**INNFT03 outcome measures include:**

- Increased knowledge about PTSD (clients and staff)
- Changes in group and one-on-one attendance
- Improvement in clinical assessments and assessment scores (surveys include the Beck’s Depression Inventory, PTSD Checklist, Post Traumatic Cognitions Inventory, PTSD Knowledge Test, Trauma History Questionnaire and Recovery Assessment Scale)
- Positive client feedback about the Trauma Recovery Project services
- Progress towards achieving client goals
- Decreased number of involuntary hospitalizations
- Decreased number of involvements with the criminal justice system
- Decreased number of evictions
- Decreased alcohol and substance abuse

**INN04: Trauma Services for Sexually Exploited Youth (up to 25 years of age)**

Creating a Safe Haven to Support Transgender and LGBTQI2-S Youth Involved in Sexual Exploitation

This 36-month project will target LGBTQI2-S youth who are (or at high risk of) being sexually exploited. The goal of this project is to create a new street-based venue intended to increase youth access to a comprehensive array of social and support services, deliv-
ered at a site specifically designed to support their needs. This program will be piloted in Central Contra Costa County and will develop a safe space and drop-in program targeting LGBTQI2-S youth with a specific focus on youth who are gender variant and/or transgender identified and who engage in street socialization, commercial sex work and/or survival sex. Additional project goals include developing replicable outreach methods that support the ability to identify and reach this underserved group; the development of assessment tools that will support identification of sexual exploitation in this population; and establishment of a referral network that will increase LGBTQ youth’s ability to integrate into mainstream social service programs.

Reluctant to Rescue

This 36-month project will target sexually exploited youth in Central and East County. The goals of the project are to: 1) gather information from sexually exploited youth about their backgrounds and reasons for entering and remaining in sexually exploitative situations as well as feedback on what would motivate and/or help them to leave these situations; 2) create a drop-in center to provide the youth needed support and services; 3) develop a training program for the care providers of sexually exploited youth; 4) determine the most effective ways of promoting and sustaining youth engagement with services; 5) determine how programs can decrease the attraction of the lifestyle some sexually exploited youth associate with their exploitation; and 6) determine what additional services and/or interventions are necessary to increase the ability of sexually exploited youth to access healthy choices and increase the number of youth who recognize they can make choices about their risk behaviors.

At this time, contracts and Work Plans associated with Reluctant to Rescue are going through the County approval process. Once approval occurs, the program will be implemented. Creating a Safe Haven to Support Transgender and LGBTQQI2-S Youth Involved in Sexual Exploitation has begun implementation and will begin to provide services to youth during Spring of 2012.

INN04 program activities will include:

- Creation of drop-in centers for sexually exploited youth/youth at risk of sexual exploitation
- Outreach to youth
- Data collection about factors influencing youth’s entrance into situations of sexual exploitation as well as factors that will motivate/help youth to leave these situations
- Provision of mental health and support services
- Development of assessment tools to identify exploited and at risk youth
• Establishment of referral network
• Intensive caregiver training
• Educating law enforcement
• Form coordinated response team for sexually exploited youth

INN04 outcome measures will include:
• Increased referrals into program(s)
• Increased number of youth utilizing services
• Increased program retention
• Decreased relapse behaviors among youth
• Decreased arrest rates among youth
• Increased knowledge of life skills among participating youth

• Improved health outcomes
• Increased number of youth who recognize they can make healthy choices in their lives
• Positive feedback about services from participants and staff
• Increased caregiver knowledge about parenting issues related to caring for a sexually exploited youth
• Increased length of home-stay among youth whose caregivers attended the caregiver training
• Changes in police policies/protocols for dealing with sexually exploited youth

“Only a man who knows what it is like to be defeated can reach down to the bottom of his soul and come up with an extra ounce of power it takes to win, when the match is even”

– Muhammad Ali
Inclusion Initiative

The Contra Costa Mental Health’s Plan (CC-MHP) Inclusion Initiative began in FY 2009-2010. Its mission is to protect Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex and Two-Spirit (LGBTQI2-S) consumers and their families from discrimination and mistreatment, and to ensure that they are welcomed in culturally affirming settings where they will receive clinically competent mental health care.

The Inclusion Initiative has three goals. The first goal is to protect LGBTQI2-S consumers and their families from discrimination and mistreatment. Initiative activities promoting Goal One ensure consumers requesting access to treatment and care through CCMHP programs and contractors are guaranteed protection from discrimination and harassment based on actual or perceived sexual orientation, gender identity or gender expression. The second goal is to ensure that CCMHP and contracted providers provide culturally affirming environments of care for LGBTQI2-S consumers and their families. Initiative activities promoting Goal Two ensure CCMHP and contracted providers have the appropriate cultural awareness, knowledge and skill to create a welcoming environment for mental health consumers of every sexual orientation, gender identity and gender expression.

The third goal is to ensure clinically competent mental health care for LGBTQI2-S consumers and their families. Initiative activities promoting Goal Three ensure clinically competent providers, care and resources are available and accessible to serve the particular mental health needs of Contra Costa residents of every sexual orientation, gender identity and gender expression, in every geographic region.
In order to achieve its goals, over the last several years, the Inclusion Initiative has developed partnerships, resources and policies for the County’s LGBTQI2-S population and their families. The following are some of the Initiative’s accomplishments to date:

- The development of the LGBTQI2-S Information and Resource Website for the EastBay (Contra Costa & Alameda Counties), www.EastbayPride.com
- Ongoing coordination with county-wide information and referral agencies to ensure information is inclusive of LGBTQI2-S resources
- Development and implementation of CC-MHP providers’ cultural competencies in working with LGBTQI2-S individuals and their families
- Incorporation of the LGBTQ Corner for educating providers on issues in meeting the needs of the community in the Mental Health Director’s bimonthly report.
- Implementation of Prevention and Early Intervention and Innovation programs targeting LGBTQI2-S individuals and their families
- A pilot project which updated CCMHP Network Provider forms to appropriately collect data regarding gender identity, relationship status and sexual orientation was initiated
- Alcohol and Other Drugs began a pilot project to train select programs and staff to collect sexual orientation and gender identity information as part of their Intake process
- Creation of the LGBTQI2-S Cultural Competency Self-Assessment & Planning tool to assess the CCMH programs readiness to serve LGBTQI2-S consumers and their families, and to assist in the development of a plan to improve their outreach and services to this population in the future
• The publication of a Web page on the CCMHP website which identifies Personal Navigators, Health Services staff and contractors who are part of the LGBTQI2-S & Straight Allies communities and able to provide personal assistance to LGBTQI2-S consumers in accessing and receiving services, in a safe and supportive environment

• The CCMHP Consumer Perception Survey was amended to collect sexual orientation and gender identity along with other demographic information

• Publication of monthly CCMH Inclusion Initiative eNewsletters which contain timely information on local trainings, online trainings, community events, surveys and research studies, jobs and scholarships, and new LGBTQI2-S resources

• In collaboration with the Health Services Department’s Pride Initiative, the Inclusion Initiative developed a non-discrimination statement inclusive of sexual orientation and gender identity—

“Contra Costa Health Services values and respects all individuals. We do not discriminate based on: age, sex, religion, sexual orientation (including lesbian, gay, bisexual), gender identity or expression (including transgender and intersex), culture, education, race, ethnicity, language, former incarceration, marital, economic or housing status, physical or mental disability, or any other basis prohibited by federal, state or local law.”

In FY 2012-2013, the Inclusion Initiative will continue towards achieving its goals. Specific activities will include: 1) the development and implementation of a comprehensive two-year training cycle to improve LGBTQI2-S competency across the CCMH programs on an ongoing basis; 2) the expansion of the number of agencies completing the LGBTQI2-S Cultural Competency Self-Assessment & Planning Tool; and 3) the development of a comprehensive set of LGBTQI2-S Policies and Procedures for improving services to CCMH consumers and their families.
Thank you for presenting and sharing your experiences with my class and I. Your presentation taught me that being open and strong can lead to a better life with or without people’s opinion. I really do hope I can be more open and strong like you guys. I am really not gonna let people get to me or put me down because I’m different. My appearance, race, sexuality and personality are always judged by people and I’m afraid to be open and strong. I want to change that. So thank you so much. You really helped me in a way I couldn’t imagine.

“Love is for All”
- Anonymous High School Student
The Information System replacement project funded by MHSA was re-directed over the last year. In light of the fact that the Epic system is currently being implemented at the County hospital (CCRMC), ambulatory care clinics, and the Contra Costa Health Plan (CCHP) and due to go live on July 1, 2012, senior management required a feasibility determination to assess whether the Epic system would work for Behavioral Health rather than use a separate system for Behavioral Health. The goal is to have a consolidated clinical record to provide a more holistic picture of clients/patients within the Health Services system. Early analyses suggest the Epic system could potentially work for most areas of clinical documentation and some aspects of managed care, but there are significant gaps in terms of Short-Doyle Medi-Cal billing, as well as Managed Care reimbursement and payment. In addition, it was questionable whether the Epic system would be sufficient to handle state mandated reporting requirements such as CSI and CalOMS. If a system other than Epic is decided on for Behavioral Health, the goal will be to utilize tools for ensuring interoperability between systems such that critical clinical information is readily shared. This functionality was built into the original plan for a new Behavioral Health system to ensure optimal clinical care for our clients in an integrated health care environment. Final direction will be provided by senior management in the Spring of 2012.

The Behavioral Health IT project team has continued on other work that is system neutral, including:

- Acquisition and installation of new workstations where needed in compliance with a new information system
- Development of a training program for staff who need more proficiency on using computers. Training has been across the board, including clerical, clinical, and management staff, starting with small classroom training and following up with one-on-one training when requested.
- Development of a draft communications plan for communicating IT project information.
- Training Behavioral Health psychiatrists and nurses on using the Epic system in select areas, such as prescriptions, lab results, and appointment scheduling.
Contra Costa County’s MHSA Capital Facilities Project Proposal was approved by the California State Department of Mental Health (hereinafter “DMH”) on May 12, 2010. This approval was granted after a long term local community planning process to develop its Mental Health Services Act (hereinafter “MHSA”) Capital Facilities Project Proposal as part of its Three Year Program and Expenditure Plan.

The project, which was approved in May 2010, called for the new construction of a 6,000 square foot Mental Health Assessment and Recovery Center (hereinafter “ARC”) on a site located at 20 Allen Street, Martinez. In addition, business and operations support were included (i.e., parking, medical records, dietary, housekeeping, staff lounge, common area). The project was projected to cost approximately $4 million. Stakeholders had also requested that there be two new programs located on the 20 Allen Street site (the ARC and also a separately constructed/funded Crisis Residential Facility [hereinafter “CRF”]). The originally approved project did not include MHSA funding requested for the construction of a CRF, but stakeholders were very firm on their desire to have both options in the county. The MHSA funds allocated to capital construction were not sufficient to cover the building costs for a CRF, but there was enough funding for the ARC.

The requested revisions were approved and adopted through an update to the Annual Plan on December 6, 2011. These revisions included the construction of the ARC, co-locating it with another Contra Costa County Health Services Department construction project for a new Integrated Primary Care Center, resulting in decreased construction cost of the ARC to $2 million.

The projected original cost of construction for the ARC was based on new construction at the 20 Allen Street site. The new construction would have included parking/garage space, business offices and other supports required to operate a free-standing facility. By co-locating the ARC with primary care, multiple cost savings on the project were realized.

The approximate $2 million construction savings from the ARC created an opportunity to move forward with the construction of the CRF. CPAW and the Mental Health Committee supported the action of obtaining construction bids to determine the financial feasibility of building the CRF. At the July 2011 CPAW meeting, the stakeholders reached consensus to solicit construction bids which would provide a detailed analysis of the cost of this project. After the construction proposals were received, it was determined that up to an additional $3,000,000 would be needed to complete the building of the CRF.

Through the community planning process, MHSA stakeholders recommended to the Health Services Department that the Department construct a 16-bed Crisis Residential Facility (CRF) with integrated dual diagnosis services. With stakeholder support, Contra Costa County is moving forward with the building and will use up to $3,000,000 from the prudent reserve. This recommendation represents the culmination of community planning and input as outlined in the October 2011 Capital Facilities Update to the FY 11-12 Annual MHSA Plan Update. The new facility is needed to provide new mental health resources in Contra Costa in order to better provide required care to mental health consumers and their family members.
System Challenges

Between March 2011 and April 2012, nine of the Program Managers in Behavioral Health retired. This created a significant loss of experience and talent in the mental health system. The first manager was replaced March 2012. During this year-long period, program Supervisors assumed the responsibilities of Program Managers without the ability to back fill their positions. The commitment of staff during this challenging time was exemplary but created stress on an already stressed system.

Prevention and Early Intervention Programs

Program 2: Coping with Trauma Related to Community Violence: This initiative continues to challenge us to develop more responsive systems, to better meet the needs of those who have been affected by the significant impact of violence. The Community Mental Health Liaisons for Violence staff were not hired pending hiring of the Program Manager. The program is being implemented, as community response teams which will provide support following incidence of violence and as liaisons for those who are experiencing acute distress and are at risk of being held involuntarily.

Program 7: Supporting Families Experiencing the Juvenile Justice System. The community based portion of this initiative is undergoing redesign which has not been completed during a period of Administrative staff retirement and replacement. It is hoped that this initiative will move forward in fiscal year 2012-13.

Innovation Programs

The implementation of The Perinatal/Postpartum Depression Collaborative Program with Public Health and the Women Infant and Child Program was delayed in implementation due to the challenge of a county personnel system which has backlogged requests for exams and position approvals. The staff have been hired and the program was officially embarked upon on April 23, 2012.

Children’s Full Service Partnership

As designed, the Children’s Full Service Partnership program was not reaching the intended target population for Full Service Partners as defined in the Welfare and Institution Code. The program ended December 31, 2011 and planning for the revised Children’s FSP is currently underway. The redesign of the Children’s FSP program is driven by data which highlights the children most in need of intensive outpatient services as evident by multiple hospitalizations, psychiatric emergency service visits or mobile response team crisis services. Implementation is anticipated to begin July 1, 2012.

Systems Development Strategies

The original MHSA planning process in 2005 resulted in six systems development strategies for the Community Services and Supports (CSS) plan. As the system transforms
and moves more towards integration, the categories of Systems Development Strategies are too narrow in scope to be effective in improving the system of care. Therefore, moving forward, the strategies will be broadened to be more inclusive of systems enhancements within various areas and will be in agreement with the Welfare and Institution Code’s definition of Systems Development Strategies.

Accessibility of Trainings:
CCMHP programs are spread out in all regions of Contra Costa County (East, Central and West), and because of how wide-spread the county is, trainings are held in the central region. This region is the most accessible of the three aforementioned. However, some staff still find it difficult to attend trainings held in this region. To alleviate this issue MHP procured an on-line learning system called Essential Learning, which is accessible anytime at anywhere with internet access. The learning system has over 500 courses available to staff. Another option the county is currently looking at is the acquisition of a video conferencing system that would allow staff view live trainings from any county mental health program location. Because we know the importance of providing trainings to staff to increase their knowledge and skill set, CCMHP will continue to look at various options that make trainings accessible by all staff at all regions of the County.

Supervision of Evidence-Based Programs (EBP):
The MHP does not currently have enough clinical supervisors to supervise the implementation of all the Evidence Based Programs (EBP) identified by the MHP. The intent of these new EBPs is to introduce new evidence practice to the workforce. The supervision of these programs is important in order to maintain fidelity and proper implementation. The MHP is currently looking at various options on how to increase the capacity of EBP supervisors in order to effectively implement identified EBP across all regions of the County.

Sustaining Knowledge Acquired at Trainings:
Some staff members have expressed that one-day trainings are not enough for them to apply newly acquired knowledge to their work. Staff have expressed that they want to apply this knowledge at work but is often difficult because they get caught up with doing business as usual and don’t necessary have a form of reinforcement to emphasize the acquired knowledge. Staff members have expressed various options that would help them sustain and utilize this knowledge; for example, having follow-up trainings (brown bag seminars). The MHP training committee will continue to explore various options to help staff sustain knowledge acquired from trainings.
Today I believe in Recovery!
By: Jami Tussing

My name is Jami, and after being given a mental health diagnosis at fourteen years old I was left feeling hopeless living in group homes and a foster home. As time passed my future seemed empty. When reaching adulthood I became dually diagnosed and with four beautiful children I could only pray they would be proud of me one day, but I had no clue as to how because I was not proud of myself.

At 30 years of age I found myself homeless and in a residential drug treatment program. Through the years of my addiction and illness, I had heard about the Service Provider Individualized Recovery Intensive Training (S.P.I.R.I.T) program. While in my residential program I asked my counselor for the application but my counselor did not believe I was ready for the class. However, I knew I was ready and I filled out the application. I felt empowered making this decision believing that good could come from this choice. I was finally doing something right for myself by applying for the S.P.I.R.I.T program.

S.P.I.R.I.T is a class for mental health consumers, taught by S.P.I.R.I.T graduates. I was accepted to the program and there I began my journey to recovery. I graduated the treatment program and began the classes at Contra Costa College, taking S.P.I.R.I.T, a nine unit certificate course.

While learning so many things, what I was really learning was how to believe in myself and take care of myself. I remember telling my instructor that “I want to be where you’re at.” I worked hard through the class, never truly thinking I could be an instructor however holding a new hope for myself as the class came to an end with graduation.

To my daily amazement three short months later I was hired for a full time permanent position as a community support worker for the Office for Consumer Empowerment as the instructor of the S.P.I.R.I.T program. This was my emerald city, my dream come true.

My confidence has grown and belief in myself comes from looking back on who I was as a youth struggling, a young woman and mother who was once lost and has now come to life. I am the woman and mother I was always meant to be. Although I have been diagnosed with two serious and persistent mental health diagnoses, I have found pride and purpose and discovered my gift to be an instructor in S.P.I.R.I.T holding the hope for students who share similar experiences. The S.P.I.R.I.T program gave me tools to help myself maintain wellness and be an example to others that although recovery looks different for everyone, I know that Recovery IS REAL!
I have been a consumer since I was 18. For 20 years of my life I have been hospitalized over 50 times just in Contra Costa County and many of these times have led to me being restrained.

When brought into the hospital, I was usually restrained in a chair for long periods of time during the admission process. After that I would act out because the process would be long and to keep me quiet I would be placed in seclusion, belted to the chair, medicated, and put into 5 point restraint which restrained me to the bed. Then I would fall asleep from the medication and moved to a regular unit.

What I found most helpful and am grateful for was the people who worked with me that were once like me, who listened and supported and encouraged me to realize I have choices and believed that I could lead my own recovery and guided me through the changes.

I started out with a referral from MHSA Behavioral Health Court to a dual diagnosis residential program called Nevin house operated by Anka Behavioral Health and graduated from that program. I then moved to a Anka Behavioral Health Sober and clean living house and began working at the Anka Phoenix Enterprise work program.

I started my journey to help others like myself and began working in the helping profession providing peer support as an apartment manager for clean and sober housing. I set an example and was promoted to case manager for behavioral health court because they believed in me. Now I have eight years clean and sober and provide hope for people who didn’t think that a life like this could be possible. I believe in recovery and now I am working with older adults to improve their quality of life and prevent hospitalizations that can become costly and traumatic.

I would like to leave you with a message “Don’t Stop Believing”
The day before my ninth birthday I was taken from my home and put into foster care. My sister and I were separated and I would leave my foster homes looking for my sister and especially my mom. All I was told was that she had a mental breakdown. I stayed in foster care except for the times I would run to my grandma’s looking for my mom until I aged out of foster care at 18. I then moved back with my grandma and mom who was using drugs and our house was foreclosed, so once again we all became separated.

There were no resources and no one helped me exit the foster care system. At this time I was using marijuana, and stealing and breaking into homes to get my high.

I had been seeing my County Psychiatrist who introduced me to Calli House (MHSA funded), a homeless shelter for youth. I was scared and never been in a shelter. I entered into Calli House who helped me with anger management, case management, employment, housing, food stamps, General Assistance, and savings. They have helped me with my legal problems and helped me get connected with additional services such as a Personal Services Coordinator with Fred Finch who also helps me with money management and encouraged me to take a class at Contra Costa College called Serviced Provider Individualized Recovery Intensive training also known as S.P.I.R.I.T., taught and funded by Mental Health Administration’s Office for Consumer Empowerment.

Today I am enrolled in SPIRIT and I help do outreach to other youth. I am learning to advocate and speak to large groups about my experiences and provide hope and inspiration to other youth, as well as participate in conference meetings with other youth and staff.

I am 20 years old and plan to get my AA degree in Dual Diagnosis, transfer to Sacramento State, get a Master Degree in Social work and open up a LGBT Homeless shelter for youth.
The Annual Update is posted on the Contra Costa County Department of Mental Health website from May 15 through June 14, 2012. The public hearing to confirm the community planning process is scheduled to be held on June 14, 2012 at 5:00pm in the 1st floor conference room at 2425 Bisso Ln., Concord CA, 94520.
Stakeholder Input Opportunities

A comprehensive communication plan was implemented during this annual update that includes:

• Email blast to Community Based Organizations, the Contra Costa Mental Health Commission, the Consolidated Planning and Advisory Workgroup (CPAW), and Behavioral Health Staff containing information updates and opportunities for stakeholder or Behavioral Health Staff input.

• From July 1, 2011 through May 3, 2012, monthly stakeholder meetings were hosted to inform stakeholders regarding current MHSA programs and services including reviewing measures and outcomes for all MHSA Programs. Stakeholders input and support for all program refinements and redesign was included in this process. The meetings were held at 2425 Bisso Ln. in Concord, California on these dates:
  
  Thursday, July 7, 2011
  Thursday, August 4, 2011
  Thursday, September 1, 2011
  Thursday, October 6, 2011
  Thursday, November 3, 2011
  Thursday, December 1, 2011
  Thursday, January 5, 2012
  Thursday, February 2, 2012
  Thursday, March 1, 2012
  Thursday, April 5, 2012
  Thursday, May 3, 2012

• In addition to the larger stakeholder body meetings of the following subcommittees provided input into program development:
  
  ♦ Transportation
  ♦ Housing
  ♦ Suicide Prevention
  ♦ Social Inclusion
  ♦ Perinatal Depression
  ♦ Aging and Older Adult
  ♦ Data
  ♦ Planning
  ♦ Innovation
  ♦ Capital Facilities and Information Technologies
  ♦ Membership
  ♦ Reducing Health Disparities

• This ongoing information and development culminated with the review of the Consumer Satisfaction Survey, the Staff Priority Needs Assessment and MHSA priorities identified in the initial planning process which were not yet funded. The priorities identified above formed the basis for recommendations for program expansion in Fiscal Year 2012-13.

• A joint Mental Health Commission and CPAW meeting was held on April 5, 2012, this meeting was also open to the public. The meeting provided an opportunity for additional input into the prioritization which framed the basis for the program expansion in Fiscal Year 2012-13.
2012-13 MHSA Budget
MHSA Increased Allocation
Flow Chart
FY 2012-2013

FY 2011-2012 Allocation
$22,156,300

20% increased allocation
$26,587,560
An additional $4,431,260

Overhead (15%) - $443,126
Administration (10%) - $664,689
Total: $1,107,815

$3,323,445
for MHSA growth

CSS – 80%
$2,658,756

CSS FSP (51%)
$949,176

Housing (30%)
$797,627

CSS Non-FSP (49%)
$911,953

PEI – 20%
$664,689

Innovation (5% of total)
$166,172

PEI Children
$254,244

PEI Other Ages
$244,273

PEI
$498,517
## FY 2012/13
### MHSA FUNDING SUMMARY

**Date:** 5/16/2012

<table>
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<tr>
<th>County:</th>
<th>Contra Costa</th>
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**MHSA Funding**

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<th></th>
<th>CSS</th>
<th>WET</th>
<th>CFTN</th>
<th>PEI</th>
<th>INN</th>
<th>Local Prudent Reserve</th>
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<tr>
<td><strong>A. Estimated FY 2012/13 Funding</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1. Estimated Unspent Funds from Prior Fiscal Years</td>
<td>$12,691,753</td>
<td>$1,904,166</td>
<td>$9,409,013</td>
<td>$7,948,439</td>
<td>$3,826,100</td>
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<td>2. Estimated New FY 2012/13 Funding</td>
<td>$20,103,120</td>
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<td>3. Transfer in FY 2012/13**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4. Access Local Prudent Reserve in FY 2012/13</td>
<td>$32,794,873</td>
<td>$1,904,166</td>
<td>$9,409,013</td>
<td>$13,104,719</td>
<td>$5,154,260</td>
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<td>5. Estimated Available Funding for FY 2012/13</td>
<td>$32,794,873</td>
<td>$1,904,166</td>
<td>$9,409,013</td>
<td>$13,104,719</td>
<td>$5,154,260</td>
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**B. Estimated FY 2012/13 Expenditures**

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<tr>
<td>1. Estimated Unspent Funds from Prior Fiscal Years</td>
<td>$22,403,305</td>
<td>$560,000</td>
<td>$7,200,000</td>
<td>$9,085,112</td>
<td>$4,045,340</td>
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<td>2. Contributions to the Local Prudent Reserve in FY12/13</td>
<td>$10,391,568</td>
<td>$1,344,166</td>
<td>$2,209,013</td>
<td>$4,019,607</td>
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**D. Estimated Local Prudent Reserve Balance**

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<td>1. Estimated Local Prudent Reserve Balance on June 30, 2012</td>
<td>$10,125,250</td>
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<td>2. Contributions to the Local Prudent Reserve in FY12/13</td>
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<td>3. Distributions from Local Prudent Reserve in FY12/13</td>
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<td>4. Estimated Local Prudent Reserve Balance on June 30, 2013</td>
<td>$7,125,250</td>
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**Per Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.**
### MHSA Funding Summary

**Date:** 5/16/2012  

**A. Estimated FY 2012/13 Funding**  
$12,691,753  
$1,904,166  
$9,409,013  
$7,948,439  
$3,826,100

**2. Estimated New FY 2012/13 Funding**  
$20,103,120  
$5,156,280  
$1,328,160

**4. Access Local Prudent Reserve in FY 2012/13**  
$32,794,873  
$1,904,166  
$9,409,013  
$13,104,719  
$5,154,260

### Estimated FY 2012/13 Expenditures

$22,403,305  
$560,000  
$7,200,000  
$9,085,112  
$4,045,340

### Estimated FY 2012/13 Contingency Funding

$10,391,568  
$1,344,166  
$2,209,013  
$4,019,607  
$1,108,920

**Total Available:**  
$10,125,250  
$0  
-$3,000,000  
$7,125,250

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**Per Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.**

### Role Based on Estimated Contingency

**County:** Contra Costa

---

### MHSA Funding Plan for Increased Allocation by Component

**CSS – Full Service Partnerships**  
**Total available: $949,176  --- Total Planned: $949,176**

<table>
<thead>
<tr>
<th>Component</th>
<th>1&lt;sup&gt;st&lt;/sup&gt; Priority</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt; Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TAY FSP</strong></td>
<td>Expansion of TAY FSP to all regions of the County</td>
<td>✓ Up to $379,670</td>
</tr>
<tr>
<td></td>
<td>✓ Up to $569,506</td>
<td>Addition of “step-down” Personal Service Coordinators to FSP Programs</td>
</tr>
</tbody>
</table>

**CSS – Systems Development Strategies**  
**Total available: $911,953  --- Total Planned: $2,190,280**

<table>
<thead>
<tr>
<th>Component</th>
<th>1&lt;sup&gt;st&lt;/sup&gt; Priority</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt; Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children SDS</strong></td>
<td>Implementation of evidence based dual diagnosis treatment program</td>
<td>✓ Included as part of the Children’s FSP contract for MDFT</td>
</tr>
<tr>
<td></td>
<td>✓ Up to $500k</td>
<td>Implementation of evidence-based dual diagnosis treatment program</td>
</tr>
<tr>
<td><strong>TAY SDS</strong></td>
<td>Transitional residential program at the Oak Grove facility</td>
<td>✓ Up to $500k</td>
</tr>
<tr>
<td></td>
<td>✓ Up to $200k-450k</td>
<td>✓ No additional funding, ✓ Incorporate this concept into all new FSP programs ✓ Work towards integrating into existing contracts</td>
</tr>
<tr>
<td><strong>Adult SDS</strong></td>
<td>Rapid Access in each of the adult Mental Health Clinics</td>
<td>✓ 3 MH Clinical Specialists - $370,482 ✓ 1.5FTE Registered Nurse – Experienced (0.5FTE for each region) - $228,834</td>
</tr>
<tr>
<td></td>
<td>✓ Use approved/funded, vacant positions to establish the crisis response for Adults ✓ 3 MH Clinical Specialists</td>
<td></td>
</tr>
<tr>
<td><strong>Older Adult SDS</strong></td>
<td>Increase access to transportation</td>
<td>✓ Create an Innovation proposal for funding ✓ Consider transportation for all age groups</td>
</tr>
<tr>
<td></td>
<td>✓ $370,482</td>
<td>✓ 3 MH Clinical Specialists - $370,482</td>
</tr>
</tbody>
</table>
### CSS – Housing

**Total available: $797,627 --- Total Planned: $150,000**

<table>
<thead>
<tr>
<th>Component</th>
<th>1st Priority</th>
<th>2nd Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSS Housing</td>
<td>Allocate 30% of all new MHSA revenue to housing</td>
<td>Residential aspect of the TAY Transitional Residential - $150k</td>
</tr>
</tbody>
</table>

### PEI – Children

**Total available: $254,244 --- Total Planned: $646,988**

<table>
<thead>
<tr>
<th>Component</th>
<th>1st Priority</th>
<th>2nd Priority</th>
<th>3rd Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEI Children</td>
<td>Expansion of alternative education programs that integrate mental health and substance abuse treatment into the school program</td>
<td>Up to $50k</td>
<td>Increase independent living skills programs for those approaching their 18th birthday</td>
</tr>
</tbody>
</table>

### PEI – Other Ages

**Total available: $244,273 --- Total Planned: $350,000**

<table>
<thead>
<tr>
<th>Component</th>
<th>1st Priority</th>
<th>2nd Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEI – All other programming</td>
<td>Additional support for families accessing PES services</td>
<td>Up to $200k</td>
</tr>
</tbody>
</table>

### Innovation

**Total available: $166,172 --- Total Planned: $0**

<table>
<thead>
<tr>
<th>Component</th>
<th>1st Priority</th>
<th>Additional Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Innovation</td>
<td>Top Priority: Integration</td>
<td>Transportation</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>Employment</td>
</tr>
</tbody>
</table>

### WET

**Total available: $0 --- Total Planned: $0**

<table>
<thead>
<tr>
<th>Component</th>
<th>1st Priority</th>
<th>2nd Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>WET</td>
<td>Training for behavioral health staff in co-occurring AOD treatment and assessment</td>
<td>This is part of the approved WET plan</td>
</tr>
</tbody>
</table>
Unspent Funds Request
Community Services & Supports (CSS)

Over the span of several years, the actual CSS expenditures have been less than the planned CSS budget resulting in a savings of funds which have been set aside for future use. As of FY 11-12, the unspent funds balance was $12,691,753. It is important to use these funds for short-term projects, one-time expenses, or for projects capitalized over several years to ensure the money is being utilized to support the system of care and those who access the services.

The following is a list of strategies, supported by stakeholders, for which unspent funds will be used:

<table>
<thead>
<tr>
<th>Item:</th>
<th>Budget: (Up to)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vehicles for programs within the system of care</td>
<td>$338,000</td>
</tr>
<tr>
<td>Infrastructure and space</td>
<td>$394,120</td>
</tr>
<tr>
<td>Additional support staff for programming</td>
<td>$270,067</td>
</tr>
<tr>
<td>Increased allocation strategies requiring additional funding</td>
<td>$1,278,327</td>
</tr>
<tr>
<td><strong>Total funds requested</strong></td>
<td><strong>$2,280,514</strong></td>
</tr>
<tr>
<td><strong>Unspent fund balance</strong></td>
<td><strong>$10,411,239</strong></td>
</tr>
</tbody>
</table>

Prevention and Early Intervention (PEI)

The Prevention and Early Intervention budget has an unspent funds balance of $7,948,439. The following is a list of strategies, supported by stakeholders, for which unspent PEI funds will be used during FY 12-13.

<table>
<thead>
<tr>
<th>Item:</th>
<th>Budget: (Up to)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEI Programming - Children</td>
<td>$392,744</td>
</tr>
<tr>
<td>PEI Programming – All Other Ages</td>
<td>$105,727</td>
</tr>
<tr>
<td>Existing PEI Programs #1-10*</td>
<td>$3,430,361</td>
</tr>
<tr>
<td><strong>Total funds requested</strong></td>
<td><strong>$3,928,832</strong></td>
</tr>
<tr>
<td><strong>Unspent fund balance</strong></td>
<td><strong>$4,019,607</strong></td>
</tr>
</tbody>
</table>

*For additional information please reference the document referenced “Plan for Increased Allocation by Component”.

MHSA Prudent Reserve Request

Through the community planning process, MHSA stakeholders recommended to the Health Services Department that the Department construct a 16-bed Crisis Residential Facility (CRF) with integrated dual diagnosis services. After the construction proposals were received, it was determined that up to an additional $3,000,000 would be needed to complete the building of the CRF. With stakeholder support, Contra Costa County is moving forward with the building and will use up to $3,000,000 from the prudent reserve. This recommendation represents the culmination of community planning and input as outlined in the October 2011 Capital Facilities Update to the FY 11-12 Annual MHSA Plan Update.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prudent Reserve (FY 11-12)</strong></td>
<td><strong>$10,125,250</strong></td>
</tr>
<tr>
<td><strong>Allocation to building the Crisis Residential Facility</strong></td>
<td><strong>$3,000,000 (up to)</strong></td>
</tr>
<tr>
<td><strong>Prudent Reserve Balance</strong></td>
<td><strong>$7,125,250</strong></td>
</tr>
</tbody>
</table>

The new facility is needed to provide new mental health resources in Contra Costa in order to better provide required care to mental health consumers and their family members.
Acknowledgments

All of those who have shared their lived experience with us. You have inspired and challenged us to co-create systems which support the recovery and resiliency which you demonstrate to us everyday.

With special recognition to the staff of the Office for Consumer Empowerment, Mental Health Consumer Concerns, Members of the Putnam Clubhouse and the many contributors to the planning and delivery of programs and services which are client centered.

To the staff of Contra Costa Behavioral Health and our partner provider organizations for the work you do each day to improve the lives of those who experience mental illness and serious emotional disturbance.

To the staff who have contributed to the development of this plan:

Mary Roy
Holly Page
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Kennisha Johnson
Imo Momoh
Steve Hahn-Smith
Caroline Sison
Heather Sweeten-Healy
Susan Medlin
Sandy Rose
Vien Tran
Jennifer Tuipulotu
Leslie Ocang
Jisel Iglesias

To the leadership of Contra Costa Mental Health for your inspiration and tireless commitment of service:

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Victor Montoya
Vern Wallace
Jan Cobaleda-Kegler
Helen Kearns
Cynthia Belon
Heartfelt thanks to the members of our MHSA Stakeholder body, the Consolidated Planning and Advisory Workgroup for their passion, commitment and investment of time to work as collaborators in the process of transformation through the Mental Health Services Act.

Stephen Boyd Jr.  
Lisa Bruce  
Brenda Crawford  
Courtney Cummings  
Doreen Gaedtke  
Tom Gilbert  
John Gragnani  
Steven Grolnic-McClurg  
Molly Hamaker  
Peggy Harris  
Lori Hefner  
Ralph Hoffman  
John Hollender  
Ron Johnson  
Dave Kahler  
Kimberly Krisch  
Beatrice Lee  
Anna Lubarov  
Susanna Marshland  
Kathi McLaughlin  
Susan Medlin  
Marianna Moore  
Ryan Nestman  
Teresa Pasquini  
Annis Pereyra  
Nayyirah Sahib  
Tony Sanders  
Thomas Sponsler  
Connie Steers  
Wayne Thurston  
Sam Yoshioka

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Evelyn Centeno  
Dave Kahler  
Peggy Kennedy  
Carole McKindley-Alvarez  
Colette O’Keeffe  
Floyd Overby  
Teresa Pasquini  
Annis Pereyra  
Gina Swirsding R.N.  
Sam Yoshioka  
Supervisor John Gioia  
Supervisor Mary Piepho

If you would like to receive email updates on new MHSA news please join our mailing list by emailing us at: MHSA@hsd.cccounty.us
When I was in Junior High, I remember loving to learn. I don’t know if it was being an only child and growing up within a very unstructured home life or just how normal high school is, but in my first semester of high school I developed severe anxiety about being in school and about what was going on at home. I would often feel knots in my stomach, feeling sick as if I needed to throw up. I remember feeling a deep sense of hopelessness. I was lost and very lonely. I failed every class that semester. I started smoking pot every day after school and using ecstasy. I think I used drugs to deal with stress, home life because I really didn’t know what I was doing so I just did that. I wasn’t involved in any that had a purposed or that really mattered. My dad was in and out and my mom was doing the best she could. As a child, I also suffered from severe OCD and was a clean freak. I was super afraid of germs. In 10th grade, I started New Leaf and found something I never knew I needed. I found a learning structure that gave me the stability I needed, but also was flexible enough for me to make different choices of how to handle my stresses and mental issues throughout the school day. One of the things that helped me a great deal was the personal and intimate relationships I developed with my teachers. I remember the first time I cried to one of them. It helped me so much knowing that at school I could be in a family environment that supported all of me and not just the part of me that need to do the academic work. At New Leaf, I learned to “first seek to understand” and other strategies for dealing with my body and my mind. I now use a variety of breathing strategies and mediation practices when I feel I need it. Now every night it bed I do breathing exercises. Learning how to do yoga and about other natural remedies also helped me so much. The particular way my teachers teach us really helps too. It is different than any other school I’ve attended. Slowly I started to see myself change and feel healthier and my teachers helped me see my growth, not only in academic credits, but in how I was dealing with my feeling and my fears of not having control. Also at New Leaf, I was exposed to so many different careers and it has helped me to imagine myself as having the skills to create a different life than my parents did. Now as a Senior, I am appreciative of this life changing experience and I want the younger students entering the program to see all that they can be given if they fully take advantage of all the resources we have at New Leaf to change our lives.
Appendices
Appendix A

Prevention and Early Intervention Programs:

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Overarching Goals for Program 1:

PROGRAM 1: Building Connections in Underserved Cultural Communities
Community engagement, mutual support and families that communicate well are protective factors against mental illness for all age groups. This program is designed to strengthen underserved cultural communities in ways that are relevant to specific communities to increase wellness and reduce stress and isolation, to decrease the likelihood of needing services of many types, and to help support strong youth and strong families.

This will be accomplished by allowing members of underserved cultural communities to:
• **Strengthen Community** – Build strengths, wellness, and connectedness in the community and implement that vision.
• **Strengthen Communications** – Implement an effective curriculum for improving intra-family communication in the community.
• **Provide Mental Health Education/System Navigation Support** – Develop or expand culturally appropriate methods to educate about and promote mental health and to offer system navigation support.

Target Population:

• Latinos
• African Americans
• Asian / Pacific Islanders
• Native Americans
• Lesbian/Gay/Bisexual/Transgender/Questioning (LGBTQ)

Overview of Intended Outcomes:

Individuals and families in communities engaged in these projects will:
• Be more actively engaged in their communities
• Have stronger communication within their families
• Have support and better skills to navigate existing public and community based systems in the county for services and supports

Did we reach those outcomes?

Four of the eight agencies in Program 1 submitted their outcomes for fiscal year 2010 to 2011. Two of the agencies that did not submit their outcomes were newly contracted for fiscal year 2010 to 2011. The other two agencies provided only demographics for this fiscal year.

Of the four agencies that submitted their outcome measures, two agencies exceeded the target goals they had established for all of their outcome measures. One agency exceeded the target goals for two-thirds of its outcomes and achieved 94% of the target for the remaining outcome. The fourth agency exceeded its target goals for 55% of their outcomes, and achieved at least 50% of the target for an additional one-third of its goals.
### Program #1 Demographics:

<table>
<thead>
<tr>
<th>Age in Years</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>114</td>
<td>2%</td>
</tr>
<tr>
<td>6-12</td>
<td>186</td>
<td>3%</td>
</tr>
<tr>
<td>13-17</td>
<td>106</td>
<td>2%</td>
</tr>
<tr>
<td>18-21</td>
<td>324</td>
<td>6%</td>
</tr>
<tr>
<td>22-25</td>
<td>361</td>
<td>6%</td>
</tr>
<tr>
<td>26-35</td>
<td>1298</td>
<td>23%</td>
</tr>
<tr>
<td>36-45</td>
<td>1334</td>
<td>23%</td>
</tr>
<tr>
<td>46-59</td>
<td>1105</td>
<td>19%</td>
</tr>
<tr>
<td>60+</td>
<td>698</td>
<td>12%</td>
</tr>
<tr>
<td>Unknown</td>
<td>204</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5730</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1975</td>
<td>35%</td>
</tr>
<tr>
<td>Female</td>
<td>3668</td>
<td>64%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>0.1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>50</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5697</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Region</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>751</td>
<td>13%</td>
</tr>
<tr>
<td>Central</td>
<td>2390</td>
<td>42%</td>
</tr>
<tr>
<td>East</td>
<td>2394</td>
<td>42%</td>
</tr>
<tr>
<td>Other</td>
<td>90</td>
<td>2%</td>
</tr>
<tr>
<td>Unknown</td>
<td>72</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5697</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>555</td>
<td>10%</td>
</tr>
<tr>
<td>Am. Indian / AK Native</td>
<td>145</td>
<td>2%</td>
</tr>
<tr>
<td>Asian / Pacific Islander</td>
<td>382</td>
<td>7%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>390</td>
<td>7%</td>
</tr>
<tr>
<td>Hispanic / Latino</td>
<td>3787</td>
<td>66%</td>
</tr>
<tr>
<td>Other</td>
<td>339</td>
<td>6%</td>
</tr>
<tr>
<td>Unknown</td>
<td>99</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5697</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Language</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Sign</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Asian</td>
<td>210</td>
<td>4%</td>
</tr>
<tr>
<td>English</td>
<td>1578</td>
<td>28%</td>
</tr>
<tr>
<td>Farsi</td>
<td>174</td>
<td>3%</td>
</tr>
<tr>
<td>Spanish</td>
<td>3470</td>
<td>61%</td>
</tr>
<tr>
<td>Other</td>
<td>177</td>
<td>3%</td>
</tr>
<tr>
<td>Unknown</td>
<td>88</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5697</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Please Note: Age category has 33 more clients because La Clinica (Project #1) ran age category report on a different day from original report for other categories: gender, region, ethnicity, and language.
Measures of Success Progress Toward Target
July 1st, 2010 – June 30th, 2011

% Target Met per Outcome Measure
Fiscal Year 2010 - 2011

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Target</th>
<th>Actual</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better understanding of cross cultural MH Concepts (Staff) (Target: 90% of 67)</td>
<td>60</td>
<td>67</td>
<td>112%</td>
</tr>
<tr>
<td>Increased Understanding of Client Referral (Target: 95% of 67)</td>
<td>64</td>
<td>67</td>
<td>105%</td>
</tr>
<tr>
<td>Clients educated regarding MH issues (Target: 225 people)</td>
<td>225</td>
<td>270</td>
<td>120%</td>
</tr>
<tr>
<td>Better understanding of cross cultural MH Concepts (Client) (Target: 80% of 270)</td>
<td>216</td>
<td>259</td>
<td>120%</td>
</tr>
<tr>
<td>Reduction in feelings of stigma (Target 80% of 270)</td>
<td>216</td>
<td>259</td>
<td>120%</td>
</tr>
<tr>
<td>Better understanding of seeking help (Target: 80% of 270)</td>
<td>216</td>
<td>254</td>
<td>118%</td>
</tr>
<tr>
<td>Clients feel less isolated &amp; more supported (Target: 80% of 270)</td>
<td>216</td>
<td>270</td>
<td>125%</td>
</tr>
<tr>
<td>Clients receiving health and MH system navigation assistance will achieve 1 or more positive outcomes (Target: 87% of 471)</td>
<td>410</td>
<td>471</td>
<td>115%</td>
</tr>
</tbody>
</table>
LA CLINICA DE LA RAZA
PROGRAM 1: VIAS DE SALUD (PATHWAYS TO HEALTH)

Measures of Success Progress Toward Target
July 1st, 2010 – June 30th, 2011

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Target</th>
<th>Actual</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Factor Screenings were completed. (Target: 3,700)</td>
<td>3,700</td>
<td>4,037</td>
<td>109%</td>
</tr>
<tr>
<td>Behavioral Health Consultations (BHC). (Target: 1,100)</td>
<td>1,100</td>
<td>1,339</td>
<td>122%</td>
</tr>
<tr>
<td>Cultural adjustment education/support group. (Target: 68)</td>
<td>68</td>
<td>72</td>
<td>106%</td>
</tr>
<tr>
<td>Participants who complete the education/support group will demonstrate reduction of risk factors. (Target: 75% of 72)</td>
<td>54</td>
<td>62</td>
<td>115%</td>
</tr>
</tbody>
</table>
NATIVE AMERICAN HEALTH CENTER
PROGRAM 1: NATIVE AMERICAN WELLNESS CENTER

Measures of Success Progress Toward Target
July 1st, 2010 – June 30th, 2011

% Target Met per Outcome Measure
Fiscal Year 2010 - 2011

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Target</th>
<th>Actual</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased social connectedness. (Target: 65% of 47)</td>
<td>31</td>
<td>29</td>
<td>94%</td>
</tr>
<tr>
<td>Increased communication skills. (Target: 60% of 47)</td>
<td>28</td>
<td>32</td>
<td>114%</td>
</tr>
<tr>
<td>Increase ability to navigate MH education/system. (Target: 50% of 43)</td>
<td>22</td>
<td>43</td>
<td>195%</td>
</tr>
</tbody>
</table>
RAINFOREST COMMUNITY CENTER
PROGRAM 1: LGBT COMMUNITY MOBILIZATION & SOCIAL SUPPORT

Measures of Success Progress Toward Target
July 1st, 2010 – June 30th, 2011

% Target Met per Outcome Measure

- Fiscal Year 2010 - 2011

GOAL: 100%
RAINFORD COMMUNITY CENTER  
PROGRAM 1: LGBT COMMUNITY MOBILIZATION & SOCIAL SUPPORT  

Measures of Success Progress Toward Target  
July 1st, 2010 – June 30th, 2011

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Target</th>
<th>Actual</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV+ Social Outreach Group. (Target: 20)</td>
<td>20</td>
<td>19</td>
<td>95%</td>
</tr>
<tr>
<td>LGBT Seniors Activity Grp. (Target: 10)</td>
<td>10</td>
<td>5</td>
<td>50%</td>
</tr>
<tr>
<td>Heterosexual Parents of LGBT youth. (Target: 20)</td>
<td>20</td>
<td>6</td>
<td>30%</td>
</tr>
<tr>
<td>HIV/AIDS Meal Outreach Program. (Target: 12)</td>
<td>12</td>
<td>28</td>
<td>233%</td>
</tr>
<tr>
<td>Lesbian Woman Outreach Group. (Target: 45)</td>
<td>45</td>
<td>44</td>
<td>98%</td>
</tr>
<tr>
<td>Gay/Bisexual Men Outreach Group. (Target: 20)</td>
<td>20</td>
<td>54</td>
<td>270%</td>
</tr>
<tr>
<td>LGBT Seniors Meal Outreach Program. (Target: 35)</td>
<td>35</td>
<td>68</td>
<td>194%</td>
</tr>
<tr>
<td>LGBT Sports Event. (Target: 20)</td>
<td>20</td>
<td>13</td>
<td>65%</td>
</tr>
<tr>
<td>Picnics &amp; Potlucks. (Target: 400)</td>
<td>400</td>
<td>430</td>
<td>108%</td>
</tr>
<tr>
<td>LGBT Families Socials. (Target: 10)</td>
<td>10</td>
<td>12</td>
<td>120%</td>
</tr>
<tr>
<td>Hay Ride &amp; Pumpkin Carving. (Target: 35)</td>
<td>35</td>
<td>13</td>
<td>37%</td>
</tr>
<tr>
<td>Volunteer Recognition Night. (Target: 35)</td>
<td>35</td>
<td>10</td>
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<tr>
<td>Gay University. (Target: 75)</td>
<td>75</td>
<td>46</td>
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<tr>
<td>10-week Women's Coming-Out Group. (Target: 8)</td>
<td>8</td>
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<td>75%</td>
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<tr>
<td>Winter Social (Casino Night). (Target: 15)</td>
<td>15</td>
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<tr>
<td>Central County Youth Support Group. (Target: 45)</td>
<td>45</td>
<td>97</td>
<td>216%</td>
</tr>
<tr>
<td>TAY Skills / Leadership Group. (Target: 15)</td>
<td>15</td>
<td>38</td>
<td>253%</td>
</tr>
<tr>
<td>HIV+ Support Group. (Target: 15)</td>
<td>15</td>
<td>35</td>
<td>233%</td>
</tr>
<tr>
<td>Spirituality Workshops. (Target: 15)</td>
<td>15</td>
<td>19</td>
<td>127%</td>
</tr>
<tr>
<td>Individual Level Counseling. (Target: 30)</td>
<td>30</td>
<td>30</td>
<td>100%</td>
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Overarching Goals for Program 2:

PROGRAM 2: Coping with Trauma Related to Community Violence
This Program has two components:

1. Coping with Community Violence – Program designed to specifically strengthen one community’s response to the trauma of violence – the West County area of Contra Costa County. Organizations and residents of West County define how and where they will respond to the impact of the community violence they all experience.

2. Community Mental Health Liaisons for Trauma – Development of Contra Costa Mental Health’s “system readiness” for trauma and trauma-informed systems of care. This effort will build upon CCMH’s Critical Incident Stress Debriefing trainings (CISDs), and CIT trainings with law enforcement that helps communities respond effectively to traumatic episodes. CISD is a group model that aids individuals exposed to trauma to recount their memories of the traumatic event, hear the perceptions of others exposed to the trauma, describe personal coping strategies and “normalize” their experience. During the group process, individuals are identified who seem in need of individual interventions, and are provided crisis intervention and are referred for further assessment and treatment.

Target Population:

- The West County effort will address some or the entire West County region defined as all areas of the county west of Martinez, including cities of Richmond, El Cerrito, Kensington, San Pablo, Pinole, and Hercules.

- The Richmond area of West County is one of the two highest violence areas of the county.

Overview of Intended Outcomes:

Individuals touched by either program will have increased supports to cope with the trauma they experience as a result of community violence.

Did we reach those outcomes?

The target goals set for Program #2 were met or exceeded for half of the Program’s outcome measures. For two-thirds of the remaining outcomes, at least 40% of the target had been achieved. Individuals touched by Program #2 have increased support to cope with the trauma they experience as a result of community violence. The RYSE Collaborative reported a positive sense of shared understanding of Trauma Response and Resilience System (TRRS). The RYSE Collaborative committed to developing a shared platform for advocacy and systems change. Furthermore, their adult stakeholders that were involved in the TRRS planning reported increase capacity to work with each other on youth positive policies.
Program #2 Demographics:

<table>
<thead>
<tr>
<th>Age in Years</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>6-12</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>13-17</td>
<td>258</td>
<td>56%</td>
</tr>
<tr>
<td>18-21</td>
<td>196</td>
<td>42%</td>
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<td>22-25</td>
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<tr>
<td>36-45</td>
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<td>0%</td>
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<tr>
<td>46-59</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>60+</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Unknown</td>
<td>9</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>463</td>
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<tr>
<th>Ethnicity</th>
<th># of Participants</th>
<th>Percentage</th>
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<tr>
<td>African American</td>
<td>234</td>
<td>50%</td>
</tr>
<tr>
<td>Am. Indian / AK Native</td>
<td>5</td>
<td>1%</td>
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<tr>
<td>Asian / Pacific Islander</td>
<td>18</td>
<td>4%</td>
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<tr>
<td>Caucasian</td>
<td>14</td>
<td>3%</td>
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<tr>
<td>Hispanic / Latino</td>
<td>151</td>
<td>33%</td>
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<tr>
<td>Other</td>
<td>41</td>
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<tr>
<td>Total</td>
<td>463</td>
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<table>
<thead>
<tr>
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<th># of Participants</th>
<th>Percentage</th>
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<tr>
<td>Female</td>
<td>215</td>
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<tr>
<td>Total</td>
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<table>
<thead>
<tr>
<th>Language</th>
<th># of Participants</th>
<th>Percentage</th>
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<tr>
<td>American Sign</td>
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<tr>
<td>Asian</td>
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<td>0.0%</td>
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<tr>
<td>English</td>
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<td>100%</td>
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<tr>
<td>Farsi</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Spanish</td>
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<tr>
<td>Total</td>
<td>463</td>
<td>100%</td>
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</tbody>
</table>
RYSE CENTER
PROGRAM 2: TRAUMA RESPONSE & RESILIENCE SYSTEM

Measures of Success Progress Toward Target
July 1st, 2010 – June 30th, 2011

% Target Met

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Target</th>
<th>Actual</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth Justice Project serving at least 100 young people will be implemented in partnership with Richmond Police, CCC Probation, and key community agencies.</td>
<td>100</td>
<td>50</td>
<td>50%</td>
</tr>
<tr>
<td>Youth involved in the Youth Justice Project will report increased feelings of hope and the ability to imagine a positive future. (Target: 75% of 50)</td>
<td>38</td>
<td>11</td>
<td>29%</td>
</tr>
<tr>
<td>RYSE Collaborative will report positively a sense of shared understanding of Trauma Response and Resilience System (TRRS). (Target: 100% of 25)</td>
<td>25</td>
<td>25</td>
<td>100%</td>
</tr>
<tr>
<td>RYSE Collaborative will commit to developing a shared platform for advocacy and systems change. (Target: 100% of 25)</td>
<td>25</td>
<td>25</td>
<td>100%</td>
</tr>
<tr>
<td>Adult Stakeholders involved in the TRRS planning will report increased capacity to work with each other on youth positive policies. (Target: 75% of 24)</td>
<td>18</td>
<td>24</td>
<td>133%</td>
</tr>
<tr>
<td>Stakeholders reached through TRRS development, training, and outreach activities will report increased awareness of priorities, needs, supports of West Contra Costa County youth communities. (Target: 75% of 249)</td>
<td>187</td>
<td>75</td>
<td>40%</td>
</tr>
</tbody>
</table>
Overarching Goals for Program 3:

Program 3: Reducing Stigma and Awareness Education

This county-wide program utilizes a multi-pronged approach to reduce mental health stigma, create awareness of stigma, and provide education about it. At risk residents are targeted, including: trauma exposed individuals; individuals experiencing onset of serious psychiatric illness; children and youth in stressed families; children and youth at risk for school failure; children and youth at risk of experiencing juvenile justice involvement and underserved cultural populations. Activities include:

- CCMH’s Office for Consumer Empowerment (OCE) will reconvene the Wellness and Recovery Task Force, renewing its efforts to rebuild its capacity for anti-stigma education and to communicate the awareness of same. A new Social Inclusion subcommittee has been created to develop new strategies to increase awareness of stigma associated with Mental Illness and develop strategies to combat both external and internalized stigma.
- A new Speaker’s Bureau, providing outreach and contacts with schools/colleges, health/mental healthcare providers, businesses, community organization and clubs, the faith based community, law enforcement and others to offer Anti-Stigma Training/Information. The Speaker’s Bureau is now known as Wellness and Recovery Education for Acceptance Choice and Hope, “W.R.E.A.C.H.”.
- “Tell Your Own Story” Workshops are being conducted for mental health clients helping them to develop their voices and their stories and prepare them for public speaking opportunities aimed to increase awareness and acceptance.
- Resumed production of a local Cable TV show highlighting Mental Health issues. One show is produced annually. The first show focused on “Suicide Prevention”, and others are under development.
- Sponsorship of an anti-stigma educational conference, produced in conjunction with the Mental Health Reducing Health Disparities Workgroup which focused on both adults and children and celebrated clients and staff accomplishments in partnering together to bring about positive change.

Target Population:
- Efforts will address stigma to both children/youth and adults/older adults
- Within each of these sub-groups, multiple underserved populations are represented and care will be taken to reach out to these underserved groups. The target population will be refined after these efforts are implemented.

Overview of Intended Outcomes:
- Individuals that interact with people with psychiatric conditions will do so in a more sensitive and helping manner.
- Individuals experiencing psychiatric conditions will experience less stigma and discrimination and will receive earlier and more effective interventions. Recovery will be stronger.
- Systems and programs that interact with people with psychiatric conditions will learn how they can interact more effectively and sensitively with consumers and their families.
Overarching Goals for Program 4:

Program 4: Suicide Prevention
The goal of this program is to develop strategies to reduce suicide in Contra Costa County. This includes educating more residents about suicide risk, to know where/how to seek help, and to provide suicide crisis line expansion to previously un-served/under-served cultural communities. The program includes key activities: Planning; and Crisis Line Capacity Expansion and the development and implementation of strategies which reduce risk in Contra Costa County. A multi-disciplinary, multi agency Suicide Prevention Committee was established, and is developing a county-wide Suicide Prevention Plan. The Committee will continue its work in implementing all aspects of the plan, to be coordinated with Statewide suicide prevention campaign and training and research efforts. Work also continues with continuing linkages between key leaders, key agencies, and the community, for suicide prevention efforts. Through a contract with an existing, nationally certified suicide crisis line, the agency has expanded and enhanced staffing of those services, by adding staff who are bi-lingual in Spanish. A workgroup of the committee has examined evidence based approaches to reducing suicide. Their activities have included examining the records of those persons who have been served by our Mental Health System and died by suicide. A pilot program has been approved to provide follow up phone calls and drop in groups for the region of our county with the highest number of suicides among our patient population.

Target Population:
- The language for the crisis line expansion will be:
  - Spanish
  - Vietnamese
  - Up to one additional language with the rationale for that language demonstrated in proposals for funding

Overview of Intended Outcomes:
- As a result of the Suicide Prevention planning and Annual Campaign, more Contra Costa residents will be informed about suicide risk and where to turn/how to help and ultimately, the suicide rate in the county will decline.
- As a result of the increased language/cultural capacity of existing crisis phone lines in the county, more individuals from underserved cultural communities will receive support / intervention / linkages and referrals from crisis lines and, ultimately, suicide rates will decline.

Did we reach those outcomes?
Program #4 exceeded their target goals for three-quarters of its outcome measures and achieved 82% of the target for the remaining outcome measure. Spanish-speaking counselors are available to answer calls from Spanish-speaking people 80 hours / week. The average response time for answering local calls to the National Suicide Prevention Line’s Spanish-Language Hotline showed that 82% of the calls were un-abandoned – average response time was 10 seconds or less. Also, 5,635 callers to be at medium to high risk of suicide are still alive one month later. Furthermore, the number of trained multilingual / multicultural crisis line volunteers has doubled in order to enhance the quality of service to diverse populations.
Program #4 Demographics:

<table>
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<tr>
<th>Age in Years</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>30</td>
<td>0.1%</td>
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<tr>
<td>6-12</td>
<td>59</td>
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</tr>
<tr>
<td>13-17</td>
<td>950</td>
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</tr>
<tr>
<td>18-21</td>
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<td>8.5%</td>
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<tr>
<td>36-45</td>
<td>5106</td>
<td>17.2%</td>
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<tr>
<td>46-59</td>
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<table>
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<tr>
<th>Ethnicity</th>
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<th>Percentage</th>
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<tr>
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<tr>
<td><strong>Total</strong></td>
<td><strong>29686</strong></td>
<td><strong>100%</strong></td>
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<table>
<thead>
<tr>
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<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
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<tr>
<td>Female</td>
<td>18108</td>
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<td>Other</td>
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</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>29686</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Language</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Sign</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Asian</td>
<td>0</td>
<td>0%</td>
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<tr>
<td>English</td>
<td>27905</td>
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<td>Farsi</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
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<thead>
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<tr>
<td>Central</td>
<td>7422</td>
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<tr>
<td>East</td>
<td>6234</td>
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<tr>
<td><strong>Total</strong></td>
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<td><strong>100%</strong></td>
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</table>
CONTRA COSTA CRISIS CENTER
PROGRAM 4: SUICIDE PREVENTION

Measures of Success Progress Toward Target
July 1st, 2010 – June 30th, 2011

% Target Met per Outcome Measure
Fiscal Year 2010 - 2011

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Target</th>
<th>Actual</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spanish-speaking counselors available to answer calls from Spanish-speaking people. (Target: 80 hours/week)</td>
<td>80</td>
<td>96</td>
<td>120%</td>
</tr>
<tr>
<td>Call abandonment rate. 10 seconds or less - average response time for answering local calls to the National Suicide Prevention Line's Spanish-Language Hotline. (Target: 90% of 713 - unabandonment)</td>
<td>642</td>
<td>525</td>
<td>82%</td>
</tr>
<tr>
<td>Callers assessed to be at medium to high risk of suicide will still be alive one month later. (Target: 95% of 5,637)</td>
<td>5,355</td>
<td>5,635</td>
<td>105%</td>
</tr>
<tr>
<td>Trained multilingual/multicultural crisis line volunteers will increase service to diverse populations. (Target: 20)</td>
<td>20</td>
<td>25</td>
<td>125%</td>
</tr>
</tbody>
</table>
**Overarching Goals for Program 5:**

**Program 5: Supporting Older Adults**
The goal of this program is to reach out to isolated and depressed older adults in their home environments and link them to appropriate community resources in a culturally competent manner. In addition, our goal is for both the Latino and Chinese Senior Peer Counseling Programs to be recognized in Contra Costa County as a resource of these underserved populations.

**Target Population:**
- Older adults age 55 and older who are experiencing aging issues such as: Grief and loss, multiple health problems, loneliness and depression and isolation.
- Seniors as a high-risk population for mental illness and suicide.
- Emphasis on serving underserved cultural communities especially:
  - Latino and
  - Asian older adults

**Overview of Intended Outcomes:** To reduce depression and isolation and connect clients to appropriate resources in the community, and to establish a culturally, competent Senior Peer Counseling Program whereby volunteers recruited would be linguistically competent to provide lay-counseling services in Spanish and Chinese.

**Did we reach those outcomes?** The agencies in Program #5 reported that they had exceeded the target goal established for all of the outcome measures for which data were routinely collected. (The data for one outcome came from the counselors’ session logs and could not easily be measured.) Senior participants reported decrease feelings of isolation. Participants also reported improved social connections and/or decreased isolation. Also, the Latino Senior Peer Counseling Program had 12 volunteers and the Chinese Senior Peer Counseling Program had 11 volunteers. In addition, the Latino and Chinese Senior Peer Counseling Program were able to serve a total of 30 clients for each program. Senior Peer Counseling continues to expand their client base by receiving referrals from community agencies.

**List indicators which we measure:**

For CHD and Lifelong Medical Care: Please see attached outcomes graphs.

For Contra Costa County Older Adults and Senior Peer Counseling Program: Link clients to culturally and linguistically appropriate community resources; provide initial orientation to senior volunteer, then an 8-week Orientation Training to determine peer counselors appropriateness to provide lay-counseling services, and provide monthly continued education related to mental health issues and community resources/services for the older adult population.

**Refinements and revisions:** Both the Latino and Chinese Senior Peer Counselor Coordinators have had to translate the training materials, create brochures and other information that is dispersed to the Latino and Chinese communities in their native language; attend and recruit senior volunteers at Health Fairs, Community Meetings, Coalition Meetings, Churches and Senior Centers in the various regions of the County. A new Senior Peer Counseling Microsoft Access database is in the process of being created to help gather significant information about the client served, as well as the senior peer counselor providing the lay-counseling.
Program #5 Demographics:

<table>
<thead>
<tr>
<th>Age in Years</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>6-12</td>
<td>0</td>
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<tr>
<td>13-17</td>
<td>34</td>
<td>10%</td>
</tr>
<tr>
<td>18-21</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>22-25</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>26-35</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>36-45</td>
<td>10</td>
<td>3%</td>
</tr>
<tr>
<td>46-59</td>
<td>52</td>
<td>16%</td>
</tr>
<tr>
<td>60+</td>
<td>192</td>
<td>59%</td>
</tr>
<tr>
<td>Unknown</td>
<td>39</td>
<td>12%</td>
</tr>
<tr>
<td>Total</td>
<td>327</td>
<td>100%</td>
</tr>
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<table>
<thead>
<tr>
<th>Ethnicity</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>199</td>
<td>61%</td>
</tr>
<tr>
<td>Am. Indian / AK Native</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Asian / Pacific Islander</td>
<td>11</td>
<td>3%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>67</td>
<td>20%</td>
</tr>
<tr>
<td>Hispanic / Latino</td>
<td>27</td>
<td>8%</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>4%</td>
</tr>
<tr>
<td>Unknown</td>
<td>9</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td>327</td>
<td>100%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>95</td>
<td>29%</td>
</tr>
<tr>
<td>Female</td>
<td>220</td>
<td>67%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Unknown</td>
<td>12</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>327</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Language</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Sign</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Asian</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>English</td>
<td>326</td>
<td>100%</td>
</tr>
<tr>
<td>Farsi</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Spanish</td>
<td>1</td>
<td>0.3%</td>
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<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Unknown</td>
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<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>327</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Region</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>226</td>
<td>69%</td>
</tr>
<tr>
<td>Central</td>
<td>87</td>
<td>27%</td>
</tr>
<tr>
<td>East</td>
<td>14</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>327</td>
<td>100%</td>
</tr>
</tbody>
</table>

Contra Costa County Older Adults and Senior Peer Counseling Program Demographics:

- **Race and Ethnicity:** Latino and Chinese monolingual older adults who have been identified as an underserved population.
- **Age:** 55 and older
- **Region of County:** West, Central, and East
- **Modes of Service:** Senior Center, home visits, local community cafes
Measures of Success Progress Toward Target
July 1st, 2010 – June 30th, 2011

% Target Met per Outcome Measure

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Target</th>
<th>Actual</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior participants reported decrease feelings of isolation. (Target: 80% of 56)</td>
<td>45</td>
<td>56</td>
<td>124%</td>
</tr>
<tr>
<td>Senior Peer Counselors (SPC) will report a positive change in the Senior</td>
<td>6</td>
<td>N/A*</td>
<td>N/A*</td>
</tr>
<tr>
<td>participants' mood and behavior. (Target: 80% of 8)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participants' in the project reported opportunities to build positive and</td>
<td>76</td>
<td>101</td>
<td>133%</td>
</tr>
<tr>
<td>healthy relationships. (Target: 75% of 101)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* For Outcome #2 above: The question: “How many Senior Peer Counselors reported a positive change in the senior participant's mood and behavior?” was not asked on the surveys, but was on each session log for the SPC to document.

The following are quotes from the SPC Session Logs:
- “[senior] got a little depressed in the middle of the meeting but bounced back.”
- “[senior] is energized”
- “[senior] is pretty low energy most of the time but I believe she enjoys our company.”
- “[senior] loves having visitors, we meet outside in the sunshine and with the hummingbirds”
LIFELONG MEDICAL CARE
PROGRAM 5: “SNAP! SENIOR NETWORK AND ACTIVITY PROGRAM”

Measures of Success Progress Toward Target
July 1st, 2010 – June 30th, 2011

% Target Met per Outcome Measure

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Target</th>
<th>Actual</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants will demonstrate self-efficacy and purpose by successfully completing at least one long-term project through SNAP or ELC. (Target: 50% of 67)</td>
<td>34</td>
<td>43</td>
<td>126%</td>
</tr>
<tr>
<td>Respondents will self-report improved feelings of morale as a result of participating in SNAP and ELC activities. (Target: 75% of 29)</td>
<td>22</td>
<td>29</td>
<td>132%</td>
</tr>
<tr>
<td>Respondents will self-report improved social connections and/or decreased isolation as a result of participating in SNAP and ELC activities. (Target: 75% of 26)</td>
<td>20</td>
<td>26</td>
<td>130%</td>
</tr>
</tbody>
</table>
Overarching Goals for Program 6:

Program 6: Parenting Education and Support
The purpose of this program is to educate and support parents and caregivers in high risk families to support the strong development of their children and youth. CCMH has included a variety of interventions to accomplish this purpose. There are three activities in this program:

- **Partnering with Parents Experiencing Challenges** – CCMH added two clinical staff, one serving children, and the other serving adults. The staff working with children in the Children’s System of Care works with families of children in Emergency Foster Care. The staff assesses families for their overall mental wellness and, where indicated, provides early intervention supports, services and linkages to existing resources to help to build resiliency in the family.

- **Parenting Education and Support** – this activity supports community-based efforts to educate and support parents of youth 0-18 to maximize children’s social/emotional and educational development. These classes are targeted to reach parents in underserved cultural communities, parents experiencing homelessness, families referred through Child Family and Services and families with co-occurring disorders and or other complex needs.

**Target Population:**
- Higher risk parents in the county who are more likely to be the lowest income residents are more likely to be from underserved racial/ethnic and/or cultural populations.
- Poverty-level Latino parents, especially immigrant parents.

**Overview of Intended Outcomes:**
Parents involved in parenting education and support efforts will report increased competence and confidence in their parenting.

**Did we reach those outcomes?**
One agency under Program #6 exceeded the target goal for all of its outcome measures for which data were routinely collected. (The agency was unable to collect data for one of its outcome measures.) One agency exceeded the target goal for three-quarters of its outcomes while achieving 92% of its remaining target. A third agency exceeded its target for one outcome and achieved at least 82% of the target for its remaining outcomes. The fourth agency exceeded the target goal for one-third of its outcomes and achieved at least 67% of the target for another third of its outcomes. Parents of program #6 are increasing their parenting skills and they are increasing their parent confidence. Youth are also attending homework club at least 75% of the time and youth grew in their habits of doing homework on a regular basis and in many cases observations show that their skills are growing considerably.

**Refinements:**

One of the refinements that we have implemented this year is the use of a parent rating scale. Agencies that work with parenting education programs are required to use the Eyberg Child Behavior Inventory (ECBI), which is a parent rating scale that assesses child behavior problems. It includes an Intensity Scale, which measures the frequency of each problem behavior and a Problem Scale which reflects parent’s tolerance of the behaviors and the distress caused. The ECBI is intended to assess both the type
of behavior problems and the degree to which parent finds them problematic. The target population for this measurement tool is children between the ages of two and sixteen.

New agency: Counseling Options and Parent Education (COPE) funded for FY 2011 – 2012. COPE provides services using the evidence-based Triple P – Positive Parenting Program Levels 2, 4, and 5 Multi-Family Support Groups, at no cost to parents. The program utilizes a self regulatory model that focuses on strengthening the positive attachment between parents and children by helping parents to develop effective skills to manage common child behavioral issues. Targeted population includes caregivers residing in underserved communities throughout Contra Costa County. COPE provides services to all regions of the County.

COPE’s outreach activities from July 1st, 2011 to December 31st, 2011 included: 3rd Annual Congresso Parent Meeting for parents of special needs children in Contra Costa & Alameda Counties, Regional Center, Care Parent Network, Jewish Family Center, Children & Family Services, Lao Family Community Center, Martinez Adult School, Grip Homes Shelter, Shelter Inc., First 5 Centers, We Care Children’s Center, Contra Costa Child Care Council, Pittsburg Adult Center, Shadeland Pre-school, Mt Diablo School District, Special Education Center, Probation Department, Juvenile Hall, Office of Education, East County Wollam House, Diablo Ranch, Reach Project, Rainbow Community Center, La Clinica, Families Forward, and Pittsburg Adult Education.
Program #6 Demographics:

<table>
<thead>
<tr>
<th>Age in Years</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>604</td>
<td>28%</td>
</tr>
<tr>
<td>6-12</td>
<td>628</td>
<td>29%</td>
</tr>
<tr>
<td>13-17</td>
<td>398</td>
<td>19%</td>
</tr>
<tr>
<td>18-21</td>
<td>62</td>
<td>3%</td>
</tr>
<tr>
<td>22-25</td>
<td>52</td>
<td>2%</td>
</tr>
<tr>
<td>26-35</td>
<td>167</td>
<td>8%</td>
</tr>
<tr>
<td>36-45</td>
<td>104</td>
<td>5%</td>
</tr>
<tr>
<td>46-59</td>
<td>34</td>
<td>2%</td>
</tr>
<tr>
<td>60+</td>
<td>3</td>
<td>0.1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>95</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2147</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>92</td>
<td>4%</td>
</tr>
<tr>
<td>Am. Indian / AK Native</td>
<td>5</td>
<td>0.2%</td>
</tr>
<tr>
<td>Asian / Pacific Islander</td>
<td>29</td>
<td>2%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>85</td>
<td>4%</td>
</tr>
<tr>
<td>Hispanic / Latino</td>
<td>1919</td>
<td>89%</td>
</tr>
<tr>
<td>Other</td>
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<td>0.05%</td>
</tr>
<tr>
<td>Unknown</td>
<td>16</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2147</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>658</td>
<td>31%</td>
</tr>
<tr>
<td>Female</td>
<td>902</td>
<td>42%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Unknown</td>
<td>587</td>
<td>27%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2147</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Language</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Sign</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Asian</td>
<td>2</td>
<td>0.1%</td>
</tr>
<tr>
<td>English</td>
<td>838</td>
<td>39%</td>
</tr>
<tr>
<td>Farsi</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Spanish</td>
<td>1213</td>
<td>57%</td>
</tr>
<tr>
<td>Other Non-English</td>
<td>2</td>
<td>0.1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>92</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2147</strong></td>
<td><strong>100%</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Region</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>821</td>
<td>38%</td>
</tr>
<tr>
<td>Central</td>
<td>615</td>
<td>29%</td>
</tr>
<tr>
<td>East</td>
<td>695</td>
<td>32%</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>1%</td>
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<td>Unknown</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2147</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
CHILD ABUSE PREVENTION COUNCIL
PROGRAM 6: THE NURTURING PARENTING PROGRAM

Measures of Success Progress Toward Target
July 1st, 2010 – June 30th, 2011

<table>
<thead>
<tr>
<th>% Target Met</th>
<th>Increase in Positive Parenting Skills</th>
<th>Graduation from Brentwood Class</th>
<th>Graduation from Concord Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>111%</td>
<td>100%</td>
<td>91%</td>
<td>83%</td>
</tr>
</tbody>
</table>

GOAL: 100%

% Target Met per Outcome Measure
Fiscal Year 2010 - 2011

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Target</th>
<th>Actual</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in Positive Parenting Skills. (Target: 90% of 63)</td>
<td>57</td>
<td>63</td>
<td>111%</td>
</tr>
<tr>
<td>Parents will graduate from Brentwood class in East County. (Target: 100% of 30)</td>
<td>30</td>
<td>25</td>
<td>83%</td>
</tr>
<tr>
<td>Parents will graduate from Concord Class in Central County. (Target: 100% of 33)</td>
<td>33</td>
<td>30</td>
<td>91%</td>
</tr>
</tbody>
</table>
CONTRA COSTA INTERFAITH HOUSING, INC.
PROGRAM 6: STRENGTHENING VULNERABLE FAMILIES

Measures of Success Progress Toward Target
July 1st, 2010 – June 30th, 2011

<table>
<thead>
<tr>
<th>% Target Met</th>
<th>Homework Club Attendance</th>
<th>Improvement in one area of self-sufficiency</th>
<th>Improvements and positive outcomes as shown by vignettes</th>
<th>Improved study habits school performance</th>
<th>Improvement for families receiving Case Mgmt</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
<td>126%</td>
<td>100%</td>
<td></td>
<td>135%</td>
</tr>
<tr>
<td>Goal:</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

% Target Met per Outcome Measure
Fiscal Year 2010 - 2011

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Target</th>
<th>Actual</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth attending homework club will attend homework club at least 75% of the time. (Target: 75% of 16)</td>
<td>12</td>
<td>12</td>
<td>100%</td>
</tr>
<tr>
<td>Improvement in at least one area of self-sufficiency as measured bi-annually on the 20 area, self-sufficiency matrix. (Target: 75% of 31)</td>
<td>23</td>
<td>29</td>
<td>126%</td>
</tr>
<tr>
<td>Vignettes showing the improvements and positive outcomes of the work of this project. (Target: 2 vignettes bi-annual)</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Improved study habits and school performance of youth attending Afterschool Program at Bella Monte and Los Medanos Village. (Target: 60% of 33)</td>
<td>20</td>
<td>N/A*</td>
<td>N/A*</td>
</tr>
<tr>
<td>Improvement for families who receive case management and other support services. (Target: 60% of 33)</td>
<td>20</td>
<td>27</td>
<td>135%</td>
</tr>
</tbody>
</table>

*Contra Costa Interfaith Housing, Inc. (CCIH) was not able to collect report cards this year for students at Bella Monte and Los Medanos Village; therefore, no specific outcome data for this goal. However, CCIH has anecdotal and observational data that “the youth grew in their habits of doing their homework on a regular basis and in many cases observed their skills grow considerably.”
LA CLINICA DE LA RAZA
PROGRAM 6: FAMILIAS FUERTES (STRONG FAMILIES)

Measures of Success Progress Toward Target
July 1st, 2010 – June 30th, 2011

% Target Met per Outcome Measure
- Fiscal Year 2010 - 2011

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Target</th>
<th>Actual</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Factor Screenings were completed. (Target: 1,200)</td>
<td>1,200</td>
<td>1,101</td>
<td>92%</td>
</tr>
<tr>
<td>Clients will receive a consultation with a Behavioral Health Consultant. (Target: 250)</td>
<td>250</td>
<td>257</td>
<td>103%</td>
</tr>
<tr>
<td>Parents/Caretakers will participate in a parenting education/support group &quot;Los Ninos Bien Educados.&quot; (Target: 48)</td>
<td>48</td>
<td>104</td>
<td>217%</td>
</tr>
<tr>
<td>Parents completing &quot;Los Ninos Bien Educados&quot; will demonstrate reduction of risk factors by a self administered pre- and post- group surveys. (Target: 80% of 104)</td>
<td>83</td>
<td>95</td>
<td>114%</td>
</tr>
</tbody>
</table>
THE LATINA CENTER
PROJECT 6: PRIMO NUESTROS NINOS (OUR CHILDREN FIRST)

Measures of Success Progress Toward Target
July 1st, 2010 – June 30th, 2011

% Target Met per Outcome Measure
Fiscal Year 2010 - 2011

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Target</th>
<th>Actual</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents will set 2-3 personal goals for creating change in their parenting.</td>
<td>240</td>
<td>164</td>
<td>68%</td>
</tr>
<tr>
<td>(Target: 240)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents will identify 1-3 individuals they can turn to for peer support.</td>
<td>150</td>
<td>100</td>
<td>67%</td>
</tr>
<tr>
<td>(Target: 150)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents will participate in family activity nights and other family support.</td>
<td>150</td>
<td>1832</td>
<td>1221%</td>
</tr>
<tr>
<td>(Target: 150)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents completing the Parenting Classes will be Latino Fathers.</td>
<td>60</td>
<td>11</td>
<td>18%</td>
</tr>
<tr>
<td>(Target: 60)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased parenting skills for those completing parenting classes.</td>
<td>225</td>
<td>115</td>
<td>51%</td>
</tr>
<tr>
<td>(Target: 225)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased parent confidence 3 months after completing the program by follow-up</td>
<td>30</td>
<td>94</td>
<td>313%</td>
</tr>
<tr>
<td>telephone interview.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Target: 30)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Overarching Goals for Program 7:

This is an early intervention program with two activities designed to identify youth in the juvenile justice system. The program is designed to provide individual and family supports that will help the youth become strong, healthy, law abiding members of their community. The activities are:

- **Community Supports to Youth on Probation** – CCMH added two mental health liaisons that are based in the probation department offices in East and West County, and they share responsibility for clients in Central County. The liaisons work intensively with youth on probation and those being released from Juvenile Hall. The following are some activities provided by the liaisons:
  
  - Coordination of after care
  - Assess youths level of need and determine appropriate linkages
  - Provide linkages to early intervention mental health services
  - Supports youth transitioning back to their communities
  - Provide direct short term therapy
  - Consultations with probation officers
  - Assist youth in navigating mental health and primary care systems
  - Provide financial counseling
  - Facilitate warm hand-offs to Community Based Organizations and to County MH Systems
  - Provide written comprehensive court-ordered mental health assessments
  - Trainings for probation officers and psycho-education for clients and their families
  - Linkages with school systems

- **Screening, Early Intervention and Discharge Support at the Boys Ranch**
  
  This program adds a mental health clinician at OAYRF (Boys Ranch) in Byron. The clinician completes a mental health assessment for youth who may present with early signs of mental illness. The clinician provides direct early intervention services such as intensive short-term therapy or less intensive services depending on the level of need. They work with the family to plan for clients’ transition and after care in the community. The clinician coordinates community based services with the two mental health liaisons.

**Target Population:**
- Youth experiencing the juvenile justice system throughout Contra Costa County.

**Overview of Intended Outcomes:**

No formalized defined outcome measures for this Program. Currently, Mental Health Liaisons are collecting data independently. Moving forward for the next fiscal year, outcome measures will be established. Contra Costa Mental Health Liaisons will collect and report data bi-annually.

**Did we reach those outcomes?**

Although no defined outcome measures are set, Mental Health Liaisons did report that with their help, the clients have more opportunities to succeed and they are able to avoid barriers by being quickly connected to services. The Mental Health Liaisons have improved communication between probation, the county and community based mental health system. The consumers, their families, and the probation officers are better informed about the services that are available in our community.
**DEMOGRAPHICS:**
From July 1st, 2010 to June 30th, 2011, two hundred forty-five (245) unduplicated participants were served under Program #7. The following charts are the breakdown of the participant’s age and gender:

**Ages of the Participants: (n=245)**

- 15-17: 22% (54)
- 18-21: 7% (17)
- Unknown: 4% (11)

Ages: Clients were predominately 13-17 (73%). Age range: 18-21 (22%) and unknown (4%). Not shown on graph: Age 0-5 (1 client = 0.4%) and 36-45 (1 client = 0.4%).

**Gender of the Participants: (n=245)**

- Female: 39% (96)
- Male: 61% (149)

Gender: Male (61%) and Female (39%).

**Refinements:**

Mental Health Clinician position at Orin Allen Youth Rehabilitation Facility is currently vacant and is in the process of being filled.

Four hundred thousand dollars ($400,000.00) of the funding is allocated for new and existing community-based contractors in the county’s mental health children’s system of care to offer an array of established evidenced-based clinical practices for youth with signs of early onset of mental illness.
Overarching Goals for Program 8:

Program 8: Supporting Families Experiencing Mental Illness

CCHM has contracted with a provider to provide a series of services to meet the needs of those experiencing mental illness and their families.

All programming, both evening/weekends and the work-ordered day, offers respite and stress reduction for caregivers and family members by providing a safe and restorative welcoming community for their loved ones to be part of, extending the system of support for recovery. The Young Adult Initiative serves those ages 18-25 experiencing the onset of mental illness, supporting them with a recovery model while encouraging connections with peers and involved in the wider world through school and work. All of those impacted by the Clubhouse are experiencing the trauma of mental illness, whether personally or in their loved ones. The Clubhouse includes a diverse staff (which includes consumers) and membership in terms of ethnicity, language fluency, sexual orientation, and age. The Clubhouse brochure is available in Spanish and staff members are fluent in Spanish.

Target Population:
- Lower income families struggling with mental illness who cannot afford respite care, in addition to those who cannot find appropriate respite care. This will certainly include families from underserved cultural populations in similar proportions to the prevalence of lower income families struggling with mental illness.

Overview of Intended Outcomes:
The intended outcome for this program is to reduce the stress and increase the wellness of those caring for loved ones with mental illness. Also, this program is intended to help decrease hospitalizations and other out-of-home placements.

Did we reach those outcomes?
Putnam Clubhouse exceeded the target goal for each of their 14 outcome measures for fiscal year 2010 to 2011.

During the 2010 to 2011 contract year, Putnam Clubhouse served 247 active participants (including 30 members 18-25 years old) who collectively spent more than 43,000 hours engaged in programming, including preparing and consuming approximately 9,000 meals at the Clubhouse. The Clubhouse operated six days (plus some Sundays), all holidays, and three evenings each week and launched the Career Development Unit. More than 4,000 rides were provided to and from Clubhouse activities.

In May 2011, members and caregivers completed an annual survey. In the caregiver survey, 90% of caregivers reported that Clubhouse activities and programs provided them with respite care. Additionally, 94% reported a high level of satisfaction with Clubhouse activities and programs that their family member attended. When combining responses to self-perceived improvement of their own mental, physical, or emotional well-being, 94% of caregivers agreed or strongly agreed theirs had improved. As well, 96% of the caregivers agreed or strongly agreed their family members had improved in the same categories. Additionally, 91% of caregivers report their family member had become more independent.
The member ratings for their own improvements to well-being in terms of emotional, physical, and mental health averaged 85%. Additionally, 90% reported both increased interactions with peers during the year and an increase in independence.

Data was collected on hospitalization and out-of-home placements for members pre- and post-membership. A statistical analysis of this data indicates that members had a statistically significant decrease in the number of episodes of hospitalizations since joining the Clubhouse.

During the 2010-2011 contract year, 53 members completed career plans. The Clubhouse provided ongoing support to the 45 members who attended school and the 48 members who were employed during some or all of this period (19 of whom began paid positions at local businesses with Clubhouse assistance during the contract period).

Putnam Clubhouse became credentialed in the spring of 2011 by the International Center for Clubhouse Development (ICCD) and follows the 36 International Standards of the ICCD Clubhouse Model of social and vocational rehabilitation. The ICCD Model is included in the United States Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence Based Practices and Programs (NREPP).

Refinements:
Following focus groups with family members during which they expressed that helping their loved ones find and retain employment was a top priority, Putnam Clubhouse's Career Development Unit was established in the 2010 to 2011 contract year to provide additional support to members in developing and achieving career goals, including resuming their educations and/or procuring and maintaining paid employment at local businesses.

A video project was also added during the 2010 to 2011 contract year. This project involved Clubhouse members and staff using the Clubhouse multimedia lab to produce four, television news-style videos on mental health recovery to be shown at mental health clinics throughout the County. The project is in collaboration with Contra Costa County’s Office of Consumer Empowerment.
Program #8 Demographics:

<table>
<thead>
<tr>
<th>Age in Years</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>6-12</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>13-17</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>18-21</td>
<td>7</td>
<td>3%</td>
</tr>
<tr>
<td>22-25</td>
<td>23</td>
<td>9%</td>
</tr>
<tr>
<td>26-35</td>
<td>52</td>
<td>21%</td>
</tr>
<tr>
<td>36-45</td>
<td>57</td>
<td>23%</td>
</tr>
<tr>
<td>46-59</td>
<td>92</td>
<td>37%</td>
</tr>
<tr>
<td>60+</td>
<td>16</td>
<td>7%</td>
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<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>247</td>
<td>100%</td>
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</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>18</td>
<td>7%</td>
</tr>
<tr>
<td>Am. Indian / AK Native</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Asian / Pacific Islander</td>
<td>21</td>
<td>9%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>180</td>
<td>73%</td>
</tr>
<tr>
<td>Hispanic / Latino</td>
<td>19</td>
<td>8%</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>2%</td>
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<tr>
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<td>0.4%</td>
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<tr>
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<table>
<thead>
<tr>
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<th># of Participants</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Male</td>
<td>145</td>
<td>59%</td>
</tr>
<tr>
<td>Female</td>
<td>101</td>
<td>41%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>247</td>
<td>100%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Language</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Sign</td>
<td>1</td>
<td>0.4%</td>
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<tr>
<td>Asian</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td>English</td>
<td>232</td>
<td>94%</td>
</tr>
<tr>
<td>Farsi</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Spanish</td>
<td>7</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>247</td>
<td>100%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Region</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>Central</td>
<td>206</td>
<td>83%</td>
</tr>
<tr>
<td>East</td>
<td>36</td>
<td>15%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>247</td>
<td>100%</td>
</tr>
</tbody>
</table>
THE CONTRA COSTA CLUBHOUSES, INC.
PROGRAM 8: SUPPORTING FAMILIES EXPERIENCING MENTAL ILLNESS

Measures of Success Progress Toward Target
July 1st, 2010 – June 30th, 2011

GOAL: 100%

% Target Met per Outcome Measure

Fiscal Year 2010 - 2011
### THE CONTRA COSTA CLUBHOUSES, INC.
PROGRAM 8: SUPPORTING FAMILIES EXPERIENCING MENTAL ILLNESS

#### Measures of Success Progress Toward Target

*July 1st, 2010 – June 30th, 2011*

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Target</th>
<th>Actual</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Adult Members (all ages) (Target: 60)</td>
<td>60</td>
<td>111</td>
<td>185%</td>
</tr>
<tr>
<td>New Adult Members (18-25 years old) (Target: 10)</td>
<td>10</td>
<td>22</td>
<td>220%</td>
</tr>
<tr>
<td>Activities held for young adult members, ages 18-25 (Target: 20)</td>
<td>20</td>
<td>24</td>
<td>120%</td>
</tr>
<tr>
<td>Annual Surveys Completed (Target: 120)</td>
<td>120</td>
<td>122</td>
<td>102%</td>
</tr>
<tr>
<td>Activities and programs provided caregivers with respite care (Target: 75% of 50)</td>
<td>37.5</td>
<td>45</td>
<td>120%</td>
</tr>
<tr>
<td>Caregivers will report high level of satisfaction with Clubhouse activities and programs. (Target: 75% of 50)</td>
<td>37.5</td>
<td>46</td>
<td>123%</td>
</tr>
<tr>
<td>Caregivers and members will report that member's independence increased. (Target: 75% of 123)</td>
<td>92</td>
<td>111</td>
<td>121%</td>
</tr>
<tr>
<td>Members who use Career Development services will indicate that they are &quot;very satisfied&quot; or &quot;satisfied&quot; with services related to employment. (Target: 75% of 47)</td>
<td>35.25</td>
<td>46</td>
<td>131%</td>
</tr>
<tr>
<td>Members who indicate education in their career plan will be referred to appropriate education resources within 14 days. (Target: 80% of 17)</td>
<td>13.6</td>
<td>16</td>
<td>118%</td>
</tr>
<tr>
<td>Members indicating employment as a goal in their career plan will be referred to employers, apply for jobs and/or job interview within 3 months of indicating goal. (Target: 80% of 36)</td>
<td>29</td>
<td>36</td>
<td>124%</td>
</tr>
<tr>
<td>Healthy meals served to members during Clubhouse participation (Target: 8,500)</td>
<td>8,500</td>
<td>8,934</td>
<td>105%</td>
</tr>
<tr>
<td>Members will report an increase in peer contacts. (Target: 75% of 123)</td>
<td>92</td>
<td>111</td>
<td>121%</td>
</tr>
<tr>
<td>Families completing the annual survey will report an increase in mental, physical, and emotional well-being. (Target: 75% of 123)</td>
<td>92</td>
<td>111</td>
<td>121%</td>
</tr>
<tr>
<td>Decrease in hospitalizations and out-of-home placements of active Clubhouse members. (No target #. Goal is to decrease hospitalizations - met or not met? 43% of active members decreased their days of hospitalizations since membership; therefore, goal was met.)</td>
<td>0</td>
<td>0</td>
<td>100%</td>
</tr>
</tbody>
</table>
Overarching Goals for Program 9:

Program 9: Youth Development
This program provides for youth-serving agencies to implement and carry out youth development activities relevant to their target population. Youth development includes strength-based efforts that build on youths’ assets and foster resiliency, as well as to help youth build knowledge and concrete life skills for a successful transition to adulthood. The primary focus is on at-risk youth. CCMH has contracted with five agencies that have provided new and innovative approaches to support youth development of a positive identity, self-esteem and positive community involvement. The purpose of this program is to see that youth engaged in the activities develop their individual strengths/assets, feel supported and connected in their communities, and less likely to engage in “system involvement”, and reduce demand on service systems such as juvenile justice, mental health and others.

Target Population:
- Youth from underserved cultural communities
- At-risk youth

Overview of Intended Outcomes:
- Youth engaged in the proposed programs will develop their strengths / assets, feel supported and connected in their communities and will be less likely to develop mental illness or SED.

Did we reach those outcomes?
Youth engaged in the proposed programs developed their strengths/assets and reported feeling supported and connected in their communities. As a group, the five agencies under Program #9 exceeded the target goal established for 20 of their 28 outcome measures and achieved at least 80% of the target for another one-fifth of their outcomes. Youth participating in Program #9 increased resiliency scores. They reported an increase in well-being, improved their CST scores and passed the CA High School Exit Exam for both English and Math portion. Students are improving their attendance issues and reducing discipline issues. Students also decreased school tardiness.
## Program #9 Demographics:

<table>
<thead>
<tr>
<th>Age in Years</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>6-12</td>
<td>206</td>
<td>6.3%</td>
</tr>
<tr>
<td>13-17</td>
<td>1348</td>
<td>41.2%</td>
</tr>
<tr>
<td>18-21</td>
<td>134</td>
<td>4.1%</td>
</tr>
<tr>
<td>22-25</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>26-35</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>36-45</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>46-59</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>60+</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1582</td>
<td>48.4%</td>
</tr>
<tr>
<td>Total</td>
<td>3270</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>503</td>
<td>15%</td>
</tr>
<tr>
<td>Am. Indian / AK Native</td>
<td>32</td>
<td>1%</td>
</tr>
<tr>
<td>Asian / Pacific Islander</td>
<td>184</td>
<td>6%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>270</td>
<td>8%</td>
</tr>
<tr>
<td>Hispanic / Latino</td>
<td>653</td>
<td>20%</td>
</tr>
<tr>
<td>Other</td>
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<td>5%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1483</td>
<td>45%</td>
</tr>
<tr>
<td>Total</td>
<td>3270</td>
<td>100%</td>
</tr>
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<table>
<thead>
<tr>
<th>Gender</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1332</td>
<td>41%</td>
</tr>
<tr>
<td>Female</td>
<td>1650</td>
<td>50%</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>0%</td>
</tr>
<tr>
<td>Unknown</td>
<td>283</td>
<td>9%</td>
</tr>
<tr>
<td>Total</td>
<td>3270</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Language</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Sign</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Asian</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>English</td>
<td>921</td>
<td>28%</td>
</tr>
<tr>
<td>Farsi</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Spanish</td>
<td>60</td>
<td>2%</td>
</tr>
<tr>
<td>Other Non-English</td>
<td>10</td>
<td>0%</td>
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<tr>
<td>Unknown</td>
<td>2278</td>
<td>70%</td>
</tr>
<tr>
<td>Total</td>
<td>3270</td>
<td>100%</td>
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<table>
<thead>
<tr>
<th>Region</th>
<th># of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>1234</td>
<td>38%</td>
</tr>
<tr>
<td>Central</td>
<td>1275</td>
<td>39%</td>
</tr>
<tr>
<td>East</td>
<td>433</td>
<td>13%</td>
</tr>
<tr>
<td>Other</td>
<td>47</td>
<td>1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>281</td>
<td>9%</td>
</tr>
<tr>
<td>Total</td>
<td>3270</td>
<td>100%</td>
</tr>
</tbody>
</table>
EL CERRITO HIGH SCHOOL
PROGRAM 9: YOUTH DEVELOPMENT – JAMES MOREHOUSE PROJECT

Measures of Success Progress Toward Target
July 1st, 2010 – June 30th, 2011

% Target Met per Outcome Measure
Fiscal Year 2010 - 2011

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Target</th>
<th>Actual</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth participating in youth development programs will cross-participate in substance abuse prevention classes and/or clinical MH services. (Target: 15% of 488)</td>
<td>73</td>
<td>83</td>
<td>114%</td>
</tr>
<tr>
<td>Students referred for violent/disruptive behavior will be enrolled in youth development programs with leadership skills training. (Target: 35)</td>
<td>35</td>
<td>44</td>
<td>126%</td>
</tr>
<tr>
<td>Students will increase their score across a range of resiliency indicators. (Target: 70% of 488)</td>
<td>342</td>
<td>361</td>
<td>106%</td>
</tr>
<tr>
<td>Students will report an increase in well-being through self-report on a locally developed qualitative evaluation tool. (Target: 70% of 488)</td>
<td>342</td>
<td>346</td>
<td>101%</td>
</tr>
</tbody>
</table>
MARTINEZ UNIFIED SCHOOL DISTRICT
PROGRAM 9: YOUTH DEVELOPMENT – NEW LEAF

Measures of Success Progress Toward Target
July 1st, 2010 – June 30th, 2011

% Target Met per Outcome Measure
■ Fiscal Year 2010 - 2011

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Target</th>
<th>Actual</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve Attendance Issues (Target: 70% of 56 students)</td>
<td>39</td>
<td>56</td>
<td>144%</td>
</tr>
<tr>
<td>Reduce Discipline Issues (Target: 70% of 56 students)</td>
<td>39</td>
<td>56</td>
<td>144%</td>
</tr>
<tr>
<td>Earn 100% Grade Level Credits (Target: 70% of 56 students)</td>
<td>39</td>
<td>45</td>
<td>115%</td>
</tr>
<tr>
<td>Improve CA Standardized Test (CST) scores (Target: 70% of 56 students)</td>
<td>39</td>
<td>39</td>
<td>100%</td>
</tr>
<tr>
<td>Pass CA High School Exit Exam (CAHSEE) English Portion (Target: 70% of 24)</td>
<td>17</td>
<td>20</td>
<td>118%</td>
</tr>
<tr>
<td>Pass CA High School Exit Exam (CAHSEE) Math Portion (Target: 70% of 24)</td>
<td>17</td>
<td>17</td>
<td>100%</td>
</tr>
<tr>
<td>Achieve 4 out of 6 ISAP goals (Target: 70% of 56 students)</td>
<td>39</td>
<td>37</td>
<td>95%</td>
</tr>
</tbody>
</table>
PEOPLE WHO CARE
PROGRAM 9: YOUTH DEVELOPMENT

Measures of Success Progress Toward Target
July 1st, 2010 – June 30th, 2011

% Target Met per Outcome Measure
Fiscal Year 2010 - 2011

<table>
<thead>
<tr>
<th>Outcome Measures:</th>
<th>Target</th>
<th>Actual</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in knowledge and skills related to entrepreneurship and &quot;green economy.&quot; (74 program participants. Only 22 took the pre and post surveys. Target 50% of 22).</td>
<td>11</td>
<td>21</td>
<td>191%</td>
</tr>
<tr>
<td>Improved youth resiliency factors (i.e. self-esteem, relationship, and engagement). (Target 50% of 23)</td>
<td>12</td>
<td>8</td>
<td>67%</td>
</tr>
<tr>
<td>Youth participants will not re-offend. (Target 75% of 51)</td>
<td>38</td>
<td>48</td>
<td>126%</td>
</tr>
<tr>
<td>Youth participants will report that they have a caring relationship with an adult in the community or at school. (Target: 60% of 27)</td>
<td>16</td>
<td>16</td>
<td>100%</td>
</tr>
<tr>
<td>Increase school day attendance. (Target 50% of 29)</td>
<td>15</td>
<td>12</td>
<td>80%</td>
</tr>
<tr>
<td>Decrease in school tardiness. (Target 50% of 29)</td>
<td>15</td>
<td>25</td>
<td>167%</td>
</tr>
</tbody>
</table>
RYSE CENTER
PROGRAM 9: RYSE HEALTH & WELLNESS

Measures of Success Progress Toward Target
July 1st, 2010 – June 30th, 2011

% Target Met

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Target</th>
<th>Actual</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least 300 additional RYSE members will have completed a wellness plan.</td>
<td>300</td>
<td>70</td>
<td>23%</td>
</tr>
<tr>
<td>RYSE members will participate in at least two programs, activities, or events (onsite and/or online) that support and facilitate healthy peer relationships, and opportunities for community engagement and leadership. (Target 75% of 91 survey respondents).</td>
<td>68</td>
<td>73</td>
<td>107%</td>
</tr>
<tr>
<td>RYSE members that participate in at least two programs, activities, or events that facilitates healthy peer relationships, and opportunities for community engagement and leadership will report increased sense of self-efficacy. (Target 75% of 91 survey respondents).</td>
<td>68</td>
<td>91</td>
<td>134%</td>
</tr>
<tr>
<td>RYSE members that participate in at least two programs, activities, or events that facilitates healthy peer relationships, and opportunities for community engagement and leadership will report improved sense of positive peer relations and youth-adult relations. (Target 75% of 91 survey respondents).</td>
<td>68</td>
<td>77</td>
<td>113%</td>
</tr>
<tr>
<td>RYSE members that participated in at least one structured program that facilitates healthy peer relationships and opportunities for community engagement and leadership will report increased sense of agency in impacting change in the community. (Target 75% of 91 survey respondents).</td>
<td>68</td>
<td>79</td>
<td>116%</td>
</tr>
</tbody>
</table>
STAND! FOR FAMILIES FREE OF VIOLENCE
PROGRAM 9: EXPECT RESPECT

Measures of Success Progress Toward Target
July 1, 2010 – June 30th, 2011

% Target Met per Outcome Measure
\[ Fiscal Year 2010 - 2011 \]

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Target</th>
<th>Actual</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students participating in YNWWV* will demonstrate increased knowledge about the</td>
<td>1,352</td>
<td>1,266</td>
<td>94%</td>
</tr>
<tr>
<td>difference between healthy &amp; unhealthy teen dating. (Target: 80% of 1,690)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students participating in YNWWV* will demonstrate increased confidence to seek</td>
<td>1,352</td>
<td>287</td>
<td>21%</td>
</tr>
<tr>
<td>help for self or others. (Target: 80% of 1,690)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participants in Expect Respect will demonstrate one or more of the following:</td>
<td>150</td>
<td>148</td>
<td>99%</td>
</tr>
<tr>
<td>knowledge about healthy &amp; unhealthy teen dating relationships; increased sense</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of belonging to positive peer groups; enhanced understanding of violence; rights</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and responsibilities dating. (Target: 80% of 188)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participants in Expect Respect will demonstrate increased self esteem,</td>
<td>150</td>
<td>149</td>
<td>99%</td>
</tr>
<tr>
<td>communication skills, and/or use of conflict resolution skills. (Target 80% of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>188)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys engaged in Expect Respect will demonstrate alternative ways to think about</td>
<td>22</td>
<td>22</td>
<td>100%</td>
</tr>
<tr>
<td>sterotypical gender-roles and being advocates for change. (Target 75% of 29)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expect Respect participants will demonstrate an increase in self esteem, reporting</td>
<td>141</td>
<td>159</td>
<td>113%</td>
</tr>
<tr>
<td>lower levels of anxiety, depression, or stress. (Target 75% of 188)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*YNWWV = "You Never Win with Violence"
Overarching Goals for Program 10:

Program 10: Multi-Family Group Therapy—An Intensive Early Psychosis Intervention
This new PEI program was approved in 2011, and intended as an intensive early psychosis intervention program. This will be modeled after the PIER Program which has been replicated and shown to reduce hospitalization increase functioning, improve family health outcomes, increase treatment compliance and decrease drug and alcohol abuse for this target population. The program will include: One “coordinating team”, consisting of a full time Psychiatrist, a full-time program supervisor, and two support staff. Three regional teams will each consist of: two treatment specialists, part-time occupational therapist, and a half-time mental health vocational counselor. A team will be assigned to each region of the county (East, West and Central). Plan development/implementation is currently underway, including identifying space, obtaining needed trainings, personnel recruitment, etc. The program will include community education, family psychoeducation, multi-family group treatment vocational and educational support and occupational support.
Program 1: Building Connections in Underserved Cultural Communities

Agency: Asian Community Mental Health Services, Inc.
Name of Program: AFRC System Navigation Program

Scope of Services
Asian Family Community Mental Health will provide comprehensive and culturally-sensitive and appropriate education and access to Mental Health Services for immigrant Asian communities, especially the Southeast Asian and Chinese population of Contra Costa County. ACMHS will employ multilingual and multidisciplinary staff from the communities which they serve. Staff will provide Prevention Activities: community outreach, home visits to senior housing sites, medication compliance education, community integration skills, older adult care giving skills, basic financial management, Survival English communication skills, travel training, health and safety education and computer education, structured group activities (on topics such as, coping with adolescents, housing issues, aid cutoff, domestic violence, criminal justice issues, health care and disability services) and health and mental health system navigation. Early Intervention Services will also be provided to those who are exhibiting signs of Mental Illness early in its manifestation. These services will be integrated into a recovery model framework assisting consumers in actively managing their own recovery process. These services will be provided for a period of under one year unless psychosis is present.

ACMHS will serve a minimum of 50 high risk and underserved Southeast Asian community members within a 12 month period 10 of which will reside in East County with the balance in West and Central.

Program 1: Building Connections in Underserved Cultural Communities

Agency: Center for Human Development
Name of Project(s): Mental Health Education/ System Navigation Support African American Health Conductors; and Senior Peer Outreach Program

Scope of Services
The Center for Human Development will implement Mental Health Education/ System Navigation Support African American Health Conductors that will provide a minimum of 120 individuals in Bay Point, Pittsburg, and surrounding communities with mental health resources. Key activities include: culturally appropriate education on mental health topics through Soul to Soul and Body and Soul support groups and other health education workshops. 20 to 30 individuals will receive navigation assistance for Mental Health referrals.

Program 1: Building Connections in Underserved Cultural Communities

Agency: Jewish Family & Children’s Services of the East Bay
Name of Project: Community Bridges

Scope of Services
During the term of this contract, Jewish Family & Children's Center of the East Bay will assist Contra Costa Mental Health to implement the Mental Health Services Act (MHSA). Prevention and Early Intervention Program will address PEI Project #1 with the Community Bridges Program to provide culturally grounded, community-directed mental health education and navigation services to 350-400 refugees and immigrants of all ages in the Latino, Afghan, Bosnian, Iranian, and Russian communities of central and east Contra Costa County. Prevention and early intervention-oriented program components include culturally and linguistically accessible mental health education; early assessment and intervention for individuals and families; and mental health system navigation assistance. Services will be provided in the context of group settings and community cultural events, as well as, with individuals and families, using a variety of convenient non-office settings such as schools, senior centers, and client homes. In addition, the program will include mental health training for frontline staff from JFCS/East Bay and other community agencies working with diverse cultural populations, especially those who are refugees and immigrants. The Contractor's program shall be carried out as set forth in the Work Plan for this Contract, which is incorporated herein by reference, a copy of which is on file in the office of the County's Mental Health Director and a copy of which the County has furnished to the Contractor.

Individuals receiving Contractor's services pursuant to this Agreement are hereinafter referred to as "Clients". These clients are also Clients of the County's Mental Health Division and other County-approved referral agencies.

Program 1: Building Connections in Underserved Cultural Communities

Agency: La Clinica de La Raza, Inc.
Name of Project(s): Vias de Salud (Pathways to Health)

Scope of Services
La Clinica de La Raza, Inc. (La Clinica) will implement Vias de Salud (Pathways to Health) to target Latinos residing in Central and East Contra Costa County with: a) 3,700 screenings for risk factors, such as symptoms of depression, anxiety, substance abuse, reactions to trauma, domestic violence, sleep difficulties, and pain; b) 1,100 assessment and early intervention services provided by a Behavioral Health Specialist to identify risk of mental illness or emotional distress, or other risk factors such as social isolation; and c) psycho-educational groups facilitated by a social worker for sixty-eight (68) adults to cover variety of topics such as isolation, stress, communication and cultural adjustment.

Program 1: Building Connections in Underserved Cultural Communities

Agency: Lao Family Community Development Inc.
Name of Program: Health and Well Being for Asian Families

Scope of Services
Lao Family Community Development, Inc. will provide a comprehensive and culturally sensitive Integrated Service System Approach for Asian and South East Asian adults. The Program activities
will include; Comprehensive Case Management, educational workshops and support groups. They will provide outreach, education, and support to develop problem solving skills, and increase families emotional well-being and stability. When necessary LFCD staff will supply support, in order to access needed health and mental health services. The staff will provide a client centered, family focused, strength based case management and planning process including home visits, brief counseling, parenting classes, advocacy and referral to other in house services such as employment services, financial education, and housing services. These services will be provided in client homes and other community based settings as well as the offices of Lao Family Community Development, Inc in San Pablo.

Program 1: Building Connections in Underserved Cultural Communities

Agency: Native American Health Center
Name of Program: Native Wellness Center

Scope of Services
Native American Health Center will provide a variety of weekly group sessions and quarterly community events for youth, adults, and elders to develop partnerships that bring consumers, families, community members and mental health professionals together and builds a community that reflects the history and values of Native American people in Contra Costa County. Community-building activities will include on elders support group, youth wellness group (including suicide prevention and violence prevention activities), a traditional arts group (beading, quilting, arts & crafts), and quarterly events tied to the seasons. Family Communications activities will include weekly Positive Indian Parenting sessions, talking and Gathering of Native Americans (GONA) to build a sense of belonging and cohesive community. Family members who need supplemental treatment for mental health and substance abuse problems will be referred to appropriate agencies. Mental Health Education/System Navigator Support will include appropriate services (with follow-up), and educational sessions about Contra Costa County’s service system. Facilitators and educators will be drawn from NAHC staff, community members, consultants, and staff. Expected outcomes include increases in social connectedness, communication skills, parenting skills, and knowledge of the human service system in the county.

Expected results from these activities include increased culturally relevant mental health services offered to the Native American Community in Contra Costa County. The Native Wellness Center is designed to build a strong community, strengthen family communications, and help Native Americans navigate the complex human service systems in Contra Costa County.

Program 1: Building Connections in Underserved Cultural Communities

Agency: Agency: Rainbow Community Center
Name of Project: LGBT Community Mobilization and Social Cultural Communities

Scope of Services
Rainbow Community Center will provide a community-based social support program designed to decrease isolation, depression and suicidal ideation among members of the Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) community residing in Contra Costa County. Key activities include:

a) Maintain and expand social and outreach programming that promotes development of social networks that are designed to promote resilience and build a sense of community affiliation in an effort to reduce stigma and isolation

b) Develop and convene support groups that are designed to promote resilience, self-efficacy and build a sense of community affiliation in an effort to reduce stigma and isolation;

c) Maintain and expand individualized (one-on-one) services that provide linkage and supports for LGBTQ community members, these services will include depression and suicidal assessments and individualized wellness plans

d) Coordinate PEI services targeted to LGBTQ youth and LGBTQ seniors that include outreach services, support groups and individualized support

e) Develop quality assurance and outcome measures to assure program management

f) Create service opportunities for community volunteers and students.

Expected results include: increased skills to combat life stressors that result from discrimination and greater communications and support among family members of LGBTQ people and LGBTQ families of choice.

Program 1: Building Connections in Underserved Cultural Communities

Agency: Young Men's Christian Association of the East Bay
Name of Project: One Family at a Time

Scope of Services
The Young Men's Christian Association in association with the Building Blocks for Kids Collaborative will provide diverse households in the Iron Triangle neighborhood of Richmond with improved access to health care, education, and Mental Health. This second year of the One Family at a Time prevention and early intervention work addresses MHSA's PEI goal of building communities in underserved cultural communities. Accordingly, the goals of the proposed second year are two-fold: (1) to build capacity of residents in the Iron triangle to influence factors that bear upon the healthy development and education of children from the community; (2) engage the community in education and health decision-making and improve community participation in education and health promotion, health protection, and violence prevention efforts; and (3) Directly assist residents in building and accessing a network of supportive mental health relationships among fellow residents and mental health service providers.
Program 2: Coping with Trauma Related to Community Violence

Agency: RYSE Center

Name of Project(s): RYSE: Trauma Response and Resilience System, and RYSE Health & Wellness

Scope of Services

RYSE Center will continue to implement the Trauma Response and Resilience System (TRRS) development process and implementation through: 1) deepening our work onsite as a critical responder and crisis relief site for young people experiencing acute incidents of violence, as well as engaging and supporting young people in realizing their individual potential and leadership, strengthening peer and youth-adult relationships, and advancing young people's collective capacity to advocate and organize for safe, vibrant, and youth-friendly communities; 2) further leveraging our success to date of integrating the TRRS framework and approach into key cross-sector stakeholder initiatives focused on addressing community violence, reintegration, and systems change. The TRRS is designed to respond to the acute needs of youth from the diverse communities of West County involved with incidents of violence by coordinating and mobilizing the appropriate supports and services. The TRRS will also engage participants in deeper, transformative work that recognizes and addresses the histories and inequitable burden of trauma and violence experienced in West Contra Costa. Key activities include: continued implementation and standardization of key components of RYSE's Youth Justice Project - the initial pilot program of the TRRS that engages young people involved with, or at acute risk of involvement, with the juvenile justice system; continued development and training for RYSE adult staff, RYSE youth staff, RYSE members, partners, key stakeholders, and key cross-sector initiatives in which RYSE participates. Training topics will include issues of trauma, trauma and adolescent development, community violence, restorative justice and healing, systems change and advocacy; continued awareness-building and outreach activities that includes culture-building events, workshops and activities that engage communities in dialogue about and celebrate resilience, and foster opportunities for healing and restoration; and deepened cross-sector stakeholders/initiatives to to develop to further the work done to date and formalize the TRRS. The ultimate aim of the Trauma Response and Resilience System development process is to implement and sustain a coordinated, multi-level response to critical incidents, addressing both the immediate and underlying conditions and impact of trauma and violence. The System will include guidelines and protocols that delineate the role and relationship between responders, incident assessment protocols, and communication protocols between and amongst responders and stakeholders.

The contractor will continue to implement RYSE Health & Wellness program, to support young people (ages 14 to 21) from the diverse communities of West County to become better informed consumers and active agents of their own health and wellness, foster healthy peer relationships and youth-adult relationships, and enable opportunities for youth leadership and advocacy. We offer a continuum of support to our members beginning with ensuring an experience of safety and respect, leading to education and self-reflection processes, through to goal-directed activities. Our Community Health programs offer tiered support for our members from community engagement to peer-to-peer education and training to individualized treatment and support systems. Programs and services include drop-in, recreational, and structured activities across areas of health & wellness; media, arts & culture; education & career; technology; and youth leadership & organizing. Key activities include: presentations, trainings, and outreach to schools, community organizations, and public agencies;
virtual outreach and engagement through a repurposed website and virtual youth center, monthly cultural events, and monthly membership meetings, expansion of the Contractor's current intake, youth-centered assessment, referral, and follow up system, as well as expansion of our data collection and evaluation system. We offer multiple peer-to-peer support groups each week, facilitated by adult staff, covering themes of emotional regulation, mindfulness, grief support, trauma support and education, LGBTQ support, and Young Women's and Men's Circles.

We will also develop formal referral systems with community partners for better utilization of our Health and Wellness services and programming. Lastly, we will initiate Community Health education projects that integrate health and wellness public education with creative arts and media outreach. Activities will be developed and implemented in partnership between adult and youth staff.

Program 4: Suicide Prevention

**Agency:** Contra Costa Crisis Center  
**Name of Project:** Suicide Prevention

**Scope of Services**
Contra Costa Crisis Center will provide services to prevent suicides throughout Contra Costa County by operating a nationally certified 24-hour suicide prevention hotline. The hotline lowers the risk of suicide at a time when people are most vulnerable, enhances safety and connectedness for suicidal individuals, and builds a bridge to community resources for at-risk persons. Key activities include: answering local calls to toll-free suicide hotlines, including a Spanish-language hotline; assisting callers whose primary language isn't English or Spanish through use of a tele-interpreter service; conducting a lethality assessment on each call consistent with national standards; making follow-up calls to persons (with their consent) who are at medium to high risk of suicide; and training all crisis line staff and volunteers in ASIST (Applied Suicide Intervention Skills Training). As a result of these service activities: 95 percent or more of people who call the crisis line and are assessed to be at medium to high risk of suicide will still be alive one month later; the number of trained, multilingual/multicultural crisis line volunteers will increase to 20 by the end of the reporting period, and the number of hours that a minimum of one Spanish-speaking counselor is on duty will be 80 per week.

Program 5: Supporting Older Adults

**Agency:** Center for Human Development  
**Name of Project(s):** Mental Health Education/ System Navigation Support African American Health Conductors; and Senior Peer Outreach Program

**Scope of Services**
The Center for Human Development will implement Mental Health Education/ System Navigation Support African American Health Conductors that will provide a minimum of 120 individuals in Bay Point, Pittsburg, and surrounding communities with mental health resources. Key activities include: culturally appropriate education on mental health topics through Soul to Soul and Body and Soul support groups and other health education workshops. 20 to 30 individuals will receive navigation assistance for Mental Health referrals.
Program 5: Supporting Older Adults

Agency: LifeLong Medical Care
Name of Project: SNAP! Senior Network and Activity Program

Scope of Services
LifeLong Medical Care will provide isolated older adults in West Contra Costa County with opportunities for social engagement and linkage to mental health and social services. A variety of group and one-on-one approaches will be employed to provide opportunities for socialization that will appeal to different groups of seniors, and reach out to those most reluctant to participate in social activities. SNAP! Senior Network and Activity Program will be provided in three housing developments that currently lack other on-site services. These activities will include regular incentivized on-site socials (3 per month for residents of each site), quarterly outings, and outreach to invite participation in group activities and develop a rapport with residents. Services will also include screening for depression and isolation and Information & Referral services. The Elders Learning Community will be provided to at least 10 frail seniors. The expected impact of these services includes: Reducing isolation and promoting feelings of wellness and self-efficacy; increasing trust and reducing reluctance to revealing unmet needs or accepting support services; and improving the quality of life by reducing loneliness and promoting friendships and connections with others.

Program 6: Parenting Education and Support

Agency: The Child Abuse Prevention Council of Contra Costa
Name of Project: The Nurturing Parenting Program

Scope of Services
The Child Abuse Prevention Council of Contra Costa will provide an evidence-based curriculum of culturally, linguistically, and developmentally appropriate, Spanish speaking families in East County, and Central County’s Monument Corridor. Four classes will be provided for 60 parents and approximately 60 children under 5-years of age. The 23 week curriculum will immerse parents in ongoing training, free of charge, designed to build new skills and alter old behavioral patterns intended to strengthen families and support the healthy development of their children in their own neighborhoods.

Program 6: Parenting Education and Support

Agency: Contra Costa Interfaith Housing, Inc.
Name of Project: Strengthening Vulnerable Families

Scope of Services
Contra Costa Interfaith Housing, Inc.(CCIH) will provide on-site, on-demand, and culturally appropriate delivery of an evidence-based Strengthening Families Program to help 27 formerly homeless families, all with special needs, at the Garden Park Apartments in Pleasant Hill to improve
parenting skills, child and adult life skills, and family communication skills. This program is designed to help families stabilize, parents achieve the highest level of self-sufficiency possible, and provide early intervention for the youth in these families who are at risk for ongoing problems due to mental illness, domestic violence, substance addiction, poverty and inadequate life skills. Key activities include: family support, support for sobriety, academic 4-day-per-week homework club, pre-school program, teen support group, and community building. The goals and outcome measures for Garden Park program include: assisting families to stabilize in permanent housing and meet their individualized goals related to self-sufficiency and sound parenting and to help the youth overcome the challenges inherent to being in a family impacted by a variety of challenges. Anticipated impact of this program will be a positive change in the social and emotional trajectory of these families, and the success of children to meet the academic benchmarks for their grade level.

Further, CCIH will provide an Afterschool Program and limited mental health and case management services at two sites in East Contra Costa County: Bella Monte Apartments in Bay Point and Los Medanos Village in Pittsburg. These complexes offer permanent affordable housing to low-income families. Anticipated impact for these East County services will be improved school performance by the youth and improved parenting skills and mental health for identified high risk families who live in these complexes.

**Program 6: Parenting Education and Support**

**Agency: C.O.P.E. Family Support Center**

**Name of Program: PEI — Triple P — Positive Parenting Education and Support Program**

**Scope of Services**
The C.O.P.E Family Support Center (Contractor) will provide services using the evidence-based Triple P — Positive Parenting Program Levels 2, 4 and 5 Multi-Family Support Groups, at no cost to parents. The program utilizes a self regulatory model that focuses on strengthening the positive attachment between parents and children by helping parents to develop effective skills to manage common child behavioral issues. Our targeted population includes caregivers residing in underserved communities throughout Contra Costa County.

Contractor will deliver 28 Triple P-Positive Parenting workshops in Spanish and/or English, as needed.

Contractor will provide orientation meetings as requested by MI-ISA. The orientation is designed to provide a comprehensive overview of the Triple P multi-level system. A briefing providing an opportunity to discuss the implementation of the program and ways to effectively support staff using the Triple P program and use of referrals is included.

Contractor will provide weekly pre-accreditation group meetings designed to provide an opportunity for individualized feedback on skill development prior to accreditation. All trained practitioners will be given the opportunity to practice specific competencies with peers in preparation for demonstration of these same competencies on accreditation day in the presence of the Triple P Trainer. These meetings will also clarify program content relevant to quiz questions.
Contractor will provide weekly clinical/peer support meeting designed to provide supervision of classes and families to problem solve issues related to the delivery of Triple P to families and provide practitioners with a supportive continuing education environment that will facilitate the transfer of learning from the training course to everyday practice.

Program 6: Parenting Education and Support

Agency: La Clinica de La Raza, Inc.
Name of Project(s): Familias Fuertes (Strong Families)

Scope of Services
Contractor will implement Familias Fuertes (Strong Families), to educate and support Latino parents and caregivers living in Central and East Contra Costa County so that they can support the strong development of their children and youth. The project activities will include: 1) Screening for risk factors in youth ages 0-18 (1,200 screenings); 2) 250 Assessment and/or parent coaching sessions with the Behavioral Health Specialist will be provided to parents/caretakers of children ages 0-18; and 3) Forty-eight (48) parents/caretakers will participate in the parent education and support group that will be facilitated by a Social Worker. The group will utilize an evidence-based and culturally relevant curriculum called Los Niños Bien Educados. All of the above services will be provided at two La Clinica Contra Costa facilities, located in Pittsburg and Pleasant Hill (Monument Blvd).

Program 6: Parenting Education and Support

Agency: The Latina Center
Name of Project: Parenting Education and Support

Scope of Services
The Latina Center will provide culturally and linguistically specific parenting education and support to at least 300 Latino parents and caregivers in West Contra Costa County supporting the strong emotional, social and educational development of children and youth ages 0-15, and reduce verbal, physical and emotional abuse. The Latina Center will enroll primarily low-income, immigrant, monolingual/bilingual Latino parents and grandparent caregivers of high-risk families in a 12-week parenting class using the Systematic Training for Effective Parenting (STEP) curriculum or PECES in Spanish (Padres Eficaces con Entrenamiento Eficaz). The Parent Advocates will be trained to conduct two parenting education classes, and 12 Parent Partners will be trained to offer mentoring, support and systems navigation and will also provide family activity nights, creative learning circles, at least two cultural celebrations, and two community forums on a parenting topic.
Program 8: Support Families Experiencing Mental Illness

Agency: The Contra Costa Clubhouses, Inc.
Name of Project: Supporting Families Experiencing Mental Illness

Scope of Services
The Contra Costa Clubhouses, Inc. will provide peer-based programming for adults throughout Contra Costa County in recovery from psychiatric disorders, helping them to develop the support networks, vocational skills, and self-confidence needed to sustain stable, productive, and more independent lives. The following services are provided with PET funding: Work-ordered day programming weekdays Monday through Friday, during which participants gain prevocational skills, social skills, healthy living skills, and access to career development options within the greater community. Career Development Services include assistance with setting goals, returning to school, finding/maintaining paid employment. On-site Life Skills, Recreational and Respite Services with meals are provided three weeknights and Saturdays at the Clubhouse in Concord and include: Multimedia Program honing new media skills in the multimedia lab; expressive arts, including music, visual arts, and creative writing; TGIF Socials, including karaoke, dancing, games, conversation, and movies; Healthy Living Program, including hikes, yoga, nutrition, and smoking cessation. Once monthly, TGIF and/or Saturday outings are offered at other locations within the County easily accessible to underserved groups. Transportation Services to and from the Clubhouse are provided at no cost by van. In-Home Peer-to-Peer Outreach up to four hours in length provided at consumer or caregiver request throughout the county. Young Adult Initiative provides special activities and programming to attract and retain younger adult members in the under-30 age group. Outreach Programs for the case managers and Social Service staff of county hospitals, medical providers, and community-based organizations; Newsletter and website, and dissemination of written materials through NAMI and other consumer- or caregiver-focused agencies, outreach events or ethnic media opportunities targeting monolingual and LEP consumers and caregivers in their community.

Program 9: Youth Development

Agency: The James Morehouse Project, the school health center at El Cerrito High School (fiscal sponsor: YMCA of the East Bay)
Name of Project: Youth Development

Scope of Services
The James Morehouse Project, the school health center at El Cerrito High School (fiscal sponsor: YMCA of the East Bay),* will provide services that increase access to mental health/health services and a wide range of innovative youth development programs for 300 multicultural youth in West Contra Costa County. Contractor will provide a wide range of innovative youth development programs through an on-campus collaborative of community-based agencies, local universities and County programs. Key activities designed to improving students' well-being and success in school include: Alcohol and Other Drug Use/Abuse Prevention; Teen Alive(anger and violence); Arts/Spoken Word (incarcerated family members); Bereavement Groups (loss of a loved one); Da Rainbow Clique (queer youth of color); Discovering the Realities of Our Communities (DROC — environmental and societal factors that contribute to substance abuse); Peer Conflict Mediation; Peer Counseling; Peer Health Education; Pregnant, Parenting & Caretaker Teens Group; Yoga (learn to focus more effectively; reduce stress, and work more skillfully with strong emotions, such as impulse control and frustration).
* In January 2010, the El Cerrito High School Community Project took James Morehouse's name to honor his 35 years of service to the El Cerrito High School community. Mr. Morehouse loved, mentored and inspired two generations of staff and students (from 1968-2003) and the James Morehouse Project, in taking on his name, commits to carrying on his legacy of love, respect and service for generations to come.

**Program 9: Youth Development**

*Agency: Martinez Unified School District*

*Name of Project: Youth Development*

**Scope of Services**

During the term of this contract, Martinez Unified School District will continue to assist Contra Costa Mental Health in implementing the Mental Health Services Act (MHSA), Prevention and Early Intervention Program #9 with the New Leaf (Youth Development) by providing "career academies" which will include individualized learning plans, place-based learning projects and career mentorships and internships for 46 high school adolescent youths in Martinez of all cultural backgrounds. Key activities include: service-learning projects, career preparation and internships where students, school staff, parents and community partners work together on projects, all derived from California standards-based curriculum. Some of the results of participation in the academies will be: A high school diploma, transferable career skills and certification, acceptance into a college or post-high school training program, strong leadership skills and the development of the assets necessary for holistic, sustainable living. The Contractor's program shall be carried out as set forth in the Work Plan for this Contract, which is incorporated herein by reference, a copy of which is on file in the office of the County's Mental Health Director and a copy of which the County has furnished to the Contractor.

Individuals receiving Contractor's services pursuant to this Agreement are hereinafter referred to as "Clients". These clients are also Clients of the County's Mental Health Division and other County-approved referral agencies.

**Program 9: Youth Development**

*Agency: People Who Care Children's Association*

*Name of Project: Youth Development*

**Scope of Services**

People Who Care Children Association will provide work experience for 150 multicultural youth residing in the Pittsburg/Bay Point and surrounding East Contra Costa County communities, as well as, programs aimed at increasing educational success among those who are either at-risk or high-risk of dropping out of school, or committing a repeat offense. Key activities include: a six day a week after school, vocational, and employment opportunity, The Hip Hop Car Wash, with referrals from Contra Costa Mental Health, Probation
Department, and Unified School Districts (Pittsburg, Antioch, etc.); will include monthly individual child assessments, academic and educational support, and peer-based juvenile delinquency prevention.

Program 9: Youth Development

Agency: RYSE Center
Name of Project(s): RYSE: Trauma Response and Resilience System, and RYSE Health & Wellness

Scope of Services
RYSE Center will continue to implement the Trauma Response and Resilience System (TRRS) development process and implementation through: 1) deepening our work onsite as a critical responder and crisis relief site for young people experiencing acute incidents of violence, as well as engaging and supporting young people in realizing their individual potential and leadership, strengthening peer and youth-adult relationships, and advancing young people's collective capacity to advocate and organize for safe, vibrant, and youth-friendly communities; 2) further leveraging our success to date of integrating the TRRS framework and approach into key cross-sector stakeholder initiatives focused on addressing community violence, reintegration, and systems change. The TRRS is designed to respond to the acute needs of youth from the diverse communities of West County involved with incidents of violence by coordinating and mobilizing the appropriate supports and services. The TRRS will also engage participants in deeper, transformative work that recognizes and addresses the histories and inequitable burden of trauma and violence experienced in West Contra Costa. Key activities include: continued implementation and standardization of key components of RYSE's Youth Justice Project - the initial pilot program of the TRRS that engages young people involved with, or at acute risk of involvement, with the juvenile justice system; continued development and training for RYSE adult staff, RYSE youth staff, RYSE members, partners, key stakeholders, and key cross-sector initiatives in which RYSE participates. Training topics will include issues of trauma, trauma and adolescent development, community violence, restorative justice and healing, systems change and advocacy; continued awareness-building and outreach activities that includes culture-building events, workshops and activities that engage communities in dialogue about and celebrate resilience, and foster opportunities for healing and restoration; and deepened cross-sector stakeholder/initiatives to to develop to further the work done to date and formalize the TRRS. The ultimate aim of the Trauma Response and Resilience System development process is to implement and sustain a coordinated, multi-level response to critical incidents, addressing both the immediate and underlying conditions and impact of trauma and violence. The System will include guidelines and protocols that delineate the role and relationship between responders, incident assessment protocols, and communication protocols between and amongst responders and stakeholders.

The contractor will continue to implement RYSE Health & Wellness program, to support young people (ages 14 to 21) from the diverse communities of West County to become better informed consumers and active agents of their own health and wellness, foster healthy peer relationships and youth-adult relationships, and enable opportunities for youth leadership and advocacy. We offer a continuum of support to our members beginning with ensuring an experience of safety and respect, leading to education and self-reflection processes, through to goal-directed activities. Our Community Health programs offer tiered support for our members from community engagement to peer-to-peer education and training to individualized treatment and support systems. Programs and services include drop-in, recreational, and structured activities
across areas of health & wellness; media, arts & culture; education & career; technology; and youth leadership & organizing. Key activities include: presentations, trainings, and outreach to schools, community organizations, and public agencies; virtual outreach and engagement through a repurposed website and virtual youth center, monthly cultural events, and monthly membership meetings, expansion of the Contractor's current intake, youth-centered assessment, referral, and follow up system, as well as expansion of our data collection and evaluation system. We offer multiple peer-to-peer support groups each week, facilitated by adult staff, covering themes of emotional regulation, mindfulness, grief support, trauma support and education, LGBTQ support, and Young Women's and Men's Circles. We will also develop formal referral systems with community partners for better utilization of our Health and Wellness services and programming. Lastly, we will initiate Community Health education projects that integrate health and wellness public education with creative arts and media outreach. Activities will be developed and implemented in partnership between adult and youth staff.

Program 9: Youth Development

Agency: STAND! Against Domestic Violence
Name of Project: Expect Respect

Scope of Services
STAND! Against Domestic Violence will provide services to address the effects of teen dating violence/domestic violence and help maintain healthy relationships of at-risk youth throughout Contra Costa County. STAND! will use two evidence-based, best-practice programs: Expect Respect and You Never Win with Violence to directly affect the behaviors of youth (preventing future violence) and enhance mental health outcomes for students already experiencing teen dating violence, Primary prevention activities include, educating middle and high school youth about teen dating through the 'You Never Win with Violence' curriculum, and providing teachers and other school personnel with knowledge and their awareness of scope and causes of dating violence, including bullying and sexual harassment and increase knowledge and awareness of the tenets of a healthy dating relationship. Secondary prevention activities include supporting youths experiencing or at-risk for teen dating violence by conducting 20 gender-based, 15-week support groups. A referral system will also be set up at each site for referring youth to the support groups. As a result of these service activities, youth experiencing or at-risk of teen dating violence will demonstrate an increased knowledge about the difference between healthy and unhealthy teen dating relationships; an increase sense of belonging to positive peer groups; an enhanced understanding that violence doesn't have to be "normal" and an increased knowledge of their rights and responsibilities in a dating relationship.
Appendix C

Suicide Prevention Summary
Contra Costa County is the ninth most populous county in California, with its population reaching approximately 1,049,025 in 2010. Over 50 percent of the population is Caucasian, approximately 24 percent are Hispanic and 17 percent are Asian. The median age is 39 years. The population is fairly distributed across all age ranges with an average of 27 percent of the population in each of the following age categories: under 18 years; 25 to 44 years; and 45 to 64 years. Nine percent of the population is between 18 and 24 years old and 12 percent are 65 years or older. Lastly, approximately 9.4 percent of Contra Costa County residents live in poverty; yet, the median household income is close to $80,000.

Contra Costa County is generally segregated into three distinct areas: West, Central and East County. Each region is geographically and demographically diverse. In 2009, in the Central region, White (64%) and Latino (20%) make up the majority. The East region of the county is largely comprised of White (39%) and Latino (33%). In contrast, the West region of the county is predominately White (26%), Latino (24%), and African-American (24%). Figure 1 shows Contra Costa County separated by zip code to detail the percent of suicides that occur in each area. The suicide death rates within Contra Costa County are highest among residents of Walnut Creek and Concord in the Central region; as well as Antioch in the East region, with suicide death rates of 13.6, 11.7 and 10.6, respectively.

In 2010, there were 119 reported suicide deaths in Contra Costa County; that represents an 8 percent increase from the previous year and a 40 percent increase from 2005. Overall, males account for a far greater proportion of all suicide deaths when compared to females in Contra Costa County. In line with California statistics, the highest numbers of suicides in Contra Costa County are completed using firearms, followed by hanging/suffocation, and drug overdose/poisoning. In 2007, the overall suicide death rate for Contra Costa County was 11.3 per 100,000 population which is higher than the California suicide death rate in 2009 of 9.8 per 100,000 population. Contra Costa County is not meeting the Healthy People 2020 goal of 10.2 suicides per 100,000 population.
Since 2001, there has been a decrease in the number of reported suicide attempts. In 2009, there were a total of 386 suicide attempts reported in Contra Costa County. Suicide attempts are thought to be drastically underreported for several reasons. First, not all suicide attempts result in a hospitalization and thus may never be reported and recorded as a suicide attempt. The Center for Disease Control and Prevention reports among young adults' ages 15 to 24 years, there are approximately 100 to 200 attempts for every completed suicide. For all ages, it is approximated that there is one suicide for every 25 attempted suicides. If this statistic is applied to Contra Costa County, it can be inferred that 2,975 people attempted suicide in 2010 (given the number of suicides deaths in 2010 was 119). This means as many as 2,589 suicide attempts went unrecognized. Many organizations have acknowledged the underreporting of suicide attempts and thus have recommended and advocated for increase sophistication of reporting methods.

In 2009, of the reported suicide attempts in Contra Costa County, approximately 67 percent of non-fatal attempts were among Caucasian people, 12 percent were among Latino and 10 percent African-American. In Contra Costa County, more men die by suicide, however more women attempt suicide; 59 percent of all reported attempts in 2009 were women in Contra Costa County. This statistic transcends the boundaries of this county and is true for the entire nation. Of those who attempted suicide in Contra Costa County, 80 percent were a result of poisoning followed by cutting/piercing at 15 percent.

### Protective Factors and Risk Factors of Suicide

Suicide is an important and preventable public health problem. The World Health Organization has estimated that 815,000 people worldwide died by suicide in year 2000, far outnumbering the reported 520,000 homicide deaths. The cause of suicide is an extremely complex issue in which multiple interacting risk and protective factors come into play. A risk factor, in this context, may be thought of as leading to or being associated with suicide; that is, people who experience the risk factors for suicide are at greater potential for suicidal behavior. However, it is important to note, many people may have these risk factors, but are not suicidal. Figure 4 describes risk factors identified in relation to suicide.
There are several protective factors related to suicide. (Figure 5) Protective factors reduce the likelihood of suicide. They can enhance resilience and may serve to counterbalance risk factors.\textsuperscript{13,14} Protective factors are quite varied and include an individuals’ attitudinal and behavioral characteristics, as well as attributes of the environment and culture.\textsuperscript{14,15}

**Influence of Age on Suicide**

Among Contra Costa County residents 15 to 34 years old, suicide is the third leading cause of death, after unintentional injuries and homicide.\textsuperscript{3} Studies show a dramatic decrease in the youth suicide rate during the past decade. Research on this trend attributes the decrease in youth suicide rate to the increase in antidepressants being prescribed to adolescents during this same time period.\textsuperscript{4} Within Contra Costa County this same trend proved to be true with an all time low number of youth suicide in 2003. There were only three reported suicides for residents under the age of 25.\textsuperscript{6} Unfortunately, the trend reversed over the last several years in Contra Costa County. The number of suicides within the same population has steadily increased since 2003 with 17 suicides being reported in 2010.\textsuperscript{6}

For those residents between the ages of 45 and 64 years old, suicide remains a leading cause of death with a death rate of approximately 18 per 100,000 people.\textsuperscript{7} (Figure 6) This rate well exceeds the State’s rate of 9.8 and the County’s overall rate of 11.3 suicides per 100,000 people.\textsuperscript{6} Yet, suicide is not in the top five leading causes of death for Contra Costa County residents over the age of 55 as the prevalence of chronic diseases increases with age.\textsuperscript{3} However, when considering the number of deaths by suicide within each age range, it is apparent the older adult population is a high-risk group even though they are more likely to die from a chronic disease than from suicide.

**Influence of Race/Ethnicity on Suicide**

In 2010, the majority of suicide deaths in Contra Costa County occurred among Caucasian residents with a suicide death rate of 13.5 per 100,000 followed by Latinos, Asians and African-Americans with suicide death rates of 7.0, 6.6, and 6.2, respectively.\textsuperscript{7} (Figure 6) When the suicide death rates are converted to percentages, approximately 70 percent of all suicides are among Caucasians; 15 percent among Latino; 8 percent are Asian and just over 5 percent are African-American.\textsuperscript{7}
Influence of Gender on Suicide

In 2007, 68 percent of people who died by suicide in Contra Costa County were male. Although more men die from suicide, more women attempt suicide. In 2009, approximately 59 percent of reported attempted suicides in Contra Costa County were female. Males and females tend to utilize different means for suicide. In most cases, males engage in far more lethal means during the attempt thus resulting in more male deaths when compared to females.

One study suggests acts of deliberate self-harm by females are more often based on non-suicidal motivation, but for males, deliberate self-harm is more often associated with greater suicidal intent. More research is needed to determine the extent to which social, genetic and biological factors, in association with gender, contribute to the risk of suicide.

Suicide and LGBTQ Youth

As previously mentioned, suicide is the third leading cause of death for people ages 15 to 24 years; however, more youth survive suicide attempts than actually die. The overall rate of suicide among youth, ages 15 to 24 years, in California is 6.9 per 100,000. While Contra Costa County’s rate is the same as for the state as a whole, 6.9 per 100,000, the rate is higher than its neighbor, Alameda County’s, rate of 6.4 per 100,000. The Suicide Prevention Resource Center reviewed studies and reports about youth suicide and concluded LGBTQQI2-S (Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex and Two-spirit) youth are a high-risk group for suicide. Their research indicates LGBTQQI2-S youth are two to four times as likely to attempt suicide as compared to heterosexual youth. Therefore, it can be inferred that the expected rate of suicide for LGBTQQI2-S youth in Contra Costa County is 14 to 28 per 100,000 people.

Moreover, recent research conducted in California, concluded the degree to which a family rejects or accepts their LGBTQQI2-S youth because of his or her sexual orientation during his or her adolescence has a correlation with the adolescent’s health outcomes. Adolescents who experienced high rejection were 8.4 times more likely to attempt suicide. The increase in suicide and suicide attempts for this specific population of youth can be attributed to an increase the sociocultural risk factors that are present in the youth’s lives. The social and internalized stigma that is intertwined with sexual identification of the youth can lead to isolation and rejection. Services available are inadequate to meet the needs of this population and the lack of a social support network further compounds the issue.

Influence of Economic Environment on Suicide

The current economic crisis being experienced worldwide, and especially in the United States, begs the question of whether or not the economic environment influences the rate of suicide. The health effects of economic insecurity are uncertain. Research conducted during the last U.S. economic depression was inconclusive. A study conducted in 1991, concluded that evidence for effects on suicide is characterized as weak or sufficiently controversial to warrant skepticism. Moreover, two studies conducted in 1978 and 1982 revealed small associations between economic stress and suicide or suicidal ideation. Contradictory, an analysis conducted in 2009 reported suicide is cyclical, meaning rates go up during an economic downturn; mental health also suffers during such periods. Lastly, a study published in 1995 stated people who died by suicide were more likely to be jobless when they died than were people who died from other causes. However, it was difficult to show job loss triggered individual acts of suicide. Psychiatric illness can predispose people to both unemployment and suicide; yet, economic insecurity may be an important variable in the causal chain leading a person to harm himself or herself.

It is apparent that the correlation between the economic situation and rates of suicide is not clearly defined and lacks consensus; however, most research supports the idea that joblessness or economic insecurity can be a risk factor for suicide, but not necessarily the primary cause of suicide.
Possible Prevention Strategies

The US Department of Health and Human Services stated suicide prevention programs need to support and reflect the experience of survivors, build on community values and standards, and integrate local cultural and ethnic perspectives. Prevention programs can be developed to target one or many risk factors and can target large populations or small subcultures directly.

In order for prevention strategies to be effective, they must incorporate stigma reduction efforts into the prevention programs. Stigma surrounding suicide has historical roots and dates back to Aristotle who argued suicide weakens the economy and upsets the gods\(^{25,26}\); such an argument initiated the stigmatization of the act. Until 1961, suicide and attempted suicide were punishable in court in England and until the early 1990’s two US states listed suicide as a crime.\(^{25,27-29}\) Today, the stigma surrounding suicide is not as intense nor is it eliminated. The stigma remains just high enough to discourage people from seeking help and instills hesitation to communicate suicidal thoughts. In addition to the individual, families, friends and relatives all experience the stigma that follows a suicide or suicide attempt; this further complicates the recovery process for all affected.\(^{24}\) Furthermore, the National Strategy for Suicide Prevention report outlines a goal to develop and implement strategies to reduce the stigma associated with being a consumer of mental health services and suicide prevention services. Educating the public about suicide should decrease stigma in general, and providing survivors with such information should decrease internalized stigma.\(^{9,24,25}\)

Additional possible inventions for suicide prevention are detailed in a matrix derived from the National Strategy for Suicide Prevention report.\(^{24}\) (Figure 9) Research helps to determine which factors can be modified to help prevent suicide and which interventions are appropriate for specific groups of people. A 2003 article published by Gould, et.al, identified promising prevention strategies specific to the youth population. Recommendations include school-based skills training; screening for at-risk youth; education of primary care physicians; media education; and lethal-means restriction.\(^{14}\)

Programs aimed at improving the ability of primary care and mental health professionals to identify and treat those at risk for suicide are recommended.\(^{30}\) Studies suggest as many as 90 percent of those who died by suicide have a mental illness.\(^{31}\) Research also demonstrated about one-half of people who died from suicide had contact with a primary care professional within one month of their suicide, and about three-quarters had contact within one year.\(^{32}\) More specifically, older adults are more likely to seek primary care services within a month of suicide when compared to other age groups\(^{32,33}\) and women, when compared to men, tend to have higher rates of contact with primary care providers prior to suicide.\(^{32}\) By improving mental health professionals and primary care provider’s ability to recognize and treat risk factors, specifically among older adults and women, suicides can be prevented.\(^{13,32}\)

![Figure 9: Matrix of Interventions for Suicide Prevention](image-url)

<table>
<thead>
<tr>
<th>Universal</th>
<th>BIOPSYCHOSOCIAL</th>
<th>ENVIRONMENT</th>
<th>SOCIOCULTURAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>The intervention is designed to affect everyone in a defined population.</td>
<td>Incorporate depression screening into all primary care practice</td>
<td>Promote safe storage of firearms and ammunition</td>
<td>Teach conflict resolution skill to elementary school children</td>
</tr>
<tr>
<td>Selective</td>
<td>Improve the screening and treatment for depression of the elderly in primary care practices</td>
<td>Reduce access to the means for self-harm in jails and prisons</td>
<td>Develop programs to reduce despair and provide opportunities (increase protective factors) for high risk populations</td>
</tr>
<tr>
<td>Indicated</td>
<td>Implement cognitive-behavioral therapy immediately after patients have been evaluated in an emergency department following a suicide attempt</td>
<td>Teach caregivers to remove firearms and old medicines from the home before hospitalized suicidal patients are discharged</td>
<td>Develop and promote honorable pathways for law enforcement officers to receive treatment for mental and substance use disorders and return to full duty without prejudice</td>
</tr>
</tbody>
</table>
Incorporating the Statewide Strategic Plan
California Department of Mental Health released the California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution in June of 2008. Several strategies for suicide prevention are detailed in the report with further detail for recommended actions at the State and local levels. The report refers to the following as “Strategic Directions”: creating a system of suicide prevention; implementing training and workforce enhancements; educating communities to take action; and improving program effectiveness and system accountability. Additionally, six core principles were defined to guide all levels of planning, service delivery and evaluation. The core principles are described below:

<table>
<thead>
<tr>
<th>Core Principle</th>
<th>Description</th>
<th>Key points</th>
</tr>
</thead>
</table>
| One            | Implement culturally competent strategies and programs that reduce disparities. | • Goal is to reduce disparities in the availability, accessibility and quality of services for racial, ethnic and cultural groups  
• Planning processes should involve members of the target population of focus |
| Two            | Eliminate barriers and increase outreach and access to services. | • Information, programs and materials:  
  o Need to be accessible and available in a variety of languages and formats  
  o Should ensure that all people of diverse backgrounds and abilities, including physical, psychiatric and age-related disabilities, have access to equitable services |
| Three          | Meaningfully involve survivors of suicide attempts; the family members, friends, and caregivers of those who have completed or attempted suicide; and representatives of target populations. | • Include those who have survived a suicide attempt and their family members, friends and caregivers as they bring important personal experiences and unique perspectives to identify service needs and gaps in the system  
• Peer Support and education are invaluable components of a comprehensive system for suicide prevention |
| Four           | Use evidence-based models and promising practices to strengthen program effectiveness. | • Attention should be given to replicating and disseminating or adapting effective program models and promising practices.  
• Program design should include consideration of how evaluation can be used as a management tool to strengthen and improve programs |
| Five           | Broaden the spectrum of partners involved in a comprehensive system of suicide prevention | • Develop long-term partnerships with a broad range of partners that transcend the traditional mental health system  
• Examples of partnership include: business community; senior centers; spiritual and faith communities; private foundations; Veterans Affairs, etc. |
| Six            | Employ a life span approach to suicide prevention. | • Suicide prevention and intervention activities should be targeted to people of all ages from children and youth, to adults, and older adults. |

As previously mentioned, these six core principles are further organized by two levels of focus for suicide prevention: strategic directions and recommended actions. When considered together, the core principles, strategic directions and recommended actions are intended to lay the foundation for a comprehensive system of suicide prevention that builds on existing infrastructure, expands capacity of co-existing systems and identifies and fills gaps in services and programs.
Citations:
33. California Department of Mental Health. (2008). California Strategic Plan on Suicide Prevention: Every Californian is a Part of the Solution.
Increasing national media attention has highlighted the challenges and risks LGBTQ youth face in finding support and acceptance. The experience of rejection and the lack of support across a wide variety of settings, including home, school, faith groups and within peer social networks have harmful impacts on the long-term health and mental health of LGBTQ youth. The Contra Costa LGBTQ Youth Collaborative was formed to identify answers to critical questions regarding the needs of LGBTQ youth and the stresses that impact their healthy development. Learning questions that guided this project include:

- What are the most potent risks that threaten the health, safety, and mental health of LGBTQ youth who live in Contra Costa County?
- What practice strategies may increase resilience and improve mental health outcomes for LGBTQ youth and lead towards evidence-based practice?
- Can developing a community-wide, integrated Social Support Model improve health outcomes and overall resilience for LGBTQ youth?

Background: The findings presented in the Background section of the full report reveal the harmful impact of rejection on the health and resilience of LGBTQ youth, including:

- High levels of family and caregiver rejection often result in significantly increased levels of depression, suicide attempts, illegal drug use and risky sexual behaviors.
- A strong correlation has also been found between high levels of harassment, victimization and violence at school (and/or other social settings) and impaired health and mental health in young adulthood.
- Victimization by both peers and school personnel has been documented and demonstrated to negatively affect school attendance, sense of safety and overall academic performance.
- Institutional barriers to accessing culturally competent support services exacerbate the harmful effects of rejection. Many health and social service professionals are not trained, or supported by their agencies, to address issues of sexual orientation or gender identity with children, youth and families. The result is a lack of inter-agency cooperation and ultimately under-utilization of health and supportive services by at-risk LGBTQ youth and families.
- Minimal research has examined the impact of faith-group rejection on health outcomes for LGBTQ youth; however, practice experience and emergent findings from this project suggest that issues of faith and religious practice are significant factors that must be addressed in order to increase family and community acceptance.
Finally, while research has clearly identified the connection between rejection at home, school, and in the community and health and mental health disparities among LGBTQ youth, there are no evidenced-based intervention models in place to guide development of effective services.

In light of the compelling evidence about the harmful effects of rejection on LGBTQ youth, the Contra Costa LGBTQ Youth Advocacy Collaborative has sought to identify effective strategies that will provide support for LGBTQ youth throughout Contra Costa County, California. The lack of evidence-based intervention models from the field underscores the vital importance of this project in identifying promising strategies that have the potential to increase resilience and improve mental health outcomes for LGBTQ youth.

Funding for this project has been provided through the Innovations component of the California Mental Health Service Act of 2004 (MHSA). MHSA has defined Innovations as “novel, creative and/or ingenious mental health practices/approaches that are expected to contribute to learning, which are developed within communities through a process that is inclusive and representative, especially of unserved and underserved individuals.”

Our work in Year 1 of the project embraced the following protective factors identified in the Background review:

- The 2011 Institute of Medicine (IOM) Report, *The Health of LGBTQ People*, notes that “the few studies that have examined protective factors for LGBT youth have considered individual and interactional factors, such as self-esteem (Savin-Williams, 1989a,b), school support, and family relatedness (Eisenberg and Resnick, 2006).”
- The IOM report also stressed that it is important to note that the majority of LGBTQ youth are typically well-adjusted and able to thrive during their adolescent years.
- Eisenberg and Resnick (2006) studied suicidal ideation and attempts among high school students with same-sex sexual experience. They found that family connectedness, adult caring, and school safety were significantly protective against suicidal ideation and attempts.
- The importance of acceptance for LGBTQ youth is both supported by and made more explicit in the work of Dr. Caitlin Ryan. Compelling ideas from Dr. Ryan’s work include the concepts that acceptance and rejection can be framed on a harm reduction continuum and interventions that reduce the rate and level of rejecting behaviors may lead to improvements in health and mental health outcomes. This is the central paradigmatic framework that has guided partner activities under this innovations Project.

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1 Institute of Medicine (IOM): The Health of LGBTQ People (2011), p. 164
2 IOM p. 147
Three year program design: The Rainbow Community Center of Contra Costa County (RCC), will work with collaborative partners to develop and implement innovative, learning-oriented activities to answer our learning questions and to identify potential practice methods that can lead towards improved health and wellness and prevent mental illness among LGBTQ youth. Year one activities focused on needs assessment and emergent design methods that mapped a baseline of services available in the community, identifying both the strengths and services in need of further development. Year two activities will focus and refine intended interventions and begin the collection of evaluation data. Year three of the project will then focus on analysis of data collected in year two and promote planning to sustain the most effective intervention methods identified during the project.

**Year 1 Objectives:** (activity summaries begin on page 35 of the full report)

Three core objectives were developed for Year 1 of the project:

1. **Form and implement a learning community of key partners and collaborators who will work together to develop a multi-level approach that promotes acceptance of LGBTQ youth**
   - The implementation of these learning goals and approaches in Year 1 has been accomplished with the support of the following key partners: Rainbow Community Center (RCC) (countywide), San Francisco State University-Marian Wright Edelman Institute’s Family Acceptance Project (countywide), RYSE Center (RYSE) (west county), Gender Spectrum (GS) (countywide), James Morehouse Project (JMP) (west county), and Center for Human Development (CHD) (east county). During Year 1, six additional ally organizations were identified and incorporated into learning activities.
   - The core activities related to this objective include: 1.) Implement at least five social support/community interventions that will reduce rejecting behaviors experienced by LGBTQ youth; 2.) Develop a community mapping process that identifies community organizations and service providers that interact with LGBTQI2-S youth; 3.) Engage community service providers in processes that change organizational practices to promote accepting behaviors and engage key ally groups in the project; and 4.) Collect formative and summative data on project processes and outcomes.

2. **Develop an LGBTQ-specific Mental Health counseling program at the Rainbow Community Center of CCC and countywide co-located sites**
   - The core activities related to this objective include: 1.) RCC will recruit and hire program and support staff to provide mental health services; 2.) train service providers in concepts based on family-inclusion and in efforts to reduce rejecting behaviors and increase accepting behaviors across different social spheres; 3.) implement use of Family Acceptance assessment instruments; and 4.) Collect formative and summative data on RCC’s counseling processes and outcomes.

3. **Disseminate educational materials developed by the Family Acceptance Project as part of one or more of five piloted social support/community interventions**
Summary of Emerging Findings from Year 1 Activities: (beginning page 81)

- **Developing a collaborative process:** The primary work in Year 1 was to form a collaborative learning community to learn more about how a Social Support Model can improve health outcomes for LGBTQ youth. Findings about the collaborative process: Innovative project designs are critical approaches to program development when addressing the needs of marginalized or hidden populations and in situations where minimal evidence-based practices are available. It is recommended that funders of collaborative models support time for planning, development of interventions, relationship-building activities and group facilitation. It must be restated that the relationship-building phase almost always takes longer and is more complex than many funders would like, however successful implementation plans incorporate this critical step into the process. Setting clear guidelines for decisions made collaboratively and those made by the lead agency or funder at the beginning of the project is a vital element of collaborative projects. Partners reported that collaborative work strengthened their individual and organizational capacity and insight. Participating organizations developed stronger intervention theories and displayed organizational growth and development. Developing a shared yet flexible framework for intervention is the best way forward. Partners should determine the capacity and approaches appropriate for each strategy and then commit to a specific plan of action that fits their organizational model and context.

- **Promoting positive LGBTQ youth development:** Much additional work must be done to develop interventions that have clearly defined logic models defining interventions that support healthy LGBTQ youth identity development. At their core, all partners serving LGBTQ youth are involved in supporting their clients through the process of identify development. Yet, a key finding from year one of our project is that agencies lacked explicit guidelines or a theory of change to help guide this developmental work. Year 2 efforts must identify more explicit interventions, and the methods needed to assess and measure the outcome goals in identity development work with LBTQ youth.

- **Developing LGBTQ youth-and family specific mental health services:** Mental health services are needed that assess for youth strengths as well as risks. Services must create clearer guidelines for incorporation of identity development treatment goals with LGBTQ counseling clients. A clearer theory of change must be developed that creates stronger assessments and treatment plans for work with parents of LGBTQ youth and incorporates the newly developed FAPRisk Assessment Tool. An additional key finding from year one efforts is that many clients request mental health counseling services but that this request reflects an unidentified need for a range of behavioral health services such as case management, vocational rehab, and HIV prevention. More work is needed to properly assess client needs and as noted there is a serious lack of a county-based referral network.

- **Promoting community engagement:** One of the core values and goals of this project is to create an Integrated Service Experience county-wide for LGTBQ youth and their families. Building awareness of the existence of the Collaborative is an ongoing challenge. As awareness has
grown, opportunities have emerged to overcome the isolation among supportive providers that point toward the great potential of developing integrated assessment, referral and service strategies. The Mapping Process established a baseline of LGBTQ-specific youth and family services available in Contra Costa County when this project began. There has been some growth in services through Collaborative efforts. The mapping process has identified an immediate need for a unified approach to LGBTQ cultural competency training from both a service provider and an administrative perspective. There is a significant need for deeper work in the education, child welfare and juvenile justice systems with regard to cultural competence in addressing sexual orientation and gender expression. Recent legislation on the federal and state level is creating new opportunities to engage in work on behalf of LGBTQ youth and families.

• **Building social support networks:** The three-year goal of this project is to determine whether a Social Support Model can improve health and mental health outcomes for LGBTQ youth. The first year goal was to determine the key characteristics of and strategies to implement a Social Support model for LGBTQ youth targeting families and caregivers, schools and faith groups.

Year one findings regarding social support networks:

- **Families and caregivers:** While significant effort went into forming support groups for parents, these efforts had limited success in engaging family members with school-aged children. The conclusion is that group-level interventions are not cost effective strategies at this time. Instead it is our recommendation that the project evaluate community mobilization strategies to raise awareness about the impact of rejection on LGBTQ youth. At this time more efforts are needed to identify and create cohorts of family members who are ready to participate in group-level interventions. Strategies that promote individual-level services and training for all providers engaging with LGBTQ youth and their families will also be explored in year 2 project efforts.

- **Schools:** Reported experience of all participating organizations makes it clear that issues of harassment and victimization noted in the Background section of this report are evident in public schools across Contra Costa County. School systems continue to foster climates that promote the rejection of LGBTQ and gender non-conforming children and adolescents. It also appears unlikely that schools will create needed changes from within. Conversations with policy makers rarely move from consent to committed action. There is an unmet need for organizations who can work effectively with schools to advocate for the needs of LGBTQ youth. The Collaborative has formed a Schools Strategy Team to work on these issues in Year 2.

- **Faith Groups:** All Collaborative partners have reported that youth in their programs speak about the stigma and rejection they experience at church and report that they are negatively affected by those experiences. Given the pervasive nature and importance of issues of faith for LGBTQ youth, the Collaborative Strategy Teams will incorporate work on these issues into their plans for Year 2. The work of our faith-based mini-grant partners will form the basis of the dialogue and outreach.
The Contra Costa LGBTQ Youth Advocacy Collaborative was formed to address the need to reduce the harmful health disparities experienced by LGBTQ youth in Contra Costa County, CA. The three-year goal of this innovations project is to determine whether a Social Support Model can improve health and mental health outcomes for LGBTQ youth. On the basis of our analysis of lessons learned and our summary of emerging findings, a plan for year two efforts has been established.

The primary target groups for year-two strategy implementation are: 1.) LGBTQ youth/TAY and their straight peers and allies; 2.) families and caregivers; and 3.) community-based organizations, including schools, faith groups and service providers. The overall goal is to create suggested strategy and evaluation toolkits for use with each target group. The following recommendations form the basis for strategy development and implementation in Year 2 to complete the infrastructure for a Social Support Model for LGBTQ youth in Contra Costa County.

The goal with LGBTQ youth and peers is to build the capacity of CCC community-based youth services to promote the health and wellbeing of LGBTQ youth; to engage LGBTQ youth voice and leadership; and to develop, implement and evaluate core strategies and tools designed to promote positive identity development and reduce health risk factors for LGBTQ youth. Key strategies include:

- Facilitate LGBTQ youth development and empowerment groups in all regions of the county in order to promote an integrative program model supporting a culture of acceptance and healthy LGBTQ identity development. These services will be provided by RCC, CHD, RYSE and JMP in conjunction with a variety of mini-grant partners.
- A Youth Strategy Team will be formed to create a strategy and evaluation toolkit for use by organizations providing youth development and support services for LGBTQ youth.
- A youth-designed and led digital and social media campaign will be developed to nurture new support connections among a diverse group of LGBTQ youth and to build capacity to create a unified message and voice for LGBTQ youth county-wide.
- Online resources and outreach will be established to build a strong social media strategy that elevates LGBTQ youth voice in Contra Costa County.

The goal with families and caregivers is to build county-wide awareness of the harmful effects of rejection and to promote positive parental role models for the acceptance of LGBTQ youth. It is also our intent to engage the voice and leadership of LGBTQ youth and their families in developing and implementing the proposed strategies. The strategies with families will be adapted from Community PROMISE, an evidence-based community level intervention which was designed to mobilize social networks to build trust and partnerships and reduce HIV risk behaviors. Key strategies to be developed by the Families Strategy Team include:

- Promote community-level awareness of harmful effects of rejection by developing role models stories about peer-family support and that highlight accepting behaviors for families and caregivers of LGBTQ youth.
• **Promote Education and Awareness events and forums** to support the role models of acceptance initiative and expand the influence and awareness of the FAP psycho-educational model.

• **Family Counseling** will be provided by RCC and accessed through a codified referral network established among all service providers participating in the extended collaborative.

• **Home-based outreach and support for families and caregivers** will be developed based on FAP research, including training on making contacts, home visits, crisis intervention and making appropriate referrals for services.

• **An online resource and referral network** will be established based on an online service directory and other resources developed and maintained by the Contra Costa Crisis Center.

The primary goal with community-based organizations (schools, faith groups and service providers) is to build the capacity to create a climate of acceptance for LGBTQ youth. We will develop, implement and evaluate strategies and tools designed to reduce rejecting behaviors and increase accepting behaviors in schools, faith groups and service providers. Additionally, our intent is to engage LGBTQ youth voice and leadership. Key strategies include:

• **Build a base network of allies** in schools county-wide by establishing two Inclusive Schools Coalitions; one in west county and one in central-east county

• **Develop and promote LGBTQ cultural competency assessment and training** for administrators, teachers and other school district staff based on collaborative funded training models.

• **Develop and promote a tool kit of strategies and activities for action in schools countywide.**

• **Advocate for implementation of current CA education policies** in order to create more inclusive and accepting environments in county schools.

• **Hold targeted forums** to promote acceptance in West Contra Costa Unified School District elementary schools.

• **Prepare for a county-wide symposium** for educators and allies in the fall of 2012.

• **Build a base network of allies among faith group leaders; including networking opportunities and awareness raising efforts based on the FAP model of family engagement.**

• **Develop and promote workshops and forums** designed to address issues of faith, families and acceptance of LGBTQ youth county-wide.

• **Establish an individual counseling, case management and referral network** to develop protocols for intake and referral for assessment, counseling and case management services.

• **Develop and deliver LGBTQ cultural competency assessment and training** in partnership with collaborative partners and all organizations receiving mini-grant funding.

The strategies listed above along with sustainability and evaluation strategies will be developed, implemented and tested during Year 2 and Year 3 of the project.
PUBLIC HEARING
Draft MHSA 2012/2013
Annual Update to the 3-Year Program and Expenditure Plan

June 14, 2012
Meeting Packet
The Contra Costa County Mental Health Commission has a dual mission: 1) To influence the County's Mental Health System to ensure the delivery of quality services which are effective, efficient, culturally relevant and responsive to the needs and desires of the clients it serves with dignity and respect; and 2) to be the advocate with the Board of Supervisors, the Mental Health Division, and the community on behalf of all Contra Costa County residents who are in need of mental health services.

PUBLIC HEARING
Fiscal Year 2012-2013
Mental Health Services Act Plan Update
Thursday, June 14, 2012 • 5:40-7:40 p.m.
2425 Bisso Lane, Downstairs Conference Room, Concord

The Commission will provide reasonable accommodations for persons with disabilities planning to participate in Commission meetings. Contact the Executive Assistant at 925-957-5140 at least 48 hours prior to the meeting.

AGENDA

1. 5:40 Call to Order / Introductions

2. 5:45 Opening Comments by the Mental Health Commission (MHC) Chair/Vice Chair
   A. Review of authority for Public Hearing [Welfare & Institutions Code 5848(a)(b)]
      (a) Each plan and update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, and other important interests. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans.
      (b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft plan and annual updates at the close of the 30-day comment period required by subdivision (a). Each adopted plan and update shall include any substantive written recommendations for revisions. The adopted plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the county mental health department for revisions.
   B. Review of Public Hearing purpose
      To confirm and complete the process.

3. 5:55 Fiscal Year 2012-2013 Mental Health Services Act (MHSA) Plan Update
   - Mary Roy, LMFT, MHSA Program Manager
   The Plan update is available for review at:

The Contra Costa County Mental Health Commission is appointed by the Board of Supervisors to advise them on all matters related to the county's mental health system, in accordance with mandates set forth in the California State Welfare & Institutions Code, Sections 5604 (a)(4)(B) 5605.5. Any comments are recommendations made by the Mental Health Commission or its individual members, and they do not represent the official position of the county or any of its officers.
4. **6:35 Public Comment On Plan**
Members of the public may comment on any item of public interest within the jurisdiction of the Mental Health Commission. **Public Comment cards are available on the table at the back of the room. Please turn them in to the Mental Health Commission’s Executive Assistant.** In the interest of time and equal opportunity, speakers are requested to observe a 3-minute maximum time limit (subject to change at the discretion of the Chair). In accordance with the Brown Act, if a member of the public addresses an item not on the Agenda, no response, discussion, or action on the item may occur.

5. **7:00 Develop List of Comments and Recommendations to the County Mental Health Administration (MHA) and to the Board of Supervisors (BOS).**

6. **7:40 Adjourn Public Hearing**

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Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the staff to a majority of the members of the Mental Health Commission less than 96 hours to that meeting are available for public inspection at 1340 Arnold Drive, Ste. 200, Martinez during normal business hours.
### Public Comment Compiled

**Annual Update for MHSA FY 2012/2013 Annual Plan Update – Input from public & stakeholder comments, for the period May 15, 2012 through June 14, 2012, and also for the Public Hearing conducted by the Mental Health Commission on June 14, 2012, 5:30-7:30 p.m.**

*Reading from left to right: the first column references the comment number, the second column contains the stakeholder name, and the third column identifies the public comment and/or stakeholder input received. County responses to the following comments can be found on page 84.*

<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Public Comment and/or Stakeholder Input and Response to Comments and/or Proposal Changes to Draft:</th>
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</thead>
</table>
| 1   | Janet Marshall Wilson | Public Comment:  
- The unanimous rate for 30% increase in new funding being spent on housing (CPAW & INH Commission) should help solve the housing challenges listed on p.20. Also, housing must be developed (continuum of care) for out-of-county placed conservatees as well as for county m.h. clients placed in substandard living (eg Jackie Brown’s unlicensed homes in East County). Clients who need care and supervision (as defined in Tittle 22) should be in licensed board +care homes; those more independent (and efforts should be made to help clients, become independent) should be placed in permanent subsidized housing with the understanding that identified priority request of consumers is master-leased scattered site housing, with available transportation. Housing for mental health clients takes political will. Dually diagnosed clients (MH/AOD) should NOT be co housed with “serious + persistent” mental health clients. |
| 2   | Melinda Oiday       | Public Comment:  
- Need more advocates  
- Need More peer to peer  
- Need bus passes |
| 3   | Melinda Oiday       | Public Comment:  
- We need a shuttle bus to pick up + drop off consumers  
- We need more affordable housing  
- We need more assistance with paying for medication |
| 4   | Marvin Edwards      | Public Comment:  
- Transportation – 7 passenger van  
- More peer to peer supporter |
| 5   | Scott,R             | Public Comment:  
- Transportation  
- Support in recovery |
| 6   | Marvin Edwards      | Public Comment:  
- More adults peer support program  
- Leadership Academy  
- Shuttle service- peer run |
| 7   | Christopher Rollins | Public Comment:  
- More peer counselor jobs will be appreciated thank you! |
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<tr>
<th></th>
<th>Name</th>
<th>Public Comment</th>
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<tbody>
<tr>
<td>8</td>
<td>Yvette E Anderson</td>
<td>• I think that we should use the funds toward affordable optometrist, dentistry; orthodontist for Medical/Medicare, new groups for dentistry for example DVC + have medical county cards again for the Contra Costa County. People need glasses + good hygiene(dentists)</td>
</tr>
<tr>
<td>9</td>
<td>Chelsey Holer</td>
<td>• I am a consumer provider for MHCC. Many of our consumers cannot get to the center. We have even lost consumers because this issue. I get calls all the time from consumers who are stuck in their house and cannot get to the center. Please fund us for a consumer run shuttle program so that we can reach more people. Also we need more peer counselors and full time assistants. Please continue the leadership academy so we can continue to empower consumers to advocate for others.</td>
</tr>
</tbody>
</table>
| 10| Peggy Harris        | • I would like to see MHSA funds used for additional transportation needs to support consumers to not isolate and be driver to wellness & recovery community centers.  
• I would also like money to be set aside for housing in Contra Costa County. It is very rare in Central County. |
| 11| David Selig         | • It would be good to have a shuttle to take consumers home because the public transportation (busses) doesn’t run often  
• It would be good if we could reach out to the local community so we could educate them about mental health |
| 12| Arthur Dell         | • Better dental and vision coverage/ Medical  
• Free shuttle bus from home to recovery centers and doctors  
• More low income apartment for people with mental health  
• Easier access to section 8 and shelter, plus care certificates for people  
• I think it should be automatic sec. 8 or shelter plus care for people who are on SSI because we have a limited income and cannot afford the high cost of rent and be able to buy food and pay bills |
| 13| James Faeman        | • Need subsidized housing  
• Cheaper medication  
• Need transportation  
• Need dental services |
| 14| Susan Reyes         | • Transportation  
• Good doctors  
• Increase benefits such as income |
| 15| Jonathan Tran       | • Coming for fun and meeting new people and help other out. Also, information on how to get a good job and school. |
| 16| Loretta Winchester  | • Subsidized housing  
• I need transportation |
|   | Cheaper medication  
|   | I need transportation to run errands  
|   | I need good doctors and therapist  
|   | Increase benefits and medical benefits  
| 17 | Jose Saucedo | Public Comment:  
|   | Information on how to get housing  
|   | Information on how to receive higher benefits  
|   | Information on how to get back to work  
|   | Information on how to get back to school  
|   | Information for vocational job training  
| 18 | Dawn Elizondo | Public Comment:  
|   | I need cheaper medication, transportation and the therapist and good medical doctors. Also, we need good apartments for people with cheaper rent for people who cannot pay a lot of rent.  
| 19 | Judith J Germany | Public Comment:  
|   | As a coordinator for a wellness a recovery center I witness firsthand what the consumers concerns are regarding their daily wants and needs. My consumers express to me they wish they had more choices of permanent supporting housing, more wrap around services, subsidized housing, transportation to and from clinics, shopping, wellness centers. They want vocational training, better medical care such as vision and dental services.  
| 20 | Michael Reeves | Public Comment:  
|   | We need transportation  
|   | Housing needs  
|   | More doctor’s help  
| 21 | Joy Witt | Public Comment:  
|   | We need more class B Drivers  
|   | More vans for pick up for consumers  
|   | Money for outing  
| 22 | Jeffrey Lawe | Public Comment:  
|   | I need affordable housing, transportation  
|   | Better mental health care services  
|   | Better medical coverage  
|   | We need van transportation  
| 23 | Daniel Ben Eliezea | Public Comment:  
|   | Dental health care still is needed  
|   | Subsidized housing  
|   | Transportation  
| 24 | Camelle Thompson | Public Comment:  
|   | Better transportation  
|   | Better medical care  
|   | Better housing  
|   | Raise more outing money  
| 25 | Yvette E. Anderson | Public Comment:  
|   | Smoke zero program , to ban smoking for mental health for good as well as health in general  
|   | Teach philosophy to have the power to quit smoking  

75
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<tr>
<th></th>
<th>Name</th>
<th>Public Comment:</th>
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<tbody>
<tr>
<td>26</td>
<td>Joseph Larkin</td>
<td>• We need teachers</td>
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<tr>
<td></td>
<td></td>
<td>Public Comment: We need transportation for consumers who have a hard time making to the center. And when they can't get here sometimes they end up walking the street. This is not right.</td>
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<td>27</td>
<td>Anne Lang</td>
<td>• Everything on the board</td>
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<tr>
<td></td>
<td></td>
<td>• Peer counselors</td>
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<td></td>
<td></td>
<td>• Wellness nurse / week days</td>
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<td></td>
<td></td>
<td>• Shuttle services</td>
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<td></td>
<td></td>
<td>• Older Adult support group</td>
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<tr>
<td>28</td>
<td>Loni Feldman</td>
<td>• Need a wellness nurse every week</td>
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<tr>
<td></td>
<td></td>
<td>• Older Adult Counselor</td>
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<tr>
<td></td>
<td></td>
<td>• Consume shuttle service</td>
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<tr>
<td>29</td>
<td>Peter Cordova</td>
<td>• Transportation is an issue for my family. Please recognize my family.</td>
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<td>Transportation is needed for my family. Family member is going deaf and has eyesight 4.1 and 4.0 for eyesight. Documents show this.</td>
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<tr>
<td>30</td>
<td>Hiram “Jack” Feldman</td>
<td>• More peer counselors</td>
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<td></td>
<td></td>
<td>• Increase the wellness nurse</td>
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<td></td>
<td></td>
<td>• Support the whole health model</td>
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<td></td>
<td></td>
<td>• Consumer run shuttle service, purchase vans</td>
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<td></td>
<td></td>
<td>• Three full time advocates</td>
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<td></td>
<td></td>
<td>• Support for ongoing leadership training</td>
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<tr>
<td></td>
<td></td>
<td>• Older adult peer support program</td>
</tr>
<tr>
<td>31</td>
<td>Wayne Fens</td>
<td>• I think mental health services have helped me in my wellness and recovery.</td>
</tr>
<tr>
<td>32</td>
<td>Stan Baraghin</td>
<td>• Transportation / mini vans- 7 passengers</td>
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<td></td>
<td></td>
<td>• Paid peer counselor</td>
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<td></td>
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<td>• Health &amp; Nutrition assistance</td>
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<td></td>
<td></td>
<td>• Transpiration will help consumer stay later at the centers</td>
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<tr>
<td>33</td>
<td>Ranier Butiong</td>
<td>• I would like to see the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Consumer run shuttle services- this will certainly help consumers get to and from MHCC. It will help me the most because I live away from MHCC.</td>
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<td></td>
<td>2. Housing Advocate- Independent Living- I definitely need help trying to get my own housing and independent living. I need to get out of my board and care living situation.</td>
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<tr>
<td>34</td>
<td>Dale W. Hendrickson</td>
<td>• What to say on an interview by themselves, it not just an application that you fill out about yourself.</td>
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<tr>
<td>35</td>
<td>Julie Driscoll</td>
<td>• Social services</td>
</tr>
<tr>
<td>36</td>
<td>Dale Hendrickson</td>
<td>• How to write out an application for a job interview for some of the client that don't know anything about it</td>
</tr>
</tbody>
</table>
| 37 | Steven L. Judkins | Public Comment:  
- I would add. There is a need for transportation services. Also, educational services. Such as education for independent living. As well in job training services. |
| 38 | Daniel Gibson | Public Comment:  
- We need a van for consumer, to pick up and drop off at appointments  
- Full time nurse  
- 3 full time advocates  
- Funds for the leadership program |
| 39 | Yvette Elaine Anderson | Public Comment:  
- We need help for the deaf and blind  
- New board and care  
They are treating them wrong.  
Disability threatening ;ex “If you do this again you going to the hospital”  
When all they need are resources. The communication between one another is mediocre.  
Also need new board and care directors |
| 40 | Sherry Bradley | Public Comment:  
- The new format, and content of the 2012-13 Annual MHSA Plan is very user friendly, and not overwhelming. My hats are off to the staff that created the content for this Annual MHSA Plan. Thanks to all of you for the good work |
| 41 | Michaela Mougenkoff | Public Comment:  
- Mary you deserve so much credit for identifying the need and designing these very critical services, these will so benefit our consumers, thanks |
| 42 | Jan Cobaleda-Kegler | Public Comment:  
This is a good plan. It addresses needs and gaps in our system and provides a reasonable array of services to meet those needs. Many thanks to the members of CPAW for hanging in there and taking the time to look at the system as a whole and design helpful sustainable solutions.  
Outstanding is the Capital Facilities Plan to build the Assessment and Recovery Center, a long-awaited milestone in our county! It will help so many families and consumers, of all ages.  
A few other items that are especially noteworthy:  
-the redesign of Children’s Full Service Partnership program to include evidence-based programs for youth across the county that will include adequate supervision of these EVPs  
-expanding services to very young children  
-support to families using our psycyhiatric emergency services  
-an independent living skills program for youth who are not in the foster care system.  
These are all good ideas that leave me feeling hopeful for the future of our system of care |
| 43 | Peggy Harris | Public Comment:  
I would like to see MHSA funds used for public anti stigma campaigns.  
TRANSPORTATION vehicles for consumer. Most importantly independent affordable |
<table>
<thead>
<tr>
<th></th>
<th>Housing in Contra Costa County.</th>
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| 44 | Tim Richardson | Public Comment: I would like to express that there are needs within the Mental Health services that are crucial in providing for individuals in our communities. These are just a few of these that I am seeing as absolutely necessary:  
- A much more affordable and available public transportation system. Individual’s agency shuttle would greatly relieve this situation.  
- Housing is an ongoing need that must be considered as a top priority in budget needs  
- Continue and increase available funds for fitness + nutrition training programs. This type of service makes a definitive difference in the life expectancy + quality of life in the life of mental health clients and needs to be supported and strengthened for the people in our communities. |
| 45 | Stephen Mark | Public Comment: Consumers in Contra Costa County, who do not live near public transit stops, need to have transportation to all of the various mental health services for consumers. Many consumers spend most or all of their time wandering in the vicinity of their board and care residences and cannot afford to pay transit fare every day. With more vans and drivers more people could receive services that might lead them toward actualizing their life goals. It can also be another source of employment for consumers as the drivers. There is a need for advocates who can assist and mediate for consumers with their discrepancies with board and care managers, room and board managers, conservators and various service providers. And speaking of room and boards there is a crying need for housing for consumers in this county.  
Most WRAP groups in Contra Costa County have only one facilitator per group. They need to be co-facilitated by two facilitators at each workshop. And there are plenty of places, like the clinics, that need to have WRAP workshops too. People in the Full Service Partnership need more peer support and life skills training than they are currently getting. |
| 46 | Jim Baba | Public Comment:  
- Transportation  
- Prescription |
| 47 | Clifford Clliott | Public Comment:  
- A large space to hold groups  
- More mental health vans to take trips  
- More Mental Health Events  
- Needs more help to go to Dr. |
| 48 | Mark Shadinger | Public Comment:  
- West County Recovery Center needs a bigger place and provide transportation I don’t want to have to pay for medication and to see the doctor |
| 49 | Mikal Vasin | Public Comment:  
- I would like more help in recovery, love to see others as well get help  
- More education on Mental Health issue like understanding how to treat us |
<p>| 50 | Wanda Thomas | Public Comment: I wish there was a place to go on the weekends, that’s when I am usually depressed. I wish we had a van to go out on more outings. Also, they only approved my therapist until November. I need her all the time! Jude Yven, I see her every 2 weeks unless I’m too depressed to go. Please be here to help us. Do not be like the governors. |</p>
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<th>Public Comment</th>
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<tr>
<td>51</td>
<td>Nate Suchai</td>
<td>Public Comment:</td>
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<tr>
<td></td>
<td></td>
<td>• Transportation</td>
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<td>• Housing</td>
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<td></td>
<td></td>
<td>• Advocates</td>
</tr>
<tr>
<td>52</td>
<td>Hector Castro</td>
<td>Public Comment: We need a bigger place, so that we can get space. We need</td>
</tr>
<tr>
<td></td>
<td></td>
<td>more community activities (the west county community center), so that we</td>
</tr>
<tr>
<td></td>
<td></td>
<td>can continue to do mental health activities. Have room to help new</td>
</tr>
<tr>
<td></td>
<td></td>
<td>consumers. We also need housing programs, for consumers, who need housing.</td>
</tr>
<tr>
<td>53</td>
<td>James Kizer</td>
<td>Public Comment: We need a bigger place to mingle more comfortable.</td>
</tr>
<tr>
<td>55</td>
<td>Charlotte Allen</td>
<td>Public Comment: We need a bigger building and parking lot MHCC-WCWRC more</td>
</tr>
<tr>
<td></td>
<td></td>
<td>housing and communication with Alameda county agency and transportation.</td>
</tr>
<tr>
<td>56</td>
<td>Andrea Agredan</td>
<td>Public Comment: I just started wellness and recovery, transportation would be</td>
</tr>
<tr>
<td></td>
<td></td>
<td>well.</td>
</tr>
<tr>
<td>57</td>
<td>Theresa Marie Repass</td>
<td>Public Comment:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• We need IHSS to be approved. Said she is not needy enough. She is!</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Building capacity is 14. Have 20 people here</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More groups are needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Need more transportation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Housing needs to be more available</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More mental health centers around our county</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• MHCC &amp; WCWRC are needy of bigger space</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Internet access</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Door to door transportation for mental health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More activities for mental programs</td>
</tr>
<tr>
<td>58</td>
<td>Monty Shelton</td>
<td>Public Comment:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More social skills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More transportation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Big rooms and space</td>
</tr>
<tr>
<td>59</td>
<td>Tinsley</td>
<td>Public Comment:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The Community center needs more advising</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• We would like more housing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More transportation</td>
</tr>
<tr>
<td>60</td>
<td>Vicki Lynn Legaux</td>
<td>Public Comment:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• I have (neuropathy) I don’t understand why I was denied IHSS. Due to my</td>
</tr>
<tr>
<td></td>
<td></td>
<td>health (fibromyalasis). Sensitive to light color, sound tough and taste. Due</td>
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<tr>
<td></td>
<td></td>
<td>to my neuropathy at times I do not feel my arms or legs, I fall a lot at</td>
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<tr>
<td></td>
<td></td>
<td>times, and I can’t even hold or lift items. I have chronic pain; chronic</td>
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<tr>
<td></td>
<td></td>
<td>fatigue is hard for my daily living. Even my hygiene and to cook for myself.</td>
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<tr>
<td></td>
<td></td>
<td>At time I burn things. I am hard of hearing have to wear hearing aids; I feel</td>
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<tr>
<td></td>
<td></td>
<td>left out and left behind at times. MHCC-WCWRC- We need more space at the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>mental center. I have walker, wheel chair, hearing aids and glasses.</td>
</tr>
<tr>
<td>61</td>
<td>Kathleen Forsythe</td>
<td>Public Comment:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• We need bigger building</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• We need transportation</td>
</tr>
</tbody>
</table>
| 62 | Peter Hodges | Public Comment:  
We have plenty of reason to thank (West County—MHCC). The program and groups offered weekly have enabled me to get back on my feet and start looking for a job. In Richmond, CA, the West County office, part of MHCC. (Mental Health consumer concerns) is not large enough to fit additional and the current number of members. I Peter would like to have a large size boiling still located in the city of Richmond. The staff and members would appreciate our concerns to be considered. Also, please consider more housing available for independent living. |
| 63 | Jesse Hart | Public Comment:  
I want permanent affordable housing in Richmond for people with a mental health diagnosis because there is a serious lack of housing for low income consumers. I want regular psychiatrist at the county clinics, because I switch psychiatrist too often. I also don’t have access to a therapist at any clinic and want that to change. I want the Mental Health consumers on the West County to have a large site because it is very cramped for the amount of people that go. I want transportation available for appointments here is none warranty. |
| 64 | Monty Shelton | Public Comment:  
Through MHCC I want to be able to reach my goal and advance into learning more by learning social skills through more activities and opportunities. Hoping to get to these places with transportation, with lots of more friends and people, with more space and big rooms. |
| 65 | Kevin Burns | Public Comment:  
Creating a part time jobs program would be wonderful. It would give consumers a boost in self-esteem. Some extra cash, and the opportunity to meet new people, take on some responsibility. |
| 66 | Carolyn Moore | Public Comment:  
There is an increasing need for more MH programs in West County due to the growing number of MH participants. The West County facility needs more space in order to serve a longer capacity. Each facility would benefit greatly from having a van to assist members with transportation while increasing their social skills and interactive skills. All staff, including part time workers need specialized training. There needs to be more social interactions between agencies. Members should be acknowledged and celebrated for their accomplishments. There should be more vouchers made available for MH members receiving SSI. |
| 67 | Artis Swozya | Public Comment:  
They need more transportation, more Doctor help and help with education. |
| 68 | Frederick Calapini | Public Comment:  
- We need more art therapy  
- Larger facilities  
- We need more programs  
- We need our van |
| 69 | Andrew Dyes | Public Comment:  
People in locked facilities should be allowed more free times. Or more trips, like baseball, football, tennis, track, softball games. More control over prescribed medications. We want to know what we are taking. |
| 70 | Carolyne Moore | Public Comment:  
The members and staff would benefit greatly from a larger facility that would allow for
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| 71 | Nayyirah Sahib | Public Comment:  
- There should be some type of system in place for those individuals who were working consistently and were abruptly fired should be a way to bring them back into recovery.  
- Things they need (art, crafts, better cable stations, better music (stereo system).  
- I have housing but there are many of my peers who do not have housing. |
| 72 | Renee Owens | Public Comment:  
MHCC-West County Wellness & Recovery Center is too small. It has a capacity of 14 persons. This center services up to 25 persons a day. We need a bigger space so that continue to service our community. |
| 73 | Renee Owens | Public Comment:  
I think that there should be a transportation system. In Contra Costa County there are many individuals that need to get to jobs, training, doctors, and recovery centers. Many consumers cannot make it to appointment, programs, etc., due to transportation. There should be more peer ran recovery centers to service the needs of all MH consumers. MHCC need a van for each of the centers, because a part of wellness is adventuring out, fresh air, site seeing,. On a weekly basis. There should be more places where consumers can get used clothing, jobs, and training. We need more recreations that bring us all closer (picnic, night movies, skating days and dinners) |
| 74 | Mary Long | Public Comment:  
I would like to make the suggestion on that forms posted to site should be “writable”- Whether an acrobat form or word template as some folks may not have the ability to scan and email their written comments, or some may only have access to a fax machine.  
There is a huge need for either better public transportation schedules/connections/holiday availability or some type of consumer shuttle service to pick up and drop off at centralized locations (if not from their home). For instance, many folks without access to a car or carpool would be challenged to get to this meeting at this time 5:45pm)  
County connections routes/schedules vary from 30/60/90 minutes and most stop running after 6:30pm/7:30pm. If you have multiple connections it can be a disaster. Another important need for consumers is access to more comprehensive dental care; some have serious dental needs that affect not only whole body health but self-esteem and employment. Housing & out of county placements: accessibility for consumers and family members as well as expense. Need for more consumers/ patients’ rights advocacy. |
| 75 | Sandra Wright | Public Comment:  
You need to be involved and listen to your people. Like us. Get your head out of the
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<thead>
<tr>
<th></th>
<th>Name</th>
<th>Public Comment:</th>
</tr>
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<tbody>
<tr>
<td>76</td>
<td>Timohy Royster</td>
<td>Public Comment: Enjoy the program available. There is a lot to learn.</td>
</tr>
<tr>
<td>77</td>
<td>Steve Blum</td>
<td>Since November of 2011 have been working on implementing the Libby Madelyn Collins Trauma Recovery Project. The project is the result of a prop 63 proposal initiated by line staff at Central County Adult Mental Health. So far we have completed the first group, and are working with numerous individual clients. In July we will start the second and third groups with a Spanish language group scheduled to begin in late summer or early fall. Additionally we have provided training on trauma related issues within the SPIRIT program, and a training to assist clinicians in working with trauma issues among the SMI population throughout the country is being planned for August 2012. Since we have begun working with clients both individually and in group work there have only been two 5150s (one consumer) and no criminal justice contacts and no evictions. Many of the clients are now either working (paid and or volunteer work), in school, graduating from SPIRIT or hoping to be accepted into SPIRIT next year.</td>
</tr>
<tr>
<td>78</td>
<td>Ralph Hoffman</td>
<td>Public Comment: We need to reverse the discrimination against Mental Health Commission that has occurred in the last 4 years!</td>
</tr>
<tr>
<td>79</td>
<td>Stan Baraghin</td>
<td>Public Comment: I think the no one issue is transportation for consumers mental health consumer concerns, INC Community wellness &amp; Recovery Center needs their own transportation and second the Dental Care.</td>
</tr>
<tr>
<td>80</td>
<td>Marvin Edwards</td>
<td>Public Comment: More money for leadership academy More peer to peer program Transportation for consumer</td>
</tr>
<tr>
<td>81</td>
<td>Dawn Elizondo</td>
<td>Public Comment: Transportation Housing</td>
</tr>
<tr>
<td>82</td>
<td>Kenneth Melbin</td>
<td>Public Comment: Housing</td>
</tr>
<tr>
<td>83</td>
<td>John D. Allen</td>
<td>Public Comment: 3 MHSA Projects at Central Go MH Adult</td>
</tr>
<tr>
<td>84</td>
<td>Robyn Gatshall</td>
<td>Public Comment: Services need for funds for mental health consumer concerns consumers: Dental, Transportation, Housing, more peer to peer run programs, more peer support staff, continuous the leadership Academy, funding for more WRAP training for Wrap certified staff.</td>
</tr>
<tr>
<td>85</td>
<td>Jack F</td>
<td>Public Comment: We need transportation More peer to peer support Cognitive therapy</td>
</tr>
<tr>
<td>86</td>
<td>Anthony Brewer</td>
<td>Public Comment: We need housing We need transportation We need the governor to balance the budget</td>
</tr>
<tr>
<td>87</td>
<td>Dean Spencer</td>
<td>Public Comment: I want to share my feelings regarding housing, transportation, the lack of consumer</td>
</tr>
<tr>
<td></td>
<td>Public Comment</td>
<td>Mental Health Commission - Recommendation</td>
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<td>--------------------------------------------</td>
</tr>
<tr>
<td>88</td>
<td>Ralph Hoffman</td>
<td>After hearing comments at the June 14th, 2012 Public Hearing on the MHSA 2012-2013 Draft Plan hosted by the Contra Costa County Mental Health Commission, a motion was made by Peggy Kennedy and seconded by Teresa Pasquini for the Mental Health Commission to make the following recommendations to the County Mental Health Administration (MHA) and to the Board of Supervisors (BOS):</td>
</tr>
<tr>
<td>89</td>
<td>Patsy Taylor</td>
<td>1. Provide funding for low cost or free transportation services for consumers as well as for seniors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Provide funding for housing</td>
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<td></td>
<td>3. Provide funding for peer-run programs</td>
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<td></td>
<td>4. Provide funding for trauma services, including PTSD to prepare for returning veterans</td>
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<td>5. Provide funding for peer advocacy for mental, physical and vocational needs</td>
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<td>6. Provide funding for training for the staff, as well as for the supervisors to support the transference of learning</td>
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<td>7. Provide funding for the expansion of services for older adults</td>
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<td>8. Provide funding for effective evaluative measuring tools</td>
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<td>By a unanimous vote of 7-0, the motion was approved.</td>
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</table>
Contra Costa County Response to Public Comments and Mental Health Commission Comments and Recommendations

Stakeholder participation during the Annual Update process, including the MHC Public Hearing, was outstanding. Strong consumer participation was evident throughout the process with over 80 public comments received. The MHC Public Hearing was attended by many consumers, community members and Commissioners each having an opportunity to provide input into the Annual Plan Update.

Due to the large number of public comments, the comments were grouped into thematic areas allowing for one general response to cover many similar comments.

Transportation:

There was an overwhelming response voicing the need for better transportation in Contra Costa County. In October 2011, Stakeholders formed a Transportation Committee to analyze the barriers to transportation in the community and explore potential solutions. Among many other items, the Committee considered the benefit of additional bus busses, implementation of a shuttle service and the inherent benefit of ensuring transportation support and services are driven by consumer input and involvement.

As part of the MHSA Increased Allocation prioritization process, Stakeholders supported the idea of considering MHSA Innovation funding for transportation support programs. Mental Health Administration supports moving forward in developing solutions to some of the transportation problems in our system. It’s important to coordinate with other community partners to ensure access to services and share ideas on creating solutions to this challenge. This may involve several levels of response from accessing bus vouchers to advocacy for the clients we serve. Mental Health Administration will be soliciting innovative ideas through a Request for Proposal (RFP) process.

Employment:

Increasing opportunities for employment was a top concern expressed during the Public Comment period. For many years, the Department of Rehabilitation for Contra Costa County has supported mental health consumers in obtaining employment and they continue to be a valued resource to the mental health community. Aside from that, other programs are being considered to expand the employment opportunities available for consumers. Recently, an Innovation program was approved to being to work with employers in the community to build relationships and support for successful employment opportunities for those we serve. Additionally, through the increased MHSA allocation, Stakeholders and Mental Health Administration supported using Innovation funds to consider employment programs to create job opportunities and supports for consumers.

Housing:
The need for additional housing options and supports is an ever present problem as was expressed during the public comment period. As part of the increased allocation prioritization process, CPAW and the MHC agreed to allocate 30 percent of all new MHSA CSS revenue to housing. The additional housing dollars available through the increased allocation will be planned for by way of a community input process. Stakeholders supported the development of the Transitional Age Youth (TAY) Transitional Residential Program which will provide additional housing opportunities for those age 18 to 25 years.

Lastly, there are additional housing projects underway that will increase the supply of housing options for mental health consumers. There are independent, supported housing programs being developed in West County and Central County for individuals and families, Older Adult apartment units in East County and a shared housing complex in Central County. Mental Health Administration plans to continue developing additional housing options and supports for successful independent living.

**Physical Health:**

The MHSA Increased Allocation plan includes funding for two behaviorists within primary care. It is with hope that this integration pilot will invite more opportunities for coordination of care for mental health and primary health clients. Overall the goal is to create a system which is responsive to the mental health and physical health needs of the people we serve.

The need for dental care for mental health clients was a concern raised by both Mental Health Commissioners as well as the larger Stakeholder group. It is recognized that dental benefits are no longer covered for Medi-Cal beneficiaries creating barriers to receiving proper dental care which can impact the physical health, mental health and overall well-being of consumers. Within the context of MHSA there are funds available for dental care for those who are enrolled in a Full Service Partnership program. Within the larger system of care, case managers and money managers have made a concerted effort to encourage clients to participate low-cost dental insurance programs.

There were requests for additional medical staff at the Wellness and Recovery Centers in each region of the County. Mental Health Administration is working to ensure existing resources are redirected to provide support to consumer’s at all three regions of the County.

**Medication Support:**

Currently, the Mental Health Plan spends approximately $1.4 million annually to provide medication to clients who are uninsured or for supplemental or gap coverage for those with an urgent medication need. Additionally, the Financial Counseling Unit has worked to enroll clients in low-cost prescription programs and is available to help access those resources.
Evidence-based Practices:

The Mental Health Commission highlighted the importance of training mental health staff to meet the evolving standard of treatment through evidence-based practices. Training and supervision to ensure adherence to model fidelity is an integral part of the process. Currently, there are several evidence-based programs implemented throughout the County including: Wraparound, Cognitive Behavioral Therapy (CBT) for Depression, Trauma Focused CBT, Dialectical Behavioral Therapy (DBT), Cognitive Restructuring Training, IMPACT for Older Adults with Depression, Assertive Community Treatment (ACT), Triple P Parenting and others.

The Annual Plan Update includes several training initiatives which will enhance our current system of care as well as that of community based organizations. The training initiatives include strategies for treatment of co-occurring disorders and increasing the available service options for children zero to five years and their families. In addition, three full time staff positions will be created to support ongoing model fidelity in every region of the County.

Peer Advocacy:

The Stakeholder group and MHC recognized the importance of peer advocates in the system of care. Contra Costa County was an early implementer and is a strong promoter of peer support at all levels of care. The County currently contracts with a community based organization to provide advocacy in all regions of Contra Costa County. Currently many of the Community Support Workers provide transportation and other support services to consumers.

In order to meet both the need for additional peer supports and transportation, three Community Support Worker positions will be created to focus on transportation support for consumers. These three positions will focus on teaching consumers how to navigate existing transportation systems and provide additional transportation support. In turn this will relieve time for existing community support workers to provide more peer-support to promote recovery and wellness. The addition of the three CSW’s is the only substantive change made to the Annual Plan Update after the Community Stakeholder and Public Hearing Processes.
Mental Health Services Act (MHSA)
Fiscal Year 2012-2013

Presented to Mental Health Commission for
Public Hearing – June 14, 2012
Summary of What's Included in MHSA FY 12/13 Annual Plan

- Renewal/Approval of Existing Programs and funding expenditures for:
  - 6 Community Services and Supports (CSS) Programs
  - 13 Workforce Education and Training (WET) Programs
  - 10 Prevention and Early Intervention Programs
  - 2 Innovation Programs
  - 1 New Innovation Program
  - New Training, Technical Assistance and Capacity Building Funds Request

Prevention and Early Intervention (PEI)

Four Main PEI Initiatives

- Fostering Resilience in Children and Families Initiative
- Fostering Resilience in Older Adults Initiative
- Fostering Resilience in Youth Initiative
- Fostering Resilience in Adults Initiative
Four Main PEI Initiatives

- Fostering Resilience in Communities Initiative
  - Building Connections in Underserved Cultural Communities
  - Coping with Trauma Related to Community Violence
  - Stigma Reduction and Mental Health Awareness
  - Suicide Prevention

- Fostering Resilience in Older Adults Initiative
  - Supporting Older Adults

Four Main PEI Initiatives

- Fostering Resilience in Children and Families Initiative
  - Parenting Education and Support
  - Families Experiencing the Juvenile Justice System
  - Support for Families Experiencing Mental Illness

- Fostering Resilience in Youth/Young Adults Initiative
  - Youth Development
  - Intensive Early Psychosis Intervention

Fostering Resilience in Communities Initiative

1. Building Connections in Underserved Cultural Communities
   Serving:
   - Native Americans
   - LGBTQ
   - Latinos
   - African Americans
   - Afghans
   - Russians
   - Bosnians
   - Iranians
   - Asian/Pacific Islander

Fostering Resilience in Communities Initiative

- Coping with Trauma Related to Community Violence
  - Trauma Response and Resilience System
  - Structured Community and Crisis Response
Fostering Resilience in Communities Initiative

• Stigma Reduction and Mental Health Awareness
  o Social Inclusion Committee
  o Wellness Recovery Education for Acceptance, Choice and Hope (WREACH)
  o Recovery, Education and Outreach
    * Reality Recovery DVD Education Program
    * Behavioral Health Education Workshops and Groups
    * Monthly Writers’ Group
  o Client Involvement in MHSA Planning Processes and Advisory Committees and Commissions
  o County Peer Provider Employees

Fostering Resilience in Communities Initiative

• Suicide Prevention
  o Draft Suicide Prevention Plan for Contra Costa County
  o Henry Ford Health System Suicide Reduction Model Work Group
  o Pilot Program for follow up phone calls and individual and group support for those at risk of suicide.
  o Training in best practices on suicide prevention.

Fostering Resilience in Older Adults Initiative

• Supporting Older Adults
  o Senior Peer Counseling: expansion to reach Latino and Asian Older Adults
  o Community Based Organizations reaching isolated older adults in public housing and in their homes

Fostering Resilience in Children and Families Initiative

• Parenting Education and Support
  o 5 Community based organizations funded to provide evidence based or promising practice parenting programs throughout Contra Costa County both in English and Spanish
  o Training in Triple P Parenting: evidence based parenting program for community based partners and county staff in several languages to build capacity throughout the county
  o Collaboration between First 5 of Contra Costa and MHSA PEI Programs to provide training and classes to parents of young children who are at high risk
  o Partnering with agencies such as GRIP, Shelter Inc and Juvenile Hall to bring Triple P Parenting to clients which are in most need
<table>
<thead>
<tr>
<th>Initiative</th>
<th>Fostering Resilience in Children and Families Initiative</th>
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<tbody>
<tr>
<td><strong>Families Experiencing the Juvenile Justice System</strong></td>
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<tr>
<td>- Developed a support system for youth and their families to facilitate mental health assessment, discharge and linkages to community services to youth who are returning to their communities following incarceration.</td>
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<tr>
<td><strong>Support for Families Experiencing Mental Illness</strong></td>
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<td>- Support for the development of a Clubhouse Program</td>
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<td>- Recreational</td>
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<td>- Vocational</td>
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<tr>
<th>Initiative</th>
<th>Fostering Resilience in Youth/Young Adults Initiative</th>
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<tbody>
<tr>
<td><strong>Youth Development</strong></td>
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<tr>
<td>- Integrated Mental Health, AOD and Education Program</td>
<td></td>
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<tr>
<td>- In school mental health, and AOD supports and services</td>
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<tr>
<td>- After school program for continuation school youth with Mental Health AOD and vocational training</td>
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<tr>
<td>- Community youth development with Mental Health supports and services</td>
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<tr>
<td>- Interpersonal Violence Education</td>
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<tr>
<td><strong>Intensive Early Psychosis Intervention</strong></td>
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<tr>
<td>- Providing Community Education to identify those prodromal to the development of psychosis</td>
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<tr>
<td>- Psycho-education on the genetic basis of brain diseases and the effects of drugs and alcohol on the development of the disease</td>
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<td>- Multi Family Group</td>
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<td>- Low dose medication management</td>
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<tr>
<td>- Occupational and Educational Support</td>
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### PEI Funding Request

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
<th>Amount</th>
</tr>
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<tbody>
<tr>
<td>Prog 1</td>
<td>Building Connections in Underserved Cultural Communities</td>
<td>$1,245,960</td>
</tr>
<tr>
<td>Prog 2</td>
<td>Coping with Trauma Related to Community Violence</td>
<td>$523,693</td>
</tr>
<tr>
<td>Prog 3</td>
<td>Stigma Reduction and Mental Health Awareness</td>
<td>$209,365</td>
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</tbody>
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### PEI Funding Request, Cont'd

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prog 4</td>
<td>Suicide Prevention</td>
<td>$580,000</td>
</tr>
<tr>
<td>Prog 5</td>
<td>Supporting Older Adults</td>
<td>$453,200</td>
</tr>
<tr>
<td>Prog 6</td>
<td>Parenting Education and Support</td>
<td>$1,006,264</td>
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<tr>
<td>Prog 7</td>
<td>Support for Families Experiencing Juvenile Justice System</td>
<td>$1,016,521</td>
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### PEI Funding Request, Cont'd

<table>
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<th>Description</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Prog 8</td>
<td>Supporting Families Experiencing Mental Illness</td>
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<td>Prog 9</td>
<td>Youth Development</td>
<td>$815,514</td>
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<tr>
<td>Prog 10</td>
<td>Early Intervention for Psychosis</td>
<td>$1,576,175</td>
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### PEI Funding Request, Cont'd

<table>
<thead>
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<th>Program</th>
<th>Description</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Total</td>
<td>Subtotal for All 10 Programs</td>
<td>$7,889,132</td>
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<tr>
<td></td>
<td>Administrative &amp; Operating Cost</td>
<td>$658,960</td>
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<tr>
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<td>Total MHSA Funds Requested</td>
<td>$9,545,092</td>
</tr>
</tbody>
</table>
2012-2013 MHSA Annual Plan Innovation
Contra Costa County
June 14, 2012

INN51: Social Supports for Lesbian, Gay, Biexual, Transgender, Queer, Questioning, Intersex and Two-Spirit (LGBTQIIS) Youth

3 Year Work Plan Approved by MHSOAC 4/9/2012

2 Awards

- County
- EFP

Contract Awardees
- Equal Voice
- Rainbow Community Center (RCC)
- Peer Providers
- Contra Costa Developmental Dance Program
- St. Vincent de Paul
- Inner Heights Project
- RCC Case

Mount View Medical Group

INN58: Early Care Services

INNFT01: Promoting Wellness, Recovery and Self-Management through Peers

- Approval/Thank You Letter from MHSOAC in April 2011
- Due to HR challenges, implementation will occur FY 12/13

- Peer Providers will serve as trained wellness, recovery & chronic disease self-management coaches
- Determine if using Peer Wellness Coaches will:
  - Improve service coordination
  - Improve consumer satisfaction
  - Improve health outcomes

- Enhance medical health recovery/recovery
INN702: Interagency Perinatal Depression Treatment Program

- Planning with Partner Agencies has begun
- Due to HR Challenges implementation will occur FY 12/13

Purpose:
- Promote interagency collaboration between MH, Public Health (PH) & WIC
- Provide & integrate MH screening & intervention (for perinatal depression) in Central County WIC

Outcome Measures:
- Changes in depression scores
- Improved treatment outcomes
- Positive feedback from mothers and providers
- Service utilization
- Changes in perceptions about stigma related to accessing mental health care
- Awareness about mental health & services
- Progress towards achieving wellness/recovery goals

INN703: Libby Madelyn Collins Trauma Recovery Project

- 2 year project
- Implementation began in November 2011

Purpose:
- Pilot the use of a Trauma Recovery Group w/ a group of 12 women diagnosed w/ co-occurring PTSD
- Executing PEAR model (Integrated Services & Recovery Management)
- Educational group for mental health/trauma
- Development of program to identify & treat PTSD
- Engage community through trauma education
- Provide tools to assist in recovery
- 7 people graduated from the 1st group in spring of 2012

Outcome Measures:
- Knowledge about PTSD (clients & staff)
- Changes in group & one-on-one attendance
- Improvement in clinical assessments
- Cognitive & assessment scores
- "The Beck Depression Inventory" (PTSD Checklist, Post-Traumatic Cognition Inventory, PTSD Knowledge Test, Trauma History Questionnaire & Recovery Assessment Scale)
- Positive client feedback about the Trauma Recovery Project services
- Progress towards achieving client goals
- # of involuntary hospitalizations
- # of inpatient/treatment programs
- # of evictions
- Alcohol & substance abuse

INN94: Trauma Services for Sexually Exploited Youth (up to 25 years old)

- 2 year project
- 2 year project应在 FY 11/12

Purpose:
- Promote quality of service, including better access for sexually exploited youth
- Creation of drop-in centers for sexually exploited youth at locations of youth
- Outreach to youth
- Engage youth & parents of youth in the development of service plans as well as the implementation of services
- Knowledge of life skills among participating youth
- Improved health outcomes
- # of youth who recognize they can make healthy choices in their lives
- Positive feedback about services from parents & youth
- Positive feedback about services from parents & caregivers
- Changes in parenting behaviors related to the care of sexually exploited youth
- Length of stay among youth whose caregivers attended the caregiver training

Outcome Measures:
- # of referrals to program (s)
- # of youth utilizing service
- # of youth attending group therapy
- # of youth attending individual therapy
- # of youth attending family therapy
- # of youth attending care coordination services
- # of youth attending other services
- # of youth attending other services

Community Services and Supports
FY 10-11

MENTAL HEALTH COMMISSION MEETING
JUNE 14, 2012
Community Services & Supports (CSS)

- Program #1: Children's FSP
- Program #2: TAY FSP
- Program #3: Adult FSP
- Program #4: Older Adult Mental Health
- Program #5: Housing
- Program #6: Systems Development Strategies

Overall Goal
- Planning took into consideration the current programs in the Children's System of Care, the gaps in service and the opportunities for improvement and creativity.
- Work towards integration of services and remove the silos that FSP Programs tend to create.

3 major components:
1. County-wide Assessment Team
2. Personal Service Coordinators
3. Evidence-based Practices
   - Co-occurring
   - Juvenile Justice involvement

Child's FSP Planning

County-wide Assessment Team
- Teams of clinicians and family partners
- Complete initial assessments on all youth Level 3 and above
  - Provide treatment recommendations to the family
- CALOCUS
  - Participate in reauthorization of services
  - Help to facilitate movement through the system and ensure youth are receiving the appropriate level of care
PERSONAL SERVICE COORDINATORS (PSC)

- Shifted the paradigm of FSP
  - Program-based model to individual-based model
- Entry would occur through the county-wide assessment team.
  - Out of home placements, juvenile justice system, repeated presentations at FSPs, hospitalizations and those experiencing co-occurring disorders
- FSPs would receive additional supports such as 24/7 contact with their PSC, transportation support, flexible funds
- However, they would access the same treatment services as children/youth who are not FSPs

EVIDENCE-BASED PRACTICES

1. Multidimensional Family Therapy (MDFT)
   - Family-based outpatient or partial hospitalization program
   - Adolescents with co-occurring mental health and substance use issues
   - 12-16 week program, meeting 1-2 times per week
   - Treatment modules target the following 4 social interactions:
     - Social functioning with parents and peers
     - Parenting practices and level of adult functioning independent of their parenting role
     - Parent-child interactions in therapy sessions
     - Communication between family members and key social systems (school, child welfare, mental health, etc.)

EVIDENCE-BASED PRACTICES

1. Multisystemic Therapy (MST) for Juvenile Offenders
   - Fosters youth's social network
   - Empowers families to build a healthier environment through mobilizing existing resources
   - 16 week program, multiple therapist-family contacts each week
   - Three primary goals of treatment:
     - Decrease rates of antisocial behavioral and other clinical problems
     - Improve functioning (family relations, school performance, peer interactions)
     - Reduce the use of out-of-home placements such as incarceration, residential treatment and hospitalisation

Program 2: TAY FSP

- Target enrollment: 90 FSPs
- Served 88 FSPs during the FY
  - Average concurrent enrollment is 60 FSPs
- 56% identify as African American
- Diagnosis:
  - Psychotic Disorders (50%)
  - Mood Disorders (30%)
  - Anxiety Disorders (20%)
Program Participants: Post-Enrollment

- Housing
  - 27% increase in those who live in an "apartment alone" (n=7 vs. n=26)
  - 42% decrease in those who are in emergency shelters

- CSU Visits/Hospitalizations
  - # of people hospitalized
  - # of people with PFS visits
  - Total # of PFS visits

- Meaningful Activities
  - 75% of TAV enrolled for at least 6 months were involved in one of the following activities: Employment; School; Volunteerism; Vocational Training
  - 32% reported being employed

Adult FSP

- Concurrent target enrollment is 185 FSPs
  - Served 230 FSPs during the FY

- Majority of participants are African-American (38%), followed by Caucasian (34%) and Latino (17%).

- Profile of Diagnoses:
  - Psychotic Disorders (32%)
  - Mood Disorders (46%)
  - Anxiety Disorders or other disorders (21%)

Program Participants: At Enrollment

- Almost all of the participants experienced one or more of the following at the time of enrollment:
  - Incarceration (37%)
  - Hospitalizations (50%+)
  - Homelessness (47%)

- LOCUS Score of 22 $\rightarrow$ Level 4 Placement
  - "Medically Monitored Non-Residential Service"
  - Over 650 LOCUS Assessments
  - Average reduction in score by 2 points after 4 assessments

Program Participants: Post-Enrollment

- PFS Visits
  - # of people with PFS visits
  - Total # of PFS visits

- Hospitalizations
  - # of people hospitalized
  - # of hospitalizations
  - # of days hospitalized

- Employment
  - Approximately 52 FSPs reported being employed on the latest Key Event Tracking Form
  - This includes the following employment types: competitive, supported, transitional and volunteer work
  - Approximately half of the Adult FSPs state that employment is a recovery goal
Wellness & Recovery Centers

- On average, 66 unduplicated consumers attended the WRC in each region
- MHCC provides peer support services to Adult FSPs
- Staff participated in a series of in-service trainings conducted by CASRA and Recovery Innovations
- Working on expanding the TLC Program with the West and Central FSP locations
- Provided over 200 hours of Physical Education and Nutrition classes at the WRCs

Older Adult: Intensive Care Management

- 159 unduplicated participants (74% female)
- Majority are Caucasian (55%) followed by African-American (19%) and Latino (13%).
- Psychiatric Emergency Services (PES)
  - # of people with PES visits
  - Total # of PES visits
  - # of hospitalizations

IMPACT

- 89 unduplicated participants
  - 76% PHQ-9 Assessments have been completed
  - 36% improvement in PHQ-9 scores
  - Average of 6 sessions
  - “Mild” Depression

- Areas of greatest concern (as reported on the PHQ-9):
  - Energy
  - Depressed Mood
  - Sleep
Program 5: Housing

- 168 FSPs received a MHSA Housing Subsidy
  - Permanent Housing – 88 FSPs
  - Transitional Housing – 33 FSPs
  - Board and Care – 47 FSPs

Program 6: Systems Development Strategies

- Strategy #1: Office for Consumer Empowerment (OCE)
- Strategy #2: Plan for Future Systems Development
- Strategy #3: Peer Benefits Advocates
- Strategy #4: Expansion of the Family Partner Program
- Strategy #5: Wellness Nurses
- Strategy #6: Transformation Training

Program 6: Systems Development Strategies

- New SDS Categories
  - Direct providers for treatment and case management
  - Peer support and wellness centers
  - Improving the County mental health service delivery system for all clients and their families
- All existing SDS strategies will be incorporated into the new structure

CSS Funding Requested

<table>
<thead>
<tr>
<th>CSS Program Component</th>
<th>Funding Amount</th>
</tr>
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<tbody>
<tr>
<td>Children's FSP</td>
<td>$2,138,594</td>
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<tr>
<td>TAY FSP</td>
<td>$1,599,582</td>
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<tr>
<td>Adult FSP</td>
<td>$4,168,225</td>
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<tr>
<td>Other Adult</td>
<td>$2,749,449</td>
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<tr>
<td>Housing</td>
<td>$4,497,443</td>
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<tr>
<td>Systems Development Strategies</td>
<td>$5,437,411</td>
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<tr>
<td>TOTAL REQUESTED FOR CSS</td>
<td>$20,990,904</td>
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</table>
Mental Health Services Act - Workforce Education and Training (WET) Component

Funding Categories:
- Workforce Staffing Support
- Training and Technical Assistance
- Mental Health Career Pathways Programs
- Residency and Internship Programs
- Financial Incentive Programs

There are Thirteen (13) Action Items in the WET plan that fall under the above funding categories.

WET Strategies

INCREASE MENTAL HEALTH CAREER DEVELOPMENT OPPORTUNITIES
Psychosocial Rehabilitation Certificate (PSR)

Develop a Mental Health Certificate Program that would support the need for well-trained Staff (including Consumers & Family Members) who may not have resources to complete a bachelors or graduate degree.

Psichosocial Rehabilitation Certificate (PSR)

- Partnership with Contra Costa College (CCC) in West County
- Curriculum from California Association of Social Rehabilitation Agencies (CASRA)
- Classes began Fall 2010
- The Certificate of Specialization in Psychosocial Rehabilitation program is made up of 12 course units
- Contract was renewed to continue program in FY 2011-2012

eLearning System

- In FY 2011-12, expansion of Essential Learning users to include all Behavioral Health Staff (Mental Health, AIDS, and Homeless Program)
- New courses added to library, now 500 courses available
- Continuing Education Units for most courses
- Courses available include: Clinical skills, Cultural Competence trainings, Leadership trainings, HIPPA, Law & Ethics, Computer trainings.

WET OBJECTIVE

PROMOTE DISTANT LEARNING TECHNIQUES
**WET OBJECTIVE:**

**CREATE STIPEND PROGRAMS**

---

**Internship Programs**

- **Graduate Level Internship Program**
  - CCMH offers internship to 20-30 MFT, Psychologists and Social Work interns annual.
  - Emphasis on recruiting multiracial/multilingual interns (pay differential available)

- **Nursing Internship Program**
  - CCMH offers internship to 6-9 nursing interns annual

- **Community Based Organization (CBO) Internship Program**
  - CCMH offers opportunities to CBOs to increase workforce capacity by offering funds to hire interns.

---

**Internship Outcomes: FY 11/12**

- 22 Graduate Level Interns for FY 11/12
  - Placements include Central Children’s Mental Health, Contra Costa Regional Medical Centers, CONRAD West Adult Mental Health, Juvenile Hall

- 2 Nurse Practitioner Interns for FY 11/12

- Implementation of the CBO internship program
  - In FY 11/12, five (5) Community Based Organizations (CBOs) were awarded funds to hire interns

---

**WET OBJECTIVE:**

**EXPAND POSTSECONDARY EDUCATION CAPACITY**
Development MH Curriculum for High School Academies

- In May 2011, CCMH was awarded a grant by the Office of Statewide Planning and Development (OSHPD) to develop a Health Careers Training Program for the duration of the grant contract (through Fall 2012).
- The goal of this project is to provide students in underserved communities an opportunity to learn about various mental health career options and also to reduce mental health stigma.
- Curriculum implemented in 3 high schools in all regions of the county. So far 102 students have participated in the program.
- In May 2012, CCMH was awarded an additional grant to continue the Health Career Training Program.

Service Provider Individualized Recovery Intensive Program (SPIRIT)

- SPIRIT is a 14-week consumer training program followed by a supervised internship.
- In CY 2011, twenty-seven (27) students graduated from the SPIRIT program.
- The outcomes of those employed are currently being developed.

NAMI Family to Family

- In FY 11/12, NAMI was awarded funds to provide a Family Psycho Education Program for Contra Costa County Spanish speaking families
- The program, De Familia A Familia, will help meet the underserved needs of the Spanish speaking community regarding family support for families who have severely mentally ill loved ones
LOAN REPAYMENT PROGRAMS

- Mental Health Loan Assumption Program (MHLAP)
  - State loan forgiveness program in order to retain qualified professionals working within the Public Mental Health System

- Healthcare Professional Shortage Area
  - Mental health professionals can apply for the Federal & State Loan Repayment Program
  - Current areas covered include parts of East and West County

- County Scholarship Program (WET Plan)
  - Designed to award staff that meet program criteria with funds to repay educational loans in exchange for 2 years of service obligation

TRAININGS & CONFERENCES

Trainings Offered to County Staff and Network Providers in FY 2011-2012, including:

- Law & Ethics for Providers
- Improving the Quality of Services and Support for LGBTQ Consumers
- Meeting the Mental Health Needs of African American Consumers
- Crisis Intervention Training for Law Enforcement
- Understanding the Consumers Role in Wellness & Recovery
- Vicarious Traumatization

Conferences:
- Recovery & Resiliency Conference
- Celebrating Aging (Older Adult Training)
Examples of Evidence-Based Training Programs in the County
- Trauma Focused Cognitive Behavioral Therapy
- Dialectical Behavior Therapy
- Child and Family Wraparound
- Triple P Parenting
- Motivational Interviewing

Trainings – FY 10/11 Outcome

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<tr>
<th>Training Type</th>
<th># Offered</th>
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<tbody>
<tr>
<td>Total Trainings Offered in FY 10-11</td>
<td>150</td>
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<tr>
<td>Cultural Competency Trainings</td>
<td>50</td>
</tr>
<tr>
<td>Trainings by Internal Experts</td>
<td>28</td>
</tr>
<tr>
<td>Online Trainings via Essential Learning</td>
<td>541</td>
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</table>

WET – Tools Used Measure Outcomes
- Training Lists
- Personnel Records & Reports
- Pre-and-Post Training Tests
- Intern Records
- Training Evaluations
- Quarterly Reports

FY 12/13
- NO CHANGES IN ANNUAL UPDATE -
Continue program planning and Implementation

Questions on WET:
CCMH.Training@mad.cccounty.us
### CSS Housing
**Total Available:** $197,847  
**Total Planned:** $150,000

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<th>Description</th>
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<th>Total Planned</th>
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<tr>
<td>Housing</td>
<td>Non-Indian rental to housing</td>
<td>$179,200</td>
<td>$150,000</td>
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<tr>
<td>Housing</td>
<td>Residential aspect of the IES Transitional Residential - $1,947</td>
<td>$179,200</td>
<td>$150,000</td>
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### PEI - Children
**Total Available:** $254,244  
**Total Planned:** $646,988

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<th>Component</th>
<th>Description</th>
<th>Total Available</th>
<th>Total Planned</th>
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</thead>
<tbody>
<tr>
<td>Children</td>
<td>Preventive, educational programs that encourage personal, social, and academic development and academic achievement through support and school programs</td>
<td>$254,244</td>
<td>$646,988</td>
</tr>
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### PEI - All Other Ages
**Total Available:** $244,273  
**Total Planned:** $350,000

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<th>Component</th>
<th>Description</th>
<th>Total Available</th>
<th>Total Planned</th>
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<tbody>
<tr>
<td>All Other</td>
<td>Additional support for core/behavioral health services</td>
<td>$237,000</td>
<td>$350,000</td>
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### Innovation
**Total Available:** $166,172  
**Total Planned:** $0

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<th>Component</th>
<th>Description</th>
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<th>Total Planned</th>
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<td>Innovation</td>
<td>Support core/behavioral health services</td>
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**WET**

Total Available: $0  
Total Planned: $0

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<tbody>
<tr>
<td>WET</td>
<td>$0</td>
<td>$0</td>
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</table>

**CSS Unspent Funds Request**

Total Available: $12,691,703  
Total Planned: $22,260,314

- Vehicles  
  - $338,000
- Infrastructure and Space  
  - $394,120
- Increased Allocation Strategies needing additional funding  
  - $1,278,327
- Additional Support Staff for Programming  
  - $270,067

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**MHSA Funding Summary - FY 2012-2013**

<table>
<thead>
<tr>
<th>County</th>
<th>Code</th>
<th>MHSA Funding</th>
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<td>CSS</td>
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<tr>
<td>9. Estimated FY 2012-13 Funding</td>
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<tr>
<td>1. Estimated Current Funds from Prior Years</td>
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<tr>
<td>2. Estimated New FY 2013 Funding</td>
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<td>3. Transfer in Prior FY</td>
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<td>4. Reserve Local Prudent Reserve Fr 2013</td>
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<tr>
<td>5. Estimated Available Funding Fr FY 2013</td>
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<tr>
<td>6. Estimated FY 2013 Expenditures</td>
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</tr>
<tr>
<td>7. Estimated FY 2014 Expenditures</td>
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**Prudent Reserve**

<table>
<thead>
<tr>
<th>Description</th>
<th>Estimated Local Prudent Reserve Balance</th>
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<tbody>
<tr>
<td>1. Estimated Local Prudent Reserve Balance Fr June 30, 2012</td>
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<tr>
<td>2. Contributions to Local Prudent Reserve Fr FY 2013</td>
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<tr>
<td>3. Distributions from Local Prudent Reserve Fr FY 2013</td>
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<tr>
<td>4. Estimated Local Prudent Reserve Balance Fr June 30, 2013</td>
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*For more information, visit the Code Section 1915(c)(3).*